Date of Hearing: July 15, 2025

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 306 (Becker) – As Amended April 28, 2025

**SENATE VOTE**: 37-0

**SUBJECT**: Health care coverage: prior authorizations.

**SUMMARY:** Prohibits a health plan or health insurer, if a health insurer or a health plan or an entity with which the plan contracts for prior authorization (PA) imposes PA on a covered health care service, and approved 90% or more of the requests for a covered service in the prior calendar year, from imposing PA or prior notification on that service for a period of one year. Requires a plan or insurer to list any covered service that is exempted from PA pursuant to this bill in a prominent location on its internet website by March 15 of each calendar year.
Specifically, **this bill**:

1) Prohibits a health plan or health insurer, if a health insurer or a health plan or an entity with which the plan contracts for prior authorization imposes prior authorization on a covered health care service, and approved 90% or more of the requests for a covered service in the prior calendar year, from imposing PA or prior notification on that service for a period of one year beginning April 1 of the current calendar year for in-network contracted providers.

2) Exempts a health plan from the prohibition for a covered health care service that was not subject to PA in the prior calendar year, including a service that was exempted from PA under this bill.

3) Requires a plan or insurer to list any covered service that is exempted from PA pursuant to this bill in a prominent location on its internet website by March 15 of each calendar year.

4) Requires a health plan and health insurer to also reflect the changes in PA requirements in all relevant health plan and health insurance contract documents issued to enrollees and insureds and in utilization management policies, as applicable.

5) Requires a health plan's and health insurer's approval rate to be calculated for each covered health care service that is subject to PA by dividing the total number of requests that were approved during the prior calendar year by the total number of PA decisions issued by the plan in the same period for that service.

6) Requires a health plan to publicly report the following information on its internet website by March 15 of each calendar year:

    a) A list of covered health care services that were subject to PA during the prior calendar year; and,

    b) The health plan's and health insurer's approval rate for each covered health care service identified and calculated above.

7) Requires a covered health care service that is exempted from PA under this bill to constitute a service authorized by the health plan or health insurer for purposes of a specified provision

of existing law that prohibits plans and insurers from rescinding or modifying after the provider renders the health care service in good faith and pursuant to an 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.

8) Defines a "covered health care service" to mean any health care item, product, procedure, treatment, or service covered by a health care service plan contract or health insurance policy.

9) Defines "PA" to mean:

   a) The process by which utilization review determines the medical necessity or medical appropriateness of otherwise covered health care services prior to, or concurrent with, the rendering of those health care services; and,

   b) A requirement by a health plan or health insurer that an enrollee or insured or health professional obtain approval from the health plan or health insurer before a health care service is provided, including preauthorization, precertification, and prior approval.

**EXISTING LAW**:

1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 and the California Department of Insurance (CDI) to regulate health insurance under the Insurance Code. [Health and Safety Code (HSC) § 1340, *et seq*., Insurance Code (INS) § 106, *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 (UR) or utilization management (UM) 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 under 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 to demonstrate that medical decisions are rendered by qualified medical providers, unhindered by fiscal and administrative management. [HSC § 1367]

4) Requires health plans and disability insurers and any contracted entity that performs UR or UM functions, prospectively, retrospectively, or concurrently, based on medical necessity requests to comply with specified requirements. [HSC § 1367.01 and INS § 10123.135]

5) Requires decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent with the provision of health care services to be made in a timely fashion that does not to exceed five business days from the health plan or health insurer's receipt of the information reasonably necessary and requested by the plan to make the determination. Requires, in cases where the review is retrospective, the decision to be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and be communicated to the provider in a manner that is consistent with current law. [HSC § 1367.01 and INS § 10123.135]

6) Requires decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services, to be made in a timely fashion appropriate for the nature of the enrollee or insured's condition, not to exceed 72 hours when an individual's condition is such that they face an imminent and serious threat to their health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. [HSC § 1367.01 and INS § 10123.135]

**FISCAL EFFECT**: According to the Senate Appropriations Committee:

1) DMHC estimates costs of approximately $741,000 in 2025-26, $2,333,000 in 2026-27, $1,722,000 in 2027-28, and $1,715,000 in 2028-29 and annually thereafter for state administration (Managed Care Fund).

2) CDI indicates no fiscal impact for state administration.

3) Unknown, ongoing cost pressures in the Medi-Cal program (General Fund and federal funds) to the extent prior authorization or other utilization review is prohibited and would lead to potentially greater utilization of services.

**COMMENTS**:

**1) PURPOSE OF THIS BILL**. According to the author, too often, California patients are denied critical care or forced to endure unnecessary pain due to excessive bureaucracy within the healthcare system. Insurance companies frequently use "PA" as a cost-control tool, but this often results in delays or denials of essential treatments for patients. This process also wastes valuable time for health care providers, who must spend time advocating for care instead of treating patients. By the time treatment is approved, patients' conditions may have deteriorated, making it harder to effectively address their health issues. This bill will bar insurance companies from harming California patients solely for the purpose of protecting their bottom line. The bill requires health plans to eliminate PA requirements for any service that is approved more than 90% of the time, striking a reasonable balance on access to high approval services while reducing administrative waste without compromising oversight.

**2) BACKGROUND**. UM and 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.

**a) Overall impact of PA**. 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.

**b) Cost impacts**. 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.

**c) Access to and utilization of care**. Across state-regulated commercial 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.

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

**e) Antiquated systems**. 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 like PA.

In January of 2024, the federal Centers for Medicare & Medicaid Services (CMS) released the CMS Interoperability and PA 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 PA 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, established 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.

**3) SUPPORT**. The California Medical Association (CMA), sponsor of this bill, states that by reducing the overall volume of PA requests, this bill will free up time and resources for health plans to focus more quickly on reviewing other PA requests, while ensuring that patients are treated in a timely manner. In a 2023 physician survey, the AMA found that, on average, physicians complete 43 PAs per week; spending 12 hours each working week on paperwork rather than treating patients. This time spent on inefficient and burdensome tasks comes at the expense of treating patients and eats away at time physicians could be spending with patients in the exam room, coordinating care for patients with chronic diseases and increasing access to care for new patients. Burdensome PA processes also contribute to more adverse effects on patient care outcomes, especially when they result in delays in treatment. According to the AMA survey, 87% of physicians said that PAs result in an overall higher

utilization of health care services as patients that are delayed or denied appropriate care through PA often resort to other or ineffective treatment, 94% said that the PA process always, often, or sometimes delays patients' accessing necessary care, 19% said PA resulted in a serious adverse event leading to a patient being hospitalized, 13% said PA resulted in a serious adverse event leading to a life-threatening event or requiring intervention to prevent permanent impairment or damage, and 7% said PA resulted in a serious adverse event leading to a patient's disability, permanent bodily damage, congenital anomaly, birth defect or death.

Inevitably, CMA argues, these patients return for more visits after that treatment fails, some resulting in emergency care. CMA argues that denials and delays in care that result when physicians and patients must go through an appeals process to ultimately get care result in real patient harm. Specifically, patients and physicians are burdened by PA requests for services that are approved at a high rate. In many cases these services are recurring or routine, yet still critical in providing timely care to patients. CMA concludes the overall volume of PA requests is drastically slowing down the delivery of care across our health care delivery system and this bill will directly address that issue.

Health Access California writes in support that care delayed is care denied. By eliminating prior authorization requests for services that are nearly universally approved, Health Access argues consumers will experience fewer harmful treatment delays.

4) **SUPPORT IF AMENDED**. The California Optometric Association (COA) writes requesting amendments to explicitly include "specialty health care service plans" and "specialty health insurers" to encompass vision services which are essential to the broader health care system. COA states these amendments will ensure that specialty health plans, including vision plans, are subject to the same PA reforms, thereby improving efficiency and reducing delays in access to vision care. COA concludes that increasing transparency and fairness in utilization management practices ensures that patients receive timely and appropriate care, regardless of whether they are covered under a full service or specialty plan.

5) **OPPOSE UNLESS AMENDED**. America's Physician Groups (APG) writes this bill needs clarification on whether the required 90% approval threshold must be calculated at the plan level or separately for each contracted risk-bearing organization (RBO) based solely on its own data, to strike "prior notification," and distinguish it from PA, to phase in the implementation or provide a statutory grace period to ensure an orderly and compliant rollout, and to delay the proposed implementation date. APG proposes a different approach than the service exemptions proposed by this bill and would leverage the existing data reporting infrastructure whereby RBOs report to plans detailed PA data on a frequent basis. Under APG's approach, a 0-5% denial guardrail would be established for RBOs, outliers who exceeded that threshold would be subject to audit, and existing Knox-Keene enforcement mechanisms would apply. DMHC would review PA performance as part of their existing three-year audit cycle of plans.

6) **OPPOSITION**. The California Association of Health Plans (CAHP) and Association of California Life and Health Insurance Companies (ACLHIC) oppose this bill, stating medical and utilization management tools, like PA, are key to promoting safe and effective care for all enrollees and insureds. To that end, health plans and insurers act as stewards of the premium dollar and therefore have an obligation to invest those dollars in proper and

effective care. In recognition of the need to streamline the process, many health plans and insurers are currently implementing their own enhanced PA programs to help ease the burden on providers and enrollees. CAHP and ACLHIC argue this bill is missing many of the necessary elements that are critical to ensuring that plans/insurers can uphold the "right care, right place, right time" approach on behalf of its enrollees/insureds. CAHP and ACLHIC state they believe this bill is not ready to advance in its current form and would recommend it be made into a 2-year bill, so that a stakeholder process can be convened to allow all interested parties the opportunity to collectively work toward a solution that advances our shared goal of improving patient care.

**7) RELATED LEGISLATION**.

**a)** AB 384 (Connolly) would have prohibited a health plan, health insurer, or Medi-Cal from requiring PA for an individual to be admitted to medically necessary 24-hour inpatient settings for mental health and substance use disorders (SUDs) and for any medically necessary health care services provided to an individual while admitted for that care. AB 384 was held on the Assembly Appropriations Committee suspense file.

**b)** AB 510 (Addis) would have required, upon request, an appeal or grievance regarding a decision by a health plan or health insurer delaying, denying, or modifying a health care service based in whole or in part on medical necessity, to be reviewed by a peer physician or health care professional of the same or similar specialty as the requesting provider. AB 510 was held on the Assembly Appropriations Committee suspense file.

**c)** AB 512 (Harabedian) would require health plan and health insurer decisions based on medical necessity to approve, modify, or deny requests by providers prior to the provision of health care services to enrollees to be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 48 hours for standard requests, or 24 hours for urgent requests, from the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. AB 512 is pending in the Senate Appropriations Committee.

**d)** AB 539 (Schiavo) would require a PA for a health care service to remain valid for a period of at least one year from the date of approval. AB 539 is a two-year bill in the Senate Health Committee.

**e)** AB 574 (Mark González) would prohibit a health plan or health insurer that provides coverage for physical therapy (PT) from requiring PA for the initial 12 treatment visits for a new condition for PT. For a recurring condition, this bill would allow a health plan or insurer to impose PA if the individual seeks care within 180 days of their last physical therapy intervention for that condition. AB 574 is on the Senate Floor.

**f)** AB 669 (Haney) would prohibit concurrent or retrospective review of medical necessity for the first 28 days of in-network inpatient SUD stay. Would prohibit concurrent or retrospective review of medical necessity of in-network outpatient SUD visits. Would prohibit retrospective review of medical necessity for the first 28 days of in-network intensive outpatient or partial hospitalization SUD services, as specified. Would prohibit PA for in-network coverage of medically necessary outpatient prescription drugs to treat SUD. AB 669 passed out of the Senate Health Committee as amended on July 9th and will go to the Senate Appropriations Committee.

**8) PREVIOUS LEGISLATION**.

**a)** SB 516 (Skinner) of 2024, would have required DMHC and CDI, by July 1, 2025, 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 PA. SB 516 was not heard in the Assembly Health Committee.

**b)** SB 598 (Skinner) of 2023 would have prohibited a health plan or insurer from requiring a contracted health professional to complete or obtain a PA for any covered health care services if the plan or insurer approved or would have approved not less than 90% of the PA requests they submitted in the most recent completed one-year contracted period. SB 598 was held on suspense in the Assembly Appropriations Committee.

**c)** SB 250 (Pan) of 2022 was similar to SB 598 and was held on suspense in the Assembly Appropriations Committee.

**d)** AB 1880 (Arambula) of 2022 would have required a health plan or insurer's UM process to ensure that an appeal of a denial, is reviewed by a clinical peer, as specified. Would have defined clinical peer as a physician or other health professional who holds an unrestricted license or certification from any state and whose practice is in the same or a similar specialty as the medical condition, procedures, or treatment under review. AB 1880 was vetoed by Governor Newsom who stated in part:

> Health plans and health insurers should make every effort to streamline UM processes and reduce barriers to all medically necessary care. However, the bill's requirements, which are limited to denied authorizations for prescription drugs, are duplicative of California's existing independent medical review requirements, which provide enrollees, insureds, and their designated representatives with the opportunity to request an external review from an independent provider. I encourage the Legislature to pursue options that leverage existing requirements and resources, rather than creating duplicative new processes.

**e)** AB 1268 (Rodriguez) of 2019 would have required a health plan or health insurer, on or before July 1, 2020, and annually on July 1 thereafter, to report to the appropriate department the number of times in the preceding calendar year that it approved or denied each of the 30 health care services for which prospective review was most frequently requested. AB 1268 was held on suspense in the Assembly Appropriations Committee.

**9) DMHC TECHNICAL ASSISTANCE**. On July 9, 2025, DMHC released approved "technical assistance" (TA) language on several bills, including this one. The proposed TA is similar to the TA that was provided on SB 516 (Skinner) in 2024. The proposed language would delete the current contents of this bill, and would instead require 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 PA. Requires the DMHC and CDI to evaluate the reports received from health plans and insurers. Permits DMHC and CDI to consider specified factors when determining the appropriateness of removing prior authorization. Requires DMHC and CDI, after evaluating the reports, to identify and publish a list of, the most frequently approved or modified services, items, and supplies no longer subject to PA by December 31, 2027, and

how a health plan and insurers could reinstate PA upon a showing of good cause. Exempts specialized health plans and insurers, except to the extent the plans provide or administer essential health benefits (EHBs), health plans contracting with the Department of Health Care Services (DHCS) for Medi-Cal, or a nonprofit health plan with at least 3.5 million enrollees (in effect, Kaiser). Sunsets the provisions of this bill on January 1, 2033.

The author has agreed to include a modified version of the DMHC technical assistance (TA) following discussions with the Committee in this bill in lieu of the current bill. The new language will differ from the DMHC TA by applying the exemption from PA only to network providers, the language will not exempt Kaiser from the provisions of the bill, PA will continue to be allowed for Tier 3 and 4 prescription drugs, experimental and investigational services and novel services (except where is medical or scientific evidence), a drug or medical device prescribed or recommended for a use that is different from the use for which the drug or medical device has been cleared or approved for marketing by the federal Food and Drug Administration, health care service that are prescribed or recommended for a use that is a novel application of an existing therapy or technology, and a covered health care service, item, outpatient prescription drug, product, procedure, treatment or service delivered, furnished or dispensed by a non-contracted provider. In addition, the existing requirement in SB 306 that requires a covered health care service that is exempted from PA under this bill to constitute a service authorized by the health plan or health insurer for purposes of a specified provision of existing law that prohibits plans and insurers from rescinding or modifying after the provider renders the health care service in good faith would remain in the bill. Finally, a health plan would be allowed to reinstate PA for a specific health care provider, but only if specified criteria are met (such as fraud), and the implementation date of this bill would be expedited and the sunset date would be extended by an additional two years (to January 1, 2035) than the proposed TA.

**REGISTERED SUPPORT / OPPOSITION**:

**Support**

California Medical Association (sponsor)
American Academy of Pediatrics, California
California Academy of Child and Adolescent Psychiatry
California Association of Medical Product Suppliers
California Chapter American College of Cardiology
California Kidney Care Alliance
California Orthopedic Association
California Podiatric Medical Association
California Retired Teachers Association
California Society of Health System Pharmacists
Children's Specialty Care Coalition
Health Access California
Osteopathic Physicians and Surgeons of California
Physician Association of California
Planned Parenthood Affiliates of California
San Francisco Marin Medical Society
The ALS Association
United Hospital Association

**Opposition**

Association of California Life & Health Insurance Companies
California Association of Health Plans

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