Date of Hearing: August 20, 2025

ASSEMBLY COMMITTEE ON APPROPRIATIONS
Buffy Wicks, Chair
SB 306 (Becker) – As Amended July 17, 2025

Policy Committee: Health Vote: 16 - 0

Urgency: No State Mandated Local Program: Yes Reimbursable: No

**SUMMARY**:

This bill requires the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI) collect and analyze data on all covered health care services that are subject to prior authorization (PA) and develop a list of the most frequently approved health services. The bill prohibits health plans and insurers from requiring PA for services on the list of most frequently approved services.

Specifically, this bill:

1) Requires DMHC and CDI, on or before July 1, 2026, issue instructions and a standard reporting template to health plans and insurers (collectively, "health plans") to report all covered health care services subject to PA, the rate at which each service is approved or modified by the health plan or its delegated entity, and other relevant information.

2) Requires a health plan, on or before December 31, 2026, report to DMHC or CDI, as appropriate, the data requested by DMHC or CDI pursuant to item 1, above. If a health plan delegates responsibility for PA decisions to another entity, requires the health plan obtain information from each delegated entity for the health plan's report to DMHC or CDI.

3) Requires DMHC and CDI evaluate the reports received pursuant to this section and identify the health services most frequently approved by health plans or their delegated entities. Defines "most frequently approved" to mean approved or modified at a threshold rate DMHC or CDI determines, not to exceed 90%.

4) Authorizes DMHC and CDI to consider all of the following factors when determining the appropriateness of removing PA for a specific covered health service, regardless of its approval percentage rate:

    a) Utilization of a health service in a manner inconsistent with current clinical practice guidelines, as specified.

    b) The potential for fraud, waste, and abuse.

    c) The potential for cost savings from eliminating PA, including out-of-pocket cost savings to the enrollee.

d) The potential for improvements in quality of care, health care outcomes, and timely access to care for enrollees from eliminating prior authorization.

e) Other factors DMHC and CDI deem appropriate.

5) Requires DMHC and CDI consult interested stakeholders before finalizing the list of most frequently approved health services ("list").

6) Requires DMHC and CDI, on or before July 1, 2027, publish the list and, beginning the date specified in item 7, below, prohibits a health plan from imposing PA on a covered health service included on the list.

7) Requires DMHC and CDI issue instructions to health plans regarding all of the following:

a) The date by which the health care service plan and its delegated entities must cease requiring PA for the covered health services on the list. Specifies the date must be no later than January 1, 2028.

b) Requirements for notifying providers of the change in PA requirements.

c) The process by which a health plan may petition DMHC to reinstate the health plan's ability to use PA for a particular health service upon a showing of good cause that a lack of PA for the covered health service has resulted in an increase in the cost of care or decrease in the quality of care, including fraud, waste, or abuse. Requires DMHC or CDI make a determination on such a petition within 60 days of receipt of all necessary information. Prohibits a health plan from reinstating PA for a health service until authorized by DMHC or CDI.

8) Allows DMHC and CDI to issue other instructions as necessary and appropriate.

9) Notwithstanding the list, allows a health plan to impose PA on any of the following:

a) Outpatient prescription drugs in tier three or four of a health plan's formulary, as defined by reference (generally brand name and specialty drugs).

b) 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 U.S. Food and Drug Administration.

c) A covered health service that is experimental or investigational, excluding services for which there is medical or scientific evidence, as defined.

d) A covered health service that is prescribed or recommended for a use that is a novel application of an existing therapy or technology, excluding uses for which there is medical or scientific evidence, as defined.

e) A covered health service delivered, furnished, or dispensed by a noncontracting provider.

10) Provides that a covered health service that is exempted from PA pursuant to this bill constitutes a service authorized by the health plan. Prohibits a health plan or its delegated entity from denying or reducing the contracted or agreed upon payment, or the applicable rate or reimbursement methodology specified in a plan contract, for a covered health service exempted from PA pursuant to this bill unless the provider failed to substantially perform or supply the covered health service.

11) Notwithstanding the list, authorizes a health plan to reinstate PA on a covered health service that is on the list for a specific health care provider if the health plan has determined, based on clear and convincing evidence, that the health care provider has engaged in either of the following:

    a) Fraudulent activity related to the provision or billing of health services.

    b) A pattern or practice of repeatedly providing care that is clinically inappropriate or inconsistent with generally accepted standards of care, and that results in either potential harm to patients or excessive utilization of health care resources inconsistent with generally accepted standards of care.

12) Authorizes DMHC and CDI to contract with consultants with expertise in this subject area to assist in implementing this bill. Requires DMHC's or CDI's contract with such a consultant include conflict-of-interest provisions, as specified.

13) Requires, no later than four years after the cessation of PA requirements for services on the list, DMHC and CDI publish a report regarding the impacts of the cessation of PA requirements. Requires a health plan report specified information and data regarding the impacts of implementing this bill to be included in this report.

14) Authorizes DMHC and CDI to implement, interpret, or make specific the provisions of the bill by various means, without taking regulatory action.

15) Requires DMHC and CDI consult with each other before issuing instructions pursuant to this bill.

16) Prohibits a health plan from delegating the requirements of this bill to a delegated provider, pharmacy benefit manager, or other entity, unless the parties have negotiated and agreed upon a new provision to the parties' contract. Provides that a change to the parties' contract pursuant to this bill constitute a material change.

17) Exempts from the provisions of this bill a specialized health plan, except to the extent the plan provides or administers essential health benefits, and a Medi-Cal managed care plan contract.

18) Specifies that the bill applies only to covered health services ordered or prescribed by in-network providers.

19) Sunsets its provisions on January 1, 2034.

**FISCAL EFFECT**:

Costs to DMHC of an unknown amount, potentially in the millions to tens of millions of dollars annually until 2034, to develop the data collection template and instructions for plans to provide data, data collection and analysis, consult stakeholders and determine most frequently approved services, issue guidelines, handle complaints, monitor compliance, and conduct enforcement (Managed Care Fund).

CDI estimates costs of $984,000 in FY 2025-26, $930,000 in FY 2026-27, $357,000 in FY 2027-28, $819,000 in FY 2028-29, $1.0 million in FY 2029-30, $471,000 in FY 2030-31, $359,000 in FY 2031-32, $44,000 in FY 2032-33, and $44,000 in FY 2033-34 (Insurance Fund).

**COMMENTS**:

1) **Purpose.** According to the author, PA often results in delays or denials of essential treatments for patients, wasting valuable time for health care providers, who must spend time advocating for care instead of treating patients, and causing patients' conditions to deteriorate. The author argues this bill will bar insurance companies from harming patients solely for the purpose of protecting their bottom line, and strikes a reasonable balance on access to high approval services while reducing administrative waste without compromising oversight.

2) **Background.** ***PA***. In 2023, the California Health Benefits Review Program (CHBRP) published a report to help the Legislature better understand how PA is used in California. CHBRP noted that PA is an imperfect instrument that is generally intended to decrease costs and waste, but may also contribute to delays in treatment and barriers to care. CHBRP reported evidence is limited as to the extent to which health plans and insurers use PA and the effects of PA on the performance of the health care system, patient access to appropriate care, and the health and financial interests of the general public.

3) **Related Legislation.** Numerous bills under consideration, including AB 384 (Connolly), AB 510 (Addis), AB 512 (Harabedian), AB 574 (Mark González), and AB 669 (Haney), address PA in some manner, and SB 363 (Wiener) addresses independent medical review.

4) **Prior Legislation.** SB 516 (Skinner), of the 2023-24 Legislative Session, in its last version, was similar to this bill. SB 516 was referred to, but not heard in, the Assembly Health Committee.

   SB 598 (Skinner), of the 2023-24 Legislative Session, 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 this committee.

   SB 250 (Pan), of the 2021-22 Legislative Session, was similar to SB 598 and was held on suspense in this committee.

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