SENATE THIRD READING
SB 306 (Becker)
As Amended September 02, 2025
Majority vote

SUMMARY

Requires the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI), by July 1, 2026, to issue instructions to health plans and health insurers to report all covered health care services subject to prior authorization (PA). Requires health plans and health insurers, by December 31, 2026, to report to the DMHC and CDI respectively the covered health care services subject to PA, including the percentage rate at which they are approved or modified. Prohibits a health plan or health insurer, as of January 1, 2028, from imposing PA on any covered health care service included on the list published by the DMHC or CDI. Continues to allow health plans and insurers to impose PA for certain covered health care services, such as outpatient prescription drugs in tier three and four of a plan or insurer's formulary, 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 (FDA), and a covered service requested, ordered, prescribed, delivered, furnished or dispensed by a non-contracting provider. Requires DMHC and CDI, no later than four years after the date determined by DMHC and CDI for cessation of PA requirements under this bill, to publish a report regarding the impacts of the cessation of PA requirements. Sunsets the provisions of this bill on January 1, 2034.

Major Provisions

1) Requires DMHC and CDI to evaluate the reports received by health plans and insurers and identify the health care services most frequently approved by health plans, health insurers, or their delegated entities, defines "most frequently approved" to mean approved at a threshold rate determined by the DMHC or CDI, and prohibits a threshold rate from exceeding 90%.

2) Permits DMHC and CDI to consider specified factors when determining the appropriateness of removing PA for a specific covered health care service, regardless of its approval percentage rate, including potential for utilization of service in a manner inconsistent with current clinical practice guidelines, fraud, waste and abuse, potential for cost savings and improvements in quality, outcomes and timely access, and other factors deemed appropriate by DMHC and CDI.

3) Requires DMHC and CDI to issue instructions on a process by which a health plan or health insurer may petition DMHC or CDI to reinstate the ability of health plan or health insurer to use PA for a particular covered health care service upon a showing of good cause, as specified.

4) Permits a health plan or health insurer to reinstate PA for a specific health care provider on a health care service for which PA is otherwise prohibited only if the health plan or health insurer has determined, based on clear and convincing evidence, that the health care provider has engaged in either fraudulent activity related to the provision or billing of health care services, or 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.

5) Requires a covered health care service that is exempted from PA pursuant to 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.

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
Too often, California patients are denied critical care or forced to endure unnecessary pain due to excessive bureaucracy within the health care 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.

Arguments in 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.

Arguments in 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.

FISCAL COMMENTS

According to the Assembly Appropriations Committee:

1) DMHC estimates costs of approximately $450,000 in fiscal year (FY) 2025-26, $1.44 million in FY 2026-27, $1.83 million in FY 2027-28, and $1.79 million in FY 2028-29 and annually thereafter (Managed Care Fund). Main costs to DMHC would be to conduct legal research, issue legal guidance, review health plan contracts and other documents for compliance, and address consumer complaints.

2) 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).

VOTES

SENATE FLOOR: 37-0-3
YES: Allen, Alvarado-Gil, Archuleta, Arreguín, Ashby, Becker, Blakespear, Cabaldon, Caballero, Cervantes, Choi, Cortese, Dahle, Durazo, Gonzalez, Grayson, Grove, Hurtado, Laird, McGuire, McNerney, Menjivar, Niello, Ochoa Bogh, Padilla, Pérez, Richardson, Rubio, Seyarto, Smallwood-Cuevas, Stern, Strickland, Umberg, Valladares, Wahab, Weber Pierson, Wiener

ABS, ABST OR NV: Jones, Limón, Reyes

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

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

UPDATED

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