Office of Senate Floor Analyses
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UNFINISHED BUSINESS

Bill No: SB 306
Author: Becker (D)
Amended: 9/4/25 in Assembly
Vote: 21

SENATE HEALTH COMMITTEE: 10-0, 4/23/25
AYES: Menjivar, Durazo, Gonzalez, Grove, Limón, Padilla, Richardson, Rubio, Weber Pierson, Wiener
NO VOTE RECORDED: Valladares

SENATE APPROPRIATIONS COMMITTEE: 6-0, 5/23/25
AYES: Caballero, Seyarto, Cabaldon, Grayson, Richardson, Wahab
NO VOTE RECORDED: Dahle

SENATE FLOOR: 37-0, 5/28/25
AYES: 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
NO VOTE RECORDED: Jones, Limón, Reyes

ASSEMBLY FLOOR: 76-1, 9/8/25 - See last page for vote

SUBJECT: Health care coverage: prior authorizations

SOURCE: California Medical Association

DIGEST: This bill excludes from health plan and insurer prior authorization requirements specified covered health care service that have been approved by the plan or insurer 90% or more times as determined by the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI) after health plan and insurer reporting and evaluation by DMHC and CDI. Sunsets this bill on January 1, 2034.

Assembly Amendments of 9/4/25 require DMHC and CDI to issue instructions to plans and insurers to report all covered services subject to prior authorization and the rate they are approved and report separately, prior authorization requests which have been modified and ultimately approved, in accordance with instructions issued by DMHC and CDI. Establish criteria for DMHC and CDI to consider regarding the appropriateness of removing prior authorization for these services, and require on or before July 1, 2027, DMHC and CDI to publish the list of services of requests that meet or exceed an approval threshold rate of 90%. Require DMHC and CDI to issue instructions to plans and insurers on or before January 1, 2028. Allow for a process by which a plan or insurer may petition to reinstate prior authorization for a particular health care services. Permit health plans and insurers to impose prior authorization on outpatient prescription drugs, as specified, medical devices, as specified, experimental or investigational services, novel application of existing technology or therapy, and services requested by out of network or noncontracting providers. Require DMHC and CDI to consult with each other and issue a report four years after prior authorization ceases for the identified services. Prohibit a health plan from delegating to other entities without negotiating and agreeing upon a new provision in the contract. Exempt Medi-Cal managed care plans. Sunset this bill on January 1, 2034.

ANALYSIS:

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 (Knox-Keene Act) and the California Department of Insurance (CDI) to regulate health insurance. [Health and Safety Code (HSC) §1340, et seq. and Insurance Code (INS) §106, et seq.]

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

This bill:

1) Prohibits a health plan, health insurer, or an entity for which a plan or insurer contracts for prior authorization purposes, from imposing prior authorization on a covered health care service when 90% or more of requests for the service were approved, as determined by DMHC and CDI.

2) Requires a plan or insurer to report to DMHC and CDI covered service subject to prior authorization and the percentage rate at which they are approved or modified, data regarding requested or authorized duration, frequency, or level of care of the health care services, and other statistics as determined by DMHC and CDI.

3) Requires DMHC and CDI to consult with each other before issuing instructions and the list of covered health care services for which prior authorization is prohibited to ensure consistency to the extent practical.

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

   a) Utilization of a health care service in a manner inconsistent with current clinical practice guidelines published in peer-reviewed medical literature or United States Food and Drug Administration-approved indications, as applicable.

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

   c) The potential for cost savings from eliminating prior authorization, 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 deemed appropriate by DMHC and CDI.

5) Requires before finalizing the list of covered health care services, DMHC and CDI to consult interested stakeholders.

6) Permits a health plan or insurer to impose prior authorization on any of the following:

   a) Outpatient prescription drugs in tier three or four of a health care service plan's formulary, as those tiers are defined, as specified.

   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 United States Food and Drug Administration.

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

d) A covered health care 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, as specified.

e) A covered health care service requested, ordered, prescribed, delivered, furnished, or dispensed by an out-of-network or noncontracting provider.

f) Based on clear and convincing evidence, when the health care provider has engaged in either of the following:

   i) Fraudulent activity related to the provision or billing of health care services.
   ii) 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.

7) Exempts Medi-Cal manage care plans.

8) Defines "prior authorization" as 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 requirements by a plan or insurer that an enrollee/insured or health professional obtain approval from the plan or insurer before a health care service is provided, including preauthorization, precertification, and prior approval.

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

10) Permits DMHC and CDI to contract with consultants according to contract of interest provisions, and exempts DMHC and CDI from specified law and review or approval by the Department of General Services. Exempts DMHC and CDI from regulatory action in implementing this bill.

Comments

According to the author of this bill:

> 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 "prior authorization" 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 healthcare 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. This bill requires health plans to eliminate prior authorization 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.

Background

Prior authorization. Prior authorization is a form of utilization review or utilization management. Utilization review can occur prospectively, retrospectively, or concurrently, and a plan or insurer can approve, modify, delay or deny in whole or in part a request based on its medical necessity. California law requires written policies and procedures that are consistent with criteria or guidelines and supported by clinical principles and processes. These policies and procedures must be filed with regulators, and disclosed, upon request, to providers, plans, and enrollees or insureds. There are timelines in the law for plans and insurers to respond to requests once any medical information that is reasonably necessary to make the determination is provided. California also has a standardized form for prior authorization submissions. If a health plan or insurer fails to respond to the prior authorization request within 72 hours for nonurgent requests, and within 24 hours if exigent circumstances exist, upon the receipt of a completed form, the request is deemed granted. In 2023, at the request of the Legislature, the California Health Benefits Review Program conducted a survey of California-regulated plans and insurers and found overall, between 5% and 15% of all covered medical services, and between 16% and 25% of pharmacy benefits, were subject to prior authorization requirements. While there were significant differences among plans, some of the most frequently requested services and

treatments were not necessarily the most expensive categories of treatments. Many under the medical benefit were services or treatment for ongoing care, such as behavioral health services and physical, occupational, or speech therapies. Some were rare or more expensive, but with low utilization rates.

FISCAL EFFECT: Appropriation: No Fiscal Com.: Yes Local: Yes

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).

SUPPORT: (Verified 9/8/25)

California Medical Association (source)
Adventist Health
Alliance of Catholic Health Care
ALS Association
American Academy of Pediatrics
American Diabetes Association
California Academy of Child and Adolescent Psychiatry
California Academy of Family Physicians
California Association of Medical Product Suppliers
California Behavioral Health Association
California Chapter American College of Cardiology
California Children's Hospital Association
California Hospital Association
California Kidney Care Alliance
California Nurses Association
California Orthopedic Association
California Podiatric Medical Association
California Psychological Association
California Retired Teachers Association

California Society of Health System Pharmacists
California Society of Plastic Surgeons
California State Board of Pharmacy
Children's Specialty Care Coalition
Fresenius Medical Care
Health Access California
Loma Linda University Health
Mental Health America of California
National Health Law Program
Osteopathic Physicians and Surgeons of California
Physician Association of California
Planned Parenthood Affiliates of California
Providence
Saint Agnes Medical Program
San Francisco Marin Medical Society
Stanford Health Care
U.S. Pain Foundation
United Hospital Association

OPPOSITION: (Verified 9/8/25)

America's Physician Groups
Association of Life & Health Insurance Companies
California Association of Health Plans
California Chamber of Commerce
Local Health Plans of California

ARGUMENTS IN SUPPORT: The California Medical Association (CMA) is sponsoring this bill, indicating that burdensome prior authorization processes take physician time away from treating patients and contribute to adverse effects on patient outcomes, especially when prior authorization results in delays in treatment. CMA writes, "according to an American Medical Association survey, 87% of physicians said that prior authorizations result in an overall higher utilization of health care services or ineffective treatment. By reducing the overall volume of prior authorization requests, this bill will free up time and resources for health plans to focus more quickly on reviewing other prior authorization requests, while ensuring that patients are treated in a timely manner." Health Access California supports this bill, indicating that by removing this unnecessary step for routine approvals, patients can get the care they need without unnecessary delays. The California Hospital Association writes, "Applied correctly, prior authorization can be a valuable tool to manage utilization and support the delivery of safe and

appropriate patient care. But it can become a barrier leading to harmful and unnecessary interruptions in care and increase administrative burden on care providers and divert valuable time and resources from patient care." The Children's Specialty Care Coalition writes by focusing on high-approval services, this bill represents a balanced approach that will improve healthcare delivery while maintaining appropriate utilization management for more complex or controversial treatments. The National Health Law Program (NHLP) writes, "The United States is the only industrialized country where health decisions must first be approved by a person's health care plan before receiving treatment. This prior authorization can take weeks or even months, and often ends with erroneous denials. Health insurers deny 850 million claims yearly, yet less than 1% of people appeal, despite studies showing up to 75% of appeals succeed." NHLP believes eliminating redundant prior authorization requirements will reduce costs, improve patient outcomes, and enhance the overall healthcare experience, and that health care providers will have more time to focus on providing care for chronic conditions, coordinate treatment plans, and welcome new patients into their practices.

ARGUMENTS IN OPPOSITION: The California Association of Health Plans (CAHP) and Association of California Life and Health Insurance Companies (ACLHIC) have asked for amendments to clarify that the statute does not apply to in-patient/outpatient prescription drugs as well as pharmaceutical products and/or services because of the complexity of the prescription drug market and the increase in pharmaceutical costs. CAHP and ACLHIC also ask that the statute not apply to experimental or investigational services. They ask that the threshold be set at 95% instead of 90%. They want a standard threshold to be created for what services the plan/insurer must review. They want to establish a process for plans/insurers to disqualify specified services regardless of whether it meets the established standard. CAHP and ACLHIC indicate that some services that meet a 95% threshold may never be appropriate to remove prior authorization. They ask that the bill be limited to in-network providers with which they have contractual relationships rather than out of network providers, and, that if out of network providers are included it would grant out of network providers a benefit that further incentivizes providers not to contract with health plans and insurers. CAHP and ACLHIC also ask for a process for rescinding a prior authorization exemption, they want to create a format for evaluating a prior authorization exemption on a year over year basis, they request a delayed effective date of one year, and, they want DMHC and CDI to review the policy three years post implementation. America's Physician Groups (APG) agrees with CAHP and ACLHIC but suggests further focus on transparency mechanisms. APG indicates there is reporting to DMHC and federal automation requirements already, and that review and public

disclosure by DMHC and CDI of statistics for each organization that submits reports could occur. APG believes a threshold of 5% denial rate is reasonable and organizations that fall outside should be subject to enforcement. The California Chamber of Commerce requests to participate a health professional should submit prior authorizations electronically, the threshold should be set at 95%, prescription drugs should be excluded, and there should be a discussion about how long the exemption lasts.

ASSEMBLY FLOOR: 76-1, 9/8/25
AYES: 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, Gabriel, Gallagher, Garcia, Gipson, Jeff Gonzalez, Mark González, Hadwick, Haney, Harabedian, Hart, Hoover, Irwin, Jackson, Kalra, Krell, Lackey, Lee, Lowenthal, Macedo, McKinnor, Muratsuchi, 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
NOES: DeMaio
NO VOTE RECORDED: Johnson, Nguyen, Tangipa

Prepared by: Teri Boughton / HEALTH / (916) 651-4111
9/8/25 19:46:28

****** END ******