
SENATE COMMITTEE ON HEALTH

Senator Dr. Akilah Weber Pierson, Chair

BILL NO: SB 964
AUTHOR: Smallwood-Cuevas
VERSION: February 3, 2026
HEARING DATE: March 25, 2026
CONSULTANT: Teri Boughton

SUBJECT: Prescription drug coverage: dose adjustments

SUMMARY: Authorizes a health care professional to request, and be granted, the authority (from health plans and insurers) to adjust the dose or frequency of a drug to meet the specific medical needs of an enrollee or insured with a chronic condition or cancer, without prior authorization or subsequent utilization management, under specified conditions. Prohibits a plan or insurer from limiting or excluding coverage of a drug an enrollee or insured has been continuously using.

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 and other insurers under the Insurance Code. [HSC §1340, et seq., and INS §106, et seq.]
- 2) Prohibits a health plan contract or insurance policy that covers prescription drug benefits from limiting or excluding coverage for a drug on the basis that the drug is prescribed for a use that is different from the use for which that drug has been approved for marketing by the federal Food and Drug Administration (FDA), provided that all of the following conditions have been met:
 - a) The drug is approved by the FDA;
 - b) The drug is prescribed by a participating licensed health care professional for the treatment of a life-threatening condition; or the drug is prescribed by a participating licensed health care professional for the treatment of a chronic and seriously debilitating condition, the drug is medically necessary to treat that condition, and the drug is on the plan formulary. Requires, if the drug is not on the plan formulary, the participating subscriber's request to be considered pursuant to an expeditious process;
 - c) The drug has been recognized for treatment of that condition by any of the following:
 - i) The American Hospital Formulary Service's Drug Information;
 - ii) One of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen:
 - (1) The Elsevier Gold Standard's Clinical Pharmacology;
 - (2) The National Comprehensive Cancer Network Drug and Biologics Compendium;or,
 - (3) The Thomson Micromedex DrugDex; and,
 - d) Two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal. [HSC §1367.21 and INS §10123.195]
- 3) Requires any coverage required pursuant to 2) above to also include medically necessary services associated with the administration of a drug, subject to the conditions of the contract.

States that 2) shall not be construed to prohibit the use of a formulary, copayment, technology assessment panel, or similar mechanism as a means for appropriately controlling the utilization of a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the FDA. [HSC §1367.21 and INS §10123.195]

- 4) Defines “chronic and seriously debilitating” as diseases or conditions that require ongoing treatment to maintain remission or prevent deterioration and cause significant long-term morbidity. [HSC §1367.21 and INS §10123.195]
- 5) Prohibits a health plan contract from limiting or excluding coverage for a drug for an enrollee if the drug previously had been approved for coverage by the plan for a medical condition of the enrollee and the plan’s prescribing provider continues to prescribe the drug for the medical condition, provided that the drug is appropriately prescribed and is considered safe and effective for treating the enrollee’s condition. This does not preclude the prescriber from prescribing another covered drug that is medically appropriate or a generic substitution. This does not apply to off-label use of drugs. This does not prohibit a health plan from charging a subscriber or enrollee a copayment or a deductible for prescription drug benefits or from setting forth, by contract, limitations on maximum coverage of prescription drug benefits. [HSC §1367.22]
- 6) Requires health plans to maintain an expeditious process by which the prescribing provider may obtain authorization for a medically necessary nonformulary prescription drug, except the process is not required for nonformulary drugs that have been prescribed pursuant to 5) above. [HSC §1367.24]

This bill:

- 1) Authorizes a health care professional to request, and be granted, the authority to adjust the dose or frequency of a drug to meet the specific medical needs of the enrollee or insured, without prior authorization or subsequent utilization management if the following conditions are met:
 - a) The drug was previously approved for the enrollee/insured for a chronic medical condition or cancer treatment and the drug continues to be prescribed by the plan’s/insurer’s condition or treatment;
 - b) The drug is not an opioid or a scheduled controlled substance; and,
 - c) The dose has not been adjusted more than two times without prior authorization.
- 2) Prohibits a plan or insurer from limiting or excluding coverage of the prescription if the enrollee/insured has been continuously using a prescription drug selected by the enrollee’s/insured’s prescribing provider for the condition while covered by their current or previous coverage.
- 3) Exempts from this bill Medi-Cal managed care plans, as specified.

FISCAL EFFECT: This bill has not been analyzed by a fiscal committee.

COMMENTS:

- 1) *Author’s statement.* According to the author, more than 16 million Californians live with at least one chronic condition, and many depend on prescription medications to manage their health and, in some cases, to survive. For these patients, adjustments in dosage or frequency

are often a routine and medically necessary part of effective treatment — not a new or different therapy. Yet under current insurance practices, even minor, clinically appropriate adjustments are frequently treated as entirely new treatments. This triggers burdensome prior authorization requirements, denials, and lengthy appeals processes that delay care, disrupt treatment plans, and place unnecessary administrative strain on patients and providers. These delays can lead to worsened health outcomes due to preventable complications or disease progression. This bill addresses that gap by ensuring that patients with chronic, complex conditions — such as Crohn’s disease — may receive up to two clinically justified dose or frequency adjustments per covered medication without repeated prior authorization barriers. By protecting continuity of care while maintaining appropriate clinical safeguards, the measure supports better health outcomes, reduces avoidable delays, and promotes a more efficient and patient-centered healthcare system.

- 2) *Pharmacy benefits and utilization management.* The California Health Benefits Review Program indicates that almost all enrollees in plans and policies regulated by DMHC and CDI have pharmacy benefit coverage. Pharmacy benefits cover outpatient prescription drugs by covering prescriptions that are generally filled at a retail pharmacy, a mail-order pharmacy, or a specialty pharmacy. Plans and policies that include a pharmacy benefit may apply utilization management techniques, including prior authorization, step therapy, and formulary requirements. Utilization management generally applies to new prescriptions, but they may also be applied if there is a change in dose or dosage form (inhaled vs. oral, immediate vs. extended release, etc.) for a recurring prescription. Additionally, they may be applied to recurring prescriptions, should the enrollee’s plan or policy alter utilization management or if an enrollee switches from one plan or policy to another. Prescribers submit medical documentation along with a prior authorization request for an enrollee seeking to fill a prescription for a drug when utilization management is required.
- 3) *Chronic conditions almanac.* According to the 2024 Edition of the California Health Care Foundation (CHCF) *Quality of Care: Chronic Conditions Almanac*, many adults in California have been diagnosed with chronic conditions such as asthma, diabetes, heart disease, high blood pressure, and obesity. Diabetes and heart disease are the leading cause of illness, disability, and death in the U.S. Mortality rates for breast, prostate, lung, and colorectal cancer vary by race and ethnicity. American Indian and Alaska Native Californians experienced mortality rates for lung and colorectal cancer and breast cancer among women, more than two times higher than the state’s overall rate. The prostate cancer mortality rate for Black men was more than two times higher than the overall rate in California.
- 4) *Prior legislation.* SB 306 (Becker, Chapter 408, Statutes of 2025) 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 DMHC and CDI after health plan and insurer reporting and evaluation by DMHC and CDI. SB 306 sunsets on January 1, 2034.

AB 2169 (Bauer-Kahan of 2024) was substantially similar to this bill. *AB 2169 was held on the Senate Appropriations Committee suspense file.*

SB 70 (Wiener of 2023) would have prohibited health plans and insurers from limiting or excluding coverage for a drug, dose of a drug, or dosage form of a drug on the basis that a drug, dose of a drug, or dosage form of a drug is different from the use approved for

marketing by the FDA if specified conditions are met, including that the drug has been previously covered for a chronic condition or cancer. SB 70 would also have prohibited plans/insurers from limiting or excluding coverage, or requiring additional cost-sharing for a drug, dosage, or dosage form of a drug that was previously approved. *SB 70 was held on the Assembly Appropriations suspense file.*

SB 853 (Wiener of 2022) would have prohibited a health plan or insurer that provides coverage for prescription drugs from limiting or declining to cover a drug or dose of a drug as prescribed or imposing additional cost-sharing for covering a drug as prescribed, if specified criteria apply. SB 853 would have provided that a reduction or termination of an ongoing and approved course of treatment before the end of the treatment or the end or amendment of the policy is an adverse benefit determination, and required a health plan or insurer to notify an enrollee or insured, or their representative, and the enrollee's or insured's provider in writing, as specified. SB 853 would also have required a plan or insurer that has approved an ongoing course of treatment to provide continuing coverage pending appeal or review. Finally, SB 853 would have prohibited a health plan or insurer from limiting or declining to cover a drug or dose of a drug as prescribed, or impose additional cost-sharing for covering a drug as prescribed, if specified provisions apply, including that the drug was previously covered by the plan or insurer or the enrollees or insured's prior private or public health care coverage for the enrollees or insurer's medical condition. *SB 853 was held on the Assembly Appropriations Committee suspense file.*

- 5) *Support.* The Crohn's and Colitis Foundation, the sponsor of this bill, states that some patients require treatment tailored to the individual and when a patient is stable, disrupting treatment because of insurance company denials of medication or dose optimization of approved prescriptions puts patients at risk of hospitalization and even death. According to the sponsor, currently every dose adjustment requires approval by the health plan which often results in delays, and denials if the dose is different from the dose on the medication label. The California Advocacy Team of the U.S. Pain Foundation writes that for patients living with chronic pain and other chronic conditions, treatment plans are often carefully recalibrated over time. Even short delays in medication adjustments can result in avoidable suffering, functional decline, and increased reliance on urgent or emergency services. These supporters believe this bill promotes continuity and stability by ensuring that patients who have been continuously using prescribed medication do not face sudden loss of coverage due to administrative barriers. The California Hospital Association writes that this bill offers thoughtful and balanced reform that meaningfully reduces administrative barriers to care while preserving appropriate safeguards. Health Access California writes under existing practice, health plans often require new prior authorization for each dose or frequency adjustment, even when medically necessary, and when these requests are denied, and later overturned on appeal, this creates avoidable delays that can negatively affect patients' care and health. Health Access believes this bill would prevent unnecessary delays in access for consumers with chronic conditions and cancer by prohibiting a health plan or insurer from excluding from or limiting coverage for a prescription that the consumer has been continuously using while covered by their existing or previous health coverage.
- 6) *Opposition.* The Association of California Life and Health Insurance Companies and the California Association of Health Plans are concerned this bill may create patient safety concerns and write that when they limit a drug or specific dose of a drug, it is generally for safety reasons, including potential abuse or overuse, inconsistent usage with FDA-approved labeling or to prevent use at doses that have not been studied or shown to be efficacious. The

opposition also believes this bill will increase costs and will undermine utilization management protocols.

7) *Policy comments.*

a) SB 306 process. Beginning in July 2026, plans and insurers will report information to their regulators about prior authorization approval rates, and no later than January 1, 2028, health plans and insurers will cease requiring prior authorizations for covered services identified by the regulators with high approval rates. However, SB 306 allows health plans and insurers to continue prior authorizations on services that are used differently from the use approved or cleared by the FDA. The dosing changes that are the subject of this bill may fall into the category of this type of off-label use and therefore may not be included as part of the SB 306 prior authorization exemptions.

8) *Amendments.*

- a) The author is requesting the committee adopt an amendment to clarify that the health care professional and the enrollee's or insured's prescribing provider is the enrollee's or insured's treating provider.
- b) Subdivision (b) of the bill appears to be duplicative of existing law.

SUPPORT AND OPPOSITION:

Support: Crohn's and Colitis Foundation (sponsor)
Alliance for Headache Disorders Advocacy
California Chapter American College of Cardiology
California Chronic Care Coalition
California Hospital Association
California Life Sciences Association
California Pharmacists Association
California Retired Teachers Association
California Rheumatology Alliance
Health Access California
U.S. Pain Foundation
Western Center on Law & Poverty, Inc.

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

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