
SENATE COMMITTEE ON APPROPRIATIONS

Senator Sabrina Cervantes, Chair
2025 - 2026 Regular Session

SB 964 (Smallwood-Cuevas) - Prescription drug coverage: dose adjustments

Version: April 6, 2026

Urgency: No

Hearing Date: April 13, 2026

Policy Vote: HEALTH 11 - 0

Mandate: Yes

Consultant: Agnes Lee

Bill Summary: SB 964 would provide that a treating provider may request, and must be granted by the health plan or insurer, the authority to adjust the dose or frequency of a drug without prior authorization or subsequent utilization management if specified conditions are met.

Fiscal Impact:

- The Department of Managed Health Care (DMHC) estimates costs of approximately \$24,000 in 2026-27, \$1,233,000 in 2027-28, \$1,838,000 in 2028-29, and \$1,822,000 in 2029-30 and annually thereafter for state administration (Managed Care Fund).
- The California Department of Insurance (CDI) estimates costs of \$3,000 in 2026-27 and \$16,000 in 2027-28 for state administration (Insurance Fund).

Background: The DMHC regulates health plans under the Knox-Keene Act and the CDI regulates health insurance. Health plans and insurers that cover prescription drugs are subject to state law provisions governing the coverage of prescription drugs. Health plans and insurers may also use various utilization management techniques related to the provision of prescription drugs.

Utilization Management. Prior authorization is when the health plan/insurer or pharmacy benefit manager must authorize a particular prescription before it can be filled. Step therapy is a type of prior authorization for drugs that begins medication for a medical condition with the most preferred drug therapy and progresses to other therapies only if necessary. Prior authorization also may be used in conjunction with a step therapy system, so that a patient might be required to try a less expensive drug before receiving authorization to receive the drug originally requested. According to the California Health Benefits Review Program (CHBRP), these utilization management techniques are generally applied to new prescriptions, but they may also be applied if there is a change in dose for a recurring prescription or for off-label use of a drug.

Off-Label Use. Current law prohibits a health plan/insurer 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 United States Food and Drug Administration (FDA), provided that all of the following conditions have been met:

- The drug is approved by the FDA.

- The drug is prescribed by a participating/contracting licensed health care professional for the treatment of a life-threatening condition; or

The drug is prescribed by a participating/contracting 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's/insurer's formulary.

- The drug has been recognized for treatment of that condition by any of the following:
 - The American Hospital Formulary Service's Drug Information.
 - One of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen:
 - The Elsevier Gold Standard's Clinical Pharmacology.
 - The National Comprehensive Cancer Network Drug and Biologics Compendium.
 - The Thomson Micromedex DrugDex.
 - 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.

Proposed Law: Specific provisions of the bill would:

- Provide that an enrollee's/insured's treating provider may request, and must be granted by the health plan/insurer, the authority to adjust the dose or frequency of a drug to meet the specific medical needs of the enrollee/insured without prior authorization or subsequent utilization management if the following are met:
 - The drug previously had been approved for coverage by the plan/insurer for an enrollee's/insured's chronic medical condition or cancer treatment and the enrollee's/insured's treating provider continues to prescribe the drug for the enrollee's/insured's chronic medical condition or cancer treatment.
 - The drug is not an opioid or a scheduled controlled substance.
 - The dose has not been adjusted more than two times without prior authorization.
- Exempt Medi-Cal managed care plans.

Related Legislation: AB 2169 (Bauer-Kahan, 2024) was similar to this bill. The bill was held on the suspense file in this committee.