THIRD READING

Bill No: SB 964
Author: Smallwood-Cuevas (D)
Amended: 5/14/26
Vote: 21

SENATE HEALTH COMMITTEE: 11-0, 3/25/26
AYES: Weber Pierson, Valladares, Caballero, Durazo, Gonzalez, Grove, Menjivar, Padilla, Pérez, Rubio, Smallwood-Cuevas

SENATE APPROPRIATIONS COMMITTEE: 7-0, 5/14/26
AYES: Cervantes, Seyarto, Cabaldon, Dahle, Grayson, Richardson, Wahab

SUBJECT: Prescription drug coverage: dose adjustments

SOURCE: Crohn's and Colitis Foundation

DIGEST: This bill authorizes a treating health care provider 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.

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 and other insurers under the Insurance Code. [Health and Safety Code (HSC) §1340, et seq., and Insurance Code (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 (This is referred to "off-label" requirements):

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) 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]

5) 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 treating provider for the 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.
   d) If the adjusted dose or frequency is for an off-label use, two articles from major peer-reviewed medical journals have presented data supporting the proposed off-label use as generally safe and effective as described in existing law, as specified.

2) Exempts from this bill Medi-Cal managed care plans, as specified.

Comments

According to the author of this bill:

> 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.

Background

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.

Chronic conditions almanac. According to the 2024 Edition of the California Health Care Foundation's 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.

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

According to the Senate Appropriations Committee, unknown ongoing costs, likely low millions for DMHC (Managed Care Fund). Unknown one-time costs, likely minor, for CDI for state administration (Insurance Fund).

SUPPORT: (Verified 5/14/26)

Crohn's and Colitis Foundation (source)
Alliance for Headache Disorders Advocacy
Bleeding Disorders Council of California
California Academy of Family Physicians
California Access Coalition
California Chapter American College of Cardiology
California Chronic Care Coalition
California Hospital Association
California Pharmacists Association
California Retired Teachers Association
California Rheumatology Alliance
Cedars-Sinai Health System
Health Access California
National Health Law Program
U.S. Pain Foundation
Western Center on Law & Poverty, Inc.

OPPOSITION: (Verified 5/14/26)

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

ARGUMENTS IN SUPPORT: The Crohn's and Colitis Foundation, the source 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.

ARGUMENTS IN 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.

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