Date of Hearing: June 24, 2026

ASSEMBLY COMMITTEE ON APPROPRIATIONS
Buffy Wicks, Chair
SB 964 (Smallwood-Cuevas) – As Amended May 14, 2026

Policy Committee: Health Vote: 15 - 0

Urgency: No State Mandated Local Program: Yes Reimbursable: No

SUMMARY:

This bill prohibits a health care service plan or health insurance policy (collectively, health plan) from requiring prior authorization (PA) or subsequent utilization management (UM) for a health care provider to adjust a dose or frequency of a drug that is already prescribed to a patient to meet the patient's specific medical needs.

Specifically, this bill:

1) Authorizes a treating provider to request, and requires a health plan to grant, the authority to adjust the dose or frequency of a drug to meet the specific medical needs of an enrollee or insured without PA or subsequent UM if all the following conditions are met:

   a) The health plan had previously approved coverage of the drug for a patient's chronic medical condition or cancer treatment and the treating provider continues to prescribe the drug for the chronic medical condition or cancer treatment.

   b) The drug is not an opioid or a controlled substance.

   c) The dose has not been adjusted more than two times without PA.

   d) For an adjusted dose or frequency 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, unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

2) Exempts Medi-Cal managed care plans.

FISCAL EFFECT:

1) The Department of Managed Health Care (DMHC) estimates special fund costs of $24,000 in fiscal year (FY) 2026-27, $1.23 million in FY 2027-28, $1.84 million in FY 2028-29, and $1.82 million in FY 2029-30 and annually thereafter (Managed Care Fund). DMHC would incur these costs to conduct independent medical reviews, revise survey methodology and compliance monitoring tools, review health plan filings of UM processes, provide guidance to health plans, contract with clinical and statistical consultants for medical surveys and assessment activities, take enforcement actions, and for general administrative and technological support.

2) The Department of Insurance (CDI) anticipates minor and absorbable costs in FY 2026-27 and FY 2027-28 to review insurance policy documents (Insurance Fund).

3) The California Public Employee Retirement System (CalPERS) estimates increases in premiums for CalPERS members in DMHC-regulated health plans of around $310,000, of which the state's share is approximately $150,000 (General Fund). CalPERS costs for CDI-regulated policies would likely be less than $150,000 (General Fund).

COMMENTS:

1) **Purpose.** This bill is sponsored by the Crohn's and Colitis Foundation. 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.

2) **Background.** According to the California Health Benefit Review Program (CHBRP), almost all enrollees in health plans regulated by DMHC and CDI have coverage for pharmacy benefits, including outpatient prescription drugs that are generally filled at a retail pharmacy, a mail-order pharmacy, or a specialty pharmacy. Health plans may apply UM, including PA, step therapy, and formulary requirements to a prescription. Health plans generally apply UM to new prescriptions, but may also apply UM to a change in dose or dosage form (for example, inhaled vs. oral, or immediate vs. extended release) for a recurring prescription.

   Statute requires health plans regulated by DMHC or CDI that include a pharmacy benefit not limit or exclude coverage for a drug for an enrollee when: (a) the drug was previously approved for coverage by the plan for a medical condition of the enrollee, (b) the enrollee's prescribing provider continues to prescribe the drug for the medical condition, and (c) the drug is appropriately prescribed and is considered safe and effective for treating the enrollee's medical condition. This bill amends existing law to allow a prescriber to adjust the dose or frequency of a drug previously approved for a chronic medical condition or cancer, unless the drug is an opioid or a controlled substance.

3) **Oppose Unless Amended.** The California Association of Health Plans (CAHP) and Association of California Life and Health Insurance Companies (ACLHIC) oppose this bill

unless it is amended to require the dose and frequency of the drugs prescribed under this bill to conform to FDA-approved labeling for dosages and applicable FDA guidance. CAHP and ACLHIC state that this bill may create potential patient safety concerns for their enrollees by not requiring that a drug be prescribed consistent with FDA-labeled dosages or prescribed for something that is consistent with the use for which the FDA has approved marketing the drug. CAHP and ACLHIC continue that limiting a health plan or insurer's oversight may cause potentially adverse reactions to enrollees if a dosage change is not done correctly.

4) **Prior Legislation.**

a) SB 306 (Becker), Chapter 408, Statutes of 2025, exempts from health plan PA requirements specified covered health care services that the health plan has approved 90% or more of the time as determined by DMHC and CDI. SB 306 also requires health plans to report specified data to DMHC and CDI to determine PA approval frequencies.

b) AB 2169 (Bauer-Kahan), of the 2023-24 Legislative Session, was substantially similar to this bill. AB 2169 was held on suspense in the Senate Appropriations Committee.

c) SB 70 (Wiener), of the 2023-24 Legislative Session, would have prohibited a health plan from limiting or excluding coverage of a drug, dose of a drug, or dosage form of a drug that is prescribed for off-label use for a life-threatening or chronic and seriously debilitating condition or cancer, if the health plan or insurer previously covered the drug for the patient, regardless of whether the drug, dose, or dosage form is on the plan's or insurer's formulary. SB 70 also would have prohibited a health plan from requiring additional cost sharing for a drug that was previously approved for coverage. SB 70 was held on suspense in this committee.

d) SB 853 (Wiener), of the 2021-22 Legislative Session, would have required a health plan to provide coverage for a drug, dose of a drug, or dosage form of a drug (for example, oral or injectable) prescribed by a health care provider if that drug had been previously approved for coverage by the health plan for an enrollee's medical condition during the entire duration of utilization review and any appeals of utilization review. SB 853 also would have prohibited a health plan from imposing additional cost sharing for covering a drug as prescribed during the utilization review and any appeals, under specified circumstances. SB 853 was held on suspense in this committee.

Analysis Prepared by: Allegra Kim / APPR. / (916) 319-2081