SENATE THIRD READING
SB 964 (Smallwood-Cuevas)
As Amended August 17, 2026
Majority vote

SUMMARY

Authorizes a treating *contracting* provider to request the authority to adjust the dose or frequency of a drug to meet the specific medical needs of an enrollee or insured without prior authorization (PA) or subsequent utilization management (UM), as specified. *Requires a health plan or insurer to issue a written response to the provider within 72 hours and to authorize the request if specified conditions are met.*

Major Provisions

COMMENTS

UM and Utilization Review (UR). UM and UR are processes used by health plans to evaluate and manage the use of health care services. UR can occur prospectively, retrospectively, or concurrently and a plan can approve, modify, delay or deny in whole or in part a request based on its medical necessity. PA is a UR technique used by health plans that requires patients to obtain approval of a service or medication before care is provided. PA is intended to allow plans to evaluate whether care that has been prescribed is medically necessary for purposes of coverage. PA is one type of UM tool that′s used by health plans, along with others such as concurrent review and step therapy, to control costs, limit unnecessary care, and evaluate safety and appropriateness of a service.

Overall impact of PA. In 2023, the California Health Benefit Review Program (CHBRP) published a report to help the Legislature better understand the ways in which PA is used in California. CHBRP noted that PA is an imperfect instrument that is utilized in a myriad of ways. This poses a challenge for policymakers, payers, patients, and providers since PA is generally intended to decrease costs, but it may also contribute to delays in treatment and additional barriers to care. Currently, evidence is limited as to the extent to which health insurance uses PA and its impact on the performance of the health care system, patient access to appropriate care, and the health and financial interests of the general public. Despite the limited evidence, there is clear frustration from both patients and providers regarding PA practices. According to CHBRP, complaints range from the time required to complete the initial authorization request and pursue denials, to delays in care, to a general lack of transparency regarding the process and criteria used to evaluate PA requests. CHBRP further notes that people with disabilities, younger patients, African Americans, and people with lower incomes are more likely to report administrative burdens, including delays in care, due to PA.

Prescription drug coverage. According to CHBRP, almost all enrollees in plans and policies regulated by the Department of Managed Health Care (DMHC) and California Department of Insurance (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 UM techniques, including prior authorization, step therapy, and formulary requirements. UM techniques are generally applied 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 applicable UM techniques 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 UM requirements are present. Plans and insurers regulated by DMHC and CDI must complete UR for a completed prior authorization request within 72 hours (within 24 hours in emergency circumstances) or coverage for the script is required. UR may result in the plan or insurer covering the drug or denying coverage. Should a plan or insurer review a prior authorization request and then deny coverage, an enrollee, with assistance from the prescriber, may appeal the decision to the plan or insurer. Plans and insurers regulated by DMHC and CDI generally must review and respond to completed appeals within 30 days. The plan or insurer may agree to the appeal and cover the drug or may uphold their original denial. Should a plan or insurer review an appeal and uphold their denial, an enrollee, with assistance from the prescriber, may appeal the second denial to the appropriate regulator for state regulated health insurance. The regulator may uphold the denial or may require the plan or insurer to cover the drug.

Continuity Provisions of California Law. California law with respect to continuity of coverage requires that plans regulated by DMHC or CDI that include a pharmacy benefit not limit or exclude coverage for a drug for an enrollee when: i) the drug previously had been approved for coverage by the plan for a medical condition of the enrollee; ii) the plan′s prescribing provider continues to prescribe the drug for the medical condition; and, iii) provided that 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. This authorization does not apply to opioids or a scheduled controlled substance.

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. The author states that 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. The author continues that under current insurance practices, even minor, clinically appropriate adjustments are frequently treated as entirely new treatments. The author notes that 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. The author argues that these delays can lead to worsened health outcomes due to preventable complications or disease progression. The author states that 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. The author concludes that 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.

Arguments in Support
The Crohn′s & Colitis Foundation, sponsor of this bill, states that many chronic diseases are well-managed with the regular use of the right medication at the right dose. The sponsor continues that when providers work with patients to find an effective medication, over time they may require adjustment of the amount given, either by increasing the dose or decreasing the

dosing interval to achieve an effective therapeutic response. The sponsor notes that every single dose adjustment requires approval by the health plan, which, unfortunately, are often routinely denied requiring an appeal, particularly if the necessary dose is different than what′s on the label. The sponsor argues that most prescriptions for dose adjustment that are initially denied are ultimately approved when appealed. The sponsor cites that in 2021, 87.5% of inflammatory bowel disease (IBD) patients who appealed their insurance medication denials through DMHC′s Independent Medical Review process eventually had their request approved. The sponsor notes this means that patients were denied an effective dose of a life preserving medication for an unnecessary period. The sponsor continues that IBD is just one of many chronic illnesses for which an inadequate dose can cause serious or life threating complications. The sponsor argues that if insurance companies are allowed to continue to deny prescribed changes in dosage levels, chronically ill patients will be unable to receive the critical treatment they need. The sponsor concludes that this bill addresses this problem by ensuring patients have appropriate access to the right dose of a life-sustaining drug that meets their specific medical needs as determined by their physician.

Arguments in Opposition
The California Association of Health Plans (CAHP) and Association of California Life and Health Insurance Companies (ACLHIC) oppose this bill unless it is amended. CAHP and ACLHIC state that this bill may create potential patient safety concerns for their enrollees given that it specifically excludes language that requires that a drug must be prescribed consistent with FDA-labeled dosages or prescribed for something that is consistent with the use for which the drug has been approved for marketing by the FDA. 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. Furthermore, CAHP and ACLHIC believe that this bill will add costs to our healthcare delivery system by encouraging the use of expensive specialty and brand name drugs when a generic or lower cost brand equivalent is available and clinically appropriate, thereby impacting affordability of health care coverage in the state. Lastly, CAHP and ACLHIC argue that this bill would undermine existing UM protocols for prescription drugs by nullifying these processes and allowing a provider to increase the dosage of a drug up to two times without giving a health plan or insurer the ability to ensure clinically appropriate use. CAHP and ACLHIC appreciate recent amendments requiring two articles from major peer-reviewed medical journals supporting proposed off-label use as safe and effective, however it does not fully address concerns raised around patient safety. CAHP and ACLHIC request amendments to require the dose and frequency of the drugs prescribed under this bill to conform to FDA-approved labeling and applicable FDA guidance.

FISCAL COMMENTS

According to the Assembly Committee on Appropriations:

1) DMHC estimates minor and absorbable costs.

2) CDI anticipates minor and absorbable costs in fiscal year (FY) 2026-27 and FY 2027-28 to review insurance policy documents.

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).

VOTES

SENATE FLOOR: 39-0-1
YES: Allen, Alvarado-Gil, Archuleta, Arreguín, Ashby, Becker, Blakespear, Cabaldon, Caballero, Cervantes, Choi, Cortese, Dahle, Durazo, Gonzalez, Grayson, Grove, Hurtado, Jones, Laird, Limón, McGuire, McNerney, Menjivar, Ochoa Bogh, Padilla, Pérez, Reyes, Richardson, Rubio, Seyarto, Smallwood-Cuevas, Stern, Strickland, Umberg, Valladares, Wahab, Weber Pierson, Wiener
ABS, ABST OR NV: Niello

ASM HEALTH: 15-0-1
YES: Bonta, Chen, Addis, Aguiar-Curry, Ahrens, Caloza, Carrillo, Elhawary, Johnson, Patel, Patterson, Celeste Rodriguez, Sanchez, Sharp-Collins, Stefani
ABS, ABST OR NV: Schiavo

ASM APPROPRIATIONS: 15-0-0
YES: Wicks, Hoover, Arambula, Calderon, Caloza, Dixon, Fong, Mark González, Krell, Pacheco, Pellerin, Sharp-Collins, Solache, Ta, Tangipa

UPDATED

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