SB-306 Health care coverage: prior authorizations. (2025-2026)

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Senate Bill No. 306

CHAPTER 408

An act to add and repeal Section 1367.025 of the Health and Safety Code, and to add and repeal Section 10133.52 of the Insurance Code, relating to health care coverage.

[Approved by Governor October 06, 2025. Filed with Secretary of State October 06, 2025.]

LEGISLATIVE COUNSEL'S DIGEST

SB 306, Becker. Health care coverage: prior authorizations.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law generally authorizes a health care service plan or health insurer to use prior authorization and other utilization review or utilization management functions, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. Existing law requires a health care service plan or health insurer, including those plans or insurers that delegate utilization review or utilization management functions to medical groups, independent practice associations, or to other contracting providers, to comply with specified requirements and limitations on their utilization review or utilization management functions.

This bill would require the departments to issue instructions on or before July 1, 2026, to health care service plans and health insurers to report statistics regarding covered health care services subject to prior authorization and the percentage rate at which they are approved or modified, among other things. The bill would require a health care service plan or health insurer to report those statistics, including information from another entity to which the plan or insurer delegates responsibility for prior authorization decisions, to the appropriate department on or before December 31, 2026. The bill would require the departments to evaluate these reports, identify the health care services approved at a rate that meets or exceeds the threshold rate of 90%, and, on or before July 1, 2027, publish a list of the services identified. Beginning on the date specified by the relevant department, but no later than January 1, 2028, the bill would require a plan or insurer, or its delegated entities, to cease requiring prior authorization for the most frequently approved covered health care services. The bill would authorize a plan or insurer to reinstate prior authorization for a specific health care provider if it determines that the provider has engaged in fraudulent activity or clinically inappropriate care, as specified. No later than 4 years after the cessation of prior authorization requirements, the bill would require the departments to publish reports regarding the impact of that cessation using information reported by plans and insurers, including data on reinstatements of prior authorization for specific providers. The bill would repeal these provisions on January 1, 2034. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.
Vote: majority Appropriation: no Fiscal Committee: yes Local Program: yes

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 1367.025 is added to the Health and Safety Code, to read:

1367.025. (a) On or before July 1, 2026, the department shall issue instructions to health care service plans to report all covered health care services subject to prior authorization, the percentage rate at which they are approved or modified by the health care service plan or its delegated entity, and other statistics regarding prior authorization determinations as determined by the department. These instructions shall include a standard reporting template.

(b) (1) On or before December 31, 2026, a health care service plan shall report to the department, in accordance with the instructions issued pursuant to subdivision (a), the covered health care services subject to prior authorization, the percentage rate at which they are approved or modified by the health care service plan or its delegated entity, data regarding requested or authorized duration, frequency, or level of care of the health care services, and other statistics regarding prior authorization determinations pursuant to subdivision (a). Data regarding modifications shall be reported separately from approvals in accordance with the instructions issued pursuant to subdivision (a).

(2) If a health care service plan delegates responsibility for decisions regarding prior authorization requests to another entity, the health care service plan shall obtain information required to be reported by this section from each delegated entity and include that information in the health care service plan's report to the department. A health care service plan shall require a delegated entity to comply with a request made pursuant to this paragraph.

(c) (1) The department shall evaluate the reports received pursuant to this section and identify the health care services approved by health care service plans or their delegated entities at a rate that meets or exceeds the threshold rate of 90 percent. For purposes of this paragraph, "approved" may also include modified requests for the purpose of calculating the threshold rate as the department determines appropriate.

(2) The department may consider all of the following factors when determining the appropriateness of removing prior authorization for a specific covered health care service, regardless of its approval percentage rate:

(A) Utilization of a health care service in a manner inconsistent with current clinical practice guidelines published in peer-reviewed medical literature or United States Food and Drug Administration-approved indications, as applicable.

(B) The potential for fraud, waste, and abuse.

(C) The potential for cost savings from eliminating prior authorization, including out-of-pocket cost savings to the enrollee.

(D) The potential for improvements in quality of care, health care outcomes, and timely access to care for enrollees from eliminating prior authorization.

(E) Other factors deemed appropriate by the department.

(3) Before finalizing the list of covered health care services pursuant to this section, the department shall consult interested stakeholders.

(4) On or before July 1, 2027, the department shall publish the list of covered health care services identified pursuant to paragraph (1). As of the date specified in subparagraph (A) of paragraph (5), a health care service plan shall not impose prior authorization on a covered health care service included on the list published by the department pursuant to this paragraph.

(5) The department shall issue instructions to health care service plans regarding all of the following:

(A) The date, which shall be no later than January 1, 2028, by which the health care service plan and its delegated entities shall cease requiring prior authorization for the covered health care services identified pursuant to this subdivision. When issuing the date by which a health care service plan and its delegated entities shall cease requiring prior authorization pursuant to this section, the department shall take into consideration the time necessary for plans to update their contracts.

(B) Requirements for notifying providers of the change in prior authorization requirements.

(C) The process by which a health care service plan may petition the department to reinstate the ability of the health care service plan to use prior authorization for a particular covered health care service upon a showing of good cause that a lack of prior authorization for the covered health care service has resulted in a demonstrable increase in the cost of care or decrease in the quality of care for the health care service plan's enrollees, including fraud, waste, or abuse. The department

determination on a petition pursuant to this subparagraph shall be made within 60 days of receipt of all information necessary for the department to issue a decision on the petition. A health care service plan shall not reinstate prior authorization for a covered health care service subject to this section until authorized by the department and in accordance with any other law, as applicable.

(6) The department may issue other instructions it deems necessary and appropriate to implement this section.

(d) Notwithstanding subdivision (c), a health care service plan may impose prior authorization on any of the following:

(1) Outpatient prescription drugs in tier three or four of a health care service plan's formulary, as those tiers are defined in Section 1342.73.

(2) A drug or medical device prescribed or recommended for a use that is different from the use for which the drug or medical device has been cleared or approved for marketing by the United States Food and Drug Administration.

(3) A covered health care service that is experimental or investigational, excluding services for which there is medical or scientific evidence, as defined in Section 1370.4.

(4) A covered health care service that is prescribed or recommended for a use that is a novel application of an existing therapy or technology, excluding uses for which there is medical or scientific evidence, as defined in Section 1370.4.

(5) A covered health care service requested, ordered, prescribed, delivered, furnished, or dispensed by an out-of-network or noncontracting provider.

(e) A covered health care service that is exempted from prior authorization pursuant to this section constitutes a service authorized by the health care service plan for purposes of Section 1371.8. A health care service plan or its delegated entity shall not deny or reduce the contracted or agreed upon payment, or the applicable rate or reimbursement methodology specified in a plan contract, for a covered health care service exempted from a prior authorization requirement pursuant to this section unless the provider failed to substantially perform or supply the covered health care service.

(f) Notwithstanding subdivision (c), a health care service plan may, in accordance with any other applicable law, reinstate prior authorization for a specific health care provider on a covered health care service for which prior authorization is otherwise prohibited pursuant to subdivision (c) only if the health care service plan has determined, based on clear and convincing evidence, that the health care provider has engaged in either of the following:

(1) Fraudulent activity related to the provision or billing of health care services.

(2) Pattern or practice of repeatedly providing care that is clinically inappropriate or inconsistent with generally accepted standards of care, and that results in either potential harm to patients or excessive utilization of health care resources inconsistent with generally accepted standards of care.

(g) (1) The department may contract with a consultant or consultants with expertise in this subject area to assist the department in implementing this section, including developing instructions described in subdivision (a), evaluating the reports received by the department pursuant to subdivision (b), developing and publishing a list pursuant to subdivision (c), developing other implementation instructions, and drafting the report required pursuant to this section.

(2) The department's contract with a consultant shall include conflict-of-interest provisions to prohibit a person from participating in a report in which the person knows or has reason to know they have a material financial interest, including a person who has a consulting or other agreement with a person or organization that would be affected by the results of the report.

(3) Contracts entered into pursuant to this subdivision are exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, and Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and shall be exempt from the review or approval of any division of the Department of General Services.

(h) No later than four years after the date determined by the department for cessation of prior authorization requirements pursuant to subparagraph (A) of paragraph (5) of subdivision (c), the department shall publish a report regarding the impacts of the cessation of prior authorization requirements. A health care service plan shall report information and data regarding the impacts of implementing this section, including effects on the volume of covered health care services subjected to prior authorization, statistics on prior authorization requests and determinations, administrative costs, timely access to care, enrollee health outcomes, and data on reinstatements of prior authorization pursuant to subdivision (f), to be included in this report.

(i) (1) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of all-plan letters, methodologies, rules, definitions, policies, forms, information or data requests, or similar instructions, without taking regulatory action, until this section is repealed.

(2) The department shall consult with the Department of Insurance before issuing instructions and the list of covered health care services for which prior authorization is prohibited, pursuant to this section, to ensure consistency to the extent practical.

(j) A health care service plan shall not delegate the requirements of this section to a delegated provider, pharmacy benefit manager, or other entity, unless the parties have negotiated and agreed upon a new provision to the parties' contract, as provided in Section 1375.7. A change to the parties' contract pursuant to this subdivision shall be considered a material change. Notwithstanding delegation pursuant to this subdivision, a health care service plan shall comply with this section, including paragraph (2) of subdivision (b).

(k) (1) This section does not apply to a specialized health care service plan, except to the extent the plan provides or administers essential health benefits pursuant to health care service plan contracts subject to Section 1367.005.

(2) This section does not apply to a Medi-Cal managed care plan contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code.

(l) For purposes of this section:

(1) "Covered health care service" means a health care item, product, drug, supply, procedure, treatment, or service covered by a health care service plan contract.

(2) "Prior authorization" means the process by which utilization review determines the medical necessity or medical appropriateness of otherwise covered health care services prior to or concurrent with the rendering of those health care services. "Prior authorization" also includes a health care service plan's or its delegated entity's requirement that an enrollee or health care provider notify the health care service plan before providing a health care service, including preauthorization, precertification, and prior approval.

(m) This section shall remain in effect only until January 1, 2034, and as of that date is repealed.

SEC. 2. Section 10133.52 is added to the Insurance Code, to read:

10133.52. (a) On or before July 1, 2026, the department shall issue instructions to health insurers to report all covered health care services subject to prior authorization, the percentage rate at which they are approved or modified by the health insurer or its delegated entity, and other statistics regarding prior authorization determinations as determined by the department. These instructions shall include a standard reporting template.

(b) (1) On or before December 31, 2026, a health insurer shall report to the department, in accordance with the instructions issued pursuant to subdivision (a), the covered health care services subject to prior authorization, the percentage rate at which they are approved or modified by the health insurer or its delegated entity, data regarding requested or authorized duration, frequency, or level of care of the health care services, and other statistics regarding prior authorization determinations pursuant to subdivision (a). Data regarding modifications shall be reported separately from approvals in accordance with the instructions issued pursuant to subdivision (a).

(2) If a health insurer delegates responsibility for decisions regarding prior authorization requests to another entity, the health insurer shall obtain information required to be reported by this section from each delegated entity and include that information in the health insurer's report to the department. A health insurer shall require a delegated entity to comply with a request made pursuant to this paragraph.

(c) (1) The department shall evaluate the reports received pursuant to this section and identify the health care services approved by health insurers or their delegated entities at a rate that meets or exceeds the threshold rate of 90 percent. For purposes of this paragraph, "approved" may also include modified requests for the purpose of calculating the threshold rate as the department determines appropriate.

(2) The department may consider all of the following factors when determining the appropriateness of removing prior authorization for a specific covered health care service, regardless of its approval percentage rate:

(A) Utilization of a health care service in a manner inconsistent with current clinical practice guidelines published in peer-reviewed medical literature or United States Food and Drug Administration-approved indications, as applicable.

(B) The potential for fraud, waste, and abuse.

(C) The potential for cost savings from eliminating prior authorization, including out-of-pocket cost savings to the insured.

(D) The potential for improvements in quality of care, health care outcomes, and timely access to care for insureds from eliminating prior authorization.

(E) Other factors deemed appropriate by the department.

(3) Before finalizing the list of covered health care services pursuant to this section, the department shall consult interested stakeholders.

(4) On or before July 1, 2027, the department shall publish the list of covered health care services identified pursuant to paragraph (1). As of the date specified in subparagraph (A) of paragraph (5), a health insurer shall not impose prior authorization on a covered health care service included on the list published by the department pursuant to this paragraph.

(5) The department shall issue instructions to health insurers regarding all of the following:

(A) The date, which shall be no later than January 1, 2028, by which the health insurer and its delegated entities shall cease requiring prior authorization for the covered health care services identified pursuant to this subdivision. When issuing the date by which a health insurer and its delegated entities shall cease requiring prior authorization pursuant to this section, the department shall take into consideration the time necessary for insurers to update their policies.

(B) Requirements for notifying providers of the change in prior authorization requirements.

(C) The process by which a health insurer may petition the department to reinstate the ability of the health insurer to use prior authorization for a particular covered health care service upon a showing of good cause that a lack of prior authorization for the covered health care service has resulted in a demonstrable increase in the cost of care or decrease in the quality of care for the health insurer's insureds, including fraud, waste, or abuse. The department determination on a petition pursuant to this subparagraph shall be made within 60 days of receipt of all information necessary for the department to issue a decision on the petition. A health insurer shall not reinstate prior authorization for a covered health care service subject to this section until authorized by the department and in accordance with any other law, as applicable.

(6) The department may issue other instructions it deems necessary and appropriate to implement this section.

(d) Notwithstanding subdivision (c), a health insurer may impose prior authorization on any of the following:

(1) Outpatient prescription drugs in tier three or four of a health insurer's formulary, as those tiers are defined in Section 10123.1932.

(2) A drug or medical device prescribed or recommended for a use that is different from the use for which the drug or medical device has been cleared or approved for marketing by the United States Food and Drug Administration.

(3) A covered health care service that is experimental or investigational, excluding services for which there is medical or scientific evidence, as defined in Section 10145.3.

(4) A covered health care service that is prescribed or recommended for a use that is a novel application of an existing therapy or technology, excluding uses for which there is medical or scientific evidence, as defined in Section 10145.3.

(5) A covered health care service requested, ordered, prescribed, delivered, furnished, or dispensed by an out-of-network or noncontracting provider.

(e) A covered health care service that is exempted from prior authorization pursuant to this section constitutes a service authorized by the health insurer for purposes of Section 796.04. A health insurer or its delegated entity shall not deny or reduce the contracted or agreed upon payment, or the applicable rate or reimbursement methodology specified in a policy, for a covered health care service exempted from a prior authorization requirement pursuant to this section unless the provider failed to substantially perform or supply the covered health care service.

(f) Notwithstanding subdivision (c), a health insurer may, in accordance with any other applicable law, reinstate prior authorization for a specific health care provider on a covered health care service for which prior authorization is otherwise prohibited pursuant to subdivision (c) only if the health insurer has determined, based on clear and convincing evidence, that the health care provider has engaged in either of the following:

(1) Fraudulent activity related to the provision or billing of health care services.

(2) Pattern or practice of repeatedly providing care that is clinically inappropriate or inconsistent with generally accepted standards of care, and that results in either potential harm to patients or excessive utilization of health care resources

inconsistent with generally accepted standards of care.

(g) (1) The department may contract with a consultant or consultants with expertise in this subject area to assist the department in implementing this section, including developing instructions described in subdivision (a), evaluating the reports received by the department pursuant to subdivision (b), developing and publishing a list pursuant to subdivision (c), developing other implementation instructions, and drafting the report required pursuant to this section.

(2) The department's contract with a consultant shall include conflict-of-interest provisions to prohibit a person from participating in a report in which the person knows or has reason to know they have a material financial interest, including a person who has a consulting or other agreement with a person or organization that would be affected by the results of the report.

(3) Contracts entered into pursuant to this subdivision are exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, and Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and shall be exempt from the review or approval of any division of the Department of General Services.

(h) No later than four years after the date determined by the department for cessation of prior authorization requirements pursuant to subparagraph (A) of paragraph (5) of subdivision (c), the department shall publish a report regarding the impacts of the cessation of prior authorization requirements. A health insurer shall report information and data regarding the impacts of implementing this section, including effects on the volume of covered health care services subjected to prior authorization, statistics on prior authorization requests and determinations, administrative costs, timely access to care, insured health outcomes, and data on reinstatements of prior authorization pursuant to subdivision (f), to be included in this report.

(i) (1) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of bulletins, methodologies, rules, definitions, policies, forms, information or data requests, or similar instructions, without taking regulatory action, until this section is repealed.

(2) The department shall consult with the Department of Managed Health Care before issuing instructions and the list of covered health care services for which prior authorization is prohibited, pursuant to this section, to ensure consistency to the extent practical.

(j) This section does not apply to a specialized health insurer, except to the extent the insurer provides or administers essential health benefits pursuant to health insurance policies or certificates subject to Section 10112.27.

(k) For purposes of this section:

(1) "Covered health care service" means a health care item, product, drug, supply, procedure, treatment, or service covered by a health insurance policy or certificate.

(2) "Prior authorization" means the process by which utilization review determines the medical necessity or medical appropriateness of otherwise covered health care services prior to or concurrent with the rendering of those health care services. "Prior authorization" also includes an insurer's or its delegated entity's requirement that an insured or health care provider notify the health insurer before providing a health care service, including preauthorization, precertification, and prior approval.

(l) This section shall remain in effect only until January 1, 2034, and as of that date is repealed.

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.