



# NAVIGATING CHANGE

## California Medical Association 2025 Legislative Wrap Up

California wrapped up its 2025 legislative session on October 12, sending 1,247 bills to the Governor's desk – just over half of the 2,416 that were introduced this year. Amid shifting political priorities and an ever-changing policy landscape, each year feels more chaotic and frenetic than the last, and 2025 was no exception.

California lawmakers returned in January thinking the big issue of the year would be the budget deficit, which would grow to \$12 billion by May, only to be faced with the catastrophic wildfires in Los Angeles – the most expensive disaster in the state's history and one that hit close to home for many physicians who were both victims and first responders. Only a few months after these fires, Congress began debating HR 1, a sweeping tax and spending bill that drastically reduced health care funding. The ramifications of its passage will be felt in the California budget for the foreseeable future.

The summer recess – a period typically devoted to negotiating lingering amendments to myriad bills – was spent laying the groundwork for Proposition 50, which would drastically redraw California's congressional district lines. The national debate has largely dominated the legislative discussion in Sacramento, and many of the state's new policy proposals were aimed at responding to federal actions.

The end of session also saw a leadership change in the Senate with Pro Tem Mike McGuire being replaced by Senator Monique Limón, who represents Santa Barbara, Ventura and Oxnard. Senator Limón takes the reins November 17, and we expect allies like Senator Christopher Cabaldon, Senator Angelique Ashby and Senator Akilah Weber Pierson, M.D., to be elevated into important leadership and committee positions.

*On the following pages are highlights of the California Medical Association's (CMA) major legislative priorities this year.*

## Prior Authorization

After years of roadblocks to prior authorization reform, CMA introduced four bills to reform the state's prior authorization systems. CMA's prior authorization reform package included common-sense reforms to streamline prior authorization processes, expedite critical care for patients and free up physicians' time to focus on patients, not paperwork.

Earlier iterations (SB 277, SB 516) were previously held because of cost and implementation concerns raised by the California Department of Managed Health Care (DMHC), so we tailored this year's four-bill prior authorization reform package to be efficient to implement in light of the state's budget deficit. Ultimately, we were successful in sending two bills to the Governor's desk, SB 306 and AB 512, with the former signed and the latter vetoed. SB 306 gives the administration the authority to remove prior authorizations on a code-by-code basis, as well as to require reporting from the health plans to give us a better picture of how prior authorization is being deployed at the ground level. Another bill in the package, AB 539, advanced to the Senate Health Committee. CMA will resume working to advance it through the legislature in the 2026 legislative session. The bills in CMA's prior authorization reform package included:

- + **SB 306 (Becker):** Requires annual reporting of prior authorization data from health plans and gives DMHC the authority to remove prior authorization statewide on a code-by-code basis. **Signed by the Governor.**
- + **AB 512 (Harabedian):** Shortens the decision timeline for prior or concurrent authorization requests for health plans and health insurers to be no longer than three business days for standard requests (instead of five days in existing law) if the request is made by electronic submission, and 24 hours for urgent requests involving an imminent and serious threat to the enrollee's health if the request is made by electronic submission or 48 hours. **Vetoed by the Governor.**
- + **AB 510 (Addis):** Requires that appeals of prior authorization denials be performed by a provider of the same or similar specialty. This will help ensure that providers can discuss prior authorization denials with a professional peer who understands the recommended treatment and underlying condition. **Held in Assembly Appropriations Committee.**
- + **AB 539 (Schiavo):** Extends the validity of an approved prior authorization to one year (current industry standard is between 60-90 days). This will provide patients with a longer window of time to receive medically necessary care and avoid cumbersome prior authorization review (and ultimately appeal) processes. **Currently in Senate Health Committee.**

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## Liability Protections

CMA was successful in stopping a bill (twice!) sponsored by the Consumer Attorneys of California that would have increased medical malpractice costs.

**SB 29 (Laird)** would have extended pandemic-era legal exceptions that make it easier to sue for pain and suffering damages – including in medical malpractice cases – undoing the careful balance struck in AB 35's historic reforms to the Medical Injury Compensation Reform Act (MICRA). Unless amended to exclude medical malpractice claims, this bill would have significantly increased litigation, settlement and damages costs across California's health care system – costs that would have been passed on to physician practices, health plans and

the state itself. These increased costs would have further destabilized a system already reeling from drastic state and federal budget cuts, including the devastating multibillion-dollar Medicaid cuts under HR 1.

CMA was successful in getting the bill held in Assembly Appropriations due to its high costs to both the state and the health care system. However, in an unusual procedural move, the bill was resurrected on the evening of September 2, the very last day for bills to be amended. The CMA Government Relations team quickly sprang into action, ensuring that every single Assemblymember had been contacted by a CMA representative by 10 a.m. the following morning. The bill did not have the required votes to pass and was placed on the inactive file on the very last day of session. This bill will likely return next legislative session, but CMA will continue working with legislators to ensure that any bill that passes does not affect medical malpractice cases.

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## Private Equity

CMA also sponsored **SB 351 (Cabaldon)**, which codified Medical Board of California guidance restricting non-physicians from making business decisions that infringe upon the clinical determinations of physicians. The bill also gives the California Attorney General authority to bring its own enforcement actions, which is a critical new policy. Currently, violations of the corporate practice of medicine either have to be enforced through costly private litigation or through regulatory actions taken by the medical board. Private lawsuits, even if they are successful, typically do not provide financial remuneration, and the medical board has not devoted any resources to enforcing this law. Giving the Attorney General this power means the state can take enforcement action without having to rely solely on civil lawsuits filed by physicians.

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## Artificial Intelligence

The rapid rise of artificial intelligence emerged as a major new policy front in the California Legislature this year. Last year's CMA-sponsored **SB 1120 (Becker)** established a requirement that health plans maintain physician oversight when using AI to approve or deny claims. Building on that foundation, CMA this year sponsored **AB 489 (Bonta)**, which prohibits AI systems or similar technologies, such as internet-based chatbots, from misleading patients into thinking they are interacting with licensed health professionals.

CMA also led a health care coalition to defeat **AB 1018 (Bauer-Kahan)**, a sweeping proposal that would have imposed complex disclosure, auditing and reporting mandates on anyone using automated decision-making tools. As written, the bill would have treated every physician in California as a "deployer of AI," subjecting routine technology use to onerous compliance requirements and potential enforcement actions. Had it become law, the bill would have severely disrupted the current use of AI in health care and deterred future innovation and technological advancement.

Thanks to CMA's advocacy, the bill was placed on the inactive file, preserving physicians' ability to adopt innovative tools while policymakers continue working toward a more balanced regulatory framework.

**On the following pages, you will find summaries of many of the key bills that CMA was involved with in 2025.**

## Priority Opposed

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### **AB 280 (Aguiar-Curry) – Provider Directories**

*Status: Two-Year Bill – Held on Senate Floor Inactive File.*

This bill would have imposed new mandates related to the accuracy and maintenance of health plan provider directories. As written, this bill would have significantly increased administrative burdens without guaranteeing improved directory accuracy and would have put providers at risk of being reimbursed at the out-of-network amount – set unilaterally by the plan and often significantly below market value – when a consumer is misled by inaccurate or outdated provider directory information.

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### **AB 396 (Tangipa) – Needle and Syringe Exchange**

*Status: Two-Year Bill – Held in Assembly Health Committee.*

This bill would have required every needle provided through a needle exchange program to carry a unique identifier and required all needles through exchange programs to be properly disposed of. Any needle that had not been properly disposed of could be traced back, and the offending entity that donated the needle would be fined \$10,000 per needle. This bill would have created significant costs that threatened the existence of needle exchange programs.

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### **AB 1018 (Bauer Kahan) – Artificial Intelligence**

*Status: Two-Year Bill – Held on Senate Floor Inactive File.*

This bill would have required incredibly burdensome administrative regulations on both developers and deployers of AI. As written, every physician in the state would have been considered a “deployer of AI.”

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### **AB 1215 (Flora) – Hospitals: Medical Staff Membership**

*Status: Two-Year Bill – Held in Assembly B&P Committee.*

This bill would have required that dentists, podiatrists, clinical psychologists, nurse practitioners, nurse anesthetists, nurse midwives and other health care professionals be admitted to an organized medical staff. This bill failed to account for the diverse circumstances and requirements of different health care facilities and would have put a physician’s licensure at risk by linking enforcement of this bill to disciplinary actions by the Medical Board.

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### **AB 1453 (Tangipa) – Contraception Information**

*Status: Two-Year Bill – Held in Assembly Higher Ed Committee.*

This bill would have required the California State University and requested the University of California to provide all students with adoption information when they receive contraception or emergency contraception from their campus

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health center or pharmacy. This was an inappropriate mandate that would have undermined efforts to provide students with the reproductive health care they need.

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### **AB 1450 (Hoover) – California Children’s Services Program: Providers**

*Status: Two-Year Bill – Held in Assembly Health Committee.*

This bill would have allowed the Department of Health Care Services to approve advanced practice providers – including nurse practitioners, physician assistants and certified registered nurse anesthetists – to practice independently within the California Children’s Services program. Allowing advanced practice providers to practice independent of physician supervision is inappropriate, dangerous and at odds with delivering the safest and most effective patient care.

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### **SB 29 (Laird) – Civil Actions: Decedent’s Cause of Action**

*Status: Two-Year Bill – Held on Assembly Floor Inactive File.*

This bill would have made permanent the ability for a surviving descendant or spouse to recover non-economic damages (pain and suffering) that otherwise would have been awarded to the plaintiff had they survived. As written, this would have included medical malpractice claims, which should be excluded in light of MICRA modernization negotiated through AB 35 (Reyes, 2022).

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### **SB 579 (Padilla) – Mental Health and AI Working Group**

*Status: Two-Year Bill – Held in Senate Appropriations Committee.*

This bill would have required the Government Operations Agency to appoint a working group to study the impacts and role of artificial intelligence in mental health treatment environments, but did not require a physician to be appointed. CMA requested amendments to ensure that the working group included a physician; however, the bill was held before amendments could be taken.

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### **SB 747 (Wiener) – Wages: Behavioral Health and Medical-Surgical Employees**

*Status: Two-Year Bill – Held in Senate Rules Committee.*

This bill would have required a “covered employer” to report confidential behavioral health employee and medical-surgical employee compensation information to the Department of Industrial Relations. This bill would have diverted resources away from patient care and posed privacy and data security concerns. In September, this bill was amended and no longer pertains to the practice of medicine.

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# Successfully Negotiated

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## **AB 277 (Alanis) – Behavioral Health Centers, Facilities, and Programs: Background Checks**

*Status: Two-Year Bill – Held in Assembly Human Services Committee.*

This bill requires any person providing behavioral health treatment to undergo a background check. CMA ensured that this would not apply to physicians holding a current and valid license, as the California physician licensure process includes a fingerprint-based background check.

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## **AB 290 (Bauer-Kahan) – Emergency Services: Physician Fines**

*Status: Signed by Governor (Chapter 475, Statutes of 2025).*

This bill would have increased penalties for physicians who fail to provide emergency health care by raising monetary penalties from \$5,000 per violation to \$1 million per violation and establishing additional civil liability for physicians that violate injunctions related to a prior failure to provide emergency health care. Due to opposition, the bill was ultimately gutted and amended and no longer pertains to the practice of medicine, moving CMA to a neutral position.

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## **AB 316 (Krell) – Artificial Intelligence**

*Status: Signed by Governor (Chapter 672, Statutes of 2025).*

This bill prohibits defendants that develop or use AI from asserting a defense that AI autonomously caused harm in a legal action. While not intended to target physicians, this bill unintentionally would have put physicians at risk any time they use AI tools. Amendments were taken that allow defendants to present information for any other affirmative defense, including evidence relevant to causation or the comparative fault of any other person or entity. CMA's amendments to explicitly exempt physicians from this bill were rejected, but other amendments provide a pathway for physician liability protection.

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## **AB 348 (Krell) – Full-Service Partnerships**

*Status: Signed by Governor (Chapter 688, Statutes of 2025).*

This bill establishes criteria for serious mental illness to presumptively be eligible for a full-service partnership through their county and funded by the Mental Health Services Act. CMA collaborated with the California State Association of Psychiatrists to address concerns and ensure those with behavioral health conditions would also be presumptively eligible.

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## **AB 360 (Papan) – Menopause Survey**

*Status: Two-Year Bill – Held in Assembly Appropriations Committee.*

This bill would have created a menopause training survey to be provided to all physicians and surgeons upon license renewal to

determine the level of menopausal training they have received. While the survey would have been anonymous and optional, mandating the creation of an overly broad survey at license renewal was an inappropriate avenue to gather such information and would have likely resulted in costs to the Medical Board of California and therefore increased licensing fees. Amendments were taken that instead create a study on menopausal training by the Department of Health Care Access and Information and the medical board, removing CMA's opposition.

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## **AB 432 (Bauer-Kahan) – Menopause CME Mandate**

*Status: Vetoed by Governor.*

This bill would have imposed an ongoing continuing medical education (CME) mandate on menopause for all general internists, family physicians, obstetricians and gynecologists, cardiologists, endocrinologists, and neurologists who have a patient population composed of 25% or more adult women under 65 years of age. CMA supports efforts to improve access to educational opportunities; however, CMA opposes mandatory CME requirements, as physicians are best positioned to determine which courses are most pertinent to their practice and patient population. This bill would have broadly captured a wide range of physicians whose practices do not involve diagnosing or managing menopause. The bill now creates an incentive program that allows physicians who take a CME course in menopause to receive two credits for every one hour, removing CMA's opposition.

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## **AB 583 (Pellerin) – Death Certificates**

*Status: Signed by Governor (Chapter 271, Statutes of 2025).*

This bill allows nurse practitioners to be the attesting provider on death certificates when practicing in a skilled nursing or intermediate care facility. Amendments re-drafted the bill in different code sections to enable implementation. A neutral position was recommended because the overwhelming majority of nurse practitioners still practice under physician supervision. CMA offered amendments that would have only allowed independently practicing nurse practitioners to complete and attest on a death certificate.

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## **AB 601 (Jackson) – Child Abuse Reporting**

*Status: Two-Year Bill – Held in Senate Appropriations Committee.*

This bill introduces a variety of changes to mandated reporting for general neglect, including establishing an alternative response approach and creating a new standardized curriculum for mandated reporters that must be completed within the first three months of employment. CMA worked to ensure that physicians – who already undergo mandated reporting training – were exempted from this new requirement, moving us to neutral.

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**AB 669 (Haney) – Substance Use Disorder Coverage**

*Status: Two-Year Bill – Held in Senate Appropriations Committee.*

This bill prohibits concurrent or retrospective review of medical necessity for the first 28 days of an inpatient substance use disorder stay during each plan or policy year. However, the bill also granted psychologists the ability to prescribe drugs. CMA moved to neutral after psychologists were removed from the list of those who can prescribe drugs.

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**AB 692 (Kalra) – Employment Contracts**

*Status: Signed by Governor (Chapter 703, Statutes of 2025).*

This bill makes certain contract terms unlawful, including a term requiring a worker to pay an employer for a debt if the worker's employment is terminated. Amendments moved CMA to neutral by addressing concerns that employers would be prohibited from collecting amounts paid for training in instances where the employee was stealing or engaged in insubordination, sexual harassment or other misconduct. Amendments now allow for termination of employment prior to the retention period at the election of the employer for material noncompliance or misconduct.

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**AB 849 (Soria) – Medical Chaperones**

*Status: Signed by Governor (Chapter 442, Statutes of 2025).*

This bill requires required licensed health facilities to provide a medical chaperone to patients during sensitive examinations and required that both a hard copy and electronic notice be given to the patient or their legal guardian. CMA had concerns after the bill was amended to include "providers," creating redundant requirements for physicians. CMA moved to neutral once amendments were taken that provided a mechanism to reschedule patient exams if a medical chaperone was not available and reduced administrative burdens by requiring only a one-time notification.

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**AB 876 (Flora) – Nurse Anesthetists: Scope of Practice**

*Status: Signed by Governor (Chapter 169, Statutes of 2025).*

This bill would have allowed certified registered nurse anesthetists (CRNAs) to practice independently, without physician oversight, in hospitals, outpatient facilities and dental offices. This bill would have fundamentally changed how anesthesia care is delivered by removing critical safeguards. Recent amendments, as a direct result of CMA advocacy, struck many of the concerning provisions that would have allowed CRNAs to practice independently of any physician order or supervision. These amendments clarify that when CRNAs are providing anesthesia care in any health care setting, it must be under an order from a physician – including preoperative, intraoperative, postoperative and pain management care. This largely clarifies existing CRNA practice in California.

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**AB 970 (McKinnor) – Child Abuse and Neglect Reporting**

*Status: Two-Year Bill – Held in Assembly Public Safety Committee.*

This bill proposes a pilot program to evaluate a new model for mandatory child abuse reporting. The program would incorporate internet-based tools and decision-support systems to assist mandated reporters in assessing whether a report should be made. Amendments clarify that participation in the program is voluntary and affirm that mandated reporters – particularly physicians – retain full authority and discretion in making reporting decisions.

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**AB 1172 (Nguyen) – Antiseizure Medication**

*Status: Signed by Governor (Chapter 448, Statutes of 2025).*

This bill would have authorized a licensed adult program facility to administer inhalable seizure medication to disabled adults at the facility by trained volunteers in emergency situations. CMA had concerns regarding physician liability for incorrect administration of these medications by volunteers and worked with the author to clarify that participating physicians cannot be held liable for the actions of volunteers following their administration and observation instructions, moving CMA to neutral.

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**AB 1196 (Gallagher) – Health Facilities: Cardiac Surgery**

*Status: Two-Year Bill – Held in Assembly Appropriations Committee.*

This bill would have changed the requirements for cardiac surgical teams performing extracorporeal bypass to consist of a minimum of one surgeon and two additional medical staff persons, down from three surgeons. CMA coordinated with the California Society of Cardiologists to narrow the bill and ensure that requirements reflect current professional standards of care.

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**AB 1415 (Bonta) – California Health Care Quality and Affordability Act**

*Status: Signed by Governor (Chapter 641, Statutes of 2025).*

This bill would have broadened the definition of entities captured under the California Office of Health Care Quality and Affordability Act by including management service organizations (MSOs), hospital systems, and hedge funds under the definition of applicable entities. Additionally, this bill specified that a physician organization would be captured if it is under the same ownership or control as a hospital. Amendments, taken in collaboration with CMA, deleted the bill's newly created definition of a health system. This change was adopted in response to CMA's concerns that the bill would have subjected physician organizations that are part of larger health systems to onerous data and reporting requirements under the Office of Health Care Affordability.

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**SB 297 (Hurtado) – Valley Fever Screening**

*Status: Two-Year Bill – Held in Assembly Appropriations Committee.*

This bill would have required the California Department of Public Health to track and identify regions with Valley Fever and mandate that adult patients receiving primary care services in high-incidence regions be offered a Valley fever screening test in a culturally competent and linguistically appropriate manner. CMA opposed this mandate as it overrides a physician's clinical judgment in determining whether testing is appropriate. Amendments were negotiated to remove the mandate that every adult patient be offered a test, instead clarifying that patients in high-risk areas need to be screened according to current clinical standards, and ensuring that physicians are not subject to any licensing actions if they decide – based on their professional judgment – not to screen or offer a test for Valley fever.

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## Priority Support

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**AB 82 (Ward) – Health Care: Legally Protected Health Care Activity**

This bill extends existing privacy laws and protections to health care professionals providing gender-affirming care and services. Additionally, this bill prohibits testosterone and mifepristone from being reported to the Controlled Substances Utilization Review and Evaluation System.

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**AB 260 (Aguiar-Curry) – Sexual and Reproductive Health Care**

*Status: Signed by Governor (Chapter 136, Statutes of 2025).*

This bill allows a pharmacy to dispense abortion medication without a physician's name or pharmacy information, so long as a log with this identifying information is maintained. The bill specifies that this log may only be accessed via subpoena. AB 260 also protects healing arts practitioners from civil or criminal actions for prescribing or furnishing abortion medication and prohibits healing arts boards from taking any licensing or disciplinary action against a practitioner solely because they were disciplined or convicted in another state for prescribing abortion medication.

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**AB 408 (Berman) – Physician Health and Wellness Program**

*Status: Two-Year Bill – Held in Senate Judiciary Committee.*

This bill would establish a physician health and wellness program under the Medical Board of California to support physicians' health and protect patients. The bill would align California with national best practices to address mental health and burnout issues. This bill would protect patients by connecting impaired or at-risk physicians with treatment.

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**AB 416 (Krell) – Involuntary Commitment**

*Status: Signed by Governor (Chapter 691, Statutes of 2025).*

This bill empowers emergency department physicians to authorize 5150 holds on patients suffering from severe mental illness and in crisis.

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**AB 447 (Gonzalez, Mark) – Involuntary Commitment**

*Status: Signed by Governor (Chapter 363, Statutes of 2025).*

This bill allows physicians or authorized prescribers to dispense an unused portion of a medication to an emergency department patient upon discharge, as long as the drug is not a controlled substance, has been ordered and administered specifically to the patient, and is required for continued treatment of the patient.

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**AB 544 (Davies) – Electric Bicycles**

*Status: Signed by Governor (Chapter 36, Statutes of 2025).*

This bill updates existing law to align electric bicycles with regular bicycles regarding required safety equipment. It adds requirements for minors to wear a properly fitted and fastened helmet that meets certain safety standards when operating an e-bike and prohibits the sale of a helmet for an e-bike that does not meet those standards.

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**AB 951 (Ta) – Health Care Coverage: Behavioral Diagnoses**

*Status: Signed by Governor (Chapter 84, Statutes of 2025)*

This bill prohibits insurance companies from requiring patients to undergo repeated re-diagnoses for pervasive developmental disorders and autism as a condition of maintaining their insurance coverage.

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**AB 1127 (Gabriel) – Firearms: Converter Pistols**

*Status: Signed by Governor (Chapter 572, Statutes of 2025).*

This bill prohibits the sale of certain semi-automatic handguns that can be easily converted to automatic machine guns.

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**SB 40 (Wiener) – Health Care Coverage: Insulin**

*Status: Signed by Governor (Chapter 737, Statutes of 2025).*

This bill prohibits health plans from imposing a copay of more than \$35 for a 30-day supply of insulin and prohibits plans from imposing step-therapy protocols as a prerequisite to authorizing coverage of insulin.

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**SB 41 (Wiener) – Pharmacy Benefits**

*Status: Signed by Governor (Chapter 605, Statutes of 2025).*

This bill would prohibit pharmacy benefit managers (PBMs) from requiring use of an affiliated pharmacy or imposing conditions that would discourage the use of a non-affiliated

pharmacy. It would also limit a PBM's income to the fee for the pharmacy benefit management services provided. SB 41 bans spread pricing and mandates that drug rebates go to payers, not PBM profits.

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### **SB 439 (Weber-Pierson) – California Health Benefit Review Program**

*Status: Signed by Governor (Chapter 318, Statutes of 2025).*

This bill extends the operation of the California Health Benefit Review Program and the Health Care Benefits Fund and authorizes the continued assessment of the annual charge on health plans for that purpose through fiscal year 2032–2033.

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## **CMA-Sponsored**

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### **AB 489 (Bonta) – Health Care Professions: Deceptive Terms or Letters: Artificial Intelligence**

*Status: Signed by Governor (Chapter 615, Statutes of 2025)*

This bill would ban companies from marketing artificial AI chatbots as licensed medical professionals. AI can be a useful tool for physicians and patients; however, patients need to know when they're communicating with an AI chatbot versus a trained health care professional.

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### **AB 510 (Addis) – Prior Auth: Same or Similar Specialty**

*Status: Held in Assembly Appropriations Committee.*

This bill would have required that appeals of prior authorization delays, modifications, or denials be performed by a provider of the same or similar specialty. This would have helped ensure that providers can discuss prior authorization denials with a professional peer who understands the recommended treatment and underlying condition.

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### **AB 512 (Harabedian) – Prior Auth: Shortened Timelines**

*Status: Vetoed by Governor.*

This bill would shorten urgent prior authorization request timelines from 72 hours to 24 hours for electronic submissions and 48 hours for non-electronic submissions. For non-urgent requests, the timeline would be shortened to three business days for electronic submissions, while maintaining the existing five business days for non-electronic submissions. This change will ensure more patients can receive care or appeal denials in a timely fashion.

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### **AB 539 (Schiavo) – Prior Auth: One-Year Duration**

*Status: Two-Year Bill – Held in Senate Health Committee.*

This bill would extend the validity of an approved prior authorization to one year (current industry standard is 60–90

days). This will provide patients with a longer window of time to receive medically necessary care and avoid the cumbersome prior authorization review and appeal processes.

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### **AB 967 (Valencia) – Physicians and Surgeons: Licensure: Expedited Fee**

*Status: Two-Year Bill – Held in Senate Business, Professions, and Education Committee.*

This bill would streamline the process for licensing out-of-state physicians looking to practice in California. This will ensure that physicians can be recruited to move to California and have certainty that they will have an active license to practice when they relocate.

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### **SB 32 (Weber-Pierson) – Health Care Coverage: Timely Access to Care**

*Status: Held in Assembly Appropriations Committee.*

This bill would enhance access to maternity care services by requiring the California Department of Health Care Services, the California Department of Managed Health Care, and the California Department of Insurance to establish unique time and distance standards for perinatal units in collaboration with stakeholders.

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### **SB 306 (Becker) – Prior Auth: Volume Reduction**

*Status: Signed by Governor (Chapter 408, Statutes of 2025)*

This bill would allow the California Department of Managed Health Care to remove the requirement for prior authorization for the majority of services and lower tiers of prescription drugs that are approved at a high rate. DMHC will determine which services and items have prior authorization removed after health plans submit the required prior authorization statistics. This will reduce the overall volume of prior authorization requests and ensure that patients can receive the care they need with minimal delays and that physicians can spend more time focusing on patient care.

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### **SB 351 (Cabaldon) – Health Facilities**

*Status: Signed by Governor (Chapter 409, Statutes of 2025)*

Private equity firms are gaining influence in our health care system, leading to rising costs and undermining the quality of care. This bill empowers the Attorney General to hold private equity groups accountable for interfering with the practice of medicine, allowing the Attorney General to investigate and take action against private equity firms that unlawfully interfere in the patient–physician relationship. The goal is to restore trust in the health care system, ensuring that medical decisions are made in the best interests of patients, not financial shareholders.