SENATE COMMITTEE ON APPROPRIATIONS
Senator Anna Caballero, Chair
2025 - 2026 Regular Session

AB 682 (Ortega) - Health care coverage reporting

Version: July 17, 2025
Urgency: No
Hearing Date: August 18, 2025
Policy Vote: HEALTH 9 - 0
Mandate: Yes
Consultant: Agnes Lee

Bill Summary: AB 682 would require health plans and insurers to report prior authorization data and claims data, as specified.

Fiscal Impact:

- The Department of Managed Health Care (DMHC) estimates costs of approximately $192,000 in 2025-26, $3,222,000 in 2026-27, $3,431,000 in 2027-28, and $3,424,000 in 2028-29 and annually thereafter for state administration (Managed Care Fund).

- The California Department of Insurance (CDI) estimates costs of $71,000 in 2025-26, $110,000 in 2026-27, $98,000 in 2027-28, and $78,000 in 2028-29 and ongoing thereafter for state administration (Insurance Fund).

- Unknown potential cost pressures to capitation payments for Medi-Cal managed care plans for administration (General Fund and federal funds).

Background: Current law authorizes health plans and insurers to use prior authorization, which is a form of utilization review or utilization management, to determine whether to authorize, modify, or deny health care services. Utilization review can occur prospectively, retrospectively, or concurrently, and a health plan or insurer can approve, modify, delay or deny in whole or in part a request based on its medical necessity. California law requires written policies and procedures that are consistent with criteria or guidelines and supported by clinical principles and processes. These policies and procedures must be filed with regulators, and disclosed, upon request, to providers, enrollees/insureds, and the public.

In January 2024, the federal Centers for Medicare and Medicaid Services (CMS) issued a final rule affecting Medicare Advantage plans, Medicaid managed care plans, and others to improve the electronic exchange of health care data and to streamline the prior authorization processes. The final rule includes requirements for public reporting of prior authorization metrics.

Proposed Law: Specific provisions of the bill would:

- Require health plans and insurers that impose prior authorization to report publicly on its internet website prior authorization data, including all of the following from the previous calendar year:

    - A list of items and services that require prior authorization.

- The percentage of standard prior authorization requests that were approved, aggregated for all items and services.
- The percentage of standard prior authorization requests that were denied, aggregated for all items and services.
- The percentage of standard prior authorization requests that were approved after appeal, aggregated for all items and services.
- The percentage of prior authorization requests for which the timeframe for review was extended and the request was approved, aggregated for all items and services, as specified.
- The percentage of expedited prior authorization requests that were approved, aggregated for all items and services.
- The percentage of expedited prior authorization requests that were denied, aggregated for all items and services.
- The average and median time that elapsed between the submission of a request and a determination by the plan/insurer for standard prior authorizations, aggregated for all items and services.
- The average and median time that elapsed between the submission of a request and a decision by the plan/insurer for expedited prior authorizations, aggregated for all items and services.

- Require health plans and insurers to include in an annual plan claims payment and dispute resolution report, or in another report as specified, all of the following information for each month:
  - The number of claims processed or adjudicated.
  - The number of claims denied, adjusted, or contested.
  - The total cost of claims denied, adjusted, or contested.
  - The number and total costs of in-network claims denied, adjusted, or contested.
  - The number and total cost of out-of-network claims denied, adjusted, or contested.
  - The number and total cost of claims from an enrollee denied, adjusted, or contested.
  - The number of claims disaggregated, as specified.
  - The number and total costs of claims denied, adjusted, or contested, disaggregated by reason, as specified.
  - The number and total costs of claims denied, adjusted, or contested, disaggregated by demographic category, as specified.

- The number and total cost of claims denied, adjusted, or contested, disaggregated by specific medical procedures and diagnoses.

- Of contested claims, the number of claims denied that at any point were processed, adjudicated, or reviewed with artificial intelligence or other predictive algorithms.

Related Legislation: SB 363 (Wiener) would require health plans and insurers to report claims data and to report every treatment denial or modification, as specified. The bill is currently in the Assembly Appropriations Committee.

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