Office of Senate Floor Analyses
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THIRD READING

Bill No: AB 682
Author: Ortega (D), et al.
Amended: 7/17/25 in Senate
Vote: 21

SENATE HEALTH COMMITTEE: 9-0, 7/16/25
AYES: Menjivar, Durazo, Gonzalez, Limón, Padilla, Richardson, Rubio, Weber Pierson, Wiener
NO VOTE RECORDED: Valladares, Grove

SENATE APPROPRIATIONS COMMITTEE: 6-0, 8/29/25
AYES: Caballero, Cabaldon, Dahle, Grayson, Richardson, Wahab
NO VOTE RECORDED: Seyarto

ASSEMBLY FLOOR: 76-0, 5/27/25 (Consent) - See last page for vote

**SUBJECT:** Health care coverage reporting

**SOURCE:** California Nurses Association

**DIGEST:** This bill requires health plans, and insurers, submit provider claims payment information and prior authorization decision information to the Department of Managed Health Care and the Department of Insurance, and those departments to publish the information.

**ANALYSIS:**

Existing law:

1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act); California Department of Insurance (CDI) to regulate health and other insurance; and, the Department of Health Care Services (DHCS) to administer the Medi-Cal program. [Health and Safety Code (HSC) §1340, et

seq., Insurance (INS) §106, et seq. and Welfare and Institutions (WIC) §14000, et seq.]

2) Requires health plans to submit an audit report containing audited financial statements, as well as other financial statements, as specified, to DMHC. [HSC §1384]

3) Requires health plans and insurers to reimburse complete claims, partial claims, uncontested claims, and contested claims submitted by health care providers that are not denied, within specified timelines, or pay interest and potential fees, as specified. [HSC §1371, §1371.34, §1371.35 and INS §10123.13, §10123.147]

4) Requires health plans and insurers, and any contracted entity that performs utilization review or utilization management functions, prospectively, retrospectively, or concurrently, based on medical necessity requests to comply with specified requirements, including a decision within five business days of receiving reasonable information to make a decision, conducting retrospective review within 30 days and decisions associated with imminent and serious threat within 72 hours or sooner. [HSC §1367.01 and INS §10123.135]

5) Requires, if a health plan or insurer cannot make a decision to approve, modify, or deny a request for authorization within the required timeframes because it is not in receipt of all information reasonably necessary and requested, because a consultation by an expert reviewer is necessary, or, because an additional test or examination is necessary, the plan or insurer to notify the provider and enrollee or insured in writing. [HSC §1367.01 and INS §10123.135]

This bill:

1) Requires, on or before February 1, 2026, and annually, a health plan or insurer that imposes prior authorization, and any entities with which the plan or insurer contracts for prior authorization, to report publicly on its internet website the following prior authorization data, including all of the following from the previous calendar year:

   a) A list of items and services that require prior authorization;
   b) The percentage of standard prior authorization requests that were approved, aggregated for all items and services;

c) The percentage of standard prior authorization requests that were denied, aggregated for all items and services;
d) The percentage of standard prior authorization requests that were approved after appeal, aggregated for all items and services;
e) 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. Requires this to include the reasons for extension, aggregated for all items and services;
f) The percentage of expedited prior authorization requests that were approved, aggregated for all items and services;
g) The percentage of expedited prior authorization requests that were denied, aggregated for all items and services;
h) The average and median time that elapsed between the submission of a request and a determination by the plan for standard prior authorizations, aggregated for all items and services; and,
i) The average and median time that elapsed between the submission of a request and a decision by the plan for expedited prior authorizations, aggregated for all items and services.

2) Require a health plan or insurer to include in an annual plan claims payment and dispute resolution report, or in another report as prescribed, all of the following information for each month:

a) The number of claims processed or adjudicated;
b) The number of claims denied, adjusted, or contested;
c) The total cost of claims denied, adjusted, or contested;
d) The number and total costs of in-network claims denied, adjusted, or contested;
e) The number and total cost of out-of-network claims denied, adjusted, or contested;
f) The number and total cost of claims from an enrollee or insured denied, adjusted, or contested;
g) The number of claims disaggregated by the following:

i) Claims paid or adjusted within 30 calendar days of claim submission to a contracted network provider and noncontracted claimant, disaggregated by provider type; and,
ii) Claims paid or adjusted beyond 30 calendar days of claim submission to a claimant network contracted and noncontracted, disaggregated by provider type;

h) The number and total costs of claims denied, adjusted, or contested, disaggregated by each of the following reasons:

i) Out-of-network provider;
ii) Excluded service;
iii) Lack of prior authorization or referral.
iv) Medical necessity reasons;
v) Experimental or investigational treatment.
vi) Lack of efficacy;
vii) Medical records not provided or insufficient information;
viii) Clerical error, including claim form errors, incorrect procedure coding, or incorrect patient or provider information;
ix) Patient ineligibility or coverage rule;
x) Lack of timely filing;
xi) Other. Requires, if other is designated, the plan or insurer to specify the reason for the denial or modification; and,
xii) Any other reason as the director or commissioner may prescribe.

i) The number and total costs of claims denied, adjusted, or contested, disaggregated by the following demographic categories:

i) Age;
ii) Gender identity;
iii) Sex;
iv) Ethnicity;
v) Disability; and,
vi) Sexual orientation;

j) The number and total cost of claims denied, adjusted, or contested, disaggregated by specific medical procedures and diagnoses; and,
k) Of contested claims, the number of claims denied that at any point were processed, adjudicated, or reviewed with artificial intelligence or other predictive algorithms.

3) Requires by February 1 of each year, beginning February 1, 2027, a health plan or insurer to submit, in a form and manner prescribed by DMHC or CDI, the data described in 2) above for the preceding calendar year to DMHC or CDI. Requires the information to be posted by April 15 of each year, and be disaggregated by each plan or insurer making this filing, as specified.

4) Requires DMHC or CDI, if the number of claims disaggregated is less than 11 individuals, to aggregate and report these claims as other claims.

5) Requires data and information made public by DMHC or CDI to be disclosed in a manner that protects the personal information of patients pursuant to deidentification requirements as specified by DMHC, as well as other state and federal privacy and confidentiality laws, as specified.

6) Permits a report of data described in 2) to be rejected and requires within 30 days the deficiency to be corrected.

7) Defines:

   a) "Adjudicated" as a plan, health insurer, or other person subject to the Knox-Keene Act, or, a specified chapter of the Insurance Code, has made a determination, whether full or partial, regarding claims payment or coverage;
   b) "Claim" as a claim received by a plan or insurer asking for a payment or reimbursement by or on behalf of an in-network health care provider that is contracted with the network, a health care provider that is not contracted to be part of the network, or an enrollee of the plan or insured of the insurer; and,
   c) "Contested claim" as a claim that is incomplete and without all the information necessary to determine payer liability for the claim, or a claim in which a provider has not granted reasonable access to information concerning provider services.

**Comments:**

According to the author of this bill:

> A healthcare insurance system should provide relief, security, and fairness---not confusion, frustration, and denial. Yet today, Californians face a bureaucratic labyrinth, where unnecessarily complex processes discourage patients from pursuing the care they need. Too often, insurance claim denials rob patients of life-saving treatments and timely healthcare. This bill mandates transparency and accountability. By requiring health plans to publicly disclose detailed claim denial data—including reasons, outcomes of appeals, and frequency of denials—this bill provides the data needed to understand the scope and extent of health insurance denials, empowering

consumers to make informed choices and providing lawmakers and stakeholders crucial information that can support future health care policy.

**Background:**

*Affordable Care Act (ACA) requirements.* The ACA requires reporting by certain health plans and insurers to inform regulators and the public about claims denials rates. While the requirement applies broadly to individual and large group health plans and insurers that are "non-grandfathered" (meaning they are plans created after the ACA was enacted), according to the Kaiser Family Foundation (KFF), this requirement has not been fully implemented; and the data is not audited or used for oversight, and is only required by plans participating on the federal exchange HealthCare.gov. Data elements include claims payment policies and practices, periodic financial disclosures, data on enrollment, data on disenrollment, data on the number of claims denied, data on rating practices, information on cost-sharing and out-of-network coverage. Included in denial reason categories is the following:

- Denials due to lack of prior authorization or referral;
- Denials due to an out-of-network provider;
- Denials due to an exclusion of a service;
- Denials based on medical necessity (reported separately for behavioral health and other services);
- Denials due to enrollee benefit reached;
- Denials due to a member not being covered;
- Denials due to investigational, experimental, or cosmetic procedure;
- Denials for administrative reasons (which include claims that were duplicate, missing information, untimely, for an unapproved provider, or that met other criteria); and,
- Denials for all other reasons not specified above.

*Covered California.* KFF has published many analyses on private health plan/insurer claims denials. In a January 27, 2025 analysis on ACA Marketplace Plans, KFF indicates California requires insurers to report data on claims received and denied each year for both in- and out-of-network services, in a manner similar to HealthCare.gov insurers. Among insurers submitting complete 2023 claims data to Covered California, the in-network denial rate was 21%, similar to HealthCare.gov insurers. One insurer had a denial rate of 87%. When excluding this insurer from the analysis, the overall claims denial rate among Covered California insurers was 19%. Specified denial reason categories are the same for

both Marketplaces. At the plan-level, about 14% of in-network denials were due to lack of prior authorization or a referral, followed by about 6% due to administrative reasons, and about 1% for lacking medical necessity. The appeal rate for Covered California insurers (1%) was similar to HealthCare.gov insurers. Among all Covered California insurers with complete data, about 40% of internal appeals and 47% of external appeals filed were upheld, substantially lower than HealthCare.gov insurers. Like denials, one insurer also represented a large share of the appeals data reported. When excluding that insurer, the rate of internal appeals upheld by Covered California insurers was 61%.

*Centers for Medicare and Medical Services (CMS) Interoperability and Prior Authorization Final Rule.* On January 17, 2024 the CMS issued a final rule affecting Medicare Advantage plans, Medicaid managed care plans, Qualified Health Plans (QHPs) on Federally Facility Exchanges and others (impacted payers) to implement and maintain certain electronic standards to improve the electronic exchange of health care data and streamline prior authorization processes. These impacted payers, except QHPs, must send prior authorization decisions within 72 hours for expedited requests and seven calendar days for standard requests. This final rule excludes decisions for drugs, and requires public reporting of prior authorization metrics annually on the websites of impacted payers for data from the previous calendar year. These include:

- A list of all 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;
- 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, for standard prior authorizations, aggregated for all items and services; and,

- The average and median time that elapsed between the submission of a request and a decision by the plan for expedited prior authorizations, aggregated for all items and services.

**Related/Prior Legislation**

SB 363 (Wiener) requires health plans and insurers to annually report to their regulator their total number of claims processed and treatment denials or modifications. Makes health plans and insurers liable for penalties for each independent medical review that is resolved in favor of the consumer in excess of 50% or for each failure to report a treatment denial or modification. *SB 363 is pending in the Assembly Appropriations Committee.*

**FISCAL EFFECT:** Appropriation: No Fiscal Com.: Yes Local: Yes

According to the Senate Committee on Appropriations,

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).

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).

**SUPPORT:** (Verified 8/29/25)

California Nurses Association (Source)
AARP
American Federation of State, County, and Municipal Employees
California Alliance for Retired Americans
California Chapter American College of Cardiology
California Children's Hospital Association
California Hospital Association
California Society of Plastic Surgeons
Health Access California
Planned Parenthood Affiliates of California
Steinberg Institute
United Hospital Association

Western Center on Law & Poverty

**OPPOSITION:** (Verified 8/29/25)

Association of California Life and Health Insurance Companies
California Association of Health Plans
California Association of Dental Plans

**ARGUMENTS IN SUPPORT:** This bill is sponsored by the California Nurses Association (CNA), which believes that transparency in the insurance denial process will provide the public and policy makers with a better understanding of the impact of health insurance denials on increasing medical debt and other barriers to care. CNA indicates that DMHC previously reported claims denied each month in Schedule G of the Annual Financial Report for each health plan but stopped in 2010 because it was not required. CNA says this bill also requires health plans to report and DMHC and CDI to publicly disclose the number of claims denied each month disaggregated by reason for the denial, including information on denials based on lack of prior authorization, out-of-network provider, medical necessity, experimental or investigational treatment, insufficient information, ineligibility, untimely filing, or other reasons.

**ARGUMENTS IN OPPOSITION:** The California Association of Dental Plans indicate this bill requires data elements that dental plans cannot gather and share. *Oppose unless amended.* The California Association of Health Plans (CAHP) and the Association of California Life and Health Insurance Companies (ACLHIC) write that the extensive reporting requirements proposed in this bill present significant administrative and operational challenges for health plans/insurers that would necessitate substantial investments in data infrastructure, analytics, and reporting capabilities.

ASSEMBLY FLOOR: 76-0, 5/27/25
AYES: Addis, Aguiar-Curry, Ahrens, Alanis, Alvarez, Arambula, Ávila Farías, Bains, Bauer-Kahan, Berman, Boerner, Bonta, Bryan, Calderon, Caloza, Carrillo, Castillo, Chen, Connolly, Davies, DeMaio, Dixon, Elhawary, Ellis, Flora, Fong, Gabriel, Gallagher, Garcia, Gipson, Mark González, Hadwick, Haney, Harabedian, Hart, Hoover, Irwin, Jackson, Kalra, Krell, Lackey, Lee, Lowenthal, Macedo, McKinnor, Muratsuchi, Ortega, Pacheco, Papan, Patel, Patterson, Pellerin, Petrie-Norris, Quirk-Silva, Ramos, Ransom, Celeste Rodriguez, Michelle Rodriguez, Rogers, Blanca Rubio, Sanchez, Schiavo,

Schultz, Sharp-Collins, Solache, Soria, Stefani, Ta, Tangipa, Valencia, Wallis, Ward, Wicks, Wilson, Zbur, Rivas

NO VOTE RECORDED: Bennett, Jeff Gonzalez, Nguyen

Prepared by: Teri Boughton / HEALTH / (916) 651-4111
8/29/25 20:52:55

****** END ******