CONCURRENCE IN SENATE AMENDMENTS
AB 682 (Ortega)
As Amended September 4, 2025
Majority vote

SUMMARY

Requires health plans and insurers that impose prior authorization (PA) to annually report publicly on their internet website specified data on PA including items and services that require PA, PA approval and denial percentages for standard and expedited requests, and average and median PA processing timeframes. Requires a health plan and health insurer to report to the Department of Managed Health Care (DMHC) or the California Department of Insurance (CDI) information on the number of claims processed or adjudicated, including the number and total cost of claims denied, adjusted, or contested, in total and broken down by in-network and out-of-network and the number and total cost of claims from an enrollee denied, adjusted, or contested, disaggregated by various reasons.

Major Provisions

1) Requires health plans and insurers that impose prior authorization PA to annually report publicly each February on their internet website PA data, including all of the following from the previous calendar year:

   a) A list of items and services that require PA;

   b) The percentage of standard PA requests and expedited PA requests that were approved and denied, aggregated for all items and services;

   c) The percentage of standard PA and expedited PA requests that were approved after appeal, aggregated for all items and services;

   d) The percentage of PA requests for which the timeframe for review was extended and the request was approved, aggregated for all items and services, including the reasons for extension, aggregated for all items and services; and,

   e) The average and median time that elapsed between the submission of a request and a determination by the plan or insurer for standard PA and expedited PA, aggregated for all items and services.

2) Requires any entities with which the plan or insurer contracts for PA to report to the plan and insurer the information described above, and requires this information to be publicly reported on the plan or insurer's internet website.

3) Authorizes the Director of DMHC and the Commissioner of CDI to make rules and regulations specifying the form and content of the reports required above, and to require that the data be verified by the plan, insurer or other person in a manner as the director or commissioner may prescribe.

4) Requires a health plan and health insurer to include in an annual plan claims payment and dispute resolution report, or in another report as prescribed by the Director of DMHC or Commissioner of CDI, all of the following information for each month:

   a) The number of claims processed or adjudicated;

   b) The number and total cost of claims denied, adjusted, or contested, in total and broken down by in-network and out-of-network;

   c) The number and total cost of claims from an enrollee denied, adjusted, or contested;

   d) 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 provider, disaggregated by provider type;

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

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

         (1) Out-of-network provider;

         (2) Excluded service;

         (3) Lack of PA or referral;

         (4) Medical necessity reasons;

         (5) Experimental or investigational treatment;

         (6) Lack of efficacy;

         (7) Medical records not provided or insufficient information;

         (8) Clerical error, including claim form errors, incorrect procedure coding, or incorrect patient or provider information;

         (9) Patient ineligibility for coverage;

         (10) Lack of timely filing;

         (11) Other (if other is designated, the health plan and health insurer is required to specify the reason for the denial, adjustment, or contest); and,

         (12) Any other reason the director or commissioner may prescribe.

   e) The number and total costs of claims denied, adjusted, or contested, disaggregated by age, gender identify, sex, ethnicity, disability, sexual orientation;

f) The number and total cost of claims denied, adjusted, or contested, disaggregated by specific medical procedures and diagnoses; and,

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

5) Requires, by February 1st of each year, a health plan and health insurer to submit, in a form and manner prescribed by DMHC or CDI, the data required for the preceding calendar year to DMHC or CDI, and requires by April 15 of each year, DMHC and CDI post the information submitted on its internet website.

6) Requires information posted by DMHC and CDI to be disaggregated by each health plan and health insurer required to make this filing.

7) Permits the DMHC director or CDI commissioner to reject a report filed by notifying the plan or insurer, requires the plan or insurer, within 30 days after the receipt of the notice, to correct the deficiency, and deems a failure to correct the deficiency a violation. Requires the director and commissioner to retain a copy of all rejected filings.

8) Permits the DMHC director and CDI commissioner to make rules and regulations specifying the form and content of the reports required, and to require that these reports be verified by the plan or insurer in a manner as the director or commissioner may prescribe.

9) Defines terms (such as adjudicated, adjusted, claim, contested claim and AI) for purposes of the claims information reporting required by this bill.

Senate Amendments

1) Expand the scope of PA reporting required by this bill.

2) Delay the operative date and establish different operative dates for health plans and health insurers.

3) Define "lack of efficacy" and "total cost" for purposes of this bill.

4) Require the reporting requirements in this bill as separate reporting requirements, instead of requiring the reports in the Assembly-approved version of this bill, which require the report as part of an existing reporting to DMHC and CDI.

COMMENTS

Utilization management (UM) and utilization review **(**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. Prior authorization is a UR technique used by health plans that requires patients to obtain approval of a service or medication before care is provided. Prior authorization is intended to allow plans to evaluate whether care that has been prescribed is medically necessary for purposes of coverage. Concurrent review occurs throughout the course of a patient's treatment. Concurrent review is intended to enable a plan to scrutinize the necessity for the plan, level, and setting of care while care is being delivered. Retrospective review occurs after care was delivered and after the bill for that care was submitted. Retrospective review seeks

to confirm that the care that was delivered was appropriate and provided at the most efficient and effective level.

Across state-regulated commercial plans and policies, 100% of enrollees are subject to some sort of prior authorization in their benefits. In 2023, the California Health Benefits Review Program (CHBRP) published a report to help the Legislature better understand the ways in which prior authorization is used in California. CHBRP noted that prior authorization is an imperfect instrument that's utilized in a myriad of ways. This poses a challenge for policymakers, payers, patients, and providers since prior authorization is generally intended to decrease costs and waste, 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 prior authorization 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 prior authorization 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 prior authorization 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 prior authorization.

Under state law, if an enrollee's health plan denies, changes, or delays a request for medical services, denies payment for emergency treatment or refuses to cover experimental or investigational treatment for a serious medical condition, an enrollee can apply for an independent medical review (IMR). Before filing an IMR with the regulator, enrollees are first required to file a grievance with the health plan (absent an emergency). Once an enrollee has participated in the 30-day process with the health plan, if the issue has not been resolved or an enrollee is not satisfied with the decision, an enrollee can proceed with filing an IMR. According to CHBRP, a sizable share of prior authorization denials were overturned upon appeal, ranging from 40% to 82% of denials being overturned. This is consistent with overall appeals across the state. According to 2023 data, 72% of appeals made to DMHC resulted in a denial being reversed.

According to the Author
The health insurance system should provide relief, security, and fairness, not confusion, frustration, and denial. Yet the author argues that today, Californians face a bureaucratic labyrinth where unnecessarily complex processes discourage patients from pursuing the care they need. The author continues that too often insurance claim denials rob patients of life-saving treatments and timely healthcare. The author states that this bill mandates transparency and accountability. The author continues that by publicly disclosing detailed claim denial data, including reasons, outcomes of appeals, and frequency of denials, this bill empowers consumers to make informed choices and pressures insurance companies to compete fairly on quality of service, not just premiums and profit margins. The author argues that by providing data on the issue of claim denials, this bill would also empower lawmakers and stakeholders to create targeted interventions and sound public policy. The author concludes that this bill marks a vital advancement toward a healthcare system that prioritizes patient health, restores trust, and compels insurers to honor their commitments to patients.

Arguments in Support
The California Nurses Association (CNA), sponsor of this bill, states that by shining a light on harmful denial practices by health insurers, this bill would establish common sense requirements on the collection and reporting of information on the extent and reasoning behind health insurance denials. CNA continues that while patients and doctors report that health insurance denials are steadily on the rise, there are little to no requirements under state or federal law that insurers disclose and regulators publish data on health insurance denials. CNA notes that this bill would restore the public availability of information regarding the number of health insurance denials, which had been previously reported by DMHC, and would additionally require more robust reporting on the reasons why claims are denied, the time for appeals and denials to be processed, and other characteristics of denials. CNA argues that public transparency on health insurance denials is necessary for patients, researchers, and regulators to better understand the scope of the problem and to take well-informed action to address delays and denials in health care.

Arguments in Opposition
The California Association of Dental Plans write in opposition as they indicate this bill would require data elements that dental plans cannot gather and share.

The California Association of Health Plans (CAHP) and the Association of California Life and Health Insurance Companies (ACLHIC) have taken an oppose unless amended position, arguing 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.

FISCAL COMMENTS

According to the Senate Appropriations Committee:

1) 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).

2) 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).

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

VOTES:

ASM HEALTH: 16-0-0
YES: Bonta, Chen, Addis, Aguiar-Curry, Arambula, Carrillo, Flora, Mark González, Krell, Patel, Patterson, Celeste Rodriguez, Sanchez, Schiavo, Sharp-Collins, Stefani

ASM APPROPRIATIONS: 15-0-0
YES: Wicks, Sanchez, Arambula, Calderon, Caloza, Dixon, Elhawary, Fong, Mark González, Hart, Pacheco, Pellerin, Solache, Ta, Tangipa

ASSEMBLY FLOOR: 76-0-3

YES: 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
ABS, ABST OR NV: Bennett, Jeff Gonzalez, Nguyen

UPDATED

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