SENATE COMMITTEE ON HEALTH
Senator Caroline Menjivar, Chair

BILL NO: AB 682
AUTHOR: Ortega
VERSION: June 23, 2025
HEARING DATE: July 16, 2025
CONSULTANT: Teri Boughton

SUBJECT: Health care coverage reporting

SUMMARY: Requires health plans, insurers, and Multiple Employer Welfare Arrangements to submit a substantial amount of provider claims payment information and prior authorization decisions information to the Department of Managed Health Care and the Department of Insurance, and those departments to publish the information as part of existing financial and enrollment reports.

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. [HSC §1340, et seq., INS §106, et seq. and 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 annually report to DMHC and CDI, in a form and manner determined by DMHC and CDI, enrollment totals of covered individuals, by product type, including through multiple employer welfare arrangements (MEWAs), as specified, for the previous calendar year made publicly available no later than April 15 of each calendar year. [HSC §1348.95 and INS §10127.19]

4) 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]

5) 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]

6) 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]

7) Establishes requirements for health plans and insurers that use an artificial intelligence (AI), algorithm, or other software tool for utilization review or utilization management functions, and prohibits the AI, algorithm, or other software tool from denying, delaying, or modifying health care services based in whole or in part on medical necessity. [HSC §1367.01 and INS §10123.135]

8) Establishes requirements for a certificate of compliance to be issued by CDI to a self-funded or partially self-funded MEWA that meets specified requirements, including that it filed an application for a certificate of compliance no later than November 30, 1995. [INS §742.20-§742.43]

9) Requires a MEWA that is subject to 8) above, to provide the number of covered persons in the MEWA as of December 31 of the prior year, divided by product type, and satisfy this requirement through a data call. [INS §10127.19]

This bill:

1) Requires a health plan to include as part of required financial statements, in an annual plan claims payment and dispute resolution report or another report as prescribed by the DMHC director, and a health insurer and MEWA to include as part of the CDI covered enrollment report all of the following for each month:
   a) The number of claims processed or adjudicated.
   b) The number of claims denied or partially denied.
   c) The total cost of claims denied or partially denied.
   d) The number and total costs of in-network claims denied or partially denied.
   e) The number and total costs of prior authorization requests denied or partially denied.
   f) The number and total costs of prior authorization requests processed.
   g) The number of decisions that were approved, modified, or denied for prior authorization requests beyond the five-business-day requirement.
   h) The number of prior authorization requests that were extended and approved.
   i) The average and median time that elapsed between the submission of a prior authorization request and the decision by the plan, health insurer, or MEWA.
   j) The number and total costs of retrospective requests denied or partially denied.
   k) The number and total costs of retrospective requests processed.
   l) The number of decisions that were approved, modified, or denied for retrospective requests beyond the 30-day period.
   m) The number of retrospective requests that were extended and approved.
   n) The average and median time that elapsed between the submission of a retrospective request and the decision by the plan, health insurer, or MEWA.
   o) The number and total costs of urgent requests made that were denied or partially denied.
   p) The number and total costs of urgent requests made that were processed.
   q) The number of decisions that were approved, modified, or denied for urgent requests made beyond the 72-hour requirement.
   r) The number of urgent requests made that were extended and approved.
   s) The average and median time that elapsed between the submission of an urgent request and the decision by the plan, health insurer, or MEWA.
   t) The total out-of-pocket costs paid by an enrollee to pay for a treatment and procedure of which a claim was denied or partially denied.
   u) The number of claims disaggregated by the following:

i) Claims paid within 30 business days of claim submission to a contracted network provider and noncontracted claimant, disaggregated by provider type.
ii) Claims paid within 45 business days of claim submission to a contracted network provider and noncontracted claimant, disaggregated by provider type.
iii) Claims paid beyond 45 business days of claim submission to a claimant network contracted and noncontracted, disaggregated by provider type.
iv) Requires a health plan, insurer, or MEWA to utilize the Healthcare Provider Taxonomy codes maintained by the National Uniform Claim Committee, as specified, or other methodologies of classifying provider types as prescribed by DMHC or CDI.

v) The number and total costs of claims denied or partially denied, 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 health plan, health insurer or MEWA to specify the reason for the denial or modification.
xii) Any other reason as the director may prescribe.

w) The number and total costs of claims denied or partially denied, disaggregated by the following demographic categories:
i) Age.
ii) Gender identity.
iii) Sex.
iv) Ethnicity.
v) Disability.
vi) Sexual orientation.

x) The number and total cost of claims denied or partially denied, disaggregated by specific medical procedures and diagnoses.
y) A list of medical procedures that require prior authorization.
z) Requires a health plan, health insurer or MEWA to utilize the Current Procedural Terminology, the International Classifications of Diseases, or other methodologies of coding diagnoses, medical procedures, and medical treatments as prescribed by DMHC or CDI.
aa) The number of claims in which a denied or partially denied claim was contested internally and externally.
bb) Of contested claims, the number of internal appeals or grievances filed or processed.
cc) Of contested claims, the number of claims denied or partially denied that were overturned through internal appeals or grievances processes.
dd) Of contested claims, the number of external appeals or grievances filed.
ee) Of contested claims, the number of claims denied or partially denied that were overturned through external appeals or grievances processes.

ff) Of contested claims, the number of claims denied or partially denied that at any point were processed, adjudicated, or reviewed with artificial intelligence or other predictive algorithms.
gg) Of contested claims, the number of claims resulting in written determination.

2) Requires DMHC to publish on its internet website monthly claims denial information described in 1) above, for each plan in a manner prescribed by DMHC. Requires by April 15 of each year, beginning April 15, 2027, CDI to include the data submitted pursuant to this bill in the covered lives report required by existing law.

3) Defines:
   a) "Adjudicated" as a plan, health insurer, MEWA 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 request for payment or coverage of health care services, including prior authorization requests, submitted to or received by a plan or other person subject to the Knox-Keene Act, health insurer, MEWA or other person subject to a specified chapter of the Insurance Code; and,
   c) "Partially denied" as a claim in which a plan or other person subject to the Knox-Keene Act, health insurer, MEWA, or other person subject to a specified chapter of the Insurance Code agrees to pay only a portion of a claim and does not approve payment of the total claim made, including, but not limited to, claims that a plan, insurer, or MEWA has adjusted, made modifications to, or otherwise changed the payment amount, deductible, coinsurance, copayment, diagnosis or procedure code, or approved treatment related to the claim.

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 the Insurance Commissioner to reject any report filed pursuant to this bill by notifying the health insurer or MEWA required to make this filing of its rejection and the cause thereof. Requires the health insurer or MEWA to correct the deficiency within 30 days after the receipt of the notice.

7) Permits the Insurance Commissioner to assess an administrative penalty against a health insurer or MEWA for failure to correct the deficiency.

8) Permits the Insurance Commissioner to make rules and regulations specifying the form and content of the reports referred to in this bill, and to require that these reports be verified by the health insurer and MEWA in a manner prescribed by the Insurance Commissioner.

9) Requires a health insurer or MEWA, by February 1 of each year beginning February 1, 2027, to submit, in a form and manner prescribed by CDI the data required pursuant to this bill for the preceding calendar year to CDI.

10) Requires by April 15 of each year, beginning April 15, 2027, CDI to include the data submitted pursuant to this bill in the covered lives report required by existing law.

11) Requires information posted pursuant to this bill to be disaggregated by each health plan, insurer, or MEWA required to make this filing.

FISCAL EFFECT: This bill has not been analyzed by a fiscal committee with the additional reporting requirements amended on June 23, 2025.

PRIOR VOTES:

Assembly Floor:	76 - 0
Assembly Appropriations Committee:	15 - 0
Assembly Health Committee:	16 - 0

COMMENTS:

1) *Author's statement.* According to the author, 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.

2) *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:
   a) Denials due to lack of prior authorization or referral;
   b) Denials due to an out-of-network provider;
   c) Denials due to an exclusion of a service;
   d) Denials based on medical necessity (reported separately for behavioral health and other services);
   e) Denials due to enrollee benefit reached;
   f) Denials due to a member not being covered;
   g) Denials due to investigational, experimental, or cosmetic procedure;
   h) Denials for administrative reasons (which include claims that were duplicate, missing information, untimely, for an unapproved provider, or that met other criteria); and,
   i) Denials for all other reasons not specified above.

3) *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%.

4) *CMS Interoperability and Prior Authorization Final Rule.* On January 17, 2024 the Centers for Medicare and Medical Services (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) A list of all 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;
   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.

5) Related 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 set for hearing in the Assembly Health Committee on July 15, 2025.*

6) *Prior legislation.* SB 129 (Pan, Chapter 241, Statutes of 2019) adds a requirement to the covered lives report, a requirement that health plans and insurers report the number of enrollees in MEWAs, by MEWA name, and includes a requirement in CDI's report that certain grandfathered MEWAs report the number of enrollees covered as part of their MEWA.

   AB 1083 (Monning, Chapter 852, Statutes of 2012) establishes the annual reporting requirement for health plans and insurers to report the number of enrollees, by product type that received coverage in the prior year in each market segment (referred to as the covered lives report).

7) *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.

8) *Support if amended.* The California Chapter of the American College of Emergency Physicians requests that unpaid claims be added to the required reporting list in this bill.

   Students for Patient Advocacy Nationwide are concerned about the use of "reviewed with AI" and requests operational clarity. Specifically, they suggest the bill should also clarify that rules-based auto-adjudication is not considered AI unless it incorporates adaptive or predictive learning components, and include the following definition:
   "AI use" may include any system that:
   (a) makes an initial determination on claim outcome;
   (b) scores or prioritizes claims based on modeled criteria; or
   (c) influences final adjudication without human intervention.
   (d) rules-based auto-adjudication is not considered AI unless it incorporates adaptive or predictive learning components.

9) *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. CAHP and ACLHIC write the complexity of categorizing and reporting denial reasons could lead to inconsistencies and potential inaccuracies in the data, undermining the bill's goal of transparency and accountability, and health plans/insurers are preparing to comply with a recently finalized federal rule issued by CMS, which seeks to streamline and automate the prior authorization process while enhancing transparency. They believe it is critical that

state-level policies align with these federal requirements to avoid redundancy, reduce administrative burdens, and promote cohesive implementation.

10) *Policy comments.*
   a) *Report placement.* For both code sections, this bill places these reporting requirements in existing unrelated reports. For health plans regulated by DMHC, this bill places these reporting requirements as part of the audited financial reporting requirement. Reporting on provider claims denials and prior authorization decisions are not directly related to health plan financial documents. For health insurers regulated by CDI, this bill places these same reporting requirements on provider claims denials and prior authorization decisions in the CDI enrollment report. Of note, DMHC also has an enrollment report. However, the enrollment reports may not be the best location for this type of reporting either as that data is strictly enrollment data not related to provider claims or prior authorization decisions.
   b) *Different prior authorization reporting metrics.* Federal regulations have established prior authorization reporting metrics for Medi-Cal managed care and other health care plans. Those requirements do not apply to commercial health plans and insurers, as does this bill. The committee may wish to focus this bill instead on the same prior authorization reporting requirements required by federal regulations to ensure comparability and consistency. Additionally, since claims denial reporting is already required under federal law, and Covered California is requiring participating plans to report that data and is publicly reporting it, policymakers could require that reporting for other state regulated plans and insurers to create consistency, comparability, and administrative simplicity.
   c) *Extensive and detailed reporting requirements.*
      i) *Provider claims.* This bill is requiring detailed reporting for each month on the number and cost of provider claims paid, denied, partially denied, contested, not contested, in-network, out-of-network, paid on time by provider type, paid late by provider type, paid beyond 45 days, etc, including the reasons, internal and external appeals and grievances, patient demographic information, use of artificial intelligence and more. Some of this information may be valuable for the public and policymaking purposes but it will require additional administrative resources for each plan and each regulator. The committee may wish to evaluate the tradeoffs and narrow the focus of this reporting to preserve resources for mission critical activities that will have a direct impact on patient outcomes.
      ii) *Prior authorization decisions.* Similar to the provider claims reporting requirements, this bill is requiring detailed reporting for each month on the number and costs or requests processed, approved, modified, denied, average and median time elapsed from submission to decision, type of request, etc. There is not overlap with the federally required reporting. Some of this information may be valuable for the public and policymaking but it will also require additional administrative resources for each plan, insurer, and regulator. The committee may wish to focus the reporting on items that will improve patient outcomes.
   d) *MEWA reporting.* In addition to health plans and insurers, this bill applies to self-insured MEWAs that have been grandfathered into CDI regulation since 1995. There are four of these serving Certified Public Accountants, Printing Industries, United Agricultural Employees, and Western Growers. There are about 65,000 individuals covered under these MEWAs as of December 31, 2024. It is unclear why MEWAs are included in this bill as they are not traditional large health insurance companies.

11) *Amendments.*

a) These requirements should be drafted in different code sections that are more relevant to the subject of the reports, and exclude MEWAs.
b) Alignment with other federal reporting initiatives may be a reasonable step to provide more transparency on the topic of claims and authorization denials.

SUPPORT AND OPPOSITION:

Support: California Nurses Association (sponsor)
AARP
American Federation of State, County, and Municipal Employees
California Alliance for Retired Americans
California Chapter American College of Cardiology
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

Oppose: Association of California Life and Health Insurance Companies (unless amended)
California Association of Health Plans (unless amended)

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