AMENDED IN SENATE MAY 23, 2025

AMENDED IN SENATE APRIL 10, 2025

AMENDED IN SENATE MARCH 26, 2025

SENATE BILL No. 363

Introduced by Senator Wiener
(Coauthors: Senators ~~Becker~~ *Becker, Cortese,* and Weber Pierson)
(Coauthor: Assembly Member Schiavo)

February 13, 2025

An act to add Sections 1374.37 and 1374.38 to the Health and Safety Code, and to add Sections 10169.6 and 10169.7 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 363, as amended, Wiener. Health care coverage: independent medical review.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law establishes the Independent Medical Review System within each department, under which an enrollee or insured may seek review if a health care service has been denied, modified, or delayed by a health care service plan or health insurer and the enrollee or insured has previously filed a grievance that remains unresolved after 30 days.

This bill would require a health care service plan or health insurer to annually report to the appropriate department the total number of claims processed by the health care service plan or health insurer for the prior

year and its number of treatment denials or modifications, separated and disaggregated as specified, commencing on or before June 1, 2026. The bill would require the departments to compare the number of a health care service plan's or health insurer's treatment denials and modifications to (1) the number of successful independent medical review overturns of the plan's or insurer's treatment denials or modifications and (2) the number of treatment denials or modifications reversed by a plan or insurer after an independent medical review for the denial or modification is requested, filed, or applied for. The bill would make a health care service plan or health insurer liable for an administrative penalty, as specified, if more than 50% of the independent medical reviews filed with a health care service plan or health insurer result in an overturning or reversal of a treatment denial or modification in any one individual category of specified general types of care. The bill would make a health care service plan or health insurer liable for additional administrative penalties for each independent medical review resulting in an additional overturned or reversed denial or modification in excess of that threshold. The bill would require the departments to annually include data, analysis, and conclusions relating to these provisions in specified reports.

Because a willful violation of these provisions by a health care service plan would be a crime, this bill would impose a state-mandated local program.

Existing law creates the Managed Care Administrative Fines and Penalties Fund in the State Treasury for the deposit of fines and administrative penalties collected pursuant to provisions licensing and regulating health care service plans.

This bill would create the Managed Care Independent Medical Review Administrative Penalties Subaccount in the Managed Care Administrative Fines and Penalties Fund for the receipt and deposit of moneys generated from the administrative penalties described above with respect to health care service plans. The bill would create the Health Insurance Independent Medical Review Administrative Penalties Fund in the State Treasury for the receipt and deposit of moneys generated from the administrative penalties described above with respect to health insurers. The bill would authorize the moneys in the Managed Care Independent Medical Review Administrative Penalties Subaccount and Health Insurance Independent Medical Review Administrative Penalties Fund to be expended, as specified, upon appropriation by the Legislature.

This bill would declare that its provisions are severable.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 1374.37 is added to the Health and Safety Code, to read:

1374.37. (a) A health care service plan shall report every treatment denial or modification to the department in accordance with all of the following requirements:

(1) Every treatment denial or modification shall be separated by type of care into the following categories:

(A) Surgical.

(B) Medical.

(C) Behavioral.

(D) Pharmaceutical.

(2) Every treatment denial or modification shall be separated by diagnosis category or subcategory as determined by the department. The department shall coordinate with the Department of Insurance to ensure consistent diagnosis categories or subcategories across both departments.

(3) Reporting shall be disaggregated by age into the following groups:

(A) Enrollees 0 to 10 years of age, inclusive.

(B) Enrollees 11 to 20 years of age, inclusive.

(C) Enrollees 21 to 30 years of age, inclusive.

(D) Enrollees 31 to 40 years of age, inclusive.

(E) Enrollees 41 to 50 years of age, inclusive.

(F) Enrollees 51 to 64 years of age, inclusive.

(G) Enrollees 65 years of age or older.

(4) To the extent that demographic data is available, reporting shall be disaggregated by all of the following:

(A) Gender.

(B) Gender identity.

(C) Sexuality.
(D) Race.
(E) Ethnicity.
(5) Reporting shall include information on the health care service plan's number of denials and modifications. A health care service plan shall report the applicable reason for each denial or modification by selecting from all of the following categories:
(A) Medical necessity.
(B) Investigative or experimental.
(C) Emergency or urgent care reimbursement.
(D) Incorrect billing.
(E) Duplicate claims.
(F) Out-of-network provider.
(G) Insufficient information, including medical records and patient or provider signature.
(H) Ineligibility or coverage issue.
(I) Lack of timely submission.
(J) (i) Other.
(ii) If other is designated, the health care service plan shall specify the reason for the denial or modification.
(6) Reporting on modifications shall include information on the type of modifications made.
(b) A health care service plan shall report to the department on an annual basis the total number of claims that the plan processed in the prior year.
(c) A health care service plan shall submit its first report required by subdivisions (a) and (b) to the department on or before June 1, 2026, and annually thereafter.
(d) (1) The department shall ensure that both of the following are included in a report, as specified in paragraphs (2) and (3), at least once per year:
(A) Data, analysis, and conclusions relating to information required to be reported by health care service plans pursuant to subdivisions (a) and (b).
(B) Data, analysis, and conclusions relating to compliance with, or violations of, Section 1374.38, including, but not limited to, the number of independent medical review overturns of, and reversals of, treatment denials and modifications.

(2) If the department publishes a report not required by this code and relating to independent medical reviews, the department shall include in the report the information specified in paragraph (1).

(3) If the department is not required to include the information in a report pursuant to paragraph (2), the department shall include the information in the report required by subdivision (f) of Section 1375.7.

(4) The department shall ensure that a report required to include the information specified in paragraph (1) is published on its internet website.

SEC. 2. Section 1374.38 is added to the Health and Safety Code, to read:

1374.38. (a) (1) For each annual report submitted to the department by a health care service plan pursuant to Section 1374.37, the department shall compare the number of a health care service plan's treatment denials and modifications to both of the following:

(A) The number of successful independent medical review overturns of a health care service plan's treatment denials or modifications.

(B) The number of treatment denials or modifications reversed by the health care service plan after an independent medical review for the denial or modification is requested, filed, or applied for.

(2) (A) If more than 50 percent of a health care service plan's independent medical reviews result in an overturning or reversal of a treatment denial or modification in any one individual category enumerated in paragraph (1) of subdivision (a) of Section 1374.37, the health care service plan is in violation of this section and liable for an administrative penalty pursuant to subdivision (b). A health care service plan may be liable for multiple violations per annual report.

(B) Each independent medical review resulting in an additional overturned or reversed denial or modification in excess of the threshold described in subparagraph (A) constitutes a separate violation of this section.

(C) For purposes of this section, an independent medical review results in an overturning or reversal of a treatment denial or modification any time a treatment denial or modification is overturned or reversed after an independent medical review is requested, filed, or applied for, regardless of whether a

determination is made by an independent medical review organization or health care service plan.

(3) A failure to report a treatment denial or modification to the department pursuant to Section 1374.37 is a violation of this section.

(b) A health care service plan that violates this section, or that violates any rule or order adopted or issued pursuant to this section, is liable for administrative penalties of not less than twenty-five thousand dollars ($25,000) for the first violation, and of not less than fifty thousand dollars ($50,000) nor more than two hundred thousand dollars ($200,000) for the second violation, and of not less than five hundred thousand dollars ($500,000) for each subsequent violation.

(c) The administrative penalties available to the director pursuant to this section are not exclusive, and may be sought and employed in any combination with civil, criminal, and other administrative remedies deemed advisable by the director to enforce the provisions of this chapter.

(d) Commencing January 1, 2031, and every five years thereafter, the penalty amounts specified in this section shall be adjusted to reflect the percentage change in the calendar year average, for the five-year period, of the medical care index of the Consumer Price Index, as published by the United States Bureau of Labor Statistics.

~~(e) It is the intent of the Legislature for the funds generated from administrative penalties assessed pursuant to this section to be used to fund child health care services.~~

(e) (1) The Managed Care Independent Medical Review Administrative Penalties Subaccount is hereby created in the Managed Care Administrative Fines and Penalties Fund, as described in Section 1341.45, for the receipt and deposit of moneys generated from the administrative penalties assessed pursuant to this section.

(2) Upon appropriation by the Legislature, moneys in the subaccount may be expended for both of the following purposes:

(A) To offset the reasonable costs of implementing this section and Section 1374.37.

(B) For other purposes of the Managed Care Administrative Fines and Penalties Fund, as specified in Section 1341.45.

SEC. 3. Section 10169.6 is added to the Insurance Code, to read:

10169.6. (a) A health insurer shall report every treatment denial or modification to the department in accordance with all of the following requirements:

(1) Every treatment denial or modification shall be separated by type of care into the following categories:

(A) Surgical.

(B) Medical.

(C) Behavioral.

(D) Pharmaceutical.

(2) Every treatment denial or modification shall be separated by diagnosis category or subcategory as determined by the department. The department shall coordinate with the Department of Managed Health Care to ensure consistent diagnosis categories or subcategories across both departments.

(3) Reporting shall be disaggregated by age into the following groups:

(A) Insureds 0 to 10 years of age, inclusive.

(B) Insureds 11 to 20 years of age, inclusive.

(C) Insureds 21 to 30 years of age, inclusive.

(D) Insureds 31 to 40 years of age, inclusive.

(E) Insureds 41 to 50 years of age, inclusive.

(F) Insureds 51 to 64 years of age, inclusive.

(G) Insureds 65 years of age or older.

(4) To the extent that demographic data is available, reporting shall be disaggregated by all of the following:

(A) Gender.

(B) Gender identity.

(C) Sexuality.

(D) Race.

(E) Ethnicity.

(5) Reporting shall include information on the health insurer's number of denials and modifications. A health insurer shall report the applicable reason for each denial or modification by selecting from all of the following categories:

(A) Medical necessity.

(B) Investigative or experimental.

(C) Emergency or urgent care reimbursement.

(D) Incorrect billing.

(E) Duplicate claims.

(F) Out-of-network provider.

(G) Insufficient information, including medical records and patient or provider signature.

(H) Ineligibility or coverage issue.

(I) Lack of timely submission.

(J) (i) Other.

(ii) If other is designated, the health insurer shall specify the reason for the denial or modification.

(6) Reporting on modifications shall include information on the type of modifications made.

(b) A health insurer shall report to the department on an annual basis the total number of claims that the insurer processed in the prior year.

(c) A health insurer shall submit its first report required by subdivisions (a) and (b) to the department on or before June 1, 2026, and annually thereafter.

(d) (1) The department shall include in the annual report of the commissioner required by Section 12922, commencing with the 2026 report, both of the following:

(A) Data, analysis, and conclusions relating to information required to be reported by health insurers pursuant to subdivisions (a) and (b).

(B) Data, analysis, and conclusions relating to compliance with, or violations of, Section 10169.7, including, but not limited to, the number of independent medical review overturns of, and reversals of, treatment denials and modifications.

(2) The department shall ensure that the report required to include the information specified in paragraph (1) is published on its internet website.

SEC. 4. Section 10169.7 is added to the Insurance Code, to read:

10169.7. (a) (1) For each annual report submitted to the department by a health insurer pursuant to Section 10169.6, the department shall compare the number of a health insurer's treatment denials and modifications to both of the following:

(A) The number of successful independent medical review overturns of a health insurer's treatment denials or modifications.

(B) The number of treatment denials or modifications reversed by the health insurer after an independent medical review for the denial or modification is requested, filed, or applied for.

(2) (A) If more than 50 percent of a health insurer's independent medical reviews result in an overturning or reversal of a treatment denial or modification in any one individual category enumerated in paragraph (1) of subdivision (a) of Section 10169.6, the health insurer is in violation of this section and liable for an administrative penalty pursuant to subdivision (b). A health insurer may be liable for multiple violations per annual report.

(B) Each independent medical review resulting in an additional overturned or reversed denial or modification in excess of the threshold described in subparagraph (A) constitutes a separate violation of this section.

(C) For purposes of this section, an independent medical review results in an overturning or reversal of a treatment denial or modification any time a treatment denial or modification is overturned or reversed after an independent medical review is requested, filed, or applied for, regardless of whether a determination is made by an independent medical review organization or health insurer.

(3) A failure to report a treatment denial or modification to the department pursuant to Section 10169.6 is a violation of this section.

(b) A health insurer that violates this section, or that violates any rule or order adopted or issued pursuant to this section, is liable for administrative penalties of not less than twenty-five thousand dollars ($25,000) for the first violation, and of not less than fifty thousand dollars ($50,000) nor more than two hundred thousand dollars ($200,000) for the second violation, and of not less than five hundred thousand dollars ($500,000) for each subsequent violation.

(c) The administrative penalties available to the commissioner pursuant to this section are not exclusive, and may be sought and employed in any combination with civil, criminal, and other administrative remedies deemed advisable by the commissioner to enforce the provisions of this chapter.

(d) Commencing January 1, 2031, and every five years thereafter, the penalty amounts specified in this section shall be adjusted to reflect the percentage change in the calendar year

average, for the five-year period, of the medical care index of the Consumer Price Index, as published by the United States Bureau of Labor Statistics.

~~(e) It is the intent of the Legislature for the funds generated from administrative penalties assessed pursuant to this section to be used to fund child health care services.~~

(e) (1) The Health Insurance Independent Medical Review Administrative Penalties Fund is hereby created in the State Treasury for the receipt and deposit of moneys generated from the administrative penalties assessed pursuant to this section.

(2) Upon appropriation by the Legislature, moneys in the fund may be expended to offset the reasonable costs of implementing this section and Section 10169.6.

SEC. 5. The provisions of this act are severable. If any provision of this act or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

SEC. 6. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

O