AMENDED IN SENATE MARCH 26, 2025

SENATE BILL No. 363

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

February 13, 2025

An act to ~~amend Section 130204 of, and to add Section 1374.37 to,~~ *add Sections 1374.37 and 1374.38 to* the Health and Safety Code, and to add ~~Section 10169.6~~ *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. The bill would* require a health care service plan or health insurer to annually report its number of treatment denials or

modifications, separated by type of care *into general and specific categories* and disaggregated ~~by age,~~ *as specified,* to the appropriate department, 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 ~~half~~ *40%* 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 the 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 specify that these provisions do not apply to Medi-Cal managed care plan contracts.~~ *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 requires the Insurance Commissioner to make a report to the Governor and the Legislature, as specified, on the condition of the insurance business and interests in this state, and other matters concerning insurance.~~

~~The bill would require the department to include in the commissioner's annual report information relating to independent medical review overturns of, and reversals of, treatment denials and modifications with respect to health insurers.~~

~~Existing law establishes the Center for Data Insights and Innovation, and authorizes the center to collect and analyze data on problems and complaints by, and questions from, consumers about health care coverage. Existing law requires that data to include, among others, plan data, appeals, source of coverage, regulator, type of problem or issue or comparable types of problems or issues, and resolution of complaints,~~

~~including timeliness of resolution. Existing law requires the center to annually report this data to the Legislature.~~

~~This bill would require the center to include in that report data relating to independent medical review overturns of, and reversals of, treatment denials and modifications with respect to health care service plans. The bill would require the Department of Managed Health Care to provide related information requested by the center, as specified.~~

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) Reporting shall occur on an annual basis. A health care service plan shall submit its first report to the department on or before June 1, 2026.

(2) ~~Reporting~~ *Every treatment denial or modification* shall be separated by type of care into the following categories:

(A) Surgical.

(B) Medical.

(C) Behavioral.

(D) Pharmaceutical.

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

(A) Autism spectrum.

(B) Digestive system or gastrointestinal.

(C) Endocrine or metabolic.

(D) Infectious disease.

(E) Central nervous system or neuromuscular disorders.

(F) Orthopedic or musculoskeletal.

(G) Skin disorders.
(H) Mental disorders.
(I) Substance use disorder.
(J) Substance abuse.
(K) Alcohol abuse or addiction.
(L) Attention deficit hyperactivity disorder.
(M) Eating disorders.
(N) Depression.
(O) Traumatic brain injury.
(P) Cancer.
(Q) Cardiac or circulatory problems.
(R) Genetic diseases.
(S) Postsurgical complications.
(T) Pediatrics.
(U) Trauma or injuries.
(V) Autoimmune disorders.
(W) Immunology disorders.
(X) Genitourinary or kidney disorders.
(Y) Ears, nose, or throat.
(Z) Foot disorders.
(AA) Prevention or good health.
(AB) Respiratory system.
(AC) Blood-related disorders.
(AD) Vision.
(AE) Pregnancy or childbirth.
(AF) Dental problems.
(AG) Morbid obesity.
(AH) Pregnancy or obstetrics and gynecology.
(AI) Chronic pain syndrome.
(AJ) (i) Other.
(ii) If other is designated, the health care service plan shall specify the type of care.
(AK) (i) A category added to the list by the department pursuant to clause (ii).
(ii) The department may add categories to the list enumerated in this paragraph.
~~(3)~~
(4) Reporting shall be disaggregated by ~~age.~~ *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.
(5) 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.
~~(4)~~
(6) Reporting shall include information on the health care service plan's number of denials ~~and modifications and the reasons provided for 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) Urgent care.
(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.
~~(5)~~
(7) Reporting on modifications shall include information on the type of modifications made.
~~(b) (1) 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) If more than half of independent medical reviews filed with a health care service plan result in an overturning or reversal of a treatment denial or modification in any one individual category enumerated in paragraph (2) of subdivision (a), the health care service plan is in violation of this section and liable for an administrative penalty pursuant to subdivision (c). A health care service plan may be liable for multiple violations per annual report.~~

~~(3) Each independent medical review resulting in an additional overturned or reversed denial or modification in excess of the threshold described in paragraph (2) constitutes a separate violation of this section.~~

~~(4) A failure to report a treatment denial or modification to the department is a violation of this section.~~

~~(5) 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.~~

~~(c) 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 fifty thousand dollars ($50,000) for the first violation, and of not less than one hundred thousand dollars ($100,000) nor more than four hundred thousand dollars ($400,000) for the second violation, and of not less than one million dollars ($1,000,000) for each subsequent violation.~~

~~(d) 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.~~

~~(e) Commencing January 1, 2031, and every five years thereafter, the penalty amounts specified in this section shall be adjusted based on the average rate of change in premium rates for the individual and small group markets, and weighted by enrollment, since the previous adjustment.~~

~~(f) The department shall provide information requested by the Center for Data Insights and Innovation and relating to this section, in the time, data elements, manner, and format requested by the center.~~

~~(g) This section does not apply to Medi-Cal managed care plan contracts entered into with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code.~~

~~(h) 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.~~

(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) (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.

~~SEC. 2. Section 130204 of the Health and Safety Code is amended to read:~~

~~130204. (a) (1) The center shall compile annual publications, to be made publicly available on the center's internet website, including, but not limited to, a quality of care report card that reflects health care service plans, preferred provider organizations, and medical groups.~~

~~(2) The Department of Managed Health Care, the State Department of Health Care Services, the Department of Insurance, the Exchange, the State Department of Social Services, the Office of Statewide Health Planning and Development, and any other public health coverage program or state entity shall provide to the center data concerning the quality of care report card in the time, manner, and format requested by the center. The center may also request data related to the cost of care, quality of care, patient experience, socioeconomic status impact on health, access to care, and access to social services programs.~~

~~(3) The center may request data from and contract with academic or nonprofit organizations related to quality of health care and patient experience to develop the quality of care report card.~~

~~(b) The center shall produce an annual report to be made publicly available on the center's internet website by December 31, 2022, and annually thereafter, of health care consumer or patient assistance help centers, call centers, ombudsperson, or other assistance centers operated by the Department of Managed Health Care, the State Department of Health Care Services, the Department of Insurance, and the Exchange, that includes, at a minimum, all of the following:~~

~~(1) The types of calls received and the number of calls.~~

~~(2) The call center's role with regard to each type of call, question, complaint, or grievance.~~

~~(3) The call center's protocol for responding to requests for assistance from health care consumers, including any performance standards.~~

~~(4) The protocol for referring or transferring calls outside the jurisdiction of the call center.~~

~~(5) The call center's methodology of tracking calls, complaints, grievances, or inquiries.~~

~~(c) (1) (A) The center may collect and analyze data on problems and complaints by, and questions from, consumers about health care coverage for the purpose of providing public information about problems faced and information needed by~~

~~consumers in obtaining coverage and care. The data collected shall include demographic data, insurer or plan data, appeals, source of coverage, regulator, type of problem or issue or comparable types of problems or issues, and resolution of complaints, including timeliness of resolution. Notwithstanding Section 10231.5 of the Government Code, the center shall submit a report by December 31, 2022, and annually thereafter to the Legislature. The report shall be submitted in compliance with Section 9795 of the Government Code. The format may be modified annually as needed based upon comments from the Legislature and stakeholders.~~

~~(B) The center shall include in the annual report described in subparagraph (A) data relating to Section 1374.37 concerning independent medical review overturns of, and reversals of, treatment denials and modifications. The center shall include this data commencing with the 2026 report.~~

~~(2) The Department of Managed Health Care, the State Department of Health Care Services, the Department of Insurance, the Exchange, and any other public health coverage programs shall provide to the center data concerning call centers to meet the reporting requirements in this section in the time, data elements, manner, and format requested by the center.~~

~~(3) For the purpose of publicly reporting information as required in paragraph (1) and this paragraph about the problems faced by consumers in obtaining care and coverage, the center shall analyze data on consumer complaints, appeals, and grievances resolved by the agencies listed in subdivision (b), including demographic data, source of coverage, insurer or plan, resolution of complaints, and other information intended to improve health care and coverage for consumers.~~

~~(d) To the extent that funds are appropriated in the annual Budget Act for this purpose, the center shall do all of the following to assist state entities that provide public health coverage programs or oversight of health insurance or health care service plans:~~

~~(1) After evaluation of data from the Department of Insurance and the Department of Managed Health Care, coordinate with public health coverage programs and state oversight departments of public and commercial health coverage programs to provide assistance related to addressing the quality of care and patient experience of public and commercial health coverage programs~~

~~that have been determined to be deficient in the annual quality of care report card.~~

~~(2) Create and provide tools and education to consumers of health insurance and public health coverage programs to better enable them to access and utilize the quality of care report card and the health care services to which they are eligible.~~

~~(3) Develop tools and education related to improvement of consumer access to care, quality of care, and addressing the disparities in quality of care related to socioeconomic status.~~

~~(4) Develop and implement consumer surveys of the patient experience, quality of care, and any other topic consistent with this section.~~

~~(5) Develop standards for departments within the California Health and Human Services Agency related to public reports published by the departments to ensure consumer readability and understanding across programs.~~

~~(e) If the departmental letters or other similar instruction are only issued to other state entities, the center may implement, interpret, or make specific this section by means of a departmental letter or other similar instruction, as necessary, notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.~~

~~(f) For purposes of this section, the following definitions apply:~~

~~(1) "Data" means information that is not individually identifiable health information, as defined in Section 160.103 of Title 45 of the Code of Federal Regulations.~~

~~(2) "Exchange" means the California Health Benefit Exchange established pursuant to Title 22 (commencing with Section 100500) of the Government Code.~~

~~(3) "Health care" includes services provided by any health care coverage program.~~

~~(4) "Health care service plan" has the same meaning as that set forth in subdivision (f) of Section 1345. Health care service plan includes "specialized health care service plans," including behavioral health plans.~~

~~(5) "Health coverage program" includes the Medi-Cal program, tax subsidies and premium credits under the Exchange, the Basic Health Program, if enacted, and county health care programs.~~

~~(6) "Health insurance" has the same meaning as set forth in Section 106 of the Insurance Code.~~

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 40 percent of independent medical reviews filed with a health care service plan result in an overturning or reversal of a treatment denial or modification in any one individual category enumerated in paragraph (2) 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 fifty thousand dollars ($50,000) for the first violation, and of not less than one hundred thousand dollars ($100,000) nor more than four

hundred thousand dollars ($400,000) for the second violation, and of not less than one million dollars ($1,000,000) 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.

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) Reporting shall occur on an annual basis. A health insurer shall submit its first report to the department on or before June 1, 2026.

(2) ~~Reporting~~ *Every treatment denial or modification* shall be separated by type of care into the following categories:

(A) Surgical.

(B) Medical.

(C) Behavioral.

(D) Pharmaceutical.

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

(A) Autism spectrum.

(B) Digestive system or gastrointestinal.

(C) Endocrine or metabolic.

(D) Infectious disease.

(E) Central nervous system or neuromuscular disorders.

(F) Orthopedic or musculoskeletal.

(G) Skin disorders.

(H) Mental disorders.
(I) Substance use disorder.
(J) Substance abuse.
(K) Alcohol abuse or addiction.
(L) Attention deficit hyperactivity disorder.
(M) Eating disorders.
(N) Depression.
(O) Traumatic brain injury.
(P) Cancer.
(Q) Cardiac or circulatory problems.
(R) Genetic diseases.
(S) Postsurgical complications.
(T) Pediatrics.
(U) Trauma or injuries.
(V) Autoimmune disorders.
(W) Immunology disorders.
(X) Genitourinary or kidney disorders.
(Y) Ears, nose, or throat.
(Z) Foot disorders.
(AA) Prevention or good health.
(AB) Respiratory system.
(AC) Blood-related disorders.
(AD) Vision.
(AE) Pregnancy or childbirth.
(AF) Dental problems.
(AG) Morbid obesity.
(AH) Pregnancy or obstetrics and gynecology.
(AI) Chronic pain syndrome.
(AJ) (i) Other.
(ii) If other is designated, the health insurer shall specify the type of care.
(AK) (i) A category added to the list by the department pursuant to clause (ii).
(ii) The department may add categories to the list enumerated in this paragraph.
~~(3)~~
(4) Reporting shall be disaggregated by ~~age.~~ *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.
(5) 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.
~~(4)~~
(6) Reporting shall include information on the health insurer's number of denials ~~and modifications and the reasons provided for 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) Urgent care.
(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.
~~(5)~~
(7) Reporting on modifications shall include information on the type of modifications made.
~~(b) (1) 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) If more than half of independent medical reviews filed with a health insurer result in an overturning or reversal of a treatment denial or modification in any one individual category enumerated in paragraph (2) of subdivision (a), the health insurer is in violation of this section and liable for an administrative penalty pursuant to subdivision (c). A health insurer may be liable for multiple violations per annual report.~~

~~(3) Each independent medical review resulting in an additional overturned or reversed denial or modification in excess of the threshold described in paragraph (2) constitutes a separate violation of this section.~~

~~(4) A failure to report a treatment denial or modification to the department is a violation of this section.~~

~~(5) 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.~~

~~(c) 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 fifty thousand dollars ($50,000) for the first violation, and of not less than one hundred thousand dollars ($100,000) nor more than four hundred thousand dollars ($400,000) for the second violation, and of not less than one million dollars ($1,000,000) for each subsequent violation.~~

~~(d) 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.~~

~~(e) Commencing January 1, 2031, and every five years thereafter, the penalty amounts specified in this section shall be adjusted based on the average rate of change in premium rates for the individual and small group markets, and weighted by enrollment, since the previous adjustment.~~

(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.

~~(f)~~

(c) The department shall include~~ information relating to this section~~ in the annual report of the commissioner required by Section 12922, commencing with the 2026~~ report.~~ *report, both of the following:*

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

(2) 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.

~~(g) 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.~~

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 40 percent of independent medical reviews filed with a health insurer result in an overturning or reversal of a treatment denial or modification in any one individual category enumerated in paragraph (2) 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 fifty thousand dollars ($50,000) for the first violation, and of not less than one hundred thousand dollars ($100,000) nor more than four hundred thousand dollars ($400,000) for the second violation, and of not less than one million dollars ($1,000,000) 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.

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. 4.~~

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