

AMENDED IN SENATE MARCH 26, 2025

**SENATE BILL**

**No. 363**

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

February 13, 2025

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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:*

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

3 1374.37. (a) A health care service plan shall report every  
4 treatment denial or modification to the department in accordance  
5 with *all of* the following requirements:

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

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

11 (A) Surgical.

12 (B) Medical.

13 (C) Behavioral.

14 (D) *Pharmaceutical.*

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

17 (A) *Autism spectrum.*

18 (B) *Digestive system or gastrointestinal.*

19 (C) *Endocrine or metabolic.*

20 (D) *Infectious disease.*

21 (E) *Central nervous system or neuromuscular disorders.*

22 (F) *Orthopedic or musculoskeletal.*

- 1 (G) *Skin disorders.*
- 2 (H) *Mental disorders.*
- 3 (I) *Substance use disorder.*
- 4 (J) *Substance abuse.*
- 5 (K) *Alcohol abuse or addiction.*
- 6 (L) *Attention deficit hyperactivity disorder.*
- 7 (M) *Eating disorders.*
- 8 (N) *Depression.*
- 9 (O) *Traumatic brain injury.*
- 10 (P) *Cancer.*
- 11 (Q) *Cardiac or circulatory problems.*
- 12 (R) *Genetic diseases.*
- 13 (S) *Postsurgical complications.*
- 14 (T) *Pediatrics.*
- 15 (U) *Trauma or injuries.*
- 16 (V) *Autoimmune disorders.*
- 17 (W) *Immunology disorders.*
- 18 (X) *Genitourinary or kidney disorders.*
- 19 (Y) *Ears, nose, or throat.*
- 20 (Z) *Foot disorders.*
- 21 (AA) *Prevention or good health.*
- 22 (AB) *Respiratory system.*
- 23 (AC) *Blood-related disorders.*
- 24 (AD) *Vision.*
- 25 (AE) *Pregnancy or childbirth.*
- 26 (AF) *Dental problems.*
- 27 (AG) *Morbid obesity.*
- 28 (AH) *Pregnancy or obstetrics and gynecology.*
- 29 (AI) *Chronic pain syndrome.*
- 30 (AJ) (i) *Other.*
- 31 (ii) *If other is designated, the health care service plan shall*
- 32 *specify the type of care.*
- 33 (AK) (i) *A category added to the list by the department pursuant*
- 34 *to clause (ii).*
- 35 (ii) *The department may add categories to the list enumerated*
- 36 *in this paragraph.*
- 37 ~~(3)~~
- 38 (4) *Reporting shall be disaggregated by—age: age into the*
- 39 *following groups:*
- 40 (A) *Enrollees 0 to 10 years of age, inclusive.*

- 1 (B) *Enrollees 11 to 20 years of age, inclusive.*
- 2 (C) *Enrollees 21 to 30 years of age, inclusive.*
- 3 (D) *Enrollees 31 to 40 years of age, inclusive.*
- 4 (E) *Enrollees 41 to 50 years of age, inclusive.*
- 5 (F) *Enrollees 51 to 64 years of age, inclusive.*
- 6 (G) *Enrollees 65 years of age or older.*

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

- 9 (A) *Gender.*
- 10 (B) *Gender identity.*
- 11 (C) *Sexuality.*
- 12 (D) *Race.*
- 13 (E) *Ethnicity.*

14 ~~(4)~~

15 (6) *Reporting shall include information on the health care service*  
16 *plan's number of denials and modifications and the reasons*  
17 *provided for denials and modifications. A health care service plan*  
18 *shall report the applicable reason for each denial or modification*  
19 *by selecting from all of the following categories:*

- 20 (A) *Medical necessity.*
- 21 (B) *Investigative or experimental.*
- 22 (C) *Urgent care.*
- 23 (D) *Incorrect billing.*
- 24 (E) *Duplicate claims.*
- 25 (F) *Out-of-network provider.*
- 26 (G) *Insufficient information, including medical records and*  
27 *patient or provider signature.*
- 28 (H) *Ineligibility or coverage issue.*
- 29 (I) *Lack of timely submission.*
- 30 (J) (i) *Other.*
- 31 (ii) *If other is designated, the health care service plan shall*  
32 *specify the reason for the denial or modification.*

33 ~~(5)~~

34 (7) *Reporting on modifications shall include information on the*  
35 *type of modifications made.*

36 ~~(b) (1) The department shall compare the number of a health~~  
37 ~~care service plan's treatment denials and modifications to both of~~  
38 ~~the following:~~

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

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

7     ~~(2) If more than half of independent medical reviews filed with~~  
8     ~~a health care service plan result in an overturning or reversal of a~~  
9     ~~treatment denial or modification in any one individual category~~  
10    ~~enumerated in paragraph (2) of subdivision (a), the health care~~  
11    ~~service plan is in violation of this section and liable for an~~  
12    ~~administrative penalty pursuant to subdivision (c). A health care~~  
13    ~~service plan may be liable for multiple violations per annual report.~~

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

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

20    ~~(5) For purposes of this section, an independent medical review~~  
21    ~~results in an overturning or reversal of a treatment denial or~~  
22    ~~modification any time a treatment denial or modification is~~  
23    ~~overturned or reversed after an independent medical review is~~  
24    ~~requested, filed, or applied for, regardless of whether a~~  
25    ~~determination is made by an independent medical review~~  
26    ~~organization or health care service plan.~~

27    ~~(e) A health care service plan that violates this section, or that~~  
28    ~~violates any rule or order adopted or issued pursuant to this section,~~  
29    ~~is liable for administrative penalties of not less than fifty thousand~~  
30    ~~dollars (\$50,000) for the first violation, and of not less than one~~  
31    ~~hundred thousand dollars (\$100,000) nor more than four hundred~~  
32    ~~thousand dollars (\$400,000) for the second violation, and of not~~  
33    ~~less than one million dollars (\$1,000,000) for each subsequent~~  
34    ~~violation.~~

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

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

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

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

15 ~~(h) It is the intent of the legislature for the funds generated from~~  
16 ~~administrative penalties assessed pursuant to this section to be~~  
17 ~~used to fund child health care services.~~

18 *(b) A health care service plan shall report to the department on*  
19 *an annual basis the total number of claims that the plan processed*  
20 *in the prior year.*

21 *(c) (1) The department shall ensure that both of the following*  
22 *are included in a report, as specified in paragraphs (2) and (3),*  
23 *at least once per year:*

24 *(A) Data, analysis, and conclusions relating to information*  
25 *required to be reported by health care service plans pursuant to*  
26 *subdivisions (a) and (b).*

27 *(B) Data, analysis, and conclusions relating to compliance with,*  
28 *or violations of, Section 1374.38, including, but not limited to, the*  
29 *number of independent medical review overturns of, and reversals*  
30 *of, treatment denials and modifications.*

31 *(2) If the department publishes a report not required by this*  
32 *code and relating to independent medical reviews, the department*  
33 *shall include in the report the information specified in paragraph*  
34 *(1).*

35 *(3) If the department is not required to include the information*  
36 *in a report pursuant to paragraph (2), the department shall include*  
37 *the information in the report required by subdivision (f) of Section*  
38 *1375.7.*

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

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

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

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

19 (b) The center shall produce an annual report to be made  
20 publicly available on the center's internet website by December  
21 31, 2022, and annually thereafter, of health care consumer or  
22 patient assistance help centers, call centers, ombudsperson, or other  
23 assistance centers operated by the Department of Managed Health  
24 Care, the State Department of Health Care Services, the Department  
25 of Insurance, and the Exchange, that includes, at a minimum, all  
26 of the following:

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

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

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

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

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

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



1 consumers in obtaining coverage and care. The data collected shall  
2 include demographic data, insurer or plan data, appeals, source of  
3 coverage, regulator, type of problem or issue or comparable types  
4 of problems or issues, and resolution of complaints, including  
5 timeliness of resolution. Notwithstanding Section 10231.5 of the  
6 Government Code, the center shall submit a report by December  
7 31, 2022, and annually thereafter to the Legislature. The report  
8 shall be submitted in compliance with Section 9795 of the  
9 Government Code. The format may be modified annually as needed  
10 based upon comments from the Legislature and stakeholders.

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

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

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

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

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

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

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

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

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

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

17 (e) ~~If the departmental letters or other similar instruction are~~  
18 ~~only issued to other state entities, the center may implement,~~  
19 ~~interpret, or make specific this section by means of a departmental~~  
20 ~~letter or other similar instruction, as necessary, notwithstanding~~  
21 ~~Chapter 3.5 (commencing with Section 11340) of Part 1 of Division~~  
22 ~~3 of Title 2 of the Government Code.~~

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

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

27 (2) ~~“Exchange” means the California Health Benefit Exchange~~  
28 ~~established pursuant to Title 22 (commencing with Section 100500)~~  
29 ~~of the Government Code.~~

30 (3) ~~“Health care” includes services provided by any health care~~  
31 ~~coverage program.~~

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

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

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

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

3 1374.38. (a) (1) For each annual report submitted to the  
4 department by a health care service plan pursuant to Section  
5 1374.37, the department shall compare the number of a health  
6 care service plan's treatment denials and modifications to both of  
7 the following:

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

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

14 (2) (A) If more than 40 percent of independent medical reviews  
15 filed with a health care service plan result in an overturning or  
16 reversal of a treatment denial or modification in any one individual  
17 category enumerated in paragraph (2) of subdivision (a) of Section  
18 1374.37, the health care service plan is in violation of this section  
19 and liable for an administrative penalty pursuant to subdivision  
20 (b). A health care service plan may be liable for multiple violations  
21 per annual report.

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

26 (C) For purposes of this section, an independent medical review  
27 results in an overturning or reversal of a treatment denial or  
28 modification any time a treatment denial or modification is  
29 overturned or reversed after an independent medical review is  
30 requested, filed, or applied for, regardless of whether a  
31 determination is made by an independent medical review  
32 organization or health care service plan.

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

36 (b) A health care service plan that violates this section, or that  
37 violates any rule or order adopted or issued pursuant to this  
38 section, is liable for administrative penalties of not less than fifty  
39 thousand dollars (\$50,000) for the first violation, and of not less  
40 than one hundred thousand dollars (\$100,000) nor more than four

1 *hundred thousand dollars (\$400,000) for the second violation, and*  
2 *of not less than one million dollars (\$1,000,000) for each*  
3 *subsequent violation.*

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

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

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

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

20 10169.6. (a) A health insurer shall report every treatment  
21 denial or modification to the department in accordance with *all of*  
22 *the following requirements:*

23 (1) Reporting shall occur on an annual basis. A health insurer  
24 shall submit its first report to the department on or before June 1,  
25 2026.

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

28 (A) Surgical.

29 (B) Medical.

30 (C) Behavioral.

31 (D) Pharmaceutical.

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

34 (A) Autism spectrum.

35 (B) Digestive system or gastrointestinal.

36 (C) Endocrine or metabolic.

37 (D) Infectious disease.

38 (E) Central nervous system or neuromuscular disorders.

39 (F) Orthopedic or musculoskeletal.

40 (G) Skin disorders.

- 1 (H) *Mental disorders.*
- 2 (I) *Substance use disorder.*
- 3 (J) *Substance abuse.*
- 4 (K) *Alcohol abuse or addiction.*
- 5 (L) *Attention deficit hyperactivity disorder.*
- 6 (M) *Eating disorders.*
- 7 (N) *Depression.*
- 8 (O) *Traumatic brain injury.*
- 9 (P) *Cancer.*
- 10 (Q) *Cardiac or circulatory problems.*
- 11 (R) *Genetic diseases.*
- 12 (S) *Postsurgical complications.*
- 13 (T) *Pediatrics.*
- 14 (U) *Trauma or injuries.*
- 15 (V) *Autoimmune disorders.*
- 16 (W) *Immunology disorders.*
- 17 (X) *Genitourinary or kidney disorders.*
- 18 (Y) *Ears, nose, or throat.*
- 19 (Z) *Foot disorders.*
- 20 (AA) *Prevention or good health.*
- 21 (AB) *Respiratory system.*
- 22 (AC) *Blood-related disorders.*
- 23 (AD) *Vision.*
- 24 (AE) *Pregnancy or childbirth.*
- 25 (AF) *Dental problems.*
- 26 (AG) *Morbid obesity.*
- 27 (AH) *Pregnancy or obstetrics and gynecology.*
- 28 (AI) *Chronic pain syndrome.*
- 29 (AJ) (i) *Other.*
- 30 (ii) *If other is designated, the health insurer shall specify the*
- 31 *type of care.*
- 32 (AK) (i) *A category added to the list by the department pursuant*
- 33 *to clause (ii).*
- 34 (ii) *The department may add categories to the list enumerated*
- 35 *in this paragraph.*
- 36 ~~(3)~~
- 37 (4) *Reporting shall be disaggregated by—age. age into the*
- 38 *following groups:*
- 39 (A) *Insureds 0 to 10 years of age, inclusive.*
- 40 (B) *Insureds 11 to 20 years of age, inclusive.*

- 1 (C) *Insureds 21 to 30 years of age, inclusive.*  
2 (D) *Insureds 31 to 40 years of age, inclusive.*  
3 (E) *Insureds 41 to 50 years of age, inclusive.*  
4 (F) *Insureds 51 to 64 years of age, inclusive.*  
5 (G) *Insureds 65 years of age or older.*  
6 (5) *To the extent that demographic data is available, reporting*  
7 *shall be disaggregated by all of the following:*  
8 (A) *Gender.*  
9 (B) *Gender identity.*  
10 (C) *Sexuality.*  
11 (D) *Race.*  
12 (E) *Ethnicity.*  
13 ~~(4)~~  
14 (6) Reporting shall include information on the health insurer's  
15 number of denials and modifications and the reasons provided for  
16 denials and modifications. A health insurer shall report the  
17 applicable reason for each denial or modification by selecting  
18 from all of the following categories:  
19 (A) *Medical necessity.*  
20 (B) *Investigative or experimental.*  
21 (C) *Urgent care.*  
22 (D) *Incorrect billing.*  
23 (E) *Duplicate claims.*  
24 (F) *Out-of-network provider.*  
25 (G) *Insufficient information, including medical records and*  
26 *patient or provider signature.*  
27 (H) *Ineligibility or coverage issue.*  
28 (I) *Lack of timely submission.*  
29 (J) (i) *Other.*  
30 (ii) *If other is designated, the health insurer shall specify the*  
31 *reason for the denial or modification.*  
32 ~~(5)~~  
33 (7) Reporting on modifications shall include information on the  
34 type of modifications made.  
35 ~~(b) (1) The department shall compare the number of a health~~  
36 ~~insurer's treatment denials and modifications to both of the~~  
37 ~~following:~~  
38 ~~(A) The number of successful independent medical review~~  
39 ~~overturns of a health insurer's treatment denials or modifications.~~

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

4     ~~(2) If more than half of independent medical reviews filed with~~  
5 ~~a health insurer result in an overturning or reversal of a treatment~~  
6 ~~denial or modification in any one individual category enumerated~~  
7 ~~in paragraph (2) of subdivision (a), the health insurer is in violation~~  
8 ~~of this section and liable for an administrative penalty pursuant to~~  
9 ~~subdivision (c). A health insurer may be liable for multiple~~  
10 ~~violations per annual report.~~

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

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

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

24     ~~(e) A health insurer that violates this section, or that violates~~  
25 ~~any rule or order adopted or issued pursuant to this section, is liable~~  
26 ~~for administrative penalties of not less than fifty thousand dollars~~  
27 ~~(\$50,000) for the first violation, and of not less than one hundred~~  
28 ~~thousand dollars (\$100,000) nor more than four hundred thousand~~  
29 ~~dollars (\$400,000) for the second violation, and of not less than~~  
30 ~~one million dollars (\$1,000,000) for each subsequent violation.~~

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

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

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

4     ~~(f)~~

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

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

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

16    ~~(g) It is the intent of the legislature for the funds generated from~~  
17    ~~administrative penalties assessed pursuant to this section to be~~  
18    ~~used to fund child health care services.~~

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

21    10169.7. (a) (1) For each annual report submitted to the  
22    department by a health insurer pursuant to Section 10169.6, the  
23    department shall compare the number of a health insurer's  
24    treatment denials and modifications to both of the following:

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

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

30    (2) (A) If more than 40 percent of independent medical reviews  
31    filed with a health insurer result in an overturning or reversal of  
32    a treatment denial or modification in any one individual category  
33    enumerated in paragraph (2) of subdivision (a) of Section 10169.6,  
34    the health insurer is in violation of this section and liable for an  
35    administrative penalty pursuant to subdivision (b). A health insurer  
36    may be liable for multiple violations per annual report.

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



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

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

11 (b) A health insurer that violates this section, or that violates  
12 any rule or order adopted or issued pursuant to this section, is  
13 liable for administrative penalties of not less than fifty thousand  
14 dollars (\$50,000) for the first violation, and of not less than one  
15 hundred thousand dollars (\$100,000) nor more than four hundred  
16 thousand dollars (\$400,000) for the second violation, and of not  
17 less than one million dollars (\$1,000,000) for each subsequent  
18 violation.

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

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

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

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

37 ~~SEC. 4.~~

38 SEC. 6. No reimbursement is required by this act pursuant to  
39 Section 6 of Article XIII B of the California Constitution because  
40 the only costs that may be incurred by a local agency or school

1 district will be incurred because this act creates a new crime or  
2 infraction, eliminates a crime or infraction, or changes the penalty  
3 for a crime or infraction, within the meaning of Section 17556 of  
4 the Government Code, or changes the definition of a crime within  
5 the meaning of Section 6 of Article XIII B of the California  
6 Constitution.

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