

AMENDED IN ASSEMBLY JULY 17, 2025

AMENDED IN ASSEMBLY JUNE 24, 2025

AMENDED IN SENATE MAY 23, 2025

AMENDED IN SENATE APRIL 10, 2025

AMENDED IN SENATE MARCH 26, 2025

## **SENATE BILL**

**No. 363**

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

February 13, 2025

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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. For a health care service plan or health insurer with 10 or more independent medical reviews in a given year, the bill would make the 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:*

- 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) Every treatment denial or modification shall be separated
- 7 by type of care into the following categories:
- 8 (A) Surgical/Medical.
- 9 (B) Behavioral.
- 10 (2) Every treatment denial or modification shall be separated
- 11 by diagnosis category or subcategory as determined by the
- 12 department. The department shall coordinate with the Department
- 13 of Insurance to ensure consistent diagnosis categories or
- 14 subcategories across both departments.
- 15 (3) Reporting shall be disaggregated by age.
- 16 (4) To the extent that demographic data is available, reporting
- 17 shall be disaggregated by categories determined in accordance
- 18 with the department's recommendation in coordination with the
- 19 Department of Insurance.
- 20 (5) Reporting shall include information on the health care service
- 21 plan's number of denials and modifications. A health care service
- 22 plan shall report the applicable reason for each denial or
- 23 modification by selecting from all of the following categories:
- 24 (A) Medical necessity.
- 25 (B) Investigative or experimental.

- 1 (C) Emergency or urgent care reimbursement.
- 2 (D) Incorrect billing.
- 3 (E) Duplicate claims.
- 4 (F) Out-of-network provider.
- 5 (G) Insufficient information, including medical records and
- 6 patient or provider signature.
- 7 (H) Ineligibility or coverage issue.
- 8 (I) Lack of timely submission.
- 9 (J) (i) Other.
- 10 (ii) If other is designated, the health care service plan shall
- 11 specify the reason for the denial or modification.
- 12 (6) Reporting on modifications shall include information on the
- 13 type of modifications made.
- 14 (b) A health care service plan shall report to the department on
- 15 an annual basis the total number of claims that the plan processed
- 16 in the prior year.
- 17 (c) A health care service plan shall submit its first report required
- 18 by subdivisions (a) and (b) to the department on or before June 1,
- 19 2026, and annually thereafter.
- 20 (d) (1) The department shall ensure that both of the following
- 21 are included in a report, as specified in paragraphs (2) and (3), at
- 22 least once per year, beginning January 1, 2028:
- 23 (A) Data, analysis, and conclusions relating to information
- 24 required to be reported by health care service plans pursuant to
- 25 subdivisions (a) and (b).
- 26 (B) Data, analysis, and conclusions relating to compliance with,
- 27 or violations of, Section 1374.38, including, but not limited to, the
- 28 number of independent medical review overturns of, and reversals
- 29 of, treatment denials and modifications.
- 30 (2) If the department publishes a report not required by this code
- 31 and relating to independent medical reviews, the department shall
- 32 include in the report the information specified in paragraph (1).
- 33 (3) If the department is not required to include the information
- 34 in a report pursuant to paragraph (2), the department shall include
- 35 the information in the report required by subdivision (f) of Section
- 36 1375.7.
- 37 (4) The department shall ensure that a report required to include
- 38 the information specified in paragraph (1) is published on its
- 39 internet website.

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 care  
6 service plan's treatment denials and modifications to both of the  
7 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) For a health care service plan with 10 or more  
15 independent medical reviews in a given year, if more than 50  
16 percent of a health care service plan's independent medical reviews  
17 result in an overturning or reversal of a treatment denial or  
18 modification in any one individual category enumerated in  
19 paragraph (1) of subdivision (a) of Section 1374.37, the health  
20 care service plan is in violation of this section and liable for an  
21 administrative penalty pursuant to subdivision (b). A health care  
22 service plan may be liable for multiple violations per annual report.

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

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

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

37 (b) A health care service plan that violates this section, or that  
38 violates any rule or order adopted or issued pursuant to this section,  
39 is liable for administrative penalties of not less than twenty-five  
40 thousand dollars (\$25,000) for the first violation, and of not less

1 than fifty thousand dollars (\$50,000) nor more than two hundred  
2 thousand dollars (\$200,000) for the second violation, and of not  
3 less than five hundred thousand dollars (\$500,000) for each  
4 subsequent violation.

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

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

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

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

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

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

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

30 10169.6. (a) A health insurer shall report every treatment  
31 denial or modification to the department in accordance with all of  
32 the following requirements:

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

35 (A) Surgical/Medical.

36 (B) Behavioral.

37 (2) Every treatment denial or modification shall be separated  
38 by diagnosis category or subcategory as determined by the  
39 department. The department shall coordinate with the Department

1 of Managed Health Care to ensure consistent diagnosis categories  
2 or subcategories across both departments.

3 (3) Reporting shall be disaggregated by age.

4 (4) To the extent that demographic data is available, reporting  
5 shall be disaggregated by categories determined in accordance  
6 with the department's recommendation in coordination with the  
7 Department of Managed Health Care.

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

12 (A) Medical necessity.

13 (B) Investigative or experimental.

14 (C) Emergency or urgent care reimbursement.

15 (D) Incorrect billing.

16 (E) Duplicate claims.

17 (F) Out-of-network provider.

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

20 (H) Ineligibility or coverage issue.

21 (I) Lack of timely submission.

22 (J) (i) Other.

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

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

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

30 (c) A health insurer shall submit its first report required by  
31 subdivisions (a) and (b) to the department on or before June 1,  
32 2026, and annually thereafter.

33 (d) (1) The department shall include in the annual report of the  
34 commissioner required by Section 12922, commencing with the  
35 2028 report, both of the following:

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

39 (B) Data, analysis, and conclusions relating to compliance with,  
40 or violations of, Section 10169.7, including, but not limited to, the

1 number of independent medical review overturns of, and reversals  
2 of, treatment denials and modifications.

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

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

8 10169.7. (a) (1) For each annual report submitted to the  
9 department by a health insurer pursuant to Section 10169.6, the  
10 department shall compare the number of a health insurer's  
11 treatment denials and modifications to both of the following:

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

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

17 (2) (A) For a health insurer with 10 or more independent  
18 medical reviews in a given year, if more than 50 percent of a health  
19 insurer's independent medical reviews result in an overturning or  
20 reversal of a treatment denial or modification in any one individual  
21 category enumerated in paragraph (1) of subdivision (a) of Section  
22 10169.6, the health insurer is in violation of this section and liable  
23 for an administrative penalty pursuant to subdivision (b). A health  
24 insurer may be liable for multiple violations per annual report.

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

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

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

39 (b) A health insurer that violates this section, or that violates  
40 any rule or order adopted or issued pursuant to this section, is liable



1 for administrative penalties of not less than twenty-five thousand  
2 dollars (\$25,000) for the first violation, and of not less than fifty  
3 thousand dollars (\$50,000) nor more than two hundred thousand  
4 dollars (\$200,000) for the second violation, and of not less than  
5 five hundred thousand dollars (\$500,000) for each subsequent  
6 violation.

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

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

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

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

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

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