Date of Hearing: July 15, 2025

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 363 (Wiener) – As Amended June 24, 2025

SENATE VOTE: 29-8

SUBJECT: Health care coverage: independent medical review.

SUMMARY: Requires a health plan and health insurer report every treatment denial or modification to the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI), separated by type of care into Surgical/Medical and Behavioral. Requires every treatment denial or modification to be separated by diagnosis category or subcategory, as determined by DMHC or CDI. Requires a health plan and health insurer to report to their regulator on an annual basis the total number of claims that the plan or insurer processed in the prior year. Requires DMHC and CDI to report at least once per year, beginning January 1, 2028 on data, analysis, and conclusions relating to information required to be reported by health plans and health insurers on denials, modifications and number of claims and compliance with, or violations of this bill. Requires, for a health plan or health insurer with 10 or more independent medical reviews (IMRs) in a given year, if more than 50% of a health plan or health insurer's IMRs result in an overturn or a reversal of a treatment denial or modification in either the Surgical/Medical or Behavioral category, the health plan or health insurer to be in violation of this bill and liable for an administrative penalty. Makes a health plan or health insurer that fails to report a treatment denial or modification, that violates the IMR-related provisions of this bill, or that violates any rule or order adopted or issued pursuant to the IMR-related provisions above, liable for administrative penalties of not less than $25,000 for the first violation, of not less than $50,000 nor more than $200,000 for the second violation, and of not less than $500,000 for each subsequent violation. Specifically, **this bill**:

Health Plan and Insurer Reporting on Treatment Denials and Modifications

1) Requires a health plan and health insurer to report every treatment denial or modification to the DMHC and the CDI, respectively, in accordance with all of the following requirements:

    a) Requires every treatment denial or modification to be separated by type of care into the following two categories: Surgical/Medical and Behavioral;

    b) Requires every treatment denial or modification to be separated by diagnosis category or subcategory, as determined by DMHC or CDI;

    c) Requires DMHC and CDI to coordinate to ensure consistent diagnosis categories or subcategories across both departments;

    d) Requires reporting to be disaggregated by age;

    e) Requires reporting, to the extent that demographic data is available, to be disaggregated by categories determined in accordance with the regulator's recommendation in coordination with the other regulator;

f) Requires reporting to include information on the health plan and health insurer's number of denials and modifications. Requires a health plan and health insurer to report the applicable reason for each denial or modification by selecting from all of the following categories:

   i) Medical necessity;

   ii) Investigative or experimental;

   iii) Emergency or urgent care reimbursement;

   iv) Incorrect billing;

   v) Duplicate claims;

   vi) Out-of-network provider;

   vii) Insufficient information, including medical records and patient or provider signature;

   viii) Ineligibility or coverage issue;

   ix) Lack of timely submission; and,

   x) Other.

g) Requires, if "other" is designated, the health plan and health insurer to specify the reason for the denial or modification; and,

h) Requires reporting on modifications to include information on the type of modifications made.

Health Plan and Insurer Reporting on Number of Claims

2) Requires a health plan and health insurer to report to their regulator on an annual basis the total number of claims that the plan or insurer processed in the prior year.

3) Requires a health plan and health insurer to submit its first report to its regulator on or before June 1, 2026, and annually thereafter.

DMHC and CDI Annual Report on Denials, Modifications and Number of Claims

4) Requires DMHC and CDI to ensure both of the following are included in a report, at least once per year, beginning January 1, 2028:

   a) Relating to information required to be reported by health plans and health insurers on denials, modifications and number of claims; and,

   b) Compliance with, or violations of, this bill, including, but not limited to, the number of IMR overturns of, and reversals of, treatment denials and modifications.

5) Requires, if the DMHC or CDI publishes a report not required by existing law relating to IMRs, DMHC and CDI to include in the report the information specified above.

6) Requires, if DMHC and CDI are not required to include the information in a report pursuant to the above, DMHC and CDI to include the information in the report required under existing law under the Health Care Providers' Bill of Rights.

7) Requires DMHC and CDI to ensure that a report required includes the information specified above on its internet website.

Administrative Penalties for Health Plans and Insurers with 10 or More IMRs and an Overturn Rate of 50% or Greater

8) Requires, for a health plan or health insurer with 10 or more IMRs in a given year, if more than 50% of a health plan or health insurer's IMR result in an overturning or reversal of a treatment denial or modification in either the Surgical/Medical or Behavioral category, the health plan or health insurer to be in violation of this bill and liable for an administrative penalty. Makes a health plan or health insurer liable for multiple violations per annual report.

9) Requires each IMR resulting in an additional overturned or reversed denial or modification in excess of the 50% threshold to constitute a separate violation of this bill.

10) Requires an IMR that 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 IMR is requested, filed, or applied for, regardless of whether a determination is made by an IMR organization or health plan or health insurer.

Administrative Penalties on Health Plans and Insurers

11) Makes a health plan or health insurer that that fails to report a treatment denial or modification, violates the IMR-related provisions of this bill, or that violates any rule or order adopted or issued pursuant to the IMR-related provisions above, liable for administrative penalties of not less than $25,000 for the first violation, of not less than $50,000 nor more than $200,000 for the second violation, and of not less than $500,000 for each subsequent violation.

12) Prohibits the administrative penalties available to the DMHC Director and the CDI Commissioner under this bill from being exclusive, and permits the administrative penalties to be sought and employed in any combination with civil, criminal, and other administrative remedies deemed advisable by the Director and the Commissioner to enforce their respective provisions of their body of law.

13) Requires, commencing January 1, 2031, and every five years thereafter, the penalty amounts specified in this bill to 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.

14) Establishes the Managed Care IMR Administrative Penalties Subaccount in the Managed Care Administrative Fines and Penalties Fund, for the receipt and deposit of moneys generated from the administrative penalties assessed pursuant to this bill.

15) Permits, upon appropriation by the Legislature, moneys in the subaccount to be expended for both of the following purposes:

    a) To offset the reasonable costs of implementing this bill; and,

    b) For other purposes of the Managed Care Administrative Fines and Penalties Fund, as specified in existing law.

EXISTING LAW:

1) Establishes the DMHC to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 and CDI to regulate health insurers under the Insurance Code. [Health and Safety Code (HSC) § 1340, *et seq*., and Insurance Code (INS) § 106, *et seq*.]

2) Establishes, in DMHC and CDI, the IMR System which reviews disputed health care services that a plan, or one of its contracting entities, or insurer determines is not medically necessary. Permits enrollees and insureds to apply for IMR when all of the following conditions are met:

    a) The provider has recommended a health care service as medically necessary; or, the enrollee or insured has received urgent care or emergency services that a provider determined was medically necessary; or, has been seen by an in-plan provider for the diagnosis or treatment of the medical condition;

    b) The disputed health care service has been denied, modified, or delayed by the plan, or by one of its contracting providers, or insurer based on a decision that it is not medically necessary; and,

    c) The enrollee or insured has filed a grievance with the plan, provider, or insurer and the decision was upheld or remains unresolved after 30 days. Permits a grievance requiring expedited review to go to IMR after three days of the grievance process. [HSC § 1374.30 and INS § 10169]

3) Requires reviews, for purposes of IMR, to determine whether the disputed health care service was medically necessary based on the specific medical needs of the enrollee or insured and any of the following:

    a) Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service;

    b) Nationally recognized professional standards;

    c) Expert opinion;

    d) Generally accepted standards of medical practice; or,

    e) Treatments that are likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious. [HSC § 1374.33 and INS § 10169.3]

4) Requires health plans and disability insurers to provide an external IMR to examine the insurer's or plan's coverage decisions regarding experimental or investigational therapies for an individual with a life-threatening or seriously debilitating condition, as specified.

FISCAL EFFECT: According to the Senate Appropriations Committee analysis of the prior version of this bill, this bill would have the following fiscal impact:

1) DMHC estimates costs to be approximately $2,651,000 in 2025-26, $4,507,000 in 2026-27, $5,139,000 in 2027-28, $5,575,000 in 2028-29, $5,621,000 in 2029-30, and $5,684,000 in 2030-31 and annually thereafter for state administration (Managed Care Fund);

2) Unknown ongoing costs, likely tens of thousands to hundreds of thousands, for CDI for state administration (Insurance Fund); and,

3) Unknown revenues from administrative penalties established under the bill. Moneys from penalty revenues could be used to offset the state administration costs for DMHC/CDI.

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, this bill requires health plans and insurers to report denials and modification to provider-recommended care and imposes fines for unreasonably high rates of IMR overturns. This bill will ensure that Californians are receiving the health care to which they are entitled, and that health plans are contractually obligated to provide. The author argues we are facing a health care crisis in this country, and California must lead in finding solutions. Patients are routinely denied the provider-recommended care needed to live healthy and full lives, resulting in worsening health outcomes for individuals and our health care system. Lawmakers, regulators, and advocates are lacking the basic and essential information about these modifications and denials needed to address these issues. Without this information, and at what rate they are making these denials and modifications, targeted policies for a healthier California cannot be crafted. No industry should be able to operate in a black hole of information, especially not one so crucial to the wellbeing of our state. The author concludes that it is vital that Californians have information on the health care decisions that impact their lives and that the state creates the accountability systems to ensure plans are authorizing the care patients deserve and are entitled.

2) IMR. Under state law, if an enrollee's health plan denies, changes, or delays a request for medical services, denies payment for emergency treatment or refuses to cover experimental or investigational treatment for a serious medical condition, an enrollee can apply for an IMR. Before filing an IMR with the regulator, enrollees are first required to file a grievance with the health plan or insurer (absent an emergency). Once an enrollee has participated in the 30-day process with the health plan or insurer, if the issue has not been resolved or an enrollee is not satisfied with the decision, an enrollee can proceed with filing an IMR application with the DMHC or CDI. A grievance requiring expedited review can go to IMR after three days. IMR decisions are available on a searchable basis on the DMHC and CDI's respective websites (without the name of the patient, the medical providers, and the health plan/insurer). The database is required to be accompanied by the annual rate of IMR among the total enrolled population, the annual rate of IMR cases by health plan, the number, type, and resolution of IMR cases by health plan, and the number, type, and resolution of IMR cases by ethnicity, race, and primary language spoken.

According to the most recent DMHC data from 2023, in approximately 72% of the 2,838 IMR cases, the health plan's denial of service was reversed by the health plan (21%) or overturned by the IMR organization (51%), and the enrollee received authorization for the requested service or treatment. Decisions that are reversed by the health plan included in this data are only those decisions that are reversed after an IMR is filed, and not decisions that are reversed earlier when an enrollee files an internal grievance. Broken down by IMR type, approximately 56% of IMRs for experimental or investigational treatment were reversed or overturned, 75% of IMRs on whether an item or service is medically necessary were reversed or overturned, and 75% of disputes involving reimbursement for emergency services were reversed or overturned. CDI's 2023 IMR data contains only 221 total IMRs with 134, or 61%, overturned in favor of the consumer.

3) **REPORTING REQUIREMENT ON DENIALS, MODIFICATIONS AND CLAIMS PROCESSED**. This bill requires health plans and insures to report every treatment denial or modification and the total number of claims that the plan or insurer processed in the prior year to their respective regulators. Plans are not required to report treatment denials or modifications under existing law or regulation. Existing Knox-Keene regulations require a plan to submit to DMHC, as part of the Annual Plan Claims Payment and Dispute Resolution Mechanism Report, information disclosing the claims payment compliance status of the plan and each of its claims processing organizations and capitated providers under specified provisions of law. Existing regulations allow DMHC to review the plan's and the plan's capitated provider's claims processing system through periodic medical surveys and financial examinations under specified provisions of existing law, and when appropriate, through the investigation of complaints of demonstrable and unjust payment patterns. DMHC indicates that, as part of its surveys done of plans that are done on an every three year basis or as needed, it will ask for a log of health plan denials and review a subset of claims.

   According to the DMHC's "*Health Care Service Plans' Provider Dispute Resolution Mechanisms 2023 Annual Report*," there are 59 licensed full service health plans in California (this figure excludes that are licensed only for Medicare products, are operating as a county organized health system which are exempt from licensure, and plans had no enrollment in California) that processed approximately 175 million claims in the reporting period, and approximately 1.5% of these claims resulted in disputes.

4) **EXISTING DMHC DISCIPLINARY AUTHORITY**. The Knox-Keene Act grants DMHC the authority to regulate health care service plans and enforce compliance, with a range of penalties (DMHC regulated health plans cover over 97% of individuals in state-regulated health plan products). The DMHC can (after notice and opportunity for a hearing), suspend or revoke any license, assess administrative penalties if the director determines the plan committed specified acts constituting grounds for disciplinary action, issue cease and desist orders, and requires a plan to implement a corrective action plan.

   SB 858 (Wiener), Chapter 985, Statutes of 2022, among other provisions, increased the base amount of the civil penalty in the Knox-Keene Act from $2,500 per violation to not more than $25,000 per violation, and required DMHC Director, in assessing an administrative and civil penalty, to determine the appropriate amount for determining the penalty amount, based upon consideration of specified factors, including nature, scope, and gravity of the violation; good or bad faith of the plan; and, the plan's history of violations. SB 858 also doubled the minimum and maximum amounts of specified civil and administrative penalties, and,

beginning January 1, 2028, and every five years thereafter, requires these civil and administrative penalties be adjusted, as specified.

5) **SUPPORT**. This bill is jointly sponsored by Children Now, the California Academy of Child & Adolescent Psychiatry, and the California Chronic Care Coalition. Children Now writes that this bill will hold health insurers accountable for baseless coverage denials and provide the transparency needed to understand why denial rates are on the rise. Specifically, this bill requires health insurers to report to their respective regulator on any denials and modifications made to provider-recommended care, and would include this information in an annual report. Parents, caregivers and healthcare providers have raised the alarm that treatment denial rates have increased in recent years. Children Now states that nearly three in four providers reported an increase in denials between 2022-2024, and hospitals reported a 20% increase in private insurance coverage denials from 2022 to 2023. Children Now states the number of treatment denials or modifications is not public information, which makes it difficult to ensure that patients are receiving the care to which they are entitled. This gap in knowledge is especially concerning when paired with the high rates of IMR overturns, which indicates that much of the care being denied is appropriate and necessary. The lack of information surrounding the scope of denials and modifications is troubling and enables the industry to potentially hide mass-scale wrongdoing. If lawmakers, agencies, and advocacy organizations are unaware of the scale on which denials are taking place, it becomes difficult to ensure patients receive the care to which they are entitled. The limited data that is available further affirms why policymakers should be concerned.

   In addition, the bill imposes fines for unreasonably high rates of IMR overturns or reversals. Children Now argues that, by imposing these fines, this bill will incentivize health insurers to make sure that the denials they are making are reasonable and that they are transparent in their actions. About 72% of IMRs brought to DMHC last year resulted in a successful overturning or reversal of a denial, meaning the enrollee eventually got the services they requested, and for some demographics and diagnoses, the IMR overturn rate is even higher. For example, in 2020, 82% of health plan denials for youth mental health care were overturned by IMR. This high rate of overturns paired with the general opacity around denials results in potentially thousands of patients being denied care to which they are entitled. Without proper data and tracking, Children Now states it is impossible to hold health insurers to account, especially if the state is lacking an incentive structure to ensure that health insurers avoid superfluous denials and modifications.

   Children Now argues this bill will incentivize health insurers to make sure that the denials they are making are reasonable and that they are transparent in their reporting, and by imposing fines on outrageously high IMR overturn rates, this bill will provide strong incentives to avoid denials that are likely to be overturned and ensure patients receive the care they need. Children Now concludes this bill delivers the transparency and accountability about their care that California patients are owed and ensures that health insurers can no longer operate behind closed doors but must instead provide the care they are obligated to deliver.

6) **SUPPORT IF AMENDED**. The California Chiropractic Association (CalChiro) requests this bill be amended to explicitly include specialty health plans within its provisions. CalChiro writes that specialty health plans, including those that provide limited-scope coverage such as chiropractic, behavioral health, dental, vision, and other allied services,

play a critical role in California's health care delivery system. Like full-service plans, these entities make utilization review decisions that directly affect patient care and provider practice. CalChiro argues that they should be held to the same transparency and accountability standards established in this bill. Including specialty plans would ensure consistency in oversight, promote uniform patient protections across all health care coverage products, and provide regulators and policymakers with a more complete picture of denial patterns across California's diverse insurance marketplace. Specialty plan reporting will also help identify whether certain categories of care are disproportionately subject to inappropriate denials or unnecessary administrative burdens that delay treatment and disrupt continuity of care.

7) **OPPOSITION**. The California Association of Health Plans (CAHP) and the Association of California Life and Health Insurance Companies (ACLHIC) argue this bill severely hinders the operational integrity of health plans/insurers medical review process by imposing massive penalties on health plans and insurers when they are overturned through the IMR process. CAHP and ACLHIC argue IMR is a venue to resolve differences of opinion regarding the medical necessity of a covered service as the practice of medicine is a nuanced field where equally qualified and experienced clinicians frequently arrive at differing, yet valid, conclusions regarding a patient's needs. CAHP and ACLHIC contend that imposing penalties on plans and insurers for these inherent differences of clinical opinion, particularly on complex medical questions, is punitive and overreaching. There are many instances when denials were based on valid medical practice guidelines informed by evidence-based protocols and yet were still overturned by the IMR reviewers. CAHP and ACLHIC conclude that arbitrary and excessive penalties will not enhance care, and will instead, they will inject unnecessary complexity and ultimately increase cost.

   America's Physician Groups (APG) writes in opposition that the fine structure established in this bill is intended to penalize health plans when IMRs overturn denials. However, the bill does not distinguish between large health plans and the much smaller, delegated risk-bearing organizations (RBOs) that lack comparable financial reserves. APG writes that these fines could disproportionately impact these smaller organizations, potentially destabilizing them, despite their critical role in delivering care. APG states this bill does not account for two key considerations when assessing penalties: The total number of prior authorizations, modifications, and denials issued by an RBO, relative to the number of actual IMRs (whether overturned or upheld), and the severity of each IMR case, including whether the enrollee sustained any harm. Without this context, the bill risks penalizing organizations disproportionately and without regard to the overall quality or intent of their care coordination efforts. APG concludes that existing legal authority already exists to achieve the goals of this bill, the proposed fine structure lacks nuance and could financially destabilize smaller RBOs, and this bill undermines policy goals of care coordination, risk-sharing, and cost containment promoted by other recent legislation.

8) **RELATED LEGISLATION**. AB 682 (Ortega) would require health plans, insurers and multiple-employer welfare arrangements (MEWAs) to report specified information for each month, including information on the number of claims processed or adjudicated, claims denials, total cost of claims denied, the number and total costs of prior authorization requests denied or partially denied, the number of decisions that were approved, modified, or denied for retrospective requests beyond the 30-day requirement, the number of retrospective requests that were extended and approved, the average and median time that elapsed between

the submission of a retrospective request and the decision by the plan, the number and total costs of requests made under expedited timeframes involving an eminent and serious threat to the enrollee's health pursuant to paragraph (2) of subdivision (h) of Section 1367.01 that were denied, the total out-of-pocket costs paid by an enrollee to pay for a treatment and procedure of which a claim was denied or partially denied, claims payment timeframes, claims denied by various reasons, the number and total costs of claims denied or partially denied, broken down by age, gender identity, sex, ethnicity, disability and sexual orientation, the list of services requiring prior authorization, the number of internal appeals or grievances filed or processed on contested claims, the number of contested claims that were denied or partially denied that were overturned through internal appeals or grievances processes, the number of contested claims that were denied or partially denied that were overturned through external appeals or grievances processes, the number of contested claims denied or partially denied that at any point were processed, adjudicated, or reviewed with artificial intelligence or other predictive algorithms, and the number of contested claims that resulted in written determination. DMHC and CDI would be required to publish on their respective websites monthly claims denial information for each plan in a manner prescribed by the director. AB 682 is scheduled for hearing in the Senate Health Committee on July 16, 2025.

9) **PREVIOUS LEGISLATION**. SB 294 (Wiener) of 2024 would have established an automated grievance and IMR processes when a health plan or insurer modifies, delays, or dienes an authorization request for coverage of treatment for mental health or substance use disorders for an enrollee or insured up to age 26. SB 294 was held on the Assembly Appropriations Committee suspense file.

   AB 3260 (Pellerin) of 2024 would have made various changes to the prior authorization, grievance, and IMR processes for commercial health care coverage, including tightening the timeline for reviewing missing documents during the prior authorization process, making a provider's determination of urgency binding on the plan or insurer, automating the filing of a grievance when authorization timelines are not met, automating approvals of services when the grievance timeline is not met, eliminating exemptions from the grievance process, and requiring additional documentation to be shared with the enrollee or insured after an IMR is filed. AB 3260 was held on the Assembly Appropriations suspense file.

   SB 238 (Wiener) of 2023 would have required a health plan or insurer that modifies, delays, or denies a mental health or substance use disorder service based on medical necessity, to submit the decision to the IMR System within 24 hours, without requiring the enrollee or insured to file a grievance, for an enrollee or insured up to 26 years of age. SB 238 was held on the Assembly Appropriations Committee suspense file.

10) **AMENDMENT**. Following discussions, the provision in this bill that applies the increased fines if a plan or insurer fails to meet the requirement that plans and insurers report a treatment denial or modification, will be deleted.

11) **POLICY QUESTION**. This bill (as proposed to be amended) makes a health plan or health insurer that violates the IMR-related provisions of this bill, or that violates any rule or order adopted or issued pursuant to the IMR-related provisions above, liable for administrative penalties of not less than $25,000 for the first violation, and of not less than $50,000 nor more than $200,000 for the second violation, and not less than $500,000 for each subsequent violation. The administrative penalties available to the regulator under this bill are not

exclusive, and may be sought and employed in any combination with civil, criminal, and other administrative remedies deemed advisable by the regulator. Beginning January 1, 2031 and every five years thereafter, the penalty amounts specified in this bill are required to 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.

This approach raises several policy issues, including the dollar amount of the administrative penalties, whether the regulators should have discretion in levying the penalty, whether the regulator should have discretion in determining the amount of the penalty (versus the penalties being a minimum amount), the conduct the health plan and insurer engages in that the penalty would apply to, and whether the regulator should be required to take into account factors in existing law (such as the nature, scope and gravity of the violation, good or bad faith by the plan, the plan's history of violations, and what health plan and insurer conduct would result in a penalty). The approach taken in this bill is to make a health plan liable for minimum penalty amounts, instead of authorizing the regulator to determine the appropriateness of the fine.

REGISTERED SUPPORT / OPPOSITION:

Support

California Academy of Child & Adolescent Psychiatry (co-sponsor)
California Chronic Care Coalition (co-sponsor)
Children Now (co-sponsor)
Access Reproductive Justice
Asian Americans Advancing Justice-Southern California
Autism Speaks
California Acupuncture Coalition
California Alliance of Caregivers
California Alliance of Child and Family Services
California Association of Air Medical Services
California Association of Medical Product Suppliers
California Behavioral Health Association
California Chapter of the American College of Emergency Physicians
California Consortium of Addiction Programs and Professionals
California Hospital Association
California Orthopedic Association
California Pharmacists Association
California Physicians Alliance
California Psychological Association
California Rheumatology Alliance
California Rural Legal Assistance Foundation, Inc.
California Advocates for Nursing Home Reform
Children's Specialty Care Coalition
Council of Autism Service Providers
Courage California
Friends Committee on Legislation of California
Global Medical Response

Health Access California
Indivisible CA: StateStrong
Latino Coalition for a Healthy California
National Health Law Program
National Multiple Sclerosis Society
San Francisco Marin Medical Society
Santa Monica Democratic Club
State Council on Developmental Disabilities
Steinberg Institute
The ALS Association
The Arc California
The Children's Partnership
The Los Angeles Trust for Children's Health
Western Center on Law & Poverty, Inc.
One individual

Opposition

America's Physician Groups
Association of California Life & Health Insurance Companies
California Association of Health Plans
Local Health Plans of California
Sharp Healthcare
Several individuals

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