Date of Hearing: August 20, 2025

ASSEMBLY COMMITTEE ON APPROPRIATIONS
Buffy Wicks, Chair
SB 363 (Wiener) – As Amended July 17, 2025

Policy Committee: Health Vote: 13 - 0

Urgency: No State Mandated Local Program: Yes Reimbursable: No

SUMMARY:

This bill requires a health plan or insurer be liable for an administrative penalty if the health plan or insurer has more than 50% of independent medical reviews (IMRs) result in an overturn or reversal of a treatment denial or modification in either the surgical/medical or behavioral category.

Specifically, this bill:

Reporting Requirements for Health Plans and Health Insurers

1) Requires a health plan and health insurer (collectively, "health insurer"), beginning June 1, 2026, to annually report to the Department of Managed Health Care (DMHC) or the California Department of Insurance (CDI; collectively, "regulators"), as appropriate, the total number of claims processed in the prior year and every treatment denial or modification in accordance with specified requirements. Reports must:

    a) Include information on the health insurer's number of denials and modifications.

    b) Be separated by type of care as surgical/medical or behavioral.

    c) Be separated by diagnosis category or subcategory, as determined by the regulators.

    d) Be disaggregated by age and demographic categories determined by the regulators in coordination with one another.

    e) Include the reason for each denial or modification, selected from specified categories that include, among others, medical necessity, incorrect billing, out of network provider, and other specified reasons.

    f) Include the type of modifications made.

DMHC and CDI Analysis and Report

2) Requires each of the regulators ensure both of the following are included in a report published on the regulator's website, at least once per year, beginning January 1, 2028:
    a) Data, analysis, and conclusions relating to information on denials, modifications and number of claims that health insurers are required to report pursuant to item 1, above.

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

3) If a regulator publishes a report not required by existing law and relating to IMRs, requires the regulator include in the report the information specified in item 2, above.

4) If a regulator is not required to include the information in a report pursuant to item 3, above, requires the regulator include the information specified in item 2, above, in the dispute resolution report required under the Health Care Providers' Bill of Rights.

Administrative Penalties

5) For each annual report a health insurer submits to a regulator pursuant to item 1, above, requires the regulator compare the number of a health insurer's treatment denials and modifications to:

   a) The number of successful IMR overturns of that health insurer's treatment denials and modifications.

   b) The number of treatment denials or modifications reversed by a health insurer after an IMR is requested, filed, or applied for.

6) For a health insurer with 10 or more IMRs in a given year, if more than 50% of the health insurer's IMRs result in an overturning or reversal of a treatment denial or modification in either the surgical/medical or behavioral category, provides that the health insurer is in violation of this bill and liable for an administrative penalty. Provides that a health insurer may be liable for multiple violations per annual report.

7) Provides that each IMR resulting in an additional overturned or reversed denial or modification in excess of the 50% threshold constitutes a separate violation of this bill.

8) Provides that for the purposes of this bill, an IMR 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 insurer.

9) Makes a health insurer that violates an IMR-related provision 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, not less than $50,000 nor more than $200,000 for the second violation, and not less than $500,000 for each subsequent violation.

10) 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 the provisions of each regulator's body of law.

11) Commencing January 1, 2031, and every five years thereafter, requires 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 U.S. Bureau of Labor Statistics.

12) Establishes the Managed Care IMR Administrative Penalties Subaccount in the Managed Care Administrative Fines and Penalties Fund and the Health Insurance Independent Medical Review Administrative Penalties Fund, for the receipt and deposit of moneys generated from the assessed pursuant to this bill.

13) Permits, upon appropriation by the Legislature, administrative penalties moneys in the subaccount and fund created in item 12, above, to be expended to offset the reasonable costs of implementing this bill and for other specified purposes.

14) Provides that the provisions of this bill are severable.

FISCAL EFFECT:

DMHC estimates costs of approximately $2.65 million in fiscal year (FY) 2025-26, $4.51 million in FY 2026-27, $5.14 million in FY 2027-28, $5.57 million in FY 2028-29, $5.62 million in FY 2029-30, and $5.68 million in FY 2030-31 and annually thereafter for the following: develop the reporting template; review and analyze data and prepare the annual report; enforcement, including investigations and trial-related costs; and modernize the consumer complaint system and provide technical and administrative support, among other things (Managed Care Fund).

CDI estimates costs of approximately $255,000 FY 2025-26, $731,000 FY 2026-27, and $183,000 FY 2027-28 and ongoing (Insurance Fund).

Costs to the Department of Health Care Services (DHCS) of an unknown amount, possibly hundreds of thousands of dollars annually, for staffing to provide technical assistance to Medi-Cal managed care plans, and a possible minor increase in Medi-Cal managed care plans' capitated rates due to the costs of reporting data as required by this bill. (General Fund, federal funds).

This bill could result in revenues of an unknown amount from administrative penalties established under the bill. Such revenues, upon appropriation by the Legislature, could be used to offset costs of implementing this bill (Managed Care Administrative Fines and Penalties Fund and Health Insurance Independent Medical Review Administrative Penalties Fund).

COMMENTS:

1) **Purpose.** This bill is sponsored by Children Now, the California Academy of Child & Adolescent Psychiatry, and the California Chronic Care Coalition. According to the author:

> 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. 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…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 to.

2) **Background.** 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, the enrollee may file a grievance with the health insurer. If the enrollee has participated in the grievance process with the health insurer and, after 30 days – or three days if the grievance requires expedited review – the issue has not been resolved or the enrollee is not satisfied with the decision, the enrollee may proceed with filing an IMR application with the appropriate regulator. The IMR process must determine whether the disputed health care service was medically necessary based on the specific medical needs of the enrollee and other information, such as peer-reviewed evidence regarding the effectiveness of the disputed service, nationally recognized professional standards, expert opinion, generally accepted standards of medical practice, or the absence of other effective treatments. A health insurer must provide an external IMR to examine a coverage decision regarding experimental or investigational therapies for an individual with a life-threatening or seriously debilitating condition.

   According to 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 after an IMR was filed (21%) or overturned by the IMR organization (51%), and the enrollee received authorization for the requested service or treatment. 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 221 IMRs with 61% overturned in favor of the consumer.

3) **Prior Legislation.** SB 858 (Wiener), Chapter 985, Statutes of 2022 increased the base amount of the civil penalty for DMHC-regulated plans, from $2,500 per violation to not more than $25,000 per violation per day per enrollee, and required DMHC 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.

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