STATE OF CALIFORNIA
DEPARTMENT OF INSURANCE
300 Capitol Mall, 17th Floor
Sacramento, CA 95814

TEXT OF REGULATION

MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY IN HEALTH INSURANCE

October 4, 2022 **REG-2021-00008**

Title 10. Investment, Chapter 5. Insurance Commissioner, Subchapter 3. Insurers,
Article 15.2. Mental Health and Substance Use Disorder Parity

~~Section 2562.1. Scope of Article; Definition.~~

~~(a) This article shall apply only to coverage for services or treatments rendered for pervasive developmental disorder or autism under a policy of health insurance as defined in Insurance Code section 106.~~

~~(b) This article shall not apply to a policy described in subdivision (g) of Insurance Code section 10144.5.~~

~~(c) As used in this article, the term "behavioral health treatment" has the meaning set forth in subdivision (c)(1) of Insurance Code section 10144.51.~~

~~Note: Authority cited: Sections 10144.5, 10144.51, 12921 and 12926, Insurance Code; *CalFarm Ins. Co. v. Deukmejian*, 48 Cal.3d 805 (1989); *20th Century Ins. Co. v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 10144.5 and 10144.51, Insurance Code; *Harlick v. Blue Shield of California*, 686 F.3d 699 (2012).~~

~~Section 2562.2. Medical Necessity; Case Management and Utilization Review.~~

~~(a) Nothing in this article shall be construed to mandate coverage of services that are not medically necessary.~~

~~(b) Nothing in this article shall be construed to preclude an insurer from utilizing the following in accordance with the provisions of this article and Insurance Code sections 10144.5 and 10144.51:~~

~~(1) Case management;~~

~~(2) Managed care;~~

~~(3) Network providers;~~

~~(4) Utilization review techniques;~~

~~(5) Prior authorization;~~

~~(6) Copayments; or~~

~~(7) Other cost sharing.~~

~~Note: Authority cited: Sections 10144.5, 10144.51, 12921 and 12926, Insurance Code; *CalFarm Ins. Co. v. Deukmejian*, 48 Cal.3d 805 (1989); *20th Century Ins. Co. v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 10144.5 and 10144.51, Insurance Code; *Harlick v. Blue Shield of California*, 686 F.3d 699 (2012).~~

~~Section 2562.3. Prohibited Limitations on Coverage.~~

~~For purposes of Insurance Code section 10144.5,~~

~~(a) If treatment or services are~~

~~(1) Medically necessary,~~

~~(2) Rendered to an individual diagnosed with a health condition indicated in subdivision (d)(7) of Insurance Code section 10144.5, and~~

~~(3) Rendered for the purpose of treating that condition;~~

~~(b) Then an insurer shall not impose~~

~~(1) An annual visit limit, or~~

~~(2) An annual dollar limit, a copayment, a deductible, or any other financial term, when the same term or limit is not equally applicable to all benefits under the policy.~~

~~(c) For purposes of subdivision (a) of this section 2562.3, "treatment or services" includes but is not limited to speech therapy, occupational therapy and behavioral health treatment.~~

~~Note: Authority cited: Sections 10144.5, 10144.51, 12921 and 12926, Insurance Code; *CalFarm Ins. Co. v. Deukmejian*, 48 Cal.3d 805 (1989); *20th Century Ins. Co. v. Garamendi*, 8 Cal.4th 216 (1994). Reference: Sections 10144.5 and 10144.51, Insurance Code; *Harlick v. Blue Shield of California*, 686 F.3d 699 (2012).~~

Adopt: Section 2562. Scope of Article.

(a) This article applies to a disability insurance policy that covers hospital, medical, surgical, behavioral health, or outpatient prescription drug benefits, to a health insurance policy, and to an insurer that provides coverage under such a policy, as follows:

(1) This article does not apply to an accident-only, specified disease, hospital indemnity, Medicare supplement, dental-only, or vision-only policy.

(2) This article applies regardless of the market segment in which a policy is offered or whether it is a grandfathered health plan under Section 1251 of the Patient Protection and Affordable Care Act (42 U.S.C. Sec. 300gg-18011).

(b) A specialized behavioral health insurer, third-party administrator, contracting provider, or any other entity that performs utilization review or utilization management functions, or otherwise administers health care benefits that are subject to this article, on an insurer's behalf shall comply with this article in the performance of those duties.

(c) An insurer that delegates responsibility for performing utilization review or utilization management functions, or administering health care benefits that are subject to this article, to a contracting provider, another insurer, or any other entity shall maintain written policies and procedures describing the insurer's oversight and monitoring process for assuring the delegate or administrator complies with the requirements set forth in Insurance Code sections 10144.4, 10144.5, 10144.51, 10144.52, 10144.53, 10144.57, and this article.

(d) The provisions of this article are severable. If any provision of this article or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

NOTE: Authority cited: Sections 10144.5, 10144.52 and 10144.57, Insurance Code. Reference: Sections 106, 10270.2, 10123.135, 10144.4, 10144.5, 10144.51, 10144.52, 10144.53 and 10144.57, Insurance Code.

Adopt: Section 2562.01. Definitions.

The following definitions apply for purposes of this article:

(a) "Adverse utilization review coverage determination" means any of the following:

(1) Entirely or partially delaying, denying, reducing, terminating, modifying, or otherwise failing to provide or make payment for, a health care benefit resulting from the application of utilization review.

(2) Entirely or partially delaying, denying, reducing, terminating, modifying, or otherwise failing to provide or make payment for, a health care benefit on the basis that it is experimental or investigational.

(3) Reducing, modifying, or terminating an ongoing course of treatment for a mental health condition or substance use disorder that was approved to be provided over a period of time, or for a number of treatments, before the end of such period of time, or before such number of treatments have been provided, based on an asserted absence of medical necessity.

(b) "Behavioral health crisis services" means the continuum of services to address crisis intervention, crisis stabilization, and crisis residential treatment needs of individuals with

a mental health or substance use disorder crisis that are wellness, resiliency, and recovery oriented. These include, but are not limited to, crisis intervention, including counseling provided by 988 centers, mobile crisis teams, and crisis receiving and stabilization services, pursuant to Article 6.3 (commencing with Section 53123.1) of Chapter 1 of Part 1 of Division 2 of Title 5 of the Government Code.

(c) "Coverage document" means a contract, policy, evidence of coverage, certificate of coverage, schedule of benefits, rider, endorsement, amendment, insert policy page, or any other form, document, or notice of insurance providing coverage for hospital, medical, surgical, behavioral health, or outpatient prescription drug benefits.

(d) "Emergency health care services" means and includes any of the following:

(1) Emergency services, as defined in Insurance Code section 10112.7.

(2) Emergency medical transportation, as defined in Insurance Code section 10126.6.

(3) Behavioral health crisis services provided by a 988 center, mobile crisis team, facility, or other provider of behavioral health crisis services for an emergency medical condition or to stabilize an emergency medical condition, or that constitute urgent care services.

(4) Prevention, intervention, stabilization, receiving, and observation services for an emergency medical condition that are delivered in any location or setting, or that constitute urgent care services and are delivered in any location or setting outside the applicable network's service area, as described in subdivision (d)(5) of this section.

(5) Urgent care services that are delivered outside the applicable network's service area in any location or setting to prevent serious deterioration of an insured's health resulting from an unforeseen condition, or unforeseen complications or symptoms of an existing condition, for which treatment cannot be delayed until the insured returns to the network's service area.

(e) "Emergency medical condition" means an emergency medical condition, including a psychiatric emergency medical condition, as defined in Health and Safety Code section 1317.1.

(f) "Generally accepted standards of mental health and substance use disorder care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment pursuant to Insurance Code section 10144.51. Valid, evidence-based sources establishing generally accepted standards of mental health and substance use disorder care include peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

(g) "Health care benefit" or "benefit" means any health care item, service, procedure, medication, prescription drug, treatment modality, service intensity, or level of care for the diagnosis, prevention, or treatment of a mental health condition or substance use disorder.

(h) "Health care facility" or "facility" means an inpatient, residential, or outpatient facility, including a public facility as defined in Government Code section 8698, holding a valid license or certification from a state agency to furnish or deliver health care items and services to individuals diagnosed with a mental health condition or substance use disorder. This term shall include a provider of behavioral health crisis services that is a facility as defined in this subdivision.

(i) "Health care provider" or "provider" means any of the following:

(1) A person who is licensed under Division 2 (commencing with section 500) of the Business and Professions Code.

(2) An associate marriage and family therapist or marriage and family therapist trainee functioning pursuant to Business and Professions Code section 4980.43.3.

(3) A qualified autism service provider or qualified autism service professional certified by a national entity pursuant to Insurance Code section 10144.51.

(4) An associate clinical social worker functioning pursuant to Business and Professions Code section 4996.23.2.

(5) An associate professional clinical counselor, or professional clinical counselor trainee, functioning pursuant to Business and Professions Code section 4999.46.3.

(6) A registered psychologist, as described in Business and Professions Code section 2909.5.

(7) A registered psychological assistant, as described in Business and Professions Code section 2913.

(8) A psychology trainee or person supervised as set forth in Business and Professions Code section 2910, 2911, or 2914(d).

(9) A 988 center, mobile crisis team, or other provider of behavioral health crisis services that is described in another provision of this subdivision (i).

(j) "Iatrogenic infertility" means infertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment. For purposes of the immediately preceding sentence, a direct or indirect cause of infertility means medical treatment with a possible side effect of infertility, as established by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.

(k) "Intermittent," for purposes of eligibility for home health care services, means skilled nursing care that is either provided or needed on fewer than seven days each week, or less than eight hours of each day for an expected period of 30 days or less, with extensions as medically necessary when the need for additional care is finite.

(l) "Medically necessary," or "medical necessity," with respect to a mental health condition or substance use disorder, means a service or product addressing the specific needs of a patient for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is all the following:

(1) In accordance with generally accepted standards of mental health and substance use disorder care.

(2) Clinically appropriate in terms of type, frequency, extent, site, and duration.

(3) Not primarily for the economic benefit of the disability insurer and insureds or for the convenience of the patient, treating physician, or other health care provider.

(m) "Mental health condition or substance use disorder" means a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the World Health Organization's *International Statistical Classification of Diseases and Related Health Problems*, or that is listed in the most recent version of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*. Changes in terminology, organization, or classification of mental health and substance use disorders in future versions of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders or the World Health Organization's International Statistical Classification of Diseases and Related Health Problems shall not affect the conditions covered by this article, provided that the a condition is commonly understood to be a mental health or substance use disorder by health care providers practicing in relevant clinical specialties.

(n) "Mental Health Parity and Addiction Equity Act" means the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343), and all rules, regulations, and guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26).

(o) "Nonprofit professional association" means a not-for-profit or tax-exempt scientific organization, or a membership association of health care professionals, excluding a charitable organization, or professional or trade association, of the health insurance or health plan industry. For purposes of this article, a nonprofit professional association means one that is not owned, organized, controlled, or directed by a health insurer or health plan, including an affiliate, parent, investor, shareholder, or subsidiary of a health insurer or health plan conducting business in this or another state.

(p) "Nonquantitative treatment limitation" means a limitation on the scope or duration of coverage of a health care benefit that is not a quantitative treatment limitation.

(q) "Political subdivision" has the same meaning as defined in Government Code section 8698.

(r) "Quantitative treatment limitation" means a limitation on the scope or duration of coverage of a health care benefit that is expressed numerically.

(s) "Standard fertility preservation services" means procedures consistent with the established medical practices and professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.

(t) "Urgent care services" means medical care or treatment for which a delay in immediate access, in the opinion of an attending health care provider with knowledge of an insured's medical condition, poses a serious threat to the health of an insured, including but not limited to, severe pain, the potential loss of life, limb, or major bodily function, or serious deterioration of the insured's health. Any determination made by an insurer of whether medical care or treatment constitutes urgent care services within the meaning of this definition shall defer to the opinion of an insured's attending health care provider.

(u) "Utilization review" means either of the following:

(1) Prospectively, retrospectively, or concurrently reviewing and approving, modifying, delaying, or denying, based in whole or in part on medical necessity, requests by health care providers, insureds, or their authorized representatives for coverage of health care services prior to, retrospectively or concurrent with the provision of health care services to insureds.

(2) Evaluating the medical necessity, appropriateness, level of care, service intensity, efficacy, or efficiency of health care services, benefits, procedures, or settings, under any circumstances, to determine whether a health care service or benefit subject to a medical necessity coverage requirement in a disability insurance policy is covered as medically necessary for an insured.

(v) "Utilization review criteria" means any criteria, standards, protocols, or guidelines used by a disability insurer to conduct utilization review.

(w) "Willful," when applied to the intent with which an act is done or omitted, means a purpose or willingness to engage in conduct, commit an act, or make an omission referred to in the Insurance Code or this article. It does not require any intent to violate law, injure another, or acquire any advantage.

NOTE: Authority cited: Sections 10123.135, 10144.4, 10144.5, 10144.52 and 10144.57, Insurance Code. Reference: Sections 790.035, 10112.7, 10112.281, 10123.135, 10123.191, 10123.193, 10123.195, 10123.197, 10123.201, 10126.6, 10144.4, 10144.5, 10144.51, 10144.52, 10144.53 and 10144.57, Insurance Code; Section 1317, subdivision (b) of Section 1345 and Section 1374.551, Health and Safety Code; Sections 500 et seq., 2909.5, 2910, 2911, 2913, 2914, 4980.43.3, 4996.23.2 and 4999.46.3, Business and Professions Code; Article 6.3 of Chapter 1 of Part 1 of Division 2 of Title 5 of and Section 8698, Government Code.

Adopt: Section 2562.02. Required Clinical Criteria for Mental Health Conditions and Substance Use Disorders.

(a) An insurer shall base any medical necessity determination, and the utilization review criteria that the insurer, or any entity acting on the insurer's behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and treatment of mental health conditions and substance use disorders, on current generally accepted standards of mental health and substance use disorder care.

(b) In conducting utilization review of a health care benefit for a mental health condition or substance use disorder in children, adolescents, or adults, an insurer shall:

(1) Apply the clinical criteria and guidelines set forth in the most recent versions of treatment criteria developed by nonprofit professional associations for the relevant clinical specialty.

(2) Not apply different, additional, conflicting, or more restrictive utilization review criteria than the clinical criteria and guidelines set forth in the most recent versions of treatment criteria developed by nonprofit professional associations for the relevant clinical specialty.

(c) (1) An insurer shall apply the clinical criteria and guidelines set forth in the most recent versions of treatment criteria developed by nonprofit professional associations for the relevant clinical specialty, including recommendations based on consensus expert opinion, whenever their application would determine the medical necessity of a health care benefit for a mental health condition or substance use disorder that is under consideration in utilization review. Subject to subdivisions (c)(2) and (c)(3) of this section, clinical criteria developed by the following nonprofit professional associations, and any other nonprofit professional associations that are not specified in this subdivision, shall be used exclusively to make utilization review coverage determinations that are within the scope of the criteria:

(A) American Academy of Child and Adolescent Psychiatry.

(B) American Academy of Family Physicians.

(C) American Academy of Neurology.

(D) American Academy of Pediatrics.

(E) American Academy of Sleep Medicine.

(F) American Association for Community Psychiatry.

(G) American College of Physicians.

(H) American Medical Association.

(I) American Psychiatric Association.

(J) American Psychological Association.

(K) American Society of Addiction Medicine.

(L) Canadian Network for Mood and Anxiety Treatments.

(M) Council of Autism Service Providers.

(N) World Professional Association for Transgender Health.

(2) If a guideline, clinical criterion, or set of criteria that would otherwise be required by this section was not developed pursuant to a process that satisfied each of the requirements stated in subdivisions (c)(2)(A) through (c)(2)(E), below, then an insurer may elect to apply alternate utilization review criteria that were developed in accordance with subdivision (a) of this section, subject to compliance with Insurance Code section 10144.4 and any other applicable requirements. The provisions of this subdivision (c)(2) shall not apply to the instruments required by subdivision (a) of Section 2562.03.

(A) The guideline describes the process by which it was developed and funded, including disclosing any funding sources and the identity and professional qualifications of the individual members of the group responsible for developing the guideline, or if the process is not described therein, the nonprofit professional association provides a description upon request.

(B) The nonprofit professional association managed disclosures of interest and conflicts of interest with respect to development of the guideline pursuant to a duly adopted, publicly accessible policy that reflects consideration of incorporating best practices in managing disclosures of interest and conflicts of interest in the development of clinical practice guidelines. Best practices include recommendations of the Council of Medical Specialty Societies in *Principles for the Development of Specialty Society Clinical Guidelines* and *Code for Interactions with Companies*, and similar recommendations from reputable sources such as the National Academy of Medicine.

(C) The nonprofit professional association excluded any external, for-profit entities that develop, produce, market, or distribute drugs, devices, services, or therapies used to diagnose, treat, monitor, manage, or alleviate health conditions from directly funding, influencing, or otherwise contributing to the development of the guideline.

(D) The nonprofit professional association performed a systematic review of the evidence as part of the guideline development process, and the review methodology is described in the guideline, or if the methodology is not

described therein, the nonprofit professional association provides a description upon request.

(E) In a guideline that is initially developed or that was last reviewed following the effective date of this section, with respect to a particular clinical recommendation or criterion, the guideline summarizes the relevant available evidence, describes potential benefits and harms, and appraises the quality of the evidence and strength of the recommendation.

(3) (A) If the nonprofit professional association that developed a guideline containing a clinical criterion or set of criteria that would otherwise be required by this section indicates that such criteria will not necessarily remain clinically valid or representative of current generally accepted standards of mental health and substance use disorder care after a defined period of time, or if a guideline was initially developed or last reviewed for new evidence affecting clinical recommendations in the guideline more than five years prior, then after the prescribed period of time an insurer may confirm with the nonprofit professional association in writing whether it has reviewed, or plans to review, new evidence to assess the continued clinical validity of the criteria and recommendations in the guideline. The provisions of this subdivision (c)(3) shall not apply to the instruments required by subdivision (a) of Section 2562.03.

(B) If a nonprofit professional association confirms that it does not intend to review new evidence to assess the continued clinical validity of the criteria and recommendations in the guideline within one year of receiving the insurer's inquiry, or does not respond to at least four separate written inquiries sent over a period of 120 days, then an insurer may elect to apply alternate utilization review criteria that were developed in accordance with subdivision (a) of this section, subject to compliance with Insurance Code section 10144.4 and any other applicable requirements.

(4) If an insurer elects to apply alternate utilization review criteria under subdivision (c)(2) or (c)(3) of this section, then the insurer shall submit written documentation to the Department demonstrating that the criteria in the guideline are eligible for disqualification under the standards set forth in this subdivision (c), along with the utilization review criteria that it proposes to implement in place of any disqualified criteria, at least 120 days in advance of the proposed implementation date. The proposed utilization review criteria shall be subject to Section 2562.04.

(d) In conducting utilization review of a health care benefit for a mental health condition or substance use disorder, if applying clinical criteria developed by a nonprofit professional association, or a combination of criteria developed by nonprofit professional associations, would determine whether a health care benefit is medically necessary, that determination is within the scope of the criteria within the meaning of subdivision (c) of Insurance Code section 10144.52. In such circumstances, nonprofit professional association clinical

criteria shall be used, to the exclusion of criteria from any other source, to make a coverage determination.

(e) An insurer shall specifically document the source of each clinical criterion that it uses to conduct utilization review of a health care benefit for a mental health condition or substance use disorder. If an insurer purchases or licenses a clinical policy for utilization review from another entity, the insurer shall verify and document before use that:

(1) The source of each clinical criterion is specifically documented.

(2) Either of the following:

(A) All the criteria were sourced from nonprofit professional association treatment criteria without alteration.

(B) In the event that nonprofit professional association clinical criteria that would determine the medical necessity of a health care benefit do not exist, the clinical policy was developed in accordance with subdivision (a) of this section by documenting the sources, and evidence supporting the clinical appropriateness, of each of the utilization review criteria.

NOTE: Authority cited: Sections 10144.5, 10144.52 and 10144.57, Insurance Code. Reference: Sections 10123.135, 10123.191, 10123.193, 10123.195, 10123.197, 10123.201, 10144.4, 10144.5, 10144.51, 10144.52, 10144.53, and 10144.57, Insurance Code.

Adopt: Section 2562.03. Utilization Review Standards for Level of Care Coverage Determinations.

(a) Utilization review coverage determinations concerning service intensity, level of care placement, continued stay, and transfer or discharge that are within the scope of the following instruments shall be made by using the most current version of the instrument designated by the respective nonprofit professional association, exclusive of all other clinical criteria, decision making tools, or applications:

(1) For a primary substance use disorder diagnosis in adolescents and adults, *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions* by the American Society of Addiction Medicine.

(2) For a primary mental health diagnosis in adults nineteen (19) years of age and older, *Level of Care Utilization System* (LOCUS) by the American Association for Community Psychiatry.

(3) For a primary mental health diagnosis in children six (6) to eighteen (18) years of age, *Child and Adolescent Level of Care/Service Intensity Utilization System* (merged CALOCUS-CASII) by the American Association for Community Psychiatry and the American Academy of Child and Adolescent Psychiatry.

(4) For a primary mental health diagnosis in children five (5) years of age and younger*, Early Child Service Intensity Instrument* (ECSII) by the American Academy of Child and Adolescent Psychiatry.

(b) In using the instruments required by subdivision (a) of this section, an insurer shall prioritize safety when applying clinical judgment in utilization review. If ambiguity or uncertainty exists regarding whether:

(1) An insured has met criteria for a score within one or more of the evaluation parameters of the LOCUS, CALOCUS-CASII, or ECSII instrument, which could be due to inadequate or conflicting information or difficulty in making a judgment about whether the available information is consistent with any of the criteria for a score, then an insurer shall assign the highest score in which it is more likely than not that at least one criterion has been met.

(2) An insured has met the dimensional admission criteria of *The ASAM Criteria*, then an insurer shall authorize a more intensive level of care if it is uncertain that the insured can be safely managed in a less intensive level of care.

(c) A determination made by the instrument shall be binding on an insurer. An insurer shall cover the level of care or service intensity determined by the instrument and shall not reduce the amount of time a level of care or service intensity is covered or otherwise modify the determination made by the instrument, or require, request, or incentivize an insured to obtain services at a lower level of care or service intensity than that determined by the instrument. If a lower level of care or service intensity is requested by an insured without having been required, requested, or incentivized by the insurer to make such request, then an insurer shall cover the level of care or service intensity the insured requested. This subdivision does not prevent an insurer from covering a higher level of care or service intensity than that determined by an instrument, when clinically appropriate or legally mandated.

(d) An insurer shall continuously maintain in good standing a licensing agreement to use each instrument required by subdivision (a) of this section. An insurer shall access and use the instrument and scoring algorithm as designated by the respective nonprofit professional association, regardless of whether the instrument is offered directly by the association, or by a third party through an arrangement with the association.

NOTE: Authority cited: Sections 10144.5, 10144.52 and 10144.57, Insurance Code. Reference: Sections 10123.135, 10144.4, 10144.5, 10144.51, 10144.52, 10144.53 and 10144.57, Insurance Code.

Adopt: Section 2562.04. Gap-Filling Utilization Review Criteria.

(a) If nonprofit professional association clinical criteria that determine the medical necessity of a health care benefit or an advancement in a technology or type or level of care for a mental health condition or substance use disorder do not exist, then an insurer may use other clinical criteria to conduct utilization review, provided that:

(1) The gap-filling utilization review criteria are based on current generally accepted standards of mental health and substance use disorder care. An insurer shall document the sources, and evidence supporting the clinical appropriateness, of each of the gap-filling utilization review criteria in a clinical policy.

(2) An insurer develops and maintains, and provides upon request, the following records:

(A) To any requestor, the clinical policy containing the gap-filling utilization review criteria that the insurer uses to perform utilization review of the health care benefit.

(B) To an insured or an insured's authorized representative, and the insured's health care provider, a comparative analysis and all underlying supporting documentation demonstrating that the gap-filling utilization review criteria were designed, and in practice are applied, in compliance with the Mental Health Parity and Addiction Equity Act rule on nonquantitative treatment limitations set forth in subdivision (c)(4) of Section 147.136 of Title 45 of the Code of Federal Regulations.

(C) To an insured or an insured's authorized representative, and the insured's health care provider, a written justification prepared by appropriately qualified health care professionals that includes the following:

1. A description of the nonprofit professional association sources the insurer examined and the process the insurer followed to make its finding that nonprofit professional association clinical criteria that determine the medical necessity of a health care benefit or an advancement in a technology or type or level of care for a mental health condition or substance use disorder does not exist.

2. An explanation of the clinical rationale and evidence supporting the insurer's determination that the gap-filling utilization review criteria are based on current generally accepted standards of mental health and substance use disorder care for determining the medical necessity of a health care benefit or an advancement in a technology or type or level of care for a mental health condition or substance use disorder.

(b) If nonprofit professional association clinical criteria that determine the medical necessity of an existing technology or type or level of care of care exist, those criteria shall be used exclusively to make a utilization review coverage determination unless the specific coverage determination at issue is whether a novel or different application of an existing technology or type or level of care is medically necessary.

(c) An insurer shall perform, and document completion of, each of the following at least annually:

(1) Survey sources of nonprofit professional association clinical criteria for new or revised clinical criteria that determine the medical necessity of a health care benefit or an advancement in a technology or type or level of care that is the subject of each of the insurer's gap-filling clinical criteria and clinical policies.

(2) If new or revised nonprofit professional association clinical criteria do not exist, evaluate whether the gap-filling utilization review criteria are based on current generally accepted standards of mental health and substance use disorder care and update the clinical policy as necessary.

(3) Review the records maintained pursuant to subdivision (a)(2) of this section for contemporaneity and continued accuracy and update the records as necessary.

NOTE: Authority cited: Sections 10144.4, 10144.5, 10144.52 and 10144.57, Insurance Code. Reference: Sections 10123.135, 10123.191, 10123.193, 10123.195, 10123.197, 10123.201, 10144.4, 10144.5, 10144.51, 10144.52, 10144.53 and 10144.57, Insurance Code.

Adopt: Section 2562.05. Scope of Required Benefits for Mental Health Conditions and Substance Use Disorders.

(a) An insurer shall provide coverage of health care benefits for preventing, diagnosing, and treating mental health conditions and substance use disorders as medically necessary for an insured, in accordance with current generally accepted standards of mental health and substance use disorder care, including but not limited to, the following:

(1) Basic health care services, including the following:

(A) Emergency health care services rendered both inside and outside the service area of the applicable network.

(A) Urgent care services rendered inside the service area of the applicable network.

(B) Physician services, including but not limited to consultation and referral to other health care providers and prescription drugs when furnished or administered by a health care provider or facility.

(C) Hospital inpatient services, including services of licensed general acute care, acute psychiatric, and chemical dependency recovery hospitals.

(D) Ambulatory care services, including but not limited to physical therapy, occupational therapy, speech therapy, and infusion therapy.

(E) Diagnostic laboratory services, diagnostic and therapeutic radiologic services, and other diagnostic and therapeutic services.

(F) Home health care services.

(G) Preventive health care services, regardless of whether an insured has been diagnosed with a mental health condition or substance use disorder.

(H) Hospice care that is, at a minimum, equivalent to hospice care provided by the federal Medicare Program pursuant to Title XVIII of the Social Security Act (42 U.S.C. Sec. 1395 et seq.) and implementing regulations adopted for hospice care under Title XVIII of the Social Security Act in Part 418 of Chapter IV of Title 42 of the Code of Federal Regulations, and any amendments or successor provisions, except Subparts A, B, G, and H.

(I) Standard fertility preservation services when a covered treatment may directly or indirectly cause iatrogenic infertility.

(2) Behavioral health crisis services provided by a 988 center, mobile crisis team, facility, or other provider of behavioral health crisis services. Behavioral health crisis services shall include crisis prevention, intervention, and receiving and stabilization services delivered in any location or setting, including 23-hour non-hospital observation and crisis residential facility treatment.

(3) Behavioral health treatment for pervasive developmental disorder or autism spectrum disorder pursuant to Insurance Code section 10144.51.

(4) Coordinated specialty care for the treatment of first episode psychosis.

(5) Day treatment.

(6) Drug testing, both presumptive and definitive, including for initial and ongoing patient assessment during substance use disorder treatment.

(7) Electroconvulsive therapy.

(8) For gender dysphoria, all health care benefits identified in the most recent edition of the *Standards of Care* developed by the World Professional Association for Transgender Health.

(9) Inpatient services, including but not limited to all the following:

(A) Substance use disorder rehabilitation and withdrawal management, as described in the most recent version of *The ASAM Criteria*.

(B) High intensity acute medically managed residential programs (LOCUS and CALOCUS-CASII level 6A (version 2020), or as described in the most recent versions of LOCUS and CALOCUS-CASII).

(C) Medically managed extended care residential programs (LOCUS and CALOCUS-CASII level 6B (version 2020), or as described in the most recent versions of LOCUS and CALOCUS-CASII).

(10) Intensive community-based treatment, including assertive community treatment and intensive case management.

(11) Intensive home-based treatment.

(12) Intensive outpatient treatment.

(13) Medication management.

(14) Narcotic (opioid) treatment programs.

(15) Outpatient prescription drugs, if coverage for outpatient prescription drugs is provided. Outpatient prescription drugs prescribed for mental health and substance use disorder pharmacotherapy, including office-based opioid treatment.

(16) Outpatient professional services, including but not limited to individual, group, and family substance use and mental health counseling.

(17) Partial hospitalization.

(18) Polysomnography.

(19) Psychiatric health facility services, including structured outpatient services as described in Health and Safety Code Section 1250.2.

(20) Psychological and neuropsychological testing.

(21) Reconstructive surgery pursuant to Insurance Code section 10123.88. For gender dysphoria, reconstructive surgery of primary and secondary sex characteristics to improve function, or create a normal appearance to the extent possible, for the gender with which the insured identifies, in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery who are competent to evaluate the specific clinical issues involved in the care requested.

(22) Residential treatment facility services, including all the following:

(A) Intensive short-term residential services (LOCUS and CALOCUS-CASII level 5A (version 2020), or as described in the most recent versions of LOCUS and CALOCUS-CASII).

(B) Moderate intensity intermediate stay residential treatment programs (LOCUS and CALOCUS-CASII level 5B (version 2020), or as described in the most recent versions of LOCUS and CALOCUS-CASII).

(C) Moderate intensity long-term residential treatment programs (LOCUS and CALOCUS-CASII level 5C (version 2020), or as described in the most recent versions of LOCUS and CALOCUS-CASII).

(D) ASAM residential levels of care (3rd edition), or as described in the most recent version of *The ASAM Criteria*:

1. 3.1, clinically managed low intensity residential services.

2. 3.3, clinically managed population-specific high intensity residential services.

3. 3.5, clinically managed high intensity (adults) or medium intensity (adolescents) residential services.

(23) Schoolsite services for a mental health condition or substance use disorder that are delivered to an insured at a schoolsite pursuant to Insurance Code section 10144.53.

(24) Transcranial magnetic stimulation.

(25) Withdrawal management services, including all the following ASAM levels (3rd edition), or as described in the most recent version of *The ASAM Criteria*:

(A) 1-WM, ambulatory withdrawal management without extended on-site monitoring.

(B) 2-WM, ambulatory withdrawal management with extended on-site monitoring.

(C) 3.2-WM, clinically managed residential withdrawal management.

(D) 3.7-WM, medically monitored inpatient withdrawal management.

(E) 4-WM, medically managed intensive inpatient withdrawal management.

(b) Home health care services.

(1) An insurer shall cover home health care services if all the following conditions are satisfied:

(A) An insured is confined to the home except for infrequent or relatively short duration absences, or when absences are attributable to the need to receive medical treatment, due to a mental health condition or substance use disorder.

(B) Skilled nursing care on an intermittent basis, physical therapy, occupational therapy, or speech-language pathology services are reasonable and necessary for the evaluation or treatment of an insured's mental health condition or substance use disorder or its symptoms. For purposes of this subdivision (b)(1)(B), skilled care shall be reasonable and necessary to improve an insured's current condition, maintain an insured's

current condition, or prevent or slow further deterioration of an insured's condition.

(C) An insured's physician, physician assistant, nurse practitioner, or clinical nurse specialist attests that the conditions in subdivisions (b)(1)(A) and (b)(1)(B) of this section are met, and establishes, and periodically reviews no less frequently than once every 60 days, a plan of care that includes the services specified in subdivision (b)(2) and the frequency and duration of visits.

(2) An insurer shall cover all the following home health care services as specified in the plan of care prepared by the insured's physician, physician assistant, nurse practitioner, or clinical nurse specialist:

(A) Part-time skilled nursing care, including by a registered nurse, licensed practical nurse under the supervision of a registered nurse, or psychiatrically trained nurse.

(B) Part-time home health aide services for personal care.

(C) Physical therapy.

(D) Speech-language pathology.

(E) Occupational therapy.

(F) Medical social services.

(G) Medical supplies provided by a home health agency while an insured is under a home health plan of care.

(H) Durable medical equipment while an insured is under a home health plan of care.

(3) For purposes of subdivision (b)(2) of this section, part-time means both skilled nursing services and home health aide services furnished any number of days per week, provided that the skilled nursing services and home health aide services, combined, are furnished less than eight hours per day and 35 hours per week. If an insurer covers more than the foregoing number of hours for conditions other than mental health conditions or substance use disorders, it shall cover an equivalent or greater number of hours for a mental health condition or substance use disorder.

(4) Any quantitative or nonquantitative treatment limitations or limitations on eligibility for coverage of home health care services shall be consistent with those limitations permitted under this article and Medicare, shall not be more restrictive than such limitations permitted under this article, and shall be subject to prior review by the Department.

(c) Preventive health care services, including the following:

(1) Screening, brief intervention and referral to treatment, primary care-based interventions, and specialty services for persons with hazardous, at-risk, or harmful substance use who do not meet the diagnostic criteria for a substance use disorder, or persons for whom there is not yet sufficient information to document a substance use or addictive disorder, as described in ASAM level of care 0.5 (3rd edition), or the most recent version of *The ASAM Criteria*.

(2) Basic services for prevention and health maintenance, including: screening for mental health and developmental disorders and adverse childhood experiences; multidisciplinary assessments; expert evaluations; referrals; consultations and counseling by mental health clinicians; emergency evaluation, brief intervention and disposition; crisis intervention and stabilization; community outreach prevention and intervention programs; mental health first aid for victims of trauma or disaster; and health maintenance and violence prevention education, as described in LOCUS and CALOCUS-CASII level of care zero (version 2020), or the most recent versions of LOCUS and CALOCUS-CASII.

(3) Preventive health care services for a mental health condition or substance use disorder that are required under Insurance Code section 10112.2. Any permissible scope of coverage limitations on health care benefits required under Insurance Code section 10112.2 shall not provide a basis to limit coverage for medically necessary treatment of a mental health or substance use disorder in a manner inconsistent with Insurance Code sections 10144.4, 10144.5, 10144.51, 10144.52, 10144.53, or 10144.57, or this article.

(d) An insurer shall cover the following for a mental health condition or substance use disorder:

(1) A health care benefit that is medically necessary under the requirements of this article and is furnished or delivered by, or under the direction of, a health care provider or facility acting within the scope of practice of the provider's or facility's license or certification under applicable state law.

(2) Emergency health care services that are furnished or delivered by, or under the direction of, a health care provider or facility acting within the scope of practice of the provider's or facility's license or certification under applicable state law, including by or at a licensed or certified health care provider or facility owned or operated by, employed by, or contracted with, a political subdivision to provide emergency health care services or behavioral health crisis services, regardless of whether the insurer is contracted with the health care provider, facility, or political subdivision to furnish emergency health care services or behavioral health crisis services to its insureds.

(e) An insurer shall apply cost sharing that is compliant with Insurance Code section 10144.4 to a health care benefit whenever a benefit is furnished or delivered to prevent, diagnose, or treat a mental health condition or substance use disorder.

(f) An insurer shall not impose quantitative treatment limitations, other than limitations for home health care services as specified in subdivision (b)(3) of this section that were submitted to the Department for review in advance, or annual or lifetime limits on the dollar value of health care benefits for a mental health condition or substance use disorder. This subdivision does not prohibit a group health insurance policy from placing annual or lifetime per-insured limits on specific covered benefits that are not essential health benefits as defined under Insurance Code section 10112.27, for a health condition that is not a mental health condition or substance use disorder.

(g) An insurer shall not limit coverage of health care benefits for a mental health condition or substance use disorder to short-term treatment or alleviation of only acute symptoms.

(h) An insurer shall not limit coverage of health care benefits for a mental health condition or substance use disorder, by contract or through any other means, on the basis that those services should be or could be covered by a public entitlement program, including, but not limited to, special education or an individualized education program, Medicaid, Medicare, Supplemental Security Income, or Social Security Disability Insurance, and shall not include or enforce a contract term or formal or informal policy or practice that limits or excludes health care benefits on the basis that those services should be or could be covered by such a public entitlement program.

(i) An insurer shall not require prior authorization or precertification for any of the following:

(1) Emergency health care services, including prescription drugs.

(2) Behavioral health crisis services, including prescription drugs, provided by a 988 center, mobile crisis team, facility, or other provider of behavioral health crisis services.

(3) A health care benefit that may not be subjected to prior authorization or concurrent review pursuant to Section 2562.11 or the Mental Health Parity and Addiction Equity Act rule on nonquantitative treatment limitations set forth in subdivision (c)(4) of Section 147.136 of Title 45 of the Code of Federal Regulations.

NOTE: Authority cited: Sections 10144.4, 10144.5, 10144.52 and 10144.57, Insurance Code. Reference: Sections 10112.1, 10112.2, 10112.27, 10112.281, 10123.88, 10123.191, 10123.193, 10123.195, 10123.201, 10144.4, 10144.5, 10144.51, 10144.52, 10144.53, 10144.57, 10290 and 10291, Insurance Code; Section 1250.2, subdivision (b) of Section 1345, and Section 1374.551, Health and Safety Code.

Adopt: Section 2562.06. Network Access Standards and Arranging Coverage.

(a) An insurer shall maintain a provider and facility network with sufficient capacity to provide for the prevention, diagnosis, and treatment of mental health conditions and substance use disorders as medically necessary, including all the health care benefits required by Insurance Code section 10144.5 and this article, in a geographically accessible and timely manner consistent with good professional practice, as required by Insurance Code sections 10133.5 and 10133.54, and Article 6 of Subchapter 2 of this Chapter 5 (commencing with Section 2240).

(b) (1) An insurer shall provide access to health care benefits for the prevention, diagnosis, and treatment of mental health conditions and substance use disorders delivered by in-network health care providers or facilities within the geographic and timely access standards specified in Insurance Code section 10133.54 and Article 6 of Subchapter 2 of this chapter. If medically necessary health care benefits are not available in-network within applicable geographic or timely access standards, an insurer shall, upon request from an insured, an insured's authorized representative, or an insured's provider, arrange coverage to ensure the delivery of medically necessary out-of-network services and any medically necessary follow-up services that, to the maximum extent possible, meet applicable geographic and timely access standards.

(2) If Article 6 of Subchapter 2 of this chapter does not specify a geographic access standard for a requested health care benefit, for purposes of subdivision (b)(1) of this section an insurer shall adhere to the standard that it uses in demonstrating to the Department that its network complies with subdivision (c)(6) of Section 2240.1. In the absence of such a Section 2240.1(c)(6)-compliant standard, an insurer shall identify network and out-of-network health care providers or facilities, as applicable, that are located within reasonable proximity of the insured's residence or workplace, taking into consideration health condition and disability, transportation mode, travel conditions, and any other factors affecting an insured's ability to access services at a particular location.

(3) When an insurer receives a request for assistance in identifying health care provider or facility that can provide care or timely follow-up care for a mental health condition or substance use disorder, the insurer shall do the following:

(A) Refer the insured, or the insured's authorized representative or provider, to at least three in-network providers or facilities, as appropriate, that can deliver medically necessary and clinically appropriate health care benefits and follow-up care within the applicable geographic and timely access standards specified in Insurance Code section 10133.54, Article 6 of Subchapter 2 of this chapter, and this section.

(B) Notify the providers or facilities that are the subject of the referral of the applicable timely access standard and confirm and document that the providers or facilities have the capacity to deliver the requested care

within the timely access standard. An insurer shall treat a request for assistance in identifying a health care provider or facility as a request to which subdivision (b)(1) of this section applies if, as part of satisfying the request for assistance, the insurer determines that the requested care is inaccessible from an in-network provider or facility within the applicable geographic and timely access standards.

(C) If medically necessary and clinically appropriate care is ultimately inaccessible within the applicable timely access standard from at least one of the three providers or facilities that was the subject of a referral, then the insurer shall comply with subdivision (d) of Insurance Code section 10144.4 and this section.

(c) As used in this section, to "arrange coverage to ensure the delivery of medically necessary out-of-network services" includes, but is not limited to, providing assistance to secure medically necessary and clinically appropriate out-of-network health care benefits that are available to the insured within applicable geographic and timely access standards. Arranging coverage shall include, at a minimum, all the following:

(1) Providing the insured with a list of health care providers and facilities with the capacity and expertise to provide medically necessary and clinically appropriate health care benefits that are reasonably accessible, as described in subdivision (b)(3) of Section 2240.1, located within the applicable geographic accessibility standards, accepting new patients, and able to provide services within the applicable timely access standards.

(2) Obtaining and confirming an appointment or admission for the insured with the health care provider or facility selected by the insured.

(3) Once an insured has selected a health care provider or facility, negotiating and entering into a single case agreement or other arrangement with the out-of-network health care provider or facility as soon as is practical. An insurer shall not delay an insured's care beyond the applicable timely access standard due to the lack of an agreement being in effect. If an agreement between the insurer and out-of-network health care provider or facility is not in effect on the dates of the insured's service or services, then the insurer shall hold the insured harmless for any charges exceeding the in-network cost sharing amount until an agreement is in effect.

(d) (1) An insurer shall treat health care benefits obtained pursuant to this section and subdivision (d) of Insurance Code section 10144.5, and Insurance Code section 10144.57, as in-network, including by ensuring that the insured pays no more in cost sharing than the insured would pay for the same covered services if the services had been received from an in-network health care provider or facility. Any cost sharing paid by an insured for out-of-network health care benefits obtained pursuant to this section and subdivision (d) of Insurance Code section 10144.5, or Insurance Code section 10144.57, shall accrue to the in-

network deductible, if any, and the in-network limit on annual out-of-pocket expenses.

(2) Deductible and coinsurance amounts shall be calculated based on the lesser of the amount negotiated between the insurer and the provider or facility and the in-network rate under subdivision (d)(1) of this section. Unless another methodology is required by state law, an insurer shall calculate deductible and coinsurance amounts for purposes of the in-network rate under subdivision (d)(1) using the methodology for the qualifying payment amount in Part 49 of Subchapter B of Subtitle A of Title 45 of the Code of Federal Regulations. This paragraph is not intended to affect the rate paid to an out-of-network provider or facility for health care benefits obtained pursuant to subdivision (d) of Insurance Code section 10144.5, Insurance Code section 10144.57, or this section.

(3) This subdivision shall apply to behavioral health crisis services provided by a 988 center, mobile crisis team, facility, or other provider of behavioral health crisis services that is an out-of-network provider or facility, except that deductible and coinsurance amounts shall be calculated based on the lesser of the amount billed by the provider or facility, the amount negotiated between the insurer and the provider or facility (if any), and the in-network rate under subdivisions (d)(1) and (d)(2) of this section.

(e) For health care benefits obtained by an insured pursuant to this section and subdivision (d) of Insurance Code section 10144.5, or this section and Insurance Code section 10144.57, an insurer shall be liable for any charges exceeding the in-network cost sharing amount that is owed by the insured.

(f) If, following a request by an insured or an insured's authorized representative or provider, an insurer fails to arrange coverage within the geographic and timely access standards set forth in Insurance Code section 10133.54, Article 6 of Subchapter 2 of this chapter, and this section, that are applicable to the urgency and nature of the insured's condition and requested health care benefit, then the insurer shall cover any health care provider or facility selected by the insured as if that care had been arranged by the insurer.

(1) If neither Insurance Code section 10133.54 nor Article 6 of Subchapter 2 of this chapter specifies a timely access standard for the requested health care benefit, then an insurer shall arrange coverage to ensure the delivery of medically necessary out-of-network services in a timely manner appropriate for the nature of the insured's condition, consistent with good professional practice. If an insurer fails to arrange coverage with a geographically accessible health care provider or facility within 20 calendar days from the date of an insured's request, then the insurer shall cover any health care provider or facility that is selected by the insured as if that care had been arranged by the insurer.

(2) Upon expiration of the time allotted to arrange coverage with a geographically accessible out-of-network provider or facility set forth in Insurance Code

section 10133.54, Article 6 of Subchapter 2 of this chapter, and this section, as applicable, an insured may select any health care provider or facility and schedule an initial appointment or admission to occur within 90 calendar days of such expiration.

(3) An insurer shall not rely on a limitation or exclusion in an insured's coverage document, including but not limited to benefit design or network limitations, to deny coverage for health care benefits that were delivered to an insured by an out-of-network health care provider or facility that was selected by an insured under this subdivision. Nothing in this subdivision shall be construed to absolve an insurer of its duty to arrange coverage pursuant to Insurance Code section 10144.5(d).

(g) If an insurer cannot provide access to clinically appropriate health care benefits at the level of care or service intensity determined by an instrument required by subdivision (a) of Section 2562.03, either delivered by an in-network health care provider or facility or an out-of-network provider or facility, within applicable geographic and timely access standards, an insurer shall do the following:

(1) For an initial level of care or service intensity coverage determination, or a redetermination requiring a higher level of care or service intensity, cover the next highest level of care or service intensity that is available within applicable geographic and timely access standards.

(2) For a redetermination to a lower level of care or service intensity, not effectuate a discharge or step down until the lower level of care or service intensity is available within applicable geographic and timely access standards.

(h) For health care benefits obtained pursuant to this section or subdivision (d) of Insurance Code section 10144.5, an insurer shall cover the entire course of medically necessary treatment delivered by an out-of-network provider or facility, including follow-up care, and shall not require an insured to transition to an in-network provider or increase an insured's cost sharing responsibility during treatment.

(i) An insurer shall include a prominent disclosure on its print and online provider directories published and maintained pursuant to Insurance Code section 10133.15 of its duty to arrange coverage when medically necessary health care benefits are not available in-network within applicable geographic or timely access standards, as provided in this section and subdivision (d) of Insurance Code section 10144.5. The disclosure shall be included within the "Timely Access to Care" section of a provider directory that is required by Insurance Code section 10133.53 and shall also include the geographic accessibility standards specified in this section and Article 6 of Subchapter 2 of this chapter.

(j) An insurer shall document and retain in an insured's record all communications that are made relating to this section, including but not limited to a description of requested services, name and location of providers or facilities contacted, dates of contact, type of

provider or facility, a record of services authorized for coverage and the duration of authorization, and appointment or admission dates. If an insurer fails to arrange coverage within the geographic and timely access standards set forth in Insurance Code section 10133.54, Article 6 of Subchapter 2 of this chapter, and this section, as applicable, it shall document such failure and the date of expiration of the 90-calendar day period afforded to an insured to initiate care with any out-of-network provider or facility the insured selects. An insurer shall act as necessary to ensure that claims submitted under this section are fairly adjudicated in compliance with this section and applicable law.

(k) An insurer shall not do any of the following:

(1) Adopt, impose, or enforce terms in its coverage documents, policies and procedures for provider and facility credentialing and network admission, or health care provider or facility agreements, in writing or in operation, that undermine, alter, or conflict with the requirements of Insurance Code section 10144.4, 10144.5, 10144.51, 10144.52, 10144.53, or 10144.57, or this article.

(2) Discriminate in health care provider or facility credentialing or network admission, including with respect to a licensed or certified provider or facility owned or operated by, employed by, or under contract with, a political subdivision to deliver health care benefits required by Insurance Code section 10144.5, 10144.51, 10144.52, 10144.53, or 10144.57, or this article, in a manner that is inconsistent with Insurance Code section 10133.5, 10133.54, 10133.55, 10133.56, 10133.65, 10133.66, 10144.4, 10144.5, 10144.51, 10144.52, 10144.53, or 10144.57, the requirements set forth in Article 6 of Subchapter 2 of this chapter, or this article.

(3) Impose restrictions that limit the scope or duration of health care benefits based on geographic location, facility type, provider specialty, provider or facility characteristics, state or federal licensure standards, or any other similar criteria in a manner that is inconsistent with Insurance Code section 10144.4, 10144.5, 10144.51, 10144.52, 10144.53, or 10144.57.

(4) Fail or refuse to directly reimburse an out-of-network health care provider or facility, in compliance with Insurance Code section 10123.13 or 10123.147, as applicable, for covered health care benefits delivered by the provider or facility when requiring an assignment is prohibited by law, or pursuant to a valid assignment of benefits made by an insured to the provider or facility, irrespective of any anti-assignment provisions appearing in an insured's coverage document that conflict with direct reimbursement requirements under currently applicable law.

NOTE: Authority cited: Sections 10133.5, 10133.54, 10144.5, 10144.52 and 10144.57, Insurance Code. Reference: Sections 520, 10325, 10112.8, 10112.81, 10112.82, 10123.13, 10123.147, 10130, 10133, 10133.15, 10133.5, 10133.53, 10133.54, 10133.55, 10133.56,

10133.65, 10133.66, 10144.4, 10144.5, 10144.51, 10144.52, 10144.53, 10144.57, 10175.5, 10176, 10176.9 and 10180, Insurance Code.

Adopt: Section 2562.07. Coverage Disclosures and Policy Form Filings.

(a) A coverage document shall state the following:

(1) Coverage is provided for medically necessary health care benefits to prevent, diagnose, and treat mental health conditions and substance use disorders under the same terms and conditions that are applied to other medical conditions and in accordance with the federal Mental Health Parity and Addiction Equity Act.

(2) Coverage is provided for the full range of levels of care and may not be limited to short-term treatment or alleviation of only acute symptoms.

(3) All utilization review coverage determinations concerning service intensity, level of care placement, continued stay, and transfer or discharge of a covered person diagnosed with a mental health condition or substance use disorder must be made using the most recent versions of the following instruments:

(A) For a primary substance use disorder diagnosis in adolescents and adults, *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions* by the American Society of Addiction Medicine.

(B) For a primary mental health diagnosis in adults nineteen (19) years of age and older, *Level of Care Utilization System* (LOCUS) by the American Association for Community Psychiatry.

(C) For a primary mental health diagnosis in children six (6) to eighteen (18) years of age, *Child and Adolescent Level of Care/Service Intensity Utilization System* (merged CALOCUS-CASII) by the American Association for Community Psychiatry and the American Academy of Child and Adolescent Psychiatry.

(D) For a primary mental health diagnosis in children five (5) years of age and younger*, Early Child Service Intensity Instrument* (ECSII) by the American Academy of Child and Adolescent Psychiatry.

(4) The requirements in subdivisions (d)(2) and (d)(3) of Section 2562.06.

(5) The notice required by subdivision (b) of Section 2562.08.

(b) A coverage document shall include the following definitions, as set forth in Insurance Code sections 10144.5 and 10144.52 and this article:

(1) Emergency health care services.

(2) Emergency medical condition.

(3) Generally accepted standards of mental health and substance use disorder care.

(4) Health care benefit.

(5) Health care facility.

(6) Health care provider.

(7) Iatrogenic infertility.

(8) Intermittent.

(9) Medically necessary or medical necessity.

(10) Mental health condition or substance use disorder.

(11) Standard fertility preservation services.

(12) Urgent care services.

(13) Utilization review.

(14) Utilization review criteria.

(c) A coverage document shall disclose coverage of the following health care benefits:

(1) The health care benefits described in Section 2562.05.

(2) Any other health care benefits that are generally recognized as medically necessary to prevent, diagnose, or treat a mental health condition or substance use disorder by health care providers practicing in relevant clinical specialties.

(d) A coverage document shall list covered health care benefits for mental health conditions and substance use disorders under the following Mental Health Parity and Addiction Equity Act benefit classifications to specify the applicable cost sharing:

(1) Inpatient.

(2) Outpatient, or if outpatient benefits are subclassified, office visits and all other outpatient items and services.

(3) Emergency health care services.

(4) Prescription drugs.

(e) A coverage document shall include the following network disclosures:

(1) Medically necessary health care benefits for preventing, diagnosing, and treating mental health conditions and substance use disorders must be accessible from in-network health care providers and facilities within network standards for geographic and timely access. If a medically necessary health care benefit for a mental health condition or substance use disorder is unavailable in-network within applicable geographic or timely access standards, an insurer must arrange for an available and accessible out-of-network provider or facility to provide care. Cost sharing for out-of-network care that is arranged by an insurer due network inaccessibility is limited to the amount that would have been due to an in-network provider or facility. Cost sharing paid for arranged out-of-network care will accrue to any applicable in-network deductible and to the in-network out-of-pocket maximum.

(2) The geographic and timely access standards set forth in Insurance Code section 10133.54, Article 6 of Subchapter 2 of this chapter (commencing with Section 2240), and Section 2562.06.

(3) A complete and accurate description of the process for requesting assistance, providing in-network referrals, and arranging out-of-network coverage as set forth in subdivisions (b)(3) and (c) of Section 2562.06.

(4) A complete and accurate description of the requirements in subdivisions (e) through (h) of Section 2562.06.

(f) Cost sharing that applies to health care benefits for mental health and substance use disorders shall comply with Insurance Code section 10144.4, and such compliance shall be continuously maintained and demonstrated in a quantitative analysis submitted with policy forms for authorization, or upon request by the Department.

(g) Nonquantitative treatment limitations that are imposed on health care benefits for mental health conditions or substance use disorders shall comply with Insurance Code section 10144.4, and such compliance shall be continuously maintained and demonstrated in a comparative analysis submitted with policy forms for authorization, or upon request by the Department.

NOTE: Authority cited: Sections 10144.4, 10144.5, 10144.52 and 10144.57, Insurance Code. Reference: Sections 10270.6, 10270.9, 10290, 10291, 10291.5, 10144.4, 10144.51, 10144.52, 10144.53 and 10144.57, Insurance Code.

Adopt: Section 2562.08. Training and Provision of Utilization Review Criteria.

(a) To ensure proper application and implementation of the utilization review criteria required by Insurance Code section 10144.52 and this article, an insurer shall adopt a formal education program consistent with subdivision (e) of Insurance Code section 10144.52 that meets the following requirements:

(1) Within six (6) months of the effective date of this section, and at least every three (3) years thereafter, an insurer shall sponsor formal education programs offered by the nonprofit professional associations identified in subdivision (a) of Section 2562.03, and the World Professional Association for Transgender Health, regarding the association's clinical criteria, to educate all its utilization review staff, including supervisors, and the staff and supervisors of any entity or contracting provider that performs utilization review or utilization management functions on an insurer's behalf, on proper application of the criteria in utilization review. For purposes of this subdivision (a)(1), sponsoring includes arranging and paying for the formal education program, provided that the education program is offered by the respective nonprofit professional association, or a third party designated or licensed by the association to conduct such a program.

(2) An insurer shall ensure that all utilization review staff and supervisors subject to subdivision (a)(1) of this section have been trained in the use and application of the most recent edition of the nonprofit professional association criteria required pursuant to Section 2562.03 before making any coverage determinations concerning service intensity, level of care placement, continued stay, or transfer or discharge, or before making coverage determinations with respect to health care benefits that are within the scope of clinical criteria developed by the World Professional Association for Transgender Health.

(3) In accordance with Insurance Code section 10144.52(e)(2), an insurer shall provide the following stakeholders with access to the formal education program, without limitation on frequency of access:

(A) Network providers.

(B) Group policyholders.

(C) Insureds and their health care providers and authorized representatives.

(D) Out-of-network providers delivering health care benefits to an insured pursuant to Section 2562.06 or a coverage document's out-of-network benefits.

(b) (1) An insurer shall notify an insured or an insured's authorized representative, and the insured's health care provider, that all utilization review criteria, and training materials and resources that are part of the formal education program described in subdivision (a) of this section, are available upon request at no cost. This notice shall be published on an insurer's website; disclosed in an insurer's coverage documents; and no less frequently than semi-annually, included in its relevant updates and communications with network and out-of-network providers.

(2) Method of Delivery. Upon request, an insurer shall provide all utilization review criteria, and all training materials and resources that are part of the formal education program described in subdivision (a), to an insured, the insured's authorized representative, and the insured's health care provider at no cost. An

insurer shall provide the utilization review criteria and the training materials and resources described in subdivision (b)(1) in one or more of the following ways:

(A) In paper form delivered to the requestor's mailing address. Elements of a formal education program that cannot be provided in paper form shall instead be made available as provided in subdivision (b)(2)(C).

(B) Electronically by email. An insurer shall notify the requestor in its response that a paper copy is available at no cost and describe the process for obtaining a paper copy. Elements of a formal education program that cannot be provided by email shall instead be made available as provided in subdivision (b)(2)(C).

(C) Electronically on an insurer's website, or alternatively with respect to a formal education program's training materials and resources, on a host website directly linked from an insurer's website. In making the content available online, an insurer shall do the following:

1. Ensure the utilization review criteria and training materials and resources allow for electronic retention, such as saving and printing.

2. Make the content accessible to individuals living with disabilities in accordance with applicable federal and state law.

3. Include notice that a paper copy is available at no cost and describe the process for obtaining a paper copy.

(3) Timeframe for Delivery. The utilization review criteria and formal education program training materials and resources described in subdivision (b)(1) shall be sent to the requesting party within thirty (30) calendar days of a request.

NOTE: Authority cited: Sections 10144.5, 10144.52 and 10144.57, Insurance Code. Reference: Sections 10123.135, 10144.5, 10144.52 and 10144.57, Insurance Code.

Adopt: Section 2562.09. Interrater Reliability Requirements.

[Reserved.]

NOTE: Authority cited: Sections 10144.5, 10144.52 and 10144.57, Insurance Code. Reference: Sections 10144.5, 10144.52 and 10144.57, Insurance Code.

Adopt: Section 2562.10. Utilization Review Coverage Determinations and Notices of Adverse Coverage Determinations.

(a) An adverse utilization review coverage determination shall be made only by a licensed physician or other licensed health care provider who is competent to evaluate the specific

clinical issues involved in the health care services under review. "Competent to evaluate the specific clinical issues involved in the health care services under review" means, at a minimum, that the provider has appropriate training and experience in the field of medicine involved in the coverage determination, and the provider was trained if required by Section 2562.08.

(b) Pursuant to subdivision (h)(2) of Insurance Code section 10123.135, for utilization review coverage determinations involving urgent care services, including pursuant to a request by an insured, or an insured's authorized representative or provider, to extend an approved, ongoing course of treatment beyond the period of time or number of treatments that was previously approved, an insurer shall comply with the expedited review process that is required under Section 2719 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-19) and any subsequent regulations issued or incorporated thereunder, including Section 147.136 of Title 45 of the Code of Federal Regulations.

(1) Any determination made by an insurer of whether medical care or treatment constitutes urgent care services shall defer to the opinion of an insured's attending health care provider. An insurer's negligence or fault in not requesting or reviewing records documenting such an opinion, or when an emergency medical condition or urgent care services were documented in an insured's medical record or in or supporting a submitted claim, shall not constitute the absence of an attending provider's opinion.

(2) Subject to subdivision (i) of Section 2562.05, Insurance Code section 10123.191 and the regulations promulgated thereunder shall govern a request for coverage of a prescription drug that is based on exigent circumstances as defined in that section or involves urgent care services as defined and used in this article.

(c) An insurer shall include all the following content in written notices of adverse utilization review coverage determinations provided to an insured, or an insured's authorized representative or provider, including the notices required by subdivision (h)(4) of Insurance Code section 10123.135 and notices of final adverse utilization review coverage determinations on appeal:

(1) Information sufficient to identify the health care benefits and claim involved, including the health care benefits at issue, date of service, health care provider or facility, claim amount (if applicable), and a statement disclosing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.

(2) Reference to the location, and a description, of the applicable terms of the insured's coverage document.

(3) A description of the specific clinical criteria that will be, or was, used to make the coverage determination, including a reference to the location of the criteria in the enclosure required by subdivision (d)(9) of this section.

(4) The specific reasons for the adverse utilization review coverage determination.

(A) If an adverse coverage determination was made due to insufficient information to make the determination, a description of the additional information that is reasonably necessary to make the coverage determination, and an explanation of why such information is necessary.

(B) If an adverse coverage determination was made for a reason or reasons other than or in addition to insufficient information, a clear and concise explanation of the reasons for the adverse coverage determination, including explanation of how applying the relevant clinical criteria and terms of the insured's coverage document to the insured's specific medical circumstances supports the decision.

(C) If an adverse coverage determination was made using one of the instruments required by Section 2562.03, the dimension component and combined scores on which the coverage determination was based.

(5) A description of available internal and external appeals processes, including information regarding how to initiate an appeal. If an initial adverse utilization review coverage determination involved urgent care services, a description of the expedited review process for appeals involving urgent care services.

(6) Notice of the availability of independent medical review and an enclosure (or attachment) of the Department's application for independent medical review.

(7) Contact information for the Department's consumer assistance hotline and online consumer and provider complaint center, as provided at www.insurance.ca.gov.

(8) In a written notice to an insured's health care provider, the name, title, direct phone number, email address, and professional qualifications of the health care provider who made the adverse coverage determination.

(9) An enclosure or attachment of the complete clinical criteria or guidelines used to make the coverage determination. If the complete clinical criteria are available and accessible on an insurer's website, an insurer may instead provide the title of the applicable clinical policy and instructions for locating and accessing the clinical policy on the insurer's website and describe the process for obtaining a paper or electronic copy by email.

(10) If an adverse coverage determination was made using the instruments required by Section 2562.03, or by applying clinical criteria developed by the World Professional Association for Transgender Health, notice of the availability of the formal education programs sponsored pursuant to Section 2562.08 and instructions for obtaining access to the training materials and resources as set forth in subdivision (b) of that section.

(11) The nondiscrimination notice and taglines required by Insurance Code section 10133.11.

(d) Upon request of an insured or an insured's authorized representative for language assistance services in relation to a written notice of an adverse utilization review coverage determination, an insurer shall do the following:

(1) Provide a written translation in an indicated language, as defined by Insurance Code section 10133.8 and Article 12.1 of Subchapter 3 of this chapter (commencing with Section 2538.1), or an applicable non-English language, within 21 calendar days of receiving a request therefor. With respect to an address in any county to which a notice is sent, a non-English language is an applicable non-English language if ten percent or more of the population residing in the county is literate only in the same non-English language.

(2) For a request involving urgent care services, provide oral interpretation in an applicable non-English language during the same phone call, or for any other language, arrange for the insured or the insured's authorized representative to receive oral interpretation services in such person's preferred language free of charge within 24 hours of receiving the request.

(e) In the provision of written notices of adverse utilization review coverage determinations, an insurer shall comply with all laws governing the confidentiality and disclosure of personal information, including with respect to sensitive services under Insurance Code section 791.29.

(f) An insurer that authorizes a health care benefit for a health condition, including but not limited to a mental health condition or substance use disorder, shall not rescind or modify the authorization after a health care provider or facility renders the health care benefit in good faith pursuant to that authorization for any reason, including, but not limited to, a subsequent rescission, cancellation, or modification of the insured's contract, a subsequent determination that the insurer did not make an accurate determination of the insured's eligibility for benefits or coverage, or pursuant to a concurrent or retrospective utilization review.

NOTE: Authority cited: Sections 10123.135, 10144.5, 10144.52 and 10144.57, Insurance Code. Reference: Sections 791.02, 796.04, 791.29, 10123.135, 10123.191, 10123.193, 10123.195, 10123.197, 10123.201, 10133.8, 10133.11, 10144.4, 10144.5, 10144.51, 10144.52, 10144.53, 10144.57, 10145.3 and 10169, Insurance Code.

Adopt: Section 2562.11. Utilization Review and the Mental Health Parity and Addiction Equity Act.

(a) (1) Utilization review and utilization review criteria are a nonquantitative treatment limitation as defined by the Mental Health Parity and Addiction Equity Act. An insurer that applies and conducts utilization review of health care benefits for mental health conditions or substance use disorders shall comply with the rule on nonquantitative treatment limitations, both as written and in operation, set forth in subdivision (a)(2) of this section.

(2) The processes, strategies, evidentiary standards, or other factors used to manage the health care benefits required under Insurance Code sections 10144.5, 10144.51, 10144.52, 10144.53, and 10144.57, and this article, or any other health care benefits that an insurer covers for a mental health condition or substance use disorder, shall be comparable as written and in operation to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used to manage benefits for diagnoses that do not constitute a mental health or substance use disorder.

(b) An insurer shall not impose a nonquantitative treatment limitation on a health care benefit for a mental health condition or substance use disorder, including utilization review or a utilization review criterion, that is not compliant with, or for which the insurer has not performed and documented in advance, and updated as necessary, a comparative analysis of the design and application of the nonquantitative treatment limitation that in good faith satisfies the requirements of the Mental Health Parity and Addiction Equity Act.

(c) An insurer shall not conduct utilization review more frequently than is reasonably necessary to assess whether the health care benefits under review are medically necessary, recommended by nonprofit professional association clinical practice guidelines or the instruments required by Section 2562.03, or is permissible under Insurance Code section 10144.4.

(d) An insurer that conducts utilization review of health care benefits for mental health conditions or substance use disorders shall do so in a manner that is comparable to, and not more stringently than, the manner in which it conducts utilization review of health care benefits for diagnoses that do not constitute a mental health condition or substance use disorder.

(e) An insurer shall not impose a quantitative treatment limitation on a health care benefit for a mental health condition or substance use disorder or apply a quantitative treatment limitation to a health care benefit that was medically necessary for a for a mental health condition or substance use disorder.

(f) For purposes of this section, “health care benefit” includes the set of benefits described in Section 2562.01(g) of this article, for either:

(1) A mental health condition or substance use disorder.

(2) A diagnosis that is not a mental health condition or substance use disorder.

NOTE: Authority cited: Sections 10123.135, 10144.4, 10144.5, 10144.52 and 10144.57, Insurance Code. Reference: Section 10123.135, 10144.4, 10144.5, 10144.51, 10144.52, and 10144.53, Insurance Code.

Adopt: Section 2562.12. Record Keeping and Compliance.

(a) An insurer shall maintain, procure, and provide documentation, including contracts and written policies and procedures, and any other information requested by the Department, to demonstrate that the insurer, and any specialized behavioral health insurer, third-party administrator, contracting provider, or other entity that performs utilization review or utilization management functions on its behalf, is applying the most recent version of treatment criteria developed by a relevant nonprofit professional association pursuant to Insurance Code sections 10144.5 and 10144.52, and this article.

(b) An insurer shall preserve the books and records required under this article for the current year and the four preceding years in an easily accessible location at the headquarters office of the insurer and as required under Insurance Code sections 733 and 734, and Section 2695.3 of Title 10 of the California Code of Regulations.

NOTE: Authority cited: Sections 733-734, 790.04, 790.10, 10144.5, 10144.52, 10144.57, 12340-12417, 12921 and 12926, Insurance Code. Reference: Sections 733-734, subdivision (h) of Section 790.03, 10123.191, 10123.193, 10123.195, 10123.197, 10123.201, 10123.135, 10144.5, 10144.52 and 10144.57, Insurance Code.

Adopt: Section 2562.13. Enforcement Actions.

(a) In addition to applicable provisions of the Insurance Code, the general and formal administrative adjudication procedures of the Administrative Procedure Act (Chapters 4.5 and 5 of Part 1 of Division 3 of Title 2 of the Government Code) apply to enforcement actions that are brought under this article as provided in this section.

    (1) An adjudicative proceeding that is brought under this article may be conducted before a presiding officer who is an administrative law judge of the Administrative Hearing Bureau of the Department, except as otherwise required by the Insurance Code or Administrative Procedure Act.

    (2) The Department may serve notice of an investigation or enforcement action by electronic means to an insurer's attorney. The insurer's responses or portions thereof may be included in the record of a proceeding under this article, except as prohibited by Government Code Section 11415.60 or any applicable provision of the Insurance Code.

(b) If a civil penalty is sought in an adjudicative proceeding under this article, such proceeding shall be conducted in accordance with Chapter 5 of the Administrative Procedure Act (commencing with Section 11500 of the Government Code).

(c) The Department may elect the Administrative Procedure Act's informal hearing procedure (Article 10 of Chapter 4.5 (commencing with Section 11445.10 of the Government Code)) to seek a decision to compel an insurer to comply with, or cease and desist from violating, Insurance Code section 10144.4, 10144.5, 10144.51, 10144.52, 10144.53, or 10144.57, or this article.

(1) If interpretation of law or material facts are in dispute, the Department and insurer shall submit a pleading on the law, facts, and application of law to such facts to the presiding officer at least 15 days in advance of the proceeding, or at least 5 days in advance if the Department considers the matter urgent. In a proceeding under this subdivision, the Department deems cross-examination unnecessary for the determination of material facts unless stated otherwise in its pleading.

(2) The Department or presiding officer may convert the proceeding to a formal hearing that is subject to Chapter 5 of the Administrative Procedure Act (commencing with Section 11500 of the Government Code) at any time.

(3) A proposed decision, or portion thereof, that is adopted by the Commissioner constitutes a final order. This subdivision (c)(3) does not limit the Commissioner's or Department's authority under Government Code section 11440.10 or 11517.

(4) A decision that is sought pursuant to an informal hearing under this subdivision, and any other remedy that is available to the Commissioner, may be pursued while the Department is investigating or otherwise pursuing any other available remedies that may relate to an insurer's alleged conduct without prejudicing, to the full extent permitted by law, such other available remedies.

(d) The Department may elect to issue an emergency decision for temporary, interim relief under the procedure set forth in Article 13 of Chapter 4.5 (commencing with Section 11460.10 of the Government Code) when it has a reasonable basis to believe that an ongoing violation of Insurance Code section 10144.4, 10144.5, 10144.51, 10144.52, 10144.53, or 10144.57, or this article, or a pattern or practice of past ongoing incompliance therewith, may exist. An emergency decision may be issued to compel an insurer to comply at the time and in the manner prescribed therein. The Department shall demand of the insurer in advance that it comply and may, if practicable, afford the insurer an informal opportunity to be heard before issuing an emergency decision.

(e) If the Commissioner determines that an insurer has violated Insurance Code section 10144.4, 10144.5, 10144.51, 10144.52, 10144.53, or 10144.57, or this article, the Commissioner may, after appropriate notice and opportunity for hearing in accordance with the Administrative Procedure Act (Chapter 5 of Part 1 of Division 3 of Title 2 of the Government Code), by order, assess a civil penalty not to exceed five thousand dollars ($5,000) for each violation, or, if a violation was willful, a civil penalty not to exceed ten thousand dollars ($10,000) for each violation.

(1) A single act may constitute violations of both Sections 10144.5 and 10144.52, in which case penalties shall accrue for each such violation.

(2) An ongoing violation shall be subject to civil penalties for each day that the violation continues.

(3) If a violation affected one or more insureds, penalties shall accrue for each insured who was affected by each such violation.

(f) If the Department notifies an insurer in writing that a gap-filling clinical policy or the documentation maintained pursuant to section 2562.04 is not compliant with Insurance Code sections 10144.4, 10144.5, 10144.51, 10144.52, 10144.53, or 10144.57, or this article, failing to discontinue use of the clinical policy in utilization review shall constitute a violation of Section 10144.52 for each day that the clinical policy remains in effect, following a 15-day grace period beginning on the date the insurer was notified. This subdivision does not preclude the Commissioner from assessing civil penalties for other violations of Section 10144.52.

(g) In assessing a civil penalty, the Commissioner shall consider, to the extent applicable or practicable, but shall not be limited to considering, the following factors:

(1) The nature, scope, and gravity of the violation.

(2) The degree of actual or potential harm to insureds, and detriment to the public, that resulted or could have resulted from the violation.

(3) Whether, under the totality of the circumstances, the insurer made a good faith attempt to comply with Insurance Code sections 10144.4, 10144.5, 10144.51, 10144.52, 10144.53, 10144.57, and this article.

(4) The extent to which the insurer cooperated with the Department's investigation, and the nature of such cooperation.

(5) The extent to which the insurer aggravated or mitigated any damage caused by the violation, and the nature of the damage.

(6) The extent to which the insurer voluntarily took remedial action for past noncompliance and corrective action to assure prospective compliance, and the nature of such remedial or corrective action.

(7) The insurer's history of noncompliance with the Insurance Code and regulations promulgated thereunder.

(8) The amount of penalty that is necessary to deter similar violations in the future.

(h) An insurer shall be responsible for ensuring compliance with this article regardless of contracting or delegation arrangements and shall be subject to the assessment of civil penalties for violations of Insurance Code sections 10144.4, 10144.5, 10144.51, 10144.52, and 10144.53, or 10144.57, and this article, that are committed by any specialized behavioral health insurer, third-party administrator, contracting provider, or other entity that was acting on its behalf.

(i) A civil penalty under Insurance Code section 10144.5, 10144.51, 10144.52, 10144.53, or 10144.57, or this article, shall not constitute an exclusive remedy. This section does not preclude the Department from pursuing any other remedies that are available by law or limit the Department's procedural or substantive authority under the Insurance Code or the Administrative Procedure Act. Omission from this section of any procedures that may

be elected pursuant to Chapter 4.5 of the Administrative Procedure Act does not indicate that such procedures are unavailable, or that the Department will not elect such procedures.

NOTE: Authority cited: Sections 10144.5, 10144.52 and 10144.57, Insurance Code; Sections 11400.20, 11425.50, 11445.20, 11445.50 and 11460.20, Government Code. Reference: Sections 790.035, 10144.4, 10144.5, 10144.51, 10144.52, 10144.53, 10144.57, 12919, 12921, 12921.1, 129121.2, 12921.3, 12921.4, 12921.5, and 12926, Insurance Code; Sections 11400 et seq. and 11500 et seq., Government Code.

Amend: Section 2562.4. Behavioral Health Treatment for Pervasive Developmental Disorder or Autism Spectrum Disorder.

(a) Scope of Section. ~~In addition to the limitations on scope set forth in section 2562.1 of this article, the scope of this section 2562.4 shall be further limited by the following sentence: This section does not apply to a policy or plan described in subdivision (d) of Insurance Code section 10144.51.~~ This section applies only to coverage for services or treatments rendered for pervasive developmental disorder or autism spectrum disorder. The requirements in this section are in addition to, and do not replace, any requirements and limitations set forth in this article, in Insurance Code sections 10144.4, 10144.5, and 10144.52, or in any other applicable law.

(b) An insurer shall not impose the following on medically necessary treatment or services rendered to an individual for the treatment or diagnosis of pervasive developmental disorder or autism:

(1) An annual visit limit, or

(2) An annual dollar limit, a copayment, a deductible, or any other financial term that does not comply with Insurance Code section 10112.1, 10144.4 and 10144.5.

(c) In cases where behavioral health treatment is medically necessary, an insurer shall not modify, delay, or deny ~~or unreasonably delay~~ coverage for behavioral health treatment based on any of the following:

(1) Based on an-asserted need for cognitive, developmental or intelligence quotient (IQ) testing,

(2) On the grounds that behavioral health treatment is deemed experimental, investigational, or educational,

(3) On the grounds that-behavioral health treatment is not being, will not be, or was not, provided or supervised by a licensed person, entity or group when the provider or supervisor in question is ~~certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies,~~ a qualified autism service provider,

qualified autism service professional, or qualified autism service paraprofessional as defined in Insurance Code section 10144.51,

(4) On the grounds that behavioral health treatment has been, is being, should be or will be provided by a Regional Center contracting with the Department of Developmental Services,

(5) On the grounds that an annual visit limit has been reached or exceeded, assuming such a limit is otherwise permissible, or

(6) For any other reason, provided, however, that the insurer may apply a deductible or other financial term or limit when the same term or limit is equally applicable to all benefits under the policy, and complies with the requirements of Insurance Code sections 10144.4, 10144.5, 10144.51, 10144.52, 10144.53, and 10144.57.

(d) The following definitions apply for purposes of this section:

(1) "Behavioral health treatment" has the meaning set forth in subdivision (c)(1) of Insurance Code section 10144.51.

(2) "Treatment or services" includes, but is not limited to, speech therapy, occupational therapy, and behavioral health treatment, in addition to any other medically necessary treatment, as described in subdivision (c)(3), for pervasive developmental disorder or autism spectrum disorder.

Note: Authority cited: Sections ~~790.10,~~ 10144.5, 10144.51, ~~12921 and 12926~~ 10144.52 and 10144.57, Insurance Code~~; *CalFarm Ins. Co. v. Deukmejian*, 48 Ca1.3d 805 (1989); *20th Century Ins. Co. v. Garamendi*, 8 Cal.4th 216 (1994)~~. Reference: Sections 790.03, 10144.5~~(a)~~, ~~10144.5(c) and~~ 10144.51, 10144.52 and 10144.57, Insurance Code.