

California Code of Regulations
Title 10. Investment
Chapter 5. Insurance Commissioner
Subchapter 2. Policy Forms and Other Documents
Article 6. Provider Network Access Standards for Health Insurance

Amend Section 2240. Definitions.

As used in this Article:

(a) “Certificate” means an individual or family certificate of coverage issued pursuant to an insurance contract.

(b) “Covered person” means either a primary covered person or a dependent covered person eligible to receive health care services under the insurance contract providing network provider services.

(c) “Dependent covered person” means someone who is eligible for coverage under an insurance contract through his or her relationship with or dependency upon a primary covered person.

(d) “Emergency health care services” means health care services rendered for any condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following: (1) Placing the patient’s health in serious jeopardy, (2) Serious impairment to bodily functions, (3) Serious dysfunction of any bodily organ or part, (4) active labor. “Emergency health care services” also includes services rendered for a psychiatric emergency.

(e) “Essential community provider” (ECP) means providers that serve predominantly low-income, medically underserved individuals, as defined in 45 CFR Section 156.235, published February 27, 2015 at 80 Federal Register 10873-10874, subdivision (c) of which is incorporated herein by this reference. “Essential community provider” also includes:

(1) Disproportionate Share Hospitals as defined at Title 9, California Code of Regulations, section 1706;

(2) Indian Health Care Service Facilities as defined in subdivision (v) of Title 10, California Code of Regulations, section 2699.6500;

(3) Entities licensed as either a community clinic, or a free clinic, under Health and Safety Code section 1204 and entities that are either a community clinic as defined at subdivision (a)(1)(A) of Health and Safety Code section 1204, or a free clinic as defined at subdivision (a)(1)(B) of Health and Safety Code section 1204, that are exempt from licensure under Health and Safety Code section 1206;

(4) Federally Qualified Health Centers as defined at Title 10, California Code of Regulations, section 6410; and

(5) Physician providers whose application for the Medi-Cal Electronic Health Record Incentive Program has been accepted under Welfare and Institutions Code section 14046.2.

(f) “Facility” means an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment

centers, skilled nursing centers, residential treatment centers, urgent care centers, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic health settings.

(g) “Health care professional” means a licensee or certificate holder enumerated in Insurance Code section 10176 or as defined in Insurance Code Section 10133.4 as of the effective date of this Article or as either section may be amended thereafter.

(h) “Insurer” means an insurer who provides “health insurance” as defined in Section 106(b), and includes those who authorize insureds to select providers who have contracted with the insurer for alternative rates of payment as described in Section 10133.

(i) “Limited English proficiency” means a limited ability, or an inability, to speak, read, write, or understand the English language at a level that permits the covered person to interact effectively with his or her health care providers or health insurer.

(j) “Network” means all institutions or health care professionals that are utilized to provide medical services to covered persons pursuant to a contract with an insurer to provide such services at alternative rates as described in Insurance Code Section 10133. A network as defined herein can be directly contracted with by an insurer or leased by an insurer.

(k) “Network provider” means an institution or a health care professional which renders health care services to covered persons pursuant to a contract to provide such services at alternative rates.

(l) “Network provider services” means health care services which are covered under an insurance contract when rendered by a network provider within the service area.

(m) “Non-network provider services” means covered health care services delivered by a health care provider who is not contracted with the insurer either directly or indirectly.

(n) “Primary care physician” means a physician who is responsible for providing initial and primary care to patients, for maintaining the continuity of patient care or for initiating referral for specialist care. A primary care physician may be either a physician whose practice of medicine is limited to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist or family practitioner.

(o) “Primary covered person” means a person eligible for coverage under an insurance contract or certificate.

(p) “Service area” means the State of California or any other geographic area within the state designated in the contract within which network provider services are rendered to covered persons for covered benefits.

(q) “Tiered network” or “tiering” means a network of participating providers which has been divided into sub-groupings differentiated by the health insurer according to cost-sharing levels, provider payment, performance ratings, quality scores, or any combination of these or other factors established as a means of influencing the insured person’s choice of provider.

Note: Authority cited: Section 10133.5, Insurance Code. Reference: Sections 106(b), 10133, 10133.5, 10144.5 and 10176, Insurance Code.

Amend Section 2240.1. Adequacy and Accessibility of Provider Services.

(a) The provisions of this article apply to “health insurance” policies as defined by Insurance Code section 106(b). The requirements of this article apply to all health care services covered by the insurance policy. Notwithstanding the above, specialized health insurance policies as defined in Insurance Code section 106(c), other than specialized mental health insurance policies, are exempt from the provisions of this article, except as specified below, in subdivisions (a)(1), (a)(2), and (a)(3) of this Section 2240.1:

(1) Specialized health insurance policies that provide coverage for dental care expenses only shall comply with the following:

(A) Subdivisions (b)(7) and (e) of Section 2240.1,

(B) Subdivisions (b)(1), (b)(3), (b)(4), (b)(6), (b)(11), (b)(12), and (c)(1) of Section 2240.15,

(C) Section 2240.16, and

(D) Section 2240.3;

(2) Specialized health insurance policies that provide coverage for the pediatric oral essential health benefit (as defined in Insurance Code section 10112.27(a)(5)), including but not limited to such policies sold through the California Health Benefit Exchange, shall comply with the following:

(A) Subdivisions (c)(2) and (c)(4) of Section 2240.1,

(B) Subdivisions (c)(2) and (c)(3) of Section 2240.15,

(C) Subdivision (a) of Section 2240.4,

(D) Subdivisions (a), (b), (c), (d)(1), (d)(2), (d)(3), (d)(4), (d)(6), (d)(7), (d)(8), (d)(10), (d)(11), (d)(15), (e), and (f) of Section 2240.5, and

(E) Section 2240.7;

(3) Insurers that issue specialized health insurance policies other than specialized mental health insurance policies shall comply with subdivision (h) of Section 2240.6;

(4) For purposes of this subdivision (a), the term “specialized mental health insurance policies” includes behavioral health-only policies.

(b) In arranging for network provider services, insurers shall ensure that:

(1) Network providers are duly licensed or accredited and that they are sufficient in number, capacity, and specialty to be capable of furnishing the health care services covered by the insurance contract, taking into account the number of covered persons, their characteristics and medical needs including the frequency of accessing needed medical care within the prescribed geographic distances outlined herein and the projected demand for services by type of services. If a network provider does not provide a service otherwise within the provider’s scope of practice covered under the insurance contract, the insurer shall ensure that there are sufficient

providers in the network to provide that service. Subdivision (e) of this section shall apply if no providers in the network provide that service.

(2) Decisions pertaining to health care services to be rendered by providers to covered persons are based on such persons' medical needs and are made by or under the supervision of licensed and appropriate health care professionals.

(3) Facilities used by providers to render health care services are located within reasonable proximity to the work places or the principal residences of the primary covered persons, are reasonably accessible by public transportation and are reasonably accessible, both physically and in terms of provision of service, to covered persons with disabilities. Insurers shall establish written standards for their providers that ensure that provider facilities are accessible to people with disabilities and compliant with all applicable state and federal laws regarding access for people with disabilities.

(4) Health care services (excluding emergency health care services) are available at least 40 hours per week, except for weeks including holidays. Such services shall be available until at least 10:00 p.m. at least one day per week or for at least four hours each Saturday, except for Saturdays falling on holidays.

(5) Emergency health care services are available and accessible within the service area at all times.

(6) Health care services are accessible to covered persons through network providers, or other network arrangement. An adequate network is one in which the care provided to an insured person in a network facility is provided by network providers. The provision of care by an out-of-network provider to an insured person in a network facility renders the network inadequate unless:

(A) the insured person, without being prompted to do so, has initiated a request to receive care from that specific out-of-network provider; or

(B) coverage is provided on terms no less favorable, and at no greater cost, to the insured person than would have applied had the care been provided by an in-network provider.

(7) Network provider services are rendered pursuant to written procedures which include a documented system for monitoring and evaluating accessibility of such care. The monitoring of waiting time for appointments, as described in Sections 2240.15 and 2240.16, shall be a part of such a system.

(c) In arranging for network provider services, insurers shall ensure that, for current insured membership and anticipated enrollment growth for the year following the network report:

(1) There is the equivalent of at least one full-time physician per 1,200 covered persons and at least the equivalent of one full-time primary care physician per 2,000 covered persons.

(2) There are primary care network providers with sufficient capacity to accept covered persons within a maximum travel time of 30 minutes or a maximum travel distance of 15 miles of each covered person's residence or workplace.

(3) There are adequate full-time equivalents of primary care and specialist providers in the network accepting new patients covered by the policy to accommodate anticipated enrollment growth.

(4) There are medically required network specialists who are certified or eligible for certification by the appropriate specialty board with sufficient capacity to accept covered persons within a maximum travel time of 60 minutes or a maximum travel distance of 30 miles of each covered person's residence or workplace.

(5) Notwithstanding the above, the Commissioner may determine that certain medical needs require network specialty care located closer to covered persons when the nature and frequency of use of such health care services, and the standards of Insurance Code 10133.5(b) (3), support such modification.

(6) There are mental health and substance use disorder professionals with skills appropriate to care for the mental health and substance use disorder needs of covered persons and with sufficient capacity to accept covered persons within a maximum travel time of 30 minutes or a maximum travel distance of 15 miles of each covered person's residence or workplace. The network must adequately provide for mental health and substance use disorder treatment, including behavioral health therapy. The network must take into account the pattern and frequency with which different therapies, particularly behavioral health therapy, are provided for different patient populations at different ages, such that if it is clinically necessary for a network to have services available in closer proximity to affected covered persons than required by the minimum time and proximity standards stated above then the insurer shall make the services available in such closer proximity.

(A) Adequate networks include crisis intervention and stabilization, psychiatric inpatient hospital services, including voluntary psychiatric inpatient services, detoxification, outpatient mental health and substance use evaluation and treatment, psychological testing, outpatient services for monitoring drug therapy, partial hospitalization, intensive outpatient treatment, short-term treatment in a crisis residential program in a licensed psychiatric treatment facility with 24-hour monitoring by clinical staff for stabilization of an acute psychiatric crisis, psychiatric observation for an acute psychiatric crisis and services from mental health providers. Networks must also provide for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child, including residential care.

There must be mental health and substance use disorder providers of sufficient number and type to provide diagnosis and medically necessary treatment through providers acting within their scope of license and scope of competence established by education, training, and experience to diagnose and treat mental health and substance use disorders.

(B) An insurer must establish a reasonable standard approved by the Department for the number and geographic distribution of mental health providers who can treat severe mental illness of a person of any age and serious emotional disturbances of a child, taking into account the various types of mental health practitioners acting within the scope of their licensure, and those practitioners described in subdivision (c) of section 10144.51 of the Insurance Code.

(C) The insurer must submit a narrative report describing the adequacy of its mental health and substance use disorder network to the Department for approval no less frequently than annually as part of the network adequacy report required by Section 2240.5.

(D) An insurer must include a sufficient number of the appropriate types of mental health and substance use disorder treatment providers and facilities based on normal utilization patterns.

(E) An insurer must ensure that covered persons can access information about mental health and substance use disorder services, including benefits, providers, coverage, and other relevant information, by calling a customer service representative, or otherwise contacting the company through an accessible means, during normal business hours.

(7) There is a network hospital with sufficient capacity to accept covered persons for covered services within a maximum travel time of 30 minutes or a maximum travel distance of 15 miles of each covered person's residence or workplace. Networks must include hospitals with sufficient capacity to serve the entire population of covered persons based on normal utilization patterns.

(8) The network includes adequate numbers of available primary care providers and specialists with admitting and practice privileges at network hospitals.

(9) The network includes facilities to provide post-acute care services with sufficient capacity to serve the entire population of covered persons based on normal utilization patterns.

(10) The network includes an adequate number of network outpatient retail pharmacies located in sufficient proximity to covered persons to permit adequate routine and emergency access. Similarly, ancillary laboratory and other services dispensed by order or prescription of the prescribing provider are available from contracting providers at locations (where covered persons are personally served) within a reasonable distance from the prescribing provider.

(d) Networks shall be designed to optimize access by using a variety of facility types, such as ambulatory surgical centers. Further, access to facilities, such as dialysis centers, shall be designed to accommodate the intensity and frequency of use by the patient population.

(e) Networks must provide access to medically appropriate care from a qualified provider. If medically appropriate care cannot be provided within the network, the insurer shall arrange for the required care with available and accessible providers outside the network, with the patient responsible for paying only cost-sharing in an amount equal to the cost-sharing they would have paid for provision of that or a similar service in-network. In addition to in-network copayments and coinsurance, in-network cost sharing includes applicability of the in-network deductible and accrual of cost sharing to the in-network out-of-pocket maximum.

(f) An adequate network must also demonstrate the capacity to provide medically necessary organ, tissue, and stem cell transplant surgery. The insurer in its network adequacy report required by Section 2240.5 shall identify and locate each transplant center in its network by name and address, and type of transplant provided in the facility.

(g) An adequate network must include a sufficient number of providers to assure access to preventive services required by Insurance Code section 10112.2, including women's preventive care, which includes access to services and contraceptive methods as required by Insurance Code section 10123.196.

(h) A service area or network must not be created in a manner designed to discriminate or that results in discrimination against persons because of age, gender, actual or perceived gender identity as defined in Section 2561.1 or on the basis that the insured is a transgender person as

defined in Section 2561.1, sexual orientation, disability, national origin, sex, family structure, ethnicity, race, color, ancestry, religion, utilization of medical or mental health or substance use disorder services or supplies, marital status, health insurance coverage, present or predicted disability, expected length of life, degree of medical dependency, quality of life, health status or medical condition, including physical and mental illnesses, claims experience, medical history, genetic information, or evidence of insurability, including conditions arising out of domestic violence.

(i) Health carrier standards for the selection and tiering (if the network is a tiered network) of participating providers and facilities shall be developed for primary care professionals and each health care professional specialty and facility, shall include measures related to standards for quality of care and health outcomes, and shall be provided to the Department no less frequently than annually as part of the network adequacy report required by Section 2240.5. The standards shall be used in determining the selection of health care professionals and facilities by the health carrier, its intermediaries and any provider networks with which it contracts. Selection criteria shall not be established in a manner:

(1) That would allow a health carrier to avoid high-risk populations by excluding providers because they are located in geographic areas that contain populations or providers presenting a risk of higher than average claims, losses or health services utilization; or

(2) That would exclude providers because they treat or specialize in treating populations presenting a risk of higher than average claims, losses or health services utilization.

(j) Networks for mountainous rural areas shall take into consideration typical patterns of winter road closures, so as to comply with access and timeliness standards throughout the calendar year.

(k) An insurer that uses a tiered network shall meet the standards of this article using the providers available at the lowest cost-sharing tier.

(l) The insurer must measure the adequacy of its network at least every six months, and demonstrate and attest to the Department that it has done so, and submit a corrective action plan to the Commissioner if the standards set forth in this article are not met.

(m) Notwithstanding the above, the Commissioner may determine that certain medical needs require network providers and/or facilities located closer to covered persons when the nature and frequency of use of such health care services, and the standards of Insurance Code section 10133.5(b) (3), support such modification.

(n) Notwithstanding the above, these requirements are not intended to prevent the covered person from selecting providers as allowed by their insurance contract beyond the applicable geographic area specified by these standards.

(o) In determining whether an insurer's arrangements for network provider services comply with these regulations, the Commissioner shall consider to the extent the Commissioner deems necessary, the practices of comparable health care service plans licensed under the Knox-Keene Health Care Service Plan Act of 1975 Health and Safety Code Section 1340, et seq.

Note: Authority cited: Section 10133.5, Insurance Code. Reference: Sections 106(b), 10133 and 10133.5, Insurance Code.

Amend Section 2240.15. Network Access Appointment Waiting Time Standards; Quality Assurance; Disclosure and Education.

(a) For purposes of this section, the following definitions apply:

(1) “Appointment waiting time” means the time from the initial request for health care services by a covered person or the covered person’s treating provider to the earliest date offered for the appointment for services, inclusive of time for obtaining authorization from the insurer or completing any other condition or requirement of the insurer or its contracting providers.

(2) “Preventive care” means health care provided for prevention and early detection of disease, illness, injury or other health condition and, in the case of an insurer includes but is not limited to all of the services required by Insurance Code section 10112.2 (incorporating the requirements of 42 United States Code § 300gg-13 (Public Health Service Act §2713), and 45 Code of Federal Regulations § 146.130) and subdivision (a)(2)(A)(ii) of section 10112.27 of the Insurance Code.

(3) “Provider group” has the meaning set forth in subdivision (g)(3) of section 10133.56 of the Insurance Code.

(4) “Triage” or “screening” means the assessment of a covered person’s health concerns and symptoms via communication with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage an insured who may need care, for the purpose of determining the urgency of the covered person’s need for care.

(5) “Triage or screening waiting time” means the time waiting to speak by telephone with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage an insured who may need care.

(6) “Urgent care” means health care for a condition that requires prompt attention, consistent with subdivision (h)(2) of section 10123.135 of the Insurance Code.

(b) Standards for Timely Access to Care.

(1) Insurers shall provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the covered person’s condition consistent with good professional practice. Insurers shall establish and maintain provider networks, policies, procedures and quality assurance monitoring systems and processes sufficient to ensure compliance with this clinical appropriateness standard. An insurer that uses a tiered network must demonstrate compliance with the standards established by this section based on providers available at the lowest cost-sharing tier.

(2) Insurers shall ensure that all network and provider processes necessary to obtain covered health care services, including but not limited to prior authorization processes, are completed in a manner that assures the provision of covered health care services to covered persons in a timely manner appropriate for the covered person’s condition and in compliance with the requirements of this section.

(3) When it is necessary for a provider or a covered person to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the covered

person's health care needs, and ensures continuity of care consistent with good professional practice, and consistent with the objectives of Section 10133.5 of the Insurance Code and the requirements of this section.

(4) Interpreter services required by Section 10133.8 of the Insurance Code and Article 12 of Title 10 California Code of Regulations, commencing with Section 2538.1, shall be coordinated with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment consistent with Title 10, California Code of Regulations, section 2538.6 without imposing delay on the scheduling of the appointment. This subdivision (b)(4) does not modify the requirements established in sections 10133.8 or 10133.9 of the Insurance Code.

(5) In addition to ensuring compliance with the clinical appropriateness standard set forth at subdivision (b)(1), each insurer shall ensure that its contracted provider network has adequate capacity and availability of licensed health care providers to offer covered persons appointments that meet the following timeframes:

(A) Urgent care appointments for services that do not require prior authorization: within 48 hours of the request for appointment, except as provided in subdivision (b)(5)(G);

(B) Urgent care appointments for services that require prior authorization: within 96 hours of the request for appointment, except as provided in subdivision (b)(5)(G);

(C) Non-urgent appointments for primary care: within ten business days of the request for appointment, except as provided in subdivisions (b)(5)(G) and (b)(5)(H);

(D) Non-urgent appointments with specialist physicians: within fifteen business days of the request for appointment, except as provided in subdivisions (b)(5)(G) and (b)(5)(H);

(E) Non-urgent appointments with a non-physician mental health care or substance use disorder provider: within ten business days of the request for appointment, except as provided in subdivisions (b)(5)(G) and (b)(5)(H);

(F) Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition: within fifteen business days of the request for appointment, except as provided in subdivisions (b)(5)(G) and (b)(5)(H);

(G) The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the covered person;

(H) Preventive care services, as defined at subdivision (a)(2), and periodic follow up care, including but not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health or substance use disorder conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice.

(6) Insurers shall ensure they have sufficient numbers of contracted providers to maintain compliance with the standards established by this section. This section does not modify the requirements regarding provider adequacy and accessibility established by this Article.

(7) Insurers shall provide or arrange for the provision, 24 hours per day, 7 days per week, of triage or screening services by telephone as defined in subdivision (a)(5).

(A) Insurers shall ensure that telephone triage or screening services are provided in a timely manner appropriate for the insured's condition, and that the triage or screening waiting time does not exceed 30 minutes.

(B) An insurer may provide or arrange for the provision of telephone triage or screening services through one or more of the following means: insurer-operated telephone triage or screening services consistent with subdivision (a)(5); telephone medical advice services pursuant to Section 10279 of the Insurance Code; the insurer's contracted primary care and mental health care or substance use disorder provider network; or other method that provides triage or screening services consistent with the requirements of this subdivision (b)(7)(B).

(8) An insurer that arranges for the provision of telephone triage or screening services through contracted primary care, mental health care, and substance use disorder providers shall require those providers to maintain a procedure for triaging or screening covered persons' telephone calls, which, at a minimum, shall include the employment, during and after business hours, of a telephone answering machine and/or an answering service and/or office staff, that will inform the caller:

(A) Regarding the length of wait for a return call from the provider; and

(B) How the caller may obtain urgent or emergency care including, when applicable, how to contact another provider who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or emergency care.

(9) An insurer that arranges for the provision of triage or screening services through contracted primary care, mental health care, and substance use disorder providers who are unable to meet the time-elapsed standards established in paragraph (b)(7)(A) shall also provide or arrange for the provision of insurer-contracted or operated triage or screening services, which shall, at a minimum, be made available to covered persons affected by that portion of the insurer's network.

(10) Unlicensed staff persons handling covered person calls may ask questions on behalf of a licensed staff person in order to help ascertain the condition of a covered person so that the covered person can be referred to licensed staff. However, under no circumstances shall unlicensed staff persons use the answers to those questions in an attempt to assess, evaluate, advise, or make any decision regarding the condition of a covered person or determine when a covered person needs to be seen by a licensed medical professional.

(11) Insurers shall ensure that, during normal business hours, the waiting time for a covered person to speak by telephone with an insurer customer service representative knowledgeable and competent regarding the covered person's questions and concerns shall not exceed ten (10) minutes, or that the covered person will receive a scheduled call-back within 30 minutes.

(12) For health insurance policies providing coverage for the pediatric oral and vision essential health benefit, and specialized health insurance policies that provide coverage for dental care expenses only, insurers shall require that contracted providers employ an answering service or a telephone answering machine during non-business hours which provides instructions regarding how covered persons may obtain urgent or emergency care including, when applicable, how to contact another provider who has agreed to be on-call to triage or screen by phone or, if needed, deliver urgent or emergency care.

(c) Quality Assurance Processes. Each insurer shall have written quality assurance systems, policies and procedures designed to ensure that the insurer's provider network is sufficient to provide accessibility, availability and continuity of covered health care services as required by the Insurance Code and this section. An insurer's quality assurance program shall address:

(1) Standards for the provision of covered services in a timely manner consistent with the requirements of this section and Section 2240.16.

(2) Compliance monitoring policies and procedures, filed for the Commissioner's review and approval, designed to accurately measure the accessibility and availability of contracted providers, which shall include:

(A) Tracking and documenting network capacity and availability with respect to the standards set forth in, subdivision (b) of this Section 2240.15, and Section 2240.16; and

(B) Conducting an annual covered person experience survey, which shall be conducted in accordance with valid and reliable survey methodology and designed to ascertain compliance with the standards set forth in subdivision (b) of this section; however, for health insurance policies that provide coverage for the pediatric vision or oral essential health benefit and for specialized health insurance policies that provide coverage for the pediatric oral essential health benefit (as defined in subdivision (a)(5) of Insurance Code section 10112.27), the survey shall be designed to ascertain compliance with the standards set forth in Section 2240.16. The Department will make the aggregated results of this survey publicly available; and

(C) Conducting an annual provider survey, which shall be conducted in accordance with valid and reliable survey methodology and designed to solicit, from physicians and non-physician mental health and substance use disorder providers, perspectives and concerns regarding compliance with the standards set forth at subdivision (b) of this section; however, for health insurance policies that provide coverage for the pediatric vision or oral essential health benefit, and for specialized health insurance policies that provide coverage for the pediatric oral essential health benefit (as defined in subdivision (a)(5) of Insurance Code section 10112.27), the survey shall be designed to solicit perspectives and concerns from providers regarding compliance with the standards set forth in Section 2240.16. The Department will make the results of this survey publicly available; and

(D) Reviewing and evaluating, no less frequently than quarterly, the information available to the insurer regarding accessibility, availability and continuity of care, including but not limited to information obtained through covered person and provider surveys, covered person grievances and appeals, and triage or screening services.

(3) An insurer shall implement prompt investigation and corrective action when compliance monitoring discloses that the insurer's provider network is not sufficient to ensure timely access

as required by this section, including but not limited to taking all necessary and appropriate action to identify the cause(s) underlying identified timely access deficiencies and to bring its network into compliance. Insurers shall give advance written notice to all contracted providers affected by a corrective action, and shall include: a description of the identified deficiencies, the rationale for the corrective action, and the name and telephone number of the person authorized to respond to provider concerns regarding the insurer's corrective action.

(d) Disclosure and Education.

(1) Insurers shall disclose in all policies, certificates, and coverage materials the availability of triage or screening services and how to obtain those services. Insurers shall disclose annually, in insurer newsletters or comparable communications to covered persons, the Department's standards for timely access, the insurer's process for ensuring timely access, and what steps a covered person should take when experiencing access problems inconsistent with timely access standards, including when and how to access applicable Department and insurer helplines.

(2) The telephone number at which covered persons can access triage and screening services shall be included on covered person membership cards. An insurer may comply with this requirement through an additional selection in its automated customer service telephone answering system, where applicable, provided that the customer service number is included on the covered person's membership card.

Note: Authority cited: Section 10133.5, Insurance Code. Reference: Sections 106(b), 10133, 10133.5 and 10133.8, Insurance Code.

Amend Section 2240.16. Access Standards for Pediatric Vision and Oral Essential Health Benefits and Specialized Policies that Cover Dental Benefits Only.

(a) Health insurance policies covering the pediatric vision or oral essential health benefit, as defined in subdivision (a)(4) and (a)(5), respectively, of Insurance Code section 10112.27 (regardless of whether such coverage is provided directly through the policy or through subcontracting arrangements), specialized health insurance policies that provide coverage for the pediatric oral essential health benefit (as defined in subdivision (a)(5) of Insurance Code section 10112.27), and specialized health insurance policies that cover dental benefits only (as defined in subdivision (c) of Insurance Code section 106) must assure that there are adequate full-time equivalents of network providers accepting new patients covered by the policy to accommodate anticipated enrollment growth.

(b) In addition to ensuring compliance with the clinical appropriateness standard set forth in subdivision (b)(1) of Section 2240.15, each health insurance policy covering the pediatric oral or vision essential health benefit, specialized health insurance policies that provide coverage for the pediatric oral essential health benefit (as defined in in subdivision (a)(5) of Insurance Code section 10112.27), and specialized health insurance policies that cover dental benefits only (as defined in subdivision (c) of Insurance Code section 106) shall ensure that contracted oral and vision provider networks have adequate capacity and availability of licensed health care providers, including generalist and specialist dentists, ophthalmologists, optometrists, and opticians to offer insureds appointments for covered oral and vision services in accordance with the following requirements:

(1) Urgent appointments shall be offered within 72 hours of the time of request for appointment, when consistent with the covered person's individual needs and as required by professionally recognized standards of practice;

(2) Non-urgent appointments shall be offered within 36 business days of the request for appointment; and

(3) Preventive appointments shall be offered within 40 business days of the request for appointment.

(c) The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of the provider's practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the covered person.

Note: Authority cited: Section 10133.5, Insurance Code. Reference: Sections 106(b), 10133, 10133.5 and 10112.27 Insurance Code.

Amend Section 2240.2. Insurance Contract Provisions.

Insurance contracts containing provisions covering network provider services shall contain the following:

- (a) A provision for coverage on an indemnity or provision of service basis at in-network cost sharing at the lowest cost-sharing tier for emergency health care services rendered to covered persons, consistent with the requirements of Insurance Code section 10112.7, and any other applicable law.
- (b) A provision that the insurer shall give written notice to the contract holder, within a reasonable period of time, of any termination or permanent breach of contract by, or permanent inability to perform of, any network provider if such termination, breach or inability would materially and adversely affect the contract holder or covered persons or will result in the insurer's network not being in compliance with this article.
- (c) A provision that the contract holder shall distribute to the primary covered persons the substance of any notice given to the contract holder pursuant to subdivision (b) not later than 30 days after its receipt.
- (d) A provision that, pursuant to Insurance Code Section 10133.56, upon termination of a network provider contract, the insurer shall be liable for covered services rendered by such provider to a covered person under the care of such provider at the time of termination until such services are completed, unless reasonable and medically appropriate arrangements for assumption of such services by another network provider are made. This provision need not provide that the insurer shall be liable for any services rendered to a covered person after such person ceases to be eligible for coverage under the insurance contract.
- (e) A provision defining the service area.

Note: Authority cited: Section 10133.5, Insurance Code. Reference: Sections 10133, 10133.5 and 10133.56, Insurance Code.

Amend Section 2240.3. Provisions of Policies and Certificates.

Policies and Certificates containing provisions covering network provider services shall contain the following:

(a) A description of the coverage provided by the contract for emergency health care services rendered to covered persons outside the service area.

(b) A description of the coverage, if any, provided by the contract for dependent covered persons who both live outside the service area and away from the principal residence of the primary covered person.

(c) A brief and prominent warning reflecting the limitations in the contract pertaining to network provider services. Such warning shall identify, by caption or number, the certificate provisions required by subdivisions (d), (e) and (f), below.

(1) Where the contract provides coverage outside the service area, the warning shall be in bold-face type or set off by other means from the surrounding text, and shall clearly specify the differences in coverage between network and non-network services in and out of the service area.

(2) Where the contract provides no coverage (except for emergency health care services) outside the service area, the warning shall include the warning required in (1) above, and shall additionally warn that no coverage is provided outside the service area, except for emergency health care services. The additional warning shall be in a point size at least twice that used in the body of the certificate (excluding captions).

(d) If applicable, a provision defining the service area wherein non-emergency coverage is restricted to services provided by network providers.

(e) A provision or attachment identifying all network providers or describing where a current directory of network providers can be found on the Internet.

(f) A prominent disclosure pursuant to Insurance Code Section 510 stating that covered persons who have complaints regarding their ability to access needed health care in a timely manner may complain to the insurer and to the California Department of Insurance. The disclosure shall include the address and the customer services telephone number of the insurer and the name address and toll free telephone number of the Consumer Services Division of the Department of Insurance.

(g) A prominent disclosure of the requirements of subdivision (e) of Section 2240.1.

(h) If applicable, a prominent disclosure stating that insureds must meet higher deductibles and higher out-of-pocket maximums for out-of-network provider services than for in-network provider services.

(i) If applicable, a prominent disclosure stating that the insured's financial obligation will vary depending on the tier in which a provider is classified.

Note: Authority cited: Section 10133.5, Insurance Code. Reference: Sections 510, 10133 and 10133.5, Insurance Code.

Amend Section 2240.4. Contracts with Network Providers.

- (a) Insurers shall establish written policies and procedures for recruiting network providers, credentialing network providers, contracting with network providers, and managing their networks.
- (b) Effective June 30, 2008, contracts between network providers and insurers or their agents shall: 1) be in writing and be fair and reasonable as to the parties to such contracts; 2) provide that network providers shall not make any additional charges for rendering network services except as provided for in the contract between the insurer and the insured; 3) include all the agreements between the parties pertaining to the rendering of network provider services; 4) recite that the provider's primary consideration shall be the quality of the health care services rendered to covered persons; 5) include provisions ensuring that providers shall not discriminate against any insured in the provision of contracted services on the basis of sex, marital status, sexual orientation, race, color, religion, ancestry, national origin, disability, health status, health insurance coverage, utilization of medical or mental health or substance use disorder services or supplies, or other unlawful basis including without limitation, the filing by such insured of any complaint, grievance, or legal action against a provider.
- (c) Insurers shall afford essential community providers equal opportunity to participate in contracts for alternative rates of payment to assure adequacy of number and location of institutional facilities and professional providers in what have been determined to be underserved communities and populations.
- (1) An insurer shall not discriminate against a provider on the basis of the provider's qualifying as an essential community provider under state or federal law.
- (2) When contracting with an essential community provider, an insurer shall offer contractual terms that are fair and reasonable, and similar to the terms offered to other similarly situated providers.
- (3) Nothing in this section shall be construed to require an insurer to contract with an essential community provider if such provider refuses to accept the generally applicable payment rates of the insurer.
- (d) An insurer shall notify the Department at least 10 days before the termination of a contract with a provider, provider group, or facility, and in such notice shall demonstrate that its network remains in compliance with the network adequacy requirements of this Article. The notice shall be electronically filed with the Health Policy Approval Bureau through the "California Life & Health" instance of the System for Electronic Rate and Form Filing (SERFF) of the National Association of Insurance Commissioners (NAIC), with the title "2240.4(d) Provider/Facility Termination Notice" in the subject line. In demonstrating compliance, the notice shall describe the other providers or facilities that enable the network to continue to comply with the requirements of this article, notwithstanding the termination of the identified provider(s) or facility/facilities. For providers, an updated report as described in Section 2240.5(c)(1) is an adequate description. For facilities, the other facilities shall be identified, within an updated report as described in Section 2240.5(c)(1).

(e) If a provider has contracted with an insurer to participate in a particular network, the insurer must obtain the provider's written assent before that provider may be included as a participant in other networks of that insurer.

Note: Authority cited: Section 10133.5, Insurance Code. Reference: Sections 10133 and 10133.5, Insurance Code.

Amend Section 2240.5. Filing and Reporting Requirements.

(a) For all health insurance policies that include the option of utilizing contracted providers to provide health care services, and specialized health insurance policies, that provide coverage for the pediatric oral essential health benefit (as defined in Insurance Code section 10112.27(a)(5)), the insurer shall file a network adequacy report with the Department, with accompanying documents, as follows:

(1) Annually on June 1, a network adequacy report for all health insurance policies providing current coverage or new health insurance policies.

(2) Upon request by the Commissioner, a network adequacy report for all health insurance policies providing current coverage or new health insurance policies.

(3) Whenever an insurer seeks approval from the department for any policy form that relies upon or includes the option of utilizing contracted network providers to deliver health care services, the insurer shall at the same time file a network adequacy report for the policy form for which approval is sought.

(b) Network adequacy reports, and accompanying documents, shall be electronically filed with the Health Policy Approval Bureau through the “California Life & Health” instance of the System for Electronic Rate and Form Filing (SERFF) of the National Association of Insurance Commissioners (NAIC).

(c) Network adequacy reports shall consist of:

(1) A report describing the number and location of all network providers by county and zip code, including facilities, primary care providers, specialty providers, mental health providers, including behavioral health providers, and substance use disorder providers utilized by the insurer to provide services to covered persons and demonstrating that the insurer is in compliance with all the accessibility and availability requirements of these regulations, and identifying the location and extent of areas of non-compliance.

(2) A description of the service area covered by the network, by zip code, and describing any change to the service area since the filing of the most recently filed network adequacy report.

(d) The following documents must be submitted with the network adequacy report:

(1) An affidavit or attestation acknowledging compliance with all the applicable requirements of this regulation.

(2) A copy of the written procedures required by Section 2240.1(b)(7).

(3) Complete copies, including all appendices, attachments and exhibits, of the most commonly utilized network provider contracts for each type of provider the insurer (or its agent if using a leased network) includes in the provider network, including but not limited to hospital, individual physician, group physician, laboratory, mental health and substance use disorder providers, rehabilitation and ancillary service contracts. All material changes to provider contracts must be filed with the Health Policy Approval Bureau as they become effective.

- (4) Copies of all written policies and procedures for recruiting network providers, credentialing or accrediting network providers, contracting with network providers, and managing the insurer's networks, as required by subdivision (a) of Section 2240.4, including the selection and tiering standards (if the network is a tiered network) required by subdivision (g) of Section 2240.1, as well as copies of all written policies and procedures for the coordination of the transition of an insured person from an inpatient hospital to an appropriate community setting consistent with the insured person's post-discharge care needs.
- (5) The mental health and substance use disorder access report required by subdivision (c)(6)(C) of Section 2240.1.
- (6) The timely access standards set forth in the insurer's policies and procedures.
- (7) A report regarding the rate of compliance, during the reporting period, with the time elapsed standards set forth in Sections 2240.15(b) and 2240.16. An insurer may develop data regarding rates of compliance through statistically reliable sampling methodology, including but not limited to provider and insured survey processes.
- (8) A report regarding any noncompliance by the insurer with the provisions of this article. The report shall state whether or not an incident or pattern described in subdivision (d)(8)(A) or (d)(8)(B) below occurred during the reporting period and, if so, shall include a description of the identified non-compliance and the insurer's responsive investigation, determination and corrective action:
- (A) Any incidents of noncompliance resulting in substantial harm to an insured, or
- (B) Any patterns of non-compliance.
- (9) A description of the implementation and use by the insurer and its contracting providers of triage, telemedicine, and health information technology to provide timely access to care.
- (10) The results of the most recent annual covered person and provider surveys required by subdivisions (c)(2)(B) and (c)(2)(C), respectively, of Section 2240.15 and a comparison with the results of the prior year's surveys, if any such surveys were conducted, including a discussion of the relative change in survey results.
- (11) Data regarding the extent to which members used out-of-network services during the reporting period, including the number of out-of-network claims by type of provider, dollar value of total claims, average value per claim, total amount paid by the health plan, average amount paid per claim, total unpaid claim balances and average unpaid claim balance per claim.
- (12) Data regarding the extent to which members used emergency room services during the reporting period.
- (13) The information identifying and providing the location of each transplant center in the network by name and address, and type of transplant provided in the facility, required by subdivision (f) of Section 2240.1.

(14) A report describing, for each network hospital, the percentage of physicians in each of the specialties of (A) emergency medicine, (B) anesthesiology, (C) radiology, (D) pathology, and (E) neonatology practicing in the hospital who are in the insurer's network(s).

(15) Information confirming the status of the insurer's provider network and enrollment at the time of the report, which shall include, on a county-by-county basis, in a format approved by the Department:

(A) The insurer's enrollment in each product line; and

(B) A complete list of the insurer's contracted physicians, hospitals, and other contracted providers, including name, location, specialty and subspecialty qualifications, California license number and National Provider Identification Number, as applicable. Physician specialty designation shall specify board certification or eligibility consistent with the specialty designations recognized by the American Board of Medical Specialties.

(e) The information required by subdivision (d)(15) shall be included with the network adequacy report until the Department implements a web-based application that provides for electronic submission via a web portal designated for the collection of insurer network data. Upon the Department's implementation of the designated network data collection web portal, the information required by subdivision (d)(15) shall be submitted directly to the web portal.

(f) An insurer must notify the department immediately at any time that a material change to any of its networks results in the insurer being out of compliance with any of the provisions of these regulations and, at the same time, submit a corrective plan specifying all actions that the insurer is taking, or will take, to come into compliance with these provisions, and estimating the time required to do so.

(g) Health insurers that contract for alternative rates of payment with providers shall annually submit a report to the Department through the National Association of Insurance Commissioners (NAIC) System for Electronic Rate and Form Filing (SERFF), no later than March 31, on complaints received in the previous calendar year by the insurer regarding access to care by covered persons and issues with contracted providers. This report shall include the following:

(1) A summary of receipt and resolution of complaints from covered persons regarding access to or availability of any of the following services by type of service: primary care services, specialty care services, mental health or substance use disorder professional services and hospital services.

(2) A summary of receipt and resolution of complaints received from providers by network and type of service: primary care services, specialty care services, mental health or substance use disorder professional services, hospital services, and other services.

(3) The summaries required by subdivisions (g)(1) and (g)(2) above shall include the following:

(A) Total number of complaints in the prior calendar year.

(B) Description of complainant (as consumer, provider or other).

(C) Status of complaint as either resolved or unresolved.

(D) Date complaint received.

(E) Time from receipt of the complaint to resolution of the complaint, if applicable, or a statement that the complaint is unresolved.

(F) Reason or reasons for failure to resolve the complaint, if applicable.

(G) Description of complaint resolution, if applicable.

(h) The Commissioner may audit compliance with the requirements of this article, and the accuracy of network adequacy reports and supporting documents submitted pursuant to this article, including, without limitation, through requests for additional background information regarding surveys undertaken by an insurer, and through direct surveys of providers and covered persons.

(i) The department shall review all network adequacy reports and supporting documents submitted pursuant to this article.

(j) The department shall review these complaint reports and any complaints received by the department regarding timely access to care and shall make this information public, consistent with applicable law regarding the confidentiality of personally-identifiable information.

(k) The department's review of the reports, documents, and data submitted according to the requirements of this article does not itself act as a waiver of any requirements of this article or of conflicts with California law regarding a given network's design or implementation.

Note: Authority cited: Section 10133.5, Insurance Code. Reference: Sections 10133 and 10133.5, Insurance Code.

Amend Section 2240.6. Notice and Information to Covered Persons.

(a) Network provider directories shall be updated pursuant to the requirements set forth in this section and shall be offered to accommodate individuals with limited English proficiency or disabilities.

(b) An insurer shall post its current network provider directory on its internet web site and inform its covered persons of the availability of the internet network provider directory through its coverage materials. The network provider information provided on the website shall be updated weekly. The network provider directory shall be available online to both covered persons and consumers shopping for coverage without requirements to log on or enter a password or a policy number.

(c) An insurer shall maintain accurate provider directories for its networks as to the information referenced in subdivisions (g) and (h), below, as applicable, and shall demonstrate the accuracy of its directories at the request of the Department.

(d) In addition to providing the network provider directory on its internet web site, the insurer shall also inform its covered persons of the availability of a paper copy of the network provider directory at no cost in its coverage material and on its internet web site.

(1) The paper copy of the network provider directory shall be updated quarterly during the calendar year.

(2) An insurer may satisfy this quarterly update requirement by providing a paper copy insert or addendum to any existing paper copy network provider directory.

(e) If an insurer has more than one provider network, its provider directories shall make it reasonably clear to a covered person which network applies to each insurance product.

(f) The network provider directory shall inform covered persons regarding the availability of translations and interpreter services in languages other than English pursuant to section 10133.8 of the Insurance Code.

(g) No later than July 1, 2016, the network provider directory shall include the information required by subdivisions (g) and (h) of Insurance Code section 10133.15.

(h) No later than July 1, 2016, an insurer that issues vision-only, dental-only, or other specialized health insurance policies shall include in its provider directory the information required by subdivisions (g) and (i) of Insurance Code section 10133.15 with respect to those policies. However, an insurer that issues specialized mental health insurance policies shall provide in its provider directory the information required by subdivision (g) of this section with respect to those policies, in lieu of the information required by the immediately preceding sentence. For purposes of this subdivision (h), the term “specialized mental health insurance policies” includes behavioral health-only policies.

(i) The network provider directories, both printed and online, shall also inform consumers of the requirements of this article regarding the insurer’s obligation to offer consumers primary care and specialty care within the specified time frames.

- (j) The directory shall clearly explain out-of-network options and cost-sharing tiers.
- (k) The directory shall comply with Insurance Code section 10604.1.
- (l) The network provider directories, both printed and online, shall identify those contracting providers who are themselves multilingual or who employ other multilingual providers and/or office staff, based on language capability disclosure statements signed by the multilingual providers and/or office staff, attesting to their fluency in languages other than English; changes to this information shall be reflected in provider directory updates.
- (m) An insurer shall promptly notify those patients seen by a provider within the past year when the provider, for any reason, leaves the insurer's network. This may include, but is not limited to, the provider's decision to retire or stop practicing medicine for other reasons, relocating to an area outside the service area, leaving a group practice that is included as a participant in the network, or withdrawing from a network for any other reason.
- (n) Provider directories shall include a description of a process whereby inaccurate provider listings can be reported to the insurer in compliance with the requirements of Insurance Code section 10133.15.
- (o) The insurer shall ensure the accuracy of its provider directories in compliance with the requirements of Insurance Code section 10133.15.
- (p) An insurer's provider directory, both online and print, shall include prominent disclosure of the requirements of subdivision (e) of Section 2240.1.

Note: Authority cited: Section 10133.5, Insurance Code. Reference: Sections 10133, 10133.15, 10133.5 and 10133.8, Insurance Code.

Amend Section 2240.7. Discretionary Waiver of Network Access Standards.

(a) If an insurer is unable to meet the network access standard(s) required by this article, the insurer may apply to the Commissioner for a discretionary waiver of any network access standards and offer an alternate access delivery system. A waiver application must be resubmitted annually.

(b) An application for waiver may only be granted for the following reasons:

(1) Absence of practicing providers located within sufficient geographic proximity based upon the time or distance standards of this article.

(2) There are sufficient numbers or types of providers or facilities in the service area to meet the standards required by this article, but the insurer demonstrates, through substantial evidence, that, after good faith efforts, it is unable to contract with sufficient providers or facilities to meet the network access standards set forth in this article.

(3) An insurer's provider network has been previously approved under this article, and a provider or facility subsequently becomes unavailable within the service area.

(4) The application includes a proposal regarding innovative network design, such as primary care medical homes, "Centers of Excellence," or accountable care organizations, but only where the innovative network design is shown to provide a benefit to consumers.

(c) In order for a waiver to be granted, the insurer must:

(1) Propose an alternate access delivery system that will provide covered persons with access to medically necessary care on a reasonable basis without detriment to their health.

(2) Demonstrate that appropriate procedures are in place to ensure that covered persons obtain all covered services in the alternate access delivery system, at no greater cost to the covered persons than if the services were obtained from network providers or facilities. Coinsurance, copayments and deductible requirements shall apply to alternate access delivery systems at the same level they are applied to in-network services.

(3) Demonstrate in its alternate access delivery system proposal a reasonable basis for not meeting any standard set forth in this Article, and include an explanation of why the proposed alternative access delivery system provides covered persons with a sufficient number of the appropriate types of providers or facilities to which the standard in question applies.

(4) Demonstrate in its alternate access delivery system proposal how the insurer will assist covered persons to locate providers and facilities in a manner that assures both availability and accessibility.

(A) Covered persons must be able to obtain health care services from a provider or facility within the closest reasonable proximity of the covered person in a timely manner appropriate for the covered person's health needs.

(B) Examples of alternate access delivery systems include, but are not limited to, such insurer strategies as use of out-of-county or out-of-service-area providers or facilities, providing regular

scheduled or as-needed transportation from areas within a designated area to those providers or facilities to ensure that such providers or facilities remain reasonably accessible, and exceptions to network standards based upon rural locations in the service area.

(d) The application shall include, at a minimum, the following:

(1) A description of the affected area and covered persons in that area and how the insurer determined the absence of providers or facilities.

(2) Alternatives that were considered, including but not limited to, telemedicine or phone consultation.

(3) The applicable reason or reasons set forth in subdivision (b) of this section.

(4) Any identified issues or risks that may prevent the alternate access delivery system from providing covered persons with access to medically necessary care on a reasonable basis without detriment to their health.

(5) The alternate access delivery system proposal described, and a description of how the proposed alternate access delivery system will satisfy the standards set forth in subdivision (c).

(e) The Commissioner shall not approve an alternate access delivery system unless:

(1) The insurer provides substantial evidence of good faith efforts on its part to contract with providers or facilities and can demonstrate that there is not an available provider or facility with which the insurer can contract to meet the standards set forth in this article.

(2) The proposed alternate access delivery system will provide covered persons with access to medically necessary care on a reasonable basis without detriment to their health.

(f) The Department will post on its Internet Web site each waiver or alternative access delivery system that the Department approves under this section on or after June 1, 2016.

Note: Authority cited: Section 10133.5, Insurance Code. Reference: Sections 10133 and 10133.5, Insurance Code.