

**State of California
Office of Administrative Law**

In re:
Department of Insurance

Regulatory Action:

Title 10, California Code of Regulations

Adopt sections: 2240.15, 2240.16, 2240.6,
2240.7

Amend sections: 2240, 2240.1, 2240.4,
2240.5

Repeal sections:

**NOTICE OF APPROVAL OF EMERGENCY
REGULATORY ACTION**

**Government Code Sections 11346.1 and
11349.6**

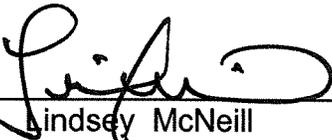
OAL File No. 2015-0120-03 E

This emergency action by the Department of Insurance (DOI) amends four sections and adopts four sections in title 10 of the California Code of Regulations (CCR) to require health insurers to maintain adequate medical provider networks to meet the healthcare needs of their policyholders, maintain accurate provider directories, and require disclosure of out-of-network providers who may participate in a patient's planned care.

OAL approves this emergency regulatory action pursuant to sections 11346.1 and 11349.6 of the Government Code.

This emergency regulatory action is effective on 1/30/2015 and will expire on 7/30/2015. The Certificate of Compliance for this action is due no later than 7/29/2015.

Date: 1/30/2015



Lindsey McNeill
Attorney

For: DEBRA M. CORNEZ
Director

Original: Dave Jones
Copy: Bruce Hinze

NOTICE PUBLICATION/REGULATIONS SUBMISSION

(See instructions on reverse)

For use by Secretary of State only

STD. 400 (REV. 01-2013)

OAL FILE NUMBERS	NOTICE FILE NUMBER Z-	REGULATORY ACTION NUMBER	EMERGENCY NUMBER 2015-0120-03E
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For use by Office of Administrative Law (OAL) only

2015 JAN 20 PM 4:46
OFFICE OF
ADMINISTRATIVE LAW

ENDORSED - FILED
in the office of the Secretary of State
of the State of California

JAN 30 2015
3:29 PM

NOTICE	REGULATIONS
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AGENCY WITH RULEMAKING AUTHORITY
Department of Insurance

AGENCY FILE NUMBER (If any)
ER-2015-00001

A. PUBLICATION OF NOTICE (Complete for publication in Notice Register)

1. SUBJECT OF NOTICE		TITLE(S)		FIRST SECTION AFFECTED		2. REQUESTED PUBLICATION DATE	
3. NOTICE TYPE <input type="checkbox"/> Notice re Proposed <input type="checkbox"/> Regulatory Action <input type="checkbox"/> Other		4. AGENCY CONTACT PERSON		TELEPHONE NUMBER		FAX NUMBER (Optional)	
OAL USE ONLY		ACTION ON PROPOSED NOTICE <input type="checkbox"/> Approved as Submitted <input type="checkbox"/> Approved as Modified <input type="checkbox"/> Disapproved/Withdrawn		NOTICE REGISTER NUMBER		PUBLICATION DATE	

B. SUBMISSION OF REGULATIONS (Complete when submitting regulations)

1a. SUBJECT OF REGULATION(S) Provider Network Adequacy	1b. ALL PREVIOUS RELATED OAL REGULATORY ACTION NUMBER(S)
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2. SPECIFY CALIFORNIA CODE OF REGULATIONS TITLE(S) AND SECTION(S) (Including title 26, if toxics related)	
SECTION(S) AFFECTED (List all section number(s) individually. Attach additional sheet if needed.)	ADOPT 2240.15, 2240.16, 2240.6, 2240.7
	AMEND 2240, 2240.1, 2240.4, 2240.5
TITLE(S) 10	REPEAL

3. TYPE OF FILING			
<input type="checkbox"/> Regular Rulemaking (Gov. Code §11346)	<input type="checkbox"/> Certificate of Compliance: The agency officer named below certifies that this agency complied with the provisions of Gov. Code §§11346.2-11347.3 either before the emergency regulation was adopted or within the time period required by statute.	<input type="checkbox"/> Emergency Readopt (Gov. Code, §11346.1(h))	<input type="checkbox"/> Changes Without Regulatory Effect (Cal. Code Regs., title 1, §100)
<input type="checkbox"/> Resubmittal of disapproved or withdrawn nonemergency filing (Gov. Code §11349.3, 11349.4)	<input type="checkbox"/> Resubmittal of disapproved or withdrawn emergency filing (Gov. Code, §11346.1)	<input type="checkbox"/> File & Print	<input type="checkbox"/> Print Only
<input checked="" type="checkbox"/> Emergency (Gov. Code, §11346.1(b))		<input type="checkbox"/> Other (Specify) _____	

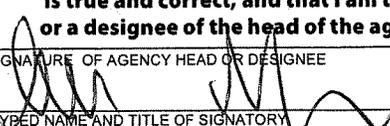
4. ALL BEGINNING AND ENDING DATES OF AVAILABILITY OF MODIFIED REGULATIONS AND/OR MATERIAL ADDED TO THE RULEMAKING FILE (Cal. Code Regs. title 1, §44 and Gov. Code §11347.1)

5. EFFECTIVE DATE OF CHANGES (Gov. Code, §§ 11343.4, 11346.1(d); Cal. Code Regs., title 1, §100)			
<input type="checkbox"/> Effective January 1, April 1, July 1, or October 1 (Gov. Code §11343.4(a))	<input checked="" type="checkbox"/> Effective on filing with Secretary of State	<input type="checkbox"/> \$100 Changes Without Regulatory Effect	<input type="checkbox"/> Effective other (Specify) _____

6. CHECK IF THESE REGULATIONS REQUIRE NOTICE TO, OR REVIEW, CONSULTATION, APPROVAL OR CONCURRENCE BY, ANOTHER AGENCY OR ENTITY			
<input type="checkbox"/> Department of Finance (Form STD. 399) (SAM §6660)	<input type="checkbox"/> Fair Political Practices Commission	<input type="checkbox"/> State Fire Marshal	
<input type="checkbox"/> Other (Specify) _____			

7. CONTACT PERSON Bruce Hinze	TELEPHONE NUMBER (415) 538-4392	FAX NUMBER (Optional)	E-MAIL ADDRESS (Optional) hinzeb@insurance.ca.gov
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8. I certify that the attached copy of the regulation(s) is a true and correct copy of the regulation(s) identified on this form, that the information specified on this form is true and correct, and that I am the head of the agency taking this action, or a designee of the head of the agency, and am authorized to make this certification.

SIGNATURE OF AGENCY HEAD OR DESIGNEE 	DATE 1/20/2015
TYPED NAME AND TITLE OF SIGNATORY Geoffrey Margolis, Deputy Commissioner and Special Counsel to the Commissioner	

For use by Office of Administrative Law (OAL) only

ENDORSED APPROVED

JAN 30 2015

Office of Administrative Law

STATE OF CALIFORNIA
DEPARTMENT OF INSURANCE
45 Fremont Street
San Francisco, California 94105

TEXT OF PROPOSED EMERGENCY REGULATION

Date: January 12, 2015

REGULATION FILE: ER-2015-00001

PROVIDER NETWORK ADEQUACY EMERGENCY REGULATION

Title 10. Investment
Chapter 5. Insurance Commissioner
Subchapter 2. Policy Forms and Other Documents
Article 6. Provider Network Access Standards for Disability Policies and Agreements

Amend § 2240. Definitions.

As used in this Article:

(a) ~~“Basic health care services” means any of the following covered health care services provided for in the applicable insurance contract or certificate of coverage:~~

~~(1) Physician services, including consultation and referral.~~

~~(2) Hospital inpatient services and ambulatory care services.~~

~~(3) Diagnostic laboratory diagnostic and therapeutic radiologic services.~~

~~(4) Home health services.~~

~~(5) Preventive health services.~~

~~(6) Emergency health care services, including ambulance services.~~

~~(7) Mental health care services including those intended to meet the requirements of Insurance Code 10144.5.~~

~~(8) Any other health care or supportive services that are covered pursuant to an insurance contract.~~

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

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

(d) ~~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.

(e) ~~d~~ “Emergency health care services” means health care services rendered for any condition ~~in which the covered person is in danger of loss of life or serious injury or illness or is experiencing severe pain and suffering, 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 May 27, 2012, subdivision (c) of which is incorporated herein by this reference.

(f) “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.

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

(h) “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.

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

(j) “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.

(k) “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 who has limited his practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist or family practitioner.

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

(m) “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.

(n) “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.

(o) “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.

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

Amend§ 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). Notwithstanding the above, the provisions of this article do not apply to supplemental specialized policies of health insurance that provide coverage for vision care expenses only or dental care expenses only.

(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 ~~or~~ size, 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.

(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 basic 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 to the physically handicapped.

(4) ~~Basic~~ 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) ~~Basic~~ Health care services are accessible to covered persons through network providers, or other network arrangement.

(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 Section 2240.15, shall be a part of such a system.

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

(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 30 minutes or 15 miles of each covered person's residence or workplace.

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

~~(3)~~ 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 60 minutes or 30 miles of a covered person's residence or workplace. 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.

~~(4)~~ 5) 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 30 minutes or 15 miles of a 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 abuse 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 abuse 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 abuse 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 an adult 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 abuse 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 during normal business hours.

(5) (6) There is a network hospital with sufficient capacity to accept covered persons for covered services within 30 minutes or 15 miles of a 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.

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

(8) 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 primary care provider are available from contracting providers at locations (where covered persons are personally served) within a reasonable distance from the primary care 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, so as to minimize the impact of accessing the service on the patient's work and life activities.

(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 the in-network cost sharing for the service. 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) Health carrier standards for the selection and tiering 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.

(h) 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.

(i) The insurer must measure the adequacy of its network at least twice a year, 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.

(j) 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.

~~(6k)~~ 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.

~~(7) If an insurer is unable to meet the network access standard(s) required by this section due to the absence of practicing providers located within sufficient geographic proximity of the insurer's covered persons, the insurer may apply to the Commissioner for a discretionary waiver of any network access standard for the applicable geographic area. Such application should include, at a minimum, a description of the affected area and covered persons in that area and how the insurer determined the absence of practicing providers.~~

~~(d)~~ In determining whether an insurer's arrangements for network provider services comply with these regulations, the Commissioner shall consider to the extent the Commission 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.

Adopt new § 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.

(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 an undue delay on the scheduling of the

appointment. This subdivision (c)(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 (c)(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 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 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 (b)(5); telephone medical advice services pursuant to Section 10279 of the Insurance Code; the insurer's contracted primary care and mental health care 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 and mental health care 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 and mental health care 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.

(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.

(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);

(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). The Department will make 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 providers, perspective and concerns regarding compliance with the standards set forth at subdivision (b). The Department will make 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 insurer's standards for timely access.

(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.

Adopt new § 2240.16. Access Standards for Pediatric Vision and Oral Essential Health Benefits.

(a) Policies covering the pediatric essential health benefit must assure that there are adequate full-time equivalents of primary care network practitioners 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 insurance policy covering the pediatric dental and/or vision essential health benefit 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 within the pediatric oral and vision provider network 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 pediatric oral and vision care 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 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.

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

Amend § 2240.4. Contracts with ~~Exclusive~~ 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.

(a)(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 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; 6) contain a provision requiring that network facilities shall determine and disclose to the insured person prior to an insured person's non-emergency episode of care the non-network providers who are likely to be involved in providing care, and the estimated cost of that non-network care to the insured person. For example, for a surgery in a network hospital, the hospital shall disclose to the insured person, prior to the surgery, all non-network providers, such as anesthesiologists, radiologists, and pathologists, who are anticipated to be involved in the insured person's care, and the estimated cost of their non-network services. This disclosure is to be made sufficiently in advance of the scheduled episode of care to afford the insured person a reasonable opportunity to explore alternate arrangements.

(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.

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

Amend § 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, the insurer shall file a network adequacy report with the Department, with accompanying documents, as follows:

(1) Beginning on June 1, 2015 and, notwithstanding any additional filings the insurer may have made, annually thereafter 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 basic health care services, the insurer shall at the same time file a network adequacy report for the policy form for which approval is sought with the Policy Approval Bureau of the California Department of Insurance:

(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 or zip code, including facilities, primary care providers, specialty providers, and mental health providers, including behavioral health 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, such as a report produced using GeoAccess GeoNetworks® software offered by Ingenix Corporation.

(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:

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

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

(4) (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 rehabilitation and ancillary service contracts. Rates or rate schedules need not be provided with this filing. All material changes to provider contracts must be filed with the 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, including the selection and tiering standards required by subdivision (g) of Section 2240.1.

(5) The mental health and substance abuse disorder access report required by subdivision (c)(5)(C) of Section 2240.1.

(b) Any insurer who by June 30, 2008 has not filed all of the information required by subsection (a) (1), (2), (3), and (4) pertaining to each network of providers used for delivery of medical services under any policy of insurance in force, sold or offered for delivery in California shall do so for each such network by that date.

(c) An insurer seeking approval for a new product which will utilize a network that has previously been described to or filed with the department pursuant to subsections (a)(1) or (b), may file an affidavit or attestation stating that the network to be utilized for the new product is substantially the same as one previously filed, and that there have been no material changes to the network that would result in failure to comply with any of the provisions of this article. Such affidavit shall clearly identify the previous filing, and shall, if appropriate, recalculate the ratios required by Section 2240.1(c)(1) taking into account projected new covered lives.

(6) The timely access standards set forth in the insurer's policies and procedures including, as may be applicable, any alternative time-elapased standards and alternatives to time-elapased standards for which the insurer obtained the Department's prior approval.

(7) A report regarding the rate of compliance, during the reporting period, with the time elapsed standards set forth in Section 2240.15(b). 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) 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)(14) 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)(14) shall be submitted directly to the web portal.

(df) 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.

(e 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, annually to the Consumer Services Division of the Department of Insurance on complaints received in the previous calendar year by the insurer regarding timely access to care by covered persons and issues with contracted providers. This report shall include the following:

(1) a 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 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 professional services, hospital services, and other services.

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

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

(B) Identity of complainant.

(C) Description of complaint.

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

(E) Date complaint received.

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

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

(H) Description of complaint resolution, if applicable.

(h) The Commissioner may audit compliance with the requirements of this article through requests for additional background information regarding surveys undertaken by an insurer, and through direct surveys of providers and covered persons.

(fi) 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.

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

Adopt new § 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 data elements listed in subdivision (g), below, 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 printed annually and 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) The network provider directory shall list the following for each provider:

- (1) The name of the provider,
- (2) The specialty area or areas of the provider,
- (3) Whether the provider is currently accepting new patients,
- (4) Whether the provider may be accessed without referral,
- (5) The location(s), including address, and contact information for the provider,
- (6) The gender of the provider,
- (7) Languages spoken by the provider,
- (8) Languages spoken by office staff,
- (9) List of network facilities where the provider has admitting privileges,
- (10) Whether the provider is a primary care physician (PCP),
and
- (11) Whether the office is ADA accessible.

(h) 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.

(i) 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 forms 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.

(j) 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.

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

Adopt new § 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 shall only be reviewed and may 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 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.

(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) 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) 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 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).

(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.

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

Code of Federal Regulations

Title 45. Public Welfare

Subtitle A. Department of Health and Human Services (Refs & Annos)

Subchapter B. Requirements Relating to Health Care Access (Refs & Annos)

Part 156. Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges (Refs & Annos)

Subpart C. Qualified Health Plan Minimum Certification Standards (Refs & Annos)

45 C.F.R. § 156.235

§ 156.235 Essential community providers.

Effective: May 29, 2012

Currentness

(a) General requirement.

(1) A QHP issuer must have a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards.

(2) A QHP issuer that provides a majority of covered professional services through physicians employed by the issuer or through a single contracted medical group may instead comply with the alternate standard described in paragraph (b) of this section.

(3) Nothing in this requirement shall be construed to require any QHP to provide coverage for any specific medical procedure provided by the essential community provider.

(b) Alternate standard. A QHP issuer described in paragraph (a)(2) of this section must have a sufficient number and geographic distribution of employed providers and hospital facilities, or providers of its contracted medical group and hospital facilities to ensure reasonable and timely access for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards.

(c) Definition. Essential community providers are providers that serve predominantly low-income, medically underserved individuals, including providers that meet the criteria of paragraph (c)(1) or (2) of this section, and providers that met the criteria under paragraph (c)(1) or (2) of this section on the publication date of this regulation unless the provider lost its status under paragraph (c)(1) or (2) of this section thereafter as a result of violating Federal law:

(1) Health care providers defined in section 340B(a)(4) of the PHS Act; and

(2) Providers described in section 1927(c)(1)(D)(i)(IV) of the Act as set forth by section 221 of Public Law 111-8.

(d) Payment rates. Nothing in paragraph (a) of this section shall be construed to require a QHP issuer to contract with an essential community provider if such provider refuses to accept the generally applicable payment rates of such issuer.

(e) Payment of federally-qualified health centers. If an item or service covered by a QHP is provided by a federally-qualified health center (as defined in section 1905(l)(2)(B) of the Act) to an enrollee of a QHP, the QHP issuer must pay the federally-qualified health center for the item or service an amount that is not less than the amount of payment that would have been paid to the center under section 1902(bb) of the Act for such item or service. Nothing in this paragraph (e) would preclude a QHP issuer and federally-qualified health center from mutually agreeing upon payment rates other than those that would have been paid to the center under section 1902(bb) of the Act, as long as such mutually agreed upon rates are at least equal to the generally applicable payment rates of the issuer indicated in paragraph (d) of this section.

SOURCE: 62 FR 16955, 17005, April 8, 1997; 62 FR 31669, June 10, 1997; 76 FR 77411, Dec. 13, 2011; 77 FR 18468, March 27, 2012; 77 FR 18469, March 27, 2012; 77 FR 42670, July 20, 2012; 78 FR 12865, Feb. 25, 2013; 78 FR 15535, March 11, 2013; 78 FR 39528, July 1, 2013; 79 FR 30350, May 27, 2014, unless otherwise noted.

AUTHORITY: Title I of the Affordable Care Act, sections 1301–1304, 1311–1313, 1321–1322, 1324, 1334, 1342–1343, 1401–1402, Pub.L. 111–148, 124 Stat. 119 (42 U.S.C. 18021–18024, 18031–18032, 18041–18042, 18044, 18054, 18061, 18063, 18071, 18082, 26 U.S.C. 36B, and 31 U.S.C. 9701).

Current through Jan. 22, 2015; 80 FR 3181.

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