AMENDED IN SENATE MARCH 22, 2021

AMENDED IN SENATE MARCH 9, 2021

SENATE BILL No. 221

Introduced by Senator Wiener
(Coauthors: Senators Leyva*, Kamlager,* and Newman)
(Coauthors: Assembly Members ~~Arambula, Kamlager,~~ *Arambula* and Waldron)

January 13, 2021

An act to amend Sections 1367.03 and 1367.031 of the Health and Safety Code, and to amend Section 10133.53 of, and to add Section 10133.54 to, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 221, as amended, Wiener. Health care coverage: timely access to care.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires each department to develop and adopt regulations to ensure that enrollees and insureds have access to needed health care services in a timely manner. Under existing law, a Medi-Cal managed care plan is required to comply with timely access standards developed by the department.

Existing regulations require a health care service plan or an insurer to ensure that their contracted provider networks have adequate capacity and availability of licensed health care providers to offer enrollees and insureds appointments that meet specified timeframes. Existing regulations require a health care service plan or an insurer to ensure

that for an enrollee requesting a nonurgent appointment with a nonphysician mental health care provider, or an insured requesting a nonurgent appointment with a nonphysician mental health care or substance use disorder provider, appointments are offered within 10 business days of the request for an appointment. Existing regulations also authorize appointments for preventive care services and periodic followup care, including periodic office visits to monitor and treat mental health or substance use disorder conditions, as specified, to be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the provider's scope of practice. These regulations of the Department of Managed *Health* Care are limited in application to mental health care providers, while those regulations of the Department of Insurance are applicable to both mental health care and substance use disorder providers.

This bill would codify the regulations adopted by the Department of Managed Health Care and the Department of Insurance to provide timely access standards for health care service plans and insurers for nonemergency health care services. The bill would require both a health care service plan and a health insurer, including a Medi-Cal Managed Care Plan, to ensure that appointments with nonphysician mental health and substance use disorder providers are subject to the timely access requirements. The bill would additionally require a health care service plan and a health insurer, including a Medi-Cal Managed Care Plan, to ensure that an enrollee or insured that is undergoing a course of treatment for an ongoing mental health or substance use disorder condition is able to get a followup appointment with a nonphysician mental health care or substance use disorder provider within 10 business days of the prior appointment. *The bill would require that a referral to a specialist by another provider meet the timely access standards.* If a health care service plan is operating in a service area that has a shortage of providers and the plan is not able to meet the geographic and timely access standards for providing mental health or substance use disorder services with an in-network provider, the bill would require the plan, including a Medi-Cal Managed Care Plan, to arrange coverage outside the plan's contracted network. By imposing new requirements on health care service plans, the willful violation of which would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. The Legislature finds and declares all of the following:

(a) It is the intent of the Legislature to ensure that all enrollees of health care service plans and health insurers who require ongoing courses of medically necessary treatment for mental health and substance use disorders are able to obtain followup appointments with nonphysician providers of mental health and substance use disorder services within timeframes that are clinically appropriate to care for their diagnoses.

(b) Existing law and regulations have been interpreted to set clear timely access standards for health care service plans and health insurers to meet enrollees' requests for initial appointments with nonphysician providers of mental health and substance use disorder services, but not to set similarly clear timely access standards for the provision of followup appointments with these providers for the many enrollees who need them.

(c) This loophole in existing law and regulations has resulted in failures to provide enrollees followup appointments with nonphysician providers of mental health and substance use disorder services within the timeframes consistent with generally accepted standards of care.

(d) Closing this loophole is urgently necessary to address the widespread and lengthy delays in access to followup appointments with nonphysician providers of mental health and substance use disorder services experienced by thousands of Californians, including individuals suffering from major disorders and reporting suicidal ideation.

(e) Closing this loophole has grown even more urgent as the prevalence of mental health and substance use disorders has increased dramatically during the COVID-19 pandemic, and efforts

to meet increased demand have focused on providing initial appointments while timely access to appropriate followup care has further diminished.

SEC. 2. Section 1367.03 of the Health and Safety Code is amended to read:

1367.03. (a) A health care service plan that provides or arranges for the provision of hospital or physician services, including a specialized mental health plan that provides physician or hospital services, or that provides mental health services pursuant to a contract with a full service plan, shall comply with the following timely access requirements:

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

(2) A health care service plan shall ensure that all plan and provider processes necessary to obtain covered health care services, ~~including~~ *including, but not limited to,* prior authorization processes, are completed in a manner that assures the provision of covered health care services to an enrollee in a timely manner appropriate for the enrollee's condition and in compliance with this section.

(3) If it is necessary for a provider or an enrollee to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the enrollee's health care needs, and ensures continuity of care consistent with good professional practice, and consistent with this ~~section.~~ *section and the regulations adopted thereunder.*

(4) Interpreter services required by Section 1367.04 of this code and Section 1300.67.04 of Title 28 of the California Code of Regulations 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.~~ *appointment without imposing delay on the scheduling of the appointment.* This

subdivision does not modify the requirements established in Section 1300.67.04 of Title 28 of the California Code of Regulations, or approved by the department pursuant to Section 1300.67.04 of Title 28 of the California Code of Regulations for a plan's language assistance program.

(5) In addition to ensuring compliance with the clinical appropriateness standard set forth in paragraph (1), a health care service plan shall ensure that its contracted provider network has adequate capacity and availability of licensed health care providers to offer enrollees 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 subparagraph (H).

(B) Urgent care appointments for services that require prior authorization: within 96 hours of the request for appointment, except as provided in subparagraph (H).

(C) Nonurgent appointments for primary care: within 10 business days of the request for appointment, except as provided in subparagraphs (H) and (I).

(D) Nonurgent appointments with specialist physicians: within 15 business days of the request for appointment, except as provided in subparagraphs (H) and (I).

(E) Nonurgent appointments with a nonphysician mental health care or substance use disorder provider: within 10 business days of the request for appointment, except as provided in subparagraphs (H) and (I).

(F) Nonurgent followup appointments with a nonphysician mental health care or substance use disorder provider: within 10 business days of the prior appointment for those undergoing a course of treatment for an ongoing mental health or substance use disorder condition, except as provided in subparagraph (H).

(G) Nonurgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition: within 15 business days of the request for appointment, except as provided in subparagraphs (H) and (I).

(H) 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 their 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 enrollee.

(I) Preventive care services, as defined in subdivision (e), and periodic followup care, including standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac, 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 their practice.

(J) A referral to a specialist by a primary care provider or another specialist shall be subject to the relevant time-elapsed standard in subparagraph (A), (B), or (D) and shall be subject to the other provisions of this section.

~~(J)~~

(K) A plan may demonstrate compliance with the primary care time-elapsed standards established by this subdivision through implementation of standards, processes, and systems providing advanced access to primary care appointments, as defined in subdivision (e).

(6) In addition to ensuring compliance with the clinical appropriateness standard set forth at paragraph (1), each dental plan, and each full service plan offering coverage for dental services, shall ensure that contracted dental provider networks have adequate capacity and availability of licensed health care providers to offer enrollees appointments for covered dental services in accordance with the following requirements:

(A) Urgent appointments within the dental plan network shall be offered within 72 hours of the time of request for appointment, if consistent with the enrollee's individual needs and as required by professionally recognized standards of dental practice.

(B) Nonurgent appointments shall be offered within 36 business days of the request for appointment, except as provided in subparagraph (C).

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

(7) A plan shall ensure it has sufficient numbers of contracted providers to maintain compliance with the standards established by this section.

(A) This section does not modify the requirements regarding provider-to-enrollee ratio or geographic accessibility established by Section 1300.51, 1300.67.2, or 1300.67.2.1 of Title 28 of the California Code of Regulations.

(B) A plan operating in a service area that has a shortage of one or more types of providers shall ensure timely access to covered health care services as required by this section, including applicable time-elapsed standards, by referring an enrollee to, or, in the case of a preferred provider network, by assisting an enrollee to locate available and accessible contracted providers in neighboring service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the enrollee's health needs. A plan shall arrange for the provision of specialty services from specialists outside the plan's contracted network if unavailable within the network if medically necessary for the enrollee's condition. Enrollee costs for medically necessary referrals to nonnetwork providers shall not exceed applicable copayments, coinsurance, and deductibles. This requirement does not prohibit a plan or its delegated provider group from accommodating an enrollee's preference to wait for a later appointment from a specific contracted provider. If medically necessary treatment of a mental health or substance use disorder is not available in network within the geographic and timely access standards set by law or regulation, a health care service plan shall arrange coverage outside the plan's contracted network in accordance with subdivision (d) of Section 1374.72.

(8) A plan 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 (e).

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

(B) A plan may provide or arrange for the provision of telephone triage or screening services through one or more of the following means: plan-operated telephone triage or screening services, telephone medical advice services pursuant to Section 1348.8, the

plan's contracted primary care and mental health care *or substance use disorder* provider network, or another method that provides triage or screening services consistent with this section.

(i) A plan that arranges for the provision of telephone triage or screening services through contracted primary ~~care and mental health care~~ *care, mental health care, and substance use disorder* providers shall require those providers to maintain a procedure for triaging or screening enrollee telephone calls, which, at a minimum, shall include the employment, during and after business hours, of a telephone answering machine, an answering service, or office staff, that shall inform the caller of both of the following:

(I) Regarding the length of wait for a return call from the provider.

(II) How the caller may obtain urgent or emergency care, including, if 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.

(ii) A plan that arranges for the provision of triage or screening services through contracted primary ~~care and mental health care~~ *care, mental health care, and substance use disorder* providers who are unable to meet the time-elapsed standards established in subparagraph (A) shall also provide or arrange for the provision of plan-contracted or operated triage or screening services, which shall, at a minimum, be made available to enrollees affected by that portion of the plan's network.

(iii) An unlicensed staff person handling enrollee calls may ask questions on behalf of a licensed staff person to help ascertain the condition of an insured so that the enrollee may be referred to licensed staff. However, an unlicensed staff person shall not, under any circumstances, use the answers to those questions in an attempt to assess, evaluate, advise, or make a decision regarding the condition of an enrollee or determine when an enrollee needs to be seen by a licensed medical professional.

(9) Dental, vision, chiropractic, and acupuncture plans shall ensure that contracted providers employ an answering service or a telephone answering machine during nonbusiness hours, which provide instructions regarding how an enrollee may obtain urgent or emergency care, including, if 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.

(10) A plan shall ensure that, during normal business hours, the waiting time for an enrollee to speak by telephone with a plan customer service representative knowledgeable and competent regarding the enrollee's questions and concerns shall not exceed 10 minutes.

(b) Dental, vision, chiropractic, and acupuncture plans shall comply with paragraphs (1), (3), (4), (7), (9), and (10) of subdivision (a).

(c) The obligation of a plan to comply with this section shall not be waived if the plan delegates to its medical groups, independent practice associations, or other contracting entities any services or activities that the plan is required to perform. A plan's implementation of this section shall be consistent with the Health Care Providers' Bill of Rights, and a material change in the obligations of a plan's contracting providers shall be considered a material change to the provider contract, within the meaning of subdivision (b) and paragraph (2) of subdivision (h) of Section 1375.7.

~~(d) This section confirms requirements for plans to provide or arrange for the provision of access to health care services in a timely manner, and establishes additional metrics for measuring and monitoring the adequacy of a plan's contracted provider network to provide enrollees with timely access to needed health care services. This section does not do any of the following:~~

~~(1) Establish professional standards of practice for health care providers.~~

~~(2) Establish requirements for the provision of emergency services.~~

~~(3) Create a new cause of action or a new defense to liability for any person.~~

(d) A plan shall not prevent, discourage, or discipline a contracting provider or employee for informing an enrollee or subscriber about the timely access standards.

(e) For purposes of this section:

(1) "Advanced access" means the provision, by an individual provider, or by the medical group or independent practice association to which an enrollee is assigned, of appointments with a primary care physician, or other qualified primary care provider such as a nurse practitioner or physician's assistant, within the same or next business day from the time an appointment is

requested, and advance scheduling of appointments at a later date if the enrollee prefers not to accept the appointment offered within the same or the next business day.

(2) "Appointment waiting time" means the time from the initial request for health care services by an enrollee or the enrollee's treating provider to the earliest date offered for the appointment for services inclusive of time for obtaining authorization from the plan or completing any other condition or requirement of the plan or its contracting providers.

(3) "Preventive care" means health care provided for prevention and early detection of disease, illness, injury, or another health condition and, in the case of a full service plan includes all of the basic health care services required by paragraph (5) of subdivision (b) of Section 1345, and subdivision (f) of Section 1300.67 of Title 28 of the California Code of Regulations.

(4) "Provider group" has the meaning set forth as in subdivision (g) of Section 1373.65.

(5) "Triage" or "screening" means the assessment of an enrollee's health concerns and symptoms via communication with a physician, registered nurse, or other qualified health professional acting within their scope of practice and who is trained to screen or triage an enrollee who may need care for the purpose of determining the urgency of the enrollee's need for care.

(6) "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 their scope of practice and who is trained to screen or triage an enrollee who may need care.

(7) "Urgent care" means health care for a condition that requires prompt attention, consistent with paragraph (2) of subdivision (h) of Section 1367.01.

(f) (1) Contracts between health care service plans and health care providers shall ensure compliance with the standards developed under this chapter. These contracts shall require reporting by health care providers to health care service plans and by health care service plans to the department to ensure compliance with the standards.

(2) Health care service plans shall report annually to the department on compliance with the standards in a manner specified by the department. The reported information shall allow consumers

to compare the performance of plans and their contracting providers in complying with the standards, as well as changes in the compliance of plans with these standards.

(3) The department shall develop standardized methodologies for reporting that shall be used by health care service plans to demonstrate compliance with this section and any regulations adopted pursuant to it. The methodologies shall be sufficient to determine compliance with the standards developed under this section for different networks of providers if a health care service plan uses a different network for Medi-Cal managed care products than for other products or if a health care service plan uses a different network for individual market products than for small group market products. The department shall consult with stakeholders in developing standardized methodologies under this paragraph.

~~(g) (1) When evaluating compliance with the standards, the department shall focus more upon patterns of noncompliance rather than isolated episodes of noncompliance.~~

~~(2)~~

(g) (1) The director may investigate and take enforcement action against plans regarding noncompliance with the requirements of this section. Where substantial harm to an enrollee has occurred as a result of plan noncompliance, the director may, by order, assess administrative penalties subject to appropriate notice of, and the opportunity for, a hearing in accordance with Section 1397. The plan may provide to the director, and the director may consider, information regarding the plan's overall compliance with the requirements of this section. The administrative penalties shall not be deemed an exclusive remedy available to the director. These penalties shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45. The director shall periodically evaluate grievances to determine if any audit, investigative, or enforcement actions should be undertaken by the department.

~~(3)~~

(2) The director may, after appropriate notice and opportunity for hearing in accordance with Section 1397, by order, assess administrative penalties if the director determines that a health care service plan has knowingly committed, or has performed with

a frequency that indicates a general business practice, either of the following:

(A) Repeated failure to act promptly and reasonably to assure timely access to care consistent with this chapter.

(B) Repeated failure to act promptly and reasonably to require contracting providers to assure timely access that the plan is required to perform under this chapter and that have been delegated by the plan to the contracting provider when the obligation of the plan to the enrollee or subscriber is reasonably clear.

(C) The administrative penalties available to the director pursuant to this section are not exclusive, and may be sought and employed in any combination with civil, criminal, and other administrative remedies deemed warranted by the director to enforce this chapter.

~~(4)~~

(3) The administrative penalties shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45.

(h) The department shall work with the patient advocate to assure that the quality of care report card incorporates information provided pursuant to subdivision (f) regarding the degree to which health care service plans and health care providers comply with the requirements for timely access to care.

(i) The department shall annually review information regarding compliance with the standards developed under this section and shall make recommendations for changes that further protect enrollees. Commencing no later than December 1, 2015, and annually thereafter, the department shall post its final findings from the review on its internet website.

(j) The department shall post on its internet website any waivers or alternative standards that the department approves under this section on or after January 1, 2015.

(k) This section shall apply to Medi-Cal managed care plan contracts entered into with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code.

SEC. 3. Section 1367.031 of the Health and Safety Code is amended to read:

1367.031. (a) A health care service plan contract that is issued, renewed, or amended on or after July 1, 2017, shall provide information to an enrollee regarding the standards for timely access to care adopted pursuant to Section 1367.03 and the information required by this section, including information related to receipt of interpreter services in a timely manner, no less than annually.

(b) A health care service plan contract that is issued, renewed, or amended on or after July 1, 2022, shall provide information to an enrollee regarding the standards for timely access to care required by Section 1367.032, adopted pursuant to Section 1367.03, and the information required by this section, including information related to receipt of interpreter services in a timely manner, no less than annually.

(c) A health care service plan at a minimum shall provide information regarding appointment wait times for urgent care, nonurgent primary care, nonurgent specialty care, and telephone screening established in Section 1367.032 or pursuant to Section 1367.03 to enrollees and contracting providers. The information shall also include notice of the availability of interpreter services at the time of the appointment pursuant to Section 1367.04. A health care service plan may indicate that exceptions to appointment wait times may apply if the department has found exceptions to be permissible.

(d) The information required to be provided pursuant to this section shall be provided to an enrollee with individual coverage upon initial enrollment and annually thereafter upon renewal, and to enrollees and subscribers with group coverage upon initial enrollment and annually thereafter upon renewal. A health care service plan may include this information with other materials sent to the enrollee. The information shall also be provided in the following manner:

(1) In a separate section of the evidence of coverage titled "Timely Access to Care."

(2) At least annually, in or with newsletters, outreach, or other materials that are routinely disseminated to the plan's enrollees.

(3) Commencing January 1, 2018, in a separate section of the provider directory published and maintained by the health care service plan pursuant to Section 1367.27. The separate section shall be titled "Timely Access to Care."

(4) On the internet website published and maintained by the health care service plan, in a manner that allows enrollees and prospective enrollees to easily locate the information.

(e) (1) A health care service plan shall provide the information required by this section to contracting providers on no less than an annual basis.

(2) A health care service plan shall also inform a contracting provider of all of the following:

(A) Information about a health care service plan's obligation under California law to provide or arrange for timely access to care.

(B) How a contracting provider or enrollee can contact the health care service plan to obtain assistance if a patient is unable to obtain a timely referral to an appropriate provider.

(C) The toll-free telephone number for the Department of Managed Health Care where providers and enrollees can file a complaint if they are unable to obtain a timely referral to an appropriate provider.

(3) A health care service plan may comply with this subdivision by including the information with an existing communication with a contracting provider.

(f) This section shall apply to Medi-Cal managed care plan contracts entered into with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code.

SEC. 4. Section 10133.53 of the Insurance Code is amended to read:

10133.53. (a) (1) A health insurance policy that is issued, renewed, or amended on or after July 1, 2017, that provides benefits through contracts with providers for alternative rates pursuant to Section 10133 shall provide information to an insured regarding the standards for timely access to care adopted pursuant to Section 10133.5 and the information required by this section, including information related to receipt of interpreter services in a timely manner, no less than annually.

(2) A health insurance policy that is issued, renewed, or amended on or after July 1, 2022, that provides benefits through contracts with providers for alternative rates pursuant to Section 10133 shall provide information to an insured regarding the standards for timely

access to care required by Section 10133.54, adopted pursuant to Section 10133.5, and the information required by this section, including information related to receipt of interpreter services in a timely manner, no less than annually.

(b) A health insurer that contracts with providers for alternative rates of payment pursuant to Section 10133 shall, at a minimum, provide information regarding appointment wait times for urgent care, nonurgent primary care, nonurgent specialty care, and telephone screening established in Section 10133.54 or pursuant to Section 10133.5 to insureds and contracting providers. The information shall also include notice of the availability of interpreter services at the time of the appointment pursuant to Section 10133.8. A health insurer may indicate that exceptions to appointment wait times may apply if the department has found exceptions to be permissible.

(c) The information required to be provided pursuant to this section shall be provided to an insured with individual coverage upon initial enrollment and annually thereafter upon renewal, and to insureds and group policyholders with group coverage upon initial enrollment and annually thereafter upon renewal. An insurer may include this information with other materials sent to the insured. The information shall also be provided in the following manner:

(1) In a separate section of the evidence of coverage titled "Timely Access to Care."

(2) At least annually, in or with newsletters, outreach, or other materials that are routinely disseminated to the policy's insureds.

(3) Commencing January 1, 2018, in a separate section of the provider directory published and maintained by the insurer pursuant to Section 10133.15. The separate section shall be titled "Timely Access to Care."

(4) On the internet website published and maintained by the insurer, in a manner that allows insureds and prospective insureds to easily locate the information.

(d) (1) A health insurer shall provide the information required by this section to contracting providers on no less than an annual basis.

(2) A health insurer shall also inform a contracting provider of all of the following:

(A) Information about a health insurer's obligation under California law to provide or arrange for timely access to care.

(B) How a contracting provider or insured can contact the health insurer to obtain assistance if a patient is unable to obtain a timely referral to an appropriate provider.

(C) The toll-free telephone number for the Department of Insurance where providers and insureds can file a complaint if they are unable to obtain a timely referral to an appropriate provider.

(3) A health insurer may comply with this subdivision by including the information with an existing communication with a contracting provider.

SEC. 5. Section 10133.54 is added to the Insurance Code, to read:

10133.54. (a) This section applies to policies of health insurance, as defined by subdivision (b) of Section 106. The requirements of this section apply to all health care services covered by a health insurance policy.

(b) Notwithstanding Section 10133.5, a health insurer shall comply with the timely access requirements in this section, but a specialized health insurance policy as defined in subdivision (c) of Section 106, other than a specialized mental health insurance policy, is exempt from the provisions of this section, except as specified in paragraph (6) and subdivision (c).

(1) A health insurer shall provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the insured's condition, consistent with good professional practice. An insurer 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 shall demonstrate compliance with the standards established by this section based on providers available at the lowest cost-sharing tier.

(2) A health insurer shall ensure that all insurer 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 an insured in a timely manner appropriate for the insured's condition and in compliance with this section.

(3) If it is necessary for a provider or an insured to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the insured's health care needs, and ensures continuity of care consistent with good professional practice, and consistent with the objectives of Section 10133.5, the regulations adopted pursuant to Section 10133.5, and this section.

(4) Interpreter services required by Section 10133.8 of this code and Article 12.1 (commencing with Section 2538.1) of Title 10 of the California Code of Regulations 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 Section 2538.6 of Title 10 of the California Code of Regulations, without imposing delay on the scheduling of the appointment. This subdivision does not modify the requirements established in Section 10133.9 of this code and Section 2538.6 of Title 10 of the California Code of Regulations, or approved by the department pursuant to Section 2538.6 of Title 10 of the California Code of Regulations for an insurer's language assistance program.

(5) In addition to ensuring compliance with the clinical appropriateness standard set forth in paragraph (1), a health insurer shall ensure that its contracted provider network has adequate capacity and availability of licensed health care providers to offer insureds 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 subparagraph (H).

(B) Urgent care appointments for services that require prior authorization: within 96 hours of the request for appointment, except as provided in subparagraph (H).

(C) Nonurgent appointments for primary care: within 10 business days of the request for appointment, except as provided in subparagraphs (H) and (I).

(D) Nonurgent appointments with specialist physicians: within 15 business days of the request for appointment, except as provided in subparagraphs (H) and (I).

(E) Nonurgent appointments with a nonphysician mental health care or substance use disorder provider: within 10 business days

of the request for appointment, except as provided in subparagraphs (H) and (I).

(F) Nonurgent followup appointments with a nonphysician mental health care or substance use disorder provider: within 10 business days of the prior appointment for those undergoing a course of treatment for an ongoing mental health or substance use disorder condition, except as provided in subparagraph (H).

(G) Nonurgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition: within 15 business days of the request for appointment, except as provided in subparagraphs (H) and (I).

(H) 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 their 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 insured.

(I) Preventive care services, as defined in subdivision (e), and periodic follow up care, including standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac, 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 their practice.

(J) A referral to a specialist by a primary care provider or another specialist shall be subject to the relevant time-elapsed standard in subparagraph (A), (B) or (D) and shall be subject to the other provisions of this section.

(6) (A) The following types of health insurance policies shall be subject to the requirements in subparagraph (B):

(i) A health insurance policy covering the pediatric oral or vision essential health benefit.

(ii) A specialized health insurance policy that provides coverage for the pediatric oral essential health benefit, as defined in paragraph (5) of subdivision (a) of Section 10112.27.

(iii) A specialized health insurance policy that covers dental benefits only, as defined in subdivision (c) of Section 106.

(B) In addition to ensuring compliance with the clinical appropriateness standard set forth at paragraph (1), each health insurance policy specified in subparagraph (A) shall ensure that contracted oral or 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 or vision services in accordance with the following requirements:

(i) Urgent appointments within the plan network shall be offered within 72 hours of the time of request for appointment, if consistent with the insured's individual needs and as required by professionally recognized standards of dental practice.

(ii) Nonurgent appointments shall be offered within 36 business days of the request for appointment, except as provided in clause (iii).

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

(iv) The applicable waiting time for a particular appointment in this paragraph 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 insured.

(7) An insurer shall ensure it has sufficient numbers of contracted providers to maintain compliance with the standards established by this section.

(A) This section does not modify the requirements regarding accessibility established by Article 6 (commencing with Section 2240) of Title 10 of the California Code of Regulations.

(B) An insurer shall ensure timely access to covered health care services as required by this section, including applicable time-elapsed standards, by assisting an insured to locate available and accessible contracted providers in a timely manner appropriate for the insured's health needs. An insurer shall arrange for the provision of services outside the insurer's contracted network if unavailable within the network if medically necessary for the

insured's condition. Insured costs for medically necessary referrals to nonnetwork providers shall not exceed applicable in-network copayments, coinsurance, and deductibles.

(8) An insurer 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 (f).

(A) An insurer 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, telephone medical advice services pursuant to Section 10279, 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 this section.

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

(I) Regarding the length of wait for a return call from the provider.

(II) How the caller may obtain urgent or emergency care, including, if 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.

(ii) An insurer that arranges for the provision of triage or screening services through contracted primary care and mental health care and substance use disorder providers who are unable to meet the time-elapsed standards established in subparagraph (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 insureds affected by that portion of the insurer's network.

(iii) An unlicensed staff person handling insured calls may ask questions on behalf of a licensed staff person to help ascertain the condition of an insured so that the insured may be referred to licensed staff. However, an unlicensed staff person shall not, under any circumstances, use the answers to those questions in an attempt to assess, evaluate, advise, or make a decision regarding the condition of an insured or determine when an insured needs to be seen by a licensed medical professional.

(9) A health insurance policy providing coverage for the pediatric oral and vision essential health benefit, and a specialized health insurance policy that provides coverage for dental care expenses only, shall require that contracted providers employ an answering service or a telephone answering machine during nonbusiness hours, which provides instructions regarding how an insured may obtain urgent or emergency care, including, if 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.

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

(c) Notwithstanding subdivision (b), a specialized health insurance policy, as defined in subdivision (c) of Section 106, other than a specialized mental health insurance policy, is exempt from this section, except as specified in this subdivision. A specialized health insurance policy that provides coverage for dental care expenses only shall comply with paragraphs (1), (3), (4), (6), (7), (9), and (10) of subdivision (b).

(d) An insurer shall not prevent, discourage, or discipline a contracting provider or employee for informing an insured or policyholder about the timely access standards.

~~(d)~~

(e) For purposes of this section:

(1) "Appointment waiting time" means the time from the initial request for health care services by an insured or the insured'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 a full service insurer includes, but is not limited to, all of the services required by all of the following laws:

(A) Section 146.130 of Title 45 of the Code of Federal Regulations.

(B) Section 10112.2 (incorporating the requirements of Section 2713 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-13)).

(C) Clause (ii) of subparagraph (A) of paragraph (2) of subdivision (a) of Section 10112.27.

(3) "Provider group" has the meaning set forth in subdivision (v) of Section 10133.15.

(4) "Triage" or "screening" means the assessment of an insured's health concerns and symptoms via communication with a physician, registered nurse, or other qualified health professional acting within their 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 insured'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 their 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 which requires prompt attention, consistent with paragraph (2) of subdivision (h) of Section 10123.135.

SEC. 6. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within

the meaning of Section 6 of Article XIII B of the California Constitution.

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