

**STATE OF CALIFORNIA  
DEPARTMENT OF INSURANCE  
45 Fremont Street, 24<sup>th</sup> Floor  
San Francisco, California 94105**

**UPDATED INFORMATIVE DIGEST**

**PROVIDER NETWORK ACCESS STANDARDS  
FOR HEALTH INSURANCE POLICIES AND AGREEMENTS**

**(also known as Network Provider Provisions  
In Health Insurance Policies And Agreements)**

OAL Notice File Number: Z-06-1114-04

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November 21, 2007

**PROCEDURAL HISTORY**

On November 22, 2006, the Department of Insurance gave notice of the proposed adoption of amendments to California Code of Regulations (“CCR”) Title 10, Chapter 5, Subchapter 3, Article 6, section 2240, 2240.1, 2240.2, 2240.3, and 2240.4, as well as the proposed adoption of a new section, section 2240.5. Notice of the proposed regulatory action was published in the Notice Register on November 24, 2006.

The notice stated that proposed changes and new section would implement the provisions of Insurance Code section 10133.5, as amended by Assembly Bill 2179 by requiring that health insurers that contract with providers for alternative rates pursuant to Insurance Code section 10133 demonstrate compliance with accessibility and availability standards regarding access to covered health care services including continuity of care, and further require that these insurers file network access measurement documents that demonstrate compliance with the proposed standards in these regulations with the Department of Insurance along with other related documents including sample provider contracts.

On September 21, 2007, and again on October 24, 2007, after considering public comments on regarding the proposed regulation, the Department of Insurance made available for public inspection certain changes to the regulation text as initially proposed. The changes were sufficiently related to the rulemaking as originally noticed such that a reasonable member of the directly affected public could have determined from the original notice that these changes could have resulted. (Cal.Code Regs., tit. 1, §42.) The following informative digest has been updated to reflect these changes, and also revised for clarification.

## **UPDATE OF INFORMATIVE DIGEST**

### **POLICY STATEMENT OVERVIEW**

In the 2002 session, the Legislature enacted Assembly Bill 2179, regarding standards that would require health insurers (regulated by the Department of Insurance) and health maintenance organizations (regulated by the Department of Managed Health Care) to provide their insureds with adequate numbers of professional providers and institutional facilities, located in sufficient proximity to their insureds, so as to ensure that their insureds can access needed health care services in a timely manner.

In enacting Assembly Bill 2179, the Legislature made the following finding:

It is the intent of the Legislature to ensure that all enrollees of health care service plans and health insurers have timely access to health care. The Legislature finds and declares that timely access to health care is essential to safe and appropriate health care and that lack of timely access to health care may be an indicator of other systemic problems such as lack of adequate provider panels, fiscal distress of a health care service plan or a health care provider, or shifts in the health needs of a covered population. It is the further intent of the Legislature in enacting this section that the department shall incorporate the standards developed under this section in licensing, survey, enforcement, and other processes intended to protect the consumer.

### **SUMMARY OF EXISTING LAW; EFFECT OF PROPOSED ACTION**

#### **Summary of Existing Law:**

Assembly Bill 2179 amended Insurance Code section 10133.5 to require that the Insurance Commissioner promulgate regulations to ensure that insure have the opportunity to access needed health care services in a timely manner. (AB 2179 also amended Health and Safety Code sections 1342 and 1367, and added Section 1367.03 to require a similar, but significantly different, regulatory response from the Department of Managed Health Care.

As amended, Insurance Code section 10133.5 requires, in pertinent part, as follows:

(a) The commissioner shall, on or before January 1, 2004, promulgate regulations applicable to health insurers which contract with providers for alternative rates pursuant to Section 10133 to ensure that insureds have the opportunity to access needed health care services in a timely manner.

(b) These regulations shall be designed to assure accessibility of

provider services in a timely manner to individuals comprising the insured or contracted group, pursuant to benefits covered under the policy or contract. The regulations shall insure:

**1.** Adequacy of number and locations of institutional facilities and professional providers, and consultants in relationship to the size and location of the insured group and that the services offered are available at reasonable times.

**2.** Adequacy of number of professional providers, and license classifications of such providers, in relationship to the projected demands for services covered under the group policy or plan. The department shall consider the nature of the specialty in determining the adequacy of professional providers.

**3.** The policy or contract is not inconsistent with standards of good health care and clinically appropriate care.

**4.** All contracts including contracts with providers, and other persons furnishing services, or facilities shall be fair and reasonable.

**(c)** In developing standards under subdivision (a), the department shall also consider requirements under federal law; requirements under other state programs and law, including utilization review; and standards adopted by other states, national accrediting organizations and professional associations. The department shall further consider the accessibility to provider services in rural areas.

**(d)** In designing the regulations the commissioner shall consider the regulations in Title 28, of the California Administrative Code of Regulations, commencing with Section 1300.67.2, which are applicable to Knox-Keene plans, and all other relevant guidelines in an effort to accomplish maximum accessibility within a cost efficient system of indemnification. The department shall consult with the Department of Managed Health Care concerning regulations developed by that department pursuant to Section 1367.03 of the Health and Safety Code and shall seek public input from a wide range of interested parties.

**(e)** Health insurers that contract for alternative rates of payment with providers shall report annually on complaints received by the insurer regarding timely access to care. The department shall review these complaints and any complaints received by the department regarding timeliness of care and shall make public this information.

Insurance Code section 10133.5 is the authority for the proposed revisions to California

Code of Regulations Title 10, Chapter 5, Subchapter 3, Article 6, section 2240, 2240.1, 2240.2, 2240.3, and 2240.4, as well as the proposed new section, section 2240.5.

The existing regulation, 10 CCR sections 2240 through 2240.4, promulgated in 1984 , applied to Exclusive Provider Organizations (“EPOs”), in which insurers developed an exclusive, closed network of providers from whom their insureds could obtain covered health care services. EPOs typically do not pay for care received outside of the closed network, and may restrict the geographic area in which care can be obtained. In calendar year 2005,EPO policies covered only 10,000 people out of a total of 2.7 million people covered by health insurance policies regulated by the Department in California. EPO insureds lives continue to decline each year in California as closed network arrangements are discontinued. In response to the legislative mandate of Insurance Code section 10133.5, the Commissioner proposes these modifications and additions to the existing EPO regulations so as to make them applicable to both EPOs and Preferred Provider Organizations (PPOs), which are by far the more common type of network arrangement. PPOs usually consist of open network arrangements in which insureds can receive health care from providers within the insurer’s network, or from providers outside the network on a limited indemnity basis. PPOs may have limited geographic areas wherein they provide service, or may instead provide both network and non-network services across the country, or even worldwide. However, the proposed regulations apply only to provider networks within California.

In both EPOs and PPOs, the insurer, in establishing provider networks for their insureds, contract with providers (such as hospitals, medical groups, or individual providers) to provide health care to its insureds at alternative rates, as described in Insurance Code section 10133.

**Effect of Proposed Action:**

The specific proposed amendments and their effect are discussed below.

**SPECIFIC PURPOSE AND REASONABLE NECESSITY FOR REGULATIONS:**

The specific purpose of each regulation and the rationale for the Commissioner’s determination that each regulation is reasonably necessary to carry out the purpose for which it is proposed is set forth below.

**TITLE 10, CHAPTER 5, SUBCHAPTER 3, ARTICLE 6**

**SECTION 2240. Definitions**

This proposed section modified the pre-existing definitions of the EPO regulation, broadening the definitions so as to make them applicable to all provider network arrangement, including PPOs.

2240(a): “Basic Health Care Services”

PURPOSE

The existing regulation uses the term “basic health services” in existing section 2240.1(a) to describe the insurer’s obligation to provide adequate hours and days of availability of care, and to contract with providers located in reasonable proximity to the insureds. The proposed amendment to the definitional section, section 2240(a), adds mental health services as one of the components of “basic health services,” and also clarifies that the definition applies to other health care services covered under an insurance contract.

NECESSITY AND RATIONALE

Insurance Code section 10133.5 requires that the Commissioner promulgate regulations “to ensure that insureds have the opportunity to access needed health care services in a timely manner. The Commissioner has determined that these amendments are necessary to clarify the existing regulation to make it clear that the term “basic health services” includes health care services covered under the insurance contract. Further, the “mental health care services” was added as a component of the definition to bring the regulation into conformity with Insurance Code section 10144.5, which requires parity between mental health benefits and other benefits offered under disability policies that cover hospital, medical, or surgical expenses.

AUTHORITY AND REFERENCE

Authority: Insurance Code section 10133.5. **Reference: Insurance Code section 10144.5.**

2240(b): “Certificate”

PURPOSE

“Insurance” was added to the phrase “a group insurance contract.”

NECESSITY AND RATIONALE

Addition of the term “insurance” was necessary to ensure clarity, in order to distinguish these contracts from contracts between insurers and providers, which are discussed elsewhere in the regulation.

AUTHORITY AND REFERENCE

Insurance Code section 10133.5.

2240(c): “Covered Person”

PURPOSE

The phrase “eligible to receive basic health care services under the insurance contract providing network provider services” was added to clarify that “covered person” refers to the services covered under the applicable insurance contract.

#### NECESSITY AND RATIONALE

The Commissioner determined that this change was necessary to clarify that the scope of the provision was limited to the services covered under the insurance contract.

#### AUTHORITY AND REFERENCE

Insurance Code section 10133.5.

2240(d): “Dependent covered person”

#### PURPOSE

The term “an insurance contract” was substituted for “a group contract” in order to clarify that the regulation applied to insurance contracts other than group insurance, and that this definition pertained to coverage under an insurance contract, not other contracts, such as those between an insurer and a provider.

#### NECESSITY AND RATIONALE

The Commissioner determined that this change was necessary to clarify the type of insurance contracts involved in this definition, and that the definition was limited to insurance contracts.

#### AUTHORITY AND REFERENCE

Insurance Code section 10133.5.

2240(f): “Network Provider”

#### PURPOSE

This paragraph of the existing regulation applied only to “exclusive providers” and therefore only Exclusive Provider Organizations. The amendments to this paragraph broaden the definition to “network providers,” so that the term can be used to describe all arrangements where insurers organize networks of providers to provide services to their insureds at alternative rates.

#### NECESSITY AND RATIONALE

Insurance Code section 10133.5 requires that the Commissioner promulgate regulations that apply to health insurers that contract for services at alternative rates, creating provider networks. The Commissioner determined the promulgation of this regulation required that a definition of “network provider” be available, and so this definition was amended to provide that needed definition.

#### AUTHORITY AND REFERENCE

Insurance Code section 10133.5.

240(g): “Network Provider Services”

PURPOSE

This paragraph of the existing regulation applied only to “exclusive providers” and therefore only Exclusive Provider Organizations. The amendments to this paragraph broaden the definition to “network providers,” so that the term can be used to describe all arrangements where insurers organize networks of providers to provide services to their insureds at alternative rates. The amendment also clarifies that the amendment applies only to services covered under an insurance contract, and that it applies to all such contracts, not just group contracts.

NECESSITY AND RATIONALE

Insurance Code section 10133.5 requires that the Commissioner promulgate regulations that apply to health insurers that contract for services at alternative rates, creating provider networks. The Commissioner determined the promulgation of this regulation required that a definition of “network provider services” be available, and so this definition was amended to provide that needed definition.

AUTHORITY AND REFERENCE

Insurance Code section 10133.5.

2240(h): “Non-Network Provider Services”

PURPOSE

This new paragraph defines “non-network provider services.”

NECESSITY AND RATIONALE

Insurance Code section 10133.5 requires that the Commissioner promulgate regulations that apply to health insurers that contract for services at alternative rates, creating provider networks. Because this amended regulation makes a distinction between network and non-network services the Commissioner determined that clarity would be enhanced by explicitly defining “non-network” services.

AUTHORITY AND REFERENCE

Insurance Code section 10133.5.

(former) 2240(h): “Group contract”

PURPOSE

As the amended regulation applies to all health insurance, and not just those pursuant to a group contract, this definition is no longer needed, and so was deleted.

### NECESSITY AND RATIONALE

Insurance Code section 10133.5 requires that the Commissioner promulgate regulations that apply to all health insurers that contract for services at alternative rates, creating provider networks, not just to group contracts. Because this amended regulation is no longer limited to group insurance policies, this definition is no longer necessary, and so, in the interests of clarity, was deleted.

### AUTHORITY AND REFERENCE

Insurance Code section 10133.5.

2240(j): “Insurer”

### PURPOSE

The term “nonprofit hospital service plan” was stricken as redundant, and the term “as defined in Section 106(b)” was added to clarify that the term “insurer” in the context of this regulation means an insurers who provides health insurance as now defined in Insurance Code section 106(b). In addition, the definition now makes clear that “insurer” includes those who contract with providers for alternate rates of payment.

### NECESSITY AND RATIONALE

Insurance Code section 10133.5 requires that the Commissioner promulgate regulations that apply to health insurers that contract for services at alternative rates, as described in Insurance Code section 10133, creating provider networks. The amendments to the definition are necessary in order to clarify the scope of the term “insured” as used in this regulation.

### AUTHORITY AND REFERENCE

Authority: Insurance Code section 10133.5. Reference: Insurance Code section 106(b), 10133, 10133.5.

2240(l): “Primary covered person”

### PURPOSE

The existing EPO regulation defined “primary covered person” in terms of a group contract or membership in a group. This amendment to the definition broadened the definition to that was no longer limited to group coverage

### NECESSITY AND RATIONALE

Insurance Code section 10133.5 requires that the Commissioner promulgate regulations that apply to health insurers that contract for services at alternative rates, creating provider networks; it is not limited to group coverage. Therefore, it is necessary to modify this definition in order for the scope of the definition to be consonant with the broader scope of section 10133.5

### AUTHORITY AND REFERENCE

Insurance Code section 10133.5.

2240(m): “Service Area”

PURPOSE

Some EPOs provide services to their insureds in a limited geographic area, referred to as a “service area.” Some PPOs also have a limited service area. This amended definition substitutes “network” for “exclusive,” in order that the term will have a scope commensurate with the scope of Insurance Code section 10133.5.

NECESSITY AND RATIONALE

Insurance Code section 10133.5 requires that the Commissioner promulgate regulations that apply to health insurers that contract for services at alternative rates, creating provider networks; it applies to both PPOs and EPOs. Therefore, it is necessary to modify this definition in order for the scope of the definition to be consonant with the broader scope of section 10133.5

AUTHORITY AND REFERENCE

Insurance Code section 10133.5.

2240(m): “Network”

PURPOSE

This new definition provides a definition of “network,” a term not previously used in the regulation, but now used throughout to describe the enlarged scope of the regulation.

NECESSITY AND RATIONALE

Insurance Code section 10133.5 requires that the Commissioner promulgate regulations that apply to health insurers that contract for services at alternative rates. The Commissioner has determined that the term “networks” is commonly used to describe the arrays of providers made available to insureds at alternative rates, and that a definition of the term for use in this regulation is necessary, and promotes clarity. The definition describes networks incorporating the “provide services at alternative rates” description contained in Insurance Code section 10133. Also, the definition provides that “networks” includes arrays of providers obtained by an insurer by contracting with another entity. This portion of the definition is necessary because the Commissioner has determined that the legislative intent in enacting Insurance Code 10133.5, that “all enrollees of health care service plans and health insurers have timely access to health care” (emphasis added), requires that these amended regulations apply to both networks established through direct contracts between the insurer and providers, as well as to networks in which the insurer contracts with an intermediary. Accordingly, this change is necessary in order to clarify that the amended regulation applies to all such contracts, in order to achieve the intent of Insurance Code 10133.5.

AUTHORITY AND REFERENCE

Insurance Code section 10133.5.

## **SECTION 2240.1. Adequacy and Accessibility of Provider Services.**

### **PURPOSE**

The amendments to the existing regulation broaden the scope of the regulation from EPOs to all network provider arrangements. It also provides for specific time and distance standards in order to ensure timely access. As initially proposed, these amendments included requirements that insurers provide care through non-network providers at network rates if the standards could not be met, as well as an exemption for “physical impossibility.” These latter proposals were subsequently deleted in response to comments, and replaced with a discretionary waiver provision.

### **NECESSITY AND RATIONALE**

Insurance Code section 10133.5 requires that these regulations “shall be designed to assure accessibility of network provider services in a timely manner to individuals comprising the insured or contracted group, pursuant to benefits covered under the policy or contract.” The changes to section 2240.1 address this statutory mandate and insure the first two requirements of the statute, namely:

1. Adequacy of number and locations of institutional facilities and professional network providers, and consultants in relationship to the size and location of the insured group and that the services offered are available at reasonable times.
2. Adequacy of number of professional network providers, and license classifications of such network providers, in relationship to the projected demands for services covered under the group policy or plan, including consideration of the nature of the medical specialty in determining the adequacy of professional network providers.

The existing EPO regulation provided a non-specific requirement for insurers to have written procedures for monitoring accessibility of care, and for a minimum ratio of physicians and primary care physician per number of covered persons. The Commissioner has determined that, as a consequence of the mandate of Insurance Code section 10133.5, which requires that these regulations “insure...adequacy of number and locations” and license classifications of professional providers, the proposed changes to section 2240.1 are necessary, including:

- 1) changing 2240.1(b)(2) to include a requirement that decisions be made by “appropriate” health care professionals, to assure that the professionals making decisions have the appropriate training for the decisions under consideration,
- 2) Specific time and distance standards.

The Commissioner has determined that specific time and distance standards are necessary to comply with the mandate of Insurance Code section 10133.5, which requires that the regulation be designed to “assure accessibility of provider services in a timely manner.” In arriving at this determination, the Commissioner considered the results of a broad solicitation of information the Department undertook regarding the types of standards used by insurers in California to assess their networks for access. The information obtained indicated that most California insurers

utilize time and distance standards to evaluate their networks using software products that determine if a given network falls within specified criteria.. Time and distance information is also used as a marketing tool to compete for clients

Pursuant to Insurance Code section 10133.5(c) and (d), the Department also consulted with the Department of Managed Health Care, and considered the regulations developed by that department pursuant to Section 1367.03 of the Health and Safety Code. However, the authorizing statute for DMHC’s timely access regulations differs significantly from Insurance Code section 10133.5. For example, Health & Safety Code section 1367.03(a)(1) provides that DMHC is to use appointment waiting times as an indicator of timeliness to access of care. In contrast, Insurance Code section 10133.5 does not mention waiting times as a criterion; this reflects, in part, the fact that, while waiting times are an appropriate measure for EPO and DMHC PPO products, other measures are needed to reflect the different nature of the PPO and other provider network-based products regulated by the Department of Insurance. In developing the present regulations, the Commissioner has determined that measuring health access requires the use of specific metrics in addition to waiting times (as already provided in the existing regulation) in order to fully meet the requirements of section 10133.5. The Department also considered the access requirements under federal law, the requirements of other states, and the requirements of other state programs. Based on this information, the Commissioner determined that the specific time and distance standards reflected in the regulation will appropriately ensure that insureds have the opportunity to access needed health care services in a timely manner, while at the same time reflecting current industry best practices. The specific time and distance standards reflected in the proposed regulation represent a determination by the Commissioner of reasonable requirements for time and distance proximity between the providers in the networks and the residence and workplaces of the insureds. These standards reflect both travel time standards, which are sensitive to the traffic conditions in urban locations, and distance standards, which reflect suburban and rural access conditions.

#### AUTHORITY AND REFERENCE

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

### **SECTION 2240.2: Insurance Contract Provisions**

#### PURPOSE

The proposed amendments eliminate obsolete references to “group” and “exclusive,” consistent with the broader scope of the proposed regulation. Also, the proposed amendment updates 2240.2(d), which provides for continuity of care, by including a reference to Insurance Code section 10133.56, the code section that now controls completion of coverage for covered conditions.

#### NECESSITY AND RATIONALE

The changes proposed to this section are necessary to make this section consistent with the other sections by removing the reference to “group” contracts, since the regulations will

apply to all contracts. Also, the changes that delete the references to “exclusive” and substitute “network” are necessary to reflect that the ambit of the regulation is no longer limited to EPOs, but, rather applies to all network arrangements; this change is necessary for clarity and consistency. Incorporating the provisions of Insurance Code 10133.56 by reference is necessary to update the regulatory requirements by including the statutory requirements pertaining to continuity of care. The existing regulation was promulgated in 1984; Insurance Code section 10133.56 was, first enacted in 1998, more than ten years after the existing regulation was promulgated. Incorporating the reference to the statute will add clarity regarding the applicable continuity of care requirements.

#### AUTHORITY AND REFERENCE

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

#### **SECTION 2240.3: Provisions of Certificates.**

##### PURPOSE

The proposed amendments eliminate obsolete references to “group” and “exclusive,” consistent with the broader scope of the proposed regulation. Surplus references to compliance with applicable law are deleted.

In 2240.3(c), references to the limitations of exclusive provider benefits are eliminated, replaced by a requirement that certificates clearly specify any difference in coverage between network and non-network services, as well as services obtained in and out of any geographically limited service area, if applicable.

Similarly, the changes to 2240.3 (e) eliminate the obsolete provision that applies only to exclusive providers (a listing of principal exclusive providers), substituting instead a requirement that network providers, or information regarding obtaining a directory, be provided. In this regard, former subdivision (f) is surplus, and is deleted.

A new subdivision, 2240.3(f), has been added, noting the disclosure requirement of Insurance Code section 510, which requires the disclosure of the Department’s consumer affairs unit to new insureds.

##### NECESSITY AND RATIONALE

The changes proposed to this section are necessary to make this section consistent with the other sections by removing the reference to “group” contracts, since the regulations will apply to all contracts. Also, the changes that delete the references to “exclusive” and substitute “network” are necessary to reflect that the ambit of the regulation is no longer limited to EPOs, but, rather applies to all network arrangements; this change is necessary for clarity and consistency. References to compliance with applicable law are deleted as surplus, in the interest of clarity.

The changes to 2240.3(c), in which references to the limitations of exclusive provider benefits are eliminated, replaced by a requirement that certificates clearly specify any difference in coverage between network and non-network services, as well as services obtained in and out of any geographically limited service area, if applicable, are necessary in order to eliminate the obsolete exclusive provider provision, and instead require disclosures that will provide insureds with the information needed to access needed health care services in a timely manner, consistent with Insurance Code section 10133.5.

The changes to 2240.3 (e), which eliminate the obsolete provision that applies only to exclusive providers (a listing of principal exclusive providers), substituting instead a requirement that network providers, or information regarding obtaining a directory, be provided, are necessary in order to assure that insureds can obtain information regarding how their network benefits can be accessed, consistent with the intent of Insurance Code section 10133.5 regarding accessibility of network health benefits. The elimination of the obsolete and redundant former subdivision (f) is necessary for clarity.

The new subdivision, 2240.3(f), regarding the disclosure requirement of Insurance Code section 510, is necessary because Insurance Code section 10133.5(e) requires that the Department review and make public complaints received by the Department regarding timeliness of care. The Commissioner has determined that including the disclosure requirements of Insurance Code section 510 in these regulations is necessary in order to ensure that consumers will be aware of the Department's complaint process, so that the Department may obtain the information required for compliance with section 10133.5(e).

#### AUTHORITY AND REFERENCE

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

### **SECTION 2240.4: Contracts with Providers.**

#### PURPOSE

The proposed amendments eliminate obsolete references to “group” and “exclusive,” with the addition instead of the term “network,” consistent with the broader scope of the proposed regulation. The proposed amendments also provide for standards regarding fairness and reasonableness.

#### NECESSITY AND RATIONALE

These amendments are necessary because Insurance Code section 10133.5(b)(4) requires that these regulations shall insure that all contracts including contracts with providers, and other persons furnishing services, or facilities shall be fair and reasonable. The Commissioner has determined that requiring that a non-discrimination provision be included as a requirement for such contracts is necessary in order to satisfy the fairness component of this statutory requirement. Further, that such non-discrimination provisions protect insureds and help guarantee their timely access to needed covered health services consistent with the authorizing statute.

Other changes proposed to this section are necessary to make this section consistent with the other sections by removing the reference to “group” contracts, since the regulations will apply to all contracts. Also, the changes that delete the references to “exclusive” and substitute “network” are necessary to reflect that the ambit of the regulation is no longer limited to EPOs, but, rather applies to all network arrangements; this change is necessary for clarity and consistency. Other changes are made for the purpose of making this section easier to read.

#### AUTHORITY AND REFERENCE

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

### **SECTION 2240.5. Filing and Reporting Requirements**

#### PURPOSE

This new section requires that insurers file the following with the Department of Insurance:

- 1) A report demonstrating compliance with the accessibility and availability requirements of the regulations. The report is to include a description of the number and location of all network providers utilized by the insurer to provide services to covered persons, and
- 2) A copy of the written procedures used to monitor and evaluate accessibility of care, and
- 3) Copies of the most commonly used network provider contracts used by the insurer, or by its agents in the case of a leased network.

The above reports and documents are to be filed concurrently with the filing of any new policy form submitted to the Department for approval. All insurers are to file these documents by June 30, 2008 for existing policies. The new section also requires that, for new product filings, insurers may instead file an affidavit or attestation stating that the networks to be used are substantially the same as a previously filed network. Insurers must notify the Department whenever a network falls out of compliance with the regulations, and submit a corrective action plan.

This new section also requires that insurers report annually to the Department regarding complaints pertaining to timely access to care. The report is to include a summary based on specified categories of service.

#### NECESSITY AND RATIONALE

AB 2179 (Chapter 297, 2002 Regular Session, section 1) also stated that “[I]t is the further intent of the Legislature in enacting this section that the department shall incorporate the standards developed under this section in licensing, survey, enforcement, and other processes intended to protect the consumer.” The reporting requirements established by this section are in furtherance of this legislative intent.

Insurance Code section 10133.5(b) requires that these regulations be designed to assure accessibility of provider services in a timely manner. The Commissioner has determined that it is necessary for insurers to report regarding compliance with these regulations, so that accessibility can be assured, as required by the statute, and so that the Department can monitor compliance with these regulations. The purpose of this monitoring is both to ensure that insureds have the opportunity to access needed health care services in a timely manner, as required by Insurance Code section 10133.5(a), and also to generate data regarding compliance that can be utilized in the triennial review of this regulation, as required by Insurance Code section 10133.5.

Similarly, Insurance Code section 10133.5(b) (3) and (4) requires that policies or contracts for provider services be not inconsistent with the standards of good health care and clinically appropriate care, and that all contracts, including contracts with providers, shall be fair and reasonable. The Commissioner has determined that it is necessary that insurers file examples of the most commonly utilized network provider contracts so that compliance with the requirements of Insurance Code sections 10133.5(b)(3) and (4) can be assured, as required by those sections, and to generate data for the triennial review required by Insurance Code section 10133.5. The Commissioner has also determined that it is necessary to permit insurers an alternative method of demonstrating compliance by attesting to substantial similarity with a previously filed network, in order to avoid needless expense and duplication of effort on the part of both the Department and the insurers. The Commissioner has determined that it is necessary to set a compliance date of June 30, 2008 for the specified reports, so as to permit adequate time for insurers to aggregate the required data, while at the same time assuring that provider services are accessible, within a reasonable time, for the benefit of the insured.

Insurance Code section 10133.5(e) requires that health insurers report annually regarding complains received by the insurer regarding timely access to care. This statute also requires that the Department review the information and make it public. This proposed regulation is necessary because requires that complaint information required by the statute be submitted, and because it specifies the manner in which the complaint data shall be organized and summarized in order to facilitate the review and public availability requirements established by Insurance Code section 10133.5(e).

#### AUTHORITY AND REFERENCE

Note: Authority cited: Section 10133.5, Insurance Code Reference: Section 10133, 10133.5

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