

**California Department of Insurance  
Draft Revision to Network Adequacy Regulation  
for Discussion at June 30, 2014 Workshop**

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

**§ 2240. Definitions.**

As used in this Article:

- (a) “Fundamental health care services” means any of the following covered health care services provided for in the applicable insurance contract or certificate of coverage:
- (1) For individual or small employer coverage, essential health benefits as described in Insurance Code section 10112.27 and section 2594.3 of title 10 of the California Code of Regulations.
  - (2) For large group coverage, “fundamental health care services” includes:
    - (A) Physician services, including consultation and referral.
    - (B) Hospital inpatient services and ambulatory care services.
    - (C) Diagnostic laboratory diagnostic and therapeutic radiologic services, and other diagnostic services.
    - (D) Home health services.
    - (E) Preventive health services, including as required to be covered under section 10112.2 of the Insurance Code.
    - (G) Emergency and urgent health care services, including ambulance services.
    - (H) Hospice services
    - (I) Mental health care and substance use disorder services including those intended to meet the requirements of Insurance Code 10144.5 and 10144.51.
    - (J) Any other health care or supportive services that are covered pursuant to an insurance contract.
- (b) “Certificate” means an individual or family certificate of coverage issued pursuant to an insurance contract.
- (c) “Covered person” means either a primary covered person or a dependent covered person eligible to receive fundamental health care services under the insurance contract providing network provider services.
- (d) “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) “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.

(f) “Essential Community Provider” (ECP) means a provider organization that by legal obligation, organizational mission, or geographic location serve a patient population that is or has been at-risk for inadequate access to care that include, but are not limited to, low income and uninsured; medically underserved rural or urban areas; or those with special care needs such as children with serious illness, persons with mental health and substance abuse disorders, the chronically ill, or target communities such as the homeless, persons with HIV/AIDS, and migrant workers. Essential Community Providers include the following:

(1) Providers listed in the Center for Medicare & Medicaid Services (CMS) non-exhaustive list of available 340B providers in the Public Health Service Act and section 1927(c)(1)(D)(i)(IV) of the Social Security Act.

(2) Facilities listed on the California Disproportionate Share Hospital Program, Final DSH Eligibility List.

(3) Federally designated 638 Tribal Health Programs and Title V Urban Indian Health Programs.

(4) Community Clinics or health centers licensed as either a “community clinic” or “free clinic”, by the State of California under Section 1204(a) of the Health and Safety Code, or a community clinic or free clinic exempt from licensure under Section 1206.

(5) Physician Providers with approved application for the HI-TECH Medi-Cal Electronic Health Record Incentive Program.

(6) Federally Qualified Health Centers (FQHCs).

(i g) “Health care professional” means a licensee or certificate holder ~~enumerated~~ described in Insurance Code 10176 as of the effective date of this Article or as that Section may be amended thereafter or a non-physician medical practitioner as defined in Insurance Code section 10133.4.

(j h) “Insurer” means an insurer who provides “health insurance” as defined in Section 106(b) of the Insurance Code, 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 of the Insurance Code.

(k i) “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 of payment 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.

(l j) “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 of payment.

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

(n l) “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.

(o m) “Primary care provider” means a physician, nurse practitioner, or physician’s assistant who is responsible for providing initial, preventive and primary care to patients, for maintaining the continuity of patient care, and who or for initiating referrals

for specialist care. A primary care physician may be either a physician whose ~~has limited~~ his practice of medicine is limited to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist or family practitioner.

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

(m o) “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.

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

### **§ 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, except that the provisions of this article apply to any policy covering the pediatric vision and/or dental essential health benefit described in Insurance Code 10112.27.

(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, 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 fundamental 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~~ persons with disabilities.

(4) Fundamental 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) Fundamental 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 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. The network has sufficient primary care providers in such numbers and distribution as to accord to all enrollees a ratio of at least one primary care provider (on a full-time equivalent basis) to each 2,000 enrollees.

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

(3) The network includes hospitals with sufficient capacity to serve the entire population of covered persons based on normal utilization.

(4) 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.

(5) 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.

(6) There are mental health professionals with skills appropriate to care for the mental health 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 it may be clinically necessary for a network to have services available in closer proximity to affected covered persons than the minimum time and proximity standards stated above.

(A) Adequate networks include crisis intervention and stabilization, psychiatric inpatient hospital services, including voluntary psychiatric inpatient services, and services from mental health providers.

There must be mental health providers of sufficient number and type to provide diagnosis and medically necessary treatment of conditions covered by the plan through providers acting within their scope of license and scope of competence established by education, training, and experience to diagnose and treat conditions found in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* or other recognized diagnostic manual or standard.

(B) An insurer must establish a reasonable standard for the number and geographic distribution of mental health providers who can treat serious 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 described in subdivision (c) section 10144.51 of the Insurance Code.

The insurer must measure the adequacy of the mental health network against this standard at least twice a year, and submit an action plan with the commissioner if the standard is not met. The insurer must submit a narrative report describing the adequacy of its mental health network to the Department for approval annually.

(C) Emergency mental health services, including crisis intervention and crisis stabilization services, must be included in an insurer's provider network.

(D) An insurer must include a sufficient number and type of mental health and substance use disorder treatment providers and facilities within a service area based on normal utilization patterns.

(E) An insurer must ensure that an enrollee can identify information about mental health services and substance use disorder treatment including benefits, providers, coverage, and other relevant information by calling a customer service representative during normal business hours.

(7) 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.

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

(9) The network includes an adequate number of network outpatient 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 on the primary care provider are available from contracting or plan-operated providers at locations (where enrollees are personally served) within a reasonable distance from the primary care provider.

(10) Networks should 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, should 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.

(d) Networks must provide adequate access for the following specialties:

1. Acupuncture
2. Addiction Medicine;
3. Allergy and Immunology;
4. Anesthesiology;
5. Bariatric (Weight Loss) Surgery;
6. Cancer Surgery;
7. Cardiothoracic Surgery;
8. Cardiovascular Disease;
9. Cardiovascular Surgery;
10. Chiropractic
11. Clinical Psychology;
12. Colorectal Surgery;
13. Critical Care Medicine;
14. Dentistry. Orthodontics, Oral Surgery;

15. Dermatology;
16. Electrophysiology;
17. Emergency Medicine;
18. Endocrinology, Diabetes and Metabolism;
19. Family Medicine;
20. Gastroenterology;
21. Geriatric Medicine
22. Geriatric Psychiatry;
23. Gynecologic Oncology;
24. Gynecology;
25. Hand Surgery;
26. Hematology;
27. HIV Disease Specialist;
28. Hospitalist;
29. Infectious Disease;
30. Internal Medicine;
31. Interventional Cardiology;
32. Maternal and Fetal Medicine;
33. Medical Oncology;
34. Microsurgery;
35. Neonatal-Perinatal Medicine;
36. Nephrology;
37. Neurology and Subspecialties;
38. Neurosurgery;
39. Nuclear Medicine;
40. Obstetrics and Gynecology;
41. Ophthalmology and Optometry;
42. Oral and Maxillofacial Surgery;
43. Orthopaedics;
44. Orthopaedic Surgery;
45. Otolaryngology (Ear, Nose and Throat);
46. Pain Management;
47. Pathology;
48. Pediatrics;
49. Pediatric Anesthesiology;
50. Pediatric Cardiology;
51. Pediatric Ophthalmology;
52. Pediatric Surgery;

53. Pediatric Subspecialties not covered above;
54. Physical Medicine and Rehabilitation;
55. Plastic Surgery;
56. Podiatry;
57. Psychiatry;
58. Pulmonary Disease;
59. Radiation Oncology;
60. Radiology;
61. Reconstructive Surgery;
62. Reproductive Endocrinology;
63. Rheumatology;
64. Sleep Medicine;
65. Spine Surgery;
66. Sports Medicine;
67. Surgery;
68. Surgical Critical Care;
69. Thoracic Surgery;
70. Vascular Surgery; and
71. Urology.

( e) An adequate network must also demonstrate the capacity to provide transplant surgery for at least heart, heart/lung, kidney, liver, lung, pancreas, stem cell, and bone marrow. If the services are not available within the network in compliance with the network adequacy standard for acute inpatient hospitals, the insurer in its network adequacy report must identify and locate each transplant center in its network by name and address.

(f) A service area or network must not be created in a manner designed to discriminate or that results in discrimination against persons because of age, gender, actual or perceived gender identity or on the basis that the insured is a transgender person, sexual orientation, disability, national origin, sex, family structure, ethnicity,race, health condition, employment status, or socioeconomic status.

(g) An insurer shall include a sufficient number and geographic distribution of essential community providers in its networks for products sold through the California Health Benefit Exchange to ensure reasonable and timely access to a broad range of providers for at-risk populations.

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

(i) Notwithstanding the above, the Commissioner may determine that certain medical needs require ~~network specialty care~~ 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 10133.5(b) (3), support such modification.

(j) 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.~~

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

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

#### **§ 2240.2. Insurance Contract Provisions.**

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

(a) A provision for coverage on an indemnity or provision of service basis for emergency health care services rendered to covered persons outside the service area.

(b) A provision that the insurer shall give written notice to the group contract holder, within a reasonable period of time, of any termination or permanent breach of contract by, or permanent inability to perform of, any network provider if such termination, breach or inability would materially and adversely affect the contract holder or covered persons or will result in the insurer's network not being in compliance with this article.

(c) A provision that the contract holder shall distribute to the primary covered persons the substance of any notice given to the contract holder pursuant to subsection (b) not later than 30 days after its receipt.

(d) A provision that, pursuant to Insurance Code Section 10133.56, upon termination of a network provider contract, the insurer shall be liable for covered services rendered by such provider to a covered person under the care of such provider at the time of termination until such services are completed, unless reasonable and medically appropriate arrangements for assumption of such services by another network provider are made. This provision need not provide that the insurer shall be liable for any services rendered to a covered person after such person ceases to be eligible for coverage under the insurance contract.

(e) A provision defining the service area.

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

**§ 2240.3. Provisions of Policies and Certificates.**

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

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

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

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

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

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

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

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

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

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

**§ 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 network.

~~(a)~~ (b) Effective June 30, 2008, e 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 gender, actual or perceived gender identity or on the basis that the insured is a transgender person, 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.

(c) Insurers shall afford essential community providers equal opportunity to participate in contracts for alternative rates of payment.

(1) An insurer shall not discriminate against a provider on the basis of the provider qualifying as an essential community provider.

(2) When contracting with an essential community provider, an insurer shall offer rates of payment at least equal to 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.

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

#### **§ 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 accompanying documents, as follows:

(1) Beginning on March 31, 2015, and annually thereafter on March 31, upon filing of new or amended policy forms, or upon request from the Commissioner, a network adequacy report for all health insurance policies providing current coverage or new health insurance policies.

(2) 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 fundamental health care services, the insurer shall at the same time file a network adequacy report, with the Policy Approval Bureau of the California Department of Insurance:

(b) The network adequacy report, 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) The network adequacy report 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, all specified specialty types, 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, such as a report produced using software offered by Quest Analytics or Optum Inc. (GeoAccess GeoNetworks)~~software offered by Ingenix Corporation.~~

(2) A description of the service area covered by the network, by geographic rating region, county, or zip code, and describing any change to the service area since the prior filing.

(d) The following documents must be submitted with the network 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 their network.

(5) The mental health access report described in section 2240.1(c)(6).

~~(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) An insurer ~~must~~ shall 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.

(7) Health insurers that contract for alternative rates of payment with providers shall annually submit a report through 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:

(A) a summary of receipt and resolution of complaints regarding access to or availability of any of the following services from covered persons by type of service:

primary care services, specialty care services, mental health professional services and hospital services.

(B) 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.

(C) The summaries in (1) and (2) above shall include the following:

(1) Total number of complaints over the last year.

(2) Identity of complainant.

(3) Description of complaint

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

(5) Date complaint received.

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

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

(8) Description of complaint resolution, if applicable.

(D) 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.

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

(9) The rate of compliance, during the reporting period, with the time elapsed standards set forth in Section 2240.1(c). An insurer may develop data regarding rates of compliance through statistically reliable sampling methodology, including but not limited to provider and insured survey processes;

(10) Whether the insurer identified, during the reporting period,

(A) any incidents of noncompliance resulting in substantial harm to an insured or

(B) any patterns of non-compliance and, if so, a description of the identified non-compliance and the insurer's responsive investigation, determination and corrective action;

(11) A list of all providers utilizing advanced access appointment scheduling;

(12) 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;

(13) The results of the most recent annual insured and provider surveys and a comparison with the results of the prior year's survey, including a discussion of the relative change in survey results; and

(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 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.

(d.) The information required by Section 2240.5(c) shall be included with the annual report submitted through SERFF 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 Section 2240.5(c) shall be submitted directly to the web portal.

(e) In determining an insurer's compliance or non-compliance with the requirements of this section, the Department will focus more upon patterns of non-compliance than isolated episodes of non-compliance and may consider all relevant factors, including but not limited to:

(1) The efforts by an insurer to evade the standards, such as referring insureds to providers who are not appropriate for an insured's condition;

(2) The nature and extent of an insurer's efforts to avoid or correct non-compliance, including whether an insurer has taken all necessary and appropriate action to identify the cause(s) underlying identified timely access deficiencies and to bring its network into compliance;

(3) The nature of physician practices, including group and individual practices, the nature of an insurer's network, and the nature of the health care services offered;

(4) The nature and extent to which a single instance of non-compliance results in, or contributes to, serious injury or damages to an insured; and

(5) 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.

(f) Other factors established in relevant provisions of law, and other factors that the Director deems appropriate in the public interest and consistent with the intent and purpose of the Act as applied to specific facts or circumstances.

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

**§ 2240.6. Notice and Information to Covered Persons.**

(a) Printed network provider directories shall be updated at least quarterly and shall be offered to accommodate individuals with limited English or non-English proficiency or disabilities. An insurer may satisfy this update requirement by providing an insert or addendum to any existing provider listing. This requirement shall not mandate a complete republishing of the insurer's provider directory.

(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 daily.

(c) 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, and how to obtain the paper copy at no cost, in its coverage materials if no paper copy is automatically provided to the covered person at least annually.

(d) If an insurer has more than one provider network, its posted provider directories shall make it reasonably clear to a covered person which network applies to the coverage.

(e) The network provider directory shall inform covered persons regarding the availability of foreign language and interpreter services pursuant to CIC § 10133.8.

(f) The network provider directory shall list the following for each provider:

(1) The specialty area or areas of each provider licensed and included in the network

(2) The providers who are not currently accepting new patients

(3) Whether the provider may be accessed without referral

(4) The locations, including address, and contact information for the provider

(g) Insurers shall ensure that, during normal business hours, the waiting time for an insured to speak by telephone with an insurance company's customer service representative knowledgeable and competent regarding the insured's questions and concerns shall not exceed ten minutes.

**§ 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.

(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 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 health plan's service area.

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(c) An alternate access delivery system shall provide covered persons with access to medically necessary care on a reasonable basis without detriment to their health.

(d) The insurer shall ensure that the 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 or shall make arrangements acceptable to the Commissioner.

(1) Copayments and deductible requirements shall apply to alternate access delivery systems at the same level they are applied to in-network services.

(2) The alternate access delivery system may result in the insurer payment of billed charges to ensure network access.

(e) The insurer shall demonstrate in its alternate access delivery request a reasonable basis for not meeting a standard as part of its request for waiver, and include an explanation of why the alternative access delivery system provides sufficient number and type of provider or facility to which the standard applies to covered persons.

(f) An insurer shall demonstrate in its alternate access delivery system how it will assist covered persons to locate providers and facilities in a manner that assures both availability and accessibility.

(1) 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.

(2) Alternate access delivery systems include, but are not limited to, such insurer strategies as use of out-of-state and out of county or service area providers or facilities and exceptions to network standards based upon rural locations in the service area.

(g) The application should 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 to be offered to the affected insurer's covered persons, including but not limited to, telemedicine, phone consultation, etc.

(3) The reason or reasons set forth in subdivision (b).

(4) Any identified issues or risks that may prevent the alternate access delivery system from meeting the requirement set forth in subdivision (c).

(5) A description of how the alternate access delivery system will comply with subdivisions (d), (e), and (f).

(h) 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 under this article.

(2) The alternate access delivery system complies with subdivision (c).

(i) The practice of entering into a single case provider or facility reimbursement agreement with a provider or facility in relation to a specific covered person's condition or treatment requirements is not an alternative access delivery system for purposes of establishing an adequate provider network. A single case provider reimbursement agreement shall be used only to address unique situations that typically occur out of network and out of service area, where a covered person required services that extend beyond stabilization or one time urgent care. Single case provider reimbursement agreements must not be used to fill holes or gaps in a network for the entire population of covered persons under a plan, and do not support a determination of network access.

### **§ 2240.8. Network Access Appointment Waiting Time Standards**

(a) This section confirms requirements for insurers to provide or arrange for the provision of access to health care services in a timely manner pursuant to subdivision (b) of Section 10133.5 of the Insurance Code, and establishes additional metrics for measuring and monitoring the adequacy of an insurer's contracted provider network to provide covered persons with timely access to needed health care services. This section does not:

- (1) Establish professional standards of practice for health care providers;
- (2) Establish requirements for the provision of emergency services; or
- (3) Create a new cause of action or a new defense to liability for any person.

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

(1) "Advanced access" means the provision, by an individual provider, or by a medical group, 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 covered person prefers not to accept the appointment offered within the same or next business day.

(2) "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.

(3) "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 45 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.

(4) "Provider group" has the meaning set forth in subsection (g) of Section 10133.56 of the Insurance Code.

(5) “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.

(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 his or her scope of practice and who is trained to screen or triage an insured who may need care.

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

(c) 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. This subsection does not modify the requirements established in Sections 10133.8 or 10133.9.

(5) In addition to ensuring compliance with the clinical appropriateness standard set forth at subsection (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 (G);

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

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

(D) Non-urgent appointments with specialist physicians: within fifteen business days of the request for appointment, except as provided in (G) and (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 (G) and (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 (G) and (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 subsection (b)(3), 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; and

(I) An insurer may demonstrate compliance with the primary care time-elapsed standards established by this subsection through implementation of standards, processes and systems providing advanced access to primary care appointments, as defined at subsection (b)(1).

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

(A) Urgent appointments within the dental 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 dental practice;

(B) Non-urgent appointments shall be offered within 36 business days of the request for appointment, except as provided in subsection (c)(6)(C); and

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

(7) Insurers shall ensure they have 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 adequacy and accessibility established by this Article.

(B) An insurer 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 covered persons to, or, in the case of a preferred provider network, by assisting covered persons 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 covered person's health needs. Insurers shall arrange for the provision services outside the insurer's contracted network if unavailable within the network, when medically necessary for the covered person's condition. Covered person costs for medically necessary referrals to non-network providers shall not exceed applicable co-payments, co-insurance and deductibles. This requirement does not prohibit an insurer or its delegated provider group from accommodating a covered person's preference to wait for a later appointment from a specific contracted provider.

(8) 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 at subsection (b)(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 subsection (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 subsection.

(1) 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.

(2) 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 (8)(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.

(3) 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.

(9) Insurers shall ensure that, during normal business hours, the waiting time for an 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.

(d) 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 subsection (c);

(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 at subsection (c);

(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 subsection (c);

(D) Reviewing and evaluating, on not less than a quarterly basis, 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; and

(E) Verifying the advanced access programs reported by contracted providers, medical groups and independent practice associations to confirm that appointments are scheduled consistent with the definition of advanced access in subsection (b)(1).

(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.

(e) Insured Disclosure and Education

(1) Insurers shall disclose in all 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 covered person's communications, 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 or its delegated provider group may comply with this requirement through an additional selection in its automated customer service telephone answering system, where applicable, so long as the customer service number is included on the covered person's membership card.