

Introduced by Senator Wiener**(Coauthors: Senators Leyva and Newman)**

(Coauthors: Assembly Members Arambula, Kamlager, and Waldron)

January 13, 2021

An act to amend Section 1367.031 of, and to add Section 1367.032 to, the Health and Safety Code, and to amend Section 10133.53 of, and to add Section 10133.54 to, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

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

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

Existing regulations require a health care service plan or an insurer to ensure that their contracted provider networks have adequate capacity and availability of licensed health care providers to offer enrollees and insureds appointments that meet specified timeframes. Existing regulations require a health care service plan or an insurer to ensure that for an enrollee requesting a nonurgent appointment with a nonphysician mental health care provider, or an insured requesting a nonurgent appointment with a nonphysician mental health care or substance use disorder provider, appointments are offered within 10 business days of the request for an appointment. Existing regulations

also authorize appointments for preventive care services and periodic followup care, including periodic office visits to monitor and treat mental health or substance use disorder conditions, as specified, to be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the provider's scope of practice. These regulations of the Department of Managed Care are limited in application to mental health care providers, while those regulations of the Department of Insurance are applicable to both mental health care and substance use disorder providers.

This bill would codify the regulations adopted by the Department of Managed Health Care and the Department of Insurance to provide timely access standards for health care service plans and insurers for nonemergency health care services. The bill would require both a health care service plan and a health insurer to ensure that appointments with nonphysician mental health and substance use disorder providers are subject to the timely access requirements. The bill would additionally require a health care service plan or a health insurer to ensure that an enrollee or insured that is undergoing a course of treatment for an ongoing mental health or substance use disorder condition is able to get a followup appointment with a nonphysician mental health care or substance use disorder provider within 10 business days of the prior appointment. By imposing new requirements on health care service plans, the willful violation of which would be a crime, the bill would impose a state-mandated local program.

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

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

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

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

- 1 SECTION 1. The Legislature finds and declares all of the
- 2 following:
- 3 (a) It is the intent of the Legislature to ensure that all enrollees
- 4 of health care service plans and health insurers who require ongoing
- 5 courses of medically necessary treatment for mental health and

1 substance use disorders are able to obtain followup appointments
2 with nonphysician providers of mental health and substance use
3 disorder services within timeframes that are clinically appropriate
4 to care for their diagnoses.

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

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

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

23 (e) Closing this loophole has grown even more urgent as the
24 prevalence of mental health and substance use disorders has
25 increased dramatically during the COVID-19 pandemic, and efforts
26 to meet increased demand have focused on providing initial
27 appointments while timely access to appropriate followup care has
28 further diminished.

29 SEC. 2. Section 1367.031 of the Health and Safety Code is
30 amended to read:

31 1367.031. (a) A health care service plan contract that is issued,
32 renewed, or amended on or after July 1, 2017, shall provide
33 information to an enrollee regarding the standards for timely access
34 to care adopted pursuant to Section 1367.03 and the information
35 required by this section, including information related to receipt
36 of interpreter services in a timely manner, no less than annually.

37 (b) *A health care service plan contract that is issued, renewed,*
38 *or amended on or after July 1, 2022, shall provide information to*
39 *an enrollee regarding the standards for timely access to care*
40 *required by Section 1367.032, adopted pursuant to Section*

1 1367.03, and the information required by this section, including
2 information related to receipt of interpreter services in a timely
3 manner, no less than annually.

4 (b)

5 (c) A health care service plan at a minimum shall provide
6 information regarding appointment wait times for urgent care,
7 nonurgent primary care, nonurgent specialty care, and telephone
8 screening established in Section 1367.032 or pursuant to Section
9 1367.03 to enrollees and contracting providers. The information
10 shall also include notice of the availability of interpreter services
11 at the time of the appointment pursuant to Section 1367.04. A
12 health care service plan may indicate that exceptions to
13 appointment wait times may apply if the department has found
14 exceptions to be permissible.

15 (e)

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

24 (1) In a separate section of the evidence of coverage titled
25 “Timely Access to Care.”

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

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

32 (4) On the ~~Internet Web site~~ *internet website* published and
33 maintained by the health care service plan, in a manner that allows
34 enrollees and prospective enrollees to easily locate the information.

35 (d)

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

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

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

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

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

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

14 (e)

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

20 SEC. 3. Section 1367.032 is added to the Health and Safety
21 Code, to read:

22 1367.032. (a) Notwithstanding Section 1367.03, a health care
23 service plan that provides or arranges for the provision of hospital
24 or physician services, including a specialized mental health plan
25 that provides physician or hospital services, or that provides mental
26 health services pursuant to a contract with a full service plan, shall
27 comply with the following timely access requirements:

28 (1) A health care service plan shall provide or arrange for the
29 provision of covered health care services in a timely manner
30 appropriate for the nature of the enrollee’s condition consistent
31 with good professional practice. A plan shall establish and maintain
32 provider networks, policies, procedures, and quality assurance
33 monitoring systems and processes sufficient to ensure compliance
34 with this clinical appropriateness standard.

35 (2) A health care service plan shall ensure that all plan and
36 provider processes necessary to obtain covered health care services,
37 including prior authorization processes, are completed in a manner
38 that assures the provision of covered health care services to an
39 enrollee in a timely manner appropriate for the enrollee’s condition
40 and in compliance with this section.

1 (3) If it is necessary for a provider or an enrollee to reschedule
2 an appointment, the appointment shall be promptly rescheduled
3 in a manner that is appropriate for the enrollee's health care needs,
4 and ensures continuity of care consistent with good professional
5 practice, and consistent with the objectives of Section 1367.03 and
6 this section.

7 (4) Interpreter services required by Section 1367.04 of this code
8 and Section 1300.67.04 of Title 28 of the California Code of
9 Regulations shall be coordinated with scheduled appointments for
10 health care services in a manner that ensures the provision of
11 interpreter services at the time of the appointment. This subdivision
12 does not modify the requirements established in Section 1300.67.04
13 of Title 28 of the California Code of Regulations, or approved by
14 the department pursuant to Section 1300.67.04 of Title 28 of the
15 California Code of Regulations for a plan's language assistance
16 program.

17 (5) In addition to ensuring compliance with the clinical
18 appropriateness standard set forth in paragraph (1), a health care
19 service plan shall ensure that its contracted provider network has
20 adequate capacity and availability of licensed health care providers
21 to offer enrollees appointments that meet the following timeframes:

22 (A) Urgent care appointments for services that do not require
23 prior authorization: within 48 hours of the request for appointment,
24 except as provided in subparagraph (H).

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

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

31 (D) Nonurgent appointments with specialist physicians: within
32 15 business days of the request for appointment, except as provided
33 in subparagraphs (H) and (I).

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

38 (F) Nonurgent followup appointments with a nonphysician
39 mental health care or substance use disorder provider: within 10
40 business days of the prior appointment for those undergoing a

1 course of treatment for an ongoing mental health or substance use
2 disorder condition, except as provided in subparagraph (H).

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

7 (H) The applicable waiting time for a particular appointment
8 may be extended if the referring or treating licensed health care
9 provider, or the health professional providing triage or screening
10 services, as applicable, acting within the scope of their practice
11 and consistent with professionally recognized standards of practice,
12 has determined and noted in the relevant record that a longer
13 waiting time will not have a detrimental impact on the health of
14 the enrollee.

15 (I) Preventive care services, as defined in subdivision (e), and
16 periodic follow up care, including standing referrals to specialists
17 for chronic conditions, periodic office visits to monitor and treat
18 pregnancy, cardiac, mental health, or substance use disorder
19 conditions, and laboratory and radiological monitoring for
20 recurrence of disease, may be scheduled in advance consistent
21 with professionally recognized standards of practice as determined
22 by the treating licensed health care provider acting within the scope
23 of their practice.

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

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

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

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

4 (C) Preventive dental care appointments shall be offered within
5 40 business days of the request for appointment.

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

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

13 (B) A plan operating in a service area that has a shortage of one
14 or more types of providers shall ensure timely access to covered
15 health care services as required by this section, including applicable
16 time-elapsing standards, by referring an enrollee to, or, in the case
17 of a preferred provider network, by assisting an enrollee to locate
18 available and accessible contracted providers in neighboring service
19 areas consistent with patterns of practice for obtaining health care
20 services in a timely manner appropriate for the enrollee's health
21 needs. A plan shall arrange for the provision of specialty services
22 from specialists outside the plan's contracted network if unavailable
23 within the network if medically necessary for the enrollee's
24 condition. Enrollee costs for medically necessary referrals to
25 nonnetwork providers shall not exceed applicable copayments,
26 coinsurance, and deductibles. This requirement does not prohibit
27 a plan or its delegated provider group from accommodating an
28 enrollee's preference to wait for a later appointment from a specific
29 contracted provider.

30 (8) A plan shall provide or arrange for the provision, 24 hours
31 per day, 7 days per week, of triage or screening services by
32 telephone, as defined in subdivision (e).

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

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

1 plan’s contracted primary care and mental health care provider
2 network, or other method that provides triage or screening services
3 consistent with this section.

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

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

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

18 (ii) A plan that arranges for the provision of triage or screening
19 services through contracted primary care and mental health care
20 providers who are unable to meet the time-elapsd standards
21 established in subparagraph (A) shall also provide or arrange for
22 the provision of plan-contracted or operated triage or screening
23 services, which shall, at a minimum, be made available to enrollees
24 affected by that portion of the plan’s network.

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

33 (9) Dental, vision, chiropractic, and acupuncture plans shall
34 ensure that contracted providers employ an answering service or
35 a telephone answering machine during nonbusiness hours, which
36 provide instructions regarding how an enrollee may obtain urgent
37 or emergency care, including, if applicable, how to contact another
38 provider who has agreed to be on call to triage or screen by phone,
39 or if needed, deliver urgent or emergency care.

1 (10) A plan shall ensure that, during normal business hours, the
2 waiting time for an enrollee to speak by telephone with a plan
3 customer service representative knowledgeable and competent
4 regarding the enrollee's questions and concerns shall not exceed
5 10 minutes.

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

9 (c) The obligation of a plan to comply with this section shall
10 not be waived if the plan delegates to its medical groups,
11 independent practice associations, or other contracting entities any
12 services or activities that the plan is required to perform. A plan's
13 implementation of this section shall be consistent with the Health
14 Care Providers' Bill of Rights, and a material change in the
15 obligations of a plan's contracting providers shall be considered
16 a material change to the provider contract, within the meaning of
17 subdivision (b) and paragraph (2) of subdivision (h) of Section
18 1375.7.

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

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

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

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

31 (e) For purposes of this section:

32 (1) "Advanced access" means the provision, by an individual
33 provider, or by the medical group or independent practice
34 association to which an enrollee is assigned, of appointments with
35 a primary care physician, or other qualified primary care provider
36 such as a nurse practitioner or physician's assistant, within the
37 same or next business day from the time an appointment is
38 requested, and advance scheduling of appointments at a later date
39 if the enrollee prefers not to accept the appointment offered within
40 the same or the next business day.

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

7 (3) “Preventive care” means health care provided for prevention
8 and early detection of disease, illness, injury, or other health
9 condition and, in the case of a full service plan includes all of the
10 basic health care services required by paragraph (5) of subdivision
11 (b) of Section 1345 of this code, and Section 1300.67(f) of Title
12 28 of the California Code of Regulations.

13 (4) “Provider group” has the meaning set forth in subdivision
14 (g) of Section 1373.65.

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

21 (6) “Triage or screening waiting time” means the time waiting
22 to speak by telephone with a physician, registered nurse, or other
23 qualified health professional acting within their scope of practice
24 and who is trained to screen or triage an enrollee who may need
25 care.

26 (7) “Urgent care” means health care for a condition which
27 requires prompt attention, consistent with paragraph (2) of
28 subdivision (h) of Section 1367.01.

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

31 10133.53. (a) (1) A health insurance policy that is issued,
32 renewed, or amended on or after July 1, 2017, that provides benefits
33 through contracts with providers for alternative rates pursuant to
34 Section 10133 shall provide information to an insured regarding
35 the standards for timely access to care adopted pursuant to Section
36 10133.5 and the information required by this section, including
37 information related to receipt of interpreter services in a timely
38 manner, no less than annually.

39 (2) *A health insurance policy that is issued, renewed, or*
40 *amended on or after July 1, 2022, that provides benefits through*

1 *contracts with providers for alternative rates pursuant to Section*
2 *10133 shall provide information to an insured regarding the*
3 *standards for timely access to care required by Section 10133.54,*
4 *adopted pursuant to Section 10133.5, and the information required*
5 *by this section, including information related to receipt of*
6 *interpreter services in a timely manner, no less than annually.*

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

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

26 (1) In a separate section of the evidence of coverage titled
27 “Timely Access to Care.”

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

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

34 (4) On the ~~Internet Web site~~ *internet website* published and
35 maintained by the insurer, in a manner that allows insureds and
36 prospective insureds to easily locate the information.

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

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

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

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

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

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

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

17 10133.54. (a) Notwithstanding Section 10133.5, a health
18 insurer that provides or arranges for the provision of hospital or
19 physician services, including a specialized mental health insurer
20 that provides physician or hospital services, or that provides mental
21 health services pursuant to a contract with a full service insurer,
22 shall comply with the following timely access requirements:

23 (1) A health insurer shall provide or arrange for the provision
24 of covered health care services in a timely manner appropriate for
25 the nature of the insured’s condition, consistent with good
26 professional practice. An insurer shall establish and maintain
27 provider networks, policies, procedures, and quality assurance
28 monitoring systems and processes sufficient to ensure compliance
29 with this clinical appropriateness standard.

30 (2) A health insurer shall ensure that all insurer and provider
31 processes necessary to obtain covered health care services,
32 including prior authorization processes, are completed in a manner
33 that assures the provision of covered health care services to an
34 insured in a timely manner appropriate for the insured’s condition
35 and in compliance with this section.

36 (3) If it is necessary for a provider or an insured to reschedule
37 an appointment, the appointment shall be promptly rescheduled
38 in a manner that is appropriate for the insured’s health care needs,
39 and ensures continuity of care consistent with good professional

1 practice, and consistent with the objectives of Section 10133.5 and
2 this section.

3 (4) Interpreter services required by Section 10133.8 of this code
4 and Section 2538.6 of Title 10 of the California Code of
5 Regulations shall be coordinated with scheduled appointments for
6 health care services in a manner that ensures the provision of
7 interpreter services at the time of the appointment. This subdivision
8 does not modify the requirements established in Section 2538.6
9 of Title 10 of the California Code of Regulations, or approved by
10 the department pursuant to Section 2538.6 of Title 10 of the
11 California Code of Regulations for an insurer's language assistance
12 program.

13 (5) In addition to ensuring compliance with the clinical
14 appropriateness standard set forth in paragraph (1), a health insurer
15 shall ensure that its contracted provider network has adequate
16 capacity and availability of licensed health care providers to offer
17 insureds appointments that meet the following timeframes:

18 (A) Urgent care appointments for services that do not require
19 prior authorization: within 48 hours of the request for appointment,
20 except as provided in subparagraph (H).

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

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

27 (D) Nonurgent appointments with specialist physicians: within
28 15 business days of the request for appointment, except as provided
29 in subparagraphs (H) and (I).

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

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

39 (G) Nonurgent appointments for ancillary services for the
40 diagnosis or treatment of injury, illness, or other health condition:

1 within 15 business days of the request for appointment, except as
2 provided in subparagraphs (H) and (I).

3 (H) The applicable waiting time for a particular appointment
4 may be extended if the referring or treating licensed health care
5 provider, or the health professional providing triage or screening
6 services, as applicable, acting within the scope of their practice
7 and consistent with professionally recognized standards of practice,
8 has determined and noted in the relevant record that a longer
9 waiting time will not have a detrimental impact on the health of
10 the insured.

11 (I) Preventive care services, as defined in subdivision (e), and
12 periodic follow up care, including standing referrals to specialists
13 for chronic conditions, periodic office visits to monitor and treat
14 pregnancy, cardiac, mental health, or substance use disorder
15 conditions, and laboratory and radiological monitoring for
16 recurrence of disease, may be scheduled in advance consistent
17 with professionally recognized standards of practice as determined
18 by the treating licensed health care provider acting within the scope
19 of their practice.

20 (J) An insurer may demonstrate compliance with the primary
21 care time-elapsd standards established by this subdivision through
22 implementation of standards, processes, and systems providing
23 advanced access to primary care appointments, as defined in
24 subdivision (e).

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

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

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

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

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

4 (A) This section does not modify the requirements regarding
5 provider-to-insured ratio or geographic accessibility established
6 by Section 2240.1 of Title 10 of the California Code of
7 Regulations.

8 (B) An insurer operating in a service area that has a shortage of
9 one or more types of providers shall ensure timely access to
10 covered health care services as required by this section, including
11 applicable time-elapsd standards, by referring an insured to, or,
12 in the case of a preferred provider network, by assisting an insured
13 to locate available and accessible contracted providers in
14 neighboring service areas consistent with patterns of practice for
15 obtaining health care services in a timely manner appropriate for
16 the insured's health needs. An insurer shall arrange for the
17 provision of specialty services from specialists outside the insurer's
18 contracted network if unavailable within the network if medically
19 necessary for the insured's condition. Insured costs for medically
20 necessary referrals to nonnetwork providers shall not exceed
21 applicable copayments, coinsurance, and deductibles. This
22 requirement does not prohibit an insurer or its delegated provider
23 group from accommodating an insured's preference to wait for a
24 later appointment from a specific contracted provider.

25 (8) An insurer shall provide or arrange for the provision, 24
26 hours per day, 7 days per week, of triage or screening services by
27 telephone, as defined in subdivision (e).

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

32 (B) An insurer may provide or arrange for the provision of
33 telephone triage or screening services through one or more of the
34 following means: insurer-operated telephone triage or screening
35 services, telephone medical advice services pursuant to Section
36 10279, the insurer's contracted primary care and mental health
37 care provider network, or other method that provides triage or
38 screening services consistent with this section.

39 (i) An insurer that arranges for the provision of telephone triage
40 or screening services through contracted primary care and mental

1 health care providers shall require those providers to maintain a
2 procedure for triaging or screening insured telephone calls, which,
3 at a minimum, shall include the employment, during and after
4 business hours, of a telephone answering machine, an answering
5 service, or office staff, that shall inform the caller of both of the
6 following:

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

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

13 (ii) An insurer that arranges for the provision of triage or
14 screening services through contracted primary care and mental
15 health care providers who are unable to meet the time-elapsd
16 standards established in subparagraph (A) shall also provide or
17 arrange for the provision of insurer-contracted or operated triage
18 or screening services, which shall, at a minimum, be made available
19 to insureds affected by that portion of the insurer's network.

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

28 (9) Dental, vision, chiropractic, and acupuncture plans shall
29 ensure that contracted providers employ an answering service or
30 a telephone answering machine during nonbusiness hours, which
31 provide instructions regarding how an insured may obtain urgent
32 or emergency care, including, if applicable, how to contact another
33 provider who has agreed to be on call to triage or screen by phone,
34 or if needed, deliver urgent or emergency care.

35 (10) An insurer shall ensure that, during normal business hours,
36 the waiting time for an insured to speak by telephone with an
37 insurer customer service representative knowledgeable and
38 competent regarding the insured's questions and concerns shall
39 not exceed 10 minutes.

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

4 (c) The obligation of a health insurer to comply with this section
5 shall not be waived if the insurer delegates to its medical groups,
6 independent practice associations, or other contracting entities any
7 services or activities that the insurer is required to perform. An
8 insurer’s implementation of this section shall be consistent with
9 the Health Care Providers’ Bill of Rights, and a material change
10 in the obligations of an insurer’s contracting providers shall be
11 considered a material change to the provider contract, within the
12 meaning of subdivision (b) and paragraph (3) of subdivision (h)
13 of Section 10133.65.

14 (d) This section confirms requirements for insurers to provide
15 or arrange for the provision of access to health care services in a
16 timely manner, and establishes additional metrics for measuring
17 and monitoring the adequacy of an insurer’s contracted provider
18 network to provide insureds with timely access to needed health
19 care services. This section does not do any of the following:

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

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

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

26 (e) For purposes of this section:

27 (1) “Advanced access” means the provision, by an individual
28 provider, or by the medical group or independent practice
29 association to which an insured is assigned, of appointments with
30 a primary care physician, or other qualified primary care provider
31 such as a nurse practitioner or physician’s assistant, within the
32 same or next business day from the time an appointment is
33 requested, and advance scheduling of appointments at a later date
34 if the insured prefers not to accept the appointment offered within
35 the same or the next business day.

36 (2) “Appointment waiting time” means the time from the initial
37 request for health care services by an insured or the insured’s
38 treating provider to the earliest date offered for the appointment
39 for services inclusive of time for obtaining authorization from the

1 insurer or completing any other condition or requirement of the
2 insurer or its contracting providers.

3 (3) “Preventive care” means health care provided for prevention
4 and early detection of disease, illness, injury, or other health
5 condition and, in the case of a full service insurer includes all of
6 the basic health care services required by paragraph (5) of
7 subdivision (b) of Section 1345 of the Health and Safety Code,
8 and Section 2594.3 of Title 10 of the California Code of
9 Regulations.

10 (4) “Provider group” has the meaning set forth in subdivision
11 (v) of Section 10133.15.

12 (5) “Triage” or “screening” means the assessment of an insured’s
13 health concerns and symptoms via communication with a
14 physician, registered nurse, or other qualified health professional
15 acting within their scope of practice and who is trained to screen
16 or triage an insured who may need care for the purpose of
17 determining the urgency of the insured’s need for care.

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

23 (7) “Urgent care” means health care for a condition which
24 requires prompt attention, consistent with paragraph (2) of
25 subdivision (h) of Section 10123.135.

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

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