INSURANCE CODE - INS

DIVISION 2. CLASSES OF INSURANCE [1880 - 12880.8] *(Division 2 enacted by Stats. 1935, Ch. 145.)*

PART 2. LIFE AND DISABILITY INSURANCE [10110 - 11549] *(Part 2 enacted by Stats. 1935, Ch. 145.)*

CHAPTER 1. The Contract [10110 - 10198.10] *(Chapter 1 enacted by Stats. 1935, Ch. 145.)*

ARTICLE 2. Transfer [10129 - 10133.14] *(Article 2 enacted by Stats. 1935, Ch. 145.)*

10129. Sections 10130 and 10131 do not apply to group life policies, to group disability policies, or to individual disability policies providing a benefit for loss of time and which are noncancellable and guaranteed renewable for not less than five years, when any of such group life policies, group disability policies or individual disability policies expressly provide that benefits payable thereunder are not assignable, and in such case the benefits shall be paid only as provided in the policy.

(Amended by Stats. 1947, Ch. 904.)

10129.5. Sections 10130 and 10131 do not apply to annuity contracts which are within the scope of Section 401(g) of the Internal Revenue Code of the United States.

(Added by Stats. 1963, Ch. 2061.)

10130. A life or disability policy may pass by transfer, will or succession to any person, whether or not the transferee has an insurable interest. Such transferee may recover upon it whatever the insured might have recovered.

(Enacted by Stats. 1935, Ch. 145.)

10131. Notice to an insurer of a transfer of a life or disability policy is not necessary to preserve the validity of the policy unless expressly required by the policy.

(Enacted by Stats. 1935, Ch. 145.)

10132. The beneficiary under a life policy which provides for the payment of its proceeds in periodical installments, may be restrained by its provisions from disposing of or incumbering his interest in any such installment prior to the date when it becomes due and payable by the insurer.

(Enacted by Stats. 1935, Ch. 145.)

10133. (a) Upon written consent of the insured first obtained with respect to a particular claim, any disability insurer shall pay group insurance benefits contingent upon, or for expenses incurred on account of, hospitalization or medical or surgical aid to the person or persons furnishing the hospitalization or medical or surgical aid, or, on and after January 1, 1994, to the person or persons having paid for the hospitalization or medical or surgical aid, but the amount of any such payment shall not exceed the amount of benefit provided by the policy with respect to the service or billing of the provider of aid, and the amount of the payments pursuant to one or more assignments shall not exceed the amount of expenses incurred on account of the hospitalization or medical or surgical aid. Payments so made shall discharge the insurer’s obligation with respect to the amount so paid.

(b) Nothing in this section shall be construed to authorize an insurer to furnish or directly provide services of hospitals, or psychiatric health facilities, as defined in Section 1250.2 of the Health and Safety Code, or physicians and surgeons, or psychologists or in any manner to direct, participate in, or control the selection of the hospital or health facility or physician and surgeon or psychologist from whom the insured secures services or exercise medical or dental or psychological professional judgment, except that an insurer may negotiate and enter into contracts for alternative rates of payment with institutional providers, and offer the benefit of these alternative rates to insureds who select those providers.

(c) Alternatively, insurers may, by agreement with group policyholders, limit payments under a policy to services secured by insureds from institutional providers, and after July 1, 1983, from professional providers, charging alternative rates pursuant to contract with

the insurer.

(d) Pursuant to subdivision (c), when alternate rates of payment to providers are applicable to contracts with group policyholders, the contracts shall include programs for the continuous review of the quality of care, performance of medical or psychological personnel included in the plan, utilization of services and facilities, and costs, by professionally recognized unrelated third parties utilizing in the case of professional providers similarly licensed providers for each medical, psychological, or dental service covered under the plan and utilizing in the case of institutional providers appropriate professional providers. All provisions of the laws of the state relating to immunity from liability and discovery privileges for medical, psychological, and dental peer review shall apply to the licensed providers performing the foregoing activities.

(e) On or after July 1, 1983, the amendments made to this section during the 1982 portion of the 1981–82 Regular Session, shall also be applicable with respect to both professional and institutional providers.

(Amended by Stats. 1993, Ch. 744, Sec. 2. Effective January 1, 1994.)

10133.1. Insurers shall provide group policyholders with a current roster of institutional and professional providers under contract to provide services at alternative rates under their group policy and shall also make such lists available for public inspection during regular business hours at the insurer's or plan's principal office within the state.

(Added by Stats. 1982, Ch. 1594, Sec. 10.5. Effective September 30, 1982. Operative January 1, 1983, by Sec. 82 of Ch. 1594.)

10133.15. (a) Commencing July 1, 2016, a health insurer that contracts with providers for alternative rates of payment pursuant to Section 10133 shall publish and maintain provider directory or directories with information on contracting providers that deliver health care services to the insurer's insureds, including those that accept new patients. A provider directory shall not list or include information on a provider that is not currently under contract with the insurer.

(b) An insurer shall provide the online directory or directories for the specific network offered for each product using a consistent method of network and product naming, numbering, or other classification method that ensures the public, insureds, potential insureds, the department, and other state or federal agencies can easily identify the networks and insurer products in which a provider participates. By July 31, 2017, or 12 months after the date provider directory standards are developed under subdivision (k), whichever occurs later, an insurer shall use the naming, numbering, or classification method developed by the department pursuant to subdivision (k).

(c) (1) An online provider directory or directories shall be available on the insurer's Internet Web site to the public, potential insureds, insureds, and providers without any restrictions or limitations. The directory or directories shall be accessible without any requirement that an individual seeking the directory information demonstrate coverage with the insurer, indicate interest in obtaining coverage with the insurer, provide a member identification or policy number, provide any other identifying information, or create or access an account.

(2) The online provider directory or directories shall be accessible on the insurer's public Internet Web site through an identifiable link or tab and in a manner that is accessible and searchable by insureds, potential insureds, the public, and providers. By July 1, 2017, or 12 months after the date provider directory standards are developed under subdivision (k), whichever occurs later, the insurer's public Internet Web site shall allow provider searches by, at a minimum, name, practice address, city, ZIP Code, California license number, National Provider Identifier number, admitting privileges to an identified hospital, product, tier, provider language or languages, provider group, hospital name, facility name, or clinic name, as appropriate.

(d) (1) An insurer shall allow insureds, potential insureds, providers, and members of the public to request a printed copy of the provider directory or directories by contacting the insurer through the insurer's toll-free telephone number, electronically, or in writing. A printed copy of the provider directory or directories shall include the information required in subdivisions (h) and (i). The printed copy of the provider directory or directories shall be provided to the requester by mail postmarked no later than five business days following the date of the request and may be limited to the geographic region in which the requester resides or works or intends to reside or work.

(2) An insurer shall update its printed provider directory or directories at least quarterly, or more frequently, if required by federal law.

(e) (1) The insurer shall update the online provider directory or directories, at least weekly, or more frequently, if required by federal law, when informed of and upon confirmation by the insurer of any of the following:

(A) A contracting provider is no longer accepting new patients for that product, or an individual provider within a provider group is no longer accepting new patients.

(B) A contracted provider is no longer under contract for a particular product.

(C) A provider's practice location or other information required under subdivision (h) or (i) has changed.

(D) Upon the completion of the investigation described in subdivision (o), a change is necessary based on an insured complaint that a provider was not accepting new patients, was otherwise not available, or whose contact information was listed incorrectly.

(E) Any other information that affects the content or accuracy of the provider directory or directories.

(2) Upon confirmation of any of the following, the insurer shall delete a provider from the directory or directories when:

(A) A provider has retired or otherwise has ceased to practice.

(B) A provider or provider group is no longer under contract with the insurer for any reason.

(C) The contracting provider group has informed the insurer that the provider is no longer associated with the provider group and is no longer under contract with the insurer.

(f) The provider directory or directories shall include both an email address and a telephone number for members of the public and providers to notify the insurer if the provider directory information appears to be inaccurate. This information shall be disclosed prominently in the directory or directories and on the insurer's Internet Web site.

(g) The provider directory or directories shall include the following disclosures informing insureds that they are entitled to both of the following:

(1) Language interpreter services, at no cost to the insured, including how to obtain interpretation services in accordance with Section 10133.8.

(2) Full and equal access to covered services, including insureds with disabilities as required under the federal Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973.

(h) The insurer and a specialized mental health insurer shall include all of the following information in the provider directory or directories:

(1) The provider's name, practice location or locations, and contact information.

(2) Type of practitioner.

(3) National Provider Identifier number.

(4) California license number and type of license.

(5) The area of specialty, including board certification, if any.

(6) The provider's office email address, if available.

(7) The name of each affiliated provider group currently under contract with the insurer through which the provider sees enrollees.

(8) A listing for each of the following providers that are under contract with the insurer:

(A) For physicians and surgeons, the provider group, and admitting privileges, if any, at hospitals contracted with the insurer.

(B) Nurse practitioners, physician assistants, psychologists, acupuncturists, optometrists, podiatrists, chiropractors, licensed clinical social workers, marriage and family therapists, professional clinical counselors, qualified autism service providers, as defined in Section 10144.51, nurse midwives, and dentists.

(C) For federally qualified health centers or primary care clinics, the name of the federally qualified health center or clinic.

(D) For any provider described in subparagraph (A) or (B) who is employed by a federally qualified health center or primary care clinic, and to the extent their services may be accessed and are covered through the contract with the insurer, the name of the provider, and the name of the federally qualified health center or clinic.

(E) Facilities, including, but not limited to, general acute care hospitals, skilled nursing facilities, urgent care clinics, ambulatory surgery centers, inpatient hospice, residential care facilities, and inpatient rehabilitation facilities.

(F) Pharmacies, clinical laboratories, imaging centers, and other facilities providing contracted health care services.

(9) The provider directory or directories may note that authorization or referral may be required to access some providers.

(10) Non-English language, if any, spoken by a health care provider or other medical professional as well as non-English language spoken by a qualified medical interpreter, in accordance with Section 10133.8, if any, on the provider's staff.

(11) Identification of providers who no longer accept new patients for some or all of the insurer's products.

(12) The network tier to which the provider is assigned, if the provider is not in the lowest tier, as applicable. Nothing in this section shall be construed to require the use of network tiers other than contract and noncontracting tiers.

(13) All other information necessary to conduct a search pursuant to paragraph (2) of subdivision (c).

(i) A vision, dental, or other specialized insurer, except for a specialized mental health insurer, shall include all of the following information for each provider directory or directories used by the insurer for its networks:

(1) The provider's name, practice location or locations, and contact information.

(2) Type of practitioner.

(3) National Provider Identifier number.

(4) California license number and type of license, if applicable.

(5) The area of specialty, including board certification, or other accreditation, if any.

(6) The provider's office email address, if available.

(7) The name of each affiliated provider group or specialty insurer practice group currently under contract with the insurer through which the provider sees insureds.

(8) The names of each allied health care professional to the extent there is a direct contract for those services covered through a contract with the insurer.

(9) The non-English language, if any, spoken by a health care provider or other medical professional as well as non-English language spoken by a qualified medical interpreter, in accordance with Section 10133.8, if any, on the provider's staff.

(10) Identification of providers who no longer accept new patients for some or all of the insurer's products.

(11) All other applicable information necessary to conduct a provider search pursuant to paragraph (2) of subdivision (c).

(j) (1) The contract between the insurer and a provider shall include a requirement that the provider inform the insurer within five business days when either of the following occurs:

(A) The provider is not accepting new patients.

(B) If the provider had previously not accepted new patients, the provider is currently accepting new patients.

(2) If a provider who is not accepting new patients is contacted by an insured or potential insured seeking to become a new patient, the provider shall direct the insurer or potential insured to both the insurer for additional assistance in finding a provider and to the department to report any inaccuracy with the insurer's directory or directories.

(3) If an insured or potential insured informs an insurer of a possible inaccuracy in the provider directory or directories, the insurer shall promptly investigate and, if necessary, undertake corrective action within 30 business days to ensure the accuracy of the directory or directories.

(k) (1) On or before December 31, 2016, the department shall develop uniform provider directory standards to permit consistency in accordance with subdivision (b) and paragraph (2) of subdivision (c) and development of a multiplan directory by another entity. Those standards shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), until January 1, 2021. No more than two revisions of those standards shall be exempt from the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) pursuant to this subdivision.

(2) In developing the standards under this subdivision, the department shall seek input from interested parties throughout the process of developing the standards and shall hold at least one public meeting. The department shall take into consideration any requirements for provider directories established by the federal Centers for Medicare and Medicaid Services and the State Department of Health Care Services.

(3) By July 31, 2017, or 12 months after the date provider directory standards are developed under this subdivision, whichever occurs later, an insurer shall use the standards developed by the department for each product offered by the insurer.

(l) (1) An insurer shall take appropriate steps to ensure the accuracy of the information concerning each provider listed in the insurer's provider directory or directories in accordance with this section, and shall, at least annually, review and update the entire

provider directory or directories for each product offered. Each calendar year the insurer shall notify all contracted providers described in subdivisions (h) and (i) as follows:

(A) For individual providers who are not affiliated with a provider group described in subparagraph (A) or (B) of paragraph (8) of subdivision (h) and providers described in subdivision (i), the insurer shall notify each provider at least once every six months.

(B) For all other providers described in subdivision (h) who are not subject to the requirements of subparagraph (A), the insurer shall notify its contracted providers to ensure that all of the providers are contacted by the insurer at least once annually.

(2) The notification shall include all of the following:

(A) The information the insurer has in its directory or directories regarding the provider or provider group, including a list of networks and products that include the contracted provider or provider group.

(B) A statement that the failure to respond to the notification may result in a delay of payment or reimbursement of a claim pursuant to subdivision (p).

(C) Instructions on how the provider or provider group can update the information in the provider directory or directories using the online interface developed pursuant to subdivision (m).

(3) The insurer shall require an affirmative response from the provider or provider group acknowledging that the notification was received. The provider or provider group shall confirm that the information in the provider directory or directories is current and accurate or update the information required to be in the directory or directories pursuant to this section, including whether or not the provider group is accepting new patients for each product.

(4) If the insurer does not receive an affirmative response and confirmation from the provider that the information is current and accurate or, as an alternative, updates any information required to be in the directory or directories pursuant to this section, within 30 business days, the insurer shall take no more than 15 business days to verify whether the provider's information is correct or requires updates. The insurer shall document the receipt and outcome of each attempt to verify the information. If the insurer is unable to verify whether the provider's information is correct or requires updates, the insurer shall notify the provider 10 business days in advance of removal that the provider will be removed from the directory or directories. The provider shall be removed from the directory or directories at the next required update of the provider directory or directories after the 10-business day notice period. A provider shall not be removed from the provider directory or directories if he or she responds before the end of the 10-business day notice period.

(5) General acute care hospitals shall be exempt from the requirements in paragraphs (3) and (4).

(m) An insurer shall establish policies and procedures with regard to the regular updating of its provider directory or directories, including the weekly, quarterly, and annual updates required pursuant to this section, or more frequently, if required by federal law or guidance.

(1) The policies and procedures described under this subdivision shall be submitted by an insurer annually to the department for approval and in a format described by the department.

(2) Every insurer shall ensure processes are in place to allow providers to promptly verify or submit changes to the information required to be in the directory or directories pursuant to this section. Those processes shall, at a minimum, include an online interface for providers to submit verification or changes electronically and shall generate an acknowledgment of receipt from the insurer. Providers shall verify or submit changes to information required to be in the directory or directories pursuant to this section using the process required by the insurer.

(3) The insurer shall establish and maintain a process for insureds, potential insureds, other providers, and the public to identify and report possible inaccurate, incomplete, or misleading information currently listed in the insurer's provider directory or directories. This process shall, at a minimum, include a telephone number and a dedicated email address at which the insurer will accept these reports, as well as a hyperlink on the insurer's provider directory Internet Web site linking to a form where the information can be reported directly to the insurer through its Internet Web site.

(n) (1) This section does not prohibit an insurer from requiring its provider groups or contracting specialized health insurers to provide information to the insurer that is required by the insurer to satisfy the requirements of this section for each of the providers that contract with the provider group or contracting specialized health insurer. This responsibility shall be specifically documented in a written contract between the insurer and the provider group or contracting specialized health insurer.

(2) If an insurer requires its contracting provider groups or contracting specialized health insurers to provide the insurer with information described in paragraph (1), the insurer shall continue to retain responsibility for ensuring that the requirements of this section are satisfied.

(3) A provider group may terminate a contract with a provider for a pattern or repeated failure of the provider to update the information required to be in the directory or directories pursuant to this section.

(4) A provider group is not subject to the payment delay described in subdivision (p) if all of the following occurs:

(A) A provider does not respond to the provider group's attempt to verify the provider's information. As used in this paragraph, "verify" means to contact the provider in writing, electronically, and by telephone to confirm whether the provider's information is correct or requires updates.

(B) The provider group documents its efforts to verify the provider's information.

(C) The provider group reports to the insurer that the provider should be deleted from the provider group in the insurer's provider directory or directories.

(5) Section 10133.65, known as the Health Care Providers' Bill of Rights, applies to any material change to a provider contract pursuant to this section.

(o) (1) Whenever an insurer receives a report indicating that information listed in its provider directory or directories is inaccurate, the insurer shall promptly investigate the reported inaccuracy and, no later than 30 business days following receipt of the report, either verify the accuracy of the information or update the information in its provider directory or directories, as applicable.

(2) When investigating a report regarding its provider directory or directories, the insurer shall, at a minimum, do the following:

(A) Contact the affected provider no later than five business days following receipt of the report.

(B) Document the receipt and outcome of each report. The documentation shall include the provider's name, location, and a description of the insurer's investigation, the outcome of the investigation, and any changes or updates made to its provider directory or directories.

(C) If changes to an insurer's provider directory or directories are required as a result of the insurer's investigation, the changes to the online provider directory or directories shall be made no later than the next scheduled weekly update, or the update immediately following that update, or sooner if required by federal law or regulations. For printed provider directories, the change shall be made no later than the next required update, or sooner if required by federal law or regulations.

(p) (1) Notwithstanding Sections 10123.13 and 10123.147, an insurer may delay payment or reimbursement owed to a provider or provider group for any claims payment made to a provider or provider group for up to one calendar month beginning on the first day of the following month, if the provider or provider group fails to respond to the insurer's attempts to verify the provider's information as required under subdivision (l). The insurer shall not delay payment unless it has attempted to verify the provider's or provider group's information. As used in this subdivision, "verify" means to contact the provider or provider group in writing, electronically, and by telephone to confirm whether the provider's or provider group's information is correct or requires updates. An insurer may seek to delay payment or reimbursement owed to a provider or provider group only after the 10-business day notice period described in paragraph (4) of subdivision (l) has lapsed.

(2) An insurer shall notify the provider or provider group 10 days before it seeks to delay payment or reimbursement to a provider or provider group pursuant to this subdivision. If the insurer delays a payment or reimbursement pursuant to this subdivision, the insurer shall reimburse the full amount of any payment or reimbursement subject to delay to the provider or provider group according to either of the following timelines, as applicable:

(A) No later than three business days following the date on which the insurer receives the information required to be submitted by the provider or provider group pursuant to subdivision (l).

(B) At the end of the one-calendar-month delay described in paragraph (1), if the provider or provider group fails to provide the information required to be submitted to the insurer pursuant to subdivision (l).

(3) An insurer may terminate a contract for a pattern or repeated failure of the provider or provider group to alert the insurer to a change in the information required to be in the directory or directories pursuant to this section.

(4) An insurer that delays payment or reimbursement under this subdivision shall document each instance a payment or reimbursement was delayed and report this information to the department in a format described by the department. This information shall be submitted along with the policies and procedures required to be submitted annually to the department pursuant to paragraph (1) of subdivision (m).

(q) In circumstances where the department finds that an insured reasonably relied upon materially inaccurate, incomplete, or misleading information contained in an insurer's provider directory or directories, the department may require the insurer to provide coverage for all covered health care services provided to the insured and to reimburse the insured for any amount beyond what the

insured would have paid, had the services been delivered by an in-network provider under the insured's health insurance policy. Prior to requiring reimbursement in these circumstances, the department shall conclude that the services received by the insured were covered services under the insured's health insurance policy. In those circumstances, the fact that the services were rendered or delivered by a noncontracting or out-of-network provider shall not be used as a basis to deny reimbursement to the insured.

(r) Whenever an insurer determines as a result of this section that there has been a 10-percent change in the network for a product in a region, the insurer shall file a statement with the commissioner.

(s) An insurer that contracts with multiple employer welfare agreements regulated pursuant to Article 4.7 (commencing with Section 742.20) of Chapter 1 of Part 2 of Division 1 shall meet the requirements of this section.

(t) This section shall not be construed to alter a provider's obligation to provide health care services to an insured pursuant to the provider's contract with the insurer.

(u) As part of the department's routine examination of a health insurer pursuant to Section 730, the department shall include a review of the health insurer's compliance with subdivision (p).

(v) For purposes of this section, "provider group" means a medical group, independent practice association, or other similar group of providers.

(Amended by Stats. 2016, Ch. 86, Sec. 205. (SB 1171) Effective January 1, 2017.)

10133.2. When any disability insurer negotiates and enters into a contract with professional or institutional providers to provide services at alternative rates of payment of the type described in Sections 10133 and 11512 of the Insurance Code, the amount of patient copayment shall be calculated exclusively from the negotiated alternative rate for the service rendered. No disability insurer or professional or institutional provider, negotiating and entering into a contract pursuant to this section, shall charge or collect copayment amounts greater than those calculated in accordance with this section.

This section shall become operative on January 1, 1993.

(Added by Stats. 1991, Ch. 827, Sec. 1.5.)

10133.3. When any self-insured governmental plan, as defined in Section 12671, negotiates and enters into a contract with professional or institutional providers to provide services at alternative rates of payment of the type described in Sections 10133 and 11512 of the Insurance Code, the amount of patient copayment shall be calculated exclusively from the negotiated alternative rate for the service rendered. No self-insured governmental plan or professional or institutional provider, negotiating and entering into a contract pursuant to this section, shall charge or collect copayment amounts greater than those calculated in accordance with this section.

This section shall become operative on January 1, 1993.

(Added by Stats. 1991, Ch. 827, Sec. 2.)

10133.4. (a) For purposes of insurers that contract with providers for alternate rates pursuant to Section 10133, a primary care provider includes a "nonphysician medical practitioner," which is defined as a physician assistant performing services under the supervision of a primary care physician in compliance with Chapter 7.7 (commencing with Section 3500) of Division 2 of the Business and Professions Code or a nurse practitioner performing services in collaboration with a physician pursuant to Chapter 6 (commencing with Section 2700) of Division 2 of the Business and Professions Code.

(b) This section shall not require a primary care provider to accept the assignment of a number of insureds that would exceed standards of good health care as provided in Section 10133.5.

(c) This section shall not be interpreted to modify subdivision (e) of Section 2836.1 of the Business and Professions Code or subdivision (b) of Section 3516 of the Business and Professions Code.

(Amended by Stats. 2014, Ch. 71, Sec. 100. (SB 1304) Effective January 1, 2015.)

10133.5. (a) The commissioner shall, on or before January 1, 2004, promulgate regulations applicable to health insurers which contract with providers for alternative rates pursuant to Section 10133 to ensure that insureds have the opportunity to access needed health care services in a timely manner.

(b) These regulations shall be designed to assure accessibility of provider services in a timely manner to individuals comprising the insured or contracted group, pursuant to benefits covered under the policy or contract. The regulations shall insure:

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

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

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

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

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

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

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

(f) The department shall report to the Assembly Committee on Health and the Senate Committee on Insurance of the Legislature on March 1, 2003, and on March 1, 2004, regarding the progress towards the implementation of this section.

(g) Every three years, the commissioner shall review the latest version of the regulations adopted pursuant to subdivision (a) and shall determine if the regulations should be updated to further the intent of this section.

(Amended by Stats. 2002, Ch. 797, Sec. 5. Effective January 1, 2003.)

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

(2) A health insurance policy that is issued, renewed, or amended on or after July 1, 2022, that provides benefits through contracts with providers for alternative rates pursuant to Section 10133 shall provide information to an insured regarding the standards for timely access to care required by Section 10133.54, adopted pursuant to Section 10133.5, and the information required by this section, including information related to receipt of interpreter services in a timely manner, no less than annually.

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

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

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

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

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

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

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

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

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

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

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

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

(Amended by Stats. 2021, Ch. 724, Sec. 4. (SB 221) Effective January 1, 2022.)

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

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

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

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

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

(4) Interpreter services required by Section 10133.8 of this code and Article 12.1 (commencing with Section 2538.1) of Title 10 of the California Code of Regulations shall be coordinated with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment, consistent with Section 2538.6 of Title 10 of the California Code of Regulations, without imposing delay on the scheduling of the appointment. This subdivision does not modify the requirements established in Sections 10133.8 and 10133.9 of this code and Section 2538.6 of Title 10 of the California Code of Regulations, or approved by the department pursuant to Section 2538.6 of Title 10 of the California Code of Regulations for an insurer's language assistance program.

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

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

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

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

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

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

(F) Commencing July 1, 2022, nonurgent followup appointments with a nonphysician mental health care or substance use disorder provider: within 10 business days of the prior appointment for those undergoing a course of treatment for an ongoing mental health or substance use disorder condition, except as provided in subparagraph (H). This subparagraph does not limit

coverage for nonurgent followup appointments with a nonphysician mental health care or substance use disorder provider to once every 10 business days.

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

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

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

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

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

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

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

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

(B) In addition to ensuring compliance with the clinical appropriateness standard set forth in paragraph (1), each health insurance policy specified in subparagraph (A) shall ensure that contracted oral or vision provider networks have adequate capacity and availability of licensed health care providers, including generalist and specialist dentists, ophthalmologists, optometrists, and opticians, to offer insureds appointments for covered oral or vision services in accordance with the following requirements:

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

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

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

(iv) The applicable waiting time for a particular appointment in this paragraph may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of the provider's practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the insured.

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

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

(B) An insurer shall ensure timely access to covered health care services as required by this section, including applicable time-elapsed standards, by assisting an insured to locate available and accessible contracted providers in a timely manner appropriate for the insured's health needs. An insurer shall arrange for the provision of services outside the insurer's contracted network if unavailable within the network if medically necessary for the insured's condition. Insured costs for medically necessary referrals to nonnetwork providers shall not exceed applicable in-network copayments, coinsurance, and deductibles.

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

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

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

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

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

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

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

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

(9) A health insurance policy providing coverage for the pediatric oral and vision essential health benefit, and a specialized health insurance policy that provides coverage for dental care expenses only, shall require that contracted providers employ an answering service or a telephone answering machine during nonbusiness hours, which provides instructions regarding how an insured may obtain urgent or emergency care, including, if applicable, how to contact another provider who has agreed to be on call to triage or screen by phone, or if needed, deliver urgent or emergency care.

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

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

(d) An insurer shall incorporate the standards set forth in the insurer's quality assurance systems and processes, as set forth in subdivision (b), and the processes as set forth in Title 10 of the California Code of Regulations, including Sections 2240.1, 2240.15, and 2240.16. An insurer shall not prevent, discourage, or discipline a contracting provider or employee for informing an insured or policyholder about the timely access standards.

(e) For purposes of this section:

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

(2) "Preventive care" means health care provided for prevention and early detection of disease, illness, injury, or other health condition and includes, but is not limited to, all of the services required by all of the following laws:

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

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

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

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

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

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

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

(f) (1) The department may issue guidance to insurers regarding annual timely access and network reporting methodologies. The development and adoption of these methodologies shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) until December 31, 2025.

(2) Notwithstanding paragraph (1), the department may take compliance or disciplinary action, including imposition of administrative penalties, on the basis of noncompliance with any of the provisions of this section, including, but not limited to, timeframes for appointments and followup appointments.

(3) The department may review and adopt standards, in addition to those specified in this article, concerning the availability of primary care physicians, specialty physicians, hospital care, and other health care, so that consumers have timely access to care. In so doing, the department shall consider the nature of physician practices, including individual and group practices, as well as the nature of the network. The department shall also consider various circumstances affecting the delivery of care, including urgent care, care provided on the same day, and requests for specific providers. If the department finds that insurers and health care providers have difficulty meeting these standards, the department may make recommendations to the Assembly Committee on Health and the Senate Committee on Health. The development and adoption of standards under this paragraph shall not be subject to the Administrative Procedure Act until December 31, 2028. The department shall consult with stakeholders in developing the standards and methodologies described in this section.

(g) Nothing in this section shall be construed to prevent the department from developing additional standards to improve timely access to care and network adequacy.

(Amended by Stats. 2022, Ch. 601, Sec. 3. (SB 225) Effective January 1, 2023.)

10133.55. (a) (1) Except as provided in paragraph (2), every disability insurer covering hospital, medical, and surgical expenses on a group basis that contracts with providers for alternative rates pursuant to Section 10133 and limits payments under those policies to services secured by insureds and subscribers from providers charging alternative rates pursuant to these contracts, shall file with the Department of Insurance, a written policy describing how the insurer shall facilitate the continuity of care for new insureds or enrollees receiving services during a current episode of care for an acute condition from a noncontracting provider. This written policy shall describe the process used to facilitate continuity of care, including the assumption of care by a contracting provider.

(2) On or before July 1, 2002, every disability insurer covering hospital, medical, and surgical expenses on a group basis that contracts with providers for alternative rates pursuant to Section 10133 and limits payments under those policies to services secured by insureds and subscribers from providers charging alternative rates pursuant to these contracts, shall file with the department a written policy describing how the insurer shall facilitate the continuity of care for new enrollees who have been receiving services for an acute, serious, or chronic mental health condition from a nonparticipating mental health provider when the enrollee’s employer has changed policies. Every written policy shall allow the new enrollee a reasonable transition period to continue his or her course of treatment with the nonparticipating mental health provider prior to transferring to another participating provider and shall include the provision of mental health services on a timely, appropriate, and medically necessary basis from the nonparticipating provider. The policy may provide that the length of the transition period take into account the severity of the enrollee’s condition and the amount of time reasonably necessary to effect a safe transfer on a case-by-case basis. Nothing in this paragraph shall be construed to require the insurer to accept a nonparticipating mental health provider onto its panel for treatment of other enrollees. For purposes of the continuing treatment of the transferring enrollee, the insurer may require the nonparticipating mental health provider, as a condition of the right conferred under this section, to enter into the standard mental health provider contract.

(b) Notice of the policy and information regarding how enrollees may request a review under the policy shall be provided to all new enrollees, except those enrollees who are not eligible as described in subdivision (e). A copy of the written policy shall be provided to eligible enrollees upon request. The written policy required to be filed under subdivision (a) shall describe how requests to continue services with an existing noncontracting provider are reviewed by the insurer. The policy shall ensure that reasonable consideration is given to the potential clinical effect that a change of provider would have on the insured’s or subscriber’s treatment for the acute condition.

(c) An insurer may require any nonparticipating provider whose services are continued pursuant to the written policy to agree in writing to meet the same contractual terms and conditions that are imposed upon the insurer's participating providers, including location within the service area, reimbursement methodologies, and rates of payment. If the insurer determines that a patient's health care treatment should temporarily continue with the patient's existing provider or nonparticipating mental health provider, the insurer shall not be liable for actions resulting solely from the negligence, malpractice, or other tortious or wrongful acts arising out of the provision of services by the existing provider or nonparticipating mental health provider.

(d) Nothing in this section shall require an insurer to cover services or provide benefits that are not otherwise covered under the terms and conditions of the policy contract.

(e) The written policy shall not apply to any insured or subscriber who is offered an out-of-network option, or who had the option to continue with his or her previous health benefits carrier or provider and instead voluntarily chose to change.

(f) This section shall not apply to insurer contracts that include out-of-network coverage under which the insured or subscriber is able to obtain services from the insured's or subscriber's existing provider or nonparticipating mental health provider.

(g) (1) For purposes of this section, "provider" refers to a person who is described in subdivision (f) of Section 900 of the Business and Professions Code.

(2) For purposes of this section, "nonparticipating mental health provider" refers to a psychiatrist, licensed psychologist, licensed marriage and family therapist, licensed clinical social worker, or licensed professional clinical counselor who is not part of the insurer's contracted provider network.

(h) This section shall only apply to a group disability insurance policy if it provides coverage for hospital, medical, or surgical benefits.

(Amended by Stats. 2011, Ch. 381, Sec. 36. (SB 146) Effective January 1, 2012.)

10133.56. (a) (1) A health insurer that enters into a contract with a professional or institutional provider to provide services at alternative rates of payment pursuant to Section 10133 shall, at the request of an insured, arrange for the completion of covered services by a terminated provider, if the insured is undergoing a course of treatment for any of the following conditions:

(A) An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.

(B) (i) A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the health insurer in consultation with the insured and the terminated provider and consistent with good professional practice.

(ii) Completion of covered services under clause (i) shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered insured.

(C) (i) A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.

(ii) For purposes of an individual who presents written documentation of being diagnosed with a maternal mental health condition from the individual's treating health care provider, completion of covered services for the maternal mental health condition shall not exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later.

(D) A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of covered services shall be provided for the duration of a terminal illness, which may exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a new insured.

(E) The care of a newborn child between birth and age 36 months. Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered insured.

(F) Performance of a surgery or other procedure that has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered insured.

(2) The insurer may require the terminated provider whose services are continued beyond the contract termination date pursuant to this subdivision, to agree in writing to be subject to the same contractual terms and conditions that were imposed upon the provider prior to termination, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. If the terminated provider does not agree to comply or does not comply with these contractual terms and conditions, the insurer is not required to continue the provider's services beyond the contract termination date.

(3) Unless otherwise agreed upon between the terminated provider and the insurer or between the terminated provider and the provider group, the agreement shall be construed to require a rate and method of payment to the terminated provider, for the services rendered pursuant to this subdivision, that are the same as the rate and method of payment for the same services while under contract with the insurer and at the time of termination. The provider shall accept the reimbursement as payment in full and shall not bill the insured for any amount in excess of the reimbursement rate, with the exception of copayments and deductibles pursuant to subdivision (c).

(b) Notice as to the process by which an insured may request completion of covered services pursuant to this section shall be provided in any insurer evidence of coverage and disclosure form issued after March 31, 2004. An insurer shall provide a written copy of this information to its contracting providers and provider groups. An insurer shall also provide a copy to its insureds upon request. Notice as to the availability of the right to request completion of covered services shall be part of, accompany, or be sent simultaneously with any termination of coverage notice sent in the circumstances described in subdivision (i).

(c) The payment of copayments, deductibles, or other cost-sharing components by the insured during the period of completion of covered services with a terminated provider pursuant to subdivision (a) or a nonparticipating provider pursuant to subdivision (i) shall be the same copayments, deductibles, or other cost-sharing components that would be paid by the insured when receiving care from a provider currently contracting with the insurer.

(d) If an insurer delegates the responsibility of complying with this section to its contracting entities, the insurer shall ensure that the requirements of this section are met.

(e) For the purposes of this section, the following terms have the following meanings:

(1) "Provider" means a person who is a licentiate as defined in Section 805 of the Business and Professions Code or a person licensed under Chapter 2 (commencing with Section 1000) of Division 2 of the Business and Professions Code.

(2) "Provider group" includes a medical group, independent practice association, or any other similar organization.

(3) "Nonparticipating provider" means a provider who is not contracted with the insured's health insurer to provide services under the insured's policy. A nonparticipating provider does not include a terminated provider.

(4) "Terminated provider" means a provider whose contract to provide services to insureds is terminated or not renewed by the insurer or one of the insurer's contracting provider groups. A terminated provider is not a provider who voluntarily leaves the insurer or contracting provider group.

(5) "Maternal mental health condition" means a mental health condition that can impact a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery.

(f) This section does not require an insurer or provider group to provide for the completion of covered services by a provider whose contract with the insurer or provider group has been terminated or not renewed for reasons relating to medical disciplinary cause or reason, as defined in paragraph (6) of subdivision (a) of Section 805 of the Business and Professions Code, or fraud or other criminal activity.

(g) This section does not require an insurer to cover services or provide benefits that are not otherwise covered under the terms and conditions of the insurer contract.

(h) The provisions contained in this section are in addition to any other responsibilities of insurers to provide continuity of care pursuant to this chapter. This section does not preclude an insurer from providing continuity of care beyond the requirements of this section.

(i) (1) A health insurer shall, at the request of a newly covered insured under an individual insurance policy, arrange for the completion of covered services as set forth in this section by a nonparticipating provider for one of the conditions described in subdivision (a) if the newly covered insured meets both of the following:

(A) The newly covered insured's prior coverage was terminated under subdivision (d) or (e) of Section 10273.6 or paragraph (5) or (6) of subdivision (a) of Section 1365 of the Health and Safety Code, which includes circumstances when a health benefit plan is withdrawn from any portion of a market.

(B) At the time the insured's coverage became effective, the newly covered insured was receiving services from that provider for one of the conditions described in subdivision (a).

(2) The completion of covered services required to be provided under this subdivision shall apply to services rendered to the newly covered insured on and after the effective date of their new coverage.

(3) (A) The insurer may require a nonparticipating provider whose services are continued pursuant to this subdivision for a newly covered insured to agree in writing to be subject to the same contractual terms and conditions that are imposed upon currently participating providers providing similar services who are practicing in the same or a similar geographic area as the nonparticipating provider, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. If the nonparticipating provider does not agree to comply or does not comply with these contractual terms and conditions, the insurer is not required to continue the provider's services.

(B) Unless otherwise agreed upon by the nonparticipating provider and the insurer, the services rendered pursuant to this subdivision shall be compensated at rates and methods of payment similar to those used by the insurer for currently participating providers providing similar services who are practicing in the same or a similar geographic area as the nonparticipating provider. Neither the insurer nor the provider group is required to continue the services of a nonparticipating provider if the provider does not accept the payment rates provided for in this paragraph. The provider who agrees to provide services pursuant to this subdivision shall accept the reimbursement as payment in full and shall not bill the insured for any amount in excess of the reimbursement rate, with the exception of copayments and deductibles pursuant to subdivision (c).

(C) A provider's agreement to contractual terms and conditions and acceptance of payment rates to provide the completion of covered services to an insured pursuant to this subdivision shall not be construed as an agreement to contractual terms and conditions or acceptance of payment rates for any other insureds or for any services other than covered services pursuant to this subdivision, nor shall it be construed as agreement to any other contract.

(Amended by Stats. 2019, Ch. 776, Sec. 2. (AB 577) Effective January 1, 2020.)

10133.6. It is the intent of the Legislature to ensure that the citizens of this state receive high-quality health care coverage in the most efficient and cost-effective manner possible. In furtherance of this intent, the Legislature finds and declares that it is in the public interest to promote various types of contracts between public or private payers of health care coverage, and institutional or professional providers of health care services. This intent has been demonstrated by the recent enactment of Chapters 328, 329, and 1594 of the Statutes of 1982 authorizing various types of contracts to be entered into between public or private payers of health care coverage, and institutional or professional providers of health care services. The Legislature further finds and declares that individual providers, whether institutional or professional and individual purchasers, have not proven to be efficient-sized bargaining units for these contracts, and that the formation of groups and combinations of institutional and professional providers and purchasing groups for the purpose of creating efficient-sized contracting units represents a meaningful addition to the health care marketplace. The Legislature further finds and declares that the public interest in ensuring that citizens of this state receive high-quality health care coverage in the most efficient and cost-effective manner possible is furthered by permitting negotiations for alternative rate contracts between purchasers and payers and both institutional and professional providers, or through a person or entity acting for, or on behalf of, a health insurer or an institutional or professional provider, pursuant to Sections 10133 and 11512. It is the intent of the Legislature, therefore, that the formation of groups and combinations of purchasers, payers, and institutional and professional providers of health care services for the purpose of creating efficient-sized contracting units be recognized as the creation of a new product within the health care marketplace, and be subject, therefore, only to those antitrust prohibitions applicable to the conduct of other presumptively legitimate enterprises.

This section does not change existing antitrust law as it relates to any agreement or arrangement to exclude from any of the above-described groups or combinations, any person who is lawfully qualified to perform the services to be performed by the members of the group or combination, where the ground for the exclusion is failure to possess the same license or certification as is possessed by the members of the group or combination.

(Added by Stats. 1985, Ch. 1592, Sec. 3.)

10133.64. (a) A contract issued, amended, renewed, or delivered on or after January 1, 2015, by or on behalf of a health insurer and a provider or supplier shall not contain any provision that restricts the ability of the health insurer to furnish consumers or purchasers information concerning any of the following:

(1) The cost range of a procedure or a full course of treatment, including, but not limited to, facility, professional, and diagnostic services, prescription drugs, durable medical equipment, and other items and services related to the treatment.

(2) The quality of services performed by the provider or supplier.

(b) Any contractual provision inconsistent with this section shall be void and unenforceable.

(c) A health insurer shall provide the provider or supplier an advance opportunity of 30 days to review the methodology and data developed and compiled by the health insurer, and used pursuant to subdivision (a), before cost or quality information is provided to

consumers or purchasers, including material revisions or additions of new information. At the time the health insurer provides a provider or supplier with the opportunity to review the methodology and data, it shall also notify the provider or supplier in writing of their opportunity to provide an Internet Web site link pursuant to subdivision (f).

(d) If the information proposed to be furnished to policyholders and insureds on the quality of services performed by a provider or supplier is data that the insurer has developed and compiled, the insurer shall utilize appropriate risk adjustment factors to account for different characteristics of the population, such as case mix, severity of patient's condition, comorbidities, outlier episodes, and other factors to account for differences in the use of health care resources among providers and suppliers.

(e) Any Internet Web site owned or controlled by a health insurer, or operated by another person or entity under contract with or on behalf of a health insurer, that displays the information developed and compiled by the health insurer as referenced by this section shall prominently post the following statement:

"Individual health care facilities or providers may disagree with the methodology used to define the cost ranges, the cost data, or quality measures. Many factors may influence cost or quality, including, but not limited to, the cost of uninsured and charity care, the type and severity of procedures, the case mix of a facility, special services such as trauma centers, burn units, medical and other educational programs, research, transplant services, technology, payer mix, and other factors affecting individual health care facilities and providers."

A health insurer and a provider or supplier shall not be precluded from mutually agreeing in writing to an alternative method of conveying this statement.

(f) If a provider or supplier chooses to provide an Internet Web site link where a response to the health insurer's posting may be found, it shall do so in a timely manner in order to satisfy the requirements of this section. If a provider or supplier chooses to provide a response, an insurer shall post, in an easily identified manner, a prominent link to the provider's or supplier's Internet Web site where a response to the health insurer's posting may be found. A health insurer and a provider or supplier shall not be precluded from mutually agreeing in writing to an alternative method to convey a provider's or supplier's response.

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

(1) "Consumers" means policyholders or insureds of the health insurer or beneficiaries of a self-funded health coverage arrangement administered by the health insurer or other persons entitled to access services through a network established by the health insurer.

(2) "Provider" has the same meaning as that term is defined in Section 10117.52.

(3) "Purchasers" means the sponsors of a self-funded health coverage arrangement administered by the health insurer.

(4) "Supplier" has the same meaning as that term is defined in Section 10117.52.

(Amended by Stats. 2014, Ch. 83, Sec. 2. (SB 1340) Effective January 1, 2015.)

10133.641. (a) A contract issued, amended, or renewed on or after January 1, 2024, between a health insurer and a provider of health care services shall not contain any term that would result in termination or nonrenewal of the contract or otherwise penalize the provider, based solely on a civil judgment issued in another state, a criminal conviction in another state, or another professional disciplinary action in another state, if the judgment, conviction, or professional disciplinary action is based solely on the application of another state's law that interferes with a person's right to receive care that would be lawful if provided in this state.

(b) A health insurer shall not discriminate, with respect to the provision of, or contracts for, professional services, against a licensed provider solely on the basis of a civil judgment issued in another state, a criminal conviction in another state, or another professional disciplinary action in another state if the judgment, conviction, or professional disciplinary action is based solely on the application of another state's law that interferes with a person's right to receive care that would be lawful if provided in this state.

(c) This section does not apply to a civil judgment, a criminal conviction, or a disciplinary action imposed in another state based upon conduct that would subject a provider to claim, charge, or action under the laws of this state.

(d) The commissioner may enforce this section pursuant to Chapter 4.5 (commencing with Section 11400) or Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code. This subdivision does not impair or restrict the commissioner's enforcement authority pursuant to another provision of this code or the Administrative Procedure Act.

(Added by Stats. 2023, Ch. 261, Sec. 3. (SB 487) Effective January 1, 2024.)

10133.65. (a) This section shall be known and may be cited as the Health Care Providers' Bill of Rights.

(b) No contract issued, amended, or renewed on or after January 1, 2003, between a health insurer and a health care provider for the provision of covered benefits at alternative rates of payment to an insured shall contain any of the following terms:

(1) A provision that requires a health care provider to accept additional patients beyond the contracted number or in the absence of a number if, in the reasonable professional judgment of the provider, accepting additional patients would endanger patients' access to, or continuity of, care.

(2) A requirement to comply with quality improvement or utilization management programs or procedures of a health insurer, unless the requirement is fully disclosed to the health care provider at least 15 business days prior to the provider executing the contract. However, the health insurer may make a change to the quality improvement or utilization management programs or procedures at any time if the change is necessary to comply with state or federal law or regulations or any accreditation requirements of a private sector accreditation organization. A change to the quality improvement or utilization management programs or procedures shall be made pursuant to subdivision (c).

(3) A provision that waives or conflicts with any provision of the Insurance Code.

(4) A requirement to permit access to patient information in violation of federal or state laws concerning the confidentiality of patient information.

(c) If a contract is with a health insurer that negotiates and arranges for alternative rates of payment with the provider to provide benefits to insureds, the contract may contain provisions permitting a material change to the contract by the health insurer if the health insurer provides at least 45 business days' notice to the provider of the change, and the provider has the right to terminate the contract prior to implementation of the change.

(d) With respect to a health insurance policy covering dental services or a specialized health insurance policy covering dental services, all of the following shall apply:

(1) If a material change is made to the health insurer's rules, guidelines, policies, or procedures concerning dental provider contracting or coverage of or payment for dental services, the insurer shall provide at least 45 business days' written notice to the dentists contracting with the health insurer to provide services under the insurer's individual or group health insurance policies, including specialized health insurance policies. For purposes of this paragraph, written notice shall include notice by electronic mail or facsimile transmission. This paragraph shall apply in addition to the other applicable requirements imposed under this section.

(2) For purposes of paragraph (1), a material change made to a health insurer's rules, guidelines, policies, or procedures concerning dental provider contracting or coverage of or payment for dental services is a change to the system by which the insurer adjudicates and pays claims for treatment that may cause delays or disruptions in processing claims or making eligibility determinations, or a change to the general coverage or general policies of the insurer that affect rates and fees paid to providers.

(3) An insurer that automatically renews a contract with a dental provider shall annually make available to the provider, within 60 days following a request by the provider, either online, via email, or in paper form, a copy of its current contract and a summary of the changes described in subdivision (c) that have been made since the contract was issued or last renewed.

(e) Any contract provision that violates subdivision (b), (c), or (d) shall be void, unlawful, and unenforceable.

(f) The Department of Insurance shall annually compile all provider complaints that it receives under this section, and shall report to the Legislature and the Governor the number and nature of those complaints by March 15 of each calendar year.

(g) Nothing in this section shall be construed or applied as setting the rate of payment to be included in contracts between health insurers and health care providers.

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

(1) "Health care provider" means any professional person, medical group, independent practice association, organization, health facility, or other person or institution licensed or authorized by the state to deliver or furnish health care services.

(2) "Health insurer" means any admitted insurer writing health insurance, as defined in Section 106, that enters into a contract with a provider to provide covered benefits at alternative rates of payment.

(3) "Material" means a provision in a contract to which a reasonable person would attach importance in determining the action to be taken upon the provision.

(Amended by Stats. 2012, Ch. 447, Sec. 2. (AB 2252) Effective January 1, 2013.)

10133.66. A health insurer shall comply with all the following:

(a) Deadlines shall not be imposed for the receipt of a claim from a professional provider who submits a claim on behalf of an insured or pursuant to a professional provider's contract with a health insurer that is less than 90 days for contracted providers and 180 days for noncontracted providers after the date of service, except as required by any state or federal law or regulation. If a health insurer is not the primary payor under coordination of benefits, the insurer shall not impose a deadline for submitting

supplemental or coordination of benefits claims to any secondary payor that is less than 90 days from the date of payment or date of contest, denial, or notice from the primary payor. A health insurer that denies a claim because it was filed beyond the claim filing deadline shall, upon provider's demonstration of good cause for the delay, accept and adjudicate the claim according to Section 10123.13 or 10123.147, whichever is applicable. This subdivision shall not alter or affect any rights providers may have under any applicable statute of limitations or antiforfeiture provisions available under the laws of the State of California.

(b) Reimbursement requests for the overpayment of a claim shall not be made, including requests made pursuant to Section 10123.145, unless a written request for reimbursement is sent to the provider within 365 days of the date of payment on the overpaid claim. The written notice shall clearly identify the claim, the name of the patient, and the date of service, and shall include a clear explanation of the basis upon which it is believed the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim. The 365-day time limit shall not apply if the overpayment was caused in whole or in part by fraud or misrepresentation on the part of the provider.

(c) The receipt of each claim shall be identified and acknowledged, whether or not complete, and the recorded date of receipt shall be disclosed in the same manner as the claim was submitted or provided through an electronic means, by telephone, Web site, or another mutually agreeable accessible method of notification, by which the provider may readily confirm the insurer's receipt of the claim and the recorded date of receipt within 15 working days of the date of receipt of the claim by the office designated to receive the claim.

If a claimant submits a claim to a health insurer using a claims clearinghouse, its identification and acknowledgment to the clearinghouse within the timeframes set forth above shall constitute compliance with this section.

(d) Beginning July 1, 2006, prior to contracting, annually thereafter on or before the contract anniversary date, and in addition, upon the contracted provider's written request, the health insurer shall disclose to contracting providers all of the following information in an electronic format:

(1) The amount of payment for each service to be provided under the contract, including any fee schedules or other factors or units used in determining the fees for each service. To the extent that reimbursement is made pursuant to a specified fee schedule, the contract shall incorporate that fee schedule by reference, including the year of the schedule. For any proprietary fee schedule, the contract shall include sufficient detail that payment amounts related to that fee schedule can be accurately predicted.

(2) The detailed payment policies and rules and nonstandard coding methodologies used to adjudicate claims, that shall, unless otherwise prohibited by state law do all of the following:

(A) When available, be consistent with Current Procedural Terminology (CPT), and standards accepted by nationally recognized medical societies and organizations, federal regulatory bodies, and major credentialing organizations.

(B) Clearly and accurately state what is covered by any global payment provisions for both professional and institutional services, any global payment provisions for all services necessary as part of a course of treatment in an institutional setting, and any other global arrangements such as per diem hospital payments.

(C) At a minimum, clearly and accurately state the policies regarding all of the following:

(i) Consolidation of multiple services or charges, and payment adjustments due to coding changes.

(ii) Reimbursement for multiple procedures.

(iii) Reimbursement for assistant surgeons.

(iv) Reimbursement for the administration of immunizations and injectable medications.

(v) Recognition of CPT modifiers.

The information disclosures required by this section shall be in sufficient detail and in an understandable format that does not disclose proprietary trade secret information or violate copyright law or patented processes, so that a reasonable person with sufficient training, experience, and competence in claims processing can determine the payment to be made according to the terms of the contract.

A health insurer may disclose the fee schedules mandated by this section through the use of a Web site so long as it provides written notice to the contracted provider at least 45 days prior to implementing a Web site transmission format or posting any changes to the information on the Web site.

(Added by Stats. 2005, Ch. 441, Sec. 4. Effective January 1, 2006.)

10133.661. On or before July 1, 2006, the commissioner, pursuant to his or her authority under Section 12921.1, shall also complete all of the following duties:

(a) Provide announcements that inform health insurance consumers and their health care providers of the department's toll-free telephone number that is dedicated to the handling of complaints and of the availability of the Internet Web page established under this section, and the process to register a complaint with the department and to submit an inquiry to it.

(b) Establish an Internet Web page located on the department's public Internet Web site dedicated exclusively to processing complaints and inquiries relating to health insurance issues from insureds and their health care providers. The Web page shall provide insureds and their health care providers with information concerning filing a complaint and making an inquiry concerning a health insurer and, at a minimum, shall provide the following information:

(1) The department's toll-free telephone number.

(2) A list of all health insurers licensed by the department.

(3) Educational and informational guides for health insurance consumers and health care providers describing their rights under this code. The guides shall be easy to read and understand and shall be made available to the public, including access on the department's Internet Web site.

(4) A separate, standardized complaint form for health care providers to file a complaint.

(c) An insured or health care provider may file a written complaint with the department with respect to the handling of a claim or other obligation under a health insurance policy by a health insurer or production agency, or with respect to the alleged misconduct by a health insurer or production agency. The commissioner shall notify the complainant of the receipt of the complaint within 10 business days of its receipt. The commissioner shall make a determination on the complaint within 60 calendar days of the date of its receipt, unless the commissioner, in his or her discretion, determines that additional time is reasonably necessary to fully and fairly evaluate the complaint. The commissioner shall notify the complainant of the final action taken on his or her complaint within 30 days of the final action. The notification shall include a summary explaining the commissioner's reasons for the final action.

(Added by renumbering Section 10133.66 (as added by Stats. 2005, Ch. 723) by Stats. 2006, Ch. 405, Sec. 9. Effective September 22, 2006. Operative January 1, 2007, by Sec. 14 of Ch. 405.)

10133.67. Pursuant to Section 12921, the commissioner may also agree to payment to a health care provider who submitted a claim for health care benefits provided to an insured that are covered under the insured's health insurance policy.

(Added by Stats. 2005, Ch. 723, Sec. 7. Effective January 1, 2006.)

10133.7. (a) On and after January 1, 1994, any disability insurer shall pay group insurance benefits contingent upon, or for expenses incurred on account of, hospitalization or medical or surgical aid to the person or persons having provided or having paid for the hospitalization or medical or surgical aid where that person has qualified for reimbursement by submitting the items and information specified in subdivisions (b) and (c). The amount of any such payment shall not exceed the amount of benefit provided by the policy with respect to the service or billing of the provider of aid, and the amount of payments shall not exceed the amount of expenses incurred on account of the hospitalization or medical or surgical aid. Payment so made shall discharge the insurer's obligation with respect to the amount so paid.

(b) The items which shall be submitted to the insurer for reimbursement pursuant to subdivision (a) are as follows:

(1) Proof of payment of medical services and a provider's itemized bill for service.

(2) In the case where the insured does not reside with the person or persons seeking hospitalization or medical or surgical aid, either a copy of the judicial order requiring the insured to provide dependent coverage or a state approved form verifying the existence of a judicial order to be filed with the insurer on an annual basis.

(3) In the case where the insured does not reside with the person or persons seeking hospitalization or medical or surgical aid, and the provider is seeking direct reimbursement, an itemized bill with the signature of the custodial parent or guardian certifying that services being billed for have been provided and, on an annual basis, either a copy of the judicial order requiring the insured to provide dependent coverage or a state approved form verifying the existence of a judicial order.

(c) When seeking payment from an insurer, a person shall provide an insurer the items specified in subdivision (b) with the name and address of the person to be reimbursed, the name and policy number of the insured, the name of the individual for whom hospitalization or medical or surgical aid has been provided, and other necessary information directly related to coverage under the policy.

(d) In the case of a Medi-Cal beneficiary, where the State Department of Health Services has paid for the hospitalization or medical or surgical aid, any disability insurer shall pay group insurance benefits to the State Department of Health Services for expenses contingent upon, or incurred on account of hospitalization or medical or surgical aid. Payment so made shall discharge the insurer's obligation with respect to the amount so paid. The amount of any such payment shall not exceed the amount of benefit provided by

the policy with respect to the service or billing of the provider of aid, and the amount of payments shall not exceed the amount of expenses incurred on account of hospitalization or medical or surgical aid.

(Added by Stats. 1993, Ch. 744, Sec. 2.5. Effective January 1, 1994.)

10133.8. (a) The commissioner shall, on or before January 1, 2006, promulgate regulations applicable to all individual and group policies of health insurance establishing standards and requirements to provide insureds with appropriate access to translated materials and language assistance in obtaining covered benefits. A health insurer that participates in the Healthy Families Program may assess the Healthy Families Program enrollee population separately from the remainder of its population for purposes of subparagraph (A) of paragraph (3) of subdivision (b). An insurer that chooses to separate its Healthy Families Program enrollment from the remainder of its population shall treat the Healthy Families Program population separately for purposes of determining whether subparagraph (A) of paragraph (3) of subdivision (b) is applicable and shall also treat the Healthy Families Program population separately for purposes of applying the percentage and numerical thresholds in subparagraph (A) of paragraph (3) of subdivision (b).

(b) The regulations described in subdivision (a) shall include the following:

(1) A requirement to conduct an assessment of the needs of the insured group, pursuant to this subdivision.

(2) Requirements for surveying the language preferences and assessment of linguistic needs of insureds within one year of the effective date of the regulations that permit health insurers to utilize various survey methods, including, but not limited to, the use of existing enrollment and renewal processes, newsletters, or other mailings. Health insurers shall update the linguistic needs assessment, demographic profile, and language translation requirements every three years. However, the regulations may provide that the surveys and assessments by insurers of supplemental insurance products may be conducted less frequently than three years if the commissioner determines that the results are unlikely to affect the translation requirements.

(3) Requirements for the translation of vital documents that include the following:

(A) A requirement that all vital documents, as defined pursuant to subparagraph (B), be translated into an indicated language, as follows:

(i) A health insurer with an insured population of 1,000,000 or more shall translate vital documents into the top two languages other than English as determined by the needs assessment pursuant to paragraph (2) and any additional languages when 0.75 percent or 15,000 of the insured population, whichever number is less, indicates in the needs assessment pursuant to paragraph (2) a preference for written materials in that language.

(ii) A health insurer with an insured population of 300,000 or more but less than 1,000,000 shall translate vital documents into the top one language other than English as determined by the needs assessment pursuant to paragraph (2) and any additional languages when 1 percent or 6,000 of the insured population, whichever number is less, indicates in the needs assessment pursuant to paragraph (2) a preference for written materials in that language.

(iii) A health insurer with an insured population of less than 300,000 shall translate vital documents into a language other than English when 3,000 or more or 5 percent of the insured population, whichever number is less, indicates in the needs assessment pursuant to paragraph (2) a preference for written materials in that language.

(B) Specification of vital documents produced by the insurer that are required to be translated. The specification of vital documents shall not exceed that of the United States Department of Health and Human Services (HHS) Office for Civil Rights (OCR) Policy Guidance (65 Federal Register 52762 (August 30, 2000)), but shall include all of the following:

(i) Applications.

(ii) Consent forms.

(iii) Letters containing important information regarding eligibility or participation criteria.

(iv) Notices pertaining to the denial, reduction, modification, or termination of services and benefits, the right to file a complaint or appeal.

(v) Notices advising limited-English-proficient persons of the availability of free language assistance and other outreach materials that are provided to insureds.

(vi) Translated documents shall not include an insurer's explanation of benefits or similar claim processing information that are sent to insureds unless the document requires a response by the insured.

(C) For those documents described in subparagraph (B) that are not standardized but contain insured specific information, health insurers shall not be required to translate the documents into the threshold languages identified by the needs assessment pursuant to paragraph (2) but rather shall include with the document a written notice of the availability of interpretation services in the threshold languages identified by the needs assessment pursuant to paragraph (2). A health insurer subject to the requirements in Section 10133.11 shall also include with the documents a written notice of the availability of interpretation services in the top 15 languages spoken by limited-English-proficient (LEP) individuals in California as determined by the State Department of Health Care Services.

(i) Upon request, the insured shall receive a written translation of those documents. The health insurer shall have up to, but not to exceed, 21 days to comply with the insured's request for a written translation. If an enrollee requests a translated document, all timeframes and deadlines requirements related to the documents that apply to the health insurer and insureds under the provisions of this chapter and under any regulations adopted pursuant to this chapter shall begin to run upon the health insurer's issuance of the translated document.

(ii) For appeals that require expedited review and response in accordance with the statutes and regulations of this chapter, the health insurer may satisfy this requirement by providing notice of the availability and access to oral interpretation services.

(D) A requirement that health insurers advise limited-English-proficient insureds of the availability of interpreter services.

(4) Standards to ensure the quality and accuracy of the written translation and that a translated document meets the same standards required for the English version of the document. The English language documents shall determine the rights and obligations of the parties, and the translated documents shall be admissible in evidence only if there is a dispute regarding a substantial difference in the material terms and conditions of the English language document and the translated document.

(5) Requirements for individual access to interpretation services that include the following:

(A) A requirement that an interpreter meets, at a minimum, all of the following qualifications:

(i) Demonstrated proficiency in both English and the target language.

(ii) Knowledge in both English and the target language of health care terminology and concepts relevant to health care delivery systems.

(iii) Adheres to generally accepted interpreter ethics principles, including client confidentiality.

(B) A requirement that the insured with limited English proficiency shall not be required to provide their own interpreter or rely on a staff member who does not meet the qualifications described in subparagraph (A) to communicate directly with the limited-English-proficient insured.

(C) A requirement that the insured with limited English proficiency shall not be required to rely on an adult or minor child accompanying the insured to interpret or facilitate communication except under either of the following circumstances:

(i) In an emergency, as described in Section 1317.1 of the Health and Safety Code, if a qualified interpreter is not immediately available for the insured with limited English proficiency.

(ii) If the individual with limited English proficiency specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide that assistance, and reliance on that accompanying adult for that assistance is appropriate under the circumstances.

(6) Standards to ensure the quality and timeliness of oral interpretation services provided by health insurers.

(c) In developing the regulations, standards, and requirements described in this section, the commissioner shall consider the following:

(1) Publications and standards issued by federal agencies, including the Culturally and Linguistically Appropriate Services (CLAS) in Health Care issued by the United States Department of Health and Human Services Office of Minority Health in December 2000, and the United States Department of Health and Human Services (HHS) Office for Civil Rights (OCR) Policy Guidance 65 (65 Federal Register 52762 (August 30, 2000)).

(2) Other cultural and linguistic requirements under state programs, including the Medi-Cal Managed Care Policy Letters, cultural and linguistic requirements imposed by the State Department of Health Care Services on health care service plans that contract to

provide Medi-Cal managed care services, and cultural and linguistic requirements imposed by the Managed Risk Medical Insurance Board on health insurers that contract to provide services in the Healthy Families Program.

(3) Standards adopted by other states pertaining to language assistance requirements for health insurers.

(4) Standards established by California or nationally recognized accrediting, certifying, or licensing organizations and medical and health care interpreter professional associations regarding interpretation services.

(5) Publications, guidelines, reports, and recommendations issued by state agencies or advisory committees, such as the report card to the public on the comparative performance of plans and reports on cultural and linguistic services issued by the Center for Data Insights and Innovation and the report to the Legislature from the Task Force on Culturally and Linguistically Competent Physicians and Dentists required pursuant to former Section 852 of the Business and Professions Code.

(6) Examples of best practices relating to language assistance services by health care providers and health insurers that contract for alternative rates of payment with providers, including existing practices.

(7) Information gathered from complaints to the commissioner and consumer assistance help lines regarding language assistance services.

(8) The cost of compliance and the availability of translation and interpretation services and professionals.

(9) Flexibility to accommodate variations in networks and method of service delivery. The commissioner shall allow for health insurer flexibility in determining compliance with the standards for oral and written interpretation services.

(d) In designing the regulations, the commissioner shall consider all other relevant guidelines in an effort to accomplish maximum accessibility within a cost-efficient system of indemnification. The commissioner shall seek public input from a wide range of interested parties.

(e) Services, verbal communications, and written materials provided by or developed by the health insurers that contract for alternative rates of payment with providers, shall comply with the standards developed under this section.

(f) Beginning on January 1, 2008, the department shall report biennially to the Legislature regarding health insurer compliance with the standards established by this section, including results of compliance audits made in conjunction with other audits and reviews. The department shall also utilize the reported information to make recommendations for changes that further enhance standards pursuant to this section. The commissioner shall work to ensure that the biennial reports required by this section, and the data collected for the reports, do not require duplicative or conflicting data collection with other reports that may be required by government-sponsored programs. The commissioner may also delay or otherwise phase in implementation of the standards and requirements in recognition of costs and availability of translation and interpretation services and professionals.

(g) This section does not prohibit government purchasers from including in their contracts additional translation or interpretation requirements, to meet the linguistic and cultural needs, beyond those set forth pursuant to this section.

(Amended by Stats. 2021, Ch. 696, Sec. 16. (AB 172) Effective October 8, 2021.)

10133.9. Within a year after the health insurer's assessment pursuant to paragraph (2) of subdivision (b) of Section 10133.8, health insurers shall report to the Department of Insurance on internal policies and procedures related to cultural appropriateness, in a format specified by the department, in the following ways:

(a) Collection of data regarding the insured population based on the needs assessment as required by paragraph (2) of subdivision (b) of Section 10133.8.

(b) Education of health insurer staff who have routine contact with insureds regarding the diverse needs of the insured population.

(c) Recruitment and retention efforts that encourage workforce diversity.

(d) Evaluation of the health insurer's programs and services with respect to the insurer's enrollee populations, using processes such as an analysis of complaints and satisfaction survey results.

(e) The periodic provision of information regarding the ethnic diversity of the insurer's insured population and any related strategies to insurers providers. Insurers may use existing means of communication.

(f) The periodic provision of educational information to insureds on the insurer's services and programs. Insurers may use existing means of communication.

(Added by Stats. 2003, Ch. 713, Sec. 5. Effective January 1, 2004.)

10133.10. (a) An insurer that markets, advertises, or produces educational materials for a health insurance policy, as defined in Section 106, in the individual or small group health insurance markets, or allows any other person or business to market or advertise

on its behalf in the individual or small group health insurance markets, in a non-English language that does not meet the requirements set forth in Sections 10133.8 and 10133.9, shall provide the following documents in the same non-English language:

(1) Welcome letters or notices of initial coverage, if applicable.

(2) Applications for health insurance and any information pertinent to eligibility or participation.

(3) Notices advising limited-English-proficient persons of the availability of no-cost translation and interpretation services.

(4) Notices pertaining to the right and instructions on how an insured may file a grievance.

(5) The uniform summary of benefits and coverage required pursuant to paragraph (2) of subdivision (a) of Section 10603.

(b) An insurer shall use trained and qualified translators for the translation of all marketing and advertising materials relating to health insurance products and for all of the documents specified in subdivision (a).

(c) This section shall not apply to a specialized health insurance policy that does not offer an essential health benefit as defined in Section 10112.27.

(Added by Stats. 2013, Ch. 447, Sec. 2. (SB 353) Effective January 1, 2014.)

10133.11. (a) An insurer shall notify insureds and members of the public of all of the following information:

(1) The availability of language assistance services, including oral interpretation and translated written materials, free of charge and in a timely manner pursuant to Section 10133.8, and how to access these services. This information shall be available in the top 15 languages spoken by limited-English-proficient individuals in California as determined by the State Department of Health Care Services.

(2) The availability of appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats, free of charge and in a timely manner, when those aids and services are necessary to ensure an equal opportunity to participate for individuals with disabilities.

(3) An insurer does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

(4) How to file a complaint, including the name of the health insurer representative and the telephone number, address, and email address of the health insurer representative who may be contacted about the complaint, and how to submit the complaint to the department for review.

(5) How to file a discrimination complaint with the United States Department of Health and Human Services Office for Civil Rights if there is a concern of discrimination based on race, color, national origin, age, disability, or sex.

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

(1) In a conspicuously visible location in the evidence of coverage.

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

(3) On the Internet Web site published and maintained by the health insurer, in a manner that allows insureds, prospective insureds, and members of the public to easily locate the information.

(c) (1) A specialized health insurance policy that is not a covered entity, as defined in Section 92.4 of Title 45 of the Code of Federal Regulations, subject to Section 1557 of the federal Patient Protection and Affordable Care Act (42 U.S.C. Sec. 18116) may request a waiver from the requirements under this section.

(2) The department shall not grant a waiver under this subdivision to a specialized health insurance policy that arranges for mental health or behavioral health benefits.

(3) The department shall provide information on its Internet Web site about any waivers granted under this subdivision.

(Amended by Stats. 2018, Ch. 92, Sec. 156. (SB 1289) Effective January 1, 2019.)

10133.12. (a) Commencing January 1, 2027, or when final federal rules are implemented, whichever occurs later, the department shall require a health insurer to establish and maintain the following application programming interfaces (API) for the benefit of all insureds and contracted providers, as applicable:

(1) Patient access API.

(2) Provider access API.

(3) Payer-to-payer API.

(4) Prior authorization API.

(b) API described in subdivision (a) shall be in accordance with standards published in a final rule issued by the federal Centers for Medicare and Medicaid Services and published in the Federal Register, and shall align with federal effective dates, including enforcement delays and suspensions, issued by the federal Centers for Medicare and Medicaid Services.

(c) Until January 1, 2027, the commissioner may issue guidance to health insurers regarding compliance with this section and that guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(d) This section does not limit existing requirements under this chapter, including, but not limited to, Section 10133.15.

(Amended by Stats. 2024, Ch. 386, Sec. 2. (AB 2198) Effective January 1, 2025.)

10133.13. (a) (1) Within six months after the department issues guidance pursuant to paragraph (1) of subdivision (d), and no later than March 1, 2025, a health insurer that issues, sells, renews, or offers health insurance policies for health care coverage in this state, including a grandfathered health insurance policy, but not including specialized health insurance policies that provide only dental or vision services, shall require all of its health insurer staff who are in direct contact with insureds in the delivery of care or insured services to complete evidence-based cultural competency training for the purpose of providing trans-inclusive health care for individuals who identify as transgender, gender diverse, or intersex (TGI).

(2) An evidence-based cultural competency training implemented pursuant to paragraph (1) shall include all of the following:

(A) Information about the effects, including, but not limited to, ongoing personal effects, of historical and contemporary exclusion and oppression of TGI communities.

(B) Information about communicating more effectively across gender identities, including TGI-inclusive terminology, using people's correct names and pronouns, even when they are not reflected in records or legal documents; avoiding language, whether verbal or nonverbal, that demeans, ridicules, or condemns TGI individuals; and avoiding making assumptions about gender identity by using gender-neutral language and avoiding language that presumes all individuals are heterosexual, cisgender or gender conforming, or nonintersex.

(C) Discussion on health inequities within the TGI community, including family and community acceptance.

(D) Perspectives of diverse, local constituency groups and TGI-serving organizations, including, but not limited to, the California Transgender Advisory Council.

(E) Recognition of the difference between personal values and professional responsibilities with regard to serving TGI people.

(F) Facilitation by TGI-serving organizations.

(3) Use of any training curricula for purposes of implementing paragraph (1) shall be subject to approval by the department, following stakeholder engagement with local constituency groups and TGI-serving organizations, including, but not limited to, the California Transgender Advisory Council.

(4) After first-time completion of the evidence-based cultural competency training, in the form of initial basic training, an individual described in paragraph (1) shall complete a refresher course if a complaint has been filed, and a decision has been made in favor of the complainant, against that individual for not providing trans-inclusive health care, or on a more frequent basis if deemed necessary by the health insurer or the department for purposes of providing trans-inclusive health care.

(b) (1) No later than September 1, 2024, the department shall develop and implement procedures, and may impose sanctions pursuant to any applicable enforcement provisions, to ensure that a health insurer is compliant with the requirements described in subdivision (a).

(2) Within six months after the department issues guidance pursuant to paragraph (1) of subdivision (d), the department shall track and monitor complaints received by the department related to trans-inclusive health care and publicly report this data with other complaint data on its website or with other public reports containing complaint data.

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

(1) “TGI” means transgender, gender diverse, or intersex.

(2) “TGI-serving organization” has the same meaning as set forth in paragraph (2) of subdivision (f) of Section 150900 of the Health and Safety Code.

(3) “Trans-inclusive health care” means comprehensive health care that is consistent with the standards of care for individuals who identify as TGI, honors an individual’s personal bodily autonomy, does not make assumptions about an individual’s gender, accepts gender fluidity and nontraditional gender presentation, and treats everyone with compassion, understanding, and respect.

(d) (1) Within six months of development of the quality standard and recommendations for curriculum pursuant to Section 150950 of the Health and Safety Code and no later than September 1, 2024, the department shall develop guidance and procedures for compliance with this section. In developing guidance pursuant to this subdivision, the department shall consider the recommendations made by the working group pursuant to Section 150950 of the Health and Safety Code.

(2) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall implement, interpret, or make specific this section by means of guidance or similar instructions, until regulations are adopted.

(3) The department shall adopt regulations for purposes of this section by July 1, 2027, in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. The department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations are adopted. In developing the regulations, the department shall consider the recommendations made by the working group pursuant to Section 150950 of the Health and Safety Code.

(e) If a health insurer delegates duties under this section to a contracted entity, including, but not limited to, a medical group or independent practice association, then the entity to which those duties are delegated shall comply with this section.

(f) The commissioner may take enforcement action, including, but not limited to, imposing penalties for noncompliance with the requirements of this section or regulations promulgated thereunder. If the commissioner determines that a health insurer, or an entity contracted with the health insurer, has violated this section, the commissioner may, after appropriate notice and opportunity for hearing in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), by order, assess a civil penalty not to exceed five thousand dollars ($5,000) for each violation, or if a violation was willful, a civil penalty not to exceed ten thousand dollars ($10,000) for each violation.

(Added by Stats. 2022, Ch. 822, Sec. 5. (SB 923) Effective January 1, 2023.)

10133.14. No later than March 1, 2025, a health insurer subject to Section 10133.13 shall include information within or accessible from the insurer’s provider directory, and accessible through the insurer’s call center, that identifies which of an insurer’s in-network providers have affirmed that they offer and have provided gender-affirming services, including, but not limited to, feminizing mammoplasty, male chest reconstruction, mastectomy, gender-confirming facial surgery, hysterectomy, oophorectomy, penectomy, orchiectomy, feminizing genitoplasty, metoidioplasty, phalloplasty, scrotoplasty, voice masculinization or feminization, hormone therapy related to gender dysphoria or intersex conditions, gender-affirming gynecological care, or voice therapy related to gender dysphoria or intersex conditions. This information shall be updated when an in-network provider requests its inclusion or exclusion as a provider that offers and provides gender-affirming services. Nothing in this act alters any business establishment’s obligation to provide full and equal services to customers or patients regardless of their sex and other protected characteristics, pursuant to the Unruh Civil Rights Act (Section 51 of the Civil Code) and other applicable law.

(Added by Stats. 2022, Ch. 822, Sec. 6. (SB 923) Effective January 1, 2023.)