AB-371 Dental coverage. (2025-2026)

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CALIFORNIA LEGISLATURE— 2025–2026 REGULAR SESSION

ASSEMBLY BILL NO. 371

Introduced by Assembly Member Haney

(Coauthors: Assembly Members Addis and Rogers)

February 03, 2025

An act to amend Section 1367.03 of, and to add Section 1374.191 to, the Health and Safety Code, and to amend Section 10133.54 of, and to add Section 10120.6 to, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 371, as amended, Haney. Dental coverage.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act's requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law prohibits a contract between a plan or insurer and a dentist from requiring a dentist to accept an amount set by the plan or insurer as payment for dental care services provided to an enrollee or insured that are not covered services under the enrollee's contract or the insured's policy. Existing law requires a plan or insurer to make specified disclosures to an enrollee or insured regarding noncovered dental services.

Existing law requires a health care service plan or health insurer to comply with specified timely access requirements. For a specified plan or insurer offering coverage for dental services, existing law requires urgent dental appointments to be offered within 72 hours of a request, nonurgent dental appointments to be offered within 36 business days of a request, and preventive dental care appointments to be offered within 40 business days of a request, as specified. Existing law requires a contract between a health care service plan and health care provider to ensure compliance with network adequacy standards and to require reporting by providers to plans to ensure compliance. Under existing law, a health care service plan is required to annually report to the Department of Managed Health Care on this compliance. Existing law authorizes the Department of Insurance to issue guidance to insurers regarding annual timely access and network reporting methodologies.

If a health care service plan or health insurer pays a contracting dental provider directly for covered services, this bill would require the plan or insurer to pay a noncontracting dental provider directly for covered services if the noncontracting provider submits to the plan or insurer a written assignment of benefits form signed by the enrollee or insured. The bill would require the plan or insurer to provide a predetermination or prior authorization to the dental provider and to reimburse the provider for not less than that amount, except as specified. The bill would require the plan or insurer to notify the enrollee or insured that the provider was paid and that the out-of-network cost may count towards their annual or lifetime maximum. The bill would require a noncontracting dental provider to make specified disclosures to an enrollee or insured before accepting an assignment of benefits.

This bill would require specified plans and insurers that cover dental services to offer urgent dental appointments within 48 hours of a request, nonurgent dental appointments within 18 business days of a request, and preventive dental care appointments within 20 business days of a request, as specified. The bill would ~~require dentists to be available within 15 miles or 30 minutes from an enrollee's or insured's residence or workplace.~~ *subject dentists to the relevant department's regulatory geographic accessibility standards.* The bill would require plans and insurers to report comprehensive information regarding the networks that each dental provider ~~serves, including the plan's or insurer's self-insured network.~~ *serves.* The bill would require the Department of Managed Health Care or the Department of Insurance to review the adequacy of an entire dental provider network, including the portions of the network serving plans and insurers not regulated by the respective department.

Because a willful violation of the above-described provisions by a health care service plan would be a crime, this bill would impose a state-mandated local program.

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

This bill would provide that no reimbursement is required by this act for a specified reason.
Vote: majority Appropriation: no Fiscal Committee: yes Local Program: yes

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THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 1367.03 of the Health and Safety Code is amended to read:

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

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

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

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

(4) Interpreter services required by Section 1367.04 of this code and Section 1300.67.04 of Title 28 of the California Code of Regulations shall be coordinated with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment without imposing delay on the scheduling of the appointment. This subdivision does not modify the requirements established in Section 1300.67.04 of Title 28 of the California Code of Regulations, or approved by the department pursuant to Section 1300.67.04 of Title 28 of the California Code of Regulations for a plan's language assistance program.

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

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

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

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

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

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

(F) 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 enrollee.

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

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

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

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

(A) Urgent appointments within the dental plan network shall be offered within 48 hours of the time of request for appointment, if consistent with the enrollee's individual needs and as required by professionally recognized standards of dental practice.

(B) Nonurgent appointments shall be offered within 18 business days of the request for appointment, except as provided in subparagraph (C).

(C) Preventive dental care appointments shall be offered within 20 business days of the request for appointment.

(D) Dentists shall be available ~~within 15 miles or 30 minutes from an enrollee's residence or workplace.~~ *pursuant to the geographic accessibility standards in Section 1300.67.2 of Title 28 of the California Code of Regulations.*

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

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

(B) A plan operating in a network service area that has a shortage of one or more types of providers shall ensure timely access to covered health care services as required by this section, including applicable time-elapsed standards, by referring an enrollee to, or, in the case of a preferred provider network, by assisting an enrollee to locate available and accessible network providers in neighboring network service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the enrollee's health needs.

(C) A plan shall arrange for the provision of covered services from providers outside the plan's network if unavailable within the network if medically necessary for the enrollee's condition. A plan shall ensure that enrollee costs for medically necessary referrals to nonnetwork providers shall not exceed applicable in-network copayments, coinsurance, and deductibles. This requirement does not prohibit a plan or its delegated provider group from accommodating an enrollee's preference to wait for a later appointment from a specific network provider. If medically necessary treatment of a mental health or substance use disorder is not available in network within the geographic and timely access standards set by law or regulation, a health care service plan shall arrange coverage outside the plan's network in accordance with subdivision (d) of Section 1374.72.

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

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

(B) A plan may provide or arrange for the provision of telephone triage or screening services through one or more of the following means: plan-operated telephone triage or screening services, telephone medical advice services pursuant to Section 1348.8, the plan's primary care and mental health care or substance use disorder network, or another method that provides triage or screening services consistent with this section.

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

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

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

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

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

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

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

(b) With regard to subdivision (a), dental, vision, chiropractic, and acupuncture plans shall comply with paragraphs (1), (3), (4), (7), (9), and (10).

(c) The obligation of a plan to comply with this section shall not be waived if the plan delegates to its provider groups or other contracting entities any services or activities that the plan is required to perform. A plan's implementation of this section shall be consistent with the Health Care Providers' Bill of Rights, and a material change in the obligations of a plan's network providers

shall be considered a material change to the provider contract, within the meaning of subdivision (b) and paragraph (2) of subdivision (h) of Section 1375.7.

(d) A health care service plan shall incorporate the standards set forth in subdivision (a) into the health plan's quality assurance systems and the processes set forth in Sections 1367 and 1370 of this code and Title 28 of the California Code of Regulations, including Sections 1300.67.2, 1300.67.2.2, 1300.68, and 1300.70. A plan shall not prevent, discourage, or discipline a network provider or employee for informing an enrollee or subscriber about the timely access standards.

(e) For purposes of this section:

(1) "Advanced access" means the provision, by a network provider, or by the provider group to which an enrollee is assigned, of appointments with a primary care physician, or other qualified primary care provider such as a nurse practitioner or physician's assistant, within the same or next business day from the time an appointment is requested, and advance scheduling of appointments at a later date if the enrollee prefers not to accept the appointment offered within the same or the next business day.

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

(3) "Preventive care" means health care provided for prevention and early detection of disease, illness, injury, or another health condition and, in the case of a full service plan includes all of the basic health care services required by Sections 1345, 1367.002, 1367.3, and 1367.35 of this code and subdivision (f) of Section 1300.67 of Title 28 of the California Code of Regulations.

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

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

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

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

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

(2) Health care service plans shall report annually to the department on compliance with the standards in a manner specified by the department. The reported information shall allow consumers to compare the performance of plans and their network providers in complying with the standards, as well as changes in the compliance of plans with these standards.

(3) The department shall develop standardized methodologies for reporting that shall be used by health care service plans to demonstrate compliance with this section and any regulations adopted pursuant to it, including demonstration of the average waiting time for each class of appointment regulated under this section, except the department may develop methodologies to demonstrate compliance with, and the average appointment wait time for, each class of appointments regulated under paragraph (6) of subdivision (a). The methodologies shall be sufficient to determine compliance with the standards developed under this section for different networks of providers if a health care service plan uses a different network for Medi-Cal managed care products than for other products or if a health care service plan uses a different network for individual market products than for small group market products. The 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. The department shall consult with stakeholders in developing standardized methodologies under this paragraph.

(4) Notwithstanding paragraph (3), the department may take compliance or disciplinary action, including assessment 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.

(5) Information reported by a plan to the department pursuant to paragraph (2) shall include comprehensive information regarding the dental provider networks that each dental provider ~~serves, including the plan's self-insured network.~~ *serves.*

Comprehensive information shall include the number of covered lives per line of business, including ~~self-insured, third-party,~~ *third party* or administrative service organizations, as applicable. For the purpose of determining network adequacy and compliance with time and distance requirements, the department shall review the adequacy of an entire dental provider network, as reported by the health care service plans, including the portions of the network serving plans and insurers not regulated by the department.

(6) 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 plan 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 health care service plans 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 pursuant to subdivision (i). 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) (1) The director may investigate and, by order, take enforcement action against plans, including, but not limited to, assessing administrative penalties subject to appropriate notice of, and the opportunity for, a hearing in accordance with Section 1397, regarding noncompliance with the requirements of this section. The director shall consider, as an aggravating factor when assessing administrative penalties, if harm to an enrollee, including financial or health impacts to an enrollee or substantial harm as defined in Section 3428 of the Civil Code, has occurred as a result of plan noncompliance. The director has the discretion to determine what harm constitutes harm to an enrollee. The plan may provide to the director, and the director may consider, information regarding the plan's overall compliance with the requirements of this section. When taking enforcement action against a plan, the director may consider patterns of noncompliance. The administrative penalties shall not be deemed an exclusive remedy available to the director. These penalties shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45. The director shall periodically evaluate grievances to determine if any audit, investigative, or enforcement actions should be undertaken by the department.

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

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

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

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

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

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

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

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

(k) This section applies to a licensed health care service plan that provides services to Medi-Cal beneficiaries. Except for appointment wait time standards set forth in paragraph (5) of subdivision (a) of this section and in Section 1300.67.2.2 of Title 28 of the California Code of Regulations, this section does not alter the requirements or standards of the State Department of Health Care Services specified in Section 14197 of the Welfare and Institutions Code.

(l) This section does not prevent the department from developing additional standards to improve timely access to care and network adequacy.

SEC. 2. Section 1374.191 is added to the Health and Safety Code, to read:

1374.191. (a) If a health care service plan pays a contracting dental provider directly for covered services rendered to an enrollee, the plan shall pay a noncontracting dental provider directly for covered services rendered to an enrollee if the noncontracting provider submits to the plan a written assignment of benefits form signed by the enrollee.

(b) Before accepting an assignment of benefits, a noncontracting dental provider shall disclose all of the following information to an enrollee:

(1) That the provider is a noncontracting dental provider.

(2) That the enrollee may experience lower out-of-pocket costs if services are rendered by a contracting network dentist.

(3) An estimate of what the planned treatment would cost and the enrollee's portion of the cost.

(c) A plan shall provide notice to the enrollee that the out-of-network cost may count towards their annual or lifetime maximum, as applicable, and shall inform the enrollee that payment was sent to the provider.

(d) A plan shall provide a predetermination or prior authorization to the dental provider and shall not reimburse the provider less than the amount set forth in the predetermination or prior authorization for the services, except in cases of fraud, billing error, or loss of coverage.

(e) For purposes of this section, "assignment of benefits" means the transfer of reimbursement or other rights provided for under a health care service plan contract to a treating provider for services or items rendered to an enrollee.

(f) This section applies only to a health care service plan contract covering dental services or a specialized health care service plan contract covering dental services pursuant to this chapter.

(g) This section does not apply to Medi-Cal managed care plan contracts, including dental managed care contracts, authorized under Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code.

SEC. 3. Section 10120.6 is added to the Insurance Code, to read:

10120.6. (a) If a health insurer pays a contracting dental provider directly for covered services rendered to an insured, the insurer shall pay a noncontracting dental provider directly for covered services rendered to an insured if the noncontracting provider submits to the insurer a written assignment of benefits form signed by the insured.

(b) Before accepting an assignment of benefits, a noncontracting dental provider shall disclose all of the following information to an insured:

(1) That the provider is a noncontracting dental provider.

(2) That the insured may experience lower out-of-pocket costs if services are rendered by a contracting network dentist.

(3) An estimate of what the planned treatment would cost and the insured's portion of the cost.

(c) An insurer shall provide notice to the insured that the out-of-network cost may count towards their annual or lifetime maximum, as applicable, and shall inform the insured that payment was sent to the provider.

(d) An insurer shall provide a predetermination or prior authorization to the dental provider and shall not reimburse the provider less than the amount set forth in the predetermination or prior authorization for the services, except in cases of fraud, billing error, or loss of coverage.

(e) For purposes of this section, "assignment of benefits" means the transfer of reimbursement or other rights provided for under a health insurance policy to a treating provider for services or items rendered to an insured.

(f) This section applies only to a health insurance policy covering dental services or a specialized health insurance policy covering dental services pursuant to this part.

SEC. 4. Section 10133.54 of the Insurance Code is amended to read:

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

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

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

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

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

(4) Interpreter services required by Section 10133.8 of this code and Article 12.1 (commencing with Section 2538.1) of Title 10 of the California Code of Regulations shall be coordinated with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment, consistent with Section 2538.6 of Title 10 of the California Code of Regulations, without imposing delay on the scheduling of the appointment. This subdivision does not modify the requirements established in 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 applicable requirements in subparagraphs (B) and (C):

(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 applicable health insurance policy specified in subparagraph (A) shall ensure that contracted vision provider networks have adequate capacity and availability of licensed health care providers, including ophthalmologists, optometrists, and opticians, to offer insureds appointments for covered 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.

(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.

(C) Each applicable health insurance policy specified in subparagraph (A) shall ensure that contracted oral provider networks have adequate capacity and availability of licensed health care providers, including generalist and specialist dentists, to offer insureds appointments for covered oral services in accordance with the following requirements:

(i) Urgent appointments within the insurer network shall be offered within 48 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 18 business days of the request for appointment, except as provided in clause (iii).

(iii) Preventive care appointments shall be offered within 20 business days of the request for appointment.

(iv) Dentists shall be available ~~within 15 miles or 30 minutes from an insured's residence or workplace.~~ *pursuant to the geographic accessibility standards in Section 2240.1 of Title 10 of the California Code of Regulations.*

(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 conditions 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 that 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) Information reported by an insurer to the department pursuant to this article shall include comprehensive information regarding the dental provider networks that each dental provider ~~serves, including the insurer’s self-insured network.~~ *serves.* Comprehensive information shall include the number of covered lives per line of business, including ~~self-insured, third-party,~~ *third party* or administrative service organizations, as applicable. For the purpose of determining network adequacy and compliance with time and distance requirements, the department shall review the adequacy of an entire dental provider network, as reported by the health insurers, including the portions of the network serving plans and insurers not regulated by the department.

(4) 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.

SEC. 5. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.