crowell moring

CLIENT ALERT

California Department of Insurance's Emergency Regulations on Provider Networks Go Into Effect

Feb.03.2015

On January 30, 2015, the Office of Administrative Law approved the emergency regulations for provider network adequacy standards proposed by the California Department of Insurance (CDI). The emergency regulations apply to CDI-regulated insurers offering health insurance; they do not modify existing requirements for plans licensed by the California Department of Managed Care that are subject to California's Knox-Keene Act.

The newly-approved regulations, which were introduced earlier this month by the CDI, impose several requirements on health insurers, including the following.

- **Adequate Provider Networks**. Title 10, section 2240.16 was amended to require that insurer provider networks include adequate number and types of providers within 30 minutes or 15 miles of the insureds that offer substance use disorder treatment (based on utilization patterns), crisis intervention and stabilization programs, and specified types of inpatient psychiatric services. Plans must be "designed to optimize" access by using ancillary service providers, and demonstrate "capacity" to provide access to transplant centers within the network. The network's contracted hospitals are required to have "adequate number" of available primary care providers and specialists with admitting and practice privileges. If care cannot be provided within the plan's network, insurers must arrange for medically necessary services using out of network providers but may only charge enrollees in-network rates for patient-responsibility payments (i.e. copay, coinsurance, and deductibles). Policies covering pediatric essential health benefits must also include an adequate network of oral and vision service providers to allow urgent appointments within 72 hours, non-urgent appointment s within 36 business days, and preventative care within 40 business days of the appointment request. Cal. Code Regs. tit. 10, § 2240.16.

- **Timely Access to Care.** Newly adopted section 2240.15 establishes standards for timely access to care, and requires insurers to maintain written quality assurance programs to ensure that the plan's network is sufficient to provide accessibility, availability, and continuity of covered services. Wait times must be clinically appropriate. Unless a referring or treating provider specifically notes that a longer wait time is not medically detrimental, health plans must also offer urgent care appointments with 48 to 96 hours, primary care physician or mental health provider appointments within 10 business days, and specialist appointment within 15 days of the appointment request. Telephone triage and screening services must be available 24/7 and may not have waiting times exceeding 30 minutes.

- **Network Adequacy Reports.** Starting in June 1, 2015, insurers must annually file a network adequacy report for all current or new health policies. Cal. Code Regs. tit. 10, § 2240.5(a)(1). Among other things, the reports must include:
    - a narrative of the adequacy of mental health and substance abuse disorder providers;
    - geographical distribution and number of mental health providers for treating severe mental illness of an adult and serious emotional disturbances of a child;
    - plan's process for selection and tiering of providers and facilities; and

- policies and procedures related to recruiting, credentialing, contracting, and managing provider networks.

To assist the CDI in its oversight, the network adequacy report must also include information on the plan's rates of compliance and noncompliance with the network adequacy and timely access standards. Upon a request by the Commissioner, the plans must provide a network adequacy report even prior to June 1, 2015.

- **Network Directories.** To ensure that enrollees have adequate notice and information about their networks, the regulations impose additional disclosure and education requirements related to the provider networks. Provider network directories must be current, accurate, and conform to specified listing standards. The provider directory must also be available online (updated weekly), and offered to accommodate patients with limited English proficiency. Cal. Code Regs. tit. 10, § 2240.6.

- **Discretionary Waiver**. The Commissioner has the discretion to waive these standards if a plan proposes an alternate access delivery system. Cal. Code Regs. tit. 10, § 2240.7.

The emergency regulations became effective on January 30, and will remain in effect until July 30, 2015, the maximum 180 days allowed under the California Government Code. The regulations will become permanent if the CDI engages in a regular rulemaking process, and submits a Certificate of Compliance by July 29, 2015, that is approved by the Office of Administrative Law within 30 days. The regulations place new compliance burdens on health insurers, but it remains to be seen how the new standards will change existing network adequacy practices for health insurers regulated by the CDI.

For more information, please contact the professional(s) listed below, or your regular Crowell & Moring contact.

Peter Roan
Partner – Los Angeles
Phone: +1 213.443.5571
Email: proan@crowell.com