

AMENDED IN ASSEMBLY MARCH 13, 2025

CALIFORNIA LEGISLATURE—2025–26 REGULAR SESSION

ASSEMBLY BILL

No. 371

Introduced by Assembly Member Haney

February 3, 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. 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. 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.

State-mandated local program: yes.

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

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

3 1367.03. (a) A health care service plan that provides or
4 arranges for the provision of hospital or physician services,
5 including a specialized mental health plan that provides physician
6 or hospital services, or that provides mental health services
7 pursuant to a contract with a full service plan, shall comply with
8 the following timely access requirements:

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

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

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

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

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

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

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

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

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

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

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

1 health care or substance use disorder provider to once every 10
2 business days.

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

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

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

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

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

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

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

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

8 (C) Preventive dental care appointments shall be offered within
9 20 business days of the request for appointment.

10 (D) Dentists shall be available within 15 miles or 30 minutes
11 from an enrollee's residence or workplace.

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

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

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

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

1 arrange coverage outside the plan's network in accordance with
2 subdivision (d) of Section 1374.72.

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

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

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

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

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

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

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

38 (iii) An unlicensed staff person handling enrollee calls may ask
39 questions on behalf of a licensed staff person to help ascertain the
40 condition of an insured so that the enrollee may be referred to

1 licensed staff. However, an unlicensed staff person shall not, under
2 any circumstances, use the answers to those questions in an attempt
3 to assess, evaluate, advise, or make a decision regarding the
4 condition of an enrollee or determine when an enrollee needs to
5 be seen by a licensed medical professional.

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

13 (10) A plan shall ensure that, during normal business hours, the
14 waiting time for an enrollee to speak by telephone with a plan
15 customer service representative knowledgeable and competent
16 regarding the enrollee's questions and concerns shall not exceed
17 10 minutes.

18 (b) With regard to subdivision (a), dental, vision, chiropractic,
19 and acupuncture plans shall comply with paragraphs (1), (3), (4),
20 (7), (9), and (10).

21 (c) The obligation of a plan to comply with this section shall
22 not be waived if the plan delegates to its provider groups or other
23 contracting entities any services or activities that the plan is
24 required to perform. A plan's implementation of this section shall
25 be consistent with the Health Care Providers' Bill of Rights, and
26 a material change in the obligations of a plan's network providers
27 shall be considered a material change to the provider contract,
28 within the meaning of subdivision (b) and paragraph (2) of
29 subdivision (h) of Section 1375.7.

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

38 (e) For purposes of this section:

39 (1) "Advanced access" means the provision, by a network
40 provider, or by the provider group to which an enrollee is assigned,

1 of appointments with a primary care physician, or other qualified
2 primary care provider such as a nurse practitioner or physician's
3 assistant, within the same or next business day from the time an
4 appointment is requested, and advance scheduling of appointments
5 at a later date if the enrollee prefers not to accept the appointment
6 offered within the same or the next business day.

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

13 (3) "Preventive care" means health care provided for prevention
14 and early detection of disease, illness, injury, or another health
15 condition and, in the case of a full service plan includes all of the
16 basic health care services required by Sections 1345, 1367.002,
17 1367.3, and 1367.35 of this code and subdivision (f) of Section
18 1300.67 of Title 28 of the California Code of Regulations.

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

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

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

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

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

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

7 (3) The department shall develop standardized methodologies
8 for reporting that shall be used by health care service plans to
9 demonstrate compliance with this section and any regulations
10 adopted pursuant to it, including demonstration of the average
11 waiting time for each class of appointment regulated under this
12 section, except the department may develop methodologies to
13 demonstrate compliance with, and the average appointment wait
14 time for, each class of appointments regulated under paragraph
15 (6) of subdivision (a). The methodologies shall be sufficient to
16 determine compliance with the standards developed under this
17 section for different networks of providers if a health care service
18 plan uses a different network for Medi-Cal managed care products
19 than for other products or if a health care service plan uses a
20 different network for individual market products than for small
21 group market products. The development and adoption of these
22 methodologies shall not be subject to the Administrative Procedure
23 Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of
24 Division 3 of Title 2 of the Government Code) until December 31,
25 2025. The department shall consult with stakeholders in developing
26 standardized methodologies under this paragraph.

27 (4) Notwithstanding paragraph (3), the department may take
28 compliance or disciplinary action, including assessment of
29 administrative penalties, on the basis of noncompliance with any
30 of the provisions of this section, including, but not limited to,
31 timeframes for appointments and followup appointments.

32 (5) Information reported by a plan to the department pursuant
33 to paragraph (2) shall include comprehensive information regarding
34 the dental provider networks that each dental provider serves,
35 including the plan's self-insured network. Comprehensive
36 information shall include the number of covered lives per line of
37 business, including self-insured, third party, or administrative
38 service organizations, as applicable. For the purpose of determining
39 network adequacy and compliance with time and distance
40 requirements, the department shall review the adequacy of an entire

1 dental provider network, as reported by the health care service
2 plans, including the portions of the network serving plans and
3 insurers not regulated by the department.

4 (6) The department may review and adopt standards, in addition
5 to those specified in this article, concerning the availability of
6 primary care physicians, specialty physicians, hospital care, and
7 other health care, so that consumers have timely access to care. In
8 so doing, the department shall consider the nature of physician
9 practices, including individual and group practices, as well as the
10 nature of the plan network. The department shall also consider
11 various circumstances affecting the delivery of care, including
12 urgent care, care provided on the same day, and requests for
13 specific providers. If the department finds that health care service
14 plans and health care providers have difficulty meeting these
15 standards, the department may make recommendations to the
16 Assembly Committee on Health and the Senate Committee on
17 Health pursuant to subdivision (i). The development and adoption
18 of standards under this paragraph shall not be subject to the
19 Administrative Procedure Act until December 31, 2028. The
20 department shall consult with stakeholders in developing the
21 standards and methodologies described in this section.

22 (g) (1) The director may investigate and, by order, take
23 enforcement action against plans, including, but not limited to,
24 assessing administrative penalties subject to appropriate notice of,
25 and the opportunity for, a hearing in accordance with Section 1397,
26 regarding noncompliance with the requirements of this section.
27 The director shall consider, as an aggravating factor when assessing
28 administrative penalties, if harm to an enrollee, including financial
29 or health impacts to an enrollee or substantial harm as defined in
30 Section 3428 of the Civil Code, has occurred as a result of plan
31 noncompliance. The director has the discretion to determine what
32 harm constitutes harm to an enrollee. The plan may provide to the
33 director, and the director may consider, information regarding the
34 plan's overall compliance with the requirements of this section.
35 When taking enforcement action against a plan, the director may
36 consider patterns of noncompliance. The administrative penalties
37 shall not be deemed an exclusive remedy available to the director.
38 These penalties shall be paid to the Managed Care Administrative
39 Fines and Penalties Fund and shall be used for the purposes
40 specified in Section 1341.45. The director shall periodically

1 evaluate grievances to determine if any audit, investigative, or
2 enforcement actions should be undertaken by the department.

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

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

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

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

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

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

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

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

37 (k) This section applies to a licensed health care service plan
38 that provides services to Medi-Cal beneficiaries. Except for
39 appointment wait time standards set forth in paragraph (5) of
40 subdivision (a) of this section and in Section 1300.67.2.2 of Title

1 28 of the California Code of Regulations, this section does not
2 alter the requirements or standards of the State Department of
3 Health Care Services specified in Section 14197 of the Welfare
4 and Institutions Code.

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

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

10 1374.191. (a) If a health care service plan pays a contracting
11 dental provider directly for covered services rendered to an
12 enrollee, the plan shall pay a noncontracting dental provider
13 directly for covered services rendered to an enrollee if the
14 noncontracting provider submits to the plan a written assignment
15 of benefits form signed by the enrollee.

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

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

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

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

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

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

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

37 (f) This section applies only to a health care service plan contract
38 covering dental services or a specialized health care service plan
39 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:

1 10133.54. (a) This section applies to policies of health
2 insurance, as defined by subdivision (b) of Section 106. The
3 requirements of this section apply to all health care services
4 covered by a health insurance policy.

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

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

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

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

34 (4) Interpreter services required by Section 10133.8 of this code
35 and Article 12.1 (commencing with Section 2538.1) of Title 10 of
36 the California Code of Regulations shall be coordinated with
37 scheduled appointments for health care services in a manner that
38 ensures the provision of interpreter services at the time of the
39 appointment, consistent with Section 2538.6 of Title 10 of the
40 California Code of Regulations, without imposing delay on the

1 scheduling of the appointment. This subdivision does not modify
2 the requirements established in Sections 10133.8 and 10133.9 of
3 this code and Section 2538.6 of Title 10 of the California Code of
4 Regulations, or approved by the department pursuant to Section
5 2538.6 of Title 10 of the California Code of Regulations for an
6 insurer's language assistance program.

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

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

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

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

21 (D) Nonurgent appointments with specialist physicians: within
22 15 business days of the request for appointment, except as provided
23 in subparagraphs (H) and (I).

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

28 (F) Commencing July 1, 2022, nonurgent followup appointments
29 with a nonphysician mental health care or substance use disorder
30 provider: within 10 business days of the prior appointment for
31 those undergoing a course of treatment for an ongoing mental
32 health or substance use disorder condition, except as provided in
33 subparagraph (H). This subparagraph does not limit coverage for
34 nonurgent followup appointments with a nonphysician mental
35 health care or substance use disorder provider to once every 10
36 business days.

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

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

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

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

23 (6) (A) The following types of health insurance policies shall
24 be subject to the applicable requirements in subparagraphs (B) and
25 (C):

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

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

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

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

1 (i) Urgent appointments within the plan network shall be offered
2 within 72 hours of the time of request for appointment.

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

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

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

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

22 (i) Urgent appointments within the insurer network shall be
23 offered within 48 hours of the time of request for appointment, if
24 consistent with the insured's individual needs and as required by
25 professionally recognized standards of dental practice.

26 (ii) Nonurgent appointments shall be offered within 18 business
27 days of the request for appointment, except as provided in clause
28 (iii).

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

31 (iv) Dentists shall be available within 15 miles or 30 minutes
32 from an insured's residence or workplace.

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

36 (A) This section does not modify the requirements regarding
37 accessibility established by Article 6 (commencing with Section
38 2240) of Title 10 of the California Code of Regulations.

39 (B) An insurer shall ensure timely access to covered health care
40 services as required by this section, including applicable

1 time-elapsed standards, by assisting an insured to locate available
2 and accessible contracted providers in a timely manner appropriate
3 for the insured's health needs. An insurer shall arrange for the
4 provision of services outside the insurer's contracted network if
5 unavailable within the network if medically necessary for the
6 insured's condition. Insured costs for medically necessary referrals
7 to nonnetwork providers shall not exceed applicable in-network
8 copayments, coinsurance, and deductibles.

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

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

16 (B) An insurer may provide or arrange for the provision of
17 telephone triage or screening services through one or more of the
18 following means: insurer-operated telephone triage or screening
19 services, telephone medical advice services pursuant to Section
20 10279, the insurer's contracted primary care and mental health
21 care or substance use disorder provider network, or other method
22 that provides triage or screening services consistent with this
23 section.

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

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

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

38 (ii) An insurer that arranges for the provision of triage or
39 screening services through contracted primary care and mental
40 health care and substance use disorder providers who are unable

1 to meet the time-elapsed standards established in subparagraph
2 (A) shall also provide or arrange for the provision of
3 insurer-contracted or operated triage or screening services, which
4 shall, at a minimum, be made available to insureds affected by that
5 portion of the insurer's network.

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

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

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

30 (c) Notwithstanding subdivision (b), a specialized health
31 insurance policy, as defined in subdivision (c) of Section 106,
32 other than a specialized mental health insurance policy, is exempt
33 from this section, except as specified in this subdivision. A
34 specialized health insurance policy that provides coverage for
35 dental care expenses only shall comply with paragraphs (1), (3),
36 (4), (6), (7), (9), and (10) of subdivision (b).

37 (d) An insurer shall incorporate the standards set forth in the
38 insurer's quality assurance systems and processes, as set forth in
39 subdivision (b), and the processes as set forth in Title 10 of the
40 California Code of Regulations, including Sections 2240.1,

1 2240.15, and 2240.16. An insurer shall not prevent, discourage,
2 or discipline a contracting provider or employee for informing an
3 insured or policyholder about the timely access standards.

4 (e) For purposes of this section:

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

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

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

17 (B) Section 10112.2 (incorporating the requirements of Section
18 2713 of the federal Public Health Service Act (42 U.S.C. Sec.
19 300gg-13)).

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

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

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

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

35 (6) "Urgent care" means health care for a condition that requires
36 prompt attention, consistent with paragraph (2) of subdivision (h)
37 of Section 10123.135.

38 (f) (1) The department may issue guidance to insurers regarding
39 annual timely access and network reporting methodologies. The
40 development and adoption of these methodologies shall not be

1 subject to the Administrative Procedure Act (Chapter 3.5
2 (commencing with Section 11340) of Part 1 of Division 3 of Title
3 2 of the Government Code) until December 31, 2025.

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

9 (3) Information reported by an insurer to the department
10 pursuant to this article shall include comprehensive information
11 regarding the dental provider networks that each dental provider
12 serves, including the insurer's self-insured network. Comprehensive
13 information shall include the number of covered lives per line of
14 business, including self-insured, third party, or administrative
15 service organizations, as applicable. For the purpose of determining
16 network adequacy and compliance with time and distance
17 requirements, the department shall review the adequacy of an entire
18 dental provider network, as reported by the health insurers,
19 including the portions of the network serving plans and insurers
20 not regulated by the department.

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

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

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

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