Date of Hearing: July 6, 2021

ASSEMBLY COMMITTEE ON HEALTH
Jim Wood, Chair
SB 221 (Wiener) – As Amended June 28, 2021

SENATE VOTE: 32-7

SUBJECT: Health care coverage: timely access to care.

SUMMARY: AMENDMENTS. Codifies the regulations adopted by the Department of Managed Health Care (DMHC) and the Department of Insurance (CDI) to provide timely access standards for health care service plans (health plans) and insurers for nonemergency health care services. Requires a health plan and a health insurer, including a Medi-Cal Managed Care Plan, to ensure that an enrollee or insured that is undergoing a course of treatment for an ongoing mental health (MH) or substance use disorder (SUD) condition is able to get a followup appointment with a nonphysician MH care or SUD provider within 10 business days of the prior appointment. Requires that a referral to a specialist by another provider meet the timely access standards. Requires the health plan, including a Medi-Cal Managed Care Plan, to arrange coverage outside the plan's contracted network if a health plan is operating in a service area that has a shortage of providers and is not able to meet the geographic and timely access standards for providing MH or SUD services with an in-network provider. Specifically, **this bill**:

1) Requires a health plan or insurer, as specified, to comply with the following timely access requirements:
   a) Requires a health plan or insurer to provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the enrollee's or insured's condition consistent with good professional practice. Requires a plan or insurer to establish and maintain provider networks, policies, procedures, and quality assurance monitoring systems and processes sufficient to ensure compliance with this clinical appropriateness standard. Requires a health plan or insurer that uses a tiered network to demonstrate compliance with the standards established by this bill based on providers available at the lowest cost-sharing tier;
   b) Requires a health plan or insurer to ensure that all plan or 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 enrollee or insured in a timely manner appropriate for the enrollee or insured's condition and in compliance with bill;
   c) Requires the appointment, if it is necessary for a provider or an enrollee or insured to reschedule an appointment, to be promptly rescheduled in a manner that is appropriate for the enrollee or insured's health care needs, and ensures continuity of care consistent with good professional practice, and consistent with this bill and the regulations adopted;
   d) Requires interpreter services to 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, as specified;
   e) Requires a health plan or insurer, in addition to ensuring compliance with the clinical appropriateness standard set forth in a) above, to ensure that its contracted provider

network has adequate capacity and availability of licensed health care providers to offer enrollees or insureds appointments that meet the following timeframes:

i) Urgent care appointments for services that do not require prior authorization: within 48 hours of the request for appointment, except as provided in viii) below;

ii) Urgent care appointments for services that require prior authorization: within 96 hours of the request for appointment, except as provided in viii) below;

iii) Nonurgent appointments for primary care: within 10 business days of the request for appointment, except as provided in viii) and ix) below;

iv) Nonurgent appointments with specialist physicians: within 15 business days of the request for appointment, except as provided in viii) and ix) below;

v) Nonurgent appointments with a nonphysician MH care or SUD provider: within 10 business days of the request for appointment, except as provided in viii) and ix) below;

vi) 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 viii) below. Specifies that this bill does not limit coverage for nonurgent followup appointments with a nonphysician MH or SUD provider to once every 10 business days;

vii) 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 viii) and ix) below;

viii) Allows the applicable waiting time for a particular appointment to 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 or insured;

ix) Allows preventive care services, as defined in 5) below, and periodic followup care, including standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac, MH, or SUD conditions, and laboratory and radiological monitoring for recurrence of disease, to 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;

x) Requires a referral to a specialist by a primary care provider (PCP) or another specialist to be subject to the relevant time-elapsed standard in i), ii), iv) above, unless the requirements in viii) and ix) above are met, and to be subject to the other provisions of this bill; and,

xi) Allows a plan or insurer to 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 5) below.

f) Requires each dental plan or insurer, and each full service plan or insurer offering coverage for dental services to, in addition to ensuring compliance with the clinical appropriateness standard set forth in a) above, ensure that contracted dental provider 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:

i) Requires urgent appointments within the dental plan or insurer network to be offered within 72 hours of the time of request for appointment, if consistent with the enrollee's or insured's individual needs and as required by professionally recognized standards of dental practice;
ii) Requires nonurgent appointments to be offered within 36 business days of the request for appointment, except as provided in iii) below; and
iii) Requires preventive dental care appointments to be offered within 40 business days of the request for appointment.

g) Requires a plan or insurer to ensure it has sufficient numbers of contracted providers to maintain compliance with the standards established by this bill.
h) Specifies that this bill does not modify the requirements regarding provider-to-enrollee ratio or geographic accessibility, as specified.
i) Requires a plan operating in a service area that has a shortage of one or more types of providers to 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 contracted providers in neighboring service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the enrollee's health needs. Requires a plan to arrange for the provision of specialty services from specialists outside the plan's contracted network if unavailable within the network if medically necessary for the enrollee's condition. Prohibits enrollee costs for medically necessary referrals to non-network providers from exceeding applicable copayments, coinsurance, and deductibles. Specifies that 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 contracted provider. Requires a health plan to arrange coverage outside the plan's contracted network, as specified, if medically necessary treatment of a MH or SUD is not available in network within the geographic and timely access standards set by law or regulation.
j) Requires a plan or insurer to provide or arrange for the provision, 24 hours per day, 7 days per week, of triage or screening services by telephone, as defined in 5) below.
k) Requires a plan or insurer to 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.
l) Authorizes a plan to 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 as specified, the plan's contracted primary care and MH care or SUD provider network, or another method that provides triage or screening services consistent with this section.
m) Requires a plan or insurer that arranges for the provision of telephone triage or screening services through contracted primary care, MH care, and SUD providers to require those providers to maintain a procedure for triaging or screening enrollee telephone calls, which, at a minimum, to include the employment, during and after business hours, of a telephone answering machine, an answering service, or office staff, that inform the caller of both of the following:
    i) Regarding the length of wait for a return call from the provider; and,
    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.

n) Requires a plan or insurer that arranges for the provision of triage or screening services through contracted primary care, MH care, and SUD providers who are unable to meet the time-elapsed standards established in 1) above to also provide or arrange for the provision of plan-contracted or operated triage or screening services, which to, at a minimum, be made available to enrollees or insured affected by that portion of the plan's or insurer's network.

o) Allows an unlicensed staff person handling enrollee or insured calls to 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. Prohibits an unlicensed staff person from, under any circumstances, using 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 or insured needs to be seen by a licensed medical professional.

p) Requires dental, vision, chiropractic, and acupuncture plans to ensure that contracted 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.

q) Requires a plan or insurer to 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.

2) Requires dental, vision, chiropractic, and acupuncture plans to comply with 1) i), iii), iv), vii), ix), and x) above.

3) Prohibits the obligation of a plan to comply with this bill from being waived if the plan delegates to its medical groups, independent practice associations, or other contracting entities any services or activities that the plan is required to perform. Requires a plan's implementation of this bill to be consistent with the Health Care Providers' Bill of Rights, and a material change in the obligations of a plan's contracting providers to be considered a material change to the provider contract, as specified.

4) Prohibits a plan or insurer from preventing, discouraging, or disciplining a contracting provider or employee for informing an enrollee or subscriber about the timely access standards.

5) Defines the following:
   a) Advanced access to be the provision, by an individual provider, or by the medical group or independent practice association to which an enrollee is assigned, of appointments with a primary care physician, or other qualified PCP 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;
   b) Appointment waiting time as the time from the initial request for health care services by an enrollee or insured or the enrollee's or insurer'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 insurer or its contracting providers;

c) Preventive care as 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, as specified;
d) Provider group as set forth in existing law;
e) Triage or screening as the assessment of an enrollee's or 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 enrollee or insured who may need care for the purpose of determining the urgency of the enrollee's or insured's need for care;
f) 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.
g) Urgent care means health care for a condition that requires prompt attention, as specified.

6) Requires the Department of Managed Health Care (DMHC) to develop standardized methodologies for reporting to be used by health plans to demonstrate compliance with this bill and any regulations adopted, including demonstration of the average waiting time for each class of appointment regulated under this bill.

7) Applies this bill to Medi-Cal managed care plan contracts entered into with the State Department of Health Care (DHCS), as specified.

8) Requires a health plan contract or insurance policy, that is issued, renewed, or amended on or after July 1, 2022, to provide information to an enrollee regarding the standards for timely access to care required by 1) above, and the information required by this bill, including information related to receipt of interpreter services in a timely manner, no less than annually.

9) Makes various findings and declarations, including that existing law and regulations have been interpreted to set clear timely access standards for health care service plans and health insurers to meet enrollees' requests for initial appointments with nonphysician providers of mental health and substance use disorder services, but not to set similarly clear timely access standards for the provision of followup appointments with these providers for the many enrollees who need them.

10) Makes technical and conforming changes.

EXISTING LAW

1) Establishes the DMHC to regulate health plans and the California Department of Insurance (CDI) to regulate health insurers.

2) Establishes the federal Patient Protection and Affordable Care Act (ACA), which enacts various health care coverage market reforms including the availability of health insurance exchanges (exchanges) and new individual and small group products offered on and off the exchanges beginning 2014.

3) Requires health plans and health insurers providing health coverage in the individual and small group markets to cover, at a minimum, essential health benefits (EHBs), including the 10 EHB benefit categories in the ACA, as specified in state law, which include the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; MH and SUD services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and, pediatric services, including oral and vision care.

4) Requires health plans to provide basic health care services, including: physician services; hospital inpatient and ambulatory care services; diagnostic laboratory and diagnostic and therapeutic radiologic services; home health services; preventive health services; emergency health care services; and, hospice care.

5) Requires every health plan contract and disability insurance policy that provides hospital, medical, or surgical coverage issued, amended, or renewed on or after January 1, 2021 to provide coverage for medically necessary treatment of MH and SUD under the same terms and conditions applied to other medical conditions, as specified.

6) Defines medically necessary treatment of MH or SUD as a service or product addressing the specific needs of that patient, for the purposes of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner as specified.

7) Requires health plans to ensure that all services be readily available at reasonable times to each enrollee consistent with good professional practice, and to the extent feasible, a health plan to make all services readily accessible to all enrollees consistent with existing law on timely access to health care services.

8) Requires DMHC to develop and adopt regulations to ensure that enrollees have access to health care services in a timely manner and consider specified indicators of timeliness of access to care.

9) Requires CDI to promulgate regulations to ensure that insureds have the opportunity to access needed health care services in a timely manner and ensure adequacy of the number and locations of facilities and providers and consider the regulations adopted by DMHC.

10) Requires a health plan to annually report network adequacy data, as specified, to DMHC as part of its annual timely access compliance report, and requires DMHC to review the network adequacy data for compliance with existing requirements.

11) Requires a health plan to ensure that there is at least one full-time equivalent primary care physician for every 2,000 enrollees, and permits the number of enrollees per primary care physician to be increased by up to 1,000 additional enrollees for each full-time equivalent nonphysician medical practitioner supervised by that primary care physician.

5) Establishes the Health Care Provider's Bill of Rights which governs contracts between health care providers and health plans as well as health care providers and health insurers and, among other provisions, prohibits specified terms such as a provision that requires a health care provider to accept additional patients beyond the contracted number or in the absence of

a number if, in the reasonable professional judgment of the provider, accepting additional patients would endanger patients' access to, or continuity of, care. Requires that a plan give a provider at least 45 business days' notice of its intent to change a material contract term, unless a change in state or federal law or regulations, as specified, requires a shorter timeframe for compliance.

6) Defines provider group as a medical group, independent practice association, or any other similar organization.

7) Establishes the Medi-Cal Program, administered by DHCS, to provide comprehensive health benefits to low-income individuals who meet specified eligibility criteria.

FISCAL EFFECT: According to the Senate Appropriations Committee, CDI reports that the requirements set forth in the bill do not fully align with the existing CDI network adequacy regulations, the fiscal impact on CDI will include the one-time cost associated with drafting and adopting conforming regulations. (CDI would need $88,000 fiscal year (FY 2021-22 and $97,000 FY 2022-23) from the Insurance Fund (license fee revenue).

DHCS would require additional staffing to meet the expanded workload created by this bill. Specifically, DHCS would require one permanent full-time Health Program Specialist I position, one permanent full-time Staff Services Manager I, and two permanent full-time Associate Governmental Program Analysts in the Managed Care Quality and Monitoring Division and additional contract costs to add to the timely access survey. (DHCS would need $674,000 [$337,500 General Fund] in the first year and $638,999 [$ 319,500 General Fund] annually ongoing).

DMHC estimates the total cost of this bill to be approximately $1,488,000 Managed Care Fund (MCF) and 5.0 personnel years (PYs) in FY 2021-22, $3,424,000 MCF and 14.9 PYs in FY 2022-23, $3,667,000 MCF and 16.1 PYs in FY 2023-24, $3,472,000 MCF and 16.1 PYs in FY 2024-25, $3,562,000 MCF and 16.1 PYs in FY 2025-26 and annually thereafter. These costs are primarily a result of workload to review health plan documents, develop methodology for monitoring plan compliance, address the increased volume of health plan surveys, and enforcement costs. These costs also include legal research, and workload related to promulgating regulations to clarify the requirements set forth in this bill, and for application upgrades for health plan submittals. All costs associated with this bill would be incurred by the MCF and covered through fees assessed on health plans.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, this bill will ensure the people are able to get timely follow-up mental health appointments. Currently, people frequently have to wait long periods of time, frequently months, for follow-up appointments, thus undermining their care. This bill will establish clear, timely access standards for follow-up appointments needed by patients in ongoing, medically necessary treatment for MH and SUD. The author states that in the absence of clear, timely access standards for follow-up appointments with non-physician MH and SUD providers, such as social workers and therapists, large numbers of Californians requiring ongoing courses of treatment for MH and SUD have been unable to access care within the timeframes that are clinically appropriate for their diagnoses. This

problem is exacerbated by the significant increase in demand for MH and SUD services driven by the COVID-19 pandemic, with national survey data showing that the rate of anxiety and depression has tripled over the last year and a recent Centers for Disease Control study finding that one in four people age 18 to 24 has seriously considered suicide in the past 30 days. The author concludes that timely access to ongoing MH and SUD treatment is essential and must be accessible when medically necessary.

2) BACKGROUND.

a) **Existing Network Adequacy Requirements.** California law sets forth various network adequacy requirements on health plans and insurers. For example, health plans are subject to the following:

i) Timely Access. Timely Access Regulations require that health plans meet a set of standards which include specific time frames under which enrollees must be able to access care. These requirements generally include the following standards for appointment availability:

(1) *Urgent care without prior authorization*: **within 48 hours**;
(2) *Urgent care with prior authorization*: **within 96 hours**;
(3) *Non-urgent primary care appointments*: **within 10 business days;**
(4) *Non-urgent specialist appointments*: **within 15 business days;**
(5) Non-Urgent mental health appointments: within 15 business days for psychiatrist, within 10 business days for non-physician mental health provider; and,
(6) *Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness or other health condition*: **within 15 business days**.

Existing regulations also authorize the applicable waiting time for a particular appointment to 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 his or her 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. This bill codifies into statute existing law currently set forth in timely access regulations and adds a provision specifically related to follow up MH and SUD appointments.

ii) Geographic Access. Health plans are also generally required to ensure geographic access such that there are a sufficient number of providers located within a reasonable distance from where each enrollee lives or works. For example, PCPs and hospitals should be **located within 15 miles or 30 minutes** from work or home.

Health plans must also ensure provider capacity such that health plan networks have enough of each of the right types of providers to deliver the volume of services needed. For example, plan networks should include **one PCP for every 2,000 beneficiaries.**

iii) Grievance Process. Health plan enrollees can also file a complaint (also known as an appeal or grievance) if he or she has a problem with a health plan, for example, if he or she is unable to schedule an appointment pursuant to the above. Additionally,

enrollees can apply for an Independent Medical Review (IMR) with the DMHC when a health care service or treatment has been denied, modified or delayed. An IMR is a review by independent doctors who are not part of the health plan.

b) **Pending DMHC regulations**. Health plans report to the DMHC, on an annual basis, compliance with timely access to care standards and report to the DMHC the adequacy of the health plan's provider network. In 2010, the DMHC adopted clarifying regulations for timely access to care compliance. In the years following implementation of the regulation, health plan timely access reports received by the DMHC were filled with errors and reflected inaccurate information that was often incomplete and unhelpful during the DMHC's review. The disparate, incomplete, and poor quality information contained within the health plan reports made it impossible for the DMHC to determine timely access to care compliance. SB 964 (Hernandez), Chapter 573, Statutes of 2014, authorized DMHC to develop standardized reporting methodologies for the health plans' annual timely access reporting and annual network adequacy reporting. The authority for the DMHC to develop a standardized methodology for the annual timely access report and the annual network adequacy report is pursuant to an exemption from the Administrative Procedures Act (APA). The exemption expires on January 1, 2020. The current rulemaking process proposes to codify and implement the processes and methodologies developed during the APA exemption period. The DMHC recently concluded its third public comment period to clarify and make specific the timely access to care and annual network reporting requirements for health plans.

c) **Appointment availability surveys**. According to the California Health Care Foundation's (CHCF) 2020 survey of California residents, 52% of those who tried to make an appointment believe they waited longer than was reasonable to get one. The author also provided the results of a December 2020 survey of mental health therapists practicing at California's largest HMO, in which 88% of therapists reported that weekly individual psychotherapy treatment is unavailable for patients who need it. Fifty-one percent of therapists reported that their patients have to wait more than four weeks for a follow-up treatment appointment. Therapists reported that they had no follow-up appointments available in their schedules for an average of twenty-two business days. In another survey, Californians ranked access to mental health treatment as the state's top health care priority in a 2019 survey conducted jointly by the CHCF and the Kaiser Family Foundation. A majority (57%) of Californians responded that most people with mental health conditions in the state are not able to get the services they need, and nearly half (48%) said the same about people with alcohol or drug use problems.

d) **Work force issues**. A recent Sac Bee article reported that Sacramento County received funding to begin pairing MH counselors with law enforcement agencies and until recently could only staff six of the 11 teams funded. County officials cited the intense competition for therapists. The article also noted a 2019 report by the Legislative Analyst's Office (LAO) that concluded that there was only "mixed evidence" of a shortage. The LAO report cast doubt on the shortage assumption because salaries for MH professions were not growing at a rapid pace, a possible sign of intense competition. The LAO report referred to researchers at the University of California, San Francisco (UCSF) who project that, unless the total number of people entering MH professions in the state increases, California would face a shortage of MH professionals between 2016 and 2028. If the total number of people entering MH professions does *not* increase, these projections show that the supply of MH professionals could fall short of demand for MH professionals by

between 12% and 40% by 2028. At the time of the LAO publication, the state had experienced growth in the number of masters- and doctoral-level professional mental health graduates. The LAO report also noted that the growth in professional MH graduates brought uncertainty to whether the state is facing a shortage. To see whether the number of people entering MH professions has in fact remained constant in recent years (which would suggest that the education and training of new MH professionals is likely not meeting the state's workforce needs), the LAO reviewed data on the number of individuals graduating with professional masters or doctoral degrees in MH-related fields from California universities. From 2009-10 to 2016-17, the annual number of professional degree graduates in the fields of clinical psychology, social work, counseling, and psychiatric nursing increased from 4,700 to around 8,000—a 70% increase. (Over this same time period, California's resident population increased by about 6%.) If sustained, this increase in the number of graduates may, but is not guaranteed to, significantly ameliorate the projected MH workforce shortage that does not necessarily assume an increase. More than 80% of the increase in professional MH graduates is from graduates of private universities in the state, which do not rely on augmentations in state funding to grow enrollment.

3) **SUPPORT.** National Union of Healthcare Workers, NUHW, sponsor of this bill, writes that this bill will close a loophole in state law and regulations and establish a clear and appropriate timely access standard for follow-up appointments for MH and SUD treatment. This bill will hold health plans and insurers accountable to arrange for the timely follow-up care to which enrollees are entitled, and help minimize negative consequences associated with delays in treatment. The sponsor states that it is common for patients to wait more than four weeks for a follow-up appointment for clinically appropriate treatment. Delays in accessing appropriate treatment can lead to longer recovery times; worse outcomes; increased morbidity and mortality rates; increased time away from work; increased strain on families; increased risk of decompensation; and, accelerating crisis requiring more costly and intensive care.

4) **CONCERNS.** Kaiser Permanente writes that the change to a 10-day follow-up appointment standard for non-physician MH providers locks in a return interval not tied to clinical judgement. Return appointments for MH and SUD should meet individual patient needs and be deemed medically indicated by the patient's treating provider. This mandate will lead to an increase in caseloads for mental health therapists, which Kaiser Permanente and other health systems must manage. A primary and fundamental challenge is to build the workforce necessary to meet the current demand for MH care. As the UCSF San Francisco benchmark study of the mental health care workforce illustrates, we face a MH workforce shortage crisis in California. In 2018, UCSF noted that without concerted effort California will have 50% fewer psychiatrists and nearly 30 percent fewer therapists than we need to meet patterns of demand for behavioral health services by 2028. Forty-five percent of psychiatrists and 37% of psychologists will be approaching retirement age in that same period. Kaiser Permanente concludes that the COVID-19 pandemic has exacerbated the shortage we were already facing, as demand for MH care has greatly increased.

5) **OPPOSITION.** The California Association of Health Plans and the California Life and Health Insurance Companies are concerned that the 10-day follow-up appointment provision included in this bill may unintentionally limit access to these vital services, undermine existing

provider networks and unnecessarily create significant administrative and compliance challenges on providers, plans and insurers.

6) PREVIOUS LEGISLATION.

a) SB 855 (Wiener), Chapter 151, Statutes of 2020**,** revises and recasts California's Mental Health Parity provisions, and requires a health plan contract or disability insurance policy issued, amended, or renewed on or after January 1, 2021, to provide coverage for medically necessary treatment of MH and SUD, as defined, under the same terms and conditions applied to other medical conditions and prohibits a health plan or disability insurer from limiting benefits or coverage for MH and SUD to short-term or acute treatment. Specifies that if services for the medically necessary treatment of a MH and SUD are not available in network within the geographic and timely access standards in existing law, the health plan or insurer is required to arrange coverage to ensure the delivery of medically necessary out of network services and any medically necessary follow up services, as specified.

b) SB 964 (Hernandez), Chapter 573, Statutes of 2014, requires a health plan to annually report specified network adequacy data, as specified, to DMHC as a part of its annual timely access compliance report, and requires DMHC to review the network adequacy data for compliance.

c) AB 2179 (Cohn), Chapter 797, Statutes of 2002, requires DMHC and CDI to develop and adopted regulations to ensure that enrollees have access to needed health care services.

REGISTERED SUPPORT / OPPOSITION:

Support

National Union of Healthcare Workers (sponsor)
Association of Regional Center Agencies
Autism Speaks
CA Behavioral Health Planning Council
CA Council of Community Behavioral Health Agencies
California Access Coalition
California Alliance of Child and Family Services
California Association of Alcohol and Drug Program Executives, INC.
California Association of Marriage and Family Therapists
California Association of Social Rehabilitation Agencies
California Catholic Conference
California Consortium of Addiction Programs and Professionals
California Psychological Association
California Retired Teachers Association
California School Employees Association
California Senior Legislature
California State Association of Psychiatrists (CSAP)
Center for Autism and Related Disorders (CARD); the
Dbsa California
Disability Rights California

Friends Committee on Legislation of California
Health Access California
Housing Rights Committee of San Francisco
Mental Health & Autism Insurance Project
Mental Health America of California
National Alliance on Mental Illness (NAMI-CA)
National Association of Social Workers, California Chapter
National Health Law Program
National Union of Healthcare Workers
San Francisco Black, Jewish and Unity Group
San Francisco Board of Supervisors
Steinberg Institute
The Kennedy Forum
Western Center on Law & Poverty, INC.

Opposition

Association of California Life & Health Insurance Companies
California Association of Health Plans

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