AMENDED IN SENATE JUNE 27, 2024

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CALIFORNIA LEGISLATURE—2023–24 REGULAR SESSION

ASSEMBLY BILL No. 236

Introduced by Assembly Member Holden
(Coauthors: Assembly Members Arambula and Boerner)
(Coauthors: Senators Allen and Wiener)

January 13, 2023

An act to amend Section 1367.27 of the Health and Safety Code, and to amend Section 10133.15 of the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 236, as amended, Holden. Health care coverage: provider directories.

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 a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan and a health insurer that contracts with providers for alternative rates of payment to publish and maintain a provider directory or directories with information on contracting

providers that deliver health care services enrollees or insureds, and requires a health care service plan and health insurer to regularly update its printed and online provider directory or directories, as specified. Existing law authorizes the departments to require a plan or insurer to provide coverage for all covered health care services provided to an enrollee or insured who reasonably relied on materially inaccurate, incomplete, or misleading information contained in a health plan's provider directory or directories.

This bill would require a plan or insurer to annually verify and delete inaccurate listings from its provider directories, and would require a provider directory to be 60% accurate on July 1, 2025, with increasing required percentage accuracy benchmarks to be met each year until the directories are 95% accurate on or before July 1, 2028. The bill would subject a plan or insurer to administrative penalties for failure to meet the prescribed benchmarks. The bill would require a plan or insurer to arrange care and provide coverage for all covered health care services provided to an enrollee or insured who reasonably relied on inaccurate, incomplete, or misleading information contained in a health plan or policy's provider directory or directories and to reimburse the provider the contracted amount for those services. The bill would prohibit a provider from collecting an additional amount from an enrollee or insured other than the applicable in-network cost sharing. The bill would require a plan or insurer to provide information about in-network providers to enrollees and insureds upon request, and would limit the cost-sharing amounts an enrollee or insured is required to pay for services from those providers under specified circumstances.

On or before January 1, 2025, this bill would authorize the Department of Managed Health Care and the Department of Insurance to develop uniform formats for plans and insurers to use to request directory information from providers and to establish a methodology and processes to ensure accuracy of provider directories and consistency with other laws, regulations, or standards. The bill would require the health plan or the insurer, as applicable, to ensure the accuracy of a request to add back a provider who was previously removed from a directory and approve the request within 10 business days of receipt, if accurate.

Because a violation of the bill's requirements by a health care service plan would be a crime, the 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:

SECTION 1. The Legislature finds and declares all of the following:

(a) It has been the responsibility of each health care service plan and health insurer to maintain an accurate provider directory since the enactment of Chapter 649 of the Statutes of 2015. Despite the requirement in existing law that provider directories be accurate, both academic studies and reports of individual consumers indicate that inaccuracies in provider directories are common. Individual consumers and their representatives should be able to obtain care, including an appointment as a new patient, based on accurate information in the provider directory maintained by the health care service plan or health insurer.

(b) Too often consumers find "ghost" networks in which the provider directories of health care service plans and health insurers include doctors, hospitals, and other providers who are not accepting new patients, not accepting patients for that network of the plan or insurer, have not been compensated by the carrier in the past year, or are inaccessible to consumers because of inaccurate contact information in the provider directory. Some health care service plans and insurers advertise that there are thousands or even tens of thousands of doctors, hospitals, and other providers of care in their network, but when a consumer tries to contact a health care provider, basic information such as name and address are too often inaccurate. Even if the consumer can reach the provider who appears to be in-network for that network of the carrier, too often the consumer discovers either that the provider is not accepting new patients or not accepting patients for that network of the carrier, putting the burden of the inaccurate provider directory on the consumer, not the health care service plan or insurer. These barriers to care are most problematic for those

consumers who need care the most, such as persons with disabilities or behavioral health conditions, as well as those with other barriers to seeking care, such as limited English proficiency or lack of health care literacy.

(c) To encourage the development of a provider directory utility that could be used by all health care service plans, in 2015, the Department of Managed Health Care required an undertaking to fund the development of such a provider directory utility as a condition of the department's approval of the acquisition of CareFirst by Blue Shield of California. In the years from 2015 to the introduction of this act, the Integrated Healthcare Association, an association of health care service plans, health insurers, provider groups, and hospitals with no consumer representation, held numerous meetings and workgroups with health care industry entities to develop a provider directory utility. The Integrated Healthcare Association states that as of 2019, the provider directory utility was operational and able to assist health care service plans and health insurers in verifying and crosschecking the accuracy of provider directory information. There are also efforts by the federal Centers for Medicare and Medicaid Services to aid in the accuracy of provider updates to improve provider directories.

(d) Inclusion in a health care service plan or health insurer directory is a form of marketing for health care providers, including hospitals, laboratory services, imaging, provider groups, and individual providers because those directories provide individual consumers information about whether or not the health care provider is available through the network of the plan or insurer. Removal from the provider directory of a health care service plan or health insurer constitutes a financial penalty for a health care provider because a consumer seeking in-network care or to receive referrals from other health care providers for in-network care is less likely to seek care from a provider not included in the provider directory.

(e) It is the intent of the Legislature in enacting this act to ensure that provider directories of health care service plans and health insurers are substantially accurate and that consumers are able to rely on the information provided in those directories, including such basic information as the name of the provider, the telephone number, and the address where care may be sought. It is also the intent of the Legislature to require the improvement of accuracy

of provider directories over a number of years. In addition to the financial penalties on providers for failure to provide accurate and timely information for inclusion in the provider directory of a health care service plan or health insurer, it is the intent of the Legislature that the relevant departments have the authority to impose financial penalties on health care service plans and insurers for any failure of a plan or insurer to maintain the accuracy of its own directory.

SEC. 2. Section 1367.27 of the Health and Safety Code is amended to read:

1367.27. (a) A health care service plan shall publish and maintain a provider directory or directories with information on contracting providers that deliver health care services to the plan's enrollees, including those that accept new patients. A provider directory shall not list or include information on a provider that is not currently under contract with the plan. Commencing July 1, 2025, a health care service plan shall comply with this section as it read on January 1, 2025.

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

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

(2) The online provider directory or directories shall be accessible on the plan's public internet website through an

identifiable link or tab and in a manner that is accessible and searchable by enrollees, potential enrollees, the public, and providers. By July 31, 2017, or 12 months after the date provider directory standards are developed under subdivision (k), whichever occurs later, the plan's public internet website shall allow provider searches by, at a minimum, name, practice address, city, ZIP Code, California license number, National Provider Identifier number, admitting privileges to an identified hospital, product, tier, provider language or languages, provider group, hospital name, facility name, or clinic name, as appropriate, and the information provided shall be verified and accurate, consistent with this section.

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

(2) A health care service plan shall update its printed provider directory or directories at least quarterly, or more frequently, if required by federal law.

(3) A printed provider directory shall be dated with the date of its last update.

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

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

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

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

(D) Upon the completion of the investigation described in subdivision (o), a change is necessary based on an enrollee

complaint that a provider was not accepting new patients, was otherwise not available, or whose contact information was listed incorrectly.

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

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

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

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

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

(f) (1) The provider directory or directories shall display the date of the most recent update. The provider directory or directories shall also display a dedicated email address, telephone number, and reporting form hyperlink for members of the public and providers to report possible inaccurate, incomplete, or misleading directory information. The provider directory or directories shall also state that the enrollee may submit a complaint if the enrollee believes they reasonably relied upon materially inaccurate, incomplete, or misleading directory information. This information shall be disclosed prominently in the directory or directories and on the plan's internet website.

(2) A health care service plan shall include prominent disclosure on its print and online provider directories of its duty to arrange coverage when behavioral health benefits are not available in-network within applicable geographic and timely access standards. The disclosure shall be included within the "Timely Access to Care" section of the directory that is required by Section 1367.031 and shall also include the geographic accessibility standards.

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

(1) Language interpreter services, at no cost to the enrollee, including how to obtain interpretation services in accordance with Section 1367.04.

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

(h) A full service health care service plan and a specialized mental health plan shall include all of the following information in the provider directory or directories:

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

(2) Type of practitioner.

(3) National Provider Identifier number.

(4) California license number and type of license.

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

(6) The provider's office email address, if available to an enrollee or the public.

(7) The population served, meaning adult, pediatric, or both.

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

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

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

(B) Nurse practitioners, physician assistants, psychologists, acupuncturists, optometrists, dispensing optometrists and opticians, podiatrists, chiropractors, licensed clinical social workers, marriage and family therapists, professional clinical counselors, qualified autism service providers, as defined in Section 1374.73, nurse-midwives, and dentists.

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

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

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

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

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

(11) Non-English language, if any, spoken by a health care provider or other medical professional as well as non-English language spoken by a qualified medical interpreter, in accordance with Section 1367.04, if any, on the provider's staff.

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

(13) ~~The~~ *Whether or not the provider is in the lowest cost-sharing tier, if the product has more than one cost-sharing tier, and the* network tier to which the provider is assigned, if the provider is not in the lowest tier, as applicable. Nothing in this section shall be construed to require the use of network tiers other than contract and noncontracting tiers.

(14) The provider's contract termination date, if any. The plan shall delete the provider from the directory within five days after the termination date of the provider's contract if there is a termination date.

~~(15) Whether or not the provider is in the lowest cost-sharing tier, if the product has more than one cost-sharing tier.~~

~~(16)~~

(15) Whether or not the provider has seen patients for this product in the last year, based on financial compensation of the provider by the plan, consistent with this section.

~~(17)~~

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

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

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

(2) Type of practitioner.

(3) National Provider Identifier number.

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

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

(6) The provider's office email address, if available to an enrollee or the public.

(7) The population served, meaning adult, pediatric, or both.

(8) The name of each affiliated provider group or specialty plan practice group currently under contract with the plan through which the provider sees enrollees.

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

(10) The non-English language, if any, spoken by a health care provider or other medical professional as well as non-English language spoken by a qualified medical interpreter, in accordance with Section 1367.04, if any, on the provider's staff.

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

(12) The provider's contract termination date, if any. The plan shall delete the provider from the directory within five days after the termination date of the provider's contract if there is a termination date.

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

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

(A) The provider is not accepting new patients.

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

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

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

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

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

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

(4) On or before January 1, 2025, the department may develop a uniform format with standardized naming conventions and other aspects for each plan to use to request directory information from its providers.

(5) (A) On or before January 1, 2025, the department may establish a methodology and processes to ensure accuracy of provider directories and consistency with other state or federal laws, regulations, or standards. The department shall take into account existing methods, including surveys, plan-reported information, and benchmarks or submission information from a central utility by another entity.

(B) The department may require a health care service plan to use a central utility or designate a central utility for those providers included in the directory. In developing the methodology under this section, the department shall seek input from interested parties and may hold one or more public meetings. Standards developed pursuant to paragraph (4) and this paragraph shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing

with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) until January 1, 2028.

(C) If the plan can demonstrate it will meet the benchmarks required in paragraph (2) of subdivision (n) without using the central utility designated in subparagraph (B), the department may allow the plan to not use the central utility. If the plan fails to meet the benchmark in the future, the department may require the plan to use the central utility as a method to achieve higher accuracy of provider directory listings to comply with paragraph (2) of subdivision (n).

(*l*) (1) A plan shall take appropriate steps to ensure the accuracy of the information concerning each provider listed in the plan's provider directory or directories in accordance with this section, and shall, at least annually, review and update the entire provider directory or directories for each product offered. Each calendar year the plan shall notify all contracted providers described in subdivisions (h) and (i) as follows:

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

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

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

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

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

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

(3) The plan shall require an affirmative response from the provider or provider group acknowledging that the notification was received. The provider or provider group shall confirm that the information in the provider directory or directories is current

and accurate or update the information required to be in the directory or directories pursuant to this section, including whether or not the provider or provider group is accepting new patients for each plan product.

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

(5) If a provider that was previously removed from the provider directory or directories requests to be added back to the provider directory or directories, or if a plan requests that a provider that was previously removed from the provider directory or directories be added back to the provider directory or directories, the health plan shall ensure the accuracy of the information required under this section and approve the request within 10 business days of receipt if accurate.

(6) General acute care hospitals shall be exempt from the requirements in paragraphs (3) to (5), inclusive.

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

(1) The policies and procedures described under this subdivision shall be submitted by a plan annually to the department for approval and in a format described by the department pursuant to Section 1367.035.

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

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

(n) A plan shall be responsible for maintaining an accurate provider directory.

(1) An accurate provider directory maintains accurate information for all information to be included in the directories pursuant to subdivisions (h) and (i).

(2) The accuracy percentage of a directory shall be determined by the percentage of providers for which all information required in subdivision (h) or (i) is accurate. If there is one error *that would impact a patient's access to care* on a listing for a provider, that listing is considered inaccurate.

(A) On July 1, 2025, a plan's directories shall be at least 60-percent accurate.

(B) On or before July 1, 2026, a plan's directories shall be at least 80-percent accurate.

(C) On or before July 1, 2027, a plan's directories shall be at least 90-percent accurate.

(D) On or before July 1, 2028, a plan's directories shall be at least 95-percent accurate.

(3) A plan shall annually verify its provider directories for accuracy of all of the information required pursuant to subdivisions (h) and (i). If the department develops a methodology and standards

that permit the use of a central ~~utility,~~ *utility or central utilities,* and if a health care service plan uses ~~the~~ *a* central utility for some or all of the plan's provider directory, the plan shall ensure that information derived from the central utility is incorporated in the plan's provider directory unless the plan can demonstrate that the information is inaccurate. The plan using a central utility shall continue to retain responsibility for ensuring that the requirements of this section are satisfied, including in any contract or other agreement with the central utility. The department shall develop procedures and policies on how a plan shall conduct the verifications. In addition to verifying the information required under subdivisions (h) and (i), the plan shall do all of the following:

(A) In verifying the accuracy of information in the provider directory or directories, determine whether a provider has submitted claims or otherwise been compensated for covered benefits for enrollees in that product or network.

(B) Annually submit its accuracy verification reports and a declaration that the accuracy verification report is true and correct to the department to ensure compliance with this section.

(C) Publicly post its accuracy verification reports annually on its internet website.

(D) Verification of the accuracy of the printed directory shall be based on the date of printing, which shall be provided on each page of the printed directory.

(4) Failure by a health care service plan to comply with this section, including failure to meet the required benchmarks for accuracy, shall result in an administrative penalty consistent with this section and this chapter. In determining the appropriate amount of an administrative penalty, a listing inaccuracy *that would impact a patient's access to care* shall be treated as a denial of access to care for covered benefits. ~~For purposes of determining an administrative penalty based on an inaccuracy, required accurate information shall include, but not be limited to, the provider name, address, and telephone number, whether the provider is accepting new patients, whether the provider was financially compensated by the plan consistent with this section, and any other information as determined by the department.~~

(5) Failure to meet the required benchmarks in paragraph (2) shall result in an administrative penalty of not less than five hundred dollars ($500) per 1,000 enrollees and up to five thousand

dollars ($5,000) per 1,000 enrollees, and failure to meet the benchmark in the subsequent year shall result in an administrative penalty of not less than one thousand dollars ($1,000) per 1,000 enrollees and up to ten thousand dollars ($10,000) per 1,000 enrollees for each year following the first year that the plan failed to meet the benchmark.

(6) When assessing administrative penalties against a health care service plan, the director shall determine the appropriate penalty amount for each violation based on one or more factors as applicable, including the factors outlined in subdivision (d) of Section 1386. *The director shall take into consideration evidence provided by the plan of the plan's policies and procedures to obtain accurate provider information pursuant to this section and the plan's use of a central utility in assessing penalties pursuant to this section.*

(7) Beginning January 1, 2028, and every five years thereafter, the penalty amounts specified in this section shall be adjusted based on the average rate of change in premium rates for the individual and small group markets, and weighted by enrollment, since the previous adjustment.

(8) Administrative penalties levied by the department on the plan pursuant to this section shall be paid by the plan and shall not be paid by the provider, subscriber, or enrollee. *This paragraph does not prevent a plan from including penalties for noncompliance with verification standards in the provider contract.*

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

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

(3) A provider group may terminate a contract with a provider for a pattern or repeated failure of the provider to update the

information required to be in the directory or directories pursuant to this section.

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

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

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

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

(5) Section 1375.7, known as the Health Care Providers' Bill of Rights, applies to any material change to a provider contract pursuant to this section.

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

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

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

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

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

made no later than the next required update, or sooner if required by federal law or regulations.

(q) (1) Notwithstanding Sections 1371 and 1371.35, a plan may delay payment or reimbursement owed to a provider or provider group as specified in subparagraph (A) or (B), if the provider or provider group fails to respond to the plan's attempts to verify the provider's or provider group's information as required under subdivision (*l*). The plan shall not delay payment unless it has attempted to verify the provider's or provider group's information. As used in this subdivision, "verify" means to contact the provider or provider group in writing, electronically, and by telephone to confirm whether the provider's or provider group's information is correct or requires updates. A plan may seek to delay payment or reimbursement owed to a provider or provider group only after the 10-business-day notice period described in paragraph (4) of subdivision (*l*) has lapsed.

(A) For a provider or provider group that receives compensation on a capitated or prepaid basis, the plan may delay no more than 50 percent of the next scheduled capitation payment for up to one calendar month.

(B) For any claims payment made to a provider or provider group, the plan may delay the claims payment for up to one calendar month beginning on the first day of the following month.

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

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

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

(3) A plan may terminate a contract for a pattern or repeated failure of the provider or provider group to alert the plan to a

change in the information required to be in the directory or directories pursuant to this section.

(4) A plan that delays payment or reimbursement under this subdivision shall document each instance a payment or reimbursement was delayed and report this information to the department in a format described by the department pursuant to Section 1367.035. This information shall be submitted along with the policies and procedures required to be submitted annually to the department pursuant to paragraph (1) of subdivision (m).

(5) With respect to plans with Medi-Cal managed care contracts with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591) of the Welfare and Institutions Code, this subdivision shall be implemented only to the extent consistent with federal law and guidance.

(r) (1) In circumstances where the department finds that an enrollee reasonably relied upon inaccurate, incomplete, or misleading information contained in a health plan's provider directory or directories, the health care service plan shall arrange care and provide coverage for all covered health care services provided to the enrollee, reimburse the enrollee for any amount beyond what the enrollee would have paid, had the services been delivered by an in-network provider under the enrollee's plan contract, and reimburse the provider the amount that they would have been paid if the provider was under contract. The provider shall not collect any additional amount from the enrollee other than the applicable in-network cost sharing. Prior to requiring reimbursement in these circumstances, the department shall conclude that the services received by the enrollee were covered services under the enrollee's plan contract. In those circumstances, the fact that the services were rendered or delivered by a noncontracting or out-of-plan provider shall not be used as a basis to deny reimbursement to the enrollee.

(2) If an enrollee, by telephone call or electronic means, requests information on whether or not a provider is contracted as an in-network provider to provide covered benefits, the health care service plan shall, if the request is by telephone, tell the enrollee verbally and follow up in writing or electronic format no later than one business day after receiving the request. If the request is by

electronic means, the plan shall respond in writing or electronic format no later than one business day after receiving the request. The plan shall also provide information on whether or not the provider is accepting new patients. The plan shall retain a record of the request and the plan's response in the enrollee's file for at least two years after the date of the request.

(3) For covered benefits, if an enrollee obtained information through the plan's online directory or a request consistent with paragraph (2) that a provider was an in-network provider, the enrollee shall pay no more than in-network cost sharing if any of the following apply:

(A) The provider is not contracting with the health care service plan as an in-network provider for that product.

(B) The contracting provider is not accepting new patients for that product.

(C) The information provided is otherwise inaccurate, misleading, or incomplete.

(D) The online provider directory of the health care service plan is not accessible to enrollees at the time the enrollee seeks information and the enrollee requests information consistent with paragraph (2).

(4) If the health care service plan contract includes more than one tier of cost sharing, the plan shall document the cost-sharing tier that the provider is contracted to accept and shall provide that information to the enrollee when the enrollee seeks information about the provider. If the plan provides information indicating that a provider is on a lower cost-sharing tier and that information is not accurate, then the enrollee shall owe no more than the cost sharing for the cost-sharing tier included in the information received by the enrollee from the plan.

(5) For purposes of this subdivision, the in-network cost sharing amount for a contracted provider includes copayments, deductibles, coinsurance, and any other form of cost sharing. If the health care service plan contract includes more than one tier of cost sharing and if the enrollee was not informed accurately of the applicable cost-sharing tier, then the lowest cost-sharing tier shall apply.

(6) For purposes of this subdivision, "information" is inaccurate, incomplete, or misleading if any information in subdivision (h) or (i) is inaccurate, incomplete, or misleading.

(s) (1) Whenever a plan determines as a result of this section that there has been a 10-percent change in the network for a product in a region, the plan shall file an amendment to the plan application with the department consistent with subdivision (f) of Section 1300.52 of Title 28 of the California Code of Regulations.

(2) For a health care service plan issued, amended, or renewed on or after July 1, 2025, if a provider has not been financially compensated consistent with this section ~~or~~ *and* if the provider has failed to respond timely consistent with this section, and those providers amount to a change of 10 percent or greater in the network for a product in a region, then the plan shall file an amendment to the plan application consistent with subdivision (f) of Section 1300.52 of Title 28 of the California Code of Regulations.

(3) ~~(A)~~ A plan shall not use information about a provider for purposes of compliance with timely access requirements, network adequacy determination, or compliance with any other provision of this chapter if the plan cannot demonstrate to the department that ~~one or more of the following applies:~~ *the provider is actively contracting with the plan as determined by the department. This paragraph shall apply whether or not the provider has been deleted from the directory.*

~~(i) The provider is contracting with the plan and the provider has been financially compensated by the plan consistent with this section.~~

~~(ii) The provider has failed to respond timely consistent with this section.~~

~~(iii) The provider is not in the lowest cost-sharing tier, if the product has more than one cost-sharing tier.~~

~~(B) This paragraph shall apply whether or not the provider has been deleted from the directory.~~

(4) Consistent with Section 1360, a plan shall not advertise or otherwise represent the extent of its network, including the number or type of contracting providers, unless it is able to demonstrate that each provider is ~~contracting and has been compensated consistent with this section.~~ *contracting.*

(5) (A) For purposes of this subdivision, "financially compensated" means having paid one or more claims to a provider for that network or otherwise demonstrably financially compensated that provider for the purposes of providing covered

benefits to enrollees covered by the relevant ~~network,~~ *network in the last five years,* unless a special circumstance applies.

(B) A special circumstance requires inclusion of the provider in the directory, consistent with regulations or other guidance by the department. A special circumstance may include a provider in a rural area, a highly specialized specialist who was not used by an enrollee in the prior year, or other circumstances as determined by the department through the regulatory or other rulemaking process. The department may issue guidance to implement, interpret, or make specific the requirements under this subparagraph. The guidance shall be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(t) (1) This section applies to plans with Medi-Cal managed care contracts with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591) of the Welfare and Institutions Code to the extent consistent with federal law and guidance and state law guidance issued after January 1, 2016.

(2) Notwithstanding any other provision to the contrary in a plan contract with the State Department of Health Care Services, and to the extent consistent with federal law and guidance and state guidance issued after January 1, 2016, a Medi-Cal managed care plan that complies with the requirements of this section shall not be required to distribute a printed provider directory or directories, except as required by paragraph (1) of subdivision (d). All other provisions of this section apply to plans with Medi-Cal managed care contracts.

(u) A health plan that contracts with multiple employer welfare agreements regulated pursuant to Article 4.7 (commencing with Section 742.20) of Chapter 1 of Part 2 of Division 1 of the Insurance Code shall meet the requirements of this section.

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

(w) As part of the department's routine examination of the fiscal and administrative affairs of a health care service plan pursuant to Section 1382, the department shall include a review of the health care service plan's compliance with subdivision (q).

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

SEC. 3. Section 10133.15 of the Insurance Code is amended to read:

10133.15. (a) A health insurer that contracts with providers for alternative rates of payment pursuant to Section 10133 shall publish and maintain a provider directory or directories with information on contracting providers that deliver health care services to the insurer's insureds, including those that accept new patients. A provider directory shall not list or include information on a provider that is not currently under contract with the insurer. Commencing July 1, 2025, a health care service plan shall comply with this section as it read on January 1, 2025.

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

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

(2) The online provider directory or directories shall be accessible on the insurer's public internet website through an identifiable link or tab and in a manner that is accessible and searchable by insureds, potential insureds, the public, and providers. By July 1, 2017, or 12 months after the date provider directory standards are developed under subdivision (k), whichever

occurs later, the insurer's public internet website shall allow provider searches by, at a minimum, name, practice address, city, ZIP Code, California license number, National Provider Identifier number, admitting privileges to an identified hospital, product, tier, provider language or languages, provider group, hospital name, facility name, or clinic name, as appropriate, and the information provided shall be verified and accurate, consistent with this section.

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

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

(3) A printed directory shall be dated with the date of its last update.

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

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

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

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

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

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

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

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

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

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

(f) (1) The provider directory or directories shall display the date of the most recent update. The provider directory or directories shall also display a dedicated email address, telephone number, and reporting form hyperlink for members of the public and providers to report possible inaccurate, incomplete, or misleading directory information. The provider directory or directories shall also state that the insured may submit a complaint if the enrollee believes they reasonably relied upon materially inaccurate, incomplete, or misleading directory information. This information shall be disclosed prominently in the directory or directories and on the insurer's internet website.

(2) An insurer shall include a prominent disclosure on its print and online provider directories of its duty to arrange coverage when behavioral health benefits are not available in-network within applicable geographic and timely access standards. The disclosure shall be included within the directory and shall also include the geographic accessibility standards.

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

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

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

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

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

(2) Type of practitioner.

(3) National Provider Identifier number.

(4) California license number and type of license.

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

(6) The provider's office email address, if available to an insured or the public.

(7) The population served, meaning adult, pediatric, or both.

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

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

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

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

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

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

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

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

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

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

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

(13) ~~The~~ *Whether or not the provider is in the lowest cost-sharing tier, if the product has more than one cost-sharing tier, and the* network tier to which the provider is assigned, if the provider is not in the lowest tier, as applicable. Nothing in this section shall be construed to require the use of network tiers other than contract and noncontracting tiers.

(14) The provider's contract termination date, if any. The insurer shall delete the provider from the directory within five days after the termination date of the provider's contract if there is a termination date.

~~(15) Whether or not the provider is in the lowest cost-sharing tier, if the product has more than one cost-sharing tier.~~

~~(16)~~

(15) Whether or not the provider has seen patients for this product in the last year, based on financial compensation of the provider by the plan, consistent with this section.

~~(17)~~

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

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

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

(2) Type of practitioner.

(3) National Provider Identifier number.

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

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

(6) The provider's office email address, if available to an insured or the public.

(7) The population served, meaning adult, pediatric, or both.

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

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

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

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

(12) The provider's contract termination date, if any. The insurer shall delete the provider from the directory within five days after the termination date of the provider's contract if there is a termination date.

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

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

(A) The provider is not accepting new patients.

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

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

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

(k) (1) On or before December 31, 2016, the department shall develop uniform provider directory standards to permit consistency in accordance with subdivision (b) and paragraph (2) of subdivision (c) and development of a central utility by another entity. Those

standards shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), until January 1, 2021. No more than two revisions of those standards shall be exempt from the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) pursuant to this subdivision.

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

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

(4) On or before January 1, 2025, the department may develop a uniform format with standardized naming conventions and other aspects for each insurer to use to request directory information from its providers.

(5) (A) On or before January 1, 2025, the department may establish a methodology and processes to ensure accuracy of provider directories and consistency with other state or federal laws, regulations, or standards. The department shall take into account existing methods, including surveys, plan-reported information, and benchmarks or submission information from a central utility by another entity.

(B) The department may require an insurer to use a central utility or designate a central utility for those providers included in the directory. In developing the methodology under this section, the department shall seek input from interested parties and may hold one or more public meetings. Standards developed pursuant to paragraph (4) and this paragraph shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) until January 1, 2028.

(C) If the insurer can demonstrate it will meet the benchmarks required in paragraph (2) of subdivision (n) without using the

central utility designated in subparagraph (B), the department may allow the insurer to not use the central utility. If the insurer fails to meet the benchmark in the future, the department may require the insurer to use the central utility as a method to achieve higher accuracy of provider directory listings to comply with paragraph (2) of subdivision (n).

(*l*) (1) An insurer shall take appropriate steps to ensure the accuracy of the information concerning each provider listed in the insurer's provider directory or directories in accordance with this section, and shall, at least annually, review and update the entire provider directory or directories for each product offered. Each calendar year the insurer shall notify all contracted providers described in subdivisions (h) and (i) as follows:

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

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

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

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

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

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

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

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

(5) If a provider that was previously removed from the provider directory or directories requests to be added back to the provider directory or directories, or if an insurer requests that a provider that was previously removed from the provider directory or directories be added back to the provider directory or directories, the insurer shall ensure the accuracy of the request and approve the request within 10 business days of receipt if accurate.

(6) General acute care hospitals shall be exempt from the requirements in paragraphs (3) to (5), inclusive.

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

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

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

Providers shall verify or submit changes to information required to be in the directory or directories pursuant to this section using the process required by the insurer.

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

(n) An insurer shall be responsible for maintaining an accurate provider directory.

(1) An accurate provider directory maintains accurate information for all information to be included in the directories pursuant to subdivisions (h) and (i).

(2) The accuracy percentage of a directory shall be determined by the percentage of providers for which all information required in subdivision (h) or (i) is accurate. If there is one error *that would impact a patient's access to care* on a listing for a provider, that listing is considered inaccurate.

(A) On July 1, 2025, an insurer's directories shall be at least 60-percent accurate.

(B) On or before July 1, 2026, an insurer's directories shall be at least 80-percent accurate.

(C) On or before July 1, 2027, an insurer's directories shall be at least 90-percent accurate.

(D) On or before July 1, 2028, an insurer's directories shall be at least 95-percent accurate.

(3) An insurer shall annually verify its provider directories for accuracy of all of the information required pursuant to subdivisions (h) and (i). If the department develops a methodology and standards that permit the use of a central ~~utility,~~ *utility or central utilities,* and if an insurer uses ~~the~~ *a* central utility for some or all of the insurer's provider directory, the insurer shall ensure that information derived from the central utility is incorporated in the insurer's provider directory unless the insurer can demonstrate that the information is inaccurate. The insurer using a central utility shall continue to retain responsibility for ensuring that the

requirements of this section are satisfied, including in any contract or other agreement with the central utility. The department shall develop procedures and policies on how an insurer shall conduct the verifications. In addition to verifying the information required under subdivisions (h) and (i), the insurer shall do all of the following:

(A) In verifying the accuracy of information in the provider directory or directories, determine whether a provider has submitted claims or otherwise been compensated for covered benefits for insureds in that product or network.

(B) Annually submit its accuracy verification reports and a declaration that the accuracy verification report is true and correct to the department to ensure compliance with this section.

(C) Publicly post its accuracy verification reports annually on its internet website.

(D) Verification of the accuracy of the printed directory shall be based on the date of printing, which shall be provided on each page of the printed directory.

(4) Failure by an insurer to comply with this section, including failure to meet the required benchmarks for accuracy, shall result in an administrative penalty consistent with this section and this chapter. In determining the appropriate amount of an administrative penalty, a listing inaccuracy *that would impact a patient's access to care* shall be treated as a denial of access to care for covered benefits. ~~For purposes of determining an administrative penalty based on an inaccuracy, required accurate information shall include, but not be limited to, the provider name, address, and telephone number, whether the provider is accepting new patients, whether the provider was financially compensated by the insurer consistent with this section, and any other information as determined by the department.~~

(5) Failure to meet the required benchmarks in paragraph (2) shall result in an administrative penalty of not less than five hundred dollars ($500) per 1,000 insureds and up to five thousand dollars ($5,000) per 1,000 insureds, and failure to meet the benchmark in the subsequent year shall result in an administrative penalty of not less than one thousand dollars ($1,000) per 1,000 insureds and up to ten thousand dollars ($10,000) per 1,000 insureds for each year following the first year that the insurer failed to meet the benchmark.

(6) When assessing administrative penalties against a health insurer, the department shall determine the appropriate penalty amount for each violation based on one or more factors as applicable. *The department shall take into consideration evidence provided by the insurer of the insurer's policies and procedures to obtain accurate provider information pursuant to this section, and the insurer's use of a central utility, in assessing penalties pursuant to this section.*

(7) Beginning January 1, 2029, and every five years thereafter, the penalty amounts specified in this section shall be adjusted based on the average rate of change in premium rates for the individual and small group markets, and weighted by enrollment, since the previous adjustment.

(8) Administrative penalties levied by the department on the insurer pursuant to this section shall be paid by the insurer and shall not be paid by the provider, subscriber, or insured. *This paragraph does not prevent an insurer from including penalties for noncompliance with verification standards in the provider contract.*

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

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

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

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

(A) A provider does not respond to the provider group's attempt to verify the provider's information. As used in this paragraph,

"verify" means to contact the provider in writing, electronically, and by telephone to confirm whether the provider's information is correct or requires updates.

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

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

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

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

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

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

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

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

(q) (1) Notwithstanding Sections 10123.13 and 10123.147, an insurer may delay payment or reimbursement owed to a provider or provider group for any claims payment made to a provider or provider group for up to one calendar month beginning on the first day of the following month, if the provider or provider group fails

to respond to the insurer's attempts to verify the provider's information as required under subdivision (*l*). The insurer shall not delay payment unless it has attempted to verify the provider's or provider group's information. As used in this subdivision, "verify" means to contact the provider or provider group in writing, electronically, and by telephone to confirm whether the provider's or provider group's information is correct or requires updates. An insurer may seek to delay payment or reimbursement owed to a provider or provider group only after the 10-business-day notice period described in paragraph (4) of subdivision (*l*) has lapsed.

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

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

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

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

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

(r) (1) In circumstances where the department finds that an insured reasonably relied upon inaccurate, incomplete, or misleading information contained in an insurer's provider directory or directories, the insurer shall arrange care and provide coverage

for all covered health care services provided to the insured, reimburse the insured for any amount beyond what the insured would have paid, had the services been delivered by an in-network provider under the insured's health insurance policy, and reimburse the provider the amount that they would have been paid if the provider was under contract. The provider shall not collect any additional amount from the insured other than the applicable in-network cost sharing. Prior to requiring reimbursement in these circumstances, the department shall conclude that the services received by the insured were covered services under the insured's health insurance policy. In those circumstances, the fact that the services were rendered or delivered by a noncontracting or out-of-network provider shall not be used as a basis to deny reimbursement to the insured.

(2) If an insured, by telephone call or electronic means, requests information on whether or not a provider is contracted as an in-network provider to provide covered benefits, the insurer shall, if the request is by telephone, tell the insured verbally and follow up in writing or electronic format no later than one business day after receiving the request. If the request is by electronic means, the insurer shall respond in writing or electronic format no later than one business day after receiving the request. The insurer shall also provide information on whether or not the provider is accepting new patients. The insurer shall retain a record of the request and the insurer's response in the insured's file for at least two years after the date of the request.

(3) For covered benefits, if an insured obtained information through the plan's online directory or a request consistent with paragraph (2) that a provider was an in-network provider, the group insured shall pay no more than in-network cost sharing if any of the following apply:

(A) The provider is not contracting with the insurer as an in-network provider for that product.

(B) The contracting provider is not accepting new patients for that product.

(C) The information provided is otherwise inaccurate, misleading, or incomplete.

(D) The online provider directory of the insurer is not accessible to insureds at the time the insured seeks information and the insured requests information consistent with paragraph (2).

(4) If the health insurance policy includes more than one tier of cost sharing, the insurer shall document the cost-sharing tier that the provider is contracted to accept and shall provide that information to the insured when the insured seeks information about the provider. If the insurer provides information indicating that a provider is on a lower cost-sharing tier and that information is not accurate, then the insured shall owe no more than the cost sharing for the cost-sharing tier included in the information received by the insured from the insurer.

(5) For purposes of this subdivision, the in-network cost sharing amount for a contracted provider includes copayments, deductibles, coinsurance, and any other form of cost sharing. If the health insurance policy includes more than one tier of cost sharing and if the insured was not informed accurately of the applicable cost-sharing tier, then the lowest cost-sharing tier shall apply.

(6) For purposes of this subdivision, "information" is inaccurate, incomplete, or misleading if any information in subdivision (h) or (i) is inaccurate, incomplete, or misleading.

(s) (1) Whenever an insurer determines as a result of this section that there has been a 10-percent change in the network for a product in a region, the insurer shall file a statement with the commissioner.

(2) For an insurance policy issued, amended, or renewed on or after July 1, 2025, if a provider has not been financially compensated consistent with this section ~~or~~ *and* if the provider has failed to respond timely consistent with this section, and those providers amount to a change of 10 percent or greater in the network for a product in a region, then the insurer shall file an amendment to the policy application consistent with subdivision (f) of Section 1300.52 of Title 28 of the California Code of Regulations.

(3) ~~(A)~~ An insurer shall not use information about a provider for purposes of compliance with timely access requirements, network adequacy determination, or compliance with any other provision of this chapter if the insurer cannot demonstrate to the department that ~~one or more of the following applies:~~ *the provider is actively contracting with the insurer as determined by the department. This paragraph shall apply whether or not the provider has been deleted from the directory.*

~~(i) The provider is contracting with the insurer and the provider has been financially compensated by the insurer consistent with this section.~~

~~(ii) The provider has failed to respond timely consistent with this section.~~

~~(iii) The provider is not in the lowest cost-sharing tier, if the product has more than one cost-sharing tier.~~

~~(B) This paragraph shall apply whether or not the provider has been deleted from the directory.~~

(4) Consistent with Section 1360 of the Health and Safety Code, an insurer shall not advertise or otherwise represent the extent of its network, including the number or type of contracting providers, unless it is able to demonstrate that each provider is ~~contracting and has been compensated consistent with this section.~~ *contracting.*

(5) (A) For purposes of this subdivision, "financially compensated" means having paid one or more claims to a provider for that network or otherwise demonstrably financially compensated that provider for the purposes of providing covered benefits to insureds covered by the relevant ~~network,~~ *network in the last five years,* unless a special circumstance applies.

(B) A special circumstance requires inclusion of the provider in the directory, consistent with regulations or other guidance by the department. A special circumstance may include a provider in a rural area, a highly specialized specialist who was not used by an insured in the prior year, or other circumstances as determined by the department through the regulatory or other rulemaking process. The department may issue guidance to implement, interpret, or make specific the requirements under this subparagraph. The guidance shall be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

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

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

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

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

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

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