

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:

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

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

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

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

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

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

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

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

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

11 1367.27. (a) A health care service plan shall publish and
12 maintain a provider directory or directories with information on
13 contracting providers that deliver health care services to the plan's
14 enrollees, including those that accept new patients. A provider
15 directory shall not list or include information on a provider that is
16 not currently under contract with the plan. Commencing July 1,
17 2025, a health care service plan shall comply with this section as
18 it read on January 1, 2025.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

26 (2) A health care service plan shall include prominent disclosure
27 on its print and online provider directories of its duty to arrange
28 coverage when behavioral health benefits are not available
29 in-network within applicable geographic and timely access
30 standards. The disclosure shall be included within the "Timely
31 Access to Care" section of the directory that is required by Section
32 1367.031 and shall also include the geographic accessibility
33 standards.

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

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

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

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

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

10 (2) Type of practitioner.

11 (3) National Provider Identifier number.

12 (4) California license number and type of license.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24 ~~(16)~~

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

28 ~~(17)~~

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

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

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

37 (2) Type of practitioner.

38 (3) National Provider Identifier number.

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

- 1 (5) The area of specialty, including board certification, or other
2 accreditation, if any.
- 3 (6) The provider’s office email address, if available to an
4 enrollee or the public.
- 5 (7) The population served, meaning adult, pediatric, or both.
- 6 (8) The name of each affiliated provider group or specialty plan
7 practice group currently under contract with the plan through which
8 the provider sees enrollees.
- 9 (9) The names of each allied health care professional to the
10 extent there is a direct contract for those services covered through
11 a contract with the plan.
- 12 (10) The non-English language, if any, spoken by a health care
13 provider or other medical professional as well as non-English
14 language spoken by a qualified medical interpreter, in accordance
15 with Section 1367.04, if any, on the provider’s staff.
- 16 (11) Identification of providers who no longer accept new
17 patients for some or all of the plan’s products.
- 18 (12) The provider’s contract termination date, if any. The plan
19 shall delete the provider from the directory within five days after
20 the termination date of the provider’s contract if there is a
21 termination date.
- 22 (13) All other applicable information necessary to conduct a
23 provider search pursuant to paragraph (2) of subdivision (c).
- 24 (j) (1) The contract between the plan and a provider shall
25 include a requirement that the provider inform the plan within five
26 business days when either of the following occurs:
 - 27 (A) The provider is not accepting new patients.
 - 28 (B) If the provider had previously not accepted new patients,
29 the provider is currently accepting new patients.
- 30 (2) If a provider who is not accepting new patients is contacted
31 by an enrollee or potential enrollee seeking to become a new
32 patient, the provider shall direct the enrollee or potential enrollee
33 to both the plan for additional assistance in finding a provider and
34 to the department to report any inaccuracy with the plan’s directory
35 or directories.
- 36 (3) If an enrollee or potential enrollee informs a plan of a
37 possible inaccuracy in the provider directory or directories, the
38 plan shall promptly investigate and, if necessary, undertake
39 corrective action within 30 business days to ensure the accuracy
40 of the directory or directories.

1 (k) (1) On or before December 31, 2016, the department shall
2 develop uniform provider directory standards to permit consistency
3 in accordance with subdivision (b) and paragraph (2) of subdivision
4 (c) and development of a central utility by another entity. Those
5 standards shall not be subject to the Administrative Procedure Act
6 (Chapter 3.5 (commencing with Section 11340) of Part 1 of
7 Division 3 of Title 2 of the Government Code), until January 1,
8 2021. No more than two revisions of those standards shall be
9 exempt from the Administrative Procedure Act (Chapter 3.5
10 (commencing with Section 11340) of Part 1 of Division 3 of Title
11 2 of the Government Code) pursuant to this subdivision.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5 (4) If the plan does not receive an affirmative response and
6 confirmation from the provider that the information is current and
7 accurate or, as an alternative, updates any information required to
8 be in the directory or directories pursuant to this section, within
9 30 business days, the plan shall take no more than 15 business
10 days to verify whether the provider's information is correct or
11 requires updates. The plan shall document the receipt and outcome
12 of each attempt to verify the information. If the plan is unable to
13 verify whether the provider's information is correct or requires
14 updates, the plan shall notify the provider 10 business days in
15 advance of removal that the provider will be removed from the
16 provider directory or directories. The provider shall be removed
17 from the provider directory or directories at the next required
18 update of the provider directory or directories after the
19 10-business-day notice period. A provider shall not be removed
20 from the provider directory or directories if the provider responds
21 before the end of the 10-business-day notice period.

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

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

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

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

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

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

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

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

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

30 (A) On July 1, 2025, a plan’s directories shall be at least
 31 60-percent accurate.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5 (A) A provider does not respond to the provider group’s attempt
6 to verify the provider’s information. As used in this paragraph,
7 “verify” means to contact the provider in writing, electronically,
8 and by telephone to confirm whether the provider’s information
9 is correct or requires updates.

10 (B) The provider group documents its efforts to verify the
11 provider’s information.

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

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

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

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

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

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

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

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

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

17 (A) For a provider or provider group that receives compensation
18 on a capitated or prepaid basis, the plan may delay no more than
19 50 percent of the next scheduled capitation payment for up to one
20 calendar month.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 (s) (1) Whenever a plan determines as a result of this section
2 that there has been a 10-percent change in the network for a product
3 in a region, the plan shall file an amendment to the plan application
4 with the department consistent with subdivision (f) of Section
5 1300.52 of Title 28 of the California Code of Regulations.

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

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

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

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

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

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

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

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

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

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

14 (t) (1) This section applies to plans with Medi-Cal managed
15 care contracts with the State Department of Health Care Services
16 pursuant to Chapter 7 (commencing with Section 14000), Chapter
17 8 (commencing with Section 14200), or Chapter 8.75 (commencing
18 with Section 14591) of the Welfare and Institutions Code to the
19 extent consistent with federal law and guidance and state law
20 guidance issued after January 1, 2016.

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

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

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

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

1 (x) For purposes of this section, “provider group” means a
2 medical group, independent practice association, or other similar
3 group of providers.

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

6 10133.15. (a) A health insurer that contracts with providers
7 for alternative rates of payment pursuant to Section 10133 shall
8 publish and maintain a provider directory or directories with
9 information on contracting providers that deliver health care
10 services to the insurer’s insureds, including those that accept new
11 patients. A provider directory shall not list or include information
12 on a provider that is not currently under contract with the insurer.
13 Commencing July 1, 2025, a health care service plan shall comply
14 with this section as it read on January 1, 2025.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- 1 (h) The insurer and a specialized mental health insurer shall
2 include all of the following information in the provider directory
3 or directories:
- 4 (1) The provider's name, practice location or locations, and
5 contact information, including telephone number.
- 6 (2) Type of practitioner.
- 7 (3) National Provider Identifier number.
- 8 (4) California license number and type of license.
- 9 (5) The area of specialty, including board certification, if any.
- 10 (6) The provider's office email address, if available to an insured
11 or the public.
- 12 (7) The population served, meaning adult, pediatric, or both.
- 13 (8) The name of each affiliated provider group currently under
14 contract with the insurer through which the provider sees insureds.
- 15 (9) A listing for each of the following providers that are under
16 contract with the insurer:
- 17 (A) For physicians and surgeons, the provider group, and
18 admitting privileges, if any, at hospitals contracted with the insurer.
- 19 (B) Nurse practitioners, physician assistants, psychologists,
20 acupuncturists, optometrists, dispensing optometrists and opticians,
21 podiatrists, chiropractors, licensed clinical social workers, marriage
22 and family therapists, professional clinical counselors, qualified
23 autism service providers, as defined in Section 10144.51,
24 nurse-midwives, and dentists.
- 25 (C) For federally qualified health centers or primary care clinics,
26 the name of the federally qualified health center or clinic.
- 27 (D) For any provider described in subparagraph (A) or (B) who
28 is employed by a federally qualified health center or primary care
29 clinic, and to the extent their services may be accessed and are
30 covered through the contract with the insurer, the name of the
31 provider, and the name of the federally qualified health center or
32 clinic.
- 33 (E) Facilities, including, but not limited to, general acute care
34 hospitals, skilled nursing facilities, urgent care clinics, ambulatory
35 surgery centers, inpatient hospice, residential care facilities, and
36 inpatient rehabilitation facilities.
- 37 (F) Pharmacies, clinical laboratories, imaging centers, optical
38 dispensaries, and other facilities providing contracted health care
39 services.

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

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

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

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

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

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

21 ~~(16)~~

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

25 ~~(17)~~

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

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

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

34 (2) Type of practitioner.

35 (3) National Provider Identifier number.

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

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

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

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

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

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

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

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

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

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

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

23 (A) The provider is not accepting new patients.

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

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

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

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

1 standards shall not be subject to the Administrative Procedure Act
2 (Chapter 3.5 (commencing with Section 11340) of Part 1 of
3 Division 3 of Title 2 of the Government Code), until January 1,
4 2021. No more than two revisions of those standards shall be
5 exempt from the Administrative Procedure Act (Chapter 3.5
6 (commencing with Section 11340) of Part 1 of Division 3 of Title
7 2 of the Government Code) pursuant to this subdivision.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 (4) If the insurer does not receive an affirmative response and
2 confirmation from the provider that the information is current and
3 accurate or, as an alternative, updates any information required to
4 be in the directory or directories pursuant to this section, within
5 30 business days, the insurer shall take no more than 15 business
6 days to verify whether the provider's information is correct or
7 requires updates. The insurer shall document the receipt and
8 outcome of each attempt to verify the information. If the insurer
9 is unable to verify whether the provider's information is correct
10 or requires updates, the insurer shall notify the provider 10 business
11 days in advance of removal that the provider will be removed from
12 the directory or directories. The provider shall be removed from
13 the directory or directories at the next required update of the
14 provider directory or directories after the 10-business-day notice
15 period. A provider shall not be removed from the provider directory
16 or directories if the provider responds before the end of the
17 10-business-day notice period.

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

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

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

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

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

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

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

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

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

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

23 (A) On July 1, 2025, an insurer's directories shall be at least
24 60-percent accurate.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 “verify” means to contact the provider in writing, electronically,
2 and by telephone to confirm whether the provider’s information
3 is correct or requires updates.

4 (B) The provider group documents its efforts to verify the
5 provider’s information.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16 (6) For purposes of this subdivision, “information” is inaccurate,
17 incomplete, or misleading if any information in subdivision (h) or
18 (i) is inaccurate, incomplete, or misleading.

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

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

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

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

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

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

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

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

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

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

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

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

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

4 (w) For purposes of this section, “provider group” means a
5 medical group, independent practice association, or other similar
6 group of providers.

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

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