

AMENDED IN ASSEMBLY APRIL 7, 2025
AMENDED IN ASSEMBLY MARCH 17, 2025
CALIFORNIA LEGISLATURE—2025–26 REGULAR SESSION

ASSEMBLY BILL

No. 787

Introduced by Assembly Member Papan

February 18, 2025

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 787, as amended, Papan. Provider directory disclosures.

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 specified health care service plans and health insurers to publish and maintain a provider directory or directories with information on contracting providers that deliver health care services to enrollees or insureds, and requires a health care service plan or health insurer to regularly update its printed and online provider directory or directories, as specified. Existing law requires provider directories to include specified information and disclosures.

This bill would require a full service health care service plan, specialized mental health plan, health insurer, or specialized mental health insurer to include in its provider directory or directories a statement at the top of the directory advising an enrollee or insured to

contact the plan or insurer for assistance in finding an in-network provider. The bill would require the plan or insurer to respond within ~~24 hours~~ *one business day* if contacted for that assistance, and to provide a list of in-network providers confirmed to be accepting new patients within 2 business days. Because a violation of these provisions 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. Section 1367.27 of the Health and Safety Code
2 is amended to read:
3 1367.27. (a) Commencing July 1, 2016, a health care service
4 plan shall publish and maintain a provider directory or directories
5 with information on contracting providers that deliver health care
6 services to the plan's enrollees, including those that accept new
7 patients. A provider directory shall not list or include information
8 on a provider that is not currently under contract with the plan.
9 (b) A health care service plan shall provide the directory or
10 directories for the specific network offered for each product using
11 a consistent method of network and product naming, numbering,
12 or other classification method that ensures the public, enrollees,
13 potential enrollees, the department, and other state or federal
14 agencies can easily identify the networks and plan products in
15 which a provider participates. By July 31, 2017, or 12 months after
16 the date provider directory standards are developed under
17 subdivision (k), whichever occurs later, a health care service plan
18 shall use the naming, numbering, or classification method
19 developed by the department pursuant to subdivision (k).
20 (c) (1) An online provider directory or directories shall be
21 available on the plan's internet website to the public, potential
22 enrollees, enrollees, and providers without any restrictions or
23 limitations. The directory or directories shall be accessible without

1 any requirement that an individual seeking the directory
2 information demonstrate coverage with the plan, indicate interest
3 in obtaining coverage with the plan, provide a member
4 identification or policy number, provide any other identifying
5 information, or create or access an account.

6 (2) The online provider directory or directories shall be
7 accessible on the plan's public internet website through an
8 identifiable link or tab and in a manner that is accessible and
9 searchable by enrollees, potential enrollees, the public, and
10 providers. By July 31, 2017, or 12 months after the date provider
11 directory standards are developed under subdivision (k), whichever
12 occurs later, the plan's public internet website shall allow provider
13 searches by, at a minimum, name, practice address, city, ZIP Code,
14 California license number, National Provider Identifier number,
15 admitting privileges to an identified hospital, product, tier, provider
16 language or languages, provider group, hospital name, facility
17 name, or clinic name, as appropriate.

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

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

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

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

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

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

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

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

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

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

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

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

18 (f) The provider directory or directories shall include both an
19 email address and a telephone number for members of the public
20 and providers to notify the plan if the provider directory
21 information appears to be inaccurate. This information shall be
22 disclosed prominently in the directory or directories and on the
23 plan's internet website.

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

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

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

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

37 (1) The provider's name, practice location or locations, and
38 contact information.

39 (2) Type of practitioner.

40 (3) National Provider Identifier number.

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

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

3 (6) The provider's office email address, if available.

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

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

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

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

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

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

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

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

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

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

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

37 (12) The network tier to which the provider is assigned, if the
38 provider is not in the lowest tier, as applicable. This section does
39 not require the use of network tiers other than contract and
40 noncontracting tiers.

1 (13) A statement at the top of the directory advising an enrollee
2 to contact the health care service plan for assistance in finding an
3 in-network provider.

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

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

10 (1) The provider's name, practice location or locations, and
11 contact information.

12 (2) Type of practitioner.

13 (3) National Provider Identifier number.

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

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

17 (6) The provider's office email address, if available.

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

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

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

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

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

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

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

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

38 (2) If a provider who is not accepting new patients is contacted
39 by an enrollee or potential enrollee seeking to become a new
40 patient, the provider shall direct the enrollee or potential enrollee

1 to both the plan for additional assistance in finding a provider and
2 to the department to report any inaccuracy with the plan's directory
3 or directories.

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

9 (k) (1) On or before December 31, 2016, the department shall
10 develop uniform provider directory standards to permit consistency
11 in accordance with subdivision (b) and paragraph (2) of subdivision
12 (c) and development of a multiplan directory by another entity.
13 Those standards shall not be subject to the Administrative
14 Procedure Act (Chapter 3.5 (commencing with Section 11340) of
15 Part 1 of Division 3 of Title 2 of the Government Code), until
16 January 1, 2021. No more than two revisions of those standards
17 shall be exempt from the Administrative Procedure Act (Chapter
18 3.5 (commencing with Section 11340) of Part 1 of Division 3 of
19 Title 2 of the Government Code) pursuant to this subdivision.

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

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

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

38 (A) For individual providers who are not affiliated with a
39 provider group described in subparagraph (A) or (B) of paragraph

(8) of subdivision (h) and providers described in subdivision (i), the plan shall notify each provider at least once every six months.

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

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

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

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

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

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

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

1 from the provider directory or directories if the provider responds
2 before the end of the 10-business-day notice period.

3 (5) General acute care hospitals shall be exempt from the
4 requirements in paragraphs (3) and (4).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23 (A) For a provider or provider group that receives compensation
24 on a capitated or prepaid basis, the plan may delay no more than
25 50 percent of the next scheduled capitation payment for up to one
26 calendar month.

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

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

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

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

5 (3) A plan may terminate a contract for a pattern or repeated
6 failure of the provider or provider group to alert the plan to a
7 change in the information required to be in the directory or
8 directories pursuant to this section.

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

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

23 (q) In circumstances where the department finds that an enrollee
24 reasonably relied upon materially inaccurate, incomplete, or
25 misleading information contained in a health plan's provider
26 directory or directories, the department may require the health plan
27 to provide coverage for all covered health care services provided
28 to the enrollee and to reimburse the enrollee for any amount beyond
29 what the enrollee would have paid, had the services been delivered
30 by an in-network provider under the enrollee's plan contract. Prior
31 to requiring reimbursement in these circumstances, the department
32 shall conclude that the services received by the enrollee were
33 covered services under the enrollee's plan contract. In those
34 circumstances, the fact that the services were rendered or delivered
35 by a noncontracting or out-of-plan provider shall not be used as a
36 basis to deny reimbursement to the enrollee.

37 (r) Whenever a plan determines as a result of this section that
38 there has been a 10-percent change in the network for a product
39 in a region, the plan shall file an amendment to the plan application

1 with the department consistent with subdivision (f) of Section
2 1300.52 of Title 28 of the California Code of Regulations.

3 (s) If an enrollee contacts a health care service plan for
4 assistance in finding an in-network provider, the plan shall respond
5 within ~~24 hours~~ *one business day* and shall provide search results
6 within two business days. For purposes of this subdivision, “search
7 results” means a list of providers covered by the enrollee’s contract
8 that are accepting patients, which shall be confirmed by the health
9 care service plan at the time of the enrollee’s request. *Search results*
10 *shall only include providers that have responded to requests to*
11 *verify their listing information in the health care service plan’s*
12 *last annual verification pursuant to subdivision (l).*

13 (t) This section applies to plans with Medi-Cal managed care
14 contracts with the State Department of Health Care Services
15 pursuant to Chapter 7 (commencing with Section 14000), Chapter
16 8 (commencing with Section 14200), or Chapter 8.75 (commencing
17 with Section 14591) of the Welfare and Institutions Code to the
18 extent consistent with federal law and guidance and state law
19 guidance issued after January 1, 2016. Notwithstanding any other
20 provision to the contrary in a plan contract with the State
21 Department of Health Care Services, and to the extent consistent
22 with federal law and guidance and state guidance issued after
23 January 1, 2016, a Medi-Cal managed care plan that complies with
24 the requirements of this section shall not be required to distribute
25 a printed provider directory or directories, except as required by
26 paragraph (1) of subdivision (d).

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

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

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

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

1 SEC. 2. Section 10133.15 of the Insurance Code is amended
2 to read:

3 10133.15. (a) Commencing July 1, 2016, a health insurer that
4 contracts with providers for alternative rates of payment pursuant
5 to Section 10133 shall publish and maintain provider directory or
6 directories with information on contracting providers that deliver
7 health care services to the insurer's insureds, including those that
8 accept new patients. A provider directory shall not list or include
9 information on a provider that is not currently under contract with
10 the insurer.

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

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

31 (2) The online provider directory or directories shall be
32 accessible on the insurer's public internet website through an
33 identifiable link or tab and in a manner that is accessible and
34 searchable by insureds, potential insureds, the public, and
35 providers. By July 1, 2017, or 12 months after the date provider
36 directory standards are developed under subdivision (k), whichever
37 occurs later, the insurer's public internet website shall allow
38 provider searches by, at a minimum, name, practice address, city,
39 ZIP Code, California license number, National Provider Identifier
40 number, admitting privileges to an identified hospital, product,

1 tier, provider language or languages, provider group, hospital
2 name, facility name, or clinic name, as appropriate.

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

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

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

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

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

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

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

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

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

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

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

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

4 (f) The provider directory or directories shall include both an
5 email address and a telephone number for members of the public
6 and providers to notify the insurer if the provider directory
7 information appears to be inaccurate. This information shall be
8 disclosed prominently in the directory or directories and on the
9 insurer's internet website.

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

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

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

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

23 (1) The provider's name, practice location or locations, and
24 contact information.

25 (2) Type of practitioner.

26 (3) National Provider Identifier number.

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

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

29 (6) The provider's office email address, if available.

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

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

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

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

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

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

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

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

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

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

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

23 (12) The network tier to which the provider is assigned, if the
24 provider is not in the lowest tier, as applicable. This section does
25 not require the use of network tiers other than contract and
26 noncontracting tiers.

27 (13) A statement at the top of the directory advising an insured
28 to contact the insurer for assistance in finding an in-network
29 provider.

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

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

36 (1) The provider's name, practice location or locations, and
37 contact information.

38 (2) Type of practitioner.

39 (3) National Provider Identifier number.

40 (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.

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

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

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

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

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

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

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

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

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

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

35 (k) (1) On or before December 31, 2016, the department shall
36 develop uniform provider directory standards to permit consistency
37 in accordance with subdivision (b) and paragraph (2) of subdivision
38 (c) and development of a multiplan directory by another entity.
39 Those standards shall not be subject to the Administrative
40 Procedure Act (Chapter 3.5 (commencing with Section 11340) of

1 Part 1 of Division 3 of Title 2 of the Government Code), until
2 January 1, 2021. No more than two revisions of those standards
3 shall be exempt from the Administrative Procedure Act (Chapter
4 3.5 (commencing with Section 11340) of Part 1 of Division 3 of
5 Title 2 of the Government Code) pursuant to this subdivision.

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

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

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

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

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

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

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

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

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

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

12 (4) If the insurer does not receive an affirmative response and
13 confirmation from the provider that the information is current and
14 accurate or, as an alternative, updates any information required to
15 be in the directory or directories pursuant to this section, within
16 30 business days, the insurer shall take no more than 15 business
17 days to verify whether the provider's information is correct or
18 requires updates. The insurer shall document the receipt and
19 outcome of each attempt to verify the information. If the insurer
20 is unable to verify whether the provider's information is correct
21 or requires updates, the insurer shall notify the provider 10 business
22 days in advance of removal that the provider will be removed from
23 the directory or directories. The provider shall be removed from
24 the directory or directories at the next required update of the
25 provider directory or directories after the 10-business-day notice
26 period. A provider shall not be removed from the provider directory
27 or directories if the provider responds before the end of the
28 10-business-day notice period.

29 (5) General acute care hospitals shall be exempt from the
30 requirements in paragraphs (3) and (4).

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

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

39 (2) Every insurer shall ensure processes are in place to allow
40 providers to promptly verify or submit changes to the information

1 required to be in the directory or directories pursuant to this section.
2 Those processes shall, at a minimum, include an online interface
3 for providers to submit verification or changes electronically and
4 shall generate an acknowledgment of receipt from the insurer.
5 Providers shall verify or submit changes to information required
6 to be in the directory or directories pursuant to this section using
7 the process required by the insurer.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

33 (p) (1) Notwithstanding Sections 10123.13 and 10123.147, an
34 insurer may delay payment or reimbursement owed to a provider
35 or provider group for any claims payment made to a provider or
36 provider group for up to one calendar month beginning on the first
37 day of the following month, if the provider or provider group fails
38 to respond to the insurer's attempts to verify the provider's
39 information as required under subdivision (l). The insurer shall
40 not delay payment unless it has attempted to verify the provider's

1 or provider group's information. As used in this subdivision,
2 "verify" means to contact the provider or provider group in writing,
3 electronically, and by telephone to confirm whether the provider's
4 or provider group's information is correct or requires updates. An
5 insurer may seek to delay payment or reimbursement owed to a
6 provider or provider group only after the 10-business-day notice
7 period described in paragraph (4) of subdivision (l) has lapsed.

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

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

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

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

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

34 (q) In circumstances where the department finds that an insured
35 reasonably relied upon materially inaccurate, incomplete, or
36 misleading information contained in an insurer's provider directory
37 or directories, the department may require the insurer to provide
38 coverage for all covered health care services provided to the insured
39 and to reimburse the insured for any amount beyond what the
40 insured would have paid, had the services been delivered by an

1 in-network provider under the insured's health insurance policy.
2 Prior to requiring reimbursement in these circumstances, the
3 department shall conclude that the services received by the insured
4 were covered services under the insured's health insurance policy.
5 In those circumstances, the fact that the services were rendered or
6 delivered by a noncontracting or out-of-network provider shall not
7 be used as a basis to deny reimbursement to the insured.

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

11 (s) If an insured contacts an insurer for assistance in finding an
12 in-network provider, the insurer shall respond within ~~24 hours~~ *one*
13 *business day* and shall provide search results within two business
14 days. For purposes of this subdivision, "search results" means a
15 list of providers covered by the insured's policy that are accepting
16 patients, which shall be confirmed by the insurer at the time of the
17 insured's request. *Search results shall only include providers that*
18 *have responded to requests to verify their listing information in*
19 *the insurer's last annual verification pursuant to subdivision (l).*

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

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

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

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

33 SEC. 3. No reimbursement is required by this act pursuant to
34 Section 6 of Article XIII B of the California Constitution because
35 the only costs that may be incurred by a local agency or school
36 district will be incurred because this act creates a new crime or
37 infraction, eliminates a crime or infraction, or changes the penalty
38 for a crime or infraction, within the meaning of Section 17556 of
39 the Government Code, or changes the definition of a crime within

1 the meaning of Section 6 of Article XIII B of the California
2 Constitution.

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