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 ~~127345~~ *1367.27* of the Health and Safety Code, ~~relating to hospitals.~~ *and to amend Section 10133.15 of the Insurance Code, relating to health care coverage.*

LEGISLATIVE COUNSEL'S DIGEST

AB 787, as amended, Papan. ~~Hospitals: community benefits.~~ *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 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.

~~Existing law requires a private not-for-profit acute hospital to annually adopt and update a community benefits plan that describes the activities that the hospital has undertaken to address identified community needs within its mission and financial capacity. Under existing law, "community benefit" includes, among other things, health care services rendered to vulnerable populations, including, but not limited to, charity care and the unreimbursed cost of providing services to the uninsured, underinsured, and persons eligible for specified public health care programs. Existing law requires the hospital to annually submit its community benefits plan to the Department of Health Care Access and Information.~~

~~This bill would make technical, nonsubstantive changes to certain definitions for purposes of the above-described provisions.~~

Vote: majority. Appropriation: no. Fiscal committee: ~~no~~ *yes*. State-mandated local program: ~~no~~ *yes*.

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

SECTION 1. Section 1367.27 of the Health and Safety Code is amended to read:

1367.27. (a) Commencing July 1, 2016, a health care service plan shall publish and maintain a provider directory or directories with information on contracting providers that deliver health care services to the plan's enrollees, including those that accept new patients. A provider directory shall not list or include information on a provider that is not currently under contract with the plan.

(b) A health care service plan shall provide the directory or directories for the specific network offered for each product using

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

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

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

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

to the geographic region in which the requester resides or works or intends to reside or work.

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

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

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

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

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

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

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

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

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

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

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

(f) The provider directory or directories shall include both an email address and a telephone number for members of the public and providers to notify the plan if the provider directory information appears to be inaccurate. This information shall be disclosed prominently in the directory or directories and on the plan's ~~Internet Web site.~~ *internet website.*

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

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

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

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

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

(2) Type of practitioner.

(3) National Provider Identifier number.

(4) California license number and type of license.

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

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

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

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

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

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

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

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

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

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

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

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

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

(12) The network tier to which the provider is assigned, if the provider is not in the lowest tier, as applicable. ~~Nothing in this section shall be construed to~~ *This section does not* require the use of network tiers other than contract and noncontracting tiers.

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

~~(13)~~

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

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

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

(2) Type of practitioner.

(3) National Provider Identifier number.

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

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

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

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

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

(9) The non-English language, if any, spoken by a health care provider or other medical professional as well as non-English

language spoken by a qualified medical interpreter, in accordance with Section 1367.04, if any, on the provider's staff.

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

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

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

(A) The provider is not accepting new patients.

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

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

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

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

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

Centers for Medicare and Medicaid Services and the State Department of Health Care Services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) The plan shall establish and maintain a process for enrollees, potential enrollees, other providers, and the public to identify and

report possible inaccurate, incomplete, or misleading information currently listed in the plan's provider directory or directories. This process shall, at a minimum, include a telephone number and a dedicated email address at which the plan will accept these reports, as well as a hyperlink on the plan's provider directory ~~Internet Web site~~ *internet website* linking to a form where the information can be reported directly to the plan through its ~~Internet Web site.~~ *internet website.*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) For a provider or provider group that receives compensation on a capitated or prepaid basis, the plan may delay no more than

50 percent of the next scheduled capitation payment for up to one calendar month.

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

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

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

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

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

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

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

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

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

(s) If an enrollee contacts a health care service plan for assistance in finding an in-network provider, the plan shall respond within 24 hours and shall provide search results within two business days. For purposes of this subdivision, "search results" means a list of providers covered by the enrollee's contract that are accepting patients, which shall be confirmed by the health care service plan at the time of the enrollee's request.

~~(s)~~

(t) This section applies to plans with Medi-Cal managed care contracts with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591) of the Welfare and Institutions Code to the extent consistent with federal law and guidance and state law guidance issued after January 1, 2016. Notwithstanding any other provision to the contrary in a plan contract with the State Department of Health Care Services, and to the extent consistent with federal law and guidance and state guidance issued after January 1, 2016, a Medi-Cal managed care plan that complies with the requirements of this section shall not be required to distribute

a printed provider directory or directories, except as required by paragraph (1) of subdivision (d).

~~(t)~~

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

~~(u)~~

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

~~(v)~~

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

~~(w)~~

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

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

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

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

or classification method developed by the department pursuant to subdivision (k).

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

(2) The online provider directory or directories shall be accessible on the insurer's public ~~Internet Web site~~ *internet website* through an identifiable link or tab and in a manner that is accessible and searchable by insureds, potential insureds, the public, and providers. By July 1, 2017, or 12 months after the date provider directory standards are developed under subdivision (k), whichever occurs later, the insurer's public ~~Internet Web site~~ *internet website* shall allow provider searches by, at a minimum, name, practice address, city, ZIP Code, California license number, National Provider Identifier number, admitting privileges to an identified hospital, product, tier, provider language or languages, provider group, hospital name, facility name, or clinic name, as appropriate.

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

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

(e) (1) The insurer shall update the online provider directory or directories, at least weekly, or more frequently, if required by

federal law, when informed of and upon confirmation by the insurer of any of the following:

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

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

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

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

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

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

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

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

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

(f) The provider directory or directories shall include both an email address and a telephone number for members of the public and providers to notify the insurer if the provider directory information appears to be inaccurate. This information shall be disclosed prominently in the directory or directories and on the insurer's ~~Internet Web site.~~ *internet website.*

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

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

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

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

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

(2) Type of practitioner.

(3) National Provider Identifier number.

(4) California license number and type of license.

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

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

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

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

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

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

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

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

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

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

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

(10) Non-English language, if any, spoken by a health care provider or other medical professional as well as non-English

language spoken by a qualified medical interpreter, in accordance with Section 10133.8, if any, on the provider's staff.

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

(12) The network tier to which the provider is assigned, if the provider is not in the lowest tier, as applicable. ~~Nothing in this section shall be construed to~~ *This section does not* require the use of network tiers other than contract and noncontracting tiers.

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

~~(13)~~

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

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

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

(2) Type of practitioner.

(3) National Provider Identifier number.

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

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

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

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

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

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

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

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

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

(A) The provider is not accepting new patients.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) If the insurer does not receive an affirmative response and confirmation from the provider that the information is current and accurate or, as an alternative, updates any information required to be in the directory or directories pursuant to this section, within 30 business days, the insurer shall take no more than 15 business days to verify whether the provider's information is correct or

requires updates. The insurer shall document the receipt and outcome of each attempt to verify the information. If the insurer is unable to verify whether the provider's information is correct or requires updates, the insurer shall notify the provider 10 business days in advance of removal that the provider will be removed from the directory or directories. The provider shall be removed from the directory or directories at the next required update of the provider directory or directories after the ~~10-business day~~ *10-business-day* notice period. A provider shall not be removed from the provider directory or directories if ~~he or she~~ *the provider* responds before the end of the ~~10-business day~~ *10-business-day* notice period.

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

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

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

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

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

the information can be reported directly to the insurer through its ~~Internet Web site.~~ *internet website.*

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

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

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

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

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

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

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

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

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

the information in its provider directory or directories, as applicable.

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

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

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

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

(p) (1) Notwithstanding Sections 10123.13 and 10123.147, an insurer may delay payment or reimbursement owed to a provider or provider group for any claims payment made to a provider or provider group for up to one calendar month beginning on the first day of the following month, if the provider or provider group fails to respond to the insurer's attempts to verify the provider's information as required under subdivision (*l*). The insurer shall not delay payment unless it has attempted to verify the provider's or provider group's information. As used in this subdivision, "verify" means to contact the provider or provider group in writing, electronically, and by telephone to confirm whether the provider's or provider group's information is correct or requires updates. An insurer may seek to delay payment or reimbursement owed to a provider or provider group only after the ~~10-business-day~~ *10-business-day* notice period described in paragraph (4) of subdivision (*l*) has lapsed.

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

payment or reimbursement subject to delay to the provider or provider group according to either of the following timelines, as applicable:

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

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

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

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

(q) In circumstances where the department finds that an insured reasonably relied upon materially inaccurate, incomplete, or misleading information contained in an insurer's provider directory or directories, the department may require the insurer to provide coverage for all covered health care services provided to the insured and to reimburse the insured for any amount beyond what the insured would have paid, had the services been delivered by an in-network provider under the insured's health insurance policy. Prior to requiring reimbursement in these circumstances, the department shall conclude that the services received by the insured were covered services under the insured's health insurance policy. In those circumstances, the fact that the services were rendered or delivered by a noncontracting or out-of-network provider shall not be used as a basis to deny reimbursement to the insured.

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

(s) If an insured contacts an insurer for assistance in finding an in-network provider, the insurer shall respond within 24 hours

and shall provide search results within two business days. For purposes of this subdivision, "search results" means a list of providers covered by the insured's policy that are accepting patients, which shall be confirmed by the insurer at the time of the insured's request.

~~(s)~~

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

~~(t)~~

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

~~(u)~~

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

~~(v)~~

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

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

~~SECTION 1. Section 127345 of the Health and Safety Code is amended to read:~~

~~127345. As used in this article, the following terms have the following meanings:~~

~~(a) "Charity care" means free health services provided without expectation of payment to persons who meet the organization's criteria for financial assistance and are unable to pay for all or a portion of the services. Charity care shall be reported at cost, as reported to the Department of Health Care Access and Information.~~

~~Charity care does not include bad debt, defined as uncollectible charges that the organization recorded as revenue but wrote off due to a patient's failure to pay.~~

~~(b) "Community benefits plan" means the written document prepared for annual submission to the Department of Health Care Access and Information that shall include, but shall not be limited to, a description of the activities that the hospital has undertaken in order to address identified community needs within its mission and financial capacity, and the process by which the hospital developed the plan in consultation with the community.~~

~~(c) "Community" means the service areas or patient populations for which the hospital provides health care services.~~

~~(d) (1) Solely for the planning and reporting purposes of this article, "community benefit" means a hospital's activities that are intended to address community needs and priorities primarily through disease prevention and improvement of health status, including, but not limited to, any of the following:~~

~~(A) Health care services, rendered to vulnerable populations, including, but not limited to, charity care and the unreimbursed cost of providing services to the uninsured, underinsured, and those eligible for Medi-Cal, Medicare, California Children's Services Program, or county indigent programs.~~

~~(B) The unreimbursed cost of services included in subdivision (d) of Section 127340.~~

~~(C) Financial or in-kind support of public health programs.~~

~~(D) Donation of funds, property, or other resources that contribute to a community priority.~~

~~(E) Health care cost containment.~~

~~(F) Enhancement of access to health care or related services that contribute to a healthier community.~~

~~(G) Services offered without regard to financial return because they meet a community need in the service area of the hospital, and other services including health promotion, health education, prevention, and social services.~~

~~(H) Food, shelter, clothing, education, transportation, and other goods or services that help to maintain a person's health.~~

~~(2) "Community benefit" does not mean activities or programs that are provided primarily for marketing purposes or are more beneficial to the organization than to the community.~~

~~(e) "Community needs assessment" means the process by which the hospital identifies, for its primary service area as determined by the hospital, unmet community needs.~~

~~(f) "Community needs" means those requisites for improvement or maintenance of health status in the community.~~

~~(g) "Hospital" means a private not-for-profit acute hospital licensed under subdivision (a), (b), or (f) of Section 1250 and is owned by a corporation that has been determined to be exempt from taxation under the United States Internal Revenue Code. "Hospital" does not mean any of the following:~~

~~(1) Hospitals that are dedicated to serving children and that do not receive direct payment for services to any patient.~~

~~(2) Small and rural hospitals, as defined in Section 124840, unless the hospital is part of a hospital system.~~

~~(3) A district hospital organized and governed pursuant to the Local Health Care District Law (Division 23 (commencing with Section 32000)) or a nonprofit corporation that is affiliated with the health care district hospital owner by means of the district's status as the nonprofit corporation's sole corporate member pursuant to subparagraph (B) of paragraph (1) of subdivision (h) of Section 14169.31 of the Welfare and Institutions Code.~~

~~(h) "Mission statement" means a hospital's primary objectives for operation as adopted by its governing body.~~

~~(i) "Vulnerable populations" means any population that is exposed to medical or financial risk by virtue of being uninsured, underinsured, or eligible for Medi-Cal, Medicare, California Children's Services Program, or county indigent programs. "Vulnerable populations" also includes both of the following:~~

~~(1) Racial and ethnic groups experiencing disparate health outcomes, including Black/African American, American Indian, Alaska Native, Asian Indian, Cambodian, Chinese, Filipino, Hmong, Japanese, Korean, Laotian, Vietnamese, Native Hawaiian, Guamanian or Chamorro, Samoan, or other nonwhite racial groups, as well as individuals of Hispanic/Latino origin, including Mexicans, Mexican Americans, Chicanos, Salvadorans, Guatemalans, Cubans, and Puerto Ricans.~~

~~(2) Socially disadvantaged groups, including all of the following:~~

~~(A) The unhoused.~~

~~(B) Communities with inadequate access to clean air and safe drinking water, as defined by an environmental California Healthy Places Index score of 50 percent or lower.~~

~~(C) People with disabilities.~~

~~(D) People identifying as lesbian, gay, bisexual, transgender, or queer.~~

~~(E) Individuals with limited English proficiency.~~

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