Introduce by Senator Hernandez

January 26, 2015

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

LEGISLATIVE COUNSEL'S DIGEST

SB 137, as introduced, Hernandez. Health care coverage: provider directories.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. A willful violation of the act is a crime. Existing law requires a health care service plan to provide a list of contracting providers within a requesting enrollee’s or prospective enrollee’s general geographic area.

Existing law also provides for the regulation of health insurers by the Insurance Commissioner. Existing law requires insurers subject to regulation by the commissioner to provide group policyholders with a current roster of institutional and professional providers under contract to provide services at alternative rates.

This bill would require health care service plans and insurers subject to regulation by the commissioner for services at alternative rates to make a provider directory available on its Internet Web site and to update the directory weekly. The bill would require the Department of Managed Health Care and the Department of Insurance to develop a standard provider directory template. By placing additional requirements on health care service plans, the violation of which is 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.


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

SECTION 1. Section 1367.27 is added to the Health and Safety Code, to read:

1367.27. (a) (1) A health care service plan shall make available a provider directory or directories which shall provide information on contracting providers, including those that accept new patients. A provider directory shall not include information on a provider that does not have a current contract with the plan and that has not submitted a claim within the past three months.

(2) If a plan uses different provider networks for different products, then the requirements of this section shall apply for each of the provider directories for each product. The plan shall provide information on different provider networks for different products in a manner that allows the public, enrollees, potential enrollees, the department, and other state or federal agencies to identify which providers participate in which networks for which products.

(3) The information regarding a provider directory or directories shall be available to the public and potential enrollees without any requirement that a member of the public or potential enrollee indicate intent to obtain coverage from the plan. The directory or directories shall be available to the public without requiring that an individual intends to purchase coverage or has coverage by providing a policy number or any other identifying information and without requiring an individual to create or access an account.

(b) (1) The provider directory or directories shall be posted on the plan’s public Internet Web site through a clearly identifiable link or tab and in a manner that is accessible and searchable by the public, potential enrollees, enrollees and providers. If another technology emerges that takes the place of Internet Web sites, the department shall direct the plan to make the information required under this section available on the subsequent technology. The
plan shall also make a hard copy of the directory or directories available upon request.

(2) The plan shall update weekly the provider directory or directories posted pursuant to paragraph (1) with any change to contracting providers, including whether a contracting provider is accepting new patients.

(3) The provider directory or directories shall include both an email address and a telephone number for members of the public to notify the plan if the provider directory information appears to be inaccurate.

(4) By September 15, 2016, or no later than six months after the date that a standard provider directory template is developed under subdivision (d), a plan shall use the template developed pursuant to subdivision (d) to display the provider directory or directories for each product offered by the plan.

(c) The plan shall provide all of the following information for each of the provider directories used for a network:

(1) The provider's location and contact information.

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

(3) (A) For physicians, the medical group, if any.

(B) Psychologists, acupuncturists, optometrists, podiatrists, chiropractors, licensed clinical social workers, marriage and family therapists, professional clinical counselors, and nurse midwives to the extent their services may be accessed and are covered through the contract with the plan.

(4) Hospital admitting privileges, if any, for physicians and other health professionals contracted with the plan.

(5) Non-English language, if any, spoken by a health professional as well as non-English language, if any, spoken by staff to the provider.

(6) Access for persons with disabilities.

(7) Whether a provider is accepting new patients with the product selected by the enrollee or potential enrollee.

(d) (1) By March 15, 2016, the department and the Department of Insurance shall develop a standard provider directory template for purposes of paragraph (3) of subdivision (b). The template shall include a glossary of terms used in the template. The template shall include information on how to contact the plan and the department.
(2) The template shall be sufficiently standardized to permit a single uniform directory that would allow a member of the public to determine whether a physician or other provider is available to an enrollee of the California Health Benefit Exchange as well as a beneficiary of the Medi-Cal program enrolled in a Medi-Cal managed care plan. The template shall also be sufficiently standardized to permit a single uniform directory that would allow a member of the public to determine whether a physician or other provider is available to an enrollee with group coverage as well as to a beneficiary of the Medi-Cal program enrolled in a Medi-Cal managed care plan or to an enrollee of the California Health Benefit Exchange.

(3) The department and the Department of Insurance shall seek input from interested parties, including holding at least one public meeting. In developing the directory template, the department shall take into consideration any requirements for provider directories established by the federal Centers for Medicare and Medicaid Services.

(e) (1) The plan shall provide the directory or directories to the department in a format and manner to be specified by the department.

(2) The plan shall demonstrate no less than quarterly to the department that the information provided in the provider directory or directories is consistent with the information required under Sections 1367.03 and 1367.035, and other provisions of this chapter. The plan shall assure that other information reported to the department is consistent with the information provided to enrollees, potential enrollees, and the department pursuant to this section.

(3) The plan shall demonstrate to the department that enrollees or potential enrollees seeking a provider that is contracted with the network for a particular product can identify these providers and that the provider is accepting new patients. The plan shall ensure that the accuracy of the provider directory meets or exceeds 97 percent.

(4) The plan shall contact any provider which is listed in the provider directory and which has not submitted a claim within the prior quarter to determine whether the provider is accepting patients or referrals from the plan. If the provider does not respond within
30 days, the plan shall remove the provider from the provider
directory.

(f) The plan shall provide an electronic copy of, or upon request,
one physical copy of the provider directory or directories to the
following:
(1) To the State Department of Health Care Services for
Medi-Cal managed care networks.
(2) To the California Health Benefit Exchange for the networks
of the products offered through the California Health Benefit
Exchange.
(3) On request by CalPERS, to CalPERS.
(4) On request by a group purchaser, provider directory or
directories for the products available in the market segment of the
group.
(g) If a contracting provider, or the representative of a
contracting provider, informs an enrollee or potential enrollee that
the provider is not accepting new patients, the contract between
the plan and the provider shall require the provider to direct the
enrollee or potential enrollee to the plan for additional assistance
in finding a provider and also to the department to inform it of the
possible inaccuracy in the provider directory. If an enrollee or
potential enrollee informs a plan of a possible inaccuracy in the
provider directory or directories, the plan shall undertake corrective
action to assure the accuracy of the directory or directories.

(h) This section does not prohibit a plan from requiring its
contracting providers, contracting provider groups, or contracting
specialized health care plans to satisfy the requirements of this
section. If a plan delegates the responsibility of complying with
this section to its contracting providers, contracting provider
groups, or contracting specialized health care plans, the plan shall
ensure that the requirements of this section are met.

(i) Every health care service plan shall allow enrollees to request
the information required by this section through their toll-free
telephone number or in writing. On request of an enrollee or
potential enrollee, the plan shall provide the information required
under (a), (b), (c) and (g) in written form. The information provided
in written form may be limited to the geographic region in which
the enrollee or potential enrollee resides or intends to reside.

SEC. 2. Section 10133.15 is added to the Insurance Code, to
read:
10133.15. (a) (1) A health insurer that contracts with providers for alternative rates of payment pursuant to Section 10133 shall make available a provider directory or directories which shall provide information on contracting providers, including those that accept new patients. A provider directory shall not include information on a provider that does not have a current contract with the insurer and that has not submitted a claim within the past three months.

(2) If an insurer uses different provider networks for different products, then the requirements of this section shall apply for each of the provider directories for each product. The insurer shall provide information on different provider networks for different products in a manner that allows the public, enrollees, potential enrollees, the department, and other state or federal agencies to identify which providers participate in which networks for which products.

(3) The information regarding provider directory or directories shall be available to the public and potential enrollees without any requirement that a member of the public or potential enrollee indicate intent to obtain coverage from the insurer. The directory or directories shall be available to the public without requiring that an individual intends to purchase coverage or has coverage by providing a policy number or any other identifying information and without requiring an individual to create or access an account.

(b) (1) The provider directory or directories shall be posted on the insurer’s public Internet Web site through a clearly identifiable link or tab and in a manner that is accessible and searchable by the public, potential enrollees, enrollees, and providers. If another technology emerges that takes the place of Internet Web sites, the department shall direct the insurer to make the information required under this section available on the subsequent technology. The insurer shall also make a hard copy of the directory or directories available upon request.

(2) The insurer shall update weekly the provider directory or directories posted pursuant to paragraph (1) with any change to contracting providers, including whether a contracting provider is accepting new patients.

(3) The provider directory or directories shall include both an email address and a telephone number for members of the public
to notify the insurer if the provider directory information appears to be inaccurate.

(4) By September 15, 2016, or no later than six months after the date that a standard provider directory template is developed under subdivision (d), an insurer shall use the template developed pursuant to subdivision (d) to display the provider directory or directories for each product offered by the insurer.

(c) The insurer shall provide all of the following information for each of the provider directories used for a network:

1. The provider’s location and contact information.
2. The area of specialty, including board certification, if any.
3. (A) For physicians, the medical group, if any.
4. (B) Psychologists, acupuncturists, optometrists, podiatrists, chiropractors, licensed clinical social workers, marriage and family therapists, professional clinical counselors, and nurse midwives to the extent their services may be accessed and are covered through the contract with the insurer.
5. (4) Hospital admitting privileges, if any, for physicians and other health professionals contracted with the insurer.
6. (5) Non-English language, if any, spoken by a health professional as well as non-English language, if any, spoken by staff to the provider.
8. (7) Whether a provider is accepting new patients with the product selected by the enrollee or potential enrollee.

(d) (1) By March 15, 2016, the Department of Managed Health Care and the department shall develop a standard provider directory template for purposes of paragraph (3) of subdivision (b). The template shall include a glossary of terms used in the template.

The template shall include information on how to contact the plan and the department.

2. (2) The template shall be sufficiently standardized to permit a single uniform directory that would allow a member of the public to determine whether a physician or other provider is available to an enrollee of the California Health Benefit Exchange as well as a beneficiary of the Medi-Cal program enrolled in a Medi-Cal managed care plan. The template shall also be sufficiently standardized to permit a single uniform directory that would allow a member of the public to determine whether a physician or other provider is available to an enrollee with group coverage as well
as to a beneficiary of the Medi-Cal program enrolled in a Medi-Cal
managed care plan or to an enrollee of the California Health Benefit
Exchange.

(3) The department and the Department of Managed Health
Care shall seek input from interested parties, including holding at
least one public meeting. In developing the directory template, the
Department of Managed Health Care shall take into consideration
any requirements for provider directories established by the federal
Centers for Medicare and Medicaid Services.

(e) (1) The insurer shall provide the directory or directories to
the department in a format and manner to be specified by the
department.

(2) The insurer shall demonstrate no less than quarterly to the
department that the information provided in the provider directory
or directories is consistent with the information required under
Section 10133.5 and other provisions of this part. The insurer shall
assure that other information reported to the department is
consistent with the information provided to enrollees, potential
enrollees, and the department pursuant to this section.

(3) The insurer shall demonstrate to the department that enrollees
or potential enrollees seeking a provider that is contracted with
the network for a particular product can identify these providers
and that the provider is accepting new patients. The insurer shall
ensure that the accuracy of the provider directory meets or exceeds
97 percent.

(4) The insurer shall contact any provider which is listed in the
provider directory and which has not submitted a claim within the
prior quarter to determine whether the provider is accepting patients
or referrals from the plan. If the provider does not respond within
30 days, the insurer shall remove the provider from the provider
directory.

(f) The insurer shall provide an electronic copy of, or upon
request, one physical copy of the provider directory or directories
to the following:

(1) To the State Department of Health Care Services for
Medi-Cal managed care networks.

(2) To the California Health Benefit Exchange for the networks
of the products offered through the California Health Benefit
Exchange.

(3) On request by CalPERS, to CalPERS.
(4) On request by a group purchaser, provider directory or directories for the products available in the market segment of the group.

(g) If a contracting provider, or the representative of a contracting provider, informs an enrollee or potential enrollee that the provider is not accepting new patients, the contract between the insurer and the provider shall require the provider to direct the enrollee or potential enrollee to the insurer for additional assistance in finding a provider and also to the department to inform it of the possible inaccuracy in the provider directory. If an enrollee or potential enrollee informs an insurer of a possible inaccuracy in the provider directory or directories, the insurer shall undertake corrective action to assure the accuracy of the directory or directories.

(h) This section does not prohibit an insurer from requiring its contracting providers, contracting provider groups, or contracting specialized health care plans to satisfy the requirements of this section. If an insurer delegates the responsibility of complying with this section to its contracting providers, contracting provider groups, or contracting specialized health care plans, the insurer shall ensure that the requirements of this section are met.

(i) Every health insurer shall allow enrollees to request the information required by this section through their toll-free telephone number or in writing. On request of an enrollee or potential enrollee, the insurer shall provide the information required under (a), (b), (c), and (g) in written form. The information provided in written form may be limited to the geographic region in which the enrollee or potential enrollee resides or intends to reside.

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIIIB 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.