

AMENDED IN SENATE MARCH 26, 2015

SENATE BILL

No. 137

Introduced 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 amended, 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.~~ *standards*. 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.

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 is added to the Health and Safety
 2 Code, to read:
 3 1367.27. (a) (1) A health care service plan shall make
 4 available a provider directory or directories ~~which~~ *that* shall
 5 provide information on contracting providers, including those that
 6 ~~accept new patients.~~ *patients, pursuant to the requirements of this*
 7 *section and Section 1367.26.* A provider directory shall not include
 8 information on a provider that does not have a current contract
 9 with the plan ~~and that has not submitted a claim within the past~~
 10 ~~three months.~~ *plan.*
 11 ~~(2) If a plan uses different provider networks for different~~
 12 ~~products, then the requirements of this section shall apply for each~~
 13 ~~of the provider directories for each product. The plan shall provide~~
 14 ~~information on different provider networks for different products~~
 15 ~~in a manner that allows the public, enrollees, potential enrollees,~~
 16 ~~the department, and other state or federal agencies to identify which~~
 17 ~~providers participate in which networks for which products.~~
 18 *(2) A plan shall provide the directory or directories for the*
 19 *specific network offered for each product using a consistent method*
 20 *of network and product naming, numbering, or other classification*
 21 *method that ensures the public, enrollees, potential enrollees, the*
 22 *department, and other state or federal agencies can easily identify*
 23 *which providers participate in which networks for which products.*
 24 *A health plan shall use the same consistent classification method*
 25 *in provider contracts and communications to ensure that providers*
 26 *can identify the products and networks that they are legally*
 27 *contracted to provide services in. The classification shall be*

1 *consistent across plans in order to permit the department and other*
2 *state or federal agencies to construct multiplan directories.*

3 (3) ~~The information regarding a provider directory or directories~~
4 ~~shall be available on the plan's Internet Web site to the public and~~
5 ~~potential enrollees without any requirement that a member of the~~
6 ~~public or potential enrollee indicate intent to obtain coverage from~~
7 ~~the plan. The directory or directories shall be available to the public~~
8 ~~without requiring that an individual intends to purchase coverage~~
9 ~~or has coverage by providing seeking the directory information~~
10 ~~demonstrate coverage with the plan, provide a policy number or~~
11 ~~number, provide any other identifying information and without~~
12 ~~requiring an individual to information, or create or access an~~
13 ~~account.~~

14 (b) (1) ~~The provider directory or directories shall be posted~~
15 ~~accessible on the plan's public Internet Web site through a clearly~~
16 ~~identifiable link or tab and in a manner that is accessible and~~
17 ~~searchable by the public, potential enrollees, enrollees enrollees,~~
18 ~~and providers. The plan's public Internet Web site shall allow for~~
19 ~~provider searches by name, practice address, National Provider~~
20 ~~Identification number, California license, facility or identification~~
21 ~~number, product, tier, provider language, medical group, or~~
22 ~~independent practice association, hospital, or clinic, as~~
23 ~~appropriate. If another technology emerges that takes the place~~
24 ~~of Internet Web sites, the department shall direct the plan to make~~
25 ~~the information required under this section available on the~~
26 ~~subsequent technology. technology in a timeframe that allows for~~
27 ~~implementation of the technology, not to exceed six months. The~~
28 ~~plan shall also make a hard paper copy of the directory or~~
29 ~~directories available upon request.~~

30 (2) ~~The plan shall update weekly the provider directory or~~
31 ~~directories posted directories, at least weekly, pursuant to paragraph~~
32 (1) ~~with any change to contracting providers, including whether~~
33 ~~all of the following:~~

34 (A) ~~Instances where a contracting provider is no longer~~
35 ~~accepting new patients. patients, or that the provider moved or~~
36 ~~relocated from the contracted service area of the plan, or has~~
37 ~~retired or has otherwise ceased to practice.~~

38 (B) ~~Instances where the contracting provider group, if any, has~~
39 ~~identified that the provider is no longer associated with the group~~
40 ~~or is no longer accepting new patients.~~

1 (C) *Instances where the plan identified a change based on an*
 2 *enrollee complaint that a provider was not accepting new patients*
 3 *or was otherwise not available.*

4 (D) *Any other relevant information that has come to the attention*
 5 *of the plan affecting the content of the provider directory.*

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

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

16 (c) ~~The~~ A full service health care service plan shall provide
 17 include all of the following information for each of the provider
 18 directories used for a network: in the provider directory or
 19 directories:

20 (1) The provider's ~~location~~ name, location(s), and contact
 21 information.

22 (2) *Type of practitioner.*

23 (3) *National Provider Identification number.*

24 (4) *California license number and type of license.*

25 ~~(2)~~

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

27 ~~(3)~~

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

29 (B) ~~Psychologists,~~ *Nurse practitioners, physician assistants,*
 30 *psychologists, acupuncturists, optometrists, podiatrists,*
 31 *chiropractors, licensed clinical social workers, marriage and family*
 32 *therapists, professional clinical counselors, and nurse midwives*
 33 *to the extent their services may be accessed and are covered*
 34 *through the contract with the plan.*

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

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

1 *provider, and the name of the federally qualified health center or*
2 *clinic.*

3 ~~(4)~~

4 (7) Hospital admitting privileges, if any, for physicians and
5 other health professionals contracted with the ~~plan~~. *plan whose*
6 *scope of services for the plan include admitting patients and who*
7 *have admitting privileges at a hospital.*

8 ~~(5)~~

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

12 ~~(6) Access for persons with disabilities.~~

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

15 (9) *Whether a provider is accepting new patients with the*
16 *product selected by the enrollee or potential enrollee.*

17 (10) *Network tier to which the provider is assigned, if*
18 *applicable. “Tiered provider network” means a network of*
19 *participating providers that has been divided into subgroupings*
20 *differentiated by the health plan according to enrollee cost-sharing*
21 *levels or quality scores. Nothing in this section shall be construed*
22 *to require the use of network tiers other than contract and*
23 *noncontracting tiers.*

24 (11) *A disclosure that enrollees are entitled to full and equal*
25 *access to covered services, including enrollees with disabilities*
26 *as required under the Americans with Disabilities Act and Section*
27 *504 of the Rehabilitation Act.*

28 (12) *All other information necessary to conduct a search*
29 *pursuant to subdivision (b).*

30 (d) *A specialized health care service plan shall include all of*
31 *the following information for each of the provider directories used*
32 *by the plan for its networks:*

33 (1) *The provider’s name, location, and contact information.*

34 (2) *Type of Practitioner.*

35 (3) *National Provider Identification number.*

36 (4) *California license number and type of license.*

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

38 (6) *If participating in a group practice, the name of the group*
39 *practice.*

1 (7) *The names of any allied health care professionals to the*
2 *extent their services are covered through the contract with the*
3 *plan.*

4 (8) *Non-English language, if any, spoken by a health provider*
5 *as well as non-English language, if any, spoken by staff.*

6 (9) *Whether a provider is accepting new patients enrolled in*
7 *the product that the directory applies to.*

8 (10) *A disclosure that enrollees are entitled to full and equal*
9 *access to covered services, including enrollees with disabilities*
10 *as required under the Americans with Disabilities Act and Section*
11 *504 of the Rehabilitation Act.*

12 ~~(e)~~

13 (e) (1) By March 15, 2016, the department and the Department
14 of Insurance shall develop a standard provider directory template
15 standards for purposes of paragraph (3) of subdivision (b). The
16 template shall include a glossary of terms used in the template.
17 The template shall include information on how to contact the plan
18 and the department.

19 (2) The ~~template standards~~ shall be sufficiently standardized
20 sufficient to permit a single uniform *electronic* directory that would
21 allow a member of the public to determine whether a physician or
22 other provider is available to an enrollee of the California Health
23 Benefit Exchange as well as a beneficiary of the Medi-Cal program
24 enrolled in a Medi-Cal managed care plan. ~~The template shall also~~
25 ~~be sufficiently standardized standards shall be sufficient~~ to permit
26 a single uniform directory that would allow a member of the public
27 to determine whether a physician or other provider is available to
28 an enrollee with group coverage as well as to a beneficiary of the
29 Medi-Cal program enrolled in a Medi-Cal managed care plan or
30 to an enrollee of the California Health Benefit Exchange.

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

37 ~~(e)~~

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

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

9 (3) The plan shall demonstrate to the department that enrollees
10 or potential enrollees seeking a provider that is contracted with
11 the network for a particular product can identify these providers
12 and that the provider is accepting new patients. The plan shall
13 ensure that the accuracy of the provider directory meets or exceeds
14 97 percent.

15 (4) The plan shall contact any provider which is listed in the
16 provider directory and which has not submitted a claim within the
17 ~~prior quarter~~ *past three months for primary care providers, or six*
18 *months for specialty care providers, to determine whether the*
19 *provider is accepting patients or referrals from the ~~plan~~. plan, if*
20 *claims are paid by the plan. If claims are not paid by the plan, the*
21 *plan shall contact any provider that is listed in the provider*
22 *directory who has not submitted encounter data within the past*
23 *three months for primary care providers, or six months without*
24 *encounter data for a specialty care provider. If the provider does*
25 *not respond within 30 days, the plan shall remove the provider*
26 *from the provider directory. This requirement does not apply to*
27 *claims or encounter data from new primary care providers in the*
28 *first three months, or new specialty care providers in the first six*
29 *months, of the contract.*

30 (f)

31 (g) The plan shall ~~provide~~ *make available* an electronic copy
32 of, or upon request, one physical copy of the provider directory or
33 directories to the following:

34 (1) To the State Department of Health Care Services for
35 Medi-Cal managed care ~~networks~~. *plans.*

36 (2) To the California Health Benefit Exchange for the networks
37 of the products offered through the California Health Benefit
38 ~~Exchange~~. *Exchange, as required by contract.*

39 (3) On request by ~~CalPERS, to CalPERS~~. *the Public Employees'*
40 *Retirement System, to the Public Employees' Retirement System.*

1 (4) *The department and the Department of Insurance.*

2 ~~(4)~~

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

6 ~~(g)~~

7 (h) If a contracting provider, or the representative of a
8 contracting provider, informs an enrollee or potential enrollee that
9 the provider is not accepting new patients, the contract between
10 the plan and the provider shall require the provider to direct the
11 enrollee or potential enrollee to the plan for additional assistance
12 in finding a provider and also to the department to inform it of the
13 possible inaccuracy in the provider directory. If an enrollee or
14 potential enrollee informs a plan of a possible inaccuracy in the
15 provider directory or directories, the plan shall undertake *immediate*
16 corrective action to ~~assure~~ *ensure* the accuracy of the directory or
17 directories.

18 ~~(h)~~

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

26 (j) *Every health care service plan shall ensure processes are in*
27 *place to allow providers to promptly verify or submit changes to*
28 *demographic information and participation status. Those processes*
29 *shall, at a minimum, include an online interface for providers to*
30 *submit verification or changes electronically and shall allow*
31 *providers to receive an acknowledgment of receipt from the health*
32 *care service plan. Providers shall verify or submit changes to*
33 *demographic information and participation status using this*
34 *process according to the terms of their contract with the contracted*
35 *health plan. Providers shall verify or submit changes to*
36 *demographic information and participation status using this*
37 *process according to the terms of their contract with the contracted*
38 *health plan.*

39 ~~(i)~~

1 (k) Every health care service plan shall allow enrollees to request
2 the information required by this section through their toll-free
3 telephone ~~number~~ *number, electronically*, or in writing. On request
4 of an enrollee or potential enrollee, the plan shall provide the
5 information required under *subdivisions* (a), (b), ~~(e)~~ (c), and (g)
6 in written form. The information provided in written form may be
7 limited to the geographic region in which the enrollee or potential
8 enrollee resides or intends to reside.

9 SEC. 2. Section 10133.15 is added to the Insurance Code, to
10 read:

11 10133.15. (a) (1) A health insurer that contracts with providers
12 for alternative rates of payment pursuant to Section 10133 shall
13 make available a provider directory or directories ~~which~~ *that* shall
14 provide information on contracting providers, including those that
15 accept new ~~patients~~ *patients pursuant to the requirements of this*
16 *section and Section 10133.1*. A provider directory shall not include
17 information on a provider that does not have a current contract
18 with the ~~insurer and that has not submitted a claim within the past~~
19 ~~three months~~ *insurer*.

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

28 (2) *An insurer shall provide the directory or directories for the*
29 *specific network offered for each product using a consistent method*
30 *of network and product naming, numbering, or other classification*
31 *method that ensures the public, enrollees, potential enrollees, the*
32 *department, and other state or federal agencies can easily identify*
33 *which providers participate in which networks for which products.*
34 *An insurer shall use the same consistent classification method in*
35 *provider contracts and communications to ensure that providers*
36 *can identify the products and networks that they are legally*
37 *contracted to provide services in. The classification shall be*
38 *consistent across plans in order to permit the department and other*
39 *state or federal agencies to construct multiplan directories.*

1 (3) ~~The information regarding~~ provider directory or directories
 2 shall be available *on the insurer's Internet Web site* to the public
 3 and potential enrollees without any requirement that a member of
 4 the public or potential enrollee indicate intent to obtain coverage
 5 from the insurer. The directory or directories shall be available to
 6 the public without requiring that an individual ~~intends to purchase~~
 7 ~~coverage or has coverage by providing~~ *seeking the directory*
 8 *information demonstrate coverage with insurer, provide a policy*
 9 ~~number or number, provide any other identifying information and~~
 10 ~~without requiring an individual to information, or create or access~~
 11 an account.

12 (b) (1) The provider directory or directories shall be ~~posted~~
 13 *accessible* on the insurer's public Internet Web site through a
 14 clearly identifiable link or tab and in a manner that is accessible
 15 and searchable by the public, potential enrollees, enrollees, and
 16 providers. *The insurer's public Internet Web site shall allow for*
 17 *provider searches by name, practice address, National Provider*
 18 *Index number, California license number, facility or identification*
 19 *number, product, tier, provider language, medical group, or*
 20 *independent practice association, hospital, or clinic, as*
 21 *appropriate.* If another technology emerges that takes the place
 22 of Internet Web sites, the department shall direct the insurer to
 23 make the information required under this section available on the
 24 subsequent ~~technology.~~ *technology in a timeframe that allows for*
 25 *implementation of the technology, not to exceed six months.* The
 26 insurer shall also make a ~~hard~~ *paper* copy of the directory or
 27 directories available upon request.

28 (2) The insurer shall update ~~weekly~~ the provider directory ~~or~~
 29 ~~directories~~ *directories, at least weekly,* posted pursuant to paragraph
 30 (1) with any change to contracting providers, including ~~whether~~
 31 *all of the following:*

32 (A) *Instances where a contracting provider is has notified the*
 33 *insurer that the provider no longer intends to participate as a*
 34 *contracting provider, is no longer accepting new patients, patients,*
 35 *that the provider moved or relocated from the contracted service*
 36 *area of the plan, or has retired or otherwise ceased to practice.*

37 (B) *Instances where the contracting provider group, if any, has*
 38 *identified that the provider is no longer associated with the group*
 39 *or is no longer accepting new patients.*

1 (C) *Instances where the plan identified a change based on an*
2 *enrollee complaint that a provider was not accepting new patients*
3 *or was otherwise not available.*

4 (D) *Any other relevant information that has come to the attention*
5 *of the plan affecting the content of the provider directory.*

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

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

16 (c) The insurer shall ~~provide~~ *include* all of the following
17 information ~~for each of the provider directories used for a network:~~
18 *in the provider directory or directories:*

19 (1) The provider's ~~location~~ *name, location,* and contact
20 information.

21 (2) *Type of practitioner.*

22 (3) *National Provider Identification number.*

23 (4) *California license number and type of license.*

24 ~~(2)~~

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

26 ~~(3)~~

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

28 (B) ~~Psychologists,~~ *Nurse practitioners, physician assistants,*
29 *psychologists, acupuncturists, optometrists, podiatrists,*
30 *chiropractors, licensed clinical social workers, marriage and family*
31 *therapists, professional clinical counselors, and nurse midwives*
32 *to the extent their services may be accessed and are covered*
33 *through the contract with the insurer.*

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

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

1 provider, and the name of the federally qualified health center or
2 clinic.

3 ~~(4)~~

4 (7) Hospital admitting privileges, if any, for physicians and
5 other health professionals contracted with the ~~insurer~~. *insurer*
6 whose scope of services for the plan include admitting patients
7 and who have admitting privileges at a hospital.

8 ~~(5)~~

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

12 ~~(6) Access for persons with disabilities.~~

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

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

17 (10) Network tier that the provider is assigned to, if applicable.
18 “Tiered provider network” means a network of participating
19 providers that has been divided into subgroupings differentiated
20 by the insurer according to enrollee cost-sharing levels or quality
21 scores. Nothing in this section shall be construed to require the
22 use of network tiers other than contracting and noncontracting
23 tiers.

24 (11) A disclosure that insureds are entitled to full and equal
25 access to covered services, including insureds with disabilities as
26 required under the Americans with Disabilities Act and Section
27 504 of the Rehabilitation Act.

28 (12) All other information necessary to conduct a search
29 pursuant to subdivision (b).

30 (d) A specialized insurer shall include all of the following
31 information for each of the provider directories used by the insurer
32 for its networks:

33 (1) The provider’s name, location(s), and contact information.

34 (2) Type of practitioner.

35 (3) National Provider Identification number.

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

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

38 (6) If participating in a group practice, the name of the group
39 practice.

1 (7) *The names of any allied health care professionals to the*
2 *extent their services are covered through the contract with the*
3 *plan.*

4 (8) *Non-English language, if any, spoken by a health*
5 *professional as well as non-English language, if any, spoken by*
6 *staff.*

7 (9) *Whether a provider is accepting new patients enrolled in*
8 *the product that the directory applies to.*

9 (10) *A disclosure that insureds are entitled to full and equal*
10 *access to covered services, including insureds with disabilities as*
11 *required under the Americans with Disabilities Act and Section*
12 *504 of the Rehabilitation Act.*

13 ~~(d)~~

14 (e) (1) By March 15, 2016, the Department of Managed Health
15 Care and the department shall develop a ~~standard~~ provider directory
16 ~~template standards~~ for purposes of paragraph (3) of subdivision
17 (b). ~~The template shall include a glossary of terms used in the~~
18 ~~template. The template shall include information on how to contact~~
19 ~~the plan and the department.~~

20 (2) ~~The template standards shall be sufficiently standardized~~
21 ~~sufficient~~ to permit a single uniform *electronic* directory that would
22 allow a member of the public to determine whether a physician or
23 other provider is available to an enrollee of the California Health
24 Benefit Exchange as well as a beneficiary of the Medi-Cal program
25 enrolled in a Medi-Cal managed care plan. ~~The template shall also~~
26 ~~be sufficiently standardized standards shall be sufficient~~ to permit
27 a single uniform directory that would allow a member of the public
28 to determine whether a physician or other provider is available to
29 an enrollee with group coverage as well as to a beneficiary of the
30 Medi-Cal program enrolled in a Medi-Cal managed care plan or
31 to an enrollee of the California Health Benefit Exchange.

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

38 ~~(e)~~

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

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

11 (3) The insurer shall demonstrate to the department that enrollees
 12 or potential enrollees seeking a provider that is contracted with
 13 the network for a particular product can identify these providers
 14 and that the provider is accepting new patients. The insurer shall
 15 ensure that the accuracy of the provider directory meets or exceeds
 16 97 percent.

17 (4) The insurer shall contact any provider which is listed in the
 18 provider directory and which has not submitted a claim within the
 19 ~~prior quarter~~ *past three months for primary care providers, or six*
 20 *months for specialty care providers, to determine whether the*
 21 *provider is accepting patients or referrals from the ~~plan~~. plan, if*
 22 *claims are paid by the insurer. If the provider does not respond*
 23 *within 30 days, the insurer shall remove the provider from the*
 24 *provider directory. This requirement does not apply to claims or*
 25 *claim data from new primary care providers in the first three*
 26 *months, or new specialty care providers in the first six months, of*
 27 *the contract.*

28 (f)

29 (g) The insurer shall ~~provide~~ *make available* an electronic copy
 30 of, or upon request, one physical copy of the provider directory or
 31 directories to the following:

32 (1) To the State Department of Health Care Services for
 33 Medi-Cal managed care ~~networks~~. *plans*.

34 (2) To the California Health Benefit Exchange for the networks
 35 of the products offered through the California Health Benefit
 36 ~~Exchange~~. *Exchange, as required by contract.*

37 (3) On request by ~~CalPERS~~, ~~to CalPERS~~. *the Public Employees'*
 38 *Retirement System, to the Public Employees' Retirement System.*

39 (4) *The department and the Department of Managed Health*
 40 *Care.*

1 ~~(4)~~

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

5 ~~(g)~~

6 (h) If a contracting provider, or the representative of a
7 contracting provider, informs an enrollee or potential enrollee that
8 the provider is not accepting new patients, the contract between
9 the insurer and the provider shall require the provider to direct the
10 enrollee or potential enrollee to the insurer for additional assistance
11 in finding a provider and also to the department to inform it of the
12 possible inaccuracy in the provider directory. If an enrollee or
13 potential enrollee informs an insurer of a possible inaccuracy in
14 the provider directory or directories, the insurer shall undertake
15 *immediate* corrective action to ~~assure~~ *ensure* the accuracy of the
16 directory or directories.

17 ~~(h)~~

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

25 (j) *Every insurer shall ensure processes are in place to allow*
26 *providers to promptly verify or submit changes to demographic*
27 *information and participation status. Those processes shall, at a*
28 *minimum, include an online interface for providers to submit*
29 *verification or changes electronically and shall allow providers*
30 *to receive an acknowledgment of receipt from the health insurer.*
31 *Providers shall verify or submit changes to demographic*
32 *information and participation status using this process according*
33 *to the terms of their contract with the insurer.*

34 ~~(i)~~

35 (k) Every health insurer shall allow enrollees to request the
36 information required by this section through their toll-free
37 telephone ~~number~~ *number*, *electronically*, or in writing. On request
38 of an enrollee or potential enrollee, the insurer shall provide the
39 information required under *subdivisions* (a), (b), (c), and (g) in
40 written form. The information provided in written form may be

1 limited to the geographic region in which the enrollee or potential
2 enrollee resides or intends to reside.

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