AMENDED IN SENATE JUNE 1, 2015

AMENDED IN SENATE APRIL 21, 2015

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 provider directory 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:

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 that shall provide information on contracting providers, including those that accept new patients, pursuant to the requirements of this section and Section 1367.26. A provider directory shall not include information on a provider that does not have a current contract with the plan.

(2) A 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 which providers participate in which networks for which products. A health plan shall use the same consistent classification method in provider contracts and communications to ensure that providers can identify the products and networks that they are legally contracted to provide services in. The classification shall be consistent across plans in order to permit the department and other state or federal agencies to construct multiplan directories.

(3) The provider directory or directories shall be available on the plan's Internet Web site 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 seeking the directory information

demonstrate coverage with the plan, provide a policy number, provide any other identifying information, or create or access an account.

(b) (1) The provider directory or directories shall be accessible 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. The plan's public Internet Web site shall allow for provider searches by name, practice address, National Provider ~~Identification~~ *Identifier* number, California license, facility or identification number, product, tier, provider language, medical group, or independent practice association, hospital, or clinic, as appropriate. 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 in a timeframe that allows for implementation of the technology, not to exceed six months. The plan shall also make a paper copy of the directory or directories available upon request.

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

(A) Whether a contracting provider is no longer accepting new patients, or that the provider moved or relocated from the contracted service area of the plan, or has retired or has otherwise ceased to practice.

(B) Whether the contracting provider group, if any, has identified that the provider is no longer associated with the group or is no longer accepting new patients.

(C) Whether the plan identified a change based on an enrollee complaint that a provider was not accepting new patients or was otherwise not available.

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

(3) 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.

(4) By September 15, 2016, or no later than six months after the date that provider directory standards are developed under

subdivision (d), a plan shall use the developed standards pursuant to subdivision (d) for each product offered by the plan.

(c) A full service health care service 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 ~~Identification~~ *Identifier* number.

(4) California license number and type of license.

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

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

(B) Nurse practitioners, physician assistants, 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.

(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.

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

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

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

(10) Network tier to which the provider is assigned, if applicable. "Tiered provider network" means a network of participating providers that has been divided into subgroupings differentiated by the health plan according to enrollee cost-sharing levels or quality scores. Nothing in this section shall be construed to require

the use of network tiers other than contract and noncontracting tiers.

(11) A disclosure that enrollees are entitled to 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.~~ *Act of 1973.*

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

(d) A specialized health care service plan shall include all of the following information for each of the provider 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 ~~Identification~~ *Identifier* number.

(4) California license number and type of license.

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

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

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

(8) Non-English language, if any, spoken by a health provider as well as non-English language, if any, spoken by the provider's staff.

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

(10) A disclosure that enrollees are entitled to 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.~~ *Act of 1973.*

(e) (1) By March 15, 2016, the department and the Department of Insurance shall develop *uniform* provider directory standards for purposes of ~~paragraph (3) of subdivision (b).~~ *subdivision (b) which would allow directories to be aggregated and searchable to determine the plan a physician or other provider is available through.*

~~(2) The standards shall be sufficient to permit a single uniform electronic 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, a beneficiary~~

~~of the Medi-Cal program enrolled in a Medi-Cal managed care plan, as well as to an enrollee with group coverage.~~

~~(3)~~

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

(f) (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~~ *ensure* 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 past three months for primary care providers, or six months for specialty care providers, to determine whether the provider is accepting patients or referrals from the plan, if claims are paid by the plan. If claims are not paid by the plan, the plan shall contact any provider that is listed in the provider directory who has not submitted encounter data within the past three months for primary care providers, or six months without encounter data for a specialty care provider. If the provider does not respond within 30 days, the plan shall remove the provider from the provider directory. This requirement does not apply to claims or encounter data from new primary care providers in the first three months, or new specialty care providers in the first six months, of the contract.

(g) The plan shall make available 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 plans.

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

(3) On request by the Public Employees' Retirement System, to the Public Employees' Retirement System.

(4) The department and the Department of Insurance.

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

(h) 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 inform the plan that the provider is not accepting new patients and 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 immediate corrective action to ensure the accuracy of the directory or directories.

(i) 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.

(j) Every health care service plan shall ensure processes are in place to allow providers to promptly verify or submit changes to demographic information and participation status. Those processes shall, at a minimum, include an online interface for providers to submit verification or changes electronically and shall allow providers to receive an acknowledgment of receipt from the health care service plan. Providers shall verify or submit changes to

demographic information and participation status using this process according to the terms of their contract with the contracted health plan.

(k) Every health care service plan shall allow enrollees to request the information required by this section through their toll-free telephone number, electronically, or in writing. On request of an enrollee or potential enrollee, the plan shall provide the information required under subdivisions (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 that shall provide information on contracting providers, including those that accept new patients pursuant to the requirements of this section and Section 10133.1. A provider directory shall not include information on a provider that does not have a current contract with the insurer.

(2) An insurer 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, insureds, potential insureds, the department, and other state or federal agencies can easily identify which providers participate in which networks for which products. An insurer shall use the same consistent classification method in provider contracts and communications to ensure that providers can identify the products and networks that they are legally contracted to provide services in. The classification shall be consistent across products in order to permit the department and other state or federal agencies to construct multiplan directories.

(3) The provider directory or directories shall be available on the insurer's Internet Web site to the public and potential insureds without any requirement that a member of the public or potential insureds indicate intent to obtain coverage from the insurer. The directory or directories shall be available to the public without requiring that an individual seeking the directory information demonstrate coverage with *the* insurer, provide a policy number,

provide any other identifying information, or create or access an account.

(b) (1) The provider directory or directories shall be accessible 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 insureds, insureds, and providers. The insurer's public Internet Web site shall allow for provider searches by name, practice address, National Provider ~~Index~~ *Identifier* number, California license number, facility or identification number, product, tier, provider language, medical group, or independent practice association, hospital, or clinic, as appropriate. 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 in a timeframe that allows for implementation of the technology, not to exceed six months. The insurer shall also make a paper copy of the directory or directories available upon request.

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

(A) Whether a contracting provider has notified the insurer that the provider no longer intends to participate as a contracting provider, is no longer accepting new patients, that the provider moved or relocated from the contracted service area of the product, or has retired or otherwise ceased to practice.

(B) Whether the contracting provider group, if any, has identified that the provider is no longer associated with the group or is no longer accepting new patients.

(C) Whether the insurer identified a change based on an insured complaint that a provider was not accepting new patients or was otherwise not available.

(D) Any other relevant information that has come to the attention of the product affecting the content of the provider directory.

(3) 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.

(4) By September 15, 2016, or no later than six months after the date that provider directory standards are developed under

subdivision (d), an insurer shall use the developed standards pursuant to subdivision (d) for each product offered by the insurer.

(c) The 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 ~~Identification~~ *Identifier* number.

(4) California license number and type of license.

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

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

(B) Nurse practitioners, physician assistants, 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.

(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.

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

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

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

(10) Network tier that the provider is assigned to, if applicable. "Tiered provider network" means a network of participating providers that has been divided into subgroupings differentiated by the insurer according to insured cost-sharing levels or quality scores. Nothing in this section shall be construed to require the

use of network tiers other than contracting and noncontracting tiers.

(11) A disclosure that insureds are entitled to 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.~~ *Act of 1973.*

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

(d) A specialized insurer shall include all of the following information for each of the provider 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 ~~Identification~~ *Identifier* number.

(4) California license number and type of license.

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

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

(7) The names of any allied health care professionals to the extent their services are covered through the contract with the insurer.

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

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

(10) A disclosure that insureds are entitled to 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.~~ *Act of 1973.*

(e) (1) By March 15, 2016, the Department of Managed Health Care and the department shall develop ~~a~~ *uniform* provider directory standards for purposes of ~~paragraph (3) of subdivision (b).~~ *subdivision (b) which would allow directories to be aggregated and searchable to determine the plan a physician or other provider is available through.*

~~(2) The standards shall be sufficient to permit a single uniform electronic directory that would allow a member of the public to determine whether a physician or other provider is available to an~~

~~insured of the California Health Benefit Exchange, a beneficiary of the Medi-Cal program enrolled in a Medi-Cal managed care plan, as well as to an insured with group coverage.~~

~~(3)~~

(2) 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 standards, the department and 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.

(f) (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~~ *ensure* that other information reported to the department is consistent with the information provided to insureds, potential insureds, and the department pursuant to this section.

(3) The insurer shall demonstrate to the department that insureds or potential insureds 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 past three months for primary care providers, or six months for specialty care providers, to determine whether the provider is accepting patients or referrals from the insurer, if claims are paid by the insurer. If the provider does not respond within 30 days, the insurer shall remove the provider from the provider directory. This requirement does not apply to claims or claim data from new primary care providers in the first three months, or new specialty care providers in the first six months, of the contract.

(g) The insurer shall make available 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 plans.

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

(3) On request by the Public Employees' Retirement System, to the Public Employees' Retirement System.

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

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

(h) If a contracting provider, or the representative of a contracting provider, informs an insured or potential insured that the provider is not accepting new patients, the contract between the insurer and the provider shall require the provider to inform the insurer that the provider is not accepting new patients and direct the insured or potential insured 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 insured or potential insured informs an insurer of a possible inaccuracy in the provider directory or directories, the insurer shall undertake immediate corrective action to ensure the accuracy of the directory or directories.

(i) 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.

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

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

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.

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