

AMENDED IN ASSEMBLY JULY 2, 2015

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~~ *Sections 1367.27 and 1367.28* to the Health and Safety Code, and to add ~~Section~~ *Sections 10133.15 and 10133.16* 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.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services.

One of the methods by which Medi-Cal services are provided is pursuant to contracts with various types of managed health care plans.

Commencing February 1, 2016, this bill would require health care service plans, and insurers subject to regulation by the commissioner for services at alternative rates, to make an online provider directory available on its Internet Web site, as specified.

~~This~~

Commencing, March 15, 2016, the bill would require the Department of Managed Health Care and the Department of Insurance to jointly develop uniform provider directory standards. Commencing September 15, 2016, or no later than 6 months after the provider directory standards are developed, this bill would require health care service plans plans, plans with Medi-Cal managed care contracts, and insurers subject to regulation by the commissioner for services at alternative rates to make a an online 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:

- 1 SECTION 1. Section 1367.27 is added to the Health and Safety
- 2 Code, to read:
- 3 1367.27. (a) ~~(1) A~~ Commencing February 1, 2016, a health
- 4 care service plan shall make available a an online provider
- 5 directory or directories that shall provide information on
- 6 contracting providers, providers that provide health care services
- 7 to plan enrollees, including those that accept new patients, pursuant
- 8 to the requirements of this section and Section 1367.26. A provider
- 9 directory shall not include information on a provider that does not
- 10 have a current contract with the plan.

1 (2)

2 (b) A plan shall provide the *online* directory or directories for
3 the specific network offered for each product using a consistent
4 method of network and product naming, numbering, or other
5 classification method that ensures the public, enrollees, potential
6 enrollees, the department, and other state or federal agencies can
7 easily identify which providers participate in which networks for
8 which products. A health plan shall use the same consistent *naming,*
9 *numbering, or* classification method in provider contracts and
10 communications to ensure that providers can identify the products
11 and networks that they are legally contracted to provide services
12 in. The *naming, numbering, or* classification shall be consistent
13 across plans in order to permit ~~the department and other state or~~
14 ~~federal agencies to construct~~ multiplan directories.

15 (3)

16 (c) The *online* provider directory or directories shall be available
17 on the plan's Internet Web site to ~~the public and potential enrollees~~
18 *public, potential enrollees, enrollees, and providers through a*
19 *clearly identifiable link or tab and in a manner that is accessible*
20 *and searchable* without any requirement that a member of the
21 public or potential enrollee indicate intent to obtain coverage from
22 the plan. The directory or directories shall be available to the public
23 without requiring that an individual seeking the directory
24 information demonstrate coverage with the plan, provide a policy
25 number, provide any other identifying information, or create or
26 access an account.

27 ~~(b) (1) The provider directory or directories shall be accessible~~
28 ~~on the plan's public Internet Web site through a clearly identifiable~~
29 ~~link or tab and in a manner that is accessible and searchable by~~
30 ~~the public, potential enrollees, enrollees, and providers. The plan's~~
31 ~~public Internet Web site shall allow for provider searches by name,~~
32 ~~practice address, National Provider Identifier number, California~~
33 ~~license, facility or identification number, product, tier, provider~~
34 ~~language, medical group, or independent practice association,~~
35 ~~hospital, or clinic, as appropriate. If another technology emerges~~
36 ~~that takes the place of Internet Web sites, the department shall~~
37 ~~direct the plan to make the information required under this section~~
38 ~~available on the subsequent technology in a timeframe that allows~~
39 ~~for implementation of the technology, not to exceed six months.~~

1 The plan shall also make a paper copy of the directory or directories
2 available upon request.

3 ~~(2)~~

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

7 ~~(A)~~

8 (1) Whether a contracting provider is no longer accepting new
9 patients, or that the provider moved or relocated from the
10 contracted service area of the plan, or has retired or has otherwise
11 ceased to practice; *patients for that product, or whether the*
12 *contracting provider group has identified that a provider of the*
13 *group is no longer accepting new patients.*

14 (2) *Whether the provider moved or relocated from the contracted*
15 *service area of the plan, has retired, or has otherwise ceased to*
16 *practice, in which case the provider shall be deleted from the*
17 *directory.*

18 ~~(B)~~

19 (3) Whether the contracting provider group, if any, has identified
20 informed the plan that the provider is no longer associated with
21 the group or is no longer accepting new patients; *and is no longer*
22 *under contract with the plan, in which case the provider shall be*
23 *deleted from the directory.*

24 ~~(C) Whether the plan identified~~

25 (4) *When the plan identified a change is necessary based on an*
26 *enrollee complaint that a provider was not accepting new patients*
27 *or patients, was otherwise not available; available, or whose*
28 *contact information was listed incorrectly.*

29 ~~(D)~~

30 (5) Any other relevant information that has come to the attention
31 of the plan affecting the content *and accuracy* of the provider
32 directory.

33 ~~(3)~~

34 (e) The *online* provider directory or directories shall include
35 both an email address and a telephone number for members of the
36 public and providers to notify the plan if the provider directory
37 information appears to be inaccurate.

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

1 ~~subdivision (d), a plan shall use the developed standards pursuant~~
2 ~~to subdivision (d) for each product offered by the plan.~~
3 ~~(e) A full service health care service plan shall include all of~~
4 ~~the following information in the provider directory or directories:~~
5 ~~(1) The provider's name, practice location or locations, and~~
6 ~~contact information.~~
7 ~~(2) Type of practitioner.~~
8 ~~(3) National Provider Identifier number.~~
9 ~~(4) California license number and type of license.~~
10 ~~(5) The area of specialty, including board certification, if any.~~
11 ~~(6) (A) For physicians, the medical group, if any.~~
12 ~~(B) Nurse practitioners, physician assistants, psychologists,~~
13 ~~acupuncturists, optometrists, podiatrists, chiropractors, licensed~~
14 ~~clinical social workers, marriage and family therapists, professional~~
15 ~~clinical counselors, and nurse midwives to the extent their services~~
16 ~~may be accessed and are covered through the contract with the~~
17 ~~plan.~~
18 ~~(C) For federally qualified health centers or primary care clinics,~~
19 ~~the name of the federally qualified health center or clinic.~~
20 ~~(D) For any provider described in subparagraph (A) or (B) who~~
21 ~~is employed by a federally qualified health center or primary care~~
22 ~~clinic, and to the extent their services may be accessed and are~~
23 ~~covered through the contract with the plan, the name of the~~
24 ~~provider, and the name of the federally qualified health center or~~
25 ~~clinic.~~
26 ~~(7) Hospital admitting privileges, if any, for physicians and~~
27 ~~other health professionals contracted with the plan whose scope~~
28 ~~of services for the plan include admitting patients and who have~~
29 ~~admitting privileges at a hospital.~~
30 ~~(8) Non-English language, if any, spoken by a health~~
31 ~~professional as well as non-English language, if any, spoken by~~
32 ~~the provider's staff.~~
33 ~~(9) Whether a provider is accepting new patients with the~~
34 ~~product selected by the enrollee or potential enrollee.~~
35 ~~(10) Network tier to which the provider is assigned, if applicable.~~
36 ~~"Tiered provider network" means a network of participating~~
37 ~~providers that has been divided into subgroupings differentiated~~
38 ~~by the health plan according to enrollee cost-sharing levels or~~
39 ~~quality scores. Nothing in this section shall be construed to require~~

1 the use of network tiers other than contract and noncontracting
2 tiers:

3 (11) A disclosure that enrollees are entitled to full and equal
4 access to covered services, including enrollees with disabilities as
5 required under the federal Americans with Disabilities Act of 1990
6 and Section 504 of the Rehabilitation Act of 1973.

7 (12) All other information necessary to conduct a search
8 pursuant to subdivision (b):

9 (d) A specialized health care service plan shall include all of
10 the following information for each of the provider directories used
11 by the plan for its networks:

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

14 (2) Type of practitioner.

15 (3) National Provider Identifier number.

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

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

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

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

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

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

27 (10) A disclosure that enrollees are entitled to full and equal
28 access to covered services, including enrollees with disabilities as
29 required under the federal Americans with Disabilities Act of 1990
30 and Section 504 of the Rehabilitation Act of 1973.

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

36 (2) The department and the Department of Insurance shall seek
37 input from interested parties, including holding at least one public
38 meeting. In developing the directory standards, the department
39 shall take into consideration any requirements for provider

1 directories established by the federal Centers for Medicare and
2 Medicaid Services:

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

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

14 (3) The plan shall demonstrate to the department that enrollees
15 or potential enrollees seeking a provider that is contracted with
16 the network for a particular product can identify these providers
17 and that the provider is accepting new patients. The plan shall
18 ensure that the accuracy of the provider directory meets or exceeds
19 97 percent.

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

34 (g) The plan shall make available an electronic copy of, or upon
35 request, one physical copy of the provider directory or directories
36 to the following:

37 (1) To the State Department of Health Care Services for
38 Medi-Cal managed care plans:

- 1 ~~(2) To the California Health Benefit Exchange for the networks~~
2 ~~of the products offered through the California Health Benefit~~
3 ~~Exchange, as required by contract.~~
- 4 ~~(3) On request by the Public Employees' Retirement System,~~
5 ~~to the Public Employees' Retirement System.~~
- 6 ~~(4) The department and the Department of Insurance.~~
- 7 ~~(5) On request by a group purchaser, provider directory or~~
8 ~~directories for the products available in the market segment of the~~
9 ~~group.~~
- 10 ~~(h) If a contracting provider, or the representative of a~~
11 ~~contracting provider, informs an enrollee or potential enrollee that~~
12 ~~the provider is not accepting new patients, the contract between~~
13 ~~the plan and the provider shall require the provider to inform the~~
14 ~~plan that the provider is not accepting new patients and direct the~~
15 ~~enrollee or potential enrollee to the plan for additional assistance~~
16 ~~in finding a provider and also to the department to inform it of the~~
17 ~~possible inaccuracy in the provider directory. If an enrollee or~~
18 ~~potential enrollee informs a plan of a possible inaccuracy in the~~
19 ~~provider directory or directories, the plan shall undertake~~
20 ~~immediate corrective action to ensure the accuracy of the directory~~
21 ~~or directories.~~
- 22 ~~(i) This section does not prohibit a plan from requiring its~~
23 ~~contracting providers, contracting provider groups, or contracting~~
24 ~~specialized health care plans to satisfy the requirements of this~~
25 ~~section. If a plan delegates the responsibility of complying with~~
26 ~~this section to its contracting providers, contracting provider~~
27 ~~groups, or contracting specialized health care plans, the plan shall~~
28 ~~ensure that the requirements of this section are met.~~
- 29 ~~(j) Every health care service plan shall ensure processes are in~~
30 ~~place to allow providers to promptly verify or submit changes to~~
31 ~~demographic information and participation status. Those processes~~
32 ~~shall, at a minimum, include an online interface for providers to~~
33 ~~submit verification or changes electronically and shall allow~~
34 ~~providers to receive an acknowledgment of receipt from the health~~
35 ~~care service plan. Providers shall verify or submit changes to~~
36 ~~demographic information and participation status using this process~~
37 ~~according to the terms of their contract with the contracted health~~
38 ~~plan.~~
- 39 ~~(k) Every health care service plan shall allow enrollees to request~~
40 ~~the information required by this section through their toll-free~~

1 telephone number, electronically, or in writing. On request of an
2 enrollee or potential enrollee, the plan shall provide the information
3 required under subdivisions (a), (b), (c), and (g) in written form.
4 The information provided in written form may be limited to the
5 geographic region in which the enrollee or potential enrollee resides
6 or intends to reside.

7 (f) The online provider directory shall include the following
8 disclosures informing enrollees that they are entitled to both of
9 the following:

10 (1) Language interpreter services, at no cost to the enrollee,
11 including how to obtain interpretation services.

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

16 SEC. 2. Section 1367.28 is added to the Health and Safety
17 Code, to read:

18 1367.28. (a) (1) By March 15, 2016, the department and the
19 Department of Insurance shall jointly develop uniform provider
20 directory standards consistent with this section. These standards
21 shall also require directories to be aggregated and searchable to
22 determine the plan with which a physician or other provider is
23 contracted.

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

30 (3) By September 15, 2016, or no later than six months after
31 the date that provider directory standards are developed a plan
32 shall use the developed standards for each product offered by the
33 plan.

34 (4) The uniform provider directory standards shall require the
35 plan's public Internet Web site to allow for provider searches by
36 name, practice address, National Provider Identifier number,
37 California license, facility or identification number, product, tier,
38 provider language, medical group, or independent practice
39 association, hospital, or clinic, as appropriate.

- 1 **(b)** *A full service health care service plan and a specialized*
2 *mental health plan shall include all of the following information*
3 *in the online provider directory or directories:*
- 4 **(1)** *The provider's name, practice location or locations, and*
5 *contact information.*
- 6 **(2)** *Type of practitioner.*
- 7 **(3)** *National Provider Identifier number.*
- 8 **(4)** *California license number and type of license.*
- 9 **(5)** *The area of specialty, including board certification, if any.*
- 10 **(6)** *(A) For physicians, the medical group, if any.*
11 *(B) Nurse practitioners, physician assistants, psychologists,*
12 *acupuncturists, optometrists, podiatrists, chiropractors, licensed*
13 *clinical social workers, marriage and family therapists,*
14 *professional clinical counselors, nurse midwives, and dentists to*
15 *the extent their services may be accessed and are covered through*
16 *the contract with the plan. The plan may specify in the online*
17 *provider directory or directories that authorization or referral*
18 *may be required to access some providers.*
- 19 **(C)** *For federally qualified health centers or primary care*
20 *clinics, the name of the federally qualified health center or clinic.*
- 21 **(D)** *For any provider described in subparagraph (A) or (B) who*
22 *is employed by a federally qualified health center or primary care*
23 *clinic, and to the extent their services may be accessed and are*
24 *covered through the contract with the plan, the name of the*
25 *provider, and the name of the federally qualified health center or*
26 *clinic.*
- 27 **(E)** *Pharmacies.*
- 28 **(F)** *Skilled nursing facilities.*
- 29 **(G)** *Urgent care clinics.*
- 30 **(7)** *Hospital affiliation or admitting privileges, if any, for*
31 *physicians and other health professionals contracted with the plan*
32 *whose scope of services for the plan include admitting patients*
33 *and who have admitting privileges at a contracted hospital.*
- 34 **(8)** *Non-English language, if any, spoken by a health care*
35 *provider or other medical professional as well as non-English*
36 *language spoken by a skilled medical interpreter, if any, on the*
37 *provider's staff.*
- 38 **(9)** *Whether a provider is accepting new patients with the*
39 *product selected by the enrollee or potential enrollee.*

1 (10) Network tier to which the provider is assigned, if the
2 participating provider has been divided into subgroupings
3 differentiated by the health plan according to enrollee cost-sharing
4 levels. Nothing in this section shall be construed to require the use
5 of network tiers other than contract and noncontracting tiers.

6 (11) A disclosure that enrollees are entitled to full and equal
7 access to covered services, including enrollees with disabilities
8 as required under the federal Americans with Disabilities Act of
9 1990 and Section 504 of the Rehabilitation Act of 1973.

10 (12) A disclosure that enrollees are entitled to language
11 interpreter services at no cost to the enrollee, including how to
12 obtain interpretation services.

13 (13) All other information necessary to conduct a search
14 pursuant to subparagraph (A) of paragraph (4) of subdivision (a).

15 (c) A vision, dental and other specialized health care service
16 plan, except for a specialized mental health plan, shall include all
17 of the following information for each of the online provider
18 directories used by the plan for its networks:

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

21 (2) Type of practitioner.

22 (3) National Provider Identifier number.

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

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

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

27 (7) The names of any allied health care professionals to the
28 extent there is a direct contract for those services covered through
29 the contract with the plan.

30 (8) Non-English language, if any, spoken by a health care
31 provider or other medical professional as well as non-English
32 language spoken by a skilled medical interpreter, if any, on the
33 provider's staff.

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

36 (10) A disclosure that enrollees are entitled to full and equal
37 access to covered services, including enrollees with disabilities
38 as required under the federal Americans with Disabilities Act of
39 1990 and Section 504 of the Rehabilitation Act of 1973.

1 (11) A disclosure that enrollees are entitled to language
2 interpreter services at no cost to the enrollee, including how to
3 obtain interpretation services.

4 (d) (1) The plan shall provide the online directory or directories
5 to the department in a format and manner to be specified by the
6 department.

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

15 (3) The plan shall demonstrate to the department that enrollees
16 or potential enrollees seeking a provider that is contracted with
17 the network for a particular product can identify these providers
18 and that the provider is accepting new patients. The plan shall
19 ensure that the accuracy of the provider directory meets or exceeds
20 95 percent with regard to the participation of providers in the
21 network, the extent to which the provider is accepting new patients,
22 and if any non-English language is spoken by the provider or other
23 medical professionals, as well as non-English language spoken
24 by a skilled medical interpreter, if any, on the provider's staff.

25 (4) The plan shall contact any provider which is listed in the
26 provider directory and which has not submitted a claim within the
27 past six months for primary care providers, or twelve months for
28 specialty care providers, to determine whether the provider is
29 accepting patients or referrals from the plan, if claims are paid
30 by the plan. If claims are not paid by the plan, the plan shall
31 contact any provider that is listed in the provider directory who
32 has not submitted encounter data within the past six months for
33 primary care providers, or 12 months without encounter data for
34 a specialty care provider. If the provider does not respond within
35 30 days, the plan shall remove the provider from the provider
36 directory. A plan is not required to terminate a provider who is
37 removed from the directory according to this paragraph. This
38 requirement does not apply to claims or encounter data from new
39 primary care providers in the first six months, or new specialty
40 care providers in the first 12 months, of the contract. This

1 *paragraph shall not apply if a provider has affirmatively responded*
2 *under the requirements of subdivision (h) that the provider*
3 *information is accurate and the provider is continuing to*
4 *participate in the network.*

5 *(e) If a contracting provider, or the representative of a*
6 *contracting provider, informs an enrollee or potential enrollee*
7 *that the provider is not accepting new patients, the contract*
8 *between the plan and the provider shall require the provider to*
9 *inform the plan that the provider is not accepting new patients*
10 *and direct the enrollee or potential enrollee to the plan for*
11 *additional assistance in finding a provider and also to the*
12 *department to inform it of the possible inaccuracy in the provider*
13 *directory. If an enrollee or potential enrollee informs a plan of a*
14 *possible inaccuracy in the provider directory or directories, the*
15 *plan shall immediately investigate and undertake corrective action*
16 *within 30 business days to ensure the accuracy of the directory or*
17 *directories.*

18 *(f) This section does not prohibit a plan 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 a plan delegates the responsibility of complying with*
22 *this section to its contracting providers, contracting provider*
23 *groups, or contracting specialized health care plans, the plan shall*
24 *ensure that the requirements of this section are met.*

25 *(g) Every health care service plan shall ensure processes are*
26 *in place to allow providers to promptly verify or submit changes*
27 *to the information required to be in the directory pursuant to this*
28 *section. Those processes shall, at a minimum, include an online*
29 *interface for providers to submit verification or changes*
30 *electronically and shall allow providers to receive an*
31 *acknowledgment of receipt from the health care service plan.*
32 *Providers shall verify or submit changes to information required*
33 *to be in the directory pursuant to this section using the process*
34 *required by the health plan.*

35 *(h) (1) At least every six months the plan shall notify the*
36 *contracted provider or provider group of the information on the*
37 *provider or provider group contained in the directory including*
38 *a list of each product marketed by the plan for the network. The*
39 *plan shall include with this notification instructions as to how to*

1 access and update the information using the online interface in
2 subdivision (g).

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

10 (3) If the plan does not receive an affirmative response and
11 attestation from the provider within 30 business days, the provider
12 shall be removed from the directory.

13 (i) Every health care service plan shall allow enrollees to
14 request the information required by this section through their
15 toll-free telephone number, electronically, or in writing. On request
16 of an enrollee or potential enrollee, the plan shall provide the
17 provider directory in printed form. The information provided in
18 printed form may be limited to the geographic region in which the
19 enrollee or potential enrollee resides or intends to reside.

20 (j) Notwithstanding the provisions of Section 1371, a plan may
21 use reasonable compliance methods, such as delaying payment or
22 reimbursement to a provider who has not responded or removal
23 of the provider from other directories only until the plan receives
24 an affirmative response and attestation from the provider. A plan
25 may terminate a contract for a pattern or repeated failure of the
26 provider or provider group to alert the plan to a change in the
27 information required to be in the directory pursuant to this section.
28 A plan may not impose any compliance method pursuant to this
29 subdivision without first providing written notice to the provider.

30 (k) This section shall apply to plans with Medi-Cal managed
31 care contracts with the State Department of Health Care Services
32 pursuant to Chapter 7 (commencing with Section 14000) or
33 Chapter 8 (commencing with Section 14200) of the Welfare and
34 Institutions Code to the extent consistent with federal law and
35 guidance.

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

1 ~~SEC. 2.~~

2 *SEC. 3.* Section 10133.15 is added to the Insurance Code, to
3 read:

4 10133.15. (a) ~~(1)~~ *—A Commencing February 1, 2016, a health*
5 *insurer that contracts with providers for alternative rates of payment*
6 *pursuant to Section 10133 shall make available a an online provider*
7 *directory or directories that shall provide information on*
8 *contracting providers, providers that provide health care services*
9 *to insureds, including those that accept new patients pursuant to*
10 *the requirements of this section and Section 10133.1. A provider*
11 *directory shall not include information on a provider that does not*
12 *have a current contract with the insurer.*

13 ~~(2)~~

14 (b) An insurer shall provide the *online* directory or directories
15 for the specific network offered for each product using a consistent
16 method of network and product naming, numbering, or other
17 classification method that ensures the public, insureds, potential
18 insureds, the department, and other state or federal agencies can
19 easily identify which providers participate in which networks for
20 which products. An insurer shall use the same consistent *naming,*
21 *numbering, or* classification method in provider contracts and
22 communications to ensure that providers can identify the products
23 and networks that they are legally contracted to provide services
24 in. The *naming, numbering, or* classification shall be consistent
25 across products in order to permit ~~the department and other state~~
26 ~~or federal agencies to construct~~ multiplan directories.

27 ~~(3)~~

28 (c) The *online* provider directory or directories shall be available
29 on the insurer's Internet Web site to ~~the public and potential~~
30 ~~insureds~~ *public, potential insureds, insureds, and providers through*
31 *a clearly identifiable link or tab and in a manner that is accessible*
32 *and searchable* without any requirement that a member of the
33 public or potential insureds indicate intent to obtain coverage from
34 the insurer. The directory or directories shall be available to the
35 public without requiring that an individual seeking the directory
36 information demonstrate coverage with the insurer, provide a policy
37 number, provide any other identifying information, or create or
38 access an account.

39 ~~(b) (1)~~ ~~The provider directory or directories shall be accessible~~
40 ~~on the insurer's public Internet Web site through a clearly~~

1 identifiable link or tab and in a manner that is accessible and
 2 searchable by the public, potential insureds, insureds, and
 3 providers. The insurer's public Internet Web site shall allow for
 4 provider searches by name, practice address, National Provider
 5 Identifier number, California license number, facility or
 6 identification number, product, tier, provider language, medical
 7 group, or independent practice association, hospital, or clinic, as
 8 appropriate. If another technology emerges that takes the place of
 9 Internet Web sites, the department shall direct the insurer to make
 10 the information required under this section available on the
 11 subsequent technology in a timeframe that allows for
 12 implementation of the technology, not to exceed six months. The
 13 insurer shall also make a paper copy of the directory or directories
 14 available upon request.

15 (2)

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

19 (A)

20 (1) ~~Whether a contracting provider has notified the insurer that~~
 21 ~~the provider no longer intends to participate as a contracting~~
 22 ~~provider, is no longer accepting new patients, that the provider~~
 23 ~~moved or relocated from the contracted service area of the product,~~
 24 ~~or has retired or otherwise ceased to practice. patients for that~~
 25 ~~product, or whether the contracting provider group has identified~~
 26 ~~that a provider of the group is no longer accepting new patients.~~

27 (2) ~~Whether the provider moved or relocated from the contracted~~
 28 ~~service area of the insurer, or has retired or has otherwise ceased~~
 29 ~~to practice, in which case the provider shall be deleted from the~~
 30 ~~directory.~~

31 (B)

32 (3) ~~Whether the contracting provider group, if any, has identified~~
 33 ~~informed the insurer that the provider is no longer associated with~~
 34 ~~the group or is no longer accepting new patients. and is no longer~~
 35 ~~under contract with the plan, in which case the provider shall be~~
 36 ~~deleted from the directory.~~

37 (C) ~~Whether the insurer identified~~

38 (4) ~~When the plan identified a change is necessary based on an~~
 39 ~~insured complaint that a provider was not accepting new patients~~

1 ~~or patients, was otherwise not available.~~ *available, or whose*
2 *contact information was listed incorrectly.*

3 ~~(D)~~

4 (5) Any other relevant information that has come to the attention
5 of the product affecting the content *and accuracy* of the provider
6 directory.

7 ~~(3)~~

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

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

16 (e) The insurer shall include all of the following information in
17 the provider directory or directories:

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

20 ~~(2) Type of practitioner.~~

21 ~~(3) National Provider Identifier number.~~

22 ~~(4) California license number and type of license.~~

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

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

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

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

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

39 ~~(7) Hospital admitting privileges, if any, for physicians and~~
40 ~~other health professionals contracted with the insurer whose scope~~

1 of services for the product include admitting patients and who have
 2 admitting privileges at a hospital.

3 ~~(8) Non-English language, if any, spoken by a health~~
 4 ~~professional as well as non-English language, if any, spoken by~~
 5 ~~the provider’s staff.~~

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

8 ~~(10) Network tier that the provider is assigned to, if applicable.~~
 9 ~~“Tiered provider network” means a network of participating~~
 10 ~~providers that has been divided into subgroupings differentiated~~
 11 ~~by the insurer according to insured cost-sharing levels or quality~~
 12 ~~scores. Nothing in this section shall be construed to require the~~
 13 ~~use of network tiers other than contracting and noncontracting~~
 14 ~~tiers.~~

15 ~~(11) A disclosure that insureds are entitled to full and equal~~
 16 ~~access to covered services, including insureds with disabilities as~~
 17 ~~required under the federal Americans with Disabilities Act of 1990~~
 18 ~~and Section 504 of the Rehabilitation Act of 1973.~~

19 ~~(12) All other information necessary to conduct a search~~
 20 ~~pursuant to subdivision (b):~~

21 ~~(d) A specialized insurer shall include all of the following~~
 22 ~~information for each of the provider directories used by the insurer~~
 23 ~~for its networks:~~

24 ~~(1) The provider’s name, practice location or locations, and~~
 25 ~~contact information.~~

26 ~~(2) Type of practitioner.~~

27 ~~(3) National Provider Identifier number.~~

28 ~~(4) California license number and type of license.~~

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

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

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

35 ~~(8) Non-English language, if any, spoken by a health~~
 36 ~~professional as well as non-English language, if any, spoken by~~
 37 ~~the provider’s staff.~~

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

1 ~~(10) A disclosure that insureds are entitled to full and equal~~
2 ~~access to covered services, including insureds with disabilities as~~
3 ~~required under the federal Americans with Disabilities Act of 1990~~
4 ~~and Section 504 of the Rehabilitation Act of 1973.~~

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

10 ~~(2) The department and the Department of Managed Health~~
11 ~~Care shall seek input from interested parties, including holding at~~
12 ~~least one public meeting. In developing the directory standards,~~
13 ~~the department and the Department of Managed Health Care shall~~
14 ~~take into consideration any requirements for provider directories~~
15 ~~established by the federal Centers for Medicare and Medicaid~~
16 ~~Services.~~

17 ~~(f) (1) The insurer shall provide the directory or directories to~~
18 ~~the department in a format and manner to be specified by the~~
19 ~~department.~~

20 ~~(2) The insurer shall demonstrate no less than quarterly to the~~
21 ~~department that the information provided in the provider directory~~
22 ~~or directories is consistent with the information required under~~
23 ~~Section 10133.5 and other provisions of this part. The insurer shall~~
24 ~~ensure that other information reported to the department is~~
25 ~~consistent with the information provided to insureds, potential~~
26 ~~insureds, and the department pursuant to this section.~~

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

33 ~~(4) The insurer shall contact any provider which is listed in the~~
34 ~~provider directory and which has not submitted a claim within the~~
35 ~~past three months for primary care providers, or six months for~~
36 ~~specialty care providers, to determine whether the provider is~~
37 ~~accepting patients or referrals from the insurer, if claims are paid~~
38 ~~by the insurer. If the provider does not respond within 30 days,~~
39 ~~the insurer shall remove the provider from the provider directory.~~
40 ~~This requirement does not apply to claims or claim data from new~~

1 primary care providers in the first three months, or new specialty
2 care providers in the first six months, of the contract.

3 ~~(g) The insurer shall make available an electronic copy of, or
4 upon request, one physical copy of the provider directory or
5 directories to the following:~~

6 ~~(1) To the State Department of Health Care Services for
7 Medi-Cal managed care plans.~~

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

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

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

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

18 ~~(h) If a contracting provider, or the representative of a
19 contracting provider, informs an insured or potential insured that
20 the provider is not accepting new patients, the contract between
21 the insurer and the provider shall require the provider to inform
22 the insurer that the provider is not accepting new patients and direct
23 the insured or potential insured to the insurer for additional
24 assistance in finding a provider and also to the department to
25 inform it of the possible inaccuracy in the provider directory. If
26 an insured or potential insured informs an insurer of a possible
27 inaccuracy in the provider directory or directories, the insurer shall
28 undertake immediate corrective action to ensure the accuracy of
29 the directory or directories.~~

30 ~~(i) This section does not prohibit an insurer from requiring its
31 contracting providers, contracting provider groups, or contracting
32 specialized health care plans to satisfy the requirements of this
33 section. If an insurer delegates the responsibility of complying
34 with this section to its contracting providers, contracting provider
35 groups, or contracting specialized health care plans, the insurer
36 shall ensure that the requirements of this section are met.~~

37 ~~(j) Every insurer shall ensure processes are in place to allow
38 providers to promptly verify or submit changes to demographic
39 information and participation status. Those processes shall, at a
40 minimum, include an online interface for providers to submit~~

1 verification or changes electronically and shall allow providers to
2 receive an acknowledgment of receipt from the health insurer.
3 Providers shall verify or submit changes to demographic
4 information and participation status using this process according
5 to the terms of their contract with the insurer.

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

14 *(f) The online provider directory shall include the following
15 disclosures informing insureds that they are entitled to both of the
16 following:*

17 *(1) Language interpreter services, at no cost to the insured,
18 including how to obtain interpretation services.*

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

23 *SEC. 4. Section 10133.16 is added to the Insurance Code, to
24 read:*

25 *10133.16. (a) (1) By March 15, 2016, the department and the
26 Department of Managed Health Care shall jointly develop uniform
27 provider directory standards consistent with this section. These
28 standards shall also require directories to be aggregated and
29 searchable to determine the insurer with which a physician or
30 other provider is contracted.*

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

37 *(3) By September 15, 2016, or no later than six months after
38 the date that provider directory standards are developed, an
39 insurer shall use the developed standards for each product offered
40 by the insurer.*

1 (4) *The uniform provider directory standards shall require the*
2 *insurer's public Internet Web site to allow for provider searches*
3 *by name, practice address, National Provider Identifier number,*
4 *California license number, facility or identification number,*
5 *product, tier, provider language, medical group, or independent*
6 *practice association, hospital, or clinic, as appropriate.*

7 (b) *The insurer and a specialized mental health insurer shall*
8 *include all of the following information in the online provider*
9 *directory or directories:*

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

12 (2) *Type of practitioner.*

13 (3) *National Provider Identifier number.*

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

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

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

17 (B) *Nurse practitioners, physician assistants, psychologists,*
18 *acupuncturists, optometrists, podiatrists, chiropractors, licensed*
19 *clinical social workers, marriage and family therapists,*
20 *professional clinical counselors, nurse midwives, and dentists to*
21 *the extent their services may be accessed and are covered through*
22 *the contract with the insurer. The insurer may specify in the*
23 *provider directory or directories that authorization or referral*
24 *may be required to access some providers.*

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

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

33 (E) *Pharmacies.*

34 (F) *Skilled nursing facilities.*

35 (G) *Urgent care clinics.*

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

1 (8) *Non-English language, if any, spoken by a health care*
2 *provider or other medical professional as well as non-English*
3 *language spoken by a skilled medical interpreter, if any, on the*
4 *provider's staff.*

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

7 (10) *Network tier that the provider is assigned if the*
8 *participating provider has been divided into subgroupings*
9 *differentiated by the insurer according to insured cost-sharing*
10 *levels or quality scores. Nothing in this section shall be construed*
11 *to require the use of network tiers other than contract and*
12 *noncontracting tiers.*

13 (11) *A disclosure that insureds are entitled to full and equal*
14 *access to covered services, including insureds with disabilities as*
15 *required under the federal Americans with Disabilities Act of 1990*
16 *and Section 504 of the Rehabilitation Act of 1973.*

17 (12) *A disclosure that insureds are entitled to language*
18 *interpreter services at no cost to the insured, including how to*
19 *obtain interpretation services.*

20 (13) *All other information necessary to conduct a search*
21 *pursuant to subparagraph (A) of paragraph (4) of subdivision (a).*

22 (c) *A vision, dental, and other specialized insurer, except for a*
23 *specialized mental health insurer, shall include all of the following*
24 *information for each of the online provider directories used by the*
25 *insurer for its networks:*

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

28 (2) *Type of practitioner.*

29 (3) *National Provider Identifier number.*

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

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

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

34 (7) *The names of any allied health care professionals to the*
35 *extent there is a direct contract for those services covered through*
36 *the contract with the insurer.*

37 (8) *Non-English language, if any, spoken by a health care*
38 *provider or other medical professional as well as non-English*
39 *language spoken by a skilled medical interpreter, if any, on the*
40 *provider's staff.*

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

3 (10) A disclosure that insureds are entitled to full and equal
4 access to covered services, including insureds with disabilities as
5 required under the federal Americans with Disabilities Act of 1990
6 and Section 504 of the Rehabilitation Act of 1973.

7 (11) A disclosure that insureds are entitled to language
8 interpreter services at no cost to the insured, including how to
9 obtain interpretation services.

10 (d) (1) The insurer shall provide the online directory or
11 directories to the department in a format and manner to be
12 specified by the department.

13 (2) The insurer shall demonstrate no less than quarterly to the
14 department that the information provided in the provider directory
15 or directories is consistent with the information required under
16 Section 10133.5 and other provisions of this part. The insurer shall
17 ensure that other information reported to the department is
18 consistent with the information provided to insureds, potential
19 insureds, and the department pursuant to this section.

20 (3) The insurer shall demonstrate to the department that
21 insureds or potential insureds seeking a provider that is contracted
22 with the network for a particular product can identify these
23 providers and that the provider is accepting new patients. The
24 insurer shall ensure that the accuracy of the provider directory
25 meets or exceeds 95 percent with regard to the participation of
26 providers in the network, the extent to which the provider is
27 accepting new patients, as well as non-English language spoken
28 by a skilled medical interpreter, if any, on the provider's staff.

29 (4) The insurer shall contact any provider which is listed in the
30 provider directory and which has not submitted a claim within the
31 past six months for primary care providers, or 12 months for
32 specialty care providers, to determine whether the provider is
33 accepting patients or referrals from the insurer, if claims are paid
34 by the insurer. If the provider does not respond within 30 days,
35 the insurer shall remove the provider from the provider directory.
36 An insurer is not required to terminate a provider who is removed
37 from the directory according to this paragraph. This requirement
38 does not apply to claims or claim data from new primary care
39 providers in the first six months, or new specialty care providers
40 in the first 12 months, of the contract. This paragraph shall not

1 apply if a provider has affirmatively responded under the
2 requirements of subdivision (h) that the provider information is
3 accurate and the provider is continuing to participate in the
4 network.

5 (e) If a contracting provider, or the representative of a
6 contracting provider, informs an insured or potential insured that
7 the provider is not accepting new patients, the contract between
8 the insurer and the provider shall require the provider to inform
9 the insurer that the provider is not accepting new patients and
10 direct the insured or potential insured to the insurer for additional
11 assistance in finding a provider and also to the department to
12 inform it of the possible inaccuracy in the provider directory. If
13 an insured or potential insured informs an insurer of a possible
14 inaccuracy in the provider directory or directories, the insurer
15 shall immediately investigate and undertake corrective action
16 within 30 business days to ensure the accuracy of the directory or
17 directories.

18 (f) 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 (g) Every insurer shall ensure processes are in place to allow
26 providers to promptly verify or submit changes to the information
27 required to be in the directory pursuant to this section. Those
28 processes shall, at a minimum, include an online interface for
29 providers to submit verification or changes electronically and
30 shall allow providers to receive an acknowledgment of receipt
31 from the health insurer. Providers shall verify or submit changes
32 to information required to be in the directory pursuant to this
33 section using the process required by the insurer.

34 (h) (1) At least once every six months the insurer shall notify
35 the contracted provider or provider group of the information on
36 the provider or provider group contained in the directory including
37 a list of each product marketed by the insurer for the network. The
38 insurer shall include with this notification, instructions as to how
39 to access and update the information using the online interface in
40 subdivision (g).

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

8 (3) *If the insurer does not receive an affirmative response and*
 9 *attestation from the provider within 30 business days, the provider*
 10 *shall be removed from the directory.*

11 (i) *Every health insurer shall allow insureds to request the*
 12 *information required by this section through their toll-free*
 13 *telephone number, electronically, or in writing. On request of an*
 14 *insured or potential insured, the insurer shall provide the provider*
 15 *directory in printed form. The information provided in printed*
 16 *form may be limited to the geographic region in which the insured*
 17 *or potential insured resides or intends to reside.*

18 (j) *Notwithstanding the provisions of Section 10123.13, an*
 19 *insurer may use reasonable compliance methods, such as delaying*
 20 *payment or reimbursement to a provider who has not responded*
 21 *or removal of the provider from other directories only until the*
 22 *plan receives an affirmative response and attestation from the*
 23 *provider. An insurer may terminate a contract for a pattern or*
 24 *repeated failure of the provider or provider group to alert the*
 25 *insurer to a change in the information required to be in the*
 26 *directory pursuant to this section. An insurer may not impose any*
 27 *compliance method pursuant to this subdivision without first*
 28 *providing written notice to the provider.*

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

33 ~~SEC. 3.~~

34 SEC. 5. No reimbursement is required by this act pursuant to
 35 Section 6 of Article XIII B of the California Constitution because
 36 the only costs that may be incurred by a local agency or school
 37 district will be incurred because this act creates a new crime or
 38 infraction, eliminates a crime or infraction, or changes the penalty
 39 for a crime or infraction, within the meaning of Section 17556 of
 40 the Government Code, or changes the definition of a crime within

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

O