

AMENDED IN ASSEMBLY AUGUST 31, 2015

AMENDED IN ASSEMBLY JULY 16, 2015

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 1367.27 to, and *to* repeal Section 1367.26 of, 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 *health* 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.

~~This bill~~ *bill, commencing July 1, 2016, would require a health care service plan, and insurers subject to regulation by the commissioner for services at alternative rates, to plan, and a health insurer that contracts with providers for alternative rates of payment, to publish and maintain a provider directory or directories with information on contracting providers that deliver health care services to the plan's enrollees or the health insurer's insureds, and would require the plan or health insurer to make an online provider directory or directories available on its the plan or health insurer's Internet Web site, as specified.*

This bill would require the Department of Managed Health Care and the Department of Insurance to jointly develop uniform provider directory standards. ~~The bill would require health care service plans, plans with Medi-Cal managed care contracts, 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 and to update the directory, as specified.~~ *a health care service plan or health insurer to take appropriate steps to ensure the accuracy of the information contained in the plan or health insurer's directory or directories, and would require the plan or health insurer, at least annually, to review and update the entire provider directory or directories for each product offered, as specified. The bill would require a plan or insurer, at least weekly, to update its online provider directory or directories, and would require a plan or insurer, at least quarterly, to update its printed provider directory or directories.* The bill would require a health care service plan or health insurer to reimburse an enrollee or insured for any amount beyond what the ~~enrollee, enrollee~~ or insured would have paid for in-network services, if the enrollee or insured reasonably relied on the provider directory, as specified. 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 1367.26 of the Health and Safety Code
2 is repealed.

3 SEC. 2. Section 1367.27 is added to the Health and Safety
4 Code, to read:

5 1367.27. (a) ~~A~~Commencing July 1, 2016, a health care service
6 plan shall publish and maintain a provider directory or directories
7 with information on contracting providers that deliver health care
8 services to the plan’s enrollees, including those that accept new
9 patients. A provider directory shall not list or include information
10 on a provider that is not currently under contract with the plan.

11 (b) A health care service plan shall provide the directory or
12 directories for the specific network offered for each product using
13 a consistent method of network and product naming, numbering,
14 or other classification method that ensures the public, enrollees,
15 potential enrollees, the department, and other state or federal
16 agencies can easily identify the networks and plan products in
17 which a provider participates. By July 31, 2017, or ~~six~~ 12 months
18 after the date provider directory standards are developed under
19 ~~this section~~, subdivision (k), whichever occurs later, a health care
20 service plan shall use the naming, numbering, or classification
21 method developed by the department pursuant to subdivision (k).

22 (c) (1) An online provider directory or directories shall be
23 available on the plan’s Internet Web site to the public, potential
24 enrollees, enrollees, and providers without any restrictions or
25 limitations. The directory or directories shall be accessible without
26 any requirement that an individual seeking the directory
27 information demonstrate coverage with the plan, indicate interest
28 in obtaining coverage with the plan, provide a member
29 identification or policy number, provide any other identifying
30 information, or create or access an account.

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

15 (d) (1) A health care service plan shall allow enrollees, potential
 16 enrollees, *providers*, and members of the public to request a printed
 17 copy of the provider directory or directories by contacting the plan
 18 through the plan's toll-free telephone number, electronically, or
 19 in writing. A printed copy of the provider directory or directories
 20 shall include the information required in subdivisions (h) and (i).
 21 The printed copy of the provider directory or directories shall be
 22 provided to the ~~enrollee requester~~ *requester* by mail *postmarked* no later
 23 than ~~15~~ *five* business days following the date of the request and
 24 may be limited to the geographic region in which the ~~enrollee~~
 25 *requester* resides or works or intends to reside or work.

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

29 (e) (1) The plan shall update the online provider directory or
 30 directories, at least weekly, or more frequently, if required by
 31 federal law. ~~Any change in information concerning a listed~~
 32 ~~contracting provider shall be included in the updated version~~
 33 ~~required by this subdivision. A change in information includes,~~
 34 ~~but is not limited to, law, when informed of and upon confirmation~~
 35 ~~by the plan of any of the following:~~

36 (1) ~~Whether a~~

37 (A) A contracting provider is no longer accepting new patients
 38 for that product, or ~~whether the contracting provider group has~~
 39 ~~identified that a provider of the group~~ *an individual provider within*
 40 *a provider group* is no longer accepting new patients.

1 ~~(2) Whether the provider relocated out of the contracted service~~
2 ~~area of the plan, has retired, or has otherwise ceased to practice.~~
3 ~~In all of these cases, the provider shall be deleted from the~~
4 ~~directory.~~

5 ~~(3) Whether the provider is no longer contracted with the plan~~
6 ~~for any reason, in which case the provider shall be deleted from~~
7 ~~the directory.~~

8 ~~(4) Whether the contracted~~

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

11 ~~(5) Whether the~~

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

14 ~~(6) Whether the contracting medical group, independent practice~~
15 ~~association, or other group of providers, if any, has informed the~~
16 ~~plan that the provider is no longer associated with the group and~~
17 ~~is no longer under contract with the plan, in which case the provider~~
18 ~~shall be deleted from the directory.~~

19 ~~(7) Whether the contracting medical group, independent practice~~
20 ~~association, or other group of providers has informed the plan that~~
21 ~~the provider group is no longer under contract with the plan, in~~
22 ~~which case any provider of the group that does not maintain an~~
23 ~~independent contract with the plan shall be deleted from the~~
24 ~~directory.~~

25 ~~(8) When the plan identified~~

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

31 ~~(9) Any other relevant information that has come to the attention~~
32 ~~of the plan affecting~~

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

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

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

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

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

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

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

13 (1) Language interpreter services, at no cost to the enrollee,
14 including how to obtain interpretation—~~services.~~ *services in*
15 *accordance with Section 1367.04.*

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

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

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

25 (2) Type of practitioner.

26 (3) National Provider Identifier number.

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

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

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

30 (7) The name of ~~all~~ *each* ~~affiliated medical groups~~ *provider*
31 *group* currently under contract with the plan through which the
32 provider sees enrollees.

33 (8) A listing for each of the following ~~providers, facilities, and~~
34 ~~services~~ *providers* that are under contract with the plan:

35 (A) For physicians and surgeons, the ~~medical provider~~ *group*,
36 ~~and affiliation or~~ admitting privileges, if any, at hospitals contracted
37 with the plan.

38 (B) Nurse practitioners, physician assistants, psychologists,
39 acupuncturists, optometrists, podiatrists, chiropractors, licensed
40 clinical social workers, marriage and family therapists, professional

1 clinical counselors, ~~substance abuse counselors~~, qualified autism
2 service providers, *as defined in Section 1374.73*, nurse midwives,
3 and dentists.

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

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

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

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

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

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

24 (11) Identification of providers who no longer accept new
25 patients for ~~one or more~~ *some or all* of the plan's ~~products or for~~
26 ~~all of the plan's~~ products.

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

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

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

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

39 (2) Type of practitioner.

40 (3) National Provider Identifier number.

- 1 (4) California license number and type of license, if applicable.
- 2 (5) The area of specialty, including board certification, or other
- 3 accreditation, if any.
- 4 (6) The provider’s office email address, if available.
- 5 (7) The name of ~~any~~ *each* affiliated ~~medical group, independent~~
- 6 ~~practice association, provider group~~ or specialty plan practice
- 7 group currently under contract with the plan through which the
- 8 provider sees enrollees.
- 9 (8) The names of ~~any~~ *each* allied health care ~~professionals~~
- 10 *professional* to the extent there is a direct contract for those services
- 11 covered through ~~the~~ *a* contract with the plan.
- 12 (9) ~~Non-English~~ *The non-English* language, if any, spoken by
- 13 a health care provider or other medical professional as well as
- 14 non-English language spoken by a qualified medical interpreter,
- 15 in accordance with Section 1367.04, if any, on the provider’s staff.
- 16 (10) *Identification of providers who no longer accept new*
- 17 *patients for some or all of the plan’s products.*
- 18 (11) *All other applicable information necessary to conduct a*
- 19 *provider search pursuant to paragraph (2) of subdivision (c).*
- 20 (j) (1) *The contract between the plan and a provider shall*
- 21 *include a requirement that the provider inform the plan within five*
- 22 *business days when either of the following occur:*
- 23 (A) *The provider is not accepting new patients.*
- 24 (B) *If the provider had previously not accepted new patients,*
- 25 *the provider is currently accepting new patients.*
- 26 (2) *If a provider who is not accepting new patients is contacted*
- 27 *by an enrollee or potential enrollee seeking to become a new*
- 28 *patient, the provider shall direct the enrollee or potential enrollee*
- 29 *to the plan for additional assistance in finding a provider and the*
- 30 *provider shall provide information to the individual on how to*
- 31 *contact the department to report any inaccuracy with the plan’s*
- 32 *directory or directories.*
- 33 (j) ~~If a contracting provider, or the representative of a contracting~~
- 34 ~~provider, informs an enrollee or potential enrollee who contacted~~
- 35 ~~the provider based on information in the provider directory~~
- 36 ~~indicating that the provider was accepting new patients but the~~
- 37 ~~provider is not accepting new patients, then the contract between~~
- 38 ~~the plan and the provider shall require the provider to inform the~~
- 39 ~~plan that the provider is not accepting new patients and direct the~~
- 40 ~~enrollee or potential enrollee to the plan for additional assistance~~

1 in finding a provider and also to the department to inform it of the
2 possible inaccuracy in the provider directory. If

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

8 (k) (1) On or before December 31, 2016, the department shall
9 develop uniform provider directory standards ~~for purposes of this~~
10 ~~section. to permit consistency in accordance with subdivision (b)~~
11 ~~and paragraph (2) of subdivision (c) and development of a~~
12 ~~multi-plan directory by another entity.~~ Those standards shall not
13 be subject to the Administrative Procedure Act (Chapter 3.5
14 (commencing with Section 11340) of Part 1 of Division 3 of Title
15 2 of the Government Code), until January 1, 2021. *No more than*
16 *two revisions of those standards shall be exempt from the*
17 *Administrative Procedure Act (Chapter 3.5 (commencing with*
18 *Section 11340) of Part 1 of Division 3 of Title 2 of the Government*
19 *Code) pursuant to this subdivision.*

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

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

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

38 (A) *For individual providers who are not affiliated with a*
39 *provider group described in subparagraph (A) or (B) of paragraph*

1 (8) of subdivision (h) and providers described in subdivision (i),
2 the plan shall notify each provider at least once every six months.

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

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

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

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

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

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

26 (4) If the plan does not receive an affirmative response and
27 confirmation from the provider that the information is current and
28 accurate or, as an alternative, updates any information required
29 to be in the directory or directories pursuant to this section, within
30 30 business days, the plan shall take no more than 15 business
31 days to verify whether the provider's information is correct or
32 requires updates. The plan shall document the receipt and outcome
33 of each attempt to verify the information. If the plan is unable to
34 verify whether the provider's information is correct or requires
35 updates, the plan shall notify the provider 10 business days in
36 advance of removal that the provider will be removed from the
37 provider directory or directories. The provider shall be removed
38 from the provider directory or directories at the next required
39 update of the provider directory or directories after the 10-business
40 day notice period. A provider shall not be removed from the

1 *provider directory or directories if he or she responds before the*
2 *end of the 10-business day notice period.*

3 ~~(t)~~

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

9 ~~(m)~~

10 (l) The policies and procedures ~~established~~ *described* under
11 this subdivision (l) shall be submitted by a plan annually to the
12 department for approval and in a format described by the
13 department pursuant to Section 1367.035.

14 ~~(1) At a minimum, these policies and procedures shall include~~
15 ~~all of the following:~~

16 ~~(A) At least annually, the plan shall review and update the entire~~
17 ~~provider directory or directories for each product offered.~~

18 ~~(B) At least quarterly, the plan shall notify the contracted~~
19 ~~provider or provider group, if applicable, of the information the~~
20 ~~plan has in the directory or directories on the provider or provider~~
21 ~~group contained in the directory, including a list of networks and~~
22 ~~plan products that include the contracted provider or provider~~
23 ~~group. The plan shall include with this notification instructions as~~
24 ~~to how the provider or provider group can access and update the~~
25 ~~information using the online interface required by subdivision (o).~~

26 ~~(2) The plan shall require an affirmative response from the~~
27 ~~provider or provider group acknowledging that the notification~~
28 ~~was received. The provider or provider group shall attest that the~~
29 ~~information in the provider directory is current and accurate or~~
30 ~~update the information required to be in the directory pursuant to~~
31 ~~this section, including whether or not the provider or provider~~
32 ~~group is accepting new patients for each plan product.~~

33 ~~(3) If the plan does not receive an affirmative response and~~
34 ~~attestation from the provider that the information is current and~~
35 ~~accurate or, as an alternative, updates information required to be~~
36 ~~in the directory pursuant to this section, within 30 business days,~~
37 ~~the plan shall take investigatory actions as outlined in subdivision~~
38 ~~(q) to verify whether the provider's information is correct or~~
39 ~~requires updates. The plan shall complete its investigation and~~
40 ~~make any required corrections or updates to the provider directory~~

1 based on its investigation within 30 days from the date the provider
 2 was required to provide the affirmative response to the plan. If, at
 3 the completion of its investigation, the plan is unable to verify
 4 whether the provider's information is correct or requires updates,
 5 the provider shall be removed from the directory. A plan shall
 6 notify the provider 10 days in advance of removal that the provider
 7 will be removed from the directory.

8 ~~(n) This section does not prohibit a plan from requiring its~~
 9 ~~risk-bearing organizations or contracting specialized health care~~
 10 ~~plans to satisfy the requirements of this section. If a plan delegates~~
 11 ~~the responsibility of complying with this section to its risk-bearing~~
 12 ~~organizations or contracting specialized health care plans, the plan~~
 13 ~~shall ensure that the requirements of this section are met. A plan~~
 14 ~~shall retain responsibility for the implementation of this section,~~
 15 ~~unless that delegated responsibility has been separately negotiated~~
 16 ~~and specifically documented in written contracts between the plan~~
 17 ~~and a risk-bearing organization or contracting specialized health~~
 18 ~~care plan.~~

19 ~~(o)~~

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

30 ~~(p)~~

31 (3) The plan shall establish and maintain a process for enrollees,
 32 potential enrollees, other providers, and the public to identify and
 33 report possible inaccurate, incomplete, ~~confusing~~, or misleading
 34 information currently listed in the plan's provider directory or
 35 directories. These processes shall, at a minimum, include a
 36 telephone number and a dedicated email address at which the plan
 37 will accept these reports, as well as a hyperlink on the plan's
 38 provider directory Internet Web ~~page~~ *site* linking to a form where
 39 the information can be reported directly to the plan through its
 40 Internet Web site.

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

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

15 ~~(q)~~

16 (o) (1) Whenever a health care service plan receives a report
17 indicating that information listed in its provider directory or
18 directories is inaccurate, ~~incomplete, confusing, or misleading~~, the
19 plan shall ~~immediately~~ promptly investigate the reported inaccuracy
20 and, no later than 30 *business* days following receipt of the
21 ~~communication~~, *report*, either verify the accuracy of the
22 information or update the information in its provider directory or
23 directories, as applicable.

24 (2) When investigating a ~~communication~~ *report* regarding its
25 provider directory or directories, the plan shall, at a minimum, do
26 the following:

27 (A) Contact the affected provider no later than five business
28 days following receipt of the ~~communication~~. *report*.

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

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

1 ~~the monthly quarterly update immediately following that update.~~
2 *sooner if required by federal law or regulations.*

3 ~~(r) Notwithstanding~~

4 *(p) (1) Commencing July 1, 2017, notwithstanding Sections*
5 *1371 and 1371.35, a plan may delay payment or reimbursement*
6 ~~*to a provider who has not responded*~~ *owed to a provider or provider*
7 *group as specified in subparagraph (A) or (B), if the provider or*
8 *provider group fails to respond to the plan's attempts to verify the*
9 ~~*provider's information. The provider or provider group's*~~
10 *information as required under subdivision (l). The plan shall not*
11 *delay payment unless it has attempted to verify the provider's or*
12 *provider group's information by all means of communication*
13 *available to the plan, including in writing, electronically, or by*
14 *telephone. A plan may seek to delay payment or reimbursement*
15 *owed to a provider or provider group only after the 10-business*
16 *day notice period described in paragraph (4) of subdivision (l)*
17 *has lapsed.*

18 *(A) For a provider or provider group that receives*
19 *compensation on a capitated or prepaid basis, the plan may delay*
20 ~~*payment or reimbursement for up to 45 business days in addition*~~
21 ~~*to the timeframes for provider reimbursement pursuant to Sections*~~
22 ~~*1371 and 1371.35. A plan the next scheduled capitation payment*~~
23 ~~*for up to one calendar month.*~~

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

27 *(2) A plan shall notify the provider or provider group 10*
28 *business days before it seeks to delay payment or reimbursement*
29 *to a provider or provider group pursuant to this subdivision. If*
30 *the plan delays a payment or reimbursement pursuant to this*
31 *subdivision, the plan shall reimburse the full amount of any*
32 *payment or reimbursement subject to delay to the provider or*
33 *provider group no later than three business days following the*
34 *date on which the plan receives the information required to be*
35 *submitted by the provider or provider group pursuant to*
36 *subdivision (l).*

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

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

8 ~~(s) (1) In~~

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

23 ~~(2) In circumstances where an enrollee in the individual market~~
24 ~~reasonably relied upon inaccurate, incomplete, confusing, or~~
25 ~~misleading information contained in a health plan's provider~~
26 ~~directory or directories, the plan shall inform the enrollee of the~~
27 ~~special enrollment period available under subparagraph (E) of~~
28 ~~paragraph (1) of subdivision (d) of Section 1399.845.~~

29 ~~(3) "Risk-bearing organization" shall have the same meaning~~
30 ~~as defined in subdivision (g) of Section 1375.4.~~

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

36 ~~(t)~~

37 (s) *This section shall apply to plans with Medi-Cal managed*
38 *care contracts with the State Department of Health Care Services*
39 *pursuant to Chapter 7 (commencing with Section 14000) or 14000),*
40 *Chapter 8 (commencing with Section 14200) 14200), or Chapter*

1 8.75 (commencing with Section 14591) of the Welfare and
 2 Institutions Code to the extent consistent with federal law and
 3 ~~guidance~~; guidance and state law guidance issued after January
 4 1, 2016. Notwithstanding any other provision to the contrary in a
 5 plan contract with the State Department of Health Care Services,
 6 and to the extent consistent with federal law and guidance and
 7 state guidance issued after January 1, 2016, a Medi-Cal managed
 8 care plan that complies with the requirements of this section shall
 9 not be required to distribute a printed provider directory or
 10 directories, except as required by paragraph (1) of subdivision
 11 (d).

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

17 ~~(v)~~
 18 (u) Nothing in this section shall be construed to alter a provider’s
 19 obligation to provide health care services to an enrollee pursuant
 20 to the provider’s contract with the plan.

21 (v) For purposes of this section, “provider group” means a
 22 medical group, independent practice association, or other similar
 23 group of providers.

24 SEC. 3. Section 10133.15 is added to the Insurance Code, to
 25 read:

26 10133.15. (a) ~~A~~ Commencing July 1, 2016, a health insurer
 27 that contracts with providers for alternative rates of payment
 28 pursuant to Section 10133 shall publish and maintain provider
 29 directory or directories with information on contracting providers
 30 that deliver health care services to the insurer’s insureds, including
 31 those that accept new patients. A provider directory shall not list
 32 or include information on a provider that is not currently under
 33 contract with the insurer.

34 (b) An insurer shall provide the online directory or directories
 35 for the specific network offered for each product using a consistent
 36 method of network and product naming, numbering, or other
 37 classification method that ensures the public, insureds, potential
 38 insureds, the department, and other state or federal agencies can
 39 easily identify the networks and insurer products in which a
 40 provider participates. By July 31, 2017, or ~~six~~ 12 months after the

1 date provider directory standards are developed under ~~this section,~~
2 *subdivision (k), whichever occurs later*, an insurer shall use the
3 naming, numbering, or classification method developed by the
4 department pursuant to subdivision (k).

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

14 (2) The online provider directory or directories shall be
15 accessible on the insurer's public Internet Web site through ~~a~~
16 ~~clearly~~ *an identifiable link or tab* and in a manner that is accessible
17 and searchable by insureds, potential insureds, the public, and
18 providers. ~~The~~ *By July 1, 2017, or 12 months after the date*
19 *provider directory standards are developed under subdivision (k),*
20 *whichever occurs later, the insurer's public Internet Web site shall*
21 *allow provider searches* ~~by~~ *by, at a minimum, name, practice*
22 *address, distance from specified address, city, ZIP Code, California*
23 *license number, National Provider Identifier number, admitting*
24 *privileges to an identified hospital, product, tier, provider language,*
25 ~~medical group or independent practice association,~~ *language or*
26 *languages, provider group, hospital name, facility name, or clinic*
27 *name, as appropriate.*

28 (d) (1) ~~A health~~ *An* insurer shall allow insureds, potential
29 insureds, *providers*, and members of the public to request a printed
30 copy of the provider directory or directories by contacting the
31 insurer through the insurer's toll-free telephone number,
32 electronically, or in writing. A printed copy of the provider
33 directory or directories shall include the information required in
34 subdivisions (h) and (i). The printed copy of the provider directory
35 or directories shall be provided to the ~~insured~~ *requester* by mail
36 *postmarked* no later than ~~15~~ *five* business days following the date
37 of the request and may be limited to the geographic region in which
38 the ~~insured~~ *requester* resides or works or intends to reside or work.

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

4 (e) (1) The insurer shall update the online provider directory
5 or directories, at least weekly, or more frequently, if required by
6 federal law. ~~Any change in information concerning a listed~~
7 ~~contracting provider shall be included in the updated version~~
8 ~~required by this subdivision. A change in information includes,~~
9 ~~but is not limited to, law, when informed of and upon confirmation~~
10 ~~by the insurer of any of the following:~~

11 ~~(1) Whether a~~

12 ~~(A) A contracting provider is no longer accepting new patients~~
13 ~~for that product, or whether the contracting provider group has~~
14 ~~identified that a provider of the group~~ *an individual provider within*
15 *a provider group* is no longer accepting new patients.

16 ~~(2) Whether the provider relocated out of the contracted service~~
17 ~~area of the insurer, or has retired or has otherwise ceased to~~
18 ~~practice. In all of these cases, the provider shall be deleted from~~
19 ~~the directory.~~

20 ~~(3) Whether the provider is no longer contracted with the insurer~~
21 ~~for any reason, in which case the provider shall be deleted from~~
22 ~~the directory.~~

23 ~~(4) Whether the~~

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

26 ~~(5) Whether the~~

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

29 ~~(6) Whether the contracting medical group, independent practice~~
30 ~~association, or other group of providers, if any, has informed the~~
31 ~~insurer that the provider is no longer associated with the group~~
32 ~~and is no longer under contract with the insurer, in which case the~~
33 ~~provider shall be deleted from the directory.~~

34 ~~(7) Whether the contracting medical group, independent practice~~
35 ~~association, or other group of providers has informed the insurer~~
36 ~~that the provider group is no longer under contract with the insurer,~~
37 ~~in which case any provider of the group that does not maintain an~~
38 ~~independent contract with the insurer shall be deleted from the~~
39 ~~directory.~~

40 ~~(8) When the insurer identified~~

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

6 ~~(9) Any other relevant information that has come to the attention
7 of the product affecting~~

8 (E) Any other information that affects the content ~~and~~ or
9 accuracy of the provider ~~directory~~. *directory or directories.*

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

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

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

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

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

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

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

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

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

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

39 (2) Type of practitioner.

40 (3) National Provider Identifier number.

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

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

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

4 (7) The name of ~~all~~ *each* affiliated ~~medical groups provider~~
5 *group* currently under contract with the insurer through which the
6 provider sees enrollees.

7 (8) A listing for each of the following ~~providers, facilities, and~~
8 ~~services providers~~ that are under contract with the insurer:

9 (A) For physicians and surgeons, the ~~medical provider~~ group,
10 and ~~affiliation~~ or admitting privileges, if any, at hospitals contracted
11 with the insurer.

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, ~~substance abuse counselors~~, qualified autism
16 service providers, *as defined in Section 10144.51*, nurse midwives,
17 and dentists.

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 insurer, the name of the
24 provider, and the name of the federally qualified health center or
25 clinic.

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

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

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

34 (10) 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 qualified medical interpreter, in accordance
37 with ~~Section 1367.04 of the Health and Safety Code, 10133.8 of~~
38 *the Insurance Code*, if any, on the provider's staff. *For purposes*
39 *of this section, "qualified interpreter" means that the interpreter*
40 *meets the proficiency standards established pursuant to*

1 *subparagraph (H) of paragraph (2) of subdivision (c) of Section*
2 *1300.67.04 of Title 28 of the California Code of Regulations.*

3 (11) Identification of providers who no longer accept new
4 patients for ~~one or more~~ *some or all* of the insurer's ~~products or~~
5 ~~for all of the insurer's products.~~

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

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

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

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

18 (2) Type of practitioner.

19 (3) National Provider Identifier number.

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

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

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

24 (7) The name of ~~any each~~ *affiliated medical group, independent*
25 ~~practice association, provider group~~ or specialty insurer practice
26 group currently under contract with the insurer through which the
27 provider sees insureds.

28 (8) The names of ~~any each~~ *allied health care professionals*
29 *professional* to the extent there is a direct contract for those services
30 covered through ~~the a~~ contract with the insurer.

31 (9) ~~Non-English~~ *The non-English* language, if any, spoken by
32 a health care provider or other medical professional as well as
33 non-English language spoken by a qualified medical interpreter,
34 in accordance with Section ~~1367.04 of the Health and Safety~~
35 *10133.8 of the Insurance Code*, if any, on the provider's staff. *For*
36 *purposes of this section, "qualified interpreter" means that the*
37 *interpreter meets the proficiency standards established pursuant*
38 *to subparagraph (H) of paragraph (2) of subdivision (c) of Section*
39 *1300.67.04 of Title 28 of the California Code of Regulations.*

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

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

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

8 (A) The provider is not accepting new patients.

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

11 (2) If a provider who is not accepting new patients is contacted
12 by an insured or potential insured seeking to become a new patient,
13 the provider shall direct the insurer or potential insured to the
14 insurer for additional assistance in finding a provider and the
15 provider shall provide information to the individual on how to
16 contact the department to report any inaccuracy with the insurer's
17 directory or directories.

18 ~~(j) If a contracting provider, or the representative of a contracting~~
19 ~~provider, informs an insured or potential insured who contacted~~
20 ~~the provider based on information in the provider directory~~
21 ~~indicating that the provider was accepting new patients but the~~
22 ~~provider is not accepting new patients, then the contract between~~
23 ~~the insurer and the provider shall require the provider to inform~~
24 ~~the insurer that the provider is not accepting new patients and direct~~
25 ~~the insured or potential insured to the insurer for additional~~
26 ~~assistance in finding a provider and also to the department to~~
27 ~~inform it of the possible inaccuracy in the provider directory. If~~

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

33 (k) (1) On or before December 31, 2016, the department shall
34 develop uniform provider directory standards ~~for purposes of this~~
35 ~~section. to permit consistency in accordance with subdivision (b)~~
36 ~~and paragraph (2) of subdivision (c) and development of a~~
37 ~~multiplan directory by another entity. Those standards shall not~~
38 be subject to the Administrative Procedure Act (Chapter 3.5
39 (commencing with Section 11340) of Part 1 of Division 3 of Title
40 2 of the Government Code), until January 1, 2021. *No more than*

1 *two revisions of those standards shall be exempt from the*
2 *Administrative Procedure Act (Chapter 3.5 (commencing with*
3 *Section 11340) of Part 1 of Division 3 of Title 2 of the Government*
4 *Code) pursuant to this subdivision.*

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

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

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

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

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

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

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

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

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

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

12 (4) If the insurer does not receive an affirmative response and
13 confirmation from the provider that the information is current and
14 accurate or, as an alternative, updates any information required
15 to be in the directory or directories pursuant to this section, within
16 30 business days, the insurer shall take no more than 15 business
17 days to verify whether the provider's information is correct or
18 requires updates. The insurer shall document the receipt and
19 outcome of each attempt to verify the information. If the insurer
20 is unable to verify whether the provider's information is correct
21 or requires updates, the insurer shall notify the provider 10
22 business days in advance of removal that the provider will be
23 removed from the directory or directories. The provider shall be
24 removed from the directory or directories at the next required
25 update of the provider directory or directories after the 10-business
26 day notice period. A provider shall not be removed from the
27 provider directory or directories if he or she responds before the
28 end of the 10-business day notice period.

29 ~~(t)~~

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

35 ~~(m)~~

36 (l) The policies and procedures ~~established~~ described under
37 this subdivision (l) shall be submitted by an insurer annually to
38 the department for approval and in a format described by the
39 department.

1 ~~(1) At a minimum, these policies and procedures shall include~~
2 ~~all of the following:~~

3 ~~(A) At least annually, the insurer shall review and update the~~
4 ~~entire provider directory or directories for each product offered.~~

5 ~~(B) At least quarterly, the insurer shall notify the contracted~~
6 ~~provider or provider group, if applicable, of the information the~~
7 ~~insurer has in the directory or directories on the provider or~~
8 ~~provider group contained in the directory, including a list of~~
9 ~~networks and insurer products that include the contracted provider~~
10 ~~or provider group. The insurer shall include with this notification~~
11 ~~instructions as to how the provider or provider group can access~~
12 ~~and update the information using the online interface required by~~
13 ~~subdivision (o).~~

14 ~~(2) The insurer shall require an affirmative response from the~~
15 ~~provider or provider group acknowledging that the notification~~
16 ~~was received. The provider or provider group shall attest that the~~
17 ~~information in the provider directory is current and accurate or~~
18 ~~update the information required to be in the directory pursuant to~~
19 ~~this section, including whether or not the provider or provider~~
20 ~~group is accepting new patients for each insurer product.~~

21 ~~(3) If the insurer does not receive an affirmative response and~~
22 ~~attestation from the provider that the information is current and~~
23 ~~accurate or, as an alternative, updates information required to be~~
24 ~~in the directory pursuant to this section, within 30 business days,~~
25 ~~the insurer shall take investigatory actions as outlined in~~
26 ~~subdivision (q) to verify whether the provider's information is~~
27 ~~correct or requires updates. The insurer shall complete its~~
28 ~~investigation and make any required corrections or updates to the~~
29 ~~provider directory based on its investigation within 30 days from~~
30 ~~the date the provider was required to provide the affirmative~~
31 ~~response to the insurer. If, at the completion of its investigation,~~
32 ~~the insurer is unable to verify whether the provider's information~~
33 ~~is correct or requires updates, the provider shall be removed from~~
34 ~~the directory. An insurer shall notify the provider 10 days in~~
35 ~~advance of removal that the provider will be removed from the~~
36 ~~directory.~~

37 ~~(n) This section does not prohibit an insurer from requiring its~~
38 ~~risk-bearing organizations or contracting specialized health insurers~~
39 ~~to satisfy the requirements of this section. If an insurer delegates~~
40 ~~the responsibility of complying with this section to its risk-bearing~~

1 organizations or contracting specialized health insurers, the insurer
 2 shall ensure that the requirements of this section are met. An insurer
 3 shall retain responsibility for the implementation of this section,
 4 unless that delegated responsibility has been separately negotiated
 5 and specifically documented in written contracts between the
 6 insurer and a risk-bearing organization or contracting specialized
 7 health insurer.

8 (o)

9 (2) Every health insurer shall ensure processes are in place to
 10 allow providers to promptly verify or submit changes to the
 11 information required to be in the directory *or directories* pursuant
 12 to this section. Those processes shall, at a minimum, include an
 13 online interface for providers to submit verification or changes
 14 electronically and shall allow providers to receive *generate* an
 15 acknowledgment of receipt from the health insurer. Providers shall
 16 verify or submit changes to information required to be in the
 17 directory *or directories* pursuant to this section using the process
 18 required by the health insurer.

19 (p)

20 (3) The insurer shall establish and maintain a process for
 21 insureds, potential insureds, other providers, and the public to
 22 identify and report possible inaccurate, incomplete, ~~confusing~~, or
 23 misleading information currently listed in the insurer's provider
 24 directory or directories. These processes shall, at a minimum,
 25 include a telephone number and a dedicated email address at which
 26 the insurer will accept these reports, as well as a hyperlink on the
 27 insurer's provider directory Internet Web ~~page~~ *site* linking to a
 28 form where the information can be reported directly to the insurer
 29 through its Internet Web site.

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

38 (2) *If an insurer requires its contracting provider groups or*
 39 *contracting specialized health insurers to provide the insurer with*
 40 *information described in paragraph (1), the insurer shall continue*

1 *to retain responsibility for ensuring that the requirements of this*
2 *section are satisfied.*

3 ~~(q)~~

4 (o) (1) Whenever a health ~~an~~ insurer receives a report indicating
5 that information listed in its provider directory or directories is
6 inaccurate, ~~incomplete, confusing, or misleading,~~ the insurer shall
7 ~~immediately~~ *promptly* investigate the reported inaccuracy and, no
8 later than 30 *business* days following receipt of the ~~communication,~~
9 *report*, either verify the accuracy of the information or update the
10 information in its provider directory or directories, as applicable.

11 (2) When investigating a ~~communication~~ *report* regarding its
12 provider directory or directories, the insurer shall, at a minimum,
13 do the following:

14 (A) Contact the affected provider no later than five business
15 days following receipt of the ~~communication.~~ *report.*

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

21 (C) If changes to an insurer's provider directory or directories
22 are required as a result of the insurer's investigation, the changes
23 to the online provider directory *or directories* shall be made no
24 later than the next scheduled weekly update, or the update
25 immediately following that update, or sooner if required by federal
26 law or regulations. For printed provider directories, the change
27 shall be made no later than the next ~~monthly~~ *quarterly* ~~required~~
28 update, or the ~~monthly~~ *quarterly* update immediately following
29 that update. *sooner if required by federal law or regulations.*

30 ~~(r) Notwithstanding Section 10123.13,~~

31 (p) (1) *Commencing July 1, 2017, notwithstanding Sections*
32 *10123.13 and 10123.147,* an insurer may delay payment or
33 reimbursement ~~owed to a provider who has not responded or~~
34 *provider group for any claims payment made to a provider or*
35 *provider group for up to one calendar month beginning on the*
36 *first day of the following month, if the provider or provider group*
37 *fails to respond to the insurer's attempts to verify the provider's*
38 *information. The insurer may delay payment or reimbursement*
39 *for up to 45 business days in addition to the timeframes for provider*
40 *reimbursement pursuant to Section 10123.13. An information as*

1 *required under subdivision (l). The insurer shall not delay payment*
 2 *unless it has attempted to verify the provider's or provider group's*
 3 *information by all means of communication available to the*
 4 *insurer, including in writing, electronically, or by telephone. An*
 5 *insurer may seek to delay payment or reimbursement owed to a*
 6 *provider or provider group only after the 10-business day notice*
 7 *period described in paragraph (4) of subdivision (l) has lapsed.*

8 (2) *An insurer shall notify the provider or provider group 10*
 9 *days before it seeks to delay payment or reimbursement to a*
 10 *provider or provider group pursuant to this subdivision. If the*
 11 *insurer delays a payment or reimbursement pursuant to this*
 12 *subdivision, the insurer shall reimburse the full amount of any*
 13 *payment or reimbursement subject to delay to the provider or*
 14 *provider group no later than three business days following the*
 15 *date on which the insurer receives the information required to be*
 16 *submitted by the provider or provider group pursuant to*
 17 *subdivision (l).*

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

22 ~~(s) (1) In~~

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

38 ~~(2) In circumstances where an insured in the individual market~~
 39 ~~reasonably relied upon inaccurate, incomplete, confusing, or~~
 40 ~~misleading information contained in an insurer's provider directory~~

1 or directories, the insurer shall inform the insured of the special
2 enrollment period available under subparagraph (E) of paragraph
3 (1) of subdivision (d) of Section 10965.3.

4 (3) ~~“Risk-bearing organization” shall have the same meaning~~
5 ~~as defined in subdivision (g) of Section 1375.4 of the Health and~~
6 ~~Safety Code.~~

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

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

16 (u)
17 (t) Nothing in this section shall be construed to alter a provider’s
18 obligation to provide health care services to an insured pursuant
19 to the provider’s contract with the insurer.

20 (u) *For purposes of this section, “provider group” means a*
21 *medical group, independent practice association, or other similar*
22 *group of providers.*

23 SEC. 4. No reimbursement is required by this act pursuant to
24 Section 6 of Article XIII B of the California Constitution because
25 the only costs that may be incurred by a local agency or school
26 district will be incurred because this act creates a new crime or
27 infraction, eliminates a crime or infraction, or changes the penalty
28 for a crime or infraction, within the meaning of Section 17556 of
29 the Government Code, or changes the definition of a crime within
30 the meaning of Section 6 of Article XIII B of the California
31 Constitution.