Office of Senate Floor Analyses
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THIRD READING

Bill No: AB 280
Author: Aguiar-Curry (D)
Amended: 7/15/25 in Senate
Vote: 21

SENATE HEALTH COMMITTEE: 8-0, 7/9/25
AYES: Menjivar, Durazo, Gonzalez, Limón, Padilla, Richardson, Rubio, Wiener
NO VOTE RECORDED: Valladares, Grove, Weber Pierson

SENATE APPROPRIATIONS COMMITTEE: 5-0, 8/29/25
AYES: Caballero, Cabaldon, Grayson, Richardson, Wahab
NO VOTE RECORDED: Seyarto, Dahle

ASSEMBLY FLOOR: 61-7, 6/2/25 - See last page for vote

SUBJECT: Health care coverage: provider directories

SOURCE: Health Access California

DIGEST: This bill establishes health plan and insurer accuracy benchmarks for their provider directories, which require a plan or insurer's directories to be 60% accurate by July 2026 and 95% percent accurate by July 2029. Authorizes the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI) to require the use of a central utility or utilities for providers included in their directories. Requires a plan or insurer, when verifying the accuracy of provider information, to determine if the provider is actively contracting, as defined by DMHC or CDI. Exempts Medi-Cal managed care plans from the accuracy benchmarks and provisions related to administrative penalties.

ANALYSIS:

Existing law:

1) Establishes DMHC to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act); CDI to regulate health and other

insurance; and, the Department of Health Care Services (DHCS) to administer the Medi-Cal program. [Health and Safety Code (HSC) §1340, et seq., Insurance (INS) §106, et seq. and Welfare and Institutions Code (WIC) §14000, et seq.]

2) Requires health plans and insurers to publish and maintain a provider directory or directories of contracting providers, including those who are accepting new patients, and prohibits listing or including information on a provider that is not currently under contract. [HSC §1367.27 and INS §10133.15]

3) Requires the plan or insurer to update provider directories, at least weekly, with any change to contracting providers, as specified. Requires a printed directory to be updated quarterly or more frequently if required under federal law, and provided upon request and postmarked within five business days to the requestor. [HSC §1367.27 and INS §10133.15]

4) Requires plans or insurers to ensure processes are in place to allow providers to promptly verify or submit changes to demographic information and participation status that at a minimum, include an online interface for providers to submit verification or changes electronically and to allow providers to receive an acknowledgement of receipt from the plan or insurer. Allows a plan to delay payment or reimbursement owed to a provider or provider group, if the provider fails to respond to the plan's attempts to verify the provider's information. [HSC §1367.27 and INS §10133.15]

5) Authorizes DMHC or CDI to require the health plan or insurer to be responsible for covered health care services provided that provider and to reimburse the enrollee or insured for any amount beyond what would have been paid, had the services been delivered by an in-network provider under the plan contract or insurance policy. Requires prior to requiring reimbursement in these circumstances, DMHC and CDI to conclude that the services received were covered services. Prohibits in those circumstances, the fact that the services were rendered or delivered by a noncontracting or out-of-network provider from being used as a basis to deny reimbursement to the enrollee or insured. [HSC §1367.27 and INS §10133.15]

This bill:

1) Requires specified provider information such as location, contact information, type of provider, area of specialty and other information in the provider directory to be verified and accurate. Requires a plan or insurer to annually verify its provider directories for accuracy of all of the specified information.

Requires a printed provider directory to be dated with the date of its last update displayed.

2) Requires a provider to be removed from a directory under specified circumstances, such as the provider is no longer under contract. Requires the health plan or insurer, if a provider that was previously removed from a provider directory requests to be added back to ensure the accuracy of the information and approve the request within 10 business days of receipt if accurate.

3) Requires a plan or insurer to be responsible for maintaining an accurate provider directory. Requires the accuracy percentage of a directory to be determined by the percentage of providers for which all information required is accurate. If there is one error that would impact a patient's access to care on a listing for a provider, that listing is considered inaccurate. Requires:

   a) On July 1, 2026, a plan's directories to be at least 60% accurate.
   b) On or before July 1, 2027, a plan's directories to be at least 80% accurate.
   c) On or before July 1, 2028, a plan's directories to be at least 90% accurate.
   d) On or before July 1, 2029, a plan's directories to be at least 95% accurate.

4) Requires DMHC or CDI to develop procedures and policies on how a plan or insurer is to conduct the verifications. Requires a plan or insurer to respond no later than one business day after receiving a request by an enrollee or insured to a request for information about whether or not a provider is contacted as an in-network provider, as specified.

5) Requires a plan or insurer to arrange care and cover health care services provided by an out-of-network provider when an enrollee or insured relied upon inaccurate, incomplete or misleading information. Requires the enrollee or insured to pay in-network cost-sharing only (prohibits the provider from collecting more) that counts toward an in-network deductible and out-of-pocket maximum, and the provider to be paid the out-of-network amount. Adds, to the circumstances under which an enrollee or insured pays no more than in-network cost-sharing, items such as if the online directory is not accessible at the time the enrollee or insured seeks information.

6) Requires the provider directory to state the enrollee/insured may submit a complaint if the enrollee/insured believes they reasonably relied upon inaccurate, incomplete, or misleading directory information.

7) Requires a plan or insurer to include prominent disclosure on its print and online provider directories of its duty to arrange coverage when behavioral health benefits are not available in-network within applicable geographic and timely access standards. Requires the disclosure to be included within the "Timely Access to Care" section of the directory and include the geographic accessibility standards.

8) Requires a plan or insurer to notify providers that failure to respond to verification notification within five calendar days may result in a notice in the provider listing that states: "As of the last directory update, this provider is actively contracting with the plan. However, the provider has not responded to verify their listing information in the last update, so information may not be up to date." Requires a provider to respond within 30 calendar days of receiving a verification notification.

9) Requires the plan or insurer, if DMHC and CDI develops a methodology and standards that permit the use of a central utility or central utilities, and if a health plan or insurer uses a central utility for some or all of the plan's provider directory, to ensure that information derived from the central utility is incorporated in the plan's or insurer's provider directory unless the plan or insurer can demonstrate that the information from the central utility is inaccurate. Exempts these standards from the Administrative Procedure Act until January 1, 2029.

10) Permits DMHC and CDI to require a health plan or insurer to use or designate a central utility or central utilities for providers included in the directory. Permits a health plan or insurer to require providers to update their information through the central utility to update the health plan's or insurer's provider directory. Requires a plan or insurer to require providers to use the central utility or utilities if the plan or insurer is required to use one.

11) Requires the contract with the utility, if DMHC or CDI designates or requires a health plan or insurer to use a central utility or central utilities, to require that incomplete or incorrect information submitted to the central utility not be conveyed to the health plan or insurer. Requires the contract to also require that the central utility notify the submitter of incomplete or inaccurate information.

12) Permits DMHC or CDI to allow a plan or insurer not to use the central utility if the plan or insurer can demonstrate it will meet the required benchmarks without using it. Permits DMHC or CDI, if the plan fails to meet the benchmark in the future, to require the plan or insurer to use the central utility

as a method to achieve higher accuracy of provider directory listings to comply with the benchmarks in this bill.

13) Requires failure by a health plan or insurer to comply with this bill and the law it amends, including failure to meet the required benchmarks for accuracy, to result in an administrative penalty in an amount consistent with a denial of access to care for covered benefits.

14) Requires DMHC or CDI to determine the appropriate penalty amount for each violation based on one or more factors as applicable, including the factors outlined in existing law. Requires DMHC or CDI to take into consideration evidence provided by the plan or insurer of policies and procedures to obtain accurate provider information and the use of a central utility.

15) Requires penalty amounts, beginning January 1, 2029, and every five years thereafter, to be adjusted based on the average rate of change in premium rates for the individual and small group markets, and weighted by enrollment, since the previous adjustment.

16) Exempts Medi-Cal managed care plans from 3), 13), 14), and 15) above.

Comments

According to the author of this bill:

> Every health plan in California is required to maintain an accurate list of in-network health care providers for enrollees, which they must update and have reviewed by the regulating department. However, providers on these lists are often unreachable, not accepting new patients, or not part of the health plan's network. When people sign up for a health plan, they should be able to reasonably expect that most of the health professionals on the list are available to provide care. This bill will improve access to care by establishing accuracy benchmarks and authorizing the use of a third-party central utility to improve the accuracy of provider directories. This legislation provides a roadmap to improve transparency and accountability, making our healthcare system work better for everyone.

Background

Studies. Health Access California, this bill's sponsor, references a 2021 study that used California, Louisiana, and Maryland as case studies to demonstrate that existing approaches to directory access fail to protect consumers. As it relates to California, the study used raw data from 2018 provider questionnaires on timely

access requirements as a snapshot of directory accuracy for California plans. The data was not actually from provider directories. The study found high error rates across HMOs, Medicaid plans, Affordable Care Act (ACA) plans, and non-ACA plans. All types of plans had higher error rates for psychiatrists than for other types of specialists. The study suggests that SB 137 (Hernandez, Chapter 649, Statutes of 2015), the law that mandates provider directories, described as "on paper, one of the most extensive [accuracy policies] in the country" has had no appreciable effect on accuracy. The paper also suggests lax enforcement by DMHC.

FISCAL EFFECT: Appropriation: No Fiscal Com.: Yes Local: Yes

According to the Senate Appropriations Committee:

- Unknown ongoing costs, potentially low millions, for the DMHC for state administration (Managed Care Fund).
- Unknown ongoing costs, potentially low hundreds of thousands, for the CDI for state administration (Insurance Fund).
- Unknown potential cost pressures to capitation payments for Medi-Cal plans for administration (General Fund and federal funds).

SUPPORT: (Verified 8/29/25)

Health Access California (sponsor)
AARP
American Federation of State, County, and Municipal Employees
Asian Americans Advancing Justice – Southern California
Association of California State Supervisors
Autism Speaks
California Alliance of Child and Family Services
California Coalition on Family Caregiving
California Pan-Ethnic Health Network
California Pharmacists Association
California Physicians Alliance
California Public Employees' Retirement System
California Retired Teachers Association
California Senior Legislature
California State Council of Service Employees International Union
California State Retirees
California Teachers Association
Children Now
Community Clinic Association of Los Angeles County
Courage California

Family Caregiver Alliance
Health Access California
Indivisible CA: StateStrong
Latino Coalition for a Healthy California
Mental Health America of California
National Health Law Program
National Union of Healthcare Workers
Retired Public Employees Association
Small Business Majority
Steinberg Institute
The Children's Partnership
The Kennedy Forum
The Leukemia & Lymphoma Society
Western Center on Law & Poverty, Inc.

OPPOSITION: (Verified 8/29/25)

Association of California Life & Health Insurance Companies
California Association of Health Plans
California Association of Orthodontists
California Dental Association
California Medical Association
California Orthopaedic Association
California Podiatric Medical Association
Local Health Plans of California
Osteopathic Physicians & Surgeons of California
The American College of Obstetricians and Gynecologists, District IX

ARGUMENTS IN SUPPORT: Health Access California (HAC) is the sponsor of this bill. HAC writes, "A 2018 study investigated the error rates of four health plans in California and found inaccuracy rates up to 80% with a 25% inaccuracy rate for even the best-scoring plan. These inaccuracies are the worst for behavioral health providers. A recent secret shopper survey in Los Angeles revealed that only 15% of those phone calls seeking psychiatric appointments for Medi-Cal patients led to a scheduled appointment - the lowest success across the four states surveyed." HAC states that existing law puts the burden on individual consumers to complain about provider directory inaccuracies rather than requiring the health plan that created the provider directory to demonstrate its accuracy to the regulator, and, that this bill addresses the problem of provider directory inaccuracies through consumer protections, more efficient processes, and effective enforcement. The

California Public Employees' Retirement System believes this bill will increase the accuracy of provider directories for the benefit of their members, and will enable them to find providers more efficiently, make better informed decisions when choosing plans and providers and reduces barriers to accessing health care.

ARGUMENTS IN OPPOSITION: The California Association of Health Plans and the Association of California Life and Health Insurance Companies does not believe this bill addresses the root cause of the issue, and instead simply places the full responsibility of the database accuracy on health plans and insurers, without fully appreciating that this endeavor was always intended to be a shared responsibility between contracted providers and health plans/insurers. The opposition writes, "Currently, commercial health plans and insurers spend over $2.1 billion annually to maintain provider databases, clearly demonstrating the commitment health plans and insurers have to supporting accurate provider directories. We certainly appreciate that the bill acknowledges the need for a 'central utility' to collect the necessary information for accurate provider directories. However, without provider buy-in and participation, we will ultimately be in the same situation where health plans and insurers are struggling to collect the necessary information to update the provider directories." Organizations representing health and dental providers write that they have serious concerns that this bill will create an unnecessarily complex and confusing framework with the burden falling on medical groups. They raise concerns with the accuracy benchmarks and that Medi-Cal managed care plans are exempted from those requirements.

ASSEMBLY FLOOR: 61-7, 6/2/25
AYES: Addis, Aguiar-Curry, Ahrens, Alvarez, Arambula, Ávila Farías, Bains, Bauer-Kahan, Berman, Boerner, Bonta, Bryan, Calderon, Caloza, Carrillo, Chen, Connolly, Elhawary, Fong, Gabriel, Gallagher, Garcia, Gipson, Mark González, Haney, Harabedian, Hart, Irwin, Jackson, Kalra, Krell, Lee, Lowenthal, McKinnor, Muratsuchi, Nguyen, Ortega, Pacheco, Papan, Patel, Pellerin, Petrie-Norris, Quirk-Silva, Ramos, Ransom, Celeste Rodriguez, Michelle Rodriguez, Rogers, Blanca Rubio, Schiavo, Schultz, Sharp-Collins, Solache, Soria, Stefani, Valencia, Ward, Wicks, Wilson, Zbur, Rivas
NOES: Alanis, Davies, DeMaio, Dixon, Hoover, Tangipa, Wallis
NO VOTE RECORDED: Bennett, Castillo, Ellis, Flora, Jeff Gonzalez, Hadwick, Lackey, Macedo, Patterson, Sanchez, Ta

Prepared by: Teri Boughton / HEALTH / (916) 651-4111
8/30/25 11:03:06

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