THIRD READING

Bill No: AB 280
Author: Aguiar-Curry (D)
Amended: 8/21/26 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 requires the Department of Managed Health Care (DMHC) to designate a central utility for health plan and insurer provider directories and requires health plans and insurers to require their in-network or participating providers to use the central utility to update and verify information for health plan and insurer directories. Exempts a specified health plan and insurer with mutually exclusive medical group contracts, as specified. Authorizes DMHC and the California Department of Insurance (CDI) to issue guidance to implement this bill until January 1, 2032. Exempts Medi-Cal managed care plans from this bill.

Senate Floor Amendments of 8/21/2026 require DMHC to select a central utility and develop standards requiring plans and insurers to use the designated central utility to collect, manage, and verify consistency and completeness of the information required for provider directories. Require DMHC to establish a process to designate a central utility that has demonstrated the ability to meet the requirements of this bill. Require DMHC to seek input from stakeholders, including CDI. Permit CDI to add to the methodology to conform to Insurance

Code and regulations. Require contracts between health plans and insurers and providers to require the provider to submit and update their information through the central utility designated by DMHC. Require the contracts to also require the health plan or insurer to provide all information to the provider that is necessary to enable the provider to complete all information fields required by the central utility, including identifying the name of each product line for which the provider is in-network or participating. Require DMHC to develop a methodology, including a uniform format with standardized naming conventions, that a plan or insurer must use to request providers submit their information to the central utility. In developing the methodology for requesting provider information, DMHC to consider ways to minimize burden on responding providers.

Exempt nonprofit health plans or insurers with at least 3.5 million enrollees or insureds that provide health care services to enrollees or insureds in a specific geographic area through a mutually exclusive contract with a single medical group from being required to utilize the central utility for a provider that exclusively provides services to or is employed by that health plan, medical group, health facility, or health system. Require the plan or insurer to use the central utility for any network provider that is contracted to provide services to more than one health care service plan or insurer shall be required to use the central utility pursuant to this bill.

The amendments make conforming changes, add a coauthor and update the commencement date of the requirements in this bill to July 1, 2027.

Exempt Medi-Cal managed care plans from this bill.

Permit DMHC and CDI to implement by guidance or all-plan letters without regulatory action until January 1, 2032, and require DMHC and CDI to consult with interested stakeholders in developing guidance.

Permit administrative penalty if an enrollee or insured reasonably relied upon materially inaccurate, incomplete, or misleading information when selecting a plan or policy.

Delete requirements on the departments to update standardized formats, establish a methodology and process for provider directory accuracy, authorization to require plans to use central utility, and authorization for plans to require providers to use a central utility.

Delete terminology in disclosure that provider is “actively contracting” in-network with a plan or insurer.

Delete accuracy benchmark requirements for plans and insurers.

Delete requirements about assessing administrative penalties in specified amounts, with adjustments every five years.

Delete requirements associated with "actively contracting" providers, including that DMHC and CDI develop definition and exclusions from provider directory for non-actively contracting providers.

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. Requires the plan or insurer to update provider directories, at least weekly, with any change to contracting providers, as specified. 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]

3) 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. Prohibits the fact that services were rendered or delivered by a noncontracting or out-of-network provider from being used as a basis to deny reimbursement. [HSC §1367.27 and INS §10133.15]

This bill:

1) 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.

2) Requires out-of-network providers when a plan or insurer is required to cover services because of inaccurate directory to be paid an agreed upon amount or reasonable and customary for the same or similar services in the geographic region in which the services were rendered, less in-network cost sharing.

3) 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.

4) Requires a plan or insurer to include prominent disclosure on its print and online provider directories of its duty to arrange coverage when 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.

5) Permits administrative penalties if an enrollee or insured reasonably relied upon materially inaccurate, incomplete, or misleading information when selecting a plan or insurer.

6) 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.

7) Requires DMHC to select a central utility and develop standards requiring plans and insurers to use the designated central utility to collect, manage, and verify consistency and completeness of the information required for provider directories. Requires DMHC to establish a process to designate a central utility that has demonstrated the ability to meet the requirements of this bill. Requires

DMHC to seek input from stakeholders, including CDI. Permits CDI to add to the methodology to conform to Insurance Code and regulations.

8) Requires DMHC to develop a methodology, including a uniform format with standardized naming conventions, that a plan or insurer must use to request providers submit their information to the central utility. In developing the methodology for requesting provider information, requires DMHC to consider ways to minimize burden on responding providers.

9) Requires DMHC to develop a methodology for a plan or insurer to annually verify the consistency and completeness of their provider directories against information in the central utility using a consistency report created by the central utility. Requires the methodology to include all of the following requirements:

   a) The plan or insurer to submit all provider directories to the central utility to be analyzed.

   b) The central utility to create a consistency report for each directory that identifies each inconsistency between each provider directory and the central utility.

   c) The central utility to annually inform the plan or insurer and DMHC and CDI of its methodology for updating information and resolving data inconsistencies.

   d) The central utility to send consistency reports to plans and DMHC, insurers and CDI.

   e) The plans and insurers to submit attestations that affirm review of consistency report and describe how they will remedy each inconsistency.

10) Requires DMHC to annually share the methodology from the central utility with CDI. Requires DMHC and CDI to publish on their websites.

11) Requires DMHC to annually publish the results of consistency reports on its website.

12) Permits DMHC to consider terminating the contract with the central utility if accuracy issues persist and not require plans to use the central utility or to designate another central utility, as specified.

13) Exempts nonprofit health plans or insurers with at least 3.5 million enrollees or insureds that provide health care services to enrollees or insureds in a specific geographic area through a mutually exclusive contract with a single medical group from being required to utilize the central utility for a provider that exclusively provides services to or is employed by that health plan, medical group, health facility, or health system. Requires those plans and insurers to use the central utility for any network provider that is contracted to provide services to more than one health care service plan or insurer pursuant to this bill.

14) Requires a plan or insurer to be responsible for maintaining a complete and accurate provider directory that is consistent with the information in the central utility, unless the plan or insurer verifies that the information from the central utility is inaccurate based on the plan's or insurer's investigation.

15) Requires plans and insurers to notify central utility of inaccuracies and require central utility to update accordingly within five business days.

16) Requires within 12 months of DMHC designating a central utility, a plan or insurer to update the policies and procedures to require providers to submit verifications and changes to the central utility.

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.

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).

SUPPORT: (Verified 8/25/26)

Health Access California (source)
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 8/25/26)

Association of California Life & Health Insurance Companies
California Association of Health Plans
California Association of Orthodontists
California Dental 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
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