CONCURRENCE IN SENATE AMENDMENTS
AB 280 (Aguiar-Curry and Papan)
As Amended August 21, 2026
Majority vote

SUMMARY

Requires *the Department of Managed Health Care (DMHC) to select a central utility and develop uniform standards for provider directories. Requires health plans and insurers to use the designated central utility to collect, manage, and verify the consistency and completeness of their provider directories. Requires health plans and insurers to require their in-network or participating providers to use the central utility to update and verify information for provider directories. Authorizes DMHC and the California Department of Insurance (CDI) to issue guidance to implement this bill until January 1, 2032.*

Senate Amendments

1) Strike provider directory accuracy benchmark requirements for plans and insurers.

2) 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.

3) 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, require DMHC to consider ways to minimize burden on responding providers.

4) 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.

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

6) 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.

7) Delete terminology in disclosure that provider is ″actively contracting″ in-network with a plan or insurer.

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

9) Strike requirements about assessing administrative penalties in specified amounts, with adjustments every five years.

10) 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.

11) Exempt Medi-Cal managed care plans from the provisions of this bill.

12) Make technical and conforming changes, add a coauthor, and update the commencement date of the requirements in this bill to July 1, 2027.

COMMENTS

Network Adequacy Requirements. Network adequacy standards are utilized to ensure that health plans contain and maintain a network of health care providers adequate for enrollees to access medically necessary in a timely manner. In California state and federal law sets forth various network adequacy requirements on health plans and insurers, including the following:

1) *Timely Access to Care.* State law requires that health plans meet a set of standards which include specific time frames under which enrollees must be able to access care. These requirements generally provide health plan members the right to appointments within the following time frames:

   a) Urgent care without prior authorization: *within 48 hours*;

   b) Urgent care with prior authorization: *within 96 hours;*

   c) Non-urgent primary care appointments: *within 10 business days;*

   d) Non-urgent specialist appointments: *within 15 business days;*

   e) Non-Urgent mental health (MH) appointments: *within 15 business days* for psychiatrist, *within 10 business days* for non-physician MH provider; and,

   f) Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness or other health condition: *within 15 business days*.

   The Department of Managed Health Care (DMHC) publishes a Timely Access Report, with the most recent publication covering data from measurement year 2022. This report highlighted the following:

a) *Key Survey Findings for Full Service Health Plans:* For non-urgent and urgent appointments combined, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 87% to a low of 56%. For non-urgent appointments, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 94% to a low of 66%. For urgent appointments, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 84% to a low of 46%.

b) *Key Survey Findings for Behavioral Health Plans:* For non-urgent and urgent appointments combined, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 83% to a low of 66%. For non-urgent appointments, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 89% to a low of 77%. For urgent appointments, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 77% to a low of 46%.

2) *Geographic Access.* Health plans are also generally required to ensure geographic access, meaning there are a sufficient number of providers located within a reasonable distance from where each enrollee lives or works. For example, primary care physicians (PCPs) and hospitals should be *located within 15 miles or 30 minutes* from work or home.

Health plans must also ensure provider capacity such that health plan networks have enough of each of the right types of providers to deliver the volume of services needed. For example, plan networks should include *one PCP for every 2,000 beneficiaries.*

3) *Provider Directories.* Provider directories help patients identify clinicians based on specialty, location, and hours. Provider directories can also act as a tool to inform a patient′s choice in health plan, allowing them to search if a particular provider is in-network or assess how many provider choices they will have near them.

a) *California Law.* California was one of the first states to enact provider directory standards. SB 137 (Hernandez), Chapter 649, Statutes of 2015, requires health plans and insurers to maintain accurate online and paper directories as of July 1, 2016. SB 137 also requires the following:

i) DMHC and California Department of Insurance (CDI) to develop uniform provider directory standards and to take appropriate steps to ensure the accuracy of the information contained in the plan or health insurer′s directory or directories, and requires the plan or insurer, at least annually, to review and update the entire provider directory or directories for each product offered;

ii) A plan or insurer, at least weekly, to update its online provider directory or directories, and requires a plan or insurer, at least quarterly, to update its printed provider directory or directories; and,

iii) A plan or insurer to reimburse an enrollee or insured for any amount beyond what the enrollee or insured would have paid for in-network services, if the enrollee or insured reasonably relied on the provider directory and authorizes a plan or health insurer to delay payment or reimbursement owed to a provider or provider group, as specified,

if the provider or provider group fails to respond to the plan′s or health insurer′s attempts to verify the provider′s or provider group′s information.

b) *Federal Law*. Plans offered on HealthCare.gov (the federal exchange marketplace) are required to include directory links showing providers′ location, contact information, specialty, and whether they are accepting new patients. Issuers are required to update directories at least monthly. Oversight of appointment wait-time standards also rely on directory data.

Beginning in 2022, the federal No Surprises Act (NSA) requires all private health plans to maintain accurate provider directories and requires providers to regularly update plans about any changes in their information. Plans must verify and update directories at least every 90 days and, on an ongoing basis, post any changes within two business days. Plans are also required to apply in-network cost sharing for covered services provided by facilities or providers mistakenly listed as in-network.

c) *Persistent Inaccuracies*. Despite state and federal laws, a *Yale Law & Policy Review* (Yale Review) article titled, *"Laying Ghost Networks to Rest: Combatting Deceptive Health Plan Provider Directories*," revealed high error rates across provider directories in California, Louisiana, and Maryland. In California, even the lowest error rate the Yale Review identified, 21%, means that one out of five provider listings will lead enrollees seeking care to a dead end. At the high end, more than half of all provider listings led to a dead end in California.

In a secret shopper Health Affairs study of California qualified health plans (QHPs) (offered on Covered California – California′s state based exchange) in 2015, 73% of calls to providers listed in network directories were unable to secure appointments. A recent secret shopper survey in Los Angeles revealed that only 15% of phone calls seeking psychiatric appointments for Medi-Cal patients led to a scheduled appointment - the lowest success across the four states surveyed. As part of its annual compliance review, the Centers for Medicare & Medicaid Services (CMS) selects a small sample of issuers and reviews the machine-readable provider directory to verify accuracy. In 2024, CMS reported inaccuracies in all directories examined in 2022, with similar compliance problems observed in prior years.

d) *Enforcement, or lack thereof.* According to the Yale Review, when states do carry out enforcement actions, they tend to result in minimal or no fines, removing any incentive for insurers to increase the accuracy of their plans. Despite SB 137′s broad scope and detailed requirements, the Yale Review indicated that California continues to have high levels of directory errors. The Yale Review urges states, like California, to adopt frameworks to prevent directory errors. The Yale Review contends that such frameworks should be focused on regular enforcement, consistent fines for noncompliance, and engaging as many actors as possible in the enforcement scheme.

e) *DMHC draft provider directory regulations.* In December 2024, DMHC proposed regulations on provider directories. According to DMHC, these proposed regulations ″will provide clarity regarding the scope of provider directory standards and will allow DMHC to effectively enforce current law.″ DMHC continues that these proposed regulations will make clear the obligations for both health plans and the DMHC. The first public comment period on these proposed regulations recently closed in February 2025 and the regulatory

process is still underway. According to DMHC, it is anticipated to be completed by this summer.

The author and sponsor have argued that these proposed regulations do not include a defined penalty or enforcement mechanism, whereas this bill would outline a clear penalty structure, as recommended by the Yale Review, to ensure health plan compliance.

According to the Author
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. The author continues that 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. The author argues that 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. The author concludes that this legislation provides a roadmap to improve transparency and accountability, making our healthcare system work better for everyone.

Arguments in Support
Health Access (HA), sponsor of this bill, states that consumers depend on a provider directory to find an in-network provider whether it be a doctor, specialist, dentist, hospital, laboratory, imaging center, or another provider. HA continues that a consumer′s right to timely access to care is affected by a provider directory; if a consumer is unable to find a provider, they waste necessary time simply searching for one. HA states that DMHC′s monitoring of timely access to care routinely finds that 20% to 30% of providers are unreachable by the health plan, often because of inaccuracies in the health plan′s provider directory. HA argues that inaccuracies have the greatest impact on consumers who already face the worst access such as individuals with limited English proficiency, persons with disabilities, and marginalized communities, thus worsening health inequities. HA contends 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. HA further argues that while our laws and regulations on provider directories and network adequacy are, on paper, some of the strongest in the country, they are falling short for consumers and delaying the access to care they desperately need. HA states that this bill addresses the problem of provider directory inaccuracies through consumer protections, more efficient processes, and effective enforcement.

Arguments in Opposition
America's Physician Groups (APG) is opposed to this bill unless it's amended to address their concerns. APG's central concern is that this bill does not adequately recognize the role of medical groups and independent practice associations as authoritative managers of their provider rosters. APG notes that in a delegated arrangement, the physician organization often has the most current information concerning provider affiliation, practice location, availability, and acceptance of new patients. Requiring individual physicians to submit the same information separately to a central utility may create conflicting records rather than improve accuracy. APG requests that the bill expressly permit a medical group or Independent Physician Association to submit and attest to provider information on behalf of its affiliated physicians. APG further requests that the central utility should be required to accept batch files, application

programming interfaces, and other interoperable submissions from physician organizations. APG is also concerned about the provision allowing a health plan to withhold as much as 50% of a provider group's capitation payment for up to one month. APG argues that neither the mock-up nor the information supporting it establishes that physician organizations are a source of systematic provider-directory reporting failures. APG believes the inclusion of this provision, in the absence of any history that would warrant it, is troubling. APG further argues that plans and physician organizations should not face enforcement consequences for errors originating with a state-designated central utility when they have reasonably relied on the utility and acted promptly after discovering the error. APG requests that the bill provide a safe harbor or rebuttable presumption of compliance under those circumstances. APG requests that the bill also establish a clear process for resolving conflicts between verified plan or physician-organization data and information maintained by the utility before disputed information is published or used for enforcement.

FISCAL COMMENTS

According to the Senate Appropriations Committee:

1) *Unknown ongoing costs, potentially low millions, for DMHC for state administration (Managed Care Fund).*

2) *Unknown ongoing costs, potentially low hundreds of thousands, for CDI for state administration (Insurance Fund).*

VOTES:

ASM HEALTH: 11-0-4
YES: Bonta, Addis, Aguiar-Curry, Arambula, Carrillo, Mark González, Krell, Patel, Celeste Rodriguez, Schiavo, Stefani
ABS, ABST OR NV: Chen, Flora, Sanchez, Sharp-Collins

ASM APPROPRIATIONS: 11-1-3
YES: Wicks, Arambula, Calderon, Caloza, Elhawary, Fong, Mark González, Hart, Pacheco, Pellerin, Solache
NO: Dixon
ABS, ABST OR NV: Sanchez, Ta, Tangipa

ASSEMBLY FLOOR: 61-7-11
YES: 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
NO: Alanis, Davies, DeMaio, Dixon, Hoover, Tangipa, Wallis
ABS, ABST OR NV: Bennett, Castillo, Ellis, Flora, Jeff Gonzalez, Hadwick, Lackey, Macedo, Patterson, Sanchez, Ta

UPDATED

VERSION: August 21, 2026

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