

Ensuring Accurate Health Plan Provider Directories

AB 236 (Holden)

Background

Every health plan in California is required to maintain an updated list of in-network health care providers for their enrollees. These directories list providers such as doctors, mental health professionals, hospitals, labs, imaging centers, and more that are in the health plan's network. When consumers go to search for a new doctor or mental health specialist, they must be able to rely on these directories for accurate information.

When the providers on these lists are unreachable or do not actually provide care to consumers covered by that health plan, this can be referred to as a "ghost network".ⁱ

Ghost networks lead to confusion among consumers who too often have their care denied or delayed. Consumers may even feel forced to seek necessary care out-of-network and pay inflated rates.ⁱⁱ In one case, a consumer seeking help called 73 doctors and found that some had retired, others were not accepting their insurance, some had disconnected phone numbers, and a few had passed away.ⁱⁱⁱ These inaccuracies and ghost networks have the greatest impact on consumers who already face the worst access, such as those with limited English proficiency, persons with disabilities, and others in marginalized communities thus worsening inequities in health care.

Existing law, SB 137 (Hernandez 2015) requires basic information such as the provider's name, address, telephone number, languages spoken, and e-mail contact be included in these directories. The law also requires regular updates by health plans and an annual review by the regulating department to ensure that the proper information is being provided. Current law also mandates that if a consumer visits a provider listed as in-network by their plan's directory, but the provider turns out to be out-of-network, then their plan must pay as if the care were in-network.

Existing law, however, has not fully ensured the accuracy of these directories of doctors, hospitals, and other providers. Error rates vary among health plan directories but are highest for non-physician mental health professionals and psychiatrists; error rates are also high for primary care and specialty care providers.^{iv} One health plan was found to have an error rate of 80% for non-physician mental health professionals with most having error rates of 20%-30%. In contrast, one health plan was able to achieve 95% accuracy.^v Audits by the Department of Health Care Services have also found that in some cases health plans have failed to provide enrollees with any printed provider directory and excluded mental health providers.^{vi, vii}

Existing law has also not effectively enforced basic consumer protections or addressed the alarming pattern of inaccuracies in provider directories. Since the enactment of SB 137 in 2016, the Department of Managed Health Care (DMHC) has only taken five enforcement actions with fines that were small and infrequent. Health plans need a timetable and mechanism towards improvement with greater accountability to finally address this ongoing problem.

AB 236 (Holden) establishes mechanisms to improve provider directory accuracy for consumers, so that they can rely on directories to find the care that they need. The bill requires that health plans annually verify the information in their provider directories per standards set by DMHC and the Department of Insurance (CDI). The bill also ties existing requirements to accuracy benchmarks, which will serve as an effective enforcement mechanism.

Streamlining the Process

Currently, some health plans and insurers rely on contacting all the providers they contract with individually to update their information. This creates a confusing influx of requests for providers to respond to. To streamline this process, AB 236 gives DMHC and CDI the authority to require health plans and insurers to utilize a third-party central provider directory utility. Provider directory utilities are a tool used by plans and providers to streamline the gathering of information that will appear in the public-facing provider directory for each health plan and insurer. Providers update their information in the utility once, and all plans they contract with can use this centralized information to update their own directories. The utility also verifies the input information on an ongoing basis, ensuring that plans will be using accurate information for their directories.

If the departments require use of the central utility or designate one, the health plans and insurers would remain responsible for utilizing the information from the central utility, and meeting accuracy benchmarks for their individual provider directories.

Setting Accuracy Benchmarks

AB 236 establishes annually increasing provider directory accuracy benchmarks for health plans and insurers in their directories, starting at 60% accuracy, and building to 95% percent accuracy by 2028.

AB 236 includes specific penalties for failure to meet accuracy benchmarks:

- Between \$500 and \$5,000 penalty per 1,000 enrollees for the first year a health plan has failed to meet a benchmark.
- Between \$1,000 and \$10,000 penalty per 1,000 enrollees for each subsequent year that the health plan fails to meet the benchmark.

Eliminating Ghost Networks

To address ghost directories, if a provider has not filed one claim with the plan within the previous year or responded to verify their information after required attempts to verify and notice to provider, the provider would be deleted from the directory. The bill would also allow the DMHC and CDI to release guidance on specific circumstances such as providers in rural areas, specialty care, or other providers, who should be kept on directories even if they may not have a claim in the previous year. The bill would also clarify the process by which a provider may be added back to a directory, if removed.

Protecting Consumers

When a consumer relies on an inaccurate, misleading or incomplete directory listing, the bill requires that health plans and insurers arrange care for that consumer, and the consumer will not be responsible for paying out-of-network costs for the services. The bill will also improve accuracy of reporting by plans and insurers for compliance with network adequacy and timely access to care, and other laws and regulations. Lastly the bill prohibits plans from advertising inflated numbers for their insurer networks.

For any questions or concerns please contact Katie Van Deynze, Policy and Legislative Advocate: kvandeynze@health-access.org.

i. Busch, Susan H., and Kelly A. Kyanko. 2020. "Incorrect Provider Directories Associated With Out-Of-Network Mental Health Care And Outpatient Surprise Bills: An examination of the role inaccurate provider directories play in out-of-network mental health treatment and surprise bills." *Health Affairs* 39 (6): 975-983.
 ii. Burman, Abigail. 2021. "Laying Ghost Networks to Rest: Combatting Deceptive Health Plan Provider Directories." *Yale Law & Policy Review* 40.
 iii. Ellison, Katherine. 2022. "73 doctors and none available: How ghost networks hamper mental health care." *The Washington Post*.
 iv. Burman, Abigail. 2021. "Laying Ghost Networks to Rest: Combatting Deceptive Health Plan Provider Directories." *Yale Law & Policy Review* 40.
 v. Burman, Abigail. 2021. "Laying Ghost Networks to Rest: Combatting Deceptive Health Plan Provider Directories." *Yale Law & Policy Review* 40.
 vi. California Department of Health Care Services. 2020. *Report on the Medical Audit of KP, Cal LLC Kaiser Permanente GMC*
 vii. California Department of Health Care Services. 2020. *Report on the Medical Audit of CenCal Health Plan*