

## ***Ensuring Accurate Health Plan Provider Directories***

### **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.

Often, providers on these lists are unreachable or do not actually provide care to consumers covered by that health plan. This leads to confusion among consumers who then have their care denied or delayed. Consumers may even feel forced to seek necessary care out-of-network and pay inflated rates.<sup>i</sup> 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.<sup>ii</sup> These inaccuracies 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 the consumer is only responsible for their in-network cost-sharing.

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. For psychiatrists, one health plan was found to have an error rate of 80% in their Covered CA plans, and another for Medi-Cal Managed Care had an error rate of 62%. Most health plans have error rates of 20%-30%. In contrast, one health plan was able to achieve 95% accuracy.<sup>iii</sup> For patients with Medi-Cal coverage, these errors exacerbate existing barriers to finding a provider to access care, especially for behavioral health care. A recent secret shopper survey in Los Angeles showed that only 15% of phone calls seeking psychiatric appointments for Medi-Cal patients resulted in an appointment, which was the lowest of four cities in four states surveyed.<sup>iv,v</sup> 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.<sup>vi,vii</sup>

In the near decade since SB 137 (Hernandez, 2015) was enacted, the law has not effectively enforced basic consumer protections or addressed the alarming pattern of inaccuracies in provider directories. Since then, hundreds of consumers have filed complaints. But the Department of Managed Health Care (DMHC) has only taken five enforcement actions with fines that were small and infrequent, with only \$82,500 in fines for directory errors in the last 8 years.<sup>viii</sup> The existing law leaves the burden on the consumer to file complaints for errors and does not set clear enforcement for plans' failure to maintain accurate directories. Health plans need an enforceable timetable and mechanism towards improvement with greater accountability that will be a meaningful deterrent, not a drop in the bucket, to finally address this ongoing problem.

AB 280 (Aguiar-Curry) establishes these mechanisms by requiring health plans to 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 clear 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 280 gives DMHC and CDI the authority to require health plans and insurers to utilize a third-party central utility or utilities. 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 central utilities or designate one or more, 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 280 establishes annually increasing accuracy benchmarks for health plans and insurers in their provider directories, starting at 60% accuracy, and building to 95% accuracy by July of 2029. AB 280 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.

## 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.

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