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Laying Ghost Networks to Rest: Combatting Deceptive Health Plan Provider Directories

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Errors in health plans' provider directories, also known as "ghost networks," are a pernicious feature of the American health care system, with some studies showing that more than half of all directory entries contain errors. These errors disrupt patients' access to care, can lead to large, unexpected bills, and undermine the regulatory structure of the entire health insurance market. They also exacerbate existing structural inequalities. While there have been attempts to reign in ghost networks through regulation, this article analyzes state-level data to demonstrate the failure of existing directory accuracy policies. In response to the shortcomings of current regulatory approaches, this article proposes an alternative policy framework to prevent directory errors; one that is focused on regular enforcement, consistent fines for noncompliance, and engaging as many actors as possible in the enforcement scheme. Finally, this article explains why large portions of the proposed policy framework would comply with ERISA, meaning that states could apply it to all health plans. Crucially, while directory accuracy is just one piece of the puzzle that is ensuring that insurers provide adequate access to care, regulators' inability to reign in directory errors (arguably the most straightforward component of network adequacy) is a canary in the coal mine, signaling health care regulations' broader failure to effectively safeguard consumers' health and financial wellbeing.

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INTRODUCTION

KB¹ had tried very hard to be an informed consumer.² When her doctor referred her to a specialist, she used her insurer's online provider directory to make sure that the specialist was in-network.³ To confirm the online directory listing, she also called her insurer directly. Both sources confirmed that the specialist was in-network.⁴ This reassured KB that when she saw the specialist, she would owe her usual in-network co-pay of \$10 to \$50.⁵

So, KB was shocked when told that the bill for her visit was nearly \$700.⁶ It turned out that the specialist was not actually in-network, meaning that KB owed her insurer's designated co-insurance for out-of-network providers rather than the in-network co-pay.⁷ The co-insurance was thirty percent of the specialist's total charge, which came to \$700.⁸ KB was so spooked by this completely unexpected, extremely large bill that she had none of the tests and other follow-up that the specialist recommended.⁹

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1. The personal stories included in this paper are the result of both conversations that I had with individuals and social media postings. The individual interviews were arranged through Facebook posts in several groups related to health care. The social media posts were found by searching Twitter for terms related to directory accuracy.

All individuals are referred to by their initials, in deference to the sensitivity of the topic. This includes people who made public social media postings, in an attempt to balance the public nature of the posts with the fact that these people did not specifically consent to sharing their stories in this paper. I feel this is an appropriate balance because while the footnotes link to these people's tweets, the use of initials prevents this paper from being linked to their names in search results.

2. Email from KB to Abigail Burman (Sept. 11, 2019, 01:00 AM PST) (on file with author).
3. *Id.*
4. *Id.*
5. *Id.*
6. *Id.*
7. *Id.*
8. *Id.* Her bill would have been even higher if the specialist had balance billed her—billing her for the difference between his rate and the rate that KB's insurer was willing to pay—but he agreed to waive the rest of his fee. *Id.*
9. *Id.*

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KB paid hundreds of dollars more than she was expecting to because her insurer’s provider directory was inaccurate. Provider directories are the public lists of in-network providers and their specialties, addresses, and phone numbers that are maintained by insurance plans. They are typically publicly available, regardless of whether users are enrolled in a plan or not, and provided both online and in paper form. In addition to basic contact information, directories may also list more detailed sub-specialties, whether or not a provider is accepting new patients, what languages the provider speaks, whether the office is ADA accessible, and the office’s hours. In short, directories are—ideally—a deep repository of information detailing what care is available to enrollees and how that care can be accessed.

But all too often, as KB discovered, these directories are deeply flawed. Inaccurate directories are known as “ghost networks” or “phantom networks” and are a pervasive issue in the American health care system. A three-phase study of the accuracy of Medicare Advantage directories, which included over 15,000 providers, found that between forty-five and fifty-two percent of provider directory listings¹⁰ had errors, with some individual plans having error rates as high as ninety-eight percent.¹¹ Studies of particular locations and specialties have echoed these findings. For example, a study of psychiatry directory entries in Washington, D.C. found that twenty-three percent of listed phone numbers either did not work or were nonresponsive, only fifty-one percent of providers still practiced at

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10. CMS considered each combination of provider and practice location to be a separate listing.
 11. *Online Provider Directory Review Report*, CTRS. FOR MEDICARE & MEDICAID SERVS. 5 (Jan. 13, 2017) [hereinafter CMS Phase One Report], https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Provider_Directory_Review_Industry_Report_Final_01-13-17.pdf [<https://perma.cc/65BH-XBPD>]; *Online Provider Directory Review Report*, CTRS. FOR MEDICARE & MEDICAID SERVS. 3, 5 (Jan. 31, 2018) [hereinafter CMS Phase Two Report], https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Provider_Directory_Review_Industry_Report_Round_2_Updated_1-31-18.pdf [<https://perma.cc/G939-WAKU>]; *Online Provider Directory Review Report*, CTRS. FOR MEDICARE & MEDICAID SERVS. 6 (Nov. 28, 2018) [hereinafter CMS Phase Three Report], https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Provider_Directory_Review_Industry_Report_Round_3_11-28-2018.pdf [<https://perma.cc/44CB-YKR6>].

their listed numbers, and only fourteen percent of providers listed as accepting new patients actually were.¹²

These rampant directory errors erode a critical link between consumers and the care that their insurers have agreed to provide.¹³ Provider directories allow people to find a doctor and assess what the cost of a visit will be. They also inform people's initial choice of health plan, whether people are looking to see if a particular provider is in-network or want to broadly assess how many provider choices they will have, and if there are a lot of providers near them.

Unsurprisingly, given their vital role in the health care system, directory errors also cause a wide range of consumer harms. Directory errors are both a failure by insurers to make good on their representations to consumers and a barrier placed between patients and the medical care they need. At the broadest level, directory errors harm everyone who purchases a health plan by misrepresenting the breadth, and thus the value, of the plan's coverage. Individuals may also have to contend with specific harms. Some people, like KB, receive huge, unexpected medical bills. Other people, worn down by hours of calling providers who are incorrectly listed in directories, give up on finding an in-network provider at all and pay more money to see someone who is out-of-network. Even more concerning, people may delay needed care or choose to not seek care at all. These harms are not evenly distributed, disproportionately falling on members of marginalized communities.

Beyond these individualized harms, ghost networks undermine the broader regulatory structure of the American health care market. The premise of most American health care policy is that consumer choice encourages plans to strike a reasonable balance between the cost of premiums and the benefits offered, with government regulators ensuring that plans do not fall below a floor of minimum benefits. But both these forms of market regulation are dependent on accurate provider directories. Without accurate directories, consumers cannot make informed choices

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12. Am. Psychiatric Ass'n, *APA Poll Finds Access to Care Stymied by 'Phantom' Networks in D.C.*, PSYCHIATRIC NEWS (May 17, 2016), http://www.psychnews.org/update/2016_apa_daily_4d.html [<https://perma.cc/53UP-5UFB>].
 13. Unless otherwise specified, "insurer" encompasses all privately-run insurance plans, including Medicaid managed care, except for Medicare Advantage plans. See *Do Sung Uhm v. Humana, Inc.*, 620 F.3d 1134, 1158 (9th Cir. 2010) (holding that state laws related to marketing and advertising are preempted with regard to Medicare Advantage plans). Likewise, "consumer" refers to all people enrolled in a privately-run plan who have a choice of plan, regardless of whether they pay their insurer or providers.

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between plans or about where to seek care, and regulators do not have the tools they need to enforce network adequacy requirements.

The inaccuracy of provider directories has not gone unnoticed by state policymakers.¹⁴ In the mid-2010s, a wave of studies showing that provider directories were riddled with errors, coupled with widespread problems with the directories of ACA exchange plans, moved states to begin adopting directory accuracy policies.¹⁵ However, despite broad recognition that directory inaccuracies cause serious problems for consumers, there has not been any subsequent effort to evaluate the effectiveness of state directory accuracy policies.

This paper seeks to fill that gap, using California, Louisiana, and Maryland as case studies to demonstrate that existing approaches to directory accuracy fail to protect consumers. California, Louisiana, and Maryland have taken a range of approaches—in both scope and enforcement—to the directory accuracy problem, but none of their policies have managed to increase directory accuracy. Despite relatively explicit directory accuracy policies, high rates of directory errors persist, sometimes topping fifty percent. Furthermore, comparing directory accuracy rates from before and after California's directory accuracy rates reveal that the policy has had no appreciable effect on accuracy.

These states' policies are ineffective because, like most state directory accuracy policies, they lack strong enforcement mechanisms, and the few enforcement actions that are taken are far too minimal to act as deterrents. From plans' perspectives, the cost of increasing accuracy is higher than the cost of allowing inaccuracies to continue, so they have no incentive to increase the accuracy of their directories. And private litigation has not taken up the slack left by regulators. There have been very few directory accuracy cases brought by private plaintiffs, particularly cases brought after the initial rollout of the ACA exchanges.

In light of the failure of existing directory accuracy policies and directory accuracy litigation, it is imperative that states change their approach to ghost networks. States should adopt directory accuracy policy frameworks that will actually guard the interests of consumers, putting in

14. While the federal government has also enacted some directory accuracy standards, states largely remain responsible for implementation and enforcement. *See infra* notes 75–85 and accompanying text.

15. *See, e.g.*, Emily Bazar, *California Now Requires Timely Updates for Insurers' Doctor Directories*, NPR (Sept. 6, 2016, 11:32 AM), <https://www.npr.org/sections/health-shots/2016/09/06/492804674/california-requires-timely-updates-for-insurers-doctor-directories> [https://perma.cc/BVC2-XFDW] (describing the impetus for California's directory accuracy policy).

place a rigorous, broad enforcement structure and routinely fining plans whose directories are inaccurate. While these policies would be worthwhile even if they only applied to Medicaid and individual plans, large portions of them are likely to survive ERISA preemption and thus also be applicable to employer-sponsored plans.

More broadly, the failure of state directory accuracy policies signals the need to reconfigure governments' approach to regulation. The persistence of ghost networks, even in relatively highly regulated states like California, Louisiana, and Maryland, demonstrates that the existence of a regulation is not, in and of itself, enough to change insurers' behavior; yet health insurance regulations continue to pay only minimal attention to enforcement. To truly protect consumers, this approach must change. States cannot continue to respond to consumer abuses with policies that are in practice no more than position papers, lacking any of the enforcement tools that are necessary to actually protect consumers. Regulations, for both ghost networks and health care reforms more broadly, must be accompanied by low effort, sustained, and broad-based enforcement mechanisms.

I. DIRECTORY ERRORS COMPROMISE CONSUMER PROTECTIONS, LIMIT ACCESS TO HEALTH CARE, PREVENT EFFECTIVE REGULATION OF THE HEALTH INSURANCE MARKET, AND EXACERBATE SYSTEMIC INEQUALITIES.

Access to health care rests on a nexus between consumer protection, social justice, and public health, all of which are disrupted by ghost networks. As a consumer protection matter, ghost networks both cause direct financial harm to consumers by deceiving them about the extant value of their health coverage and subjecting them to abusive billing practices. At the systemic level, ghost networks undermine the ability of consumers and governments to regulate the health care market and reign in bad actors. And, by making it difficult, costly, and time consuming to access health care, ghost networks undermine public health. All of these harms are in turn particularly acute for members of marginalized groups, who lack the resources (both money and time) needed to absorb the impact of directory errors.

These harms affect both individual consumers and society as a whole. As the COVID-19 pandemic has starkly illustrated, wellbeing is a communal, not individual enterprise. If someone in a community cannot find a provider or cannot afford to seek health care, that entire community becomes more vulnerable. If one person is suddenly thrown into unaffordable medical debt by an unexpected or unavoidable bill or has to give up work hours to find care for a relative, the community as a whole becomes less resilient.

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Everyone is affected by ghost networks, whether or not they have personally encountered one.

A. Directory Errors Cause Financial Harm to Consumers

The first casualty of ghost networks is consumer protections. For many people, health care is one of the most, if not the most, expensive things people buy every year. The average American spends over \$7,000 on health insurance premiums each year, with overall health spending of nearly \$10,000. But if people face serious health problems, or get caught in the nightmare that is medical billing, these costs can quickly climb.¹⁶ Directory errors cost consumers money and erode regulatory consumer safeguards. They deceive consumers about the value of the coverage they are purchasing by concealing plans' actual provider networks, subjecting consumers to predatory billing practices, and breaking the link between consumer choices and plan practices that undergirds much of the American health insurance regulatory structure.

1. Deception About the Breadth of Plans' Networks

At the broadest level, directory errors cause an economic injury to every person who purchases or chooses an insurance plan by inducing them to make a purchase (or a decision in the case of Medicaid enrollees) on the basis of false information.¹⁷ Directories play a central role in consumers'

16. See David U. Himmelstein, Deborah Thorne, Elizabeth Warren & Steffie Woolhandler, *Medical Bankruptcy in the United States, 2007: Results of a National Study*, 122 AM. J. MED. 741, 743 (2009) (finding that sixty-two percent of bankruptcies are related to medical expenses); K. Robin Yabroff, Jingxuan Zhao, Xuesong Han & Zhiyuan Zheng, *Prevalence and Correlates of Medical Financial Hardship in the USA*, 34 J. GEN. INTERNAL MED. 1494, 1496 (2019) (finding that 137 million Americans experienced medical financial hardship in the past twelve months).

17. Consumers enrolled in Medicaid Managed Care Organizations (MCOs), like consumers enrolled in private plans, must choose between multiple plans. When MCO enrollees are deceived by directories, they are—as with private plan enrollees and the value of their premiums—being denied the full value of the benefits that are effectively their property. See *Goldberg v. Kelly*, 397 U.S. 254, 262 n.8, 264 (1970) (holding that procedural due process requires an evidentiary hearing prior to termination of certain public benefits and explaining that public benefits are “more like ‘property’ than a ‘gratuity’”).

choice of plan.¹⁸ In fact, for some consumers, directories are the exclusive basis for their choice of plan.¹⁹ Existing state directory laws underline the importance of directories to consumers' coverage decisions. Several states require insurers to make directories publicly available, without requiring any proof of plan membership, allowing prospective enrollees to view the directories.²⁰

Consumers' reliance on directories to make coverage decisions manifests in three ways. First, some consumers will seek out plans that include specific doctors or medical systems.²¹ Second, the general size of a network, including the number of in-network doctors available within a

Additionally, MCO plans are almost always operated by insurers that also offer private plans. For these reasons, it makes sense to view private plans and MCOs as part of the same ecosystem, and MCO enrollees and private plan enrollees as one group of consumers.

18. See CONSUMERS UNION, *Choice Architecture: Design Decisions that Affect Consumers' Health Plan Choices* 21–22 (2012), https://advocacy.consumerreports.org/wp-content/uploads/2013/02/Choice_Architecture_Report.pdf [<https://perma.cc/4QG9-MMFU>] (describing the importance to consumers of knowing which doctors are in insurers' networks when choosing a plan); CAL. HEALTH CARE FOUND., *Directory Assistance: Maintaining Reliable Provider Directories for Health Plan Shoppers* 3 (2015), <https://www.chcf.org/wp-content/uploads/2017/12/PDF-DirectoryAssistanceProvider.pdf> [<https://perma.cc/R59X-D9R7>] (“In 2013, consumers who were likely to purchase market- place-based coverage were surveyed. More than half of survey participants identified choice of providers as a very important factor influencing their selection of a product.”); see also ERIN AUDREY TAYLOR, KATHERINE GRACE CARMAN, ANDREA LOPEZ, ASHLEY N. MUCHOW, PARISA ROSHAN & CHRISTINE EIBNER, RAND CORP., *CONSUMER DECISIONMAKING IN THE HEALTH CARE MARKETPLACE* xv (2016) (describing consumers' desire to find plans that include their current doctor).
19. CAL. STATE AUDITOR, DEPARTMENT OF HEALTH CARE SERVICES—MILLIONS OF CHILDREN IN MEDI-CAL ARE NOT RECEIVING PREVENTIVE HEALTH SERVICES, Rep. No. 2018–111, at 39 (Mar. 2019).
20. See, e.g., CAL. HEALTH & SAFETY CODE § 1367.27(c)(1) (West 2017) (“The directory or directories shall be accessible without any requirement that an individual seeking the directory information demonstrate coverage with the plan, indicate interest in obtaining coverage with the plan, provide a member identification or policy number, provide any other identifying information, or create or access an account.”).
21. TAYLOR ET AL., *supra* note 18, at xv.

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reasonable distance, is important to consumers.²² The directory listing of the number of doctors accepting new patients in their area is one of the best proxies that consumers have for network size. Third, implicit in consumers' reliance on directories to make purchasing decisions is a belief that the directories are accurate and that the cost of their premiums includes access to reliable directory listings.²³ Had JA, a cancer patient whose experiences will be described in more detail below, known that she would have to call two hundred providers looking for a surgical oncologist before finding a single one who actually was, that fact likely would have affected her choice of plan.²⁴

Overall, false directory entries economically injure all plan enrollees by making coverage seem much more valuable than it is, inducing consumers to unwittingly purchase a "damaged product."²⁵ The fact that directories tend to be approximately fifty percent inaccurate means that insurers are routinely promising consumers fifty percent more access than is actually available, and consumers are, in turn, paying for fifty percent more access than they actually have.²⁶ Directory errors are thus consumer deception on a massive scale, the equivalent of the entire credit card industry routinely charging every consumer double the advertised interest rate.

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22. See Coleman Drake, *What Are Consumers Willing to Pay for a Broad Network Health Plan?: Evidence from Covered California*, 65 J. HEALTH ECON. 63, 64 (2019) (finding that Covered California consumers are willing to pay a mean of approximately \$46 in monthly premiums to enroll in a broad network relative to a narrow network).
 23. See Jay Hancock, *Insurers' Flawed Directories Leave Patients Scrambling for In-Network Doctors*, N.Y. TIMES (Dec. 3, 2016), <https://www.nytimes.com/2016/12/03/us/inaccurate-doctor-directories-insurance-enrollment.html> [<https://perma.cc/9JLK-FBGU>] (describing consumer frustration with inaccurate provider directories).
 24. Email from JE to Abigail Burman (Feb. 23, 2021, 01:46 PM PST) (on file with author).
 25. Jenny Gold, *Affordable Mental Health Care? It's Getting Even Tougher to Access*, KAISER HEALTH NEWS (Nov. 20, 2019), <https://khn.org/news/affordable-mental-health-care-its-getting-even-tougher-to-access> [<https://perma.cc/26K7-NRXF>].
 26. See CMS Phase One Report, *supra* note 11, at 1 (finding that 45.1% of provider listings were inaccurate); CMS Phase Two Report, *supra* note 11, at 1 (finding that 52.2% of provider listings were inaccurate); CMS Phase Three Report, *supra* note 11, at 1 (finding that 48.74% of provider listings were inaccurate).

2. Surprise Billing and Coerced Billing

In addition to the large-scale economic injury resulting from false directory entries inflating the value of insurance plans, directory errors also subject consumers to out-of-network bills. Surprise billing occurs when consumers unknowingly receive care from an out-of-network provider, resulting in a—sometimes significantly—higher medical bill than they would have otherwise received.²⁷ While surprise billing has been the focus of intense political scrutiny, also concerning is a phenomenon I am terming “coerced billing”: when people knowingly receive (more expensive) out-of-network care because, despite their best efforts, they cannot find in-network care. These people are coerced into giving up the benefits of their insurance coverage by the inadequacy of their insurers’ products. Given that more than forty percent of adults would not be able to pay an unexpected \$500 medical bill, both surprise and coerced billing can be devastating for consumers.²⁸

Ghost networks can lead to surprise bills by deceiving consumers about a provider’s network status.²⁹ Like KB, ML received a \$450 bill for a doctor

27. Lunna Lopes, Audrey Kearney & Liz Hamel, *Data Note: Public Worries About and Experience with Surprise Medical Bills*, KAISER FAM. FOUND. (Feb. 28, 2020), <https://www.kff.org/health-costs/poll-finding/data-note-public-worries-about-and-experience-with-surprise-medical-bills/> [<https://perma.cc/9RPT-PQ77>].

28. *Id.*

29. While the recently passed federal No Surprises Act is likely to limit surprise billing, the act is not comprehensive. It applies to emergency care and non-emergency care by an out-of-network provider at an in-network facility. Consolidated Appropriations Act, 2021, H.R. 133, 116th Cong. div. BB § 102 (2020). Thus, patients are still exposed to some surprise bills based on directory errors, such as—for example—a private practice psychologist who is erroneously listed in a directory. See SABRINA CORLETTE & OLIVIA HOPPE, GEO. U. HEALTH POL’Y INST., *NEW YORK’S 2014 LAW TO PROTECT CONSUMERS FROM SURPRISE OUT-OF-NETWORK BILLS MOSTLY WORKING AS INTENDED: RESULTS OF A CASE STUDY 9* (2019) (finding that even after New York adopted a law banning most surprise bills, directory errors continued to result in surprise billing). In theory, the new federal directory accuracy law, which requires insurers to cover as in-network services by providers who are mistakenly listed in directories, could ameliorate these balance bills, but the law appears to rely on patient enforcement—meaning that patients would still receive these types of surprise bills and then be obligated to contest them with their insurer. Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, div. BB § 102 (2020).

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visit even though both her insurer and the doctor had said that the visit would be in-network.³⁰ While ML's insurer was apologetic, they refused to cover the cost.³¹ Meanwhile, the practice persisted in trying to collect the bill, even though they had assured ML they were in her insurer's network, arguing that she had signed a contract to pay for the full cost of her care, regardless of what that cost was.³² ML believes that the matter was only dropped because Hurricane Katrina destroyed the practice's billing information.³³ Similarly, SM's insurer has twice billed her primary care visits as specialist visits, which have higher co-pays, even though her provider is listed as a primary care provider in the insurer's directory. These consumers' experiences are consistent with reports by advocates that directory errors are a significant source of surprise billing.³⁴

Ghost networks can also cause coerced billing, forcing consumers to turn to out-of-network providers and shoulder the associated higher costs because they cannot keep wading through error-filled directories. Although going to an out-of-network provider is technically these consumers' choice, it is usually a choice that is forced at best and unavoidable at worst. For example, KC, who manages her brother's mental health care, gave up on trying to find an in-network psychiatrist because calling potential providers was taking up so much of her time that it was more cost effective to pay out-of-network rates.³⁵ Another consumer was forced to pay for out-of-network psychiatric care when their daughter began experiencing severe mental health issues because they could not find a single in-network therapist.³⁶ Not a single one of her psychiatrists has ever been covered by their insurance, and it costs them approximately \$2,500 per month to pay for her psychiatrist appointments and medications out of pocket.³⁷ These consumers' decisions to seek out-of-network care were technically voluntary, but their hands were forced by false directory information.

30. Facebook message from ML to Abigail Burman (Sept. 10, 2019, 06:29 PM PST) (on file with author).

31. *Id.*

32. *Id.*

33. *Id.*

34. See CORLETTE & HOPPE, *supra* note 29.

35. Email from KC to Abigail Burman (Sept. 11, 2021, 07:34 PM PST) (on file with author).

36. @erinscfe, TWITTER (June 19, 2019, 07:37 PM), <https://twitter.com/erinscfe/status/1141490322851028992> [<https://perma.cc/GJ9R-NBYA>].

37. *Id.*

B. Errors Constrict Access to Health Care

An additional casualty of directory errors is consumers' health. Directory errors make it hard to find an in-network, and thus affordable, provider. Ideally, there should be no gap between when people realize they need to see a doctor and when they are able to schedule an appointment. Ghost networks interrupt this flow, forcing people to either delay care or forgo care entirely. This, to state the obvious, is also bad for public health, weakening the wellbeing and resiliency of entire communities. "Health" is a communal, not individual, metric.

A lot of medical conditions are time-sensitive, and time spent combing through directories risks delays in care. Take the experience of JA, who had an aggressive form of cancer that required immediate, specialized surgery. She scheduled the surgery with an out-of-network surgeon who was an expert in the procedure she needed. But unless she could prove that there was no in-network surgeon who could perform the procedure, her insurer would not cover the surgery, leaving her responsible for the entirety of the \$300,000 bill.³⁸ However, the directory for JA's insurer did not separately list surgical oncologists, offering only a general list of surgeons and oncologists.³⁹ So JA's sister, JE (who was managing relations with her insurer) called JA's insurer to directly ask for a list of surgical oncologists. Of the two hundred doctors that were on the lists supplied by her insurer, only two were surgical oncologists, neither of whom performed the surgery JA needed.⁴⁰ In total, JE spent approximately sixty hours calling providers.⁴¹ Were it not for the fact that JA was willing to pre-emptively schedule an appointment with the out-of-network surgeon, exposing her to hundreds of thousands of dollars in medical bills, this wild goose chase for a provider would have significantly delayed her access to care and imperiled her life. Her insurer's lack of an adequate directory forced her to choose between betting her life or betting her financial security.

Even worse than delayed care, directory errors may mean that people do not seek care at all. As described above, JI spent years trying to find an in-network mental health provider. She finally had to see an out-of-network provider, and her parents were luckily able to cover the cost. If that hadn't been the case, JI feared that she would have had a "breakdown." In another

38. Email from JE to Abigail Burman (Feb. 23, 2021, 01:46 PM PST).

39. *Id.*

40. *Id.*

41. *Id.*; Email from JE to Abigail Burman (Sept. 11, 2019, 05:09 PM PST).

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case, a parent struggled to find an in-network psychiatrist for her son who was hearing voices. Despite calling countless psychiatrists who supposedly took her insurance, she was unable to find one. One day before the nineteen-year-old got help, the police were called to the home because he locked himself in his room and was yelling. He struck a police officer and was arrested.⁴²

Unsurprisingly, “[t]he more frustrated people become as they are trying to access care, the more likely they are to defer or forgo care, or to choose more expensive options such as emergency departments.”⁴³

C. Errors Undermine Regulation of the Health Insurance Market

Inaccurate provider directories hamstring the ability of both consumers and the government to effectively regulate (and thus to protect consumers in) health care markets. In theory, both consumers and the government regulate America’s health care market. Consumers shop for the best health care plans and seek out low-cost care, pushing down health care costs. In turn, government regulators protect consumers by establishing minimum standards for insurers. However, without accurate directories, patients cannot effectively shop for individual procedures or health plans. Directories are also a key tool for regulators, who cannot fully assess network adequacy without them. Directory errors thus erode two key guardrails for health plans’ cost and quality.

Although health care is practically and morally distinct from almost every other market good,⁴⁴ much of the American health care system is still

42. Jack Turban, *Ghost Networks of Psychiatrists Hinder Patients’ Access to Care*, STAT (June 17, 2019), <https://www.statnews.com/2019/06/17/ghost-networks-psychiatrists-hinder-patient-care/> [<https://perma.cc/24GJ-8V7S>].

43. Simon F. Haeder, David L. Weimer & Dana B. Mukamel, *Secret Shoppers Find Access to Providers and Network Accuracy Lacking for Those in Marketplace and Commercial Plans*, 35 HEALTH AFFS. 1160, 1165 (2016).

44. Among other differences, demand for health care is relatively inelastic, meaning that demand tends to remain steady regardless of price. JEANNE S. RINGEL, SUSAN D. HOSEK, BEN A. VOLLAARD & SERGEI MAHNOVSKI, NAT’L DEF. RES. INST., RAND HEALTH, *THE ELASTICITY OF DEMAND FOR HEALTH CARE* xi (2002). This inelasticity is unsurprising given that not purchasing health care, unlike other goods such as a car, can lead to a significantly worse quality of life or even death. Consumers also sometimes do not have the option to *not* purchase health care, because of the severity of their injuries or the structure of the health care system. *See, e.g.*, Sarah Kliff, *A \$20,243 Bike Crash: Zuckerberg*

premised on the idea that health care prices respond to supply and demand.⁴⁵ In particular, a number of policies assume that making patients bear some costs for their health care will encourage them to shop for cheaper care, driving down health care spending overall and discouraging patients from seeking unnecessary care.⁴⁶ The structure of the ACA is one example of this phenomenon, with state ACA exchange consumers encouraged to “shop” for a new plan every year during the open enrollment

Hospital's Aggressive Tactics Leave Patients with Big Bills, Vox (Jan. 7, 2019, 04:27 PM EST), <https://www.vox.com/policy-and-politics/2019/1/7/18137967/er-bills-zuckerberg-san-francisco-general-hospital> [https://perma.cc/TN8Y-9HH2] (telling the story of a patient who was taken to an emergency room when she was not lucid and received a bill of more than \$20,000). Health care is also impossible to price before purchasing. See Rachel Bluth, *Bill Of The Month: Estimate For Cost Of Hernia Surgery Misses The Mark*, NPR (Aug. 29, 2019, 12:07 PM EST), <https://www.npr.org/sections/health-shots/2019/08/29/753506549/bill-of-the-month-estimate-for-cost-of-hernia-surgery-misses-the-mark> [https://perma.cc/UQJ6-J39C] (“Hospital estimates are often inaccurate and there is no legal obligation that they be correct, or even be issued in good faith. It’s not so in other industries. When you take out a mortgage, for instance, the lender’s estimate of origination charges has to be accurate by law; even closing fees—incur months later—cannot exceed the initial estimate by more than 10%. In construction or home remodeling, while estimates are not legal contracts, failure to live up to them can be a basis for liability or a “claim for negligent misrepresentation.”).

Health care is also, unlike most consumer goods and services, a human right. Tedros Adhanom Ghebreyesus, *Health Is a Fundamental Human Right*, WORLD HEALTH ORG. (Dec. 10, 2017), <http://www.who.int/mediacentre/news/statements/fundamental-human-right/en/> [https://perma.cc/HM97-9TV4].

45. See Anna D. Sinaiko & Richard A. Hirth, *Consumers, Health Insurance and Dominated Choices*, 30 J. HEALTH ECON. 450, 450 (2011).
46. See Ateev Mehrotra et al., *Americans Support Price Shopping for Health Care, But Few Actually Seek Out Price Information*, 36 HEALTH AFFS. 1392, 1392 (2017) (“One assumption underlying the shift of costs to patients is that greater financial responsibility (‘skin in the game’) will drive people to seek lower-cost care.”); David Anderson, *Are You Open? Directory Problems in Medicare Advantage*, BALLOON JUICE (Dec. 4, 2018, 7:20 AM), <https://www.balloon-juice.com/2018/12/04/are-you-open-directory-problems-in-medicare-advantage/> [https://perma.cc/34AV-CLEV] (describing the Medicare Advantage market as “an environment where we expect the individual buyer to assert market discipline on insurance premiums and medical costs in general”).

period.⁴⁷ Within American health care policy, the imperatives of the market function as both a justification and an excuse for spiraling consumer health care costs: patients must bear some costs to keep prices from rising even higher, while the individuals who face high out-of-pocket costs would have paid less if they were more willing to comparison shop.

Many studies have already demonstrated that shifting health care decision-making and costs to consumers does not effectively constrain health care costs, but whatever justification remains for viewing health care consumers as shoppers in a competitive market entirely collapses if the catalogue consumers are using—the provider directory—does not correctly state the products offered or their prices.⁴⁸ As explored in the

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47. Alice M. Rivlin, *People Who Wanted Market-Driven Health Care Now Have it in the Affordable Care Act*, BROOKINGS INST. (Nov. 21, 2014), <https://www.brookings.edu/opinions/people-who-wanted-market-driven-health-care-now-have-it-in-the-affordable-care-act> [https://perma.cc/9LXL-EHLR] (describing the ACA's structural reliance on markets).
48. See Michael Chernew, Zack Cooper, Eugene Larsen-Hallock & Fiona Scott Morton, *Are Health Care Services Shoppable? Evidence from the Consumption of Lower-Limb MRI Scans* 10–11 (Nat'l Bureau of Econ. Rsch., Working Paper No. 24869, 2018) (finding that consumers are not effective shoppers for lower-limb MRIs, with provider recommendations playing a greater role than patient's cost-sharing responsibilities and locations in determining where patients receive the MRIs); Jason T. Abaluck & Jonathan Gruber, *Choice Inconsistencies Among the Elderly: Evidence from Plan Choice in the Medicare Part D Program 2* (Nat'l Bureau of Econ. Rsch., Working Paper No. 14759, 2009) (finding that “the vast majority of elders are choosing plans that are not on the ‘efficient portfolio’ of plan choice in the sense that an alternative plan offers better risk protection at a lower cost”); Saurabh Bhargava, George Loewenstein & Justin Sydnor, *Choose to Lose: Health Plan Choices from a Menu with Dominated Option*, 132 Q.J. ECON. 1319, 1319 (2017) (finding that in a market where plan benefits were identical a significant number of consumers, particularly low-income consumers, chose plans whose overall cost was higher than other available plans); J. Michael McWilliams, Christopher C. Afendulis, Thomas G. McGuire & Bruce E. Landon, *Complex Medicare Advantage Choices May Overwhelm Seniors—Especially Those With Impaired Decision Making*, 30 HEALTH AFFS. 1786, 1786 (2011) (“Elderly adults with low cognitive function were less responsive to the generosity of available benefits than those with high cognitive function when choosing between traditional Medicare and Medicare Advantage.”); Tal Gross, Timothy Layton & Daniel Prinz, *The Liquidity Sensitivity of Healthcare Consumption: Evidence from Social Security Payments* 17, 37 (Nat'l Bureau of Econ. Rsch., Working Paper No. 27977, 2020) (finding that the existence of co-payments for drugs causes

previous section, if consumers think that providers and facilities are in-network when they in fact are not, consumers are being misled about the overall size of their plan's network. This, in turn, leads consumers to overvalue plans relative to the coverage they actually provide. And because consumers are not reacting to the actual networks and attendant care offered by health plans, there is no way for their decisions to impose a market penalty on plans that offer substandard networks. Additionally, consumers have no way of knowing whether directories are accurate before they sign up, since no directory accuracy policies require regular, publicly released accuracy surveys, so consumers cannot choose to avoid plans with inaccurate directories, forcing the market to self-correct and improve directory accuracy. Consumers cannot punish plans with anti-consumer practices that restrict access to health care, because they have no way of identifying which plans those are, so plans can continue those practices with no consequences for their bottom line. Consumer-driven market regulation is already showing itself to be a failed experiment, but it tips into the realm of complete absurdity if consumer decisions are based on falsehoods.

In theory, government regulators could compensate for the ineffectiveness of regulation by consumer choice, but directory errors also undermine regulators' attempts to reign in insurance markets. Just as they are for consumers, provider networks are an area of intense focus for regulators, who rely on accurate directories to fully enforce network adequacy regulations. State and federal network adequacy regulations are intended to ensure that plans' networks contain enough providers and facilities in enough locations to actually meet the health needs of all their beneficiaries.⁴⁹ Network adequacy regulations have become particularly

Medicare beneficiaries to forgo essential medications that "that lead to severe, short-term consequences if patients do not adhere to their prescriptions," and suggesting that "the conventional view of moral hazard overstates the welfare loss from inefficient over-consumption under generous coverage"); Gerard F. Anderson, Uwe E. Reinhardt, Peter S. Hussey & Varduhi Petrosyan, *It's The Prices, Stupid: Why The United States Is So Different From Other Countries*, 22 HEALTH AFFS. 89–90 (2003) (explaining that America's higher health care spending relative to other countries is driven not by higher use of health care but by the fact that health care services have higher prices).

49. See Justin Giovannelli & Ashley Williams, *Regulation of Narrow Networks: With Federal Protections in Jeopardy, State Approaches Take on Added Significance*, TO THE POINT (Feb. 2, 2017), <https://www.commonwealthfund.org/blog/2017/regulation-narrow-networks-federal-protections-jeopardy-state-approaches-take-added> [<https://perma.cc/J69H-EBPL>] (describing state and federal network adequacy approaches).

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important as the number of “narrow network” plans, plans with lower premiums but fewer in-network providers, has risen over the last few years.⁵⁰ However, without accurate directories, it is much harder for regulators to enforce network adequacy regulations.⁵¹ Nineteen percent of state insurance regulators report relying on provider surveys to assess network adequacy, surveys that require accurate lists of which doctors are in-network, accepting new patients, and available for appointments in order to be effective.⁵² If directories are inaccurate regulators have no complete list of which providers and facilities are in plans’ networks, and thus cannot assess the ratio of facilities and providers to beneficiaries or where in a plan’s coverage area the facilities and providers are located.⁵³ Provider directories are heavily intertwined with consumer choices, regulatory enforcement, and enrollee access to care. Any directory failure thus reverberates through the entire health care system.

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50. Shelby Livingston, *Most ACA Exchange Plans Feature a Narrow Network*, MODERN HEALTHCARE (Dec. 4, 2018, 12:00 AM), <https://www.modernhealthcare.com/article/20181204/NEWS/181209976/most-aca-exchange-plans-feature-a-narrow-network> [<https://perma.cc/6JQW-JGJS>].
 51. Simon F. Haeder, David L. Weimer & Dana B. Mukamel, *A Knotty Problem: Consumer Access and the Regulation of Provider Networks*, 44 J. HEALTH POL., POL’Y & L. 937, 938–40 (describing the importance of accurate provider data for network accuracy regulation).
 52. Christine Barber et al., *Ensuring Consumers’ Access to Care: Network Adequacy State Insurance Survey Findings and Recommendations for Regulatory Reforms in a Changing Insurance Market*, NAIC 25 (2014), https://www.naic.org/documents/committees_conliaison_network_adequacy_report.pdf [<https://perma.cc/BU53-688K>]; Susan H. Busch & Kelly A. Kyanko, *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*, 39 HEALTH AFFS. 975 (2020) (noting that “many [state measures of network adequacy] rely on directory data”). See also *Provider Directory Data Quality*, INST. FOR CHILD HEALTH POL’Y AT THE U. OF FLA. 3 (Dec. 2018), <https://www.hhs.texas.gov/sites/default/files/documents/about-hhs/process-improvement/quality-efficiency-improvement/provider-directory-data-quality-issues-best-practices.pdf> [<https://perma.cc/GFV9-35KE>] (explaining that Texas’ process for assuring compliance with timely access standards depends on provider directory data).
 53. Haeder et al., *supra* note 43, at 1165.

D. Errors Heighten Existing Structural and Institutional Inequalities

The harms of ghost networks are compounded by the fact that these harms disproportionately burden marginalized groups. Paying unexpected bills or paying for out-of-network care requires money, which low-income people, particularly those who are part of communities of color or are disabled, are less likely to have. Furthermore, women and people seeking mental health care are more likely to be affected by directory errors because of, respectively, the frequency of their interactions with provider directories and insurers' failure to comply with the Mental Health Parity and Addition Equity Act (MHPAEA). Directory errors thus stand at the intersection of consumer protection and social justice. Many people will, at some point in their lives, be a patient, and many people will also care for a patient, but ghost networks—like so many deep inequalities in American health care—ensure that people's experience of the health care system is highly dependent on their socioeconomic status.⁵⁴

Unsurprisingly, given the financial toll of directory errors, directory errors are particularly dangerous for lower-income people. Four in ten Americans would be unable to pay an unexpected \$400 bill in cash, and to cover it they would instead have to go into debt or sell something.⁵⁵ For low-income consumers, receiving a surprise \$700 medical bill like the one KB got or having to pay out of pocket to see a provider because they cannot find one that accepts their insurance could be catastrophic.⁵⁶ One hundred and thirty-seven million Americans experience medical financial hardship each

54. These disparities have been thrown into particularly stark relief by the COVID-19 pandemic. Leana S. Wen & Nakisa B. Sadeghi, *Addressing Racial Health Disparities in the COVID-19 Pandemic: Immediate and Long-Term Policy Solutions*, HEALTH AFFS. (July 20, 2020), <https://www.healthaffairs.org/doi/10.1377/hblog20200716.620294/full> [https://perma.cc/M3GT-D994]; Monita Karmakar, Paula M. Lantz & Renuka Tipirneni, *Association of Social and Demographic Factors with COVID-19 Incidence and Death Rates in the US*, JAMA NETWORK OPEN (Jan. 29, 2021), <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2775732> [https://perma.cc/L29F-PKWA].

55. Consumer & Cmty. Dev. Rsch. Section, *Report on the Economic Well-Being of U.S. Households in 2017*, BD. OF GOVERNORS OF THE FED. RESRV. SYS. 2 (May 2018), <https://www.federalreserve.gov/publications/files/2017-report-economic-well-being-us-households-201805.pdf> [https://perma.cc/PZQ8-DX5W].

56. *Id.* Email from KB to Abigail Burman, *supra* note 2.

year, and medical debt is a contributing factor in sixty-two percent of personal bankruptcies.⁵⁷

Compounding the danger that directory errors pose to low-income consumers is the structure of ACA exchange plans, which predominantly enroll people with incomes under four hundred percent of the federal poverty level.⁵⁸ Typically, exchange consumers can only purchase exchange plans once a year, during their state's open enrollment period.⁵⁹ States have the ability to open their own special enrollment periods (SEPs) or request SEPs from the federal Department of Health and Human Services (for states that do not run their own exchanges) in response to directory errors. However, directory error-related SEPs are discretionary.⁶⁰ So, if an SEP is not opened, exchange consumers who find that their plan falsely advertised the extent of its network remain locked into substandard coverage for the rest of the coverage year, forced to wait until next year's open enrollment period to enroll in a new plan.⁶¹

57. Yabroff et al., *supra* note 16; Himmelstein et al., *supra* note 16.

58. *Health Insurance Exchanges 2018 Open Enrollment Period Final Report*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Apr. 3, 2018), <https://www.cms.gov/newsroom/fact-sheets/health-insurance-exchanges-2018-open-enrollment-period-final-report> [<https://perma.cc/42EY-LE65>].

59. *SEP Reference Chart*, HEALTH REFORM: BEYOND THE BASICS (Feb. 2019; last updated Sept. 2021), <http://www.healthreformbeyondthebasics.org/sep-reference-chart> [<https://perma.cc/X6S5-B3BA>].

60. See Andy Miller, *Georgia Seeks New Enrollment for Patients Caught in WellStar, Anthem Contract Rift*, 90.1 FM WABE (Mar. 19, 2019), <https://www.wabe.org/georgia-seeks-new-enrollment-for-patients-caught-in-wellstar-anthem-contract-rift> [<https://perma.cc/P2Q7-SSAT>] (describing Georgia's request for a special enrollment period, which was never granted).

61. This is precisely what happened to a number of Georgia exchange consumers in 2019. Anthem Blue Cross Blue Shield had sold exchange plans that included the WellStar hospital system in their directories, and a number of people purchased Anthem plans on the basis of that inclusion during the November and December 2018 open enrollment period. Andy Miller, *Patients 'Frustrated' as WellStar, Anthem Near End of Contract*, GA. HEALTH NEWS (Jan. 28, 2019), <https://www.georgiahealthnews.com/2019/01/patients-frustrated-wellstar-anthem-contract> [<https://perma.cc/M9VA-7AWX>]. However, as Anthem had known since August 2018, WellStar had decided to not renew its contract with Anthem, so as of February 2019—just two months into plans' coverage period—WellStar was no longer in-network for Anthem exchange customers. *Id.* As noted, while the state requested an SEP from HHS, the request was never granted. Miller, *supra* note 60.

The financial dangers of ghost networks are also particularly acute for communities of color, especially Black communities. Overall, communities of color have less household wealth than White Americans, making them much less able to absorb unexpected health care costs.⁶² Thirty-one percent of Black Americans have past-due medical debt, compared to twenty-three percent of White Americans.⁶³ And Black Americans' past-due bills are twice as likely to be turned over to a collection agency than White Americans, exposing them to predatory debt-collection practices.⁶⁴ Hispanic Americans are also significantly more likely than White Americans to report having a medical debt turned over to collections.⁶⁵ Furthermore, Black Americans are seventeen percent more likely than White Americans to report difficulty paying for basic necessities because of the cost of health care.⁶⁶ But not only do consumers of color have fewer financial resources with which to combat ghost networks, they also have less time. Visits to the doctor take people of color twenty-five percent longer than White people, a disparity that is due not to increased time with the doctor but rather due to increased time waiting and completing administrative tasks.⁶⁷

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62. Neil Bhutta, Andrew C. Chang, Lisa J. Dettling & Joanne W. Hsu, *Disparities in Wealth by Race and Ethnicity in the 2019 Survey of Consumer Finances*, BD. OF GOVERNORS OF THE FED. RESRV. SYS. (Sept. 28, 2020) <https://www.federalreserve.gov/econres/notes/feds-notes/disparities-in-wealth-by-race-and-ethnicity-in-the-2019-survey-of-consumer-finances-20200928.htm> [<https://perma.cc/Y9ZN-98HV>].
63. Signe-Mary McKernan, Steven Brown & Genevieve M. Kenney, *Past-Due Medical Debt a Problem, Especially for Black Americans*, URB. INST. (Mar. 27, 2017), <https://www.urban.org/urban-wire/past-due-medical-debt-problem-especially-black-americans> [<https://perma.cc/JGL7-QA6S>].
64. NORC AT THE U. CHI., *Americans' Views of Healthcare Costs, Coverage, and Policy* (Mar. 2018), <https://www.norc.org/PDFs/WHI%20Healthcare%20Costs%20Coverage%20and%20Policy/WHI%20Healthcare%20Costs%20Coverage%20and%20Policy%20Issue%20Brief.pdf> [<https://perma.cc/LME6-G5NB>].
65. *Id.*
66. *Id.*
67. Kristin N. Ray, Amalavoyal V. Chari, John Engberg, Marnie Bertolet & Ateev Mehrotra, *Disparities in Time Spent Seeking Medical Care in the United States*, 175 JAMA INTERNAL MED. 1983 (2015). See also Annie Lowrey, *The Time Tax*, ATLANTIC (Jul. 27, 2021), <https://www.theatlantic.com/politics/archive/2021/07/how-government-learned-waste-your-time-tax/619568> [<https://perma.cc/H7G5-WWXd>] (explaining the enormous amount of time and effort required to navigate social safety net programs).

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Another group disproportionately impacted by directory errors is people with disabilities. Like Americans of color, Americans with disabilities have less household wealth, making them less able to absorb unexpected medical costs.⁶⁸ Adults with disabilities are more than twice as likely than adults without disabilities to report skipping or delaying health care because of the cost.⁶⁹ Adults with disabilities are also more likely to experience poor health and use health care at high rates (a disparity that is partially tied to discrimination by health care systems and professionals).⁷⁰ They are thus both more likely to have to seek out doctors and encounter ghost networks, costing them valuable time and energy, and to suffer financial harm from insurers' misrepresentations of their network breadth, since people with higher health needs may be more likely to pay higher premiums in exchange for a broader insurance network.⁷¹

Likewise, directory errors disproportionately affect women, who are more likely than men to manage relatives' care in addition to their own and are thus more likely to encounter directory errors.⁷² Inaccurate directories

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68. Nanette Goodman, Bonnie O'Day & Michael Morris, *Financial Capability of Adults with Disabilities*, NAT'L DISABILITY INST. 15 (2017), <https://www.nationaldisabilityinstitute.org/wp-content/uploads/2019/01/ndi-finra-report-2017.pdf> [<https://perma.cc/G8EB-N5LP>].
 69. Gloria L. Krahn, Deborah Klein Walker & Rosaly Correa-De-Araujo, *Persons With Disabilities as an Unrecognized Health Disparity Population*, 105 AM. J. PUB. HEALTH S198 (2015).
 70. *The Current State of Health Care for People with Disabilities*, NAT'L COUNCIL ON DISABILITIES 23 (2009), <https://files.eric.ed.gov/fulltext/ED507726.pdf> [<https://perma.cc/H5LW-UKQM>]; Lisa I. Iezzoni, Sowmya R. Rao, Julie Ressler, Dragana Bolcic-Jankovic, Nicole D. Agarannik, Karen Donelan, Tara Lagu & Eric G. Campbell, *Physicians' Perceptions of People with Disability and Their Health Care*, 40 HEALTH AFFS. 297, 297 (2021) (exploring the deeply discriminatory beliefs that doctors have about people with disabilities and doctors' failure to welcome people with disabilities into their practices).
 71. Coleman Drake, *What Are Consumers Willing to Pay for a Broad Network Health Plan?: Evidence from Covered California*, 65 J. HEALTH ECON. 63, 74 (2019).
 72. See Nidhi Sharma, Subho Chakrabarti & Sandeep Grover, *Gender Differences in Caregiving among Family - Caregivers of People with Mental Illnesses*, 6 WORLD J. PSYCHIATRY 7 (2016) (explaining that women are more likely than men to be informal caregivers for people with mental illnesses); Angelina Grigoryeva, *When Gender Trumps Everything: The Division of Parent Care among Siblings*, (Ctr. for the Study of Soc. Org., Working Paper No. 9, 2014),

mean that patients often cannot find an in-network provider unless they have the time, energy, and organization to make dozens of calls. All of those are hard to muster for people with health conditions, making it even more likely that the labor of dealing with directory inaccuracies will fall on female relatives. While there is no data directly assessing how directory errors, an already understudied issue, affect the work of caregiving, anecdotes indicate that errors can create a substantial burden for caregivers. As KC—who has spent years trying to find a psychiatrist for her brother—explained, “[i]ronically, I can’t imagine my brother or others in his situation being organized and effective enough to be able to make all these calls and keep track.”⁷³ By failing to ensure directory accuracy, insurers are functionally outsourcing the work of auditing their directories to millions of unpaid female caregivers.

Lastly, people seeking mental health care, a specialty where directory errors are particularly common, are disproportionately harmed by directory errors.⁷⁴ Rather than complying with MHPAEA, which requires equivalent treatment of behavioral and physical health, some insurers have used ghost networks of mental health providers to skirt parity requirements.⁷⁵ While insurers cannot explicitly refuse to cover mental

<https://www.thefyi.org/wp-content/uploads/2020/05/wp9-grigoryeva.pdf> [<https://perma.cc/D2KS-PVUN>] (finding that women are twice as likely as men to act as caregivers for their parents).

73. Email from KC to Abigail Burman (Sept. 11, 2019, 06:40 PM PST) (on file with author).

74. Am. Psychiatric Ass’n, *supra* note 12.

75. Mark Moran, *Enforcement of Parity Law Broadens to Include New Areas of Insurer Violations*, PSYCHIATRIC NEWS (May 12, 2017), <https://psychnews.psychiatryonline.org/doi/abs/10.1176/appi.pn.2017.5b30> [<https://perma.cc/3KGB-5KDU>].

Additionally, ghost networks may themselves represent parity violations, not just attempts to evade parity. Network adequacy is considered a nonquantitative treatment limit (NQTL) under MHPAEA and so must reflect insurer practices that are comparable to and no more stringent than those used for medical and surgical benefits. 45 C.F.R. § 146.136(c)(4)(i) (2021). Provider directories are a component of network adequacy, so directory errors may themselves signal parity violations. See Steve Melek & Stoddard Davenport, *Nonquantitative Treatment Limitation Analyses to Assess MHPAEA Compliance: A Uniform Approach Emerges*, MILLIMAN 5 (2019), http://www.mhtari.org/NQTL_Guidelines_White_Paper_10-07-19.pdf [<https://perma.cc/8TN9-BZ88>] (describing directory accuracy as a “key”

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health care, by making it extremely difficult to access within their networks they can achieve much the same effect. And people are extremely likely to encounter directory errors when searching for mental health care. For California Blue Cross's Medicaid Managed Care Organization⁷⁶ (MCO) plans, non-psychiatrist specialists had an information error rate of fifteen percent, while psychiatrists' error rate was a stunning forty-five percent.⁷⁷ But even that error rate pales in comparison to the rate for Molina's California plans. Eighty percent of Molina listings for psychiatrists had errors, relative to fifty

NQTL and source of data for assessing whether plans are complying with parity requirements); *FAQs about Mental Health and Substance Use Disorder Parity Implementation and the 21st Century Cures Act Part 39*, DEP'T OF LAB. (Sept. 2019), <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-39-final.pdf> [<https://perma.cc/MU9J-TKR5>] (clarifying that ERISA plans are required to provide accurate, complete directories).

76. Managed care organizations are a method of delivering government health benefits, particularly Medicaid and Medicare. Unlike traditional fee-for-service benefits where the government directly pays providers, in the MCO model, the government pays private companies a "capitation" rate per enrollee and the MCO is responsible for paying providers.
77. These statistics, like all of the California survey data, were derived from the raw data of the timely access surveys that all California providers are required to complete every year. I obtained the data through a public records request. The data collection requirements and survey process are explained in more detail in Section II.A.

These data are distinct from directory data because they reflect insurers' internal provider listings rather than the externally-facing directories. However, they are highly analogous because the criteria for inclusion in the sample overlap with categories of information that directories are required to display, so the data from the sample should (if plans are properly updating their directories) match the data in the directories. Additionally, the data count each location that a provider practices at and each plan a provider is in-network for as distinct data points. So, for example, if a provider is enrolled in three plans and practices at three locations, that provider has nine data points (one for every plan/location) combination. This approach makes sense from a consumer point of view because when consumers are using directories, the particular plans and locations that providers practice at, not just the number of available providers, are important information. Additionally, in practice, that consumer will likely have to call three locations, not one provider, to find out if they can get an appointment.

percent for non-psychiatrist specialists.⁷⁸ So a consumer using Molina's own list of doctors who take enrollee appointments would be able to actually access psychiatric care through the directory just twenty percent of the time.⁷⁹ Faced with the low odds of finding an in-network practitioner, out-of-network care, expensive though it is, may be the only option. Indeed, a study of people who had used their insurers' provider directory to find mental health care found that those who encountered directory errors were twice as likely to have been treated by an out-of-network provider.⁸⁰

While consumers could theoretically compensate for directory errors by using search engines and phone calls to conduct their own ad hoc directory audit, this is a solution that does not account for the many consumers who are older and uncomfortable with technology, lack adequate internet access, work jobs where they cannot easily make repeated phone calls during work hours, are not fluent English speakers, or simply lack the time and energy to continue tracking down doctors.⁸¹ For some consumers, making even one phone call to a provider requires a tremendous amount of wherewithal, so making a second to a different

78. *Infra* notes 110–112 and accompanying text. The California directory data are generally able to identify phone number, specialty, appointment availability, in-network status, and some address errors. These data and their limits are discussed in more detail below.

79. *Id.*

80. Susan H. Busch & Kelly A. Kyanko, *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*, 39 HEALTH AFFS. 975 (2020).

81. See @kelsaroniandchz, TWITTER (Jan. 9, 2021, 11:37 AM), <https://twitter.com/kelsaroniandchz/status/1347945553729097728> [<https://perma.cc/99P9-AFJF>] (“Honestly, expecting someone that is too depressed to get out of bed to spend the time to look up therapists in network, call as many as it takes to find availability, and set an appointment is just asking way too much.”); @threespiritfit, TWITTER (July 23, 2019, 02:33 PM), <https://twitter.com/threespiritfit/status/1153734969153544193> [<https://perma.cc/LH7G-WUKB>] (“i have just spent 50 minutes calling places listed in my health insurance directory trying to find someone to test my oldest for learning disabilities. NONE OF THEM DO IT. none of them. can you imagine if i didn't have a day off, have computer access in my home, have a phone?”).

phone number may feel out of reach entirely.⁸² And the entire process must begin again every time a consumer needs a new doctor, requiring yet more time and effort. As CMS pointed out in its directory audit review, even contact information errors (the type of error that is the easiest to identify using outside resources) can obstruct consumers' access to care.⁸³ Every directory error represents a hurdle that a person in need of care may not be able to overcome.

The American health care system consistently fails people from marginalized groups, and directory errors contribute to this failure. Low-income people, people of color, women and gender minorities, LGBTQ people, people with disabilities, and people who stand at the intersection of these identities receive worse health care and have worse health outcomes.⁸⁴ Ensuring that these people can actually find a provider, rather

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82. @poetrybygab, TWITTER (Apr. 12, 2021, 10:23 AM), <https://twitter.com/poetrybygab/status/1381613851616104449> [<https://perma.cc/VM5T-M3VE>] (“When you overcome the executive functioning issues / social anxiety / inattention / forgetfulness to call and make an appointment with a doctor only to find out they’re not accepting new patients”).
83. *Online Provider Directory Review Report*, CTRS. FOR MEDICARE & MEDICAID SERVS. 7 (Jan. 2018), https://www.cms.gov/Medicare/Health-Plans/Managed-CareMarketing/Downloads/Provider_Directory_Review_Industry_Report_Year2_Final_1-19-18.pdf [<https://perma.cc/R5LM-DXWW>].
84. See Camille Noe Pagán, *When Doctors Downplay Women’s Health Concerns*, N.Y. TIMES (May 3, 2018), <https://www.nytimes.com/2018/05/03/well/live/when-doctors-downplay-womens-health-concerns.html> [<https://perma.cc/W5ZE-MFHR>]; Press Association, *Women 50% More Likely to Be Misdiagnosed after Heart Attack – Study*, GUARDIAN (Aug. 29, 2016), <https://www.theguardian.com/society/2016/aug/30/women-50-more-likely-to-be-misdiagnosed-after-heart-attack-study> [<https://perma.cc/BG54-TU4R>]; Kimberly R. Jacob Arriola, Christina P.C. Borba & Winifred Wilkins Thompson, *The Health Status of Black Women: Breaking through the Glass Ceiling*, 1 BLACK WOMEN, GENDER & FAMS. 1 (2007); Peter J. Cunningham, *Why Even Healthy Low-Income People Have Greater Health Risks than Higher-Income People*, COMMONWEALTH FUND (Sept. 27, 2018), <https://www.commonwealthfund.org/blog/2018/healthy-low-income-people-greater-health-risks> [<https://perma.cc/J4WF-KNSG>]; Jake Miller, *On the Margins*, HARV. MED., <https://hms.harvard.edu/magazine/lgbtq-health/margins> [<https://perma.cc/8JMM-XMDB>]; Andrés J. Gallegos, *Misperceptions of People with Disabilities Lead to Low-Quality Care: How Policy Makers Can Counter the Harm and Injustice*, HEALTH AFFS. (Apr. 1, 2021), <https://www.healthaffairs.org/doi/10.1377/hblog20210325.480382/full> [<https://perma.cc/4XHQ-V6U7>].

than getting trapped in an endless cycle of wrong numbers and calls that are not returned, will not fix the health care system's deep inequalities, but it would be one small step towards a more just system of care.

II. EXISTING DIRECTORY ACCURACY POLICIES FAIL TO PROTECT CONSUMERS

Responsibility for regulating provider directories—under both state and federal law—has largely fallen on states, “the primary enforcers of both federal and state health insurance regulations in the individual market.”⁸⁵ While federal law now requires all private plans to provide accurate directories,⁸⁶ and there are specific federal accuracy requirements for marketplace⁸⁷, Medicaid⁸⁸, and Medicare Advantage⁸⁹ plans, the federal government only actively enforces the Medicare Advantage directory accuracy requirements.⁹⁰ The federal directory accuracy laws also contains no private right of action, which would be necessary for individuals to enforce directory accuracy provisions.⁹¹ As a result, states are left to enforce

85. Christine H. Monahan, *Private Enforcement of the Affordable Care Act: Toward an Implied Warranty of Legality in Health Insurance*, 126 YALE L.J. 1118, 1129 (2017).

86. Consolidated Appropriations Act, 2021, Div. BB § 116, Pub. L. No. 116-230, 134 Stat. 1182, 2878-88 (2020).

87. 45 C.F.R. § 156.230(b) (2021).

88. 42 C.F.R. § 438.10(h)(1) (2021).

89. 42 C.F.R. § 422.111 (2021).

90. See Phil Galewitz & Susan Jaffe, *21 Medicare Health Plans Warned to Fix Provider Directory Errors*, KAISER HEALTH NEWS (Jan. 18, 2017), <https://khn.org/news/21-medicare-health-plans-warned-to-fix-provider-directory-errors> [<https://perma.cc/X9P9-NUP2>].

For private insurers, the federal government steps in only if a state has not “substantially enforce[d]” federal regulations. 42 U.S.C. § 300gg-22(a)(2) (2012). Medicaid regulations likewise place responsibility for enforcement with states, with the Medicaid directory accuracy regulations governing state’s oversight of plans rather than the plans themselves. See 42 CFR § 438.10(h) (2021). See also *Key Federal Program Accountability Requirements in Medicaid Managed Care*, MEDICAID & CHIP PAYMENT & ACCESS COMM’N (MACPAC), <https://www.macpac.gov/subtopic/key-federal-program-accountability-requirements-in-medicare-managed-care> [<https://perma.cc/UN4U-59U2>].

91. *Infra* notes 199–204 and accompanying text.

federal directory standards on their own.⁹² In addition to federal provisions, states can also enforce their own directory accuracy policies.⁹³ As of 2017, twenty-nine states had some form of directory accuracy requirement,⁹⁴ although these requirements vary widely in both scope and stringency.⁹⁵ As with the federal laws, these laws typically contain no private right of action, giving states complete responsibility for their enforcement.⁹⁶

Even though states are the first line of defense in ensuring directory accuracy, states only weakly enforce directory accuracy policies and have failed to meaningfully increase accuracy. This section uses case studies of California, Louisiana, and Maryland⁹⁷ to reveal the deep limitations of existing state approaches to directory accuracy policy. These states were selected because of the availability of state-level directory accuracy data that were collected both prior to or at the beginning of the implementation of directory accuracy policies and after the policies were implemented. These states also provide a useful cross-section of both policy structures and enforcement approaches. But an analysis of state level data shows that, despite the widely differing approaches to policy and regulation, neither California, Louisiana, nor Maryland has managed to attain lasting increases in directories' accuracy, let alone eradicate directory errors.

California's directory accuracy policy is, on paper, one of the most extensive in the country, applying to both private and Medicaid MCO plans, and setting strict standards for directory content and updates. However, the law has been almost entirely unenforced by state regulators, and—as analyzing annual regulatory filings by insurers reveals—provider information errors continue to be rampant. Louisiana recently adopted a

92. Monahan, *supra* note 85, at 1129.

93. See Consolidated Appropriations Act, 2021, Div. BB § 116(a), Pub. L. No. 116-230, 134 Stat. 1182, 2878 (2020) (“Nothing in this section shall be construed to preempt any provision of State law relating to health care provider directories.”).

94. *2017 Provider Directory Laws: State Legislation Wrap-Up and Map*, ZELIS, <https://web.archive.org/web/20201021064737/https://www.zelis.com/resource/2017-provider-directory-laws-state-legislation-wrap-up-and-map/> [https://perma.cc/SL54-ZWGE] (last visited Jan. 19, 2021);

95. B. Hoyt, *Provider Directories: Litigation Regulatory and Operational Challenges*, BERKELEY RSCH. GRP. 4–5 (2015).

96. See, e.g., CAL. HEALTH & SAFETY CODE § 1367.27(q) (2017).

97. These states were selected because they are the only states that both have directory accuracy policies and have publicly available data on plan compliance after the policies were enacted.

directory accuracy policy for private plans, but has also, since 2017, written directory accuracy requirements into state Medicaid MCO plans. To enforce these contract requirements, the state conducts quarterly directory accuracy surveys of MCOs, with plans fined \$50,000 each time they are found to be non-compliant. Nonetheless, after three years of regular surveys and fines, plans have consistently had error rates near fifty percent. Lastly, Maryland, like Louisiana, has both a directory accuracy law and separate directory accuracy standards for Medicaid MCOs. Maryland conducts annual directory accuracy surveys of MCOs but has never issued fines. As with Louisiana and California, Maryland directory accuracy surveys continue to show high error rates.⁹⁸

A. California

California was the first state to adopt a stand-alone directory accuracy law.⁹⁹ The law, SB 137, applies to both private plans and Medicaid MCOs.¹⁰⁰ It requires plans to maintain accurate online and paper directories.¹⁰¹ Plans must update the printed directory at least quarterly and update the online directory at least weekly.¹⁰² The updates must reflect any information that the plan has received about inaccuracies in the directory.¹⁰³ Additionally, at least once a year, plans must review and update the entirety of their directory.¹⁰⁴ If providers do not verify their information, plans must remove the providers from their directory.¹⁰⁵ The law also permits plans to delay payments to providers who do not verify their directory information or terminate provider contracts in cases of repeated failure to verify or update

98. Unfortunately, due to different sampling and survey methods, the data discussed in this section are not comparable between states, and typically also not comparable between years.

99. *Provider Directory Data Quality*, THE INST. FOR CHILD HEALTH POL'Y AT THE U. OF FLA. 5 (Dec. 2018), <https://www.hhs.texas.gov/sites/default/files/documents/about-hhs/process-improvement/quality-efficiency-improvement/provider-directory-data-quality-issues-best-practices.pdf> [<https://perma.cc/GFV9-35KE>].

100. CAL. HEALTH & SAFETY CODE § 1367.27(s) (2017).

101. CAL. HEALTH & SAFETY CODE §§ 1367.27(a)–(d) (2017).

102. CAL. HEALTH & SAFETY CODE §§ 1367.27(d)(2), (e)(1) (2017).

103. CAL. HEALTH & SAFETY CODE § 1367.27(e)(1) (2017).

104. CAL. HEALTH & SAFETY CODE § 1367.27(l) (2017).

105. CAL. HEALTH & SAFETY CODE § 1367.27(l)(4) (2017).

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directory information.¹⁰⁶ The law further protects consumers by establishing a limited hold-harmless provision for consumers who are surprise-billed because of directory errors. If a patient mistakenly goes to an out-of-network provider because of a directory error, the state regulator may require the plan to reimburse the consumer for any costs above what the consumer would have paid to see an in-network provider.¹⁰⁷ Disappointingly, as discussed below, data from insurers and state regulators show that SB 137 has not addressed the prevalence of ghost networks.

Despite SB 137's broad scope and detailed requirements, California continues to have high levels of directory errors. California does not directly collect data about directory errors. However, to comply with California's timely access standards (how long enrollees must wait before getting an appointment with a provider), insurers regulated by the Department of Managed Health Care (DMHC) must submit yearly surveys of all providers that take appointments from enrollees to assess how soon an appointment can be scheduled.¹⁰⁸ DMHC only uses this data to compile timely access reports, but this survey also functions as a directory accuracy survey: the raw data notes when providers could not complete the timely access questionnaire because their address was incorrect, their phone number was incorrect, their specialty was incorrect, they do not take appointments at that location, they are not actually in-network, or they are no longer practicing.¹⁰⁹ Although the data generated from timely access surveys are

106. CAL. HEALTH & SAFETY CODE § 1367.27(p) (2017).

107. CAL. HEALTH & SAFETY CODE § 1367.27(q) (2017).

108. CAL. DEP'T OF MANAGED HEALTHCARE, *Measurement Year 2018 Provider Appointment Availability Survey Methodology*, CAL. HEALTH & HUM. SERVS. AGENCY 4 (Apr. 2018), https://www.dmhc.ca.gov/Portals/0/Docs/OPM/MY%202018%20PAAS%20Methodology_1.pdf, [<https://perma.cc/LD2P-V227>]. This requirement does not apply to plans that exclusively serve Medi-Cal or Medicare Advantage. *Id.* at 3.

While the provider contact lists used for the timely access surveys are not entirely analogous to directories, because they could include providers who are for some reason not listed in the directory, the two can be presumed to be extremely similar since the directory is meant to be the best tool to find providers that are taking patient appointments.

109. *Id.* at 15.

As noted above, this data is distinct from directory data, because it reflects insurers' internal provider listings rather than the externally-facing

subject to limitations, the surveys still provide a valuable snapshot of directory accuracy for California plans.¹¹⁰

Examining error rates across four types of carriers—classic HMO, private ACA and non-ACA, exclusively ACA, and Medicaid—reveals high error¹¹¹ rates across the board. Even the lowest error rate, twenty-one percent, 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 lead to a dead end. As explained above, while consumers can theoretically seek out correct addresses and phone numbers, search engines are at best a partial replacement for accurate directories. Furthermore, all three types of plans had higher error rates for psychiatrists than for other types of specialists, underlining the particular burden placed on people who need behavioral care.

directories. However, it is still highly analogous because the criteria for inclusion in the sample overlap with categories of information that directories are required to display, so the data from the sample (if plans are properly updating their directories) should match the data in the directories.

110. The error rates generated from the timely access surveys should be understood as both overcounts and undercounts. The survey undercounts errors because it does not include detailed questions about providers' addresses and specialty. The survey only verifies providers' addresses at the county level. So, if someone practices at a different address from the one the plan lists, but that address is within the same county as the plan's address, it won't show up in the DMHC data. Likewise, the survey only verifies whether provider's specialty is wrong at a broad level. For example, for primary care providers, the survey only verifies that they are in fact primary care providers. It does not drill down into whether they are pediatricians, geriatricians, or general practice. Additionally, there are very high non-response rates, and it is likely that at least some of those non-responses are due to contact information errors.

But the survey likely also overcounts errors. There is a gap of at least a few months between when the survey contact list is generated and when the survey takes place, meaning that errors either could in theory have been corrected in the directory by the time they're caught in the survey or only developed after the contact list was created.

111. The survey records when providers are not part of the listed network, when providers do not practice in the listed county, when providers' email/phone number is wrong, when providers' specialty is wrong, when providers do not actually provide appointments at all or at the given location, and when providers have retired or otherwise ceased to practice.

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Percent of Surveyed Provider Listings Containing One or More Errors in Measurement Year 2018 ¹¹²				
	Kaiser (Private ACA and non-ACA plans and Medicaid plans)	Blue Cross (Private ACA and non-ACA plans)	Molina* (ACA plans)	California Health and Wellness** (Medicaid plans)
PCPs	12%	23%	54%	39%
NPMHCPs***	38%	20%	60%	43%
Specialists	28%	20%	62%	50%
Psychiatrists	32%	25%	80%	62%

112. The data [on file with author] reflects listings that have a least one error rather than the total number of errors because the survey is terminated as soon as the first error is identified. So, for example, it is entirely possible that a listing that has been flagged for a phone number error might also be for a provider that is not in-network or not practicing at that address, but because the survey would have been terminated once it was established their number is wrong, there is no data about those other errors.

Additionally, the data counts each location that a provider practices at and each plan a provider is in-network for as a distinct listing. So, for example, if a provider is enrolled in three plans and practices at three locations, that provider has nine data points (one for every plan/location) combination. This approach makes sense from a consumer point of view because when consumers are using directories the particular plans and locations that providers practice at, not just the number of available providers, are important information. Additionally, in practice, that consumer will likely have to call three locations, not one provider, to find out if they can get an appointment.

To calculate error percentages, the total number of successful contacts and ineligible contacts for each type of provider were added together, and the percent of total responses that fell into with each ineligibility category (described above in fn. 106) was calculated. The denominator of total

While these error rates are in and of themselves stunningly high, they become even more concerning when compared to accuracy rates before SB 137 took effect—a comparison that fails to show any significant improvement in directory accuracy thanks to SB 137. In 2014, in response to consumer complaints, DMHC surveyed Anthem Blue Cross directories.¹¹³ The survey found that 12.6 percent of Anthem providers did not practice at the location given in the directory, and 1.1 percent of Anthem providers did not actually accept any of the insurers' products.¹¹⁴ In 2018, 12.4 percent of providers did not practice at their listed location and 1.7 percent of providers were not actually in-network.¹¹⁵ The 2014 survey occurred shortly before SB 137, and the 2018 survey occurred after SB 137 had been in effect for three years, but accuracy rates were virtually unchanged.

In addition to struggling with accuracy, insurers are also flouting the provisions of SB 137 that regulate directory display and content. For example, Anthem has largely failed to incorporate providers' state license numbers, as the law requires.¹¹⁶ Aetna's online directory includes state license numbers but does not list a designated email address that consumers can use to report directory inaccuracies, another requirement of

responses does not include instances where contacts went entirely unanswered.

* Molina also has Medi-Cal plans, but this data only reflects their ACA plans.

** A subsidiary of Centene.

*** Non-physician mental health care provider. This is a subcategory created by the California timely access law that includes all mental health care providers except for psychiatrists, who are considered specialists. CAL. HEALTH & SAFETY CODE §§ 1300.67.2.2 (c)(5)(d)–(e).

**** Not including psychiatrists.

113. Chad Terhune, *California Fines Top Health Insurers for Overstating Obamacare Networks*, L.A. TIMES (Nov. 3, 2015), <https://www.latimes.com/business/healthcare/la-fi-obamacare-network-probe-20151103-story.html> [<https://perma.cc/AR9P-WMFC>].
114. CAL. DEP'T OF MANAGED HEALTHCARE, FINAL REPORT: NON-ROUTINE SURVEY OF ANTHEM BLUE CROSS, A FULL SERVICE HEALTH PLAN 6 (Nov. 7, 2014).
115. Anthem Blue Cross 2018 Provider Appointment Availability Survey, raw data.
116. Letter from Jodi Black, Vice President, Ctr. for Econ. Servs. Cal. Med. Ass'n, to Shelley Rouillard, Director, Dep't of Managed Health Care, regarding Anthem Blue Cross Violations of Health & Safety Code §1367.27 (Feb. 26, 2020), <https://www.cmadocs.org/Portals/CMA/files/public/DMHC%20Complaint%20Anthem%20Provider%20Directory%202-26-20.pdf?ver=2020-03-02-133733-447> [<https://perma.cc/VW6W-2PV2>].

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SB 137.¹¹⁷ While Anthem’s directory pages do include a designated email, the email is only visible if you click the “show more” link that follows a paragraph telling consumers that they need to contact providers to verify the providers are in fact in-network and then read four more paragraphs of information.¹¹⁸ And even this extremely limited notification disappears once a consumer clicks on an individual provider listing, replaced with a warning to consumers that they should “contact the provider to confirm that they are in your plan network and that the desired service is covered.”¹¹⁹ This is far from the prominent[] display SB 137 requires.¹²⁰ However, these issues pale in comparison to Kaiser and CenCal Health Plan, which—respectively—failed to provide enrollees with any printed directory at all and excluded all mental health providers from their directory.¹²¹ In sum, SB 137 has little to show for its good intentions.

B. Louisiana

Louisiana has taken a much more proactive approach to directory accuracy than California but has still struggled to ensure the accuracy of provider directories. Until recently, Louisiana primarily addressed directory accuracy by writing accuracy standards into its Medicaid MCO contracts. Through 2017, the contracts just required the MCO’s directory to

117. Aetna Better Health of California, *Provider Search Results*, <https://www.aetnabetterhealth.com/california/find-provider> (last visited Jan. 25, 2021) [<https://perma.cc/8FD2-LG2W>]; CAL. HEALTH & SAFETY CODE § 1367.27 (m)(3) (2017).

118. Anthem Blue Cross, *Find Care & Estimate Costs for Doctors Near You*, <https://www.anthem.com/ca/find-care/> (last visited Jan. 25, 2021) (use the find care tool, enter a California zip code, then scroll to the disclaimer at the bottom of the list of providers in that area, then click “show more”) [<https://perma.cc/5SBC-LDCQ>].

119. *Id.*

120. CAL. HEALTH & SAFETY CODE § 1367.27 (i)(11) (2017).

121. CAL. DEP’T OF HEALTH CARE SERVS., *Report on the Medical Audit of: KP Cal, LLC Kaiser Permanente GMC* (Jan. 2020), <https://www.dhcs.ca.gov/services/Documents/MCQMD/Compliance%20Unit-CAP/2019Kaiser.pdf> [<https://perma.cc/H528-L8PW>]; CAL. DEP’T OF HEALTH CARE SERVS., *Report on the Medical Audit of: CenCal Health Plan* (Mar. 2020), https://www.dhcs.ca.gov/services/Documents/MCQMD/Compliance%20Unit-CAP/CenCal_Main.pdf [<https://perma.cc/9HMT-YDPR>].

be regularly updated.¹²² In 2018, the contracts were changed to require provider directories to be at least ninety percent accurate.¹²³ Then, in 2019, this benchmark was reduced to either an accuracy rate of seventy-five percent or an accuracy rate of at least fifty percent that has also improved by at least two percent since the previous accuracy audit.¹²⁴ These contract provisions are enforced with regular audits of directory accuracy. MCOs that fail to comply are fined \$50,000.¹²⁵

At the beginning of 2019, Louisiana expanded its directory accuracy standards by passing the Network Provider Directory Accessibility and Accuracy Act (NPDAAA).¹²⁶ The NPDAAA applies to most private health insurance plans, but does not cover Medicaid MCOs.¹²⁷ The law requires plans to continually review their directories, updating providers' information within ten days of them joining or leaving the plan.¹²⁸ Plans must also have an easily accessible method for people to report directory inaccuracies, and must update their directory in response to consumer inaccuracy reports.¹²⁹ The law empowers the Department of Insurance to

122. See letter from Rebecca E. Gee, Director, La. Dep't of Pub. Health, to Richard Born, CEO, Aetna Better Health, Notice of Action Regarding Provider Directory Updates (Nov. 21, 2017) (fining Aetna for "failure to provide and validate provider demographic data on a semi-annual basis to ensure current, accurate, and clean data is on file for all contracted providers").

123. LA. DEP'T OF PUB. HEALTH, *Louisiana Department of Health bolsters oversight of Medicaid managed care plans* (Aug. 6, 2018), <http://ldh.la.gov/index.cfm/newsroom/detail/4697#targetText=Per%20the%20contracts%20with%20the,fined%20each%20health%20plan%20%2450%2C000> [<https://perma.cc/Z42U-YT7S>].

124. Letter from Rebecca E. Gee, Director, La. Dep't of Pub. Health, to Richard Born, CEO, Aetna Better Health, Notice of Action Regarding the Updating of Provider Directories (Sept. 5, 2019) ("The MCO shall maintain an accuracy rate of at least 75%. The MCO will not be penalized if it can demonstrate a minimum of 50% accuracy in conjunction with a two percentage point improvement from the prior audit period.").

125. *Infra* notes 139–139 and accompanying text.

126. LA. REV. STAT. § 22:1020.1 (2018).

127. LA. REV. STAT. § 22:1020.1(C) (2018).

128. LA. REV. STAT. § 22:1020.3(A) (2018).

129. LA. REV. STAT. § 22:1020.4 (2018).

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promulgate regulations setting civil penalties for violations (up to \$500 per violation), although the aggregate fine may not exceed \$50,000.¹³⁰

Unfortunately, there are no data available on the impact of the NPDAAA, so the best available directory accuracy data concerns MCOs. But, since several MCOs are run by companies that also operate private plans, these high MCO error rates are likely a sign that errors are rampant in the private individual and group health plan markets, given that many of the plans that operate MCOs also operate private plans. For MCOs, there are two pre-2018 studies of directory accuracy. While these studies were conducted before the existence of contracted numeric accuracy targets, during the studies' periods the MCOs were still required by contract to regularly update their directories.¹³¹ The first study, which examined the accessibility of mental health care for children enrolled in Medicaid, consisted of contacting every listed Louisiana MCO provider of mental health services for children under eighteen.¹³² Of these providers, 28.5 percent either did not actually treat children or did not actually accept Medicaid.¹³³ Another 29.6 percent could not be reached, for reasons including directory errors such as incorrect phone numbers.¹³⁴ The second study was undertaken by the Louisiana Legislative Auditor, which investigated MCOs' behavioral health networks, focusing on access to specialized behavioral health services.¹³⁵ The Legislative Auditor found that forty-five percent of the mental health professionals listed in MCO directories did not have the necessary licensure to practice.¹³⁶ Additionally, more than sixty percent of psychiatrists listed in MCO directories either did not practice at their listed location or did not accept Medicaid.¹³⁷

Following the release of the Legislative Auditor's findings, the Louisiana Department of Health began regularly surveying MCO directories. Since the institution of numeric directory accuracy targets, each MCO's directory has

130. LA. REV. STAT. § 22:1020.5(D) (2018).

131. *Infra* notes 139–139 and accompanying text.

132. Michael S. Scheeringa, Alyssa M. Singer, Thao Anh Mai & Devi Miron, *Access to Medicaid Providers: Availability of Mental Health Services for Children and Adolescents in Child Welfare in Louisiana*, J. PUB. CHILD WELFARE 1 (2018).

133. *Id.* at 12.

134. *Id.* at 11.

135. LA. DEP'T OF PUB. HEALTH, NETWORK ADEQUACY OF SPECIALIZED BEHAVIORAL HEALTH PROVIDERS (Oct. 18, 2017).

136. *Id.* at C.1.

137. *Id.* at 6.

been surveyed three times. Like the pre-2018 studies, these surveys reveal continuously abysmal accuracy rates. Only three MCOs have ever been in compliance with the contracted accuracy rates, and they were only able to comply after the accuracy target was significantly lowered and have only been in compliance once. The most recent survey results show that MCO directory accuracy continues to hover under fifty percent, often with even worse accuracy rates for specialists. For example, the 2019 survey of Aetna's directory found that the overall accuracy rate was 40.3 percent, but for specialists the accuracy rate was twelve percent.¹³⁸ As with California, these accuracy rates are not significantly different from accuracy rates before directory accuracy policies were put in place, underscoring the ineffectiveness of the policies.

	<u>Percent of Directory Entries with at Least One Error</u>					
	Nov. 21, 2017 notice of action	June 25, 2018 notice of monetary penalty	Feb. 15, 2019 notice of monetary penalty	Sept. 5, 2019 notice of monetary penalty	Jan. 10, 2020 notice of monetary penalty	Oct. 16, 2020 notice of monetary penalty
Aetna Better Health ¹³⁹	61	61.7	67.4	51.5	59.7	67.7
AmeriHealth Caritas ¹⁴⁰	59	49.5	74.4	N/A ¹⁴¹	57.3	54.9
Healthy Blue ¹⁴²	51	52	N/A ¹⁴³	51.2	59.2	58.4
Louisiana Healthcare Connections ¹⁴⁴	65	38.5	65.6	N/A ¹⁴⁵	50.7	52.3
United Healthcare Community Plan ¹⁴⁶	62	46.5	67.2	52.8	60.3	53.1

138. Letter from Stacy Guidry, Section Chief, Medicaid Program Operations and Compliance to Richard Born, CEO, Aetna Better Health regarding Notice of Monetary Penalty Regarding the Updating of Provider Directories (Jan. 10, 2020), https://ldh.la.gov/assets/docs/BayouHealth/Accountability/2.0/AET/ABH_Q32019_ProviderDirectorySurveyandNOMP_1.10.2020.pdf [<https://perma.cc/V7M8-7SJU>].

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139. *Aetna Healthy Louisiana Administrative Actions, Monetary Penalties, and Sanctions*, LA. DEP'T OF PUB. HEALTH, http://ldh.la.gov/assets/docs/BayouHealth/Accountability/2.0/AET/Aetna_Noncompliance_11.5.19.pdf [<https://perma.cc/R4HF-9RDD>]; *Aetna Better Health: Louisiana Medicaid Managed Care Non-Compliance Actions*, LA. DEP'T OF PUB. HEALTH, https://ldh.la.gov/assets/docs/BayouHealth/Accountability/2.0/AET/Non-ComplianceTrackingLogTemplate_ABH_1.1.20-present.pdf [<https://perma.cc/8ME6-BPDD>].
140. *AmeriHealth Caritas Healthy Louisiana Administrative Actions, Monetary Penalties, and Sanctions*, LA. DEP'T OF PUB. HEALTH, http://ldh.la.gov/assets/docs/BayouHealth/Accountability/2.0/ACLA/ACLA_Noncompliance_10.9.19.pdf [<https://perma.cc/7U2E-JD9M>]; *AmeriHealth Caritas: Louisiana Medicaid Managed Care Non-Compliance Actions*, LA. DEP'T OF PUB. HEALTH, https://ldh.la.gov/assets/docs/BayouHealth/Accountability/2.0/ACLA/Non-ComplianceTrackingLogTemplate_ACLA_1.1.20-present.pdf [<https://perma.cc/WQH7-MTH4>].
141. Plan was in compliance; no penalty was assessed.
142. *Healthy Blue Healthy Louisiana Administrative Actions, Monetary Penalties, and Sanctions*, LA. DEP'T OF PUB. HEALTH, http://ldh.la.gov/assets/docs/BayouHealth/Accountability/2.0/AMG/HBL_Noncompliance_11.5.19.pdf [<https://perma.cc/4MFA-ZYTQ>]; *Healthy Blue: Louisiana Medicaid Managed Care Non-Compliance Actions*, LA. DEP'T OF PUB. HEALTH, https://ldh.la.gov/assets/docs/BayouHealth/Accountability/2.0/AMG/Non-ComplianceTrackingLogTemplate_HBL_1.1.20-present.pdf [<https://perma.cc/P93V-8TLJ>].
143. Plan was in compliance; no penalty was assessed.
144. *Louisiana Healthcare Connections Healthy Louisiana Administrative Actions, Monetary Penalties, and Sanctions*, LA. DEP'T OF PUB. HEALTH, http://ldh.la.gov/assets/docs/BayouHealth/Accountability/LHC/LHC_Noncompliance_11.7.19.pdf [<https://perma.cc/D8VU-BRSX>]; *Louisiana Healthcare Connections: Louisiana Medicaid Managed Care Non-Compliance Actions*, LA. DEP'T OF PUB. HEALTH, https://ldh.la.gov/assets/docs/BayouHealth/Accountability/2.0/LHC/Non-ComplianceTrackingLogTemplate_LHCC_1.1.20-present.pdf [<https://perma.cc/62JW-FXME>].
145. Plan was in compliance; no penalty was assessed.
146. *United Healthcare Community Plan Healthy Louisiana Administrative Actions, Monetary Penalties, and Sanctions*, LA. DEP'T OF PUB. HEALTH, http://ldh.la.gov/assets/docs/BayouHealth/Accountability/UHC/UHC_Noncompliance_11.7.19.pdf [<https://perma.cc/6PFK-8SS8>]; *United Healthcare Community Plan:*

C. Maryland

Maryland has a directory accuracy law that governs private insurance directories, as well as specific directory regulations for Medicaid MCOs. The law is relatively lax in comparison to California's directory accuracy law. It requires plans to update their directories within forty-five days of receiving a report of an inaccuracy.¹⁴⁷ Plans must also periodically audit a portion of the directory, but the frequency of this audit is not specified, and plans are never required to audit the entirety of their directory.¹⁴⁸ The MCO regulations are even less demanding, only requiring MCOs to update their directories within thirty days of receiving updated information from providers.¹⁴⁹ However, since 2017, the Maryland Department of Health (MDH) has augmented the MCO regulations by setting an eighty percent directory accuracy benchmark for MCOs and conducting yearly surveys of MCOs' directories.¹⁵⁰

While there are no data available about the accuracy of private insurer directories, MCO directory accuracy rates continue to cluster around fifty percent, even after the institution of the accuracy benchmark and regular state monitoring. In the 2017 survey, just fifty-nine percent of PCPs' phone numbers and addresses were accurate.¹⁵¹ That number actually fell during the 2018 survey, which found an accuracy rate of just forty-three percent.¹⁵² As the chart below shows, while accuracy rates rose in 2019, they barely managed to clear fifty percent.¹⁵³ PCPs also continue to be erroneously listed as in-network. While these errors rates are already quite high, the

Louisiana Medicaid Managed Care Non-Compliance Actions, LA. DEP'T OF PUB. HEALTH, https://ldh.la.gov/assets/docs/BayouHealth/Accountability/2.0/UHC/Non-ComplianceTrackingLogTemplate_UHC_1.1.20-present.pdf [https://perma.cc/QHJ9-TNMH].

147. MD. CODE INS. § 15-112(o)(2) (2020).

148. MD. CODE INS. § 15-112(p)(3) (2020).

149. MD. CODE REGS. § 10.67.05.02(F) (2019).

150. QLARANT, MEDICAID MANAGED CARE ORGANIZATION NETWORK ADEQUACY VALIDATION ASSESSING ACCURACY OF PROVIDER DIRECTORIES REPORT CALENDAR YEAR 2018 1-3 (Dec. 2018).

151. DELMARVA FOUND., MEDICAID MANAGED CARE ORGANIZATION NETWORK ADEQUACY VALIDATION ASSESSING ACCURACY OF PROVIDER DIRECTORIES REPORT CALENDAR YEAR 2017 24 (Feb. 2018).

152. QLARANT, *supra* note 150, at 35.

153. *Infra* notes 155-160 and accompanying text.

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California data indicates that accuracy rates are likely to be even worse for specialists and mental health providers.¹⁵⁴ And, as with Louisiana, errors in Medicaid plans likely also signal errors in private plans.

	<u>Medicaid MCO PCP Directory Errors</u> ¹⁵⁵		
	Coverage Year 2017 ¹⁵⁶	Coverage Year 2018 ¹⁵⁷	Coverage Year 2019 ¹⁵⁸
PCP has a contact information or address error ¹⁵⁹	41%	57%	46%
PCP is not part of given network ¹⁶⁰	6%	8%	5%

154. *Supra* note 112 and accompanying chart.

155. Like the California survey, the Maryland survey treats each provider/location/plan combination as a distinct data point, so a provider may be sampled multiple times if they practice at several different locations and/or participate in several MCO plans. QLARANT, MEDICAID MANAGED CARE ORGANIZATION NETWORK ADEQUACY VALIDATION ASSESSING ACCURACY OF PROVIDER DIRECTORIES REPORT CALENDAR YEAR 2019 (Nov. 2019).

156. DELMARVA FOUND., MEDICAID MANAGED CARE ORGANIZATION NETWORK ADEQUACY VALIDATION ASSESSING ACCURACY OF PROVIDER DIRECTORIES REPORT CALENDAR YEAR 2017 (Feb. 2018).

157. QLARANT, *supra* note 150.

158. QLARANT, *supra* note 155.

159. Includes instances where the phone number for the practice was incorrect, the practice is permanently closed, the provider is not actually with the practice, the provider does not work at that location of the practice, and the practice’s address was incorrect.

160. These figures differ from topline figures reported in the annual reports, which are incorrectly calculated. The reports base their calculations only on “successful contacts,” even when the reason a contact is unsuccessful is the same as the very metric being assessed. So, for example, the 2019 report states that one hundred percent of PCPs surveyed accept the listed MCO, despite the fact that twelve percent of unsuccessful contacts were due to a PCP not actually being in-network. *See* QLARANT, *supra* note 155. The one hundred percent figure only reflects surveys of PCPs that were *successful* contacts, and not taking the listed plan immediately marks a contact *unsuccessful*. Likewise,

III. STATE DIRECTORY ACCURACY POLICIES ARE UNDERCUT BY INADEQUATE AND INEFFECTIVE ENFORCEMENT.

As the above data show, California, Maryland, and Louisiana's directory policies have failed to protect consumers, but the question of why they failed remains. The answer can be found in a combination of poor drafting and poor enforcement. Directory policies are typically written to rely on consumer reports of inaccuracy, rather than any form of regular directory survey. This scattershot approach to data collection permits error-riddled directories to escape regulators' notice. Furthermore, the policies lack specific standards for accuracy, prioritizing gestures of compliance over the actual content of plans' directories. But beyond the inherent limitations of their structure, state directory policies are also hampered by the fact states rarely display any interest in enforcing directory laws and regulations. And in the rare cases when states do enforce state directory accuracy laws and regulations, there are minimal penalties for non-compliant plans.

The first barrier to enforcing provider directory policies is the structure of the policies themselves, which frequently put the onus of reporting inaccuracies to state regulators on consumers. The National Association of Insurance Commissioners (NAIC) Health Benefit Plan Network Access and Adequacy Model Act, which been adopted by four states and serves as a highly influential set of practices for state regulation, is emblematic of this shortcoming.¹⁶¹ The NAIC model only requires plans to make partial directory audits available to regulators if requested, and does not require states to perform their own regular audits.¹⁶² The only way for a state

the report only verifies that PCPs phone numbers are correctly listed in the directory if the PCPs are successful contacts, and successful contacts are by definition contacts where the telephone number that the plan provided could be used to reach the PCP. By excluding PCPs who do not have the correct phone number on file with insurers, the report artificially deflates the number of phone number-related directory errors.

161. NAT'L ASS'N OF INS. COMM'RS, THE NAIC NETWORK ADEQUACY MODEL ACT 2 (Dec. 2019), https://www.naic.org/documents/cmte_legislative_liaison_brief_network_adequacy.pdf; Michael Adelberg & Michelle Strollo, *From Machine-Readable Provider Directories, A Preview Of A Revolution*, HEALTH AFFS. (Feb. 27, 2017), <https://www.healthaffairs.org/doi/10.1377/hblog20170227.058937/full/> [<https://perma.cc/HB56-FQQ9>].

162. NAT'L ASS'N OF INS. COMM'RS, HEALTH BENEFIT PLAN NETWORK ACCESS & ADEQUACY MODEL ACT § 9(A)(2)(b) (2015), https://content.naic.org/sites/default/files/inline-files/MDL-074_0.pdf [<https://perma.cc/5GA9-FVXH>] [hereafter NAIC MODEL ACT].

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regulator to discover directory inaccuracies is to hear about them from consumers. The same is true of the California, Maryland, and Louisiana laws, which, with the exception of Medicaid MCOs, do not require any direct reporting of accuracy rates to state regulators or any regular study of accuracy rates by state regulators.¹⁶³

The problem with a complaint-based approach to regulation is that consumers are not regulators. They face numerous obstacles to filing—or even being aware that they *can* file—a complaint.¹⁶⁴ Complaint-based reporting also requires consumers who have already spent potentially significant amounts of time dealing with errors in their insurers' directory to spend even more time figuring out whether and how to complain to the state. In the words of one Medicaid enrollee who struggled with ghost networks while looking for a psychiatrist, "I believe there's an option to report inaccurate listings but like [sic] damn why is that my job?"¹⁶⁵ Unsurprisingly, a study of people who used their insurers' mental-health directories found that only three percent filed a complaint with a government agency. Further highlighting the failures of complaint-based reporting, in 2017, the median number of complaints related to mental health parity (which, as explained previously, overlaps with directory accuracy) received by state regulators per year was *four*, an absurdly low number given health plans widespread failure to comply with MHPAEA.¹⁶⁶

Complaint-based enforcement is also deeply inequitable. Consumers incomes "tend[] to correlate with willingness to complain," with affluent consumers complaining more.¹⁶⁷ Advocates have also raised concerns that consumers are reluctant to lodge complaints related to mental health care due to concerns about privacy and the potential for discrimination, so tying enforcement to complaints significantly undercuts enforcement on behalf

163. CAL. HEALTH & SAFETY CODE § 1367.27; MD. CODE INS. § 15-112 (2020); LA. REV. STAT. § 22:1020.1 (2018).

164. See U.S. GOV'T ACCOUNTABILITY OFF., GAO-20-150, STATE AND FEDERAL OVERSIGHT OF COMPLIANCE WITH PARITY REQUIREMENTS VARIES 34-36 (explaining the limitations of relying on consumer complaints to enforce MHPAEA).

165. Email from AP to Abigail Burman (Sept. 11, 2019, 12:44 PST) (on file with author).

166. U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 164, at 18.

167. Daniel Schwarcz, *Transparently Opaque: Understanding the Lack of Transparency in Insurance Consumer Protection*, 61 UCLA L. REV. 394, 417 (2014).

of people who need mental health care or experience mental illness.¹⁶⁸ Thus, relying on complaints to enforce ghost network policies shuts out the voices of the very consumers who are most at risk of being harmed.

Directory policies' other structural weakness is that they prioritize process over content, regulating insurers' treatment of directories instead of the directories themselves. The NAIC policy illustrates this problem, focusing on the frequency of directory updates rather than the actual accuracy of directories. The policy would require insurers to post accurate, current directories and update policies monthly.¹⁶⁹ But this does nothing to set the standard for what directory accuracy actually is. For example, should the benchmark for accuracy be whether directories reflect insurers' own records, even if those records contain errors that could be corrected through something as simple as a Google search, or should accuracy be determined by the number of entries that contain errors?¹⁷⁰ If the latter, what percent can be excused by the fact that directories can change rapidly, and what percent represents an unacceptable disregard for patients? Furthermore, the policy never actually requires insurers to audit their entire directory for errors, despite the fact that "[plans] that take a reactionary approach by relying solely on provider-based notification will not have valid provider directories."¹⁷¹ An insurer could theoretically be in compliance even if they never systematically verify their directory information; as long as they continue to update the directory monthly, it does not matter that they are updating the directory with incomplete data.¹⁷²

Furthermore, by failing to set specific numeric accuracy thresholds, directory accuracy policies turn enforcement into a judgement call. Since policies don't specify when, if ever, directory errors are severe enough to violate public policy, regulators would have to start each enforcement action from scratch, expending scarce resources to demonstrate why

168. U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 164, at 34–36.

169. NAIC MODEL ACT § 9(A).

170. Michael Adelberg, Austin Frakt, Daniel Polsky & Michelle Kitchman Strollo, *Improving Provider Directory Accuracy: Can Machine-Readable Directories Help?*, 25 AM. J. MANAGED CARE 241, 243 (2019) ("Google is more accurate than provider directories or the federal NPPES file for name, address, and phone number.").

171. NAIC MODEL ACT § 9; CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 83 at 8.

172. *See* NAIC MODEL ACT § 9 (requiring insurers to update their directory monthly but not requiring them to have any system for addressing consumer complaints or systematically verifying provider information).

particular plans' errors are harmful and leaving enforcement efforts open to legal challenges (which require yet more resources to respond to).¹⁷³ In contrast, establishing a specific error threshold streamlines the enforcement process by making it sufficient for regulators to simply state that plans did not meet the mandated accuracy rate.¹⁷⁴

Frustratingly, the new federal directory accuracy law, which applies to all private plans and in theory could have strengthened state laws, simply replicates the flaws in existing state policies. Under the law, insurers are required to produce accurate directories and have in place a process to verify and update directory information every ninety days.¹⁷⁵ Additionally, beginning in 2022, if patients seek care from a provider who is erroneously listed as in-network in an insurer's directory, the insurer must not charge them more than they would have been charged for in-network care.¹⁷⁶

While this law will afford most consumers more protections than they currently have, as with other directory accuracy policies there are not clear standards or enforcement provisions. "Accuracy" is left undefined, and there are no guidelines for what a plan's verification process must include. In theory, a plan could comply by only verifying information that they have been told is incorrect, without ever checking the overall accuracy of their entire directory. The law also does not designate any enforcement mechanisms. There is no requirement that plans regularly report directory accuracy information, either publicly or to a government agency. Nor is

173. See CAL. DEP'T OF MANAGED HEALTH CARE, *supra* note 114, at 15 ("Although the Plan submitted various legal arguments in support of its position that the inaccuracies in the online Provider Directory did not constitute operating at variance, when one-quarter (25.3%) of providers contacted were not at the location or were not accepting Covered California products, the Plan was clearly operating at variance, and information provided by the Plan in response to the Preliminary Report was insufficient to change or alter the Department's conclusion regarding this deficiency."). See also *id.* at 18 ("Although section 1367.25 appears to contemplate quarterly updates (rather than instantaneous) to online provider lists, Anthem's response to the Preliminary Survey Report did not demonstrate that inaccuracies in the online Provider Directory were simply the result of changes that occurred in the preceding quarter.").

174. See, e.g., Letter from Stacy Guidry, *supra* note 138 (finding that Aetna was in violation of Louisiana's Medicaid MCO directory accuracy policy because it did not meet the stipulated numeric accuracy threshold).

175. Consolidated Appropriations Act, 2021, H.R. 133, 116th Cong. Div. BB § 116 (2020).

176. *Id.*

there any explicit private right of action, so enrollees remain stuck within the confines of ERISA and state consumer protection laws. The law is focused on insurer processes, not enrollee experiences, and assumes that compliance will naturally follow enactment. It can help consumers, but only to the extent their insurer decides to follow it or they can find other legal levers to enforce it.

But the structures of directory accuracy policies are not solely responsible for their failures. Compounding these policies' in-built shortcomings is the fact that most states have little to no interest in undertaking enforcement actions. More than seventy percent of state insurance regulators report an average of one to zero enforcement actions against private insurers related to network adequacy, which includes directory accuracy, each year.¹⁷⁷ Of that extremely small number of enforcement actions, the number related to directory accuracy specifically is likely even smaller. The California DMHC has undertaken only five enforcement actions since SB 137 went into effect.¹⁷⁸ Overall, state regulators' actions on behalf of consumers are best summed up as severely underwhelming.¹⁷⁹

Attorneys General have also not enforced directory accuracy policies. Only two AGs have ever pursued directory accuracy cases.¹⁸⁰ This low case

177. Barber et al., *supra* note 52, at 27.

178. Letter from Edmund G. Brown, Jr., Governor of California, to Augustavia J. Handel, Local Initiative Health Authority for L.A. County, regarding Enforcement Matter Number 16-1967 (Nov. 14, 2017); Letter from Edmund G. Brown, Jr., Governor of California, to Terry German, Blue Cross of California, regarding Enforcement Matter Number 17-844 (June 6, 2017); Letter from Edmund G. Brown, Jr., Governor of California, to Terry German, Blue Cross of California, regarding Enforcement Matter Number 17-832 (May 30, 2017); Letter from Sonia R. Fernandes, Deputy Director, Chief Counsel, Office of Enforcement, DMHC, to Terry German, Blue Cross of California, regarding Enforcement Matter Number 19-1168 (May 14, 2020); Letter from Sonia R. Fernandes Deputy Director, Chief Counsel, Office of Enforcement, DMHC, to Douglas Shur, Health Net of California, regarding Enforcement Matter Number 20-227 (Dec. 22, 2020).

179. Monahan, *supra* note 85, at 1130.

180. Press Release, New York State Attorney General, *A.G. Schneiderman Announces Settlements Requiring Health Insurers To Publish Accurate Provider Directories* (January 19, 2012), <https://ag.ny.gov/press-release/2012/ag-schneiderman-announces-settlements-requiring-health-insurers-publish-accurate> [<https://perma.cc/33WW-CG9X>]; Deborah Becker, *AG Healey*

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count is consistent with the fact that only four AG offices have dedicated health care units.¹⁸¹ Health care issues, despite their enormous ramifications for consumers, are simply not a priority for most AG offices.

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. Since SB 137, the California directory accuracy law, came into effect, the state's largest directory-related fine has been \$7,500.¹⁸² Only three states have reported ever fining plans more than \$50,000 because of directory errors.¹⁸³ And, with the exception of Louisiana, all fines were levied in response to complaints by consumers, meaning that they were targeted at the plans that had the most vocal consumers, rather than the worst practices.¹⁸⁴ Nationwide, the vast majority of state Medicaid agencies, which regulate MCOs, "rarely" or "never" use financial penalties to enforce network adequacy standards.¹⁸⁵ Even fewer state insurance regulators, which regulate private plans, report using financial penalties to enforce network adequacy standards.¹⁸⁶

The lack of fines means that insurers have no incentive to increase the accuracy of their directories. Maryland's approach to enforcing its MCO accuracy regulations highlights the anti-consumer financial incentives that light touch regulation creates. MDH has never fined MCOs that miss the

Reaches \$1 Million Settlement With 7 Companies To Increase Behavioral Health Access, WBUR (Feb. 28, 2020), <https://www.wbur.org/commonhealth/2020/02/27/maura-healey-health-insurers-mental-health-access-settlements> [<https://perma.cc/AS5U-P97Z>] (Massachusetts).

181. California, New York, Massachusetts, and Maryland.

182. Letter from Edmund G. Brown, Jr. to Augustavia J. Handel, *supra* note 178.

183. *Supra* notes 135–139 and accompanying text (Louisiana fines); Chad Terhune, *supra* note 113 (California fines); Paige Winfield Cunningham, *The Health 202: Obamacare Plans Face Lawsuits over Erroneous Doctor Directories*, WASH. POST (Mar. 19, 2019), <https://www.washingtonpost.com/news/powerpost/paloma/the-health-202/2019/03/19/the-health-202-obamacare-plans-face-lawsuits-over-erroneous-doctor-directories/5c9011581b326b0f7f38f1cb/> [<https://perma.cc/BR87-KWQX>] (Washington State fine).

184. *Id.*

185. KAREN BRODSKY, BARBARA MARKHAM SMITH & DIANA RODIN,, MAKING AFFORDABLE CARE ACT COVERAGE A REALITY: A NATIONAL EXAMINATION OF PROVIDER NETWORK MONITORING PRACTICES BY STATES AND HEALTH PLANS 36 tbl.5 (2015).

186. *Id.*

eighty percent accuracy benchmark.¹⁸⁷ Instead, MDH placed the MCOs in corrective action plans (CAPs), even if they had repeatedly failed to comply with directory accuracy requirements. There are also no financial penalties for plans that fail to carry out their CAPs. Thus, from insurers' perspective, increasing directory accuracy has a price, but leaving directories as they are is free.

Even when state regulators do impose fines, they are too small to change plans' behavior. The fines states levy are—to put it bluntly—pocket change for insurers, unable to persuade them to comply with state regulations. In 2018, Anthem was fined \$5,000 for directory errors in individual plans.¹⁸⁸ During that same year, individual California Anthem plans collected more than \$830 million in premiums.¹⁸⁹ Anthem's 2018 directory accuracy fines from DMHC thus represented just over six millionths of Anthem's 2018 individual plan premium revenue. Even larger fines have failed to change plans' behavior. In 2014, in response to consumer complaints, DMHC surveyed the directories of Anthem and Blue Shield. They found persistent errors in both companies' directories and in 2015 fined Anthem and Blue Shield \$250,000 and \$350,000, respectively, and instituted corrective action plans.¹⁹⁰ Three months after the settlements were finalized, DMHC again surveyed Anthem's and Blue Shield's directories. The error rates from the second survey were actually worse in some instances.¹⁹¹ Likewise, Louisiana's directory enforcement efforts have failed to create any appreciable change in directory accuracy, despite being the only state to both regularly survey directories and regularly impose fines for errors.¹⁹² Louisiana fines plans \$50,000 every time a survey shows excessive directory errors. Thus far, all Louisiana plans

187. See QLARANT, *supra* note 150; DELMARVA FOUND., *supra* note 151 (declining to fine noncompliant MCOs).

188. Letter from Edmund G. Brown, Jr. to Terry German, *supra* note 178.

189. BLUE CROSS OF CAL., 2018 ANNUAL MEDICAL LOSS RATIO STATEMENT (Dec. 4, 2018).

190. CAL. DEP'T OF MANAGED HEALTH CARE, NON-ROUTINE SURVEY FOLLOW-UP REPORT OF BLUE SHIELD OF CALIFORNIA 4 (Jul. 2016); CAL. DEP'T OF MANAGED HEALTH CARE, NON-ROUTINE SURVEY FOLLOW-UP REPORT OF BLUE CROSS OF CALIFORNIA 4 (Jul. 2016).

191. CAL. DEP'T OF MANAGED HEALTH CARE, NON-ROUTINE SURVEY FOLLOW-UP REPORT OF BLUE CROSS OF CALIFORNIA, *supra* note 190, at 3, 6 (finding that during the initial survey 12.5 percent of providers were not at the listed location, and during the follow-up survey 24.7 percent of providers did not practice at the listed location).

192. *Supra* notes 136–143 and accompanying text.

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have paid between \$250,000 and \$300,000 in fines, and yet all continue to report high error rates. The grim reality of health care costs and health plan budgets—where a single kidney transplant can cost over \$400,000—means that plans do not bat an eye at a \$250,000 fine.

In short, for state insurance regulations to be effective “it has to be more expensive for [insurers] to be fined than it is for them to just do the right thing to begin with.”¹⁹³ The efficacy of state charity care laws offers a helpful example. Some states require non-profit hospitals to provide free or discounted care to certain populations, particularly those who are uninsured, a community benefit known as charity care. However, a study of hospital behavior in states that adopted charity care rules found that the mere existence of a charity care rule was insufficient to change hospitals’ behavior.¹⁹⁴ Only the regulations that were backed by state supreme court cases revoking hospitals’ non-profit status, attorney general enforcement, or widespread publicity were effective in increasing the amount of charity care hospitals offered.¹⁹⁵ Where none of these factors were present, charity care laws had no effect on hospitals’ provision of charity care, and may have actually decreased hospitals’ overall charitable benefit.¹⁹⁶ Mental health parity advocates have identified a similar dynamic, finding that “[w]hile some . . . states have adopted strong state parity laws, they are largely meaningless if not well enforced. Penalties for violations are often not strong enough to compel compliance.”¹⁹⁷ Unfortunately, the current directory accuracy enforcement structure results in only trifling costs for non-compliance, if the policies are enforced at all.

193. NAMI Maryland, *Understanding Your Health Insurance Coverage for Mental Health*, YOUTUBE (Oct. 18, 2019), <https://www.youtube.com/watch?v=JEI5BO43InE&feature=youtu.be&t=1172> [<https://perma.cc/KY3K-P9TL>]; see also Anderson, *supra* note 46 (“Directories are still seen as mostly a cost-center and not a profit center. CMS or state regulators can increase the costs of bad directories either directly with fines or indirectly by removing stars, changing auto-assignment policies for Medicaid managed care or increasing the scrutiny of plans that need state approval.”).

194. Rebecca Sachs, *How Do Hospitals Set Their Charity Care Policies? Evidence from Nonprofit Tax Returns* 16 (Nat’l Inst. on Aging, Working Paper, 2019).

195. *Id.*

196. *Id.*

197. Lindsey Vuolo, Robyn Oster & Ellen Weber, *Evaluating The Promise And Potential Of The Parity Act On Its Tenth Anniversary*, HEALTH AFFS. (Oct. 10, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20181009.356245/full/> [<https://perma.cc/928Y-VZYJ>].

IV. LITIGATION BY PRIVATE PARTIES CANNOT REPLACE STATE ENFORCEMENT

Despite the ubiquity of directory errors, there have been very few cases brought by private plaintiffs, and even fewer brought since the initial rocky rollout of the ACA marketplaces. Consumers have brought three cases in California, all of which settled¹⁹⁸; a case in Missouri that settled¹⁹⁹; a case in Georgia that was voluntarily dismissed²⁰⁰; and two ongoing cases in Ohio and Washington State.²⁰¹ Additionally, a hospital operator in Oregon has sued two health plans for repeatedly falsely representing that its hospitals are part of their networks.²⁰² As a practical matter, it is clear that there is no slate of plaintiffs' attorneys willing to step into the role of state regulators and attorneys general. While directory accuracy cases have been relatively successful, managing to stay in state court²⁰³ and resulting in large settlements,²⁰⁴ few attorneys want to take them on.

Beyond the lack of cases, several procedural and practical hurdles prevent private litigation from being a lasting solution to ghost networks. It can be difficult for plaintiffs to state claims, given the lack of private rights

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198. Order Granting Final Approval of Class Action Settlement, Award of Attorneys' fees, Payments to Class Representatives, and Reimbursement of Expenses, *Davidson v. Cigna*, No. BC558566 (Cal. Super. Ct., Dec. 4, 2018); *Felser v. Anthem Blue Cross Class Action Lawsuit Settlement Website* <https://web.archive.org/web/20170713192200/https://felseranthembluecrosscasasettlement.com> [<https://perma.cc/F6Q5-LVDM>]; Class Settlement Agreement and Release, *Blue Shield of Cal. Affordable Care Act Cases*, No. 4800, 2018 WL 3076785 (Jud. Council of Cal. Nov. 30, 2017).
 199. *Simon v. Blue Cross & Blue Shield of Kan. City*, No. 14-0587-CV-W-ODS, 2014 WL 4425734 (W.D. Mo. Sept. 9, 2014).
 200. *Kirby v. Anthem*, No. 1:19-cv-00597-ELR (N.D. Ga. Feb. 5, 2019).
 201. *Desai v. CareSource*, No. 2018-cv-1133 (Ohio Ct. C.P. Mar. 13, 2018); *Harvey v. Centene Mgmt. Co.*, No. 2:18-CV-00012-SMJ (E.D. Wash. Jan. 11, 2018).
 202. *PeaceHealth v. Health Net*, No. 6:19-CV-01648-MK (D. Or. Oct. 14, 2019).
 203. *See Desai v. CareSource*, No. 3:18-CV-118, 2019 WL 1109568 (S.D. Ohio Mar. 11, 2019) (remanding the case back to state court).
 204. *See Settlement Agreement and Release, Blue Shield of Cal. Affordable Care Act Cases*, No. 4800 (Cal. Jud. Council Coordinated Proceeding Nov. 30, 2017), <https://harringtonalonacasasettlement.com/Portals/0/Document%20Files/Signed%20Settlement%20Agreement%20web%20vers.pdf?ver=2018-01-11-101717-000> [<https://perma.cc/7ENR-T4PT>] (establishing an \$18.5 million settlement fund and authorizing up to \$4.9 million in attorney's fees for the plaintiffs).

of action in health care laws. Additionally, judges can be wary of interfering in health care markets, mistakenly perceiving them to be heavily regulated with extensive consumer protections. Finally, the slow, backwards looking nature of litigation makes it a fundamentally inappropriate tool to resolve issues of health care access, where the stakes can literally be life or death.

First, the procedural hurdle: plaintiffs in directory accuracy cases may struggle to state a claim.²⁰⁵ Most relevant state or federal insurance regulations do not contain a broad private right of action. The ACA only contains a private right of action for discrimination claims.²⁰⁶ The federal directory accuracy law and MHPAEA also contain no freestanding private right of action.²⁰⁷ While both laws are also incorporated into ERISA's private right of action, ERISA is limited to consumers enrolled in employer-sponsored plans.²⁰⁸ Additionally, since ERISA does not allow the recovery of damages, cabining these laws' private remedies to ERISA significantly undercuts their efficacy.²⁰⁹ At the state level, none of the directory accuracy laws discussed in this paper create a private right of action. State mental health parity laws also may not create a private right of action.²¹⁰

In the absence of specific statutory rights of action, plaintiffs can fall back on general false advertising and "unfair and deceptive acts and practices" (UDAP) statutes, but stating a claim under these laws is an involved process. Most state UDAP statutes don't recognize *per se*

205. While there are a number of state and federal claims—unfair competition, false advertising, violation of mental health parity protections, breach of contract, false claims, to name some—that could potentially be brought against insurers that maintain ghost networks, the specific structure and evidentiary demands of those claims are beyond the scope of this article, which is focused on regulatory responses to ghost networks.

206. Monahan, *supra* note 85, at 1123 n.23.

207. Consolidated Appropriations Act, 2021, H.R. 133, 116th Cong. Div. BB § 116 (2020); Jeremy P. Ard, *An Unfulfilled Promise: Ineffective Enforcement of Mental Health Parity*, 26 ANNALS HEALTH L. 70, 80 (2017).

208. *Id.*

209. See Meiram Bendat, *In Name Only? Mental Health Parity or Illusory Reform*, 42 PSYCHODYNAMIC PSYCHIATRY 353, 360 (Guilford Press 2014) (arguing that insurers are "emboldened by ERISA beneficiaries not being able to sue for anything more than owed benefits, injunctive relief, and at best, attorney fees—assuming that individual litigants can even find counsel to represent them in individual benefit cases since, under ERISA, damages for denial of benefits are nonexistent").

210. See, e.g., CAL. HEALTH & SAFETY CODE § 1374.72 (2020) (California's parity law).

violations.²¹¹ Thus, it would not be not enough for plaintiffs to show that an insurer violated state or federal law.²¹² Plaintiffs would also have to show that insurers engaged in an unfair, deceptive, or unconscionable trade practice.²¹³ Furthermore, a significant number of states completely exempt insurance from their UDAP laws.²¹⁴ Plaintiffs could also raise allegations related to false advertising, as in the Oregon case, since directories play a crucial role in consumers' choice of health care.²¹⁵ However, courts have yet to explicitly recognize provider directories as advertising.²¹⁶

But even if private claims are brought, they may be hamstrung by the same state enforcement procedures that fail consumers in the first place. *Harvey v. Centene*, a class action case brought in the Eastern District of Washington, highlights the difficulties that private litigants may face. The plaintiffs alleged that persistent errors in Centene's directories—which were so severe Centene was eventually fined over one million dollars by the Washington state insurance commissioner—violated the Affordable Care Act as well as state network adequacy and false advertising laws. The court denied the plaintiff's motion to certify a class because there was a superior alternative to a class action available: the insurance commissioner's dispute resolution process. The court's reasoning is worth quoting in full, arguing that the state's regulatory process is an effective means of addressing consumers' disputes:

[u]nlike the average business that fields complaints from dissatisfied customers, Centene operates in a highly regulated industry, bound by a web of statutory and regulatory requirements over which an independent state agency, the OIC, has enforcement authority. Nor does the average business permit its customers to appeal adverse decisions to an outside agency, certified by state

211. Monahan, *supra* note 85, at 1140.

212. *Id.*

213. *Id.*

214. *Id.*

215. *PeaceHealth v. Health Net*, No. 6:19-CV-01648-MK ¶ 48 (D. Or. Oct. 14, 2019); *see also supra* notes 20–23 and accompanying text (describing the importance of directories and networks to consumers' choice of a health plan).

216. This is likely related to the fact that very few directory-related cases have made it to trial, instead either settling or being dismissed before a court can rule; *see, e.g.*, *Blue Shield of Cal. Affordable Care Act Cases*, No. 4800 (Cal. Jud. Council Coordinated Proceeding Aug. 17, 2015) (alleging false advertising violations, which were later settled before the case reached trial).

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regulators, the decision of which it agrees to be bound by. In short, the Court finds the putative class members have an adequate alternative to class litigation.²¹⁷

While the court's premise is deeply mistaken, it is representative of the hurdles that private litigants would have to overcome in order to successfully press claims.²¹⁸ Without the weight of the state behind their claims, courts may view private directory accuracy cases with skepticism, assuming that the sheer volume of healthcare regulations that exist translates both to health insurance being highly regulated, and to state regulators breceiving and effectively responding to consumer complaints.

Finally, the inherently redressive, slow-moving nature of litigation makes it unable to effectively protect consumers from ghost networks. The basic tenets of standing doctrine require plaintiffs to show an injury in fact.²¹⁹ But the harms that ghost networks can inflict make it unconscionable to withhold remedies until people have suffered harm. There is no possible monetary settlement that can make up for months of untreated depression, or the exhaustion and stress of the medical debt collection process. Litigation is also an inherently slow process. It is deliberative and fact intensive, and each new case starts the process over again. This is a delay that consumers who depend on insurance directories and insurance networks to access care cannot afford. As the saying goes, if you want to make someone miserable, sue them, but you will make yourself miserable as well. Litigation is an exhausting, stressful, and confusing process, and consumers should not have to go through it in order to access basic consumer protections. Private litigation should be the method of last resort for addressing ghost networks, rather than the only avenue left to consumers in the face of government inaction.

217. Order Denying Plaintiff's Motion for Class Certification, *Harvey v. Centene Mgmt. Co.*, No. 2:18-CV-00012-SMJ (E.D. Wash. Jan. 11, 2018).

218. *See supra* notes 173–178 and accompanying text (describing state's failure to adequately regulate their health insurance markets).

219. *See Lujan v. Defs. of Wildlife*, 504 U.S. 555, 560 (1991) (explaining that the minimum requirements for constitutional standing include “an ‘injury in fact’—an invasion of a legally protected interest which is (a) concrete and particularized, and (b) “actual or imminent, not ‘conjectural’ or ‘hypothetical’” (citations omitted)).

V. STATES SHOULD ADOPT DIRECTORY ACCURACY POLICIES WITH STRONG, BROAD ENFORCEMENT MECHANISMS

In light of the failure of existing approaches to directory accuracy, states should adopt directory accuracy policies with numeric accuracy targets, comprehensive reporting requirements, and strict enforcement procedures. The foundation of this proposal is that directories can and should be highly accurate, reflecting both what insurers can attain with sufficient investment in directory content and the enormous importance of directory accuracy to consumers. To achieve this target, states should require plans to regularly update their directories, meet numeric accuracy benchmarks, and include specified information in directory entries. States should also require plans to regularly audit their entire directory, and automatically fine plans that have failed to meet accuracy benchmarks. Lastly, as a backstop to state enforcement, states should establish a broad right of action allowing providers and consumers to sue plans who fail to comply with directory accuracy policies.

While these policies would be enormously helpful to consumers even if they only applied to individual and Medicaid plans, large portions of this policy framework would likely survive an ERISA preemption challenge, meaning they can also govern employer health plans. ERISA stands for the Employee Retirement Income Security Act, a 1974 law governing employee benefit plans—including employer sponsored health insurance.²²⁰ Meant to ensure that employer benefits can be administered uniformly across states, ERISA contains several strong preemption clauses.²²¹ These clauses significantly limit states' ability to act as regulators for the sixty-one percent of Americans who receive health insurance through their jobs.²²² But despite ERISA's broad reach, its preemption is not absolute. The policies proposed here are likely to at least partly survive ERISA-preemption, allowing them to apply broadly to all of a state's consumers.²²³

220. Carmel Shachar & I. Glenn Cohen, *Restoring The Preemption Status Quo*: Rutledge, *ERISA, And State Health Policy Efforts*, HEALTH AFFS. (Dec. 17, 2020), <https://www.healthaffairs.org/doi/10.1377/hblog20201216.308813/full> [<https://perma.cc/92WY-WY44>].

221. *Id.*

222. *Id.*

223. However, the extensive analysis required even for a proposal like this one, which deals with a relatively simple administrative issue, underscores the urgent need for ERISA reform, *See* Erin C. Fuse Brown & Elizabeth Y.

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Vitality, these policies are likely both economically and politically feasible. Economically, requiring accurate directories is not likely to significantly increase insurance premiums. Rather than being driven by administrative costs, rising premiums reflect the fact that health care services are incredibly expensive and premiums are rising much faster than inflation. Premiums also continue to rise because the federal government has been eviscerating federal programs intended to lower them.²²⁴ If companies try to unreasonably pass on the cost of directory accuracy policies in their premiums, there are a several mechanisms available to protect consumers.²²⁵ Ghost network regulations are unlikely to negatively affect insurer participation in health insurance markets, with evidence from ACA marketplaces suggesting that increased regulation of health insurance (such as guaranteed issue and mandating minimum benefits) actually increases the stability of state health insurance markets.²²⁶ Additionally, it is worth noting that small Medicaid insurers—which presumably have some of the tightest profit margins—have been able to successfully implement directory verification strategies that result in high levels of

McCuskey, *The Implications of Rutledge v. PCMA For State Health Care Cost Regulation*, HEALTH AFFS. (Dec. 17, 2020), <https://www.healthaffairs.org/doi/10.1377/hblog20201216.909942/full> [<https://perma.cc/ZG5P-TLZX>] (describing the ongoing need for ERISA reform, even following *Rutledge*).

224. See Anderson et al., *supra* note 48, at 90 (finding that the reason American health care spending is so much higher than other countries' is that the goods and services themselves cost more); David Anderson, Jean M. Abraham & Coleman Drake, *Rural-Urban Differences in Individual-Market Health Plan Affordability After Subsidy Payment Cuts*, 38 HEALTH AFFS. 2032, 2039 (2019) (finding that states who replaced federal premium support and risk allocation programs were able to avoid premium hikes when the programs were eroded).
225. In a number of states regulators have the power to decide premium increases in the individual market, and all states must review premium increases of more than ten percent in the individual and small group markets. KAISER FAM. FOUND., HEALTH INSURANCE MARKET REFORMS: RATE REVIEW 2–4 (2012).
226. See Jon R. Gabel et al., *Why Are Insurance Marketplaces Thriving in Some States, Not Others?*, COMMONWEALTH FUND (Nov. 15, 2018), <https://www.commonwealthfund.org/publications/issue-briefs/2018/nov/marketplaces-thriving-some-states-struggling-others> [<https://perma.cc/7H27-BXB2>] (analyzing the performance of state ACA markets in relation to state level insurance regulations).

accuracy, indicating that accuracy need not require an enormous financial investment.²²⁷

Politically, the majority of states—as well as the federal government—have already come to an agreement on the basic principles that underscore these policies: that additional regulation of insurance directories is necessary given the scope of the harm that directory errors can cause, and that the additional burden this places on insurers is an acceptable and reasonable price to pay for the resulting benefits.²²⁸ Thus, the goal of the policies outlined here is not to stake out a new political consensus but instead to provide tools to ensure that the consensus is respected. Furthermore, these policies are in line with the post-ACA American political landscape. Even a unified Republican government could not repeal the ACA, and the law is now supported by a majority of Americans.²²⁹ Medicaid is joining Social Security and Medicare as a political “third rail” that politicians attempt to dismantle at their peril, and again and again, voters have approved referendums that expand Medicaid access.²³⁰ Americans want themselves and their communities to have access to adequate health care,

227. See CAL. STATE AUDITOR, IMPROVED MONITORING OF MEDI-CAL MANAGED CARE HEALTH PLANS IS NECESSARY TO BETTER ENSURE ACCESS TO CARE, Rep. No. 2014-134, at 2 (2015) (describing the successful directory accuracy procedures of some Medicaid MCO insurers).

228. See ZELIS, *supra* note 94 (listing the twenty-nine states that had adopted directory accuracy policies as of 2017).

229. Liz Hamel, Ashley Kirzinger, Cailer Munana, Lunna Lopes, Audrey Kearney & Mollyann Brodie, *5 Charts About Public Opinion on the Affordable Care Act and the Supreme Court*, KAISER FAM. FOUND. (Dec. 18, 2020), <https://www.kff.org/health-reform/poll-finding/5-charts-about-public-opinion-on-the-affordable-care-act-and-the-supreme-court> [<https://perma.cc/8EKN-8E8E>].

230. See Rachana Pradhan, *Medicaid Shows Its Political Clout*, POLITICO (July 19, 2017), <https://www.politico.com/story/2017/07/19/medicaid-shows-its-political-clout-240699> [<https://perma.cc/58EW-H9CK>] (“Medicaid may be the next ‘third rail’ in American politics. Resistance to cutting the health care program for the poor has emerged as a big stumbling block to Obamacare repeal, and Republicans touch it at their political peril.”); Sarah Kliff, *How Progressives Flipped the Script on Medicaid Expansion*, N.Y. TIMES (Aug. 4, 2020), <https://www.nytimes.com/2020/08/04/upshot/missouri-election-medicaid-expansion.html> [<https://perma.cc/KTT5-JBGY>] (describing the striking success of Medicaid expansion ballot initiatives which “have extended Medicaid eligibility to around one million low-income Americans living in states where governors or legislatures have opposed the program”).

and they have gone to town hall meetings, protests, and the polls to support government interventions that bring that goal further within reach.

A. Provider Directories Should Be Highly Accurate

Before laying out the proposed policy framework, it is necessary to establish how accurate directories should have to be. Some plans have attained error rates of under five percent in certain categories, demonstrating that extremely low error rates are possible.²³¹ At a minimum, provider directories should be more accurate than Google, otherwise there is no reason for them to exist at all.²³² This article does not provide a single accuracy percentage that states should use—since the precise benchmark states choose will reflect the characteristics of their health care markets, their method for monitoring directories, and political necessity—and instead proceeds on the broader premise that directories both can and should be highly accurate. The reason for this premise is twofold. First, insurers are capable of achieving extremely high accuracy rates; second, the impact that directory errors can have on consumers' health and the disproportionate burden they place on marginalized communities necessitates setting extremely strict accuracy standards.

With adequate investment of time and resources, insurers are capable of achieving extremely high accuracy rates. First, existing high error rates are not a sign that plans cannot attain accurate directories; they're a sign the plans have not even tried to attain accurate directories. CMS's study of Medicare Advantage directory errors found that a key driver of directory errors was insurers' lack of any internal process to audit and verify directory information.²³³ Instead, plans typically rely on data from outside vendors, despite the fact that those data often contain significant errors.²³⁴ However, the California State Auditor's investigation of Medicaid directory errors demonstrates that investing in accuracy plans can significantly

231. See CMS Phase One Report, *supra* note 11, at 1 (“Within each MAO directory, the percent of inaccurate locations ranged from 1.77% to 86.53%”).

232. See Michael S. Adelberg et al., *Improving the Accuracy of Health Plan Provider Directories*, COMMONWEALTH FUND (July 7, 2019), <https://www.commonwealthfund.org/publications/journal-article/2019/jun/improving-accuracy-health-plan-provider-directories> [https://perma.cc/TUX5-E2F8] (“Google was the most accurate source for a provider’s name, address, and phone number.”).

233. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 83, at 8.

234. *Id.*

increase their accuracy rates. The Auditor found that one plan, Partnership HealthPlan, had errors in only three percent of its directory entries. Partnership was able to achieve this high accuracy rate by regularly visiting all of its providers.²³⁵ In contrast, Anthem, which had no similar program of provider visits, had an error rate over twenty percent.²³⁶ Strategies to create accurate directories exist, but they are only effective if insurers adopt them.

The experience of the airline industry also demonstrates that it is entirely possible for companies to track large amounts of complex data with only minimal errors. Selling the correct number of tickets for each flight is a complex calculation that requires keeping track of the location and availability of millions of seats in real time. But despite the enormous complexity of this data, fewer than five millionths of one percent of airline passengers are denied boarding because their flights have been oversold.²³⁷ Of course, airlines have enormous financial incentives to keep their passenger data up to date. Passengers who are involuntarily bumped from their flights due to overselling are guaranteed the cash value of their ticket as well additional cash compensation if the airline cannot get them to their destination within one hour of their original arrival time.²³⁸ But the relationship between airlines' accuracy rates and strict regulatory standards further underscores both the importance of strong directory accuracy policies and the feasibility of achieving high directory accuracy rates: given sufficient economic incentives, companies can build highly efficient verification systems.

Not only are high accuracy rates feasible for insurers, setting high accuracy benchmarks would be consistent with America's broader health policy, which recognizes the need for stringent regulatory standards when consumers' health is at risk. Food safety guidelines provide a helpful analogy. The international standard for food contamination, the Codex Alimentarius, sets acceptable levels of contamination so low that they are

235. CAL. STATE AUDITOR (2015), *supra* note 227, at 2.

236. *Id.* at 2, 66.

237. OFF. OF AVIATION ENF'T & PROC., AIR TRAVEL CONSUMER REPORT 41 (Nov. 2018), <https://www.transportation.gov/sites/dot.gov/files/docs/resources/individuals/aviation-consumer-protection/327056/november-2018-atcr.pdf> [<https://perma.cc/C42K-ZCUQ>].

238. Kelli B. Grant, *Here's What You're Entitled to If You're Involuntarily Bumped from a Flight*, CNBC (Apr. 12, 2017), <https://www.cnbc.com/2017/04/12/heres-what-youre-entitled-to-if-youre-involuntarily-bumped-from-a-flight.html> [<https://perma.cc/MHG7-GZ94>].

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measured in micrograms per kilogram.²³⁹ Foodborne illness regulations can be similarly strict. In 2018, the FDA issued a mandatory recall of one manufacturer's kratom products after a salmonella outbreak connected to kratom sickened 199 people.²⁴⁰ These exacting standards reflect the enormous consequences that food contamination can have. When people's health is at risk, our regulatory system demands precise, exacting compliance. Directory error regulations should reflect the same risk calculus.

Alongside the need to protect people's health, the link between directory errors and social inequity also demands high levels of accuracy. As described above, directory errors disproportionately harm already marginalized groups. The only way to ensure that directories are equally useful for *all* consumers, not just ones with socio-economic privileges, is for directories to be entirely accurate. Directory errors imperil people's health and widen existing social chasms, and policies to address them must reflect these stakes. Anything less than maximal accuracy fails to protect consumers.

B. Proposed Directory Accuracy Policy

Instead of relying on existing directory accuracy policies, which lack the enforcement provisions needed to be effective, states should adopt the following directory accuracy framework. The goal of this framework is to produce directories with accurate data that are useful to consumers by creating incentives for insurers to invest in directory accuracy. It seeks to alleviate the policy shortcomings outlined in Sections III and IV by setting clear, enforceable directory standards, moving away from complaint-based enforcement, and creating multiple pathways for consumers and governments to penalize plans that fail to comply with these standards. To that end, the framework is split into three parts: regulation of directory content and accuracy, consumer protection, and enforcement mechanisms.

239. FOOD & AGRIC. COMM'N OF THE U.N., CODEX ALIMENTARIUS GL 3, at 9 (2016).

240. Office of the Commissioner, *FDA Orders Mandatory Recall for Kratom Products Due to Risk of Salmonella*, FOOD & DRUG ADMIN., <https://www.fda.gov/news-events/press-announcements/fda-orders-mandatory-recall-kratom-products-due-risk-salmonella> [<https://perma.cc/4K3D-8UCL>].

1. Directory Content

Plans²⁴¹ should be required to maintain accurate directories of all in-network providers and facilities. To ensure that there is a clear understanding of what “accurate” means, states should set a specific numeric accuracy threshold that plans must meet. This standard should apply both to the plan overall and to specific provider subgroups, particularly specialists and mental health providers (given the stark divide between accuracy rates for mental health care providers and other types of providers, as highlighted by the California directory accuracy data). Plans should also be required to prominently display a phone number, email address, and address where enrollees can report directory inaccuracies in all enrollment documents, all printed directories, and all directory website pages.

States should also set specific data requirements and update standards. Insurers should list, at a minimum, providers’ and facilities’ name, address, phone number, email address, hours, specialty, sub-specialty if applicable, patient population (whether they serve pediatric patients, adult patients, or both), and whether they are accepting new patients. States should also specify how soon after receiving an error report plans must verify and update directory information. If any information in a directory entry that has been flagged cannot be confirmed within the set update time period because the provider or facility is not responding to communications from the plan, the plan should remove the directory listing from the online directory until the information is confirmed. Lastly, as soon as plans know that a contract with a provider or facility will not be renewed, they should be required to list the termination date in the directory immediately after confirming the non-renewal.²⁴²

2. Consumer Protection

To allow consumers to make informed decisions when choosing a health plan, plans’ directory accuracy rates should be publicly available.

241. To offer the broadest possible protection to consumers, state directory accuracy laws should apply to all health plans licensed by the state.

242. This provision is intended to prevent plans from knowingly listing, during open enrollment, providers and facilities that they know will be terminated from a plan’s network before the coverage year ends, as recently happened in Georgia. *See supra* note 61 (describing misleading practices by a Georgia exchange plan).

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This public disclosure will help alleviate the market failure discussed above in Section I.C. States should also adopt hold-harmless provisions, mirroring those in California's SB 137 and the federal directory accuracy law, which bar plans from charging consumers out-of-network rates for providers listed as in-network in their plan's directory.²⁴³ Finally, if the accuracy of an ACA marketplace plan falls below a certain level, to be determined by state regulators, the state should be required to either institute an emergency special enrollment period for that plan's enrollees (if it runs its own exchange) or request a special enrollment period from HHS (if the state uses the HHS exchange). The state should also be required to institute or request a SEP if a health system of a certain size, also determined by state regulators, leaves an exchange plan.²⁴⁴

3. Enforcement

Enforcement is the most crucial part of this policy framework, and the one that is the most lacking in existing policies. As described above, the vast majority of states have no mechanism for proactively assessing the accuracy of directories, shifting the enforcement burden to consumers. To ensure easy enforcement, plans should be required to fully audit this data and update their entire directory at least once every three months. These audits should be submitted, under penalty of perjury, to the state. As with the quarterly audits, plans should regularly report how often entries are flagged between audits.

To create incentives for plans to comply with directory accuracy policies, every time a plan's directory audit does not meet the accuracy target, the state should automatically fine the plan. In order to ensure that the fine is large enough to incentivize compliance, fines should be tied to plans' premium revenues. If plans repeatedly fail to meet accuracy targets, increasing fines should be levied. Tying fines to plans' revenues and

243. CAL. HEALTH & SAFETY CODE § 1367.27(q) (2017); Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, Div. BB § 116(a), 134 Stat. 1182, 2878-80 (2020). A hold-harmless provision would have saved KB from the \$700 bill that she received. Even though federal law now contains such a provision, it is worth replicating at the state level because, as discussed above, the federal government's enforcement of its insurance rules is highly limited, offering consumers little recourse outside of bringing their own lawsuits.

244. This requirement would prevent the situation that unfolded in Georgia, described *supra* note 61, where a major health system left an exchange plan after open enrollment had concluded, but the state never requested a SEP, leaving many consumers abruptly cut off from their providers.

increasing them as non-compliance escalates is essential to avoiding the problem that Louisiana faces, where plans have seemingly built the state's fines, which appear high relative to the fines levied (or not) by other states—into the cost of doing business.

However, as existing directory accuracy policies show, standard state enforcement mechanisms may not always be effective. Thus, states should also ensure that their attorney general, city and county attorneys, providers, and all enrollees of any health plans subject to the state's directory law (including Medicaid MCOs) shall have standing to sue plans for violating the directory accuracy law. Plaintiffs should be permitted to seek both injunctive relief and monetary damages. In addition to damages, reasonable costs and attorney's fees should be awarded to prevailing plaintiffs. Defendants should only be permitted to recover costs and attorney's fees if the action was not brought in good faith. The goal of the consumer-standing provision is to create something akin to an "implied warranty of legality" for plan enrollees, allowing them to challenge directory inaccuracies before they have been denied benefits, in recognition of the deception and unfairness inherent in selling a product that does not comply with state and federal law, while also maximizing opportunities for government enforcement.²⁴⁵

C. Significant Portions of This Framework Would Likely Escape ERISA Preemption

Importantly, large portions of this policy framework are unlikely to be preempted by ERISA, the "black hole" for health care consumer protections that any state health care regulation must contend with. ERISA's extremely broad preemption provisions—described in more detail below—often prevent the application of state insurance consumer protection laws to people enrolled in employer-sponsored plans, particularly self-funded employer plans. For example, while recent years saw a number of states adopt initiatives to protect consumers against surprise billing, because of ERISA preemption those policies did not apply to people enrolled in self-

245. See Monahan, *supra* note 85 (arguing for the creation of an implied warranty of legality for health insurance plans); Jill E. Habig & Joanna Pearl, *Cities as Engines of Justice*, 45 *FORDHAM URB. L.J.* 1159 (2019) (describing the importance of empowering localities to enforce laws on behalf of their residents).

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funded employer plans.²⁴⁶ ERISA has also scuttled broader state attempts to reign in health care costs. Following the Supreme Court's holding in *Gobeille v. Liberty Mutual Insurance Company* that ERISA prevented states from requiring that self-funded insurance plans participate in their all-payer claims databases (repositories of health care utilization and cost data that provide vital information about public health and health care pricing), some states lost nearly a third of their claims data.²⁴⁷

But although ERISA preemption is sweeping, it is not unlimited.²⁴⁸ First and most importantly, ERISA does not apply to individual commercial plans or Medicaid plans, giving states broad scope to protect consumers in those markets.²⁴⁹ Due to the coverage expansions enabled by the ACA these are sizable markets; just over a quarter of all Americans are enrolled in an individual or Medicaid plan.²⁵⁰ Additionally, consumers from marginalized groups are disproportionately likely to be insured through individual and Medicaid plans. So even if state ghost network regulations were limited to non-ERISA plans, they would still have a significant impact. That impact would likely be further multiplied by the fact that many companies sell both ERISA and non-ERISA plans, and any chanced practices or procedures for non-ERISA plans would likely be at least partly adopted for ERISA plans.

But even for employer plans, ERISA preemption is not absolute. ERISA contains both conflict preemption and complete preemption provisions. Both are potentially implicated by state directory accuracy policies. First, conflict preemption. ERISA preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by

246. Loren Adler et al., *Stopping Surprise Medical Bills: Federal Action Is Needed*, HEALTH AFFS. (Feb. 1, 2017), <https://www.healthaffairs.org/doi/10.1377/hblog20170201.058570/full> [<https://perma.cc/4LFX-LG4P>].

247. Carmel Shachar, *The Preemption Clause That Swallowed Health Care: How ERISA Litigation Threatens State Health Policy Efforts*, HEALTH AFFS. (Oct. 15, 2020), <https://www.healthaffairs.org/doi/10.1377/hblog20201013.533063/full> [<https://perma.cc/XTN5-BPTY>].

248. Erin C. Fuse Brown, *Consumer Financial Protection in Health Care*, 95 WASH. U. L. REV. 127, 194 (2017).

249. The exception, as always, is Medicare Advantage, which has its own sweeping preemption clause. *See supra* note 13 (explaining the breadth of Medicare Advantage preemption).

250. *Health Insurance Coverage of the Total Population*, KAISER FAM. FOUND., <https://www.kff.org/other/state-indicator/total-population> [<https://perma.cc/548N-KKFP>].

ERISA.²⁵¹ A “state law relates to an ERISA plan if it has a connection with or reference to such a plan.”²⁵² To determine whether a law has a connection to an employee benefit plan, courts examine “whether a state law ‘governs a central matter of plan administration or interferes with nationally uniform plan administration.’”²⁵³ ERISA does not preempt state laws “that merely increase costs or alter incentives for ERISA plans without forcing plans to adopt any particular scheme of substantive coverage.”²⁵⁴ To determine whether a law references an ERISA plan, courts investigate whether it “acts immediately and exclusively upon ERISA plans or whe[ther] the existence of ERISA plans is essential to the law’s operation.”²⁵⁵

However, the “savings clause” of ERISA saves from preemption state laws regulating insurance.²⁵⁶ A state law regulates insurance if it is “specifically directed toward entities engaged in insurance” and “substantially affect[s] the risk pooling arrangement between the insurer and the insured.”²⁵⁷ Crucially, due to ERISA’s “deemer clause,” the savings clause carve-out does not apply to self-funded employer health plans.²⁵⁸ There are two types of employer-provided health plans: fully insured and self-funded. For fully insured plans, a health insurance company bears the financial risk for employees’ health care costs.²⁵⁹ For self-funded plans, the employer bears the financial risk, even though a health insurer may be contracted to administer the plan.²⁶⁰

In addition to conflict preemption, section 502 of ERISA completely preempts “any state-law cause of action that duplicates, supplements, or supplants” ERISA remedies.²⁶¹ Section 502 preemption applies to both fully

251. 29 U.S.C. § 1144(a) (2018).

252. *Egelhoff v. Egelhoff ex rel. Breiner*, 532 U.S. 141, 147 (2001) (internal quotation marks omitted).

253. *Rutledge v. Pharm. Care Mgmt. Ass’n*, 141 S. Ct. 474, 476 (2020) (quoting *Gobeille v. Liberty Mut. Ins. Co.*, 577 U.S. 312, 320 (2016)).

254. *Id.* at 480.

255. *Gobeille*, 577 U.S. at 319–20 (quoting *Cal. Div. of Labor Standards Enf’t v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 325 (1997)).

256. 29 U.S.C. § 1144(b)(2)(A) (2018).

257. *Ky. Ass’n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 342 (2003).

258. 29 U.S.C. § 1144(b)(2)(B) (2018).

259. *Fuse Brown*, *supra* note 248 at 185.

260. *Id.* at 188.

261. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 209 (2004).

insured and self-funded plans. The Supreme Court established the test for 502 preemption in *Aetna Health Inc. v. Davila*. Under the *Davila* test, a plaintiff's state law claim against an ERISA plan is completely preempted if the plaintiff "at some point in time, could have brought [the] claim under ERISA § 502(a)(1)(B)," and "there is no other independent legal duty that is implicated by [the] defendant's actions."²⁶² Both prongs must be met for a claim to be preempted.²⁶³

While all of the directory accuracy policies outlined above can be applied to Medicaid and individual plans, and would thus be worth pursuing even if there was no attempt to extend them to employer plans, significant portions of the policies would likely be either exempt from ERISA preemption or within the bulwark of the savings clause. The requirement that plans maintain accurate directories, meet numeric accuracy thresholds, and regularly update directories would likely be upheld with respect to all ERISA plans. While the enforcement mechanisms—regular accuracy audits reported to state regulators—would likely be preempted for self-funded plans, they would likely apply to fully insured plans. Lastly, consumer claims based on state directory laws would be unlikely to be preempted.

1. ERISA Is Unlikely to Preempt Update and Content Regulations

State policies governing how often plans must update their provider directories and what content their directories must include are unlikely to be preempted. Update and content regulations likely do not affect central matters of plan administration or undermine national uniformity because their effect, if any, on employers would be to "merely increase costs or alter incentives for ERISA plans without forcing plans to adopt any particular scheme of substantive coverage."²⁶⁴ The content and update mechanisms of provider directories are completely unrelated to the "substantive coverage" that plans provide enrollees.²⁶⁵ While complying with content and update regulations could in theory increase enrollees' costs by increasing plans' administrative costs,²⁶⁶ affecting costs is not enough to trigger ERISA

262. *Id.* at 210.

263. *Hansen v. Grp. Health Coop.*, 902 F.3d 1051, 1059 (9th Cir. 2018).

264. *Rutledge v. Pharm. Care Mgmt. Ass'n*, 141 S. Ct. 474, 480 (2020).

265. *Id.*

266. *See supra* notes 224–225 and accompanying text.

preemption.²⁶⁷ Additionally, update and content regulations would apply to all plans, so they would not “effectively dictate plan choices.”²⁶⁸ The effect of these regulations would be felt equally across all plans, ensuring that they would not even create “a compelling incentive” to purchase one plan over another, let alone completely dictate employers’ coverage decisions.²⁶⁹ These policies would also apply equally to all plans, so they would likely not impermissibly reference ERISA plans.²⁷⁰

Furthermore, directory update and content requirements would be extremely similar to the law the Supreme Court recently upheld in *Rutledge v. Pharmaceutical Care Management Association*. In *Rutledge*, the Supreme Court upheld an Arkansas law that prohibits pharmacy benefit managers (PBMs), third parties that administer health plans’ pharmacy benefits, from paying pharmacies less for drugs than the pharmacies had to pay to acquire the drugs.²⁷¹ As part of the law’s enforcement scheme, PBMs must update their reimbursement rates within statutory time frames whenever the rate changes by the amounts specified in the statute.²⁷² The Court found that this requirement was entirely outside of ERISA’s preemption provision because it applies equally to all plans and would affect only plan costs, not plan benefit design.²⁷³ Given the similarity between the proposed update requirement and the Arkansas law, it is likely that courts would hold ERISA does not preempt state-mandated directory update time frames. The logic of *Rutledge* would likely also apply to laws regulating directory content, since regulating update frequency is a form of regulating content.

267. See *Rutledge*, 141 S. Ct. at 480 (“ERISA does not pre-empt state rate regulations that merely increase costs or alter incentives for ERISA plans without forcing plans to adopt any particular scheme of substantive coverage.”).

268. See *id.* at 481 (“Nor is the effect of [the Arkansas law] so acute that it will effectively dictate plan choices. Indeed, [the law] is less intrusive than the law at issue in *Travelers*, which created a compelling incentive for plans to buy insurance from the Blues instead of other insurers. [The Arkansas law], by contrast, applies equally to all PBMs and pharmacies in Arkansas. As a result, [it] does not have an impermissible connection with an ERISA plan.” (internal citations omitted)).

269. *Id.*

270. See *id.* (holding that the Arkansas law does not impermissibly refer to ERISA “because it applies to PBMs whether or not they manage an ERISA plan”).

271. *Id.* at 479.

272. *Id.*

273. *Id.* at 480–81.

While *Rutledge* concerned a state law affecting a third-party partner of ERISA plans, its holding would likely also apply to laws—like directory content regulations and update standards—that directly affect plans. The text of the *Rutledge* opinion is not cabined to third parties. The opinion’s central holding, that “ERISA does not pre-empt state rate regulations that merely increase costs or alter incentives for ERISA plans,” is phrased broadly and contains no caveats limiting it to regulations affecting third parties.²⁷⁴ Indeed, the section of the opinion addressing whether the Arkansas law is impermissibly connected to ERISA contains no analysis of whether the fact that the law does not directly act on insurers affects its connection to ERISA plans.²⁷⁵ While the Court does note, when holding that the law does not impermissibly refer to ERISA, that “the Act does not directly regulate health benefit plans at all, ERISA or otherwise,” the Court’s primary reason for determining that the law does not refer to ERISA is the fact that it applies equally to all regulated entities, regardless of whether they deal with ERISA plans.²⁷⁶

Rutledge’s underlying reasoning is also not limited to laws affecting third parties. In reaching the conclusion that laws only affecting insurers’ costs are not preempted by ERISA, the Court’s decision relies heavily on *New York State Conference of Blue Cross and Blue Shield Plans v. Travelers Insurance Company*, going so far as to declare that “[t]he logic of *Travelers* decides this case.”²⁷⁷ While the New York law upheld in *Travelers* created indirect costs for plans by imposing a surcharge on some privately insured patients, it also imposed a surcharge directly on HMOs.²⁷⁸ And in finding that the law was not preempted by ERISA because it had “only an indirect economic effect on the relative costs of various health insurance packages,”²⁷⁹ the Court did not distinguish between the portions of the law that acted directly and indirectly on plans. The *Rutledge* opinion itself characterizes the law at issue in *Travelers* as presumably imposing a direct

274. *Id.* at 480.

275. *Id.* at 481.

276. *Id.*

277. *Id.* (citing *N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995)).

278. *N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 650 (1995).

279. *Id.* at 662.

cost on plans.²⁸⁰ Thus, “the logic of *Travelers*” encompasses both direct and indirect effects on ERISA plans.²⁸¹

2. ERISA Would Likely Partially Preempt Audit and Reporting Requirements

State laws mandating directory audits and requiring plans to report audit results to the state are likely preempted for self-funded employer plans, but not for fully insured plans. For self-funded plans, the Supreme Court’s holding in *Gobeille* all but ensures that audit and reporting requirements would be preempted. In *Gobeille*, the Supreme Court held that ERISA preempted a Vermont law requiring all plans to submit claims data to a state database.²⁸² The Court found that the state reporting requirements undermined ERISA’s goal of nationally uniform ERISA plan administration.²⁸³ Since the audit and reporting requirements proposed here are even more onerous than those at issue in *Gobeille*, which only required plans to submit data they already collect rather than collect an entirely new pool of data, courts would likely hold that ERISA preempts their application to self-funded plans.²⁸⁴

However, for fully insured plans, state audit and reporting requirements would likely fall within the savings clause, allowing them to withstand preemption.²⁸⁵ Directory audits would allow states to fully enforce their network adequacy requirements, resulting in changes to

280. *Rutledge*, 141 S. Ct. at 480.

281. *Rutledge* also cites two other cases where the law at issue acted directly on plans: *De Buono v. NYSAILA Medical and Clinical Services Fund*, 520 U. S. 806, 816 (1997), which concluded that ERISA did not preempt a state tax on gross receipts for patient services that simply increased the cost of providing benefits; and *California Division of Labor Standards Enforcement v. Dillingham Construction, N.A., Inc.*, 519 U.S. 316, 332 (1997), which held that ERISA did not preempt a California statute that incentivized, but did not require, plans to follow certain standards for apprenticeship programs. *Rutledge*, 141 S. Ct. at 480.

282. *Gobeille v. Liberty Mut. Ins. Co.*, 577 U.S. 312, 326 (2016).

283. *Id.*

284. *See id.* at 315–16 (describing the Vermont law’s reporting requirements).

285. *Gobeille* did not address the savings clause because the respondent was a self-funded plan. *Id.* at 317.

plans' benefits and network design.²⁸⁶ They would also inform regulators' approvals of plans and rates, and allow consumers to make informed decisions when choosing plans.²⁸⁷ Audit and reporting requirements would thus "alter the scope of permissible bargains between insurers and insureds," as required to avoid preemption.²⁸⁸

3. ERISA Is Unlikely to Preempt Consumers' Right of Action

Finally, ERISA is unlikely to preempt suits by ERISA-plan enrollees based on state directory accuracy policies. These suits would not fulfill the second prong of the 502(a) preemption test established by the Supreme Court in *Davila* because they would be based on an independent legal duty originating outside of the terms of enrollees' health plans.²⁸⁹ Health plans' duty to maintain accurate, regularly updated directories would stem from state law, not from ERISA plans' contracts with enrollees or the denial of benefits to enrollees.²⁹⁰

The Ninth Circuit's decision in *Hansen v. Group Health Cooperative* is helpful in illustrating the distinction. In *Hansen*, the plaintiffs asserted that the criteria the defendant used to determine mental health coverage violated Washington State's Consumer Protection Act because, among other

286. See Fuse Brown, *supra* note 248, at 186 (explaining that "[s]tate network adequacy and provider directory laws would also likely constitute insurance regulation").

287. See *id.* at 187 (arguing that state all-payer claims databases fall within the savings clause because they "provide the raw data that permit states to operate consumer price transparency tools and regulate insurance company premiums through rate review" and "thus alter the scope of permissible bargains between insurers and insureds by providing enrollees with certain benefits, such as price comparison tools; by regulating premiums; and by helping plans steer enrollees to high-value providers through cost-sharing incentives").

288. *Id.*; see also *Ky. Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 338 (2003) ("[C]onditions on the right to engage in the business of insurance must also substantially affect the risk pooling arrangement between the insurer and the insured to be covered by ERISA's saving clause.").

289. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 210 (2004).

290. See *Hansen v. Grp. Health Coop.*, 902 F.3d 1051, 1060 (9th Cir. 2018) (finding that the plaintiff's state law cause of action "is unlike those in *Davila* because it does not piggyback on, and is thus independent of, the specific rights 'established by the benefit plans'" (internal citation omitted)).

claims, the defendants used the criteria to skirt Washington's mental health parity law, which requires health plans to treat medical services and medically necessary mental health care equally.²⁹¹ The court held that this claim did not satisfy the second prong of the *Davila* test because the parity law creates a "statutory duty [that] exists apart from a plan's defined terms."²⁹² The fact that the duty requires the existence of a health plan does not erode its independence because "[t]he relevant inquiry . . . focuses on the *origin* of the duty, not its relationship with health plans."²⁹³ As the court explained, "[i]n *Davila*, the state law applied only when a benefit plan covered treatment, while [in *Hansen*] the state law applies to how all benefit plans cover mental health treatment."²⁹⁴

Courts would likely replicate the Ninth Circuit's reasoning in *Hansen* when assessing state directory accuracy policies, finding that they do not meet the second prong of *Davila* and are not preempted. Unlike the law at issue in *Davila*, whose scope was explicitly determined by the terms of enrollees' plans, directory accuracy policies would impose a duty on plans to provide accurate directories regardless of plan terms.²⁹⁵ This distinction is evidenced by the fact that plans would have a duty to make accurate directories available to anyone, regardless of whether or not they are enrolled in the plan. Even though the duty would rely on the existence of a plan, its origin would be state law—not the plan's terms.

291. *Id.* at 1055.

292. *Id.* at 1060.

293. *Id.*

294. *Id.*

295. *See Aetna Health Inc. v. Davila*, 542 U.S. 200, 213 (2004) (explaining that under the Texas law, "a managed care entity could not be subject to liability . . . if it denied coverage for any treatment not covered by the health care plan that it was administering. Thus, interpretation of the terms of respondents' benefit plans forms an essential part of their THCLA claim, and THCLA liability would exist here only because of petitioners' administration of ERISA-regulated benefit plans. Petitioners' potential liability under the THCLA in these cases, then, derives entirely from the particular rights and obligations established by the benefit plans").

CONCLUSION

Van Halen's tour rider infamously required venues to provide the band with a bowl of M&Ms but banned brown M&Ms backstage.²⁹⁶ While it seems frivolous, this actually had a deadly serious purpose.²⁹⁷ Van Halen's tour involved a huge amount of equipment, which could cause a life-threatening accident if not set up correctly.²⁹⁸ The brown M&M clause allowed the band to check the venue's attention to detail. If the M&M rule was being followed, there was a good chance the other ones were too.²⁹⁹ Similarly, the persistence of ghost networks highlights one of most pernicious, yet underdiscussed features of the American health insurance system: that despite decades of health care reforms we have not figured out how to effectively regulate it. The fact that consumers are confronting error-filled directories, that regulators are not able to ensure something as basic as correct addresses being listed for providers, is a sign of a much deeper breakdown in America's regulatory structure for health insurance.

Most American health care regulations treat the existence of regulatory standards as an end unto itself, assuming that regulations will be followed simply because they are there. As a result, what appear to be comprehensive regulations exist only on paper, with compliance checks by regulatory agencies reduced to a box-checking exercise.³⁰⁰ No one rigorously examines

296. *Fine Print*, THIS AM. LIFE (July 24, 2009), <https://www.thisamericanlife.org/386/fine-print> [<https://perma.cc/BYM6-LN8L>].

297. *Id.*

298. *Id.*

299. *Id.*

300. *See, e.g.*, Abbi Coursolle, *Exceptions to Network Adequacy Rules May Exacerbate Health Disparities in Medi-Cal Managed Care*, NAT'L HEALTH L. PROGRAM (Jul. 31, 2019), <https://healthlaw.org/exceptions-to-network-adequacy-rules-may-exacerbate-health-disparities-in-medi-cal-managed-care> [<https://perma.cc/47E9-8VF4>] (arguing that the vast number of alternative access standards approved by the California DHCS undercut the efficacy of California's Timely Access rule); CAL. STATE AUDITOR, REPORT 2018-111, DEPARTMENT OF HEALTH CARE SERVICES MILLIONS OF CHILDREN IN MEDI-CAL ARE NOT RECEIVING PREVENTIVE HEALTH SERVICES 23 (Mar. 2019) ("Federal law requires that the State's network adequacy standards consider the number of providers not accepting new Medi-Cal patients as well as the ability of providers to communicate with beneficiaries in their preferred language. However, DHCS's procedure for reviewing alternative access standards requests does not require plans to identify in their requests which providers

insurers' conduct and there are functionally no penalties for insurers that ignore state and federal regulations. California's directory accuracy regulations are, on paper, some of the strongest in the country, and yet they go almost entirely unenforced.³⁰¹ The same is true of mental health parity,³⁰² network adequacy,³⁰³ and cultural and linguistic access³⁰⁴ regulations. There is, in short, a crisis of enforcement.

To translate consumer protections from the page to people's lives, policymakers must develop and popularize sustained, low-effort, and broad-based enforcement strategies. If the only thing backstopping health care policies is a hope that insurers will comply, the policies will fail. In this effort directory accuracy policies function as a bellwether. Eradicating ghost networks would strengthen the models and skills needed to achieve a broader rebalancing of the health insurance system in favor of consumers. But if ghost networks persist and regulators continue to allow large scale consumer deception to flourish, it is a warning of what is to come for other health care reforms.

are, or are not, accepting Medi-Cal patients and what languages the providers speak.”).

301. See *supra* notes 182, 188–191 and accompanying text (describing California's minimal enforcement of directory accuracy laws).
302. See Gold, *supra* note 25 (describing the continued lack of parity for mental health care in health insurance coverage); Jocelyn Wiener, *Californians Aren't Getting the Mental Health Care They're Legally Guaranteed. Why Not?*, CALMATTERS (Dec. 8, 2019), <https://calmatters.org/projects/california-mental-health-care-parity> [<https://perma.cc/8YDP-LNHQ>] (describing the continuing failure of California's approach to parity enforcement); Jocelyn Wiener, *Mental Health Care Outcry Targets Kaiser - and State Regulators*, CALMATTERS (Dec. 18, 2019), <https://calmatters.org/projects/mental-health-care-outcry-targets-kaiser-california-parity-regulators> [<https://perma.cc/45P2-CD69>] (describing the California DMHC's failure to effectively reign in parity violations by Kaiser).
303. See R. Bruce Williams, *How Can You Stop Surprise Bills? Enforce Network Adequacy Rules*, MORNING CONSULT (Apr. 16, 2019), <https://morningconsult.com/opinions/how-can-you-stop-surprise-bills-enforce-network-adequacy-rules> [<https://perma.cc/QXK7-CKGK>] (highlighting the dearth of state regulator actions related to narrow networks).
304. See CAL. STATE AUDITOR, *supra* note 300, at 23 (detailing the California DMHC's failure to ensure that Medi-Cal MCOs are providing culturally and linguistically accessible care to enrollees).