Health plans face new liabilities for inaccurate provider directories

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In this article

The Consolidated Appropriations Act, 2021 (CAA) (Pub. L. No. 116-260) includes provisions (29 USC § 1185i) to protect health plan enrollees from unexpected out-of-network bills caused by inaccurate provider directories. Beginning in 2022, group health plans, insurance issuers and providers must take specific steps to improve provider directories and bear certain costs when inaccurate directories cause patients to incur out-of-network charges. Although implementing guidance has not come out yet, group health plans and issuers must make a good-faith effort to comply. This GRIST summarizes the CAA's provider directory provisions and identifies open issues that may pose compliance challenges.

Overview of CAA's provider directory provisions

Most health plans provide participants with a directory of participating providers, but these directories — whether in electronic or print format — sometimes have out-of-date listings. Prior to the CAA, enrollees often bore the cost of provider directory errors. When an enrollee received medical care from an out-of-network provider misidentified in the plan's directory as in network, the health plan would process the claim as out of network. Enrollees typically pay a greater share of the cost for out-of-network services, and healthcare providers bill enrollees for whatever costs their health plan does not pay.

The CAA's provider directory provisions aim to reduce this type of unexpected billing. First, the law requires that group health plans, issuers and providers take specific steps to improve the accuracy and availability of provider directories. Second, the law protects enrollees who receive inaccurate provider directory information from unexpected out-of-network charges. In this situation, the health plan must apply in-network cost sharing and count any amounts paid toward the in-network deductible and out-of-pocket maximum. The out-of-network provider must refund any payments exceeding the in-network cost sharing to the enrollee.

Types of health plans and policies affected. The CAA's provider directory provisions apply to health insurance issuers and group health plans, including church plans and nonfederal governmental plans. Excepted benefits, such as limited-scope dental and vision plans, retiree-only plans, most health flexible spending arrangements and short-term limited-duration plans, do not have to comply. The law does not explicitly exclude health plans without provider networks (such as health reimbursement arrangements or traditional indemnity plans). However, the CAA's provider directory provisions do not seem relevant to these plans; confirmation from regulators would be helpful.

Effective date. For group health plans and issuers, the provider directory provisions take effect with the 2022 plan year. Recent FAQs from the departments of Labor (DOL), Treasury, and Health and Human Services (HHS) confirm that the effective date will not be delayed, although the agencies do not expect to issue implementing regulations until sometime in 2022. Group health plans and issuers must make a good-faith effort to comply until regulations are issued.

What is good-faith compliance? The agencies will consider an issuer or group health plan to act in good-faith compliance if it limits its charges for out-of-network care (in the manner described below) to an enrollee who receives inaccurate information about the provider's network status in a provider directory or response protocol. By implication, a health plan presumably could be in good-faith compliance without satisfying the CAA's new mandates to improve the accuracy of the plan's provider directory. However, plans should immediately work to ensure that enrollees receive accurate information about the network status of providers. The more accurate the provider directory information, the fewer participants will incur unexpected out-of-network bills (which may raise plan costs, as discussed later).

New mandates to improve accuracy of provider directories

The CAA aims to improve provider directories by mandating that group health plans and issuers satisfy each requirement listed in the chart starting on the next page. The chart includes any CAA details about each requirement, as well as open questions that hopefully will be addressed in future guidance.

Provider directory requirements for group health plan and insurance issuers		
CAA requirement	**CAA compliance details**	**Unanswered questions**
Maintain a public database.	• Database must appear on the plan or issuer's public website. • Database must list each provider with which the plan has a direct or indirect contractual relationship for covered care. • For each provider, database must include this information: — Name — Address — Telephone number — Digital contact information — Specialty (required for individual providers, but not for in-network medical group/clinic/facility)	• Will a self-funded plan's link to a vendor's public website suffice? • If the plan doesn't have a public website, will the employer's public website suffice? • Is an email address, a website URL or a patient portal sufficient digital contact information? • Is additional information required in the database for a multitiered network? • Would any erroneous added details trigger the CAA's protections?
Establish verification process for database.	• Group health plan/issuer must verify and update provider directory information included in database at least every 90 days. • Process must establish procedure for removing a provider whose information can't be verified during a period specified by the group health plan/issuer. • Process must update database within 2 business days of group health plan/issuer receiving CAA-mandated information from providers.	• Are emails from the group health plan/issuer sufficient to verify the provider directory information, or will more labor-intensive telephone calls to providers be required?

Provider directory requirements for group health plan and insurance issuers		
CAA requirement	**CAA compliance details**	**Unanswered questions**
Establish response protocol for telephone inquiries from plan enrollees about a provider's network status.	• Group health plan/issuer must provide written response to the telephone call as soon as practicable, but no later than 1 business day after receiving the call. — Written response can be in electronic or paper format (whichever the individual requests). • Group health plan/issuer must keep a record of the telephone call in an individual's file for at least 2 years.	• Are group health plans/issuers *required* to permit telephone inquiries about network status? Could an employer choose not to offer provider directory assistance by telephone?
Establish response protocol for electronic inquiries from plan enrollees about network status.	• CAA gives no additional details.	• What protocol would satisfy this rule?
Include notice with print directories.	• Notice must state that directory was accurate on the date of its publication. • Notice must instruct enrollees to consult database for the most current provider directory information.	• Are print directories required? (Plans may be subject to other laws or guidance relevant to this question. For example, insured plans may be required by state law to provide print directories and ERISA-covered plans should follow DOL disclosure rules.)

CAA also requires providers to support accurate directories

The CAA requires that providers support group health plans and issuers' efforts to improve provider directories. By Jan. 1, 2022, providers must adopt business processes that ensure group health plans and issuers receive timely information. At a minimum, a provider must submit directory information to the group health plan or issuer at the following times:

- When the provider begins a network agreement
- When the provider terminates a network agreement

- When material changes affect the required provider directory information
- At any other time (including on the issuer's or plan's request) determined appropriate by the provider, facility or the secretary of HHS

The CAA does not specify how quickly a provider must alert the plan or issuer to material changes to the directory information, nor does the law explain what changes are considered material. Regulators have not issued implementation guidance for providers or expressly stated that good-faith compliance is acceptable in the interim.

Billing protections for recipients who rely on inaccurate directories

The CAA's provider directory provisions protect an enrollee from out-of-network expenses for providers incorrectly identified as in network in the plan's directory. When the protections apply, the group health plan or issuer must process the enrollee's claim as in network, and the provider must refund to the enrollee any payment exceeding the in-network cost sharing. However, the CAA does not answer key questions about this billing restriction, such as how much the group health plan or issuer must pay the out-of-network provider or what amount the out-of-network provider must accept as full payment.

Until the federal agencies issue implementing guidance, how these billing protections will operate is uncertain. Plan sponsors should ensure that the third-party administrator (TPA) or issuer is taking appropriate steps to minimize the cost impact to the plan. Self-funded plan sponsors should ask whether their TPA will indemnify them for costs associated with an inaccurate provider directory.

When do the billing protections apply?

Under the CAA, an enrollee is protected from certain out-of-network billing when *all* of the following occur:

- The plan enrollee gets medical care from an out-of-network provider.
- The medical care would be covered by the plan if an in-network provider delivered the care.
- The plan enrollee either:
  - Received through a database, provider directory or response protocol information that indicated the provider or facility participated in the plan's network with respect to a particular item or service.
  - Requested information about the provider's network status through a response protocol but didn't receive the information.

Questions about when the billing protections apply. Until regulations come out, group health plans and issuers are likely to struggle with questions about when the billing protections apply, such as the following:

- **Conflicting information.** Is an enrollee protected from out-of-network billing when one source of information wrongly identifies a provider as in network, but accurate information was readily available?

  Example 1. Paul receives a print directory before the plan year starts on Jan. 1. The print directory lists Paul's dermatologist as a participating provider. The print directory also contains the CAA-required notice, so Paul is informed that the print directory is accurate as of the publication date, but he should consult the online database for the most current network information. Paul's dermatologist leaves the network in March and is removed from the plan's online database. Paul seeks medical care in July, relying on the now out-of-date print directory instead of consulting the online database.

  Guidance clarifying whether Paul is entitled to billing protections would be helpful. It appears that Paul might qualify for protection from out-of-network billing. He received incorrect information from a provider directory, and the CAA does not expressly disqualify Paul from billing protections for failing to check the online database. However, given that Paul's print directory included the required notice instructing him to consult the publicly available online database for accurate provider information, was Paul reasonable to continue relying on the print directory without making any effort to consult the online database?

- **Reliance.** Could an enrollee with actual knowledge that a provider is out-of-network before receiving care ever qualify for the CAA's billing protections? Or are the billing protections only available to enrollees who *rely* on inaccurate provider directory information?

  Example 2. Same facts as Example 1, except when Paul arrives at the July appointment, the dermatologist's administrator asks for Paul's plan ID card and informs Paul that his dermatologist is now out-of-network. Paul checks this information by consulting the plan's online database and finds that his provider is still listed as participating. Is Paul entitled to protections from out-of-network billing under these facts?

  Arguably, Paul is not entitled to protection from out-of-network billing under these circumstances. The title of the relevant CAA provision refers to an enrollee who *relies* on inaccurate provider network information, and Paul has no reason to rely on the directory if the provider has given him accurate network information. In addition, the policy goal of these provisions is to protect enrollees from unexpected out-of-network bills, and Paul's dermatologist has told him to expect an out-of-network bill. Confirmation from the regulators would be helpful, although the plan or issuer often may be unaware of the enrollee's knowledge.

- **Documenting claims for billing protections.** May health plans limit the CAA's billing protections to those enrollees who can prove — with appropriate documentation — that they received an out-of-

network bill from a provider they thought was in-network because they relied on incorrect directory information?

> *Example 3.* Same facts as Example 2, except when Paul arrives at the July appointment, no one asks for Paul's plan ID card. Paul quickly checks the online database for his plan and sees that his provider is still listed as participating, but he doesn't keep a screen shot or record of the search. Is Paul entitled to protections from out-of-network billing under these facts? Does the TPA have to keep archived records of the database and produce the records on Paul's request?

What can the group health plan or issuer charge the enrollee?

When a plan enrollee is protected from unexpected out-of-network charges due to a provider directory error, the CAA prohibits group health plans or issuers from charging the enrollee more than the in-network cost-sharing amount. The CAA also requires that the group health plan or issuer apply the charge to the in-network deductible and out-of-pocket maximum.

What can the provider charge the enrollee?

When a plan enrollee is protected from out-of-network billing due to a provider directory error, the CAA technically does not restrict what the provider can charge the participant. However, the CAA requires the provider to refund to the enrollee any payments above in-network cost sharing in certain situations. The pertinent provision states:

> "If a health care provider submits a bill to an enrollee based on cost-sharing for treatment or services provided by the health care provider that is in excess of the normal cost-sharing applied for such treatment or services provided in-network … and the enrollee pays such bill, the provider shall reimburse the enrollee for the full amount paid by the enrollee in excess of the in-network cost sharing amount for the treatment or services involve, plus interest" (at a rate to be determined by the Secretary of HHS).

Questions about providers' obligations. Without additional guidance, m any questions remain about what providers can bill and what they must refund to an enrollee when the billing protections apply, such as:

- Do providers have to comply with the CAA provider directory provisions starting Jan. 1, 2022, without any implementing guidance? The agency FAQs confirm the deadline for good-faith compliance by group health plans and issuers, but do not address providers.
- How will the provider know when an enrollee is protected from out-of-network billing due to a provider directory error? Will the enrollee or the plan/issuer notify the provider?
- What if the provider obtains the enrollee's informed consent to balance-bill before providing medical care? Would the provider still need to refund amounts exceeding the in-network cost sharing?
- The CAA's provider directory provisions require a refund if the provider bills based on cost sharing above the "normal" in-network amount. What does that mean? If a refund is required, how will the

out-of-network provider know the enrollee's in-network cost-sharing terms (or the "normal" amount, if different)? Is there some amount that the provider could bill that would not be subject to refund?

Will plan costs increase due to the provider directory billing protections?

Plan sponsors can reasonably expect to experience at least some cost increases when the provider directory protections prevent a plan enrollee from paying out-of-network rates, but predicting those costs is difficult. The CAA doesn't mandate how much the health plan must pay the provider or what the provider must accept as payment. A health plan might reimburse an out-of-network provider at an estimated in-network rate, which would minimize the plan's added cost for the provider directory error. However, out-of-network providers might try to challenge reimbursements at the in-network level, particularly if the provider was not at fault for the incorrect information. Plan sponsors may want to consult with counsel about the likelihood of such challenges succeeding.

This issue may be resolved in the contract (or contract termination) between the TPA/issuer and the provider. The CAA expressly allows a provider to enter into a contract ensuring that the group health plan or issuer removes the provider from all directories and assumes financial responsibility when that doesn't occur. Plan sponsors should ask their issuer or TPA whether current or future provider contracts will assign financial liability for provider directory errors. While the CAA expressly permits placing the entire burden on the plan or issuer, the law doesn't expressly forbid other contractual arrangements. TPAs and issuers may be able to negotiate better terms, but that remains to be seen. Employer plan sponsors need to understand what their liability may be, especially if the directory error is due to TPA negligence.

Improving the accuracy of provider directories and response protocols will reduce the risk of triggering the billing protections. This strategy is probably the most straightforward way to mitigate the cost impact of this CAA provision.

Next steps for employers

- Employers sponsoring insured plans should confirm that the issuer intends to comply with the CAA's provider directory provisions and to satisfy the good-faith compliance standard for the 2022 plan year.
- Employers sponsoring self-funded health plans should ensure that the appropriate vendors will comply with the CAA's provider directory provisions, and prepare to monitor each vendor's compliance going forward.
  - Beginning with the 2022 plan year, confirm that the vendor will apply in-network cost sharing and apply those amounts toward the in-network deductible and out-of-pocket maximum when an enrollee receives inaccurate directory information about a provider's network status in a provider directory or response protocol.

  - Ask what steps the vendor is taking to ensure that the online database and response protocol provide accurate provider directory information to enrollees. Ask about current error rates in response to online and telephone inquiries, and what improvement is expected.
  - Prepare to post the online database on the health plan's public website. Since most self-funded health plans do not have public websites, regulatory guidance addressing how to comply would be helpful. For example, could provider directory information be provided through a vendor's public website or through the price comparison/consumer tool required under the CAA and transparency in coverage regulations?
  - Ensure that vendors are properly archiving data in the provider directory and retaining documentation of telephonic and other responses.
  - Confirm that the vendor is including in its provider contracts language addressing financial responsibility for provider directory errors. Will the TPA or issuer negotiate to see if providers will accept some amount less than their standard charge when the billing protections apply? Is the provider willing to bear some of the cost when the provider is responsible, in whole or in part, for the directory error?
  - If the employer has a multi-tiered network, consult with counsel about how to comply with the CAA's provider directory provisions, and confirm that the vendor's approach is satisfactory.
  - Ensure that vendor contracts require compliance with the CAA's provider directory requirements and any future regulations or guidance.
  - Negotiate appropriate indemnity provisions if inaccurate provider directories cause the plan's costs to increase.
  - Ask vendors for reporting of provider directory errors in order to monitor compliance.
  - Consider including a performance guarantee in the vendor contract to ensure that the vendor maintains up-to-date provider directories or adding a provision to permit an audit for directory errors.
  - Consider whether the plan should audit for directory errors.
- Because print directories are more likely to be out-of-date than the online database, employers probably will want to eliminate print directories as much as possible, while still complying with any applicable laws or guidance.
  - For example, sponsors of ERISA-covered plans should review the DOL's disclosure rules, which likely govern how to distribute provider directories. Can the plan expand its use of electronic delivery, while still satisfying the rules?
  - If print directories cannot be eliminated, ask the vendor when print directories will be updated to include the new notice. Work with the vendor to determine which enrollees must receive a print

directory, and when and how the directories will be distributed. Make it as easy as possible for enrollees to find and use the online database instead of a print directory.

- Employers sponsoring insured, church or government plans should continue to comply with any applicable state laws related to healthcare provider directories. Some states, for example, require additional information in provider directories.
- Employers will need to review and comply with agencies' implementing guidance when issued.

Related resources

Non-Mercer resources

- FAQs about implementation of the CAA 2021, Part 49 (DOL, HHS and IRS, Aug. 20, 2021)
- 29 USC § 1185i, Protecting patients and improving the accuracy of provider directory information (ERISA § 720)
- Pub. L. No. 116-260, Consolidated Appropriations Act, 2021 (Dec. 27, 2020)

Mercer Law & Policy resources

- Top 10 health, fringe and leave benefit compliance issues for 2022 (Sept. 7, 2021)

Other Mercer resources

- Regulators clarify implementation timeline of transparency provisions (Aug. 25, 2021)

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