



Improving the Accuracy of Health Insurance Plans' Provider Directories

Since the Affordable Care Act's passage in 2010, there have been vast improvements in health coverage.

These include a monumental decrease in the share of people who lack insurance, improved benefits in many health insurance plans, more accountability for how insurers spend consumers' money, and other accomplishments that have improved access to affordable care in the United States. However, one health insurance problem that existed long before the enactment of the Affordable Care Act (ACA) and still persists today is the inaccuracy of information from insurance plans about the health care providers and facilities that participate in their networks.

Why Accurate Provider Directories Are Necessary

Health plans should provide accurate information about the health care providers and facilities that participate in their networks for many reasons. These include:

Consumers need accurate information about the providers and facilities that are in health plan provider networks when shopping for coverage.

To find the plan that best meets their needs and will protect them from unnecessarily high health care costs, consumers must be able to compare accurate information about the providers and facilities that are in-network for each health plan option.

Health plan enrollees need accurate information about which providers and facilities they can visit in-network.

Once enrolled in coverage, consumers seeking care must have accurate information about in-network providers so that they can find providers and facilities that take their insurance and match their health, language, and other needs. Without this information, for example, they may end up inadvertently receiving care from providers or facilities that are out of network. This would likely expose the consumers to significantly higher charges for that care than the amount of the deductible, copayment, or other cost-sharing they would face if they received care in the network.

Accurate information is necessary for consumers, regulators, and lawmakers to assess the adequacy of an insurer's network.

To create an accurate picture of a plan's network and how robust that network is, its provider directory must be accurate. If a plan's provider directory includes many providers that are not actually in its network, or lists multiple addresses for a provider that sees patients at only one location, the plan's network will appear much more expansive than it truly is. This could lead consumers, particularly those with specific or more advanced health care needs, to feel comfortable enrolling in a plan that, in the end, will not meet their needs. It could also lead the federal and state officials responsible for assessing whether a plan's network is adequate, such as state insurance commissioners, to mistakenly believe a plan is meeting network adequacy standards when it is not.

Inaccuracies in health plan provider directories hinder consumers' ability to obtain affordable care that meets their needs. Inaccuracies also make it hard for regulators and others to assess whether provider networks are adequate to serve enrollees. Health plans and policymakers can take steps to reduce the prevalence of inaccuracies in provider directories. Certain states have already implemented policies to address this problem.

Inaccuracies in Provider Directories Are Prevalent

Consumers often find that reliable information about health insurance provider networks is not available. Common inaccuracies contained in the provider directories maintained by health plans include:

- » Providers who are not actually in the plan's network
- » Inaccurate provider contact information, such as incorrect phone numbers
- » Inaccurate information about which languages providers speak or the type of health care services they deliver

Research Documenting the Prevalence of Inaccurate Provider Directories

One study of Maryland's qualified health plans (QHPs, plans certified for sale on a health insurance marketplace under the ACA) found that less than half (only 43 percent) of psychiatrists listed in their provider directories could be reached at the numbers listed for them. Of those providers listed as psychiatrists that could be reached, 19 percent were not actually psychiatrists (some were other types of mental health providers, and others were different types of physicians, such as family doctors). Considering these and other accuracy problems, the study concluded that only 14 percent of the 1,154 individuals listed in the directories as psychiatrists were available to see new patients who needed to see a psychiatrist within 45 days.¹

As mentioned earlier, provider directory accuracy problems existed before the implementation of the ACA. A study of PPO plans in New Jersey in 2013 (one year prior to the law's implementation) found that contact information was incorrect for one-third (33 percent) of 525 of the psychiatrists listed in their directories.²

This problem is not unique to psychiatrists. California regulators conducted studies of provider directories for two of the state marketplace's major insurers in 2014 and found inaccuracies were prevalent across all types of providers. In one plan, 18.2 percent of providers were not practicing at their listed locations and 8.8 percent did not accept the plan's marketplace insurance.³ In the other plan, 12.5 percent of providers had inaccurate location information and 12.8 percent did not actually accept the plan's marketplace insurance, despite being listed in the plan's online directory as doing so.⁴

Provider Directory Requirements in the Affordable Care Act

The ACA and corresponding regulations put in place certain requirements for QHPs to make provider network information transparent. In addition to general network adequacy standards,⁵ the law requires that plans "provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers."⁶

43%
Less than half of psychiatrists in Maryland QHPs could be reached at the numbers listed for them in the provider directories.¹

Regulations to implement that section of the law are more specific, requiring QHPs to make their provider directories available both online and also in hard copy upon request. The directories must identify providers that are not accepting new patients. The rules also specify that, for 2016 plans, QHPs must publish provider directories that are “up-to-date, accurate, and complete.” Under the preamble to the rule, insurers are required to update their directories at least once a month. The rules also require that, for 2016 plans, directories must include:

- » The provider’s location
- » The provider’s contact information
- » The provider’s specialty
- » The provider’s medical group
- » Any of the provider’s institutional affiliations

Also for 2016 plans, directories must be “easily accessible.” Specifically, this means:

“...the general public is able to view all of the current providers for a plan in the provider directory on the issuer’s public website through a clearly identifiable link or tab and without creating or accessing an account or entering a policy number; and if a health plan issuer maintains multiple provider networks, the general public is able to easily discern which providers participate in which plans and which provider networks.”⁷

Many of these requirements were already in place in previous years for plans in the federally facilitated marketplaces.⁸

Also for the 2016 plan year, the U.S. Department of Health and Human Services (HHS) is requiring plans in the federally facilitated marketplaces to make their provider directory information available on their websites and to HHS in a “machine-readable” format.⁹ This will allow third parties, including HHS, to create new digital provider directory tools.

Additional Steps Are Necessary to Improve Provider Directory Accuracy

The requirements described above are a good first step to ensuring that consumers have access to necessary information in provider directories. However, given the prevalence of provider directory inaccuracies and the consequences these inaccuracies have for consumer plan usability and network adequacy, additional steps must be taken to more directly target and correct directory errors.

For example, although a standard requiring plans to update their directories each month is helpful, it is not sufficient to ensure accurate directories. In practice, if the standard is not clearly defined, a monthly update standard can amount to nothing more than a requirement that plans update their directories with any new information they have received from providers within one month of receiving that information. This requirement, although useful, will not catch any changes to information in the provider directory that are not reported by providers. This could include inaccurate information that has remained in a directory through many update cycles, possibly even for years.

1/3
of psychiatrists listed
in New Jersey PPOs
had incorrect contact
information.²

To more comprehensively address the need for accurate information in provider directories, state and federal policymakers and health plans should require or adopt the following practices:

Establish a process for the public to report inaccuracies:

This may take the form of a web-based “pop-up” box, email address, or phone number displayed prominently on all provider directories for enrollees, potential enrollees, or any member of the public to use to directly notify a plan when they identify provider directory information that is inaccurate, and a guarantee that the plan will investigate these reports and modify directories accordingly in a timely manner. Plans should investigate reports of inaccuracies and modify directories (such as by removing providers no longer in the network) in accordance with their findings within no more than 30 days. Plans should report annually to regulators (such as the state insurance department or HHS) on the number of reports received, the timeliness of the plans’ response, and the corrective actions taken. These data should be available to the public.

Conduct regular audits of provider directories, with directory edits based on findings: Plans should contact a significant sample or all of the providers and facilities in each specialty in their directory twice a year to assess the accuracy of information, such as: 1) whether their contact information is correct, 2) whether they are really in the plan’s network, 3) whether they

are taking new patients. If the directory lists which languages other than English providers speak (see text box on page 6), plans should also assess the accuracy of that information. If any of the information listed in the directory is found to be inaccurate based on the findings of the audit, the directory should be updated within no longer than one month of the date in which the inaccuracy is noted.

Contact inactive providers: Plans should contact providers listed as in-network who have not submitted claims within the past six months to determine whether the providers still intend to participate in the network. Based on the providers’ responses, plans should update their directories accordingly. If providers do not respond within 30 days, plans should attempt contact again, and if providers do not respond within another 30 days, plans should remove the providers from the directory.

Guarantee to honor provider directory information: Plans should give consumers the guarantee that, if consumers rely on materially inaccurate information from a directory indicating that a provider is in-network and receive care from that provider, consumers will be held harmless. Plans should charge consumers only the in-network amount of cost-sharing and allow consumers’ costs to count toward the in-network deductible and out-of-pocket maximum. Consumers must not be responsible for any costs beyond these charges from either the provider (a “balance bill”) or the plan.

18.2%
of providers in
one plan were not
practicing at their
listed locations.³

Plans and policymakers should also explore more efficient ways of populating provider directories with accurate information so that health plans do not have to rely solely on gathering individual pieces of information from separate providers and facilities to compile a directory. For example, policymakers and

plans should explore whether the databases that plans use to determine whether to pay a provider an in-network or out-of-network rate at the time a provider delivers a service could also be used for populating provider directories with information about which providers are in a plan's network.

Provider Directories and Language Accessibility

Ensuring that provider directories have information necessary for people with limited-English proficiency is important to help ensure that all communities are able to access care that effectively meets their needs. However, under federal requirements, health plans do not have to list which languages, other than English, providers speak. Fortunately, some health plans voluntarily list this information. To broadly ensure that provider directories include this information, federal policymakers should require plans to list information about which languages, other than English, providers speak, when applicable. Policymakers at the state level can also act to implement this requirement.

It is not only critical that health plans include information about what languages other than English providers speak, but also that this information is accurate. When this information is included in directories, audits to assess provider directory accuracy should evaluate whether information about the languages providers speak is accurate, and plans should correct any inaccurate directory information about languages providers speak in a timely manner. In addition, directories should only list health care professionals as having the ability to provide care in languages other than English if a health care provider who speaks that language or a trained medical interpreter is available. A directory should not list non-English language abilities if only administrative office staff who are not trained in medical interpretation speak the non-English languages. Health plans should also be able to accept reports of provider directory inaccuracies from the public in languages other than English so that they can remove inaccurate information that consumers with limited-English proficiency identify.

In order to make provider directories useful for all communities, they should be available in non-English languages. The District of Columbia, for example, is launching a Spanish language provider directory for its health insurance marketplace for the 2016 plan year, which will be available on www.DChealthlink.com.

Health plans, the federal government, and states should also take similar steps to provide and maintain accurate and specific information to ensure that provider directories can meet the needs of individuals with disabilities.

Provider Directory Standards from the States

Some states have already enacted the types of policies described previously that can directly address and help eliminate provider directory inaccuracies. Health plans, federal officials, and policymakers in other states can look to these states as models when working to implement policies to tackle provider directory inaccuracies.

California

In 2015, the California legislature passed a bill that would take significant steps to identify and ameliorate provider directory inaccuracies and protect consumers from their negative impacts.

Notable requirements in CA SB 137¹⁰

Regular directory audits and outreach to providers:

At least annually, health plans shall review and update their entire provider directories. They shall notify providers of the information they have in their directories, including a list of networks and plan products that include the providers. For most providers, this notification should be issued every six months¹¹ and include instructions on how the providers can access and update the information using an online interface¹² and a statement that failure to respond may result in delayed payment or reimbursement of a claim.

- » Providers shall confirm that the information in the directory is accurate or update it, including whether they are accepting new patients for each plan product. If the plan does not receive confirmation that the information is accurate or an update within 30 business days, the plan shall take no more than 15 business days to verify whether the provider's information is correct or requires updates. The plan shall document the receipt and outcome of each attempt to verify the information.
- » If the plan is unable to verify the information, the plan shall notify the provider 10 business days in advance of removal that the provider will be removed from the directories. The provider shall be removed at the next required update after the 10-day notice period. Providers shall not be removed if they respond before the end of the notice period.

Regular updating of directories: Insurers must update their online directories at least weekly, or more frequently if required by federal law. The triggers for updates include confirmed enrollee complaints that a provider is not accepting new patients, has incorrect contact information in the directory, or is otherwise not available.

Process for the public to report inaccuracies: The plan shall maintain a process for enrollees, potential enrollees, providers, and the public to report possible inaccurate, incomplete, confusing, or misleading information listed

in the provider directories. This process shall, at a minimum, include a telephone number and dedicated email address at which the plan will accept these reports, as well as a link on the plan's provider directory webpage to a form where the information can be reported directly to the plan.

- » Whenever a plan receives such a report, the plan shall promptly investigate it, and, no later than 30 business days following receipt of the report, either verify the accuracy of the information or update the information, as applicable.
- » When investigating a report regarding its provider directories, the plan shall, at a minimum: 1) contact the affected provider no later than five business days following receipt of the report; and 2) document the receipt and outcome of each report, including: the provider's name, location, and a description of the plan's investigation, the outcome of the investigation, and any changes or updates made to its provider directory.
- » If changes to a provider directory are required as a result of the plan's investigation, changes to the online directory shall be made no later than the next scheduled weekly update, or the update immediately thereafter, or sooner if required by federal law or regulations. For printed provider directories, the change shall be made no later than the next required update, or sooner if required by federal law or regulations.

Enforcement and oversight: A plan may delay payment or reimbursement to a provider who fails to respond to attempts to verify the provider's information in writing, electronically, and by telephone. A plan shall notify the provider 10 business days before it seeks to delay payment or reimbursement. A plan that delays payment or reimbursement shall document each instance and report this information to regulators. A plan may terminate a contract with a provider for a pattern or repeated failure to alert the plan to a change in the information required to be in the directories.¹³

If plans determine that, as a result of removing directory information for non-responsive providers, there has been a 10 percent change in the network for a product in a region, the plan shall file an amendment to the plan's application (which provides detailed information about the plan for oversight purposes) with state regulators.

A guarantee to honor provider directory information: If regulators find that a consumer reasonably relied upon materially inaccurate, incomplete, or misleading information in a provider directory, the regulator may require the insurer to provide coverage for all covered services provided to the consumer and to reimburse the consumer for any amount beyond what the consumer would have paid had the services been delivered by an in-network provider.

District of Columbia

The Executive Board of the District of Columbia's state-based marketplace implemented a resolution¹⁴ establishing requirements applicable to all QHPs (which include most individual market and small group plans in D.C.¹⁵) to take the following steps to ensure provider directory accuracy:

Process for the public to report inaccuracies: In time for the third open enrollment (for the 2016 plan year), prominently post a phone number or email address in online and print provider directories (although not necessarily a dedicated phone number or email address) for consumers to report inaccurate provider directory information.

Insurers will be required, within 30 days, to validate reports that directories are inaccurate or incomplete and, when appropriate, to correct the information. Insurers will be required to maintain a log of consumer-reported directory complaints that will be accessible to the insurance department or the marketplace authority upon request.

Regular audits or outreach to providers: Beginning in 2015, insurers are required to take at least one of the following steps annually and report such steps to the insurance department:

1. Perform regular audits reviewing provider directory information.
2. Validate provider information when a provider has not filed a claim with an insurer in 2 years (or a shorter period of time).

3. Take other innovative and effective actions approved by the insurance department to maintain accurate provider directories. An example could be validating provider information based on provider demographic factors such as an age where retirement is likely.

New Jersey

New Jersey regulations require a measure to help ensure that provider directory information stays current, as follows:

Outreach to inactive providers: Insurers shall confirm the participation of any provider who has not submitted a claim for 12 months or otherwise communicated with the insurer in a manner that demonstrates the provider's intention to continue to participate in the network and for whom no change in provider status has been reported. The process for confirming participation shall be as follows:

1. The insurer shall contact the provider and request that the provider confirm his or her intention to continue to participate in the network. Based on the provider's response, the insurer shall update its directories as necessary.
2. If the provider fails to respond to an insurer's communication, the insurer shall mail a follow-up request to the provider by certified mail, return receipt requested. If the provider fails to respond within 30 days, the insurer shall remove the provider from its network and update its directories as necessary.¹⁶

Texas

Texas regulations protect consumers from the adverse consequences of inaccurate provider directories as follows:

A guarantee to honor provider directory

information: Texas regulations provide protection for consumers in most managed care plans when consumers receive inaccurate information about in-network providers from a provider listing or other information online from their insurer or an entity designated by the insurer to provide information to enrollees. If such information incorrectly states that a given provider is in-network, the consumer will be protected from some or all (depending on the type of plan) of the additional costs for care from that provider if that provider is actually out-of-network and the consumer receives care from the provider believing the provider is in-network. To qualify for this protection, the consumer must have obtained the information no more than 30 days before receiving services from the provider. An insured consumer who qualifies will be protected as follows:¹⁷

- » For exclusive provider organizations (EPOs) (also proposed for HMOs):¹⁸ The consumer will be held harmless for paying any amounts beyond the copayment, deductible, and co-insurance rate that the insured would have paid for the same services from an in-network provider. The insurer must pay the out-of-network provider at the usual and customary rate or at a rate agreed to by the insurer and the provider.¹⁹

- » For PPOs: The insurer must pay the out-of-network provider at the usual and customary charge, using a reimbursement methodology based on providers' billed amounts. If consumers are charged co-insurance, the in-network co-insurance rate must apply. In addition, the consumer's out-of-pocket costs, including any balance bills paid, will count toward the in-network deductible and out-of-pocket maximum.

Process for the public to report inaccuracies:

Effective for the 2016 plan year, insurance plans that use provider networks must conspicuously display in their provider directories an email address and toll-free phone number to which any individual may report any inaccuracy in the directory. When the plan receives a report that specifically identifies potentially inaccurate information, the plan must investigate the report and correct the information, as necessary, no later than the seventh day after the report is received.²⁰

Other Standards for Provider Directory Accuracy

In addition to examples of legislation and regulation from the states, policymakers and regulators may want to consider additional sources of standards for provider directory accuracy when weighing options for addressing this issue.

Medicare Advantage: In its 2016 call letter for Medicare Advantage plans (released April 6, 2015), the Centers for Medicare and Medicaid Services (CMS) outlined provider directory accuracy standards for those

plans that are more robust than CMS currently requires for QHPs or Medicaid plans. These Medicare Advantage standards include direct auditing of provider directories for accuracy and compliance and enforcement actions for plans that fail to maintain complete and accurate directories.²¹

Health Plan Accreditors: Health plan accreditors are independent entities that review plans for quality against the accreditor’s benchmark standards. QHPs must meet certain requirements for accreditation by federally recognized entities.²² The National Committee for Quality Assurance (NCQA), one such entity, recently released its 2016 accreditation standards, which include updates to its provider directory standards.²³ URAC, another federally recognized accreditor, also assesses health plans on provider directory accuracy.²⁴

NAIC (National Association of Insurance Commissioners): The NAIC is currently updating its model law on network adequacy. This model act will contain requirements related to provider directory accuracy and is slated to be complete before the end of 2015.²⁵

Conclusion

Although provider directory inaccuracies have caused problems for consumers and other stakeholders for many years, there are many steps policymakers, regulators, and health plans can take to help ameliorate this issue. Policymakers and regulators at the state and federal levels should prioritize this issue both for private insurance and for public programs like Medicaid, as accurate provider directories are critical to ensuring that coverage works for consumers. Accurate directories protect consumers from inadvertently visiting out-of-network providers who could leave them with high bills and they allow consumers to correctly identify providers who meet their language, location, and other needs. What’s more, they create a true picture of which providers are actually in a plan’s network, making it easier to assess whether or not a network is adequate. By committing to take steps to address provider directory accuracy, federal and state policymakers, as well as health plans directly, can make a meaningful impact on consumers’ health insurance experience and access to providers.

Health plans and policymakers can employ these approaches to ensure provider directory accuracy—and meaningfully improve consumers’ health insurance experience and access to providers.

Endnotes

1 Mental Health Association of Maryland, *Access to Psychiatrists in 2014 Health Plans* (Baltimore, MD: MHAMD, January 2015), available online at: <http://mhamd.org/wp-content/uploads/2014/01/2014-QHP-Psychiatric-Network-Adequacy-Report.pdf>.

2 Mental Health Association of New Jersey, *Managed Care Network Adequacy Report* (Verona, NJ: MHANJ, September, 2014), available online at: <http://www.mhanj.org/wp-content/uploads/2014/09/Network-Adequacy-Report-Final.pdf>.

3 California Department of Managed Health Care Help Center, Division of Plan Surveys, *Final Report: Non-Routine Survey of Blue Shield of California* (Sacramento, CA: DMHC, November 18, 2014), available online at: <http://www.dmhc.ca.gov/desktopmodules/dmhc/medsurveys/surveys/043fsnr111814.pdf>.

4 California Department of Managed Health Care Help Center, Division of Plan Surveys, *Final Report: Non-Routine Survey of Anthem Blue Cross* (Sacramento, CA: DMHC, November 18, 2014), available online at: <http://www.dmhc.ca.gov/desktopmodules/dmhc/medsurveys/surveys/303fsnr111814.pdf>.

5 42 US Code § 18031(c)(1)(B); 45 CFR 156.230.

6 42 US Code § 18031(c)(1)(B)

7 45 CFR 156.230

8 Center for Consumer Information and Insurance Oversight, *2015 Letter to Issuers in the Federally-facilitated Marketplaces* (Washington: CMS, March 14, 2015), available online at: <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf>.

9 45 CFR 156.230

10 California Legislature, *SB 137 Health Care Coverage: Provider Directories*, enrolled September 15, 2015, available online at: <http://www.leginfo.ca.gov>.

11 General acute care hospitals are exempt from these requirements. Federally qualified health centers and primary care clinics, skilled nursing facilities, urgent care centers, ambulatory surgery centers, inpatient hospice, residential care facilities, inpatient rehabilitation facilities, pharmacies, clinical laboratories, and imaging centers must only receive notice of provider directory information once per year.

12 Under SB 137, every plan shall ensure processes are in place to allow providers to verify or submit changes to the information in the directory. Those processes shall, at a minimum, include an online interface for providers to submit verification or changes electronically and shall generate an acknowledgment of receipt from the plan.

13 Limits on payment delays are as follows: Plans may delay payments for up to one calendar month beginning on the first day of the following month. Plans may delay no more than 50 percent of the next scheduled capitation payment for up to one calendar month for providers that receive compensation on a capitated or prepaid basis. If a provider submits the required directory information, the plan must reimburse the full amount of any payment or reimbursement subject to delay no later than three business days following the date on which the plan receives the information.

14 Executive Board of the District of Columbia Health Benefit Exchange Authority, *Resolution to Update*

the Qualified Health Plan Certification Requirements (Washington: DCHBX, February 9, 2015), available online at: <http://hbx.dc.gov/sites/default/files/dc/sites/hbx/publication/attachments/Resolution20to%20Update%20the%20Qualified%20Health%20Plan%20Certification%20Requirement.pdf>; Executive Board of the District of Columbia Health Benefit Exchange Authority, *Qualified Health Plan Certification Requirement Recommendations* (District of Columbia: DCHBX, January 21, 2015), available online at: <http://hbx.dc.gov/sites/default/files/dc/sites/hbx/publication/attachments/Qualified%20Health%20Plan%20Certification%20Requirements.pdf>.

15 The District of Columbia enacted a law to centralize the sale of all individual and small group health insurance through its marketplace. Although some plans may remain grandfathered, eventually all non-grandfathered individual and small group plans will be QHPs. For information on how this transition is occurring, see District of Columbia Health Benefit Exchange Authority, *Health Benefit Exchange Board Approves Transition to Competitive Insurance Market* (Washington: DCHBX, March 13, 2013), available online at: <http://hbx.dc.gov/release/health-benefit-exchange-board-approves-transition-competitive-insurance-market>.

16 N.J.A.C. 11:24C—4.6, “Standards for Accuracy of Provider Directory Information.”

17 28 Tex. Admin. Code §3.3705, available online at: [http://texreg.sos.state.tx.us/public/readtac\\$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=28&pt=1&ch=3&rl=3705](http://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=28&pt=1&ch=3&rl=3705).

18 The Texas Department of Insurance has issued an informal rule update to expand these requirements to HMO plans. See p. 133: <http://www.tdi.texas.gov/rules/life/documents/chapter11informal2.pdf>.

19 In addition, the insurer must provide an explanation of benefits to the consumer, along with a request that the consumer notify the insurer if the provider bills the consumer for amounts beyond the amount paid by the insurer (i.e., balance bills the consumer). For EPOs only, the insurer may require that the consumer request mediation for the insurer and the provider regarding the costs beyond what the insurer pays the provider under the state's official balance billing mediation process, but the consumer will still be held harmless for those costs. Texas Department of Insurance, *Mediation for Out-of-Network Hospital-based Health Care Provider Claims* (Austin, TX: TDI, July 30, 2015), available online at: <http://www.tdi.texas.gov/consumer/cpmmediation.html>.

20 State of Texas, *HB No. 1624: An Act Relating to Transparency of Certain Information Related to Certain Health Benefit Plan Coverage*, June 19, 2015, available online at: <http://www.capitol.state.tx.us/tlodocs/84R/billtext/html/HBO1624F.htm>.

21 Centers for Medicare and Medicaid Services, *Announcement of Calendar Year (CY) 2016 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter* (Washington: CMS, April 6, 2015), p. 138-140, available at: <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2016.pdf>.

22 42 US Code § 18031(c)(1)(D); 45 CFR 156.275.

23 National Committee for Quality Assurance, *Health Plan Accreditation (HPA)- 2016 Standards* (Washington: NCQA, July 28, 2015), available online at: <http://www.ncqa.org/Programs/Accreditation/HealthPlanAccreditation2016Standards.aspx>.

24 URAC, *Health Plan with Health Insurance Marketplace v7.2 Accreditation* (Washington: URAC, June 23-24, 2015), available online at: https://www.urac.org/forms/uploadFiles/2BC761000000D4.filename.Health_Plan_with_Insurance_Marketplace.pdf.

25 For information see: National Association of Insurance Commissioners, *Network Adequacy Model Review (B) Subgroup*, available online at: http://www.naic.org/committees_b_rftf_namr_sg.htm.

A selected list of relevant publications to date:

*Standards for Health Insurance Provider Networks:
Examples From the States* (November 2014)

*Improving Private Health Insurance Networks
for Communities of Color* (August 2014)

For a more current list, visit:

www.familiesusa.org/publications

Publication ID: 000ACA100315

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The author would like to thank Stacey Pogue,
Senior Policy Analyst at the Center for Public Policy
Priorities, for her assistance with this brief.

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