

Pregnancy-Related Churn and Access to Care in the Context of Narrow Networks in Washington
State

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Abstract

Pregnancy-Related Churn and Access to Care in the Context of Narrow Networks in Washington State

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Much is still unknown about the practical impact of narrowing networks and network adequacy on access to care for pregnant women who churn between Medicaid and Qualified Health Plan (QHP) coverage due to an eligibility overlap on their access to health care. This capstone report, conducted in collaboration with Northwest Health Law Advocates (NoHLA), seeks to better understand this impact within the construct of access to OB/GYN providers; first, by examining both the federal and state legal landscapes around network adequacy; second, by exploring to what extent providers are shared across Medicaid and QHP networks by conducting a comparison analysis of King County OB/GYN providers covered by carriers using online provider directories; and third, by providing recommendations to address the challenges and findings.

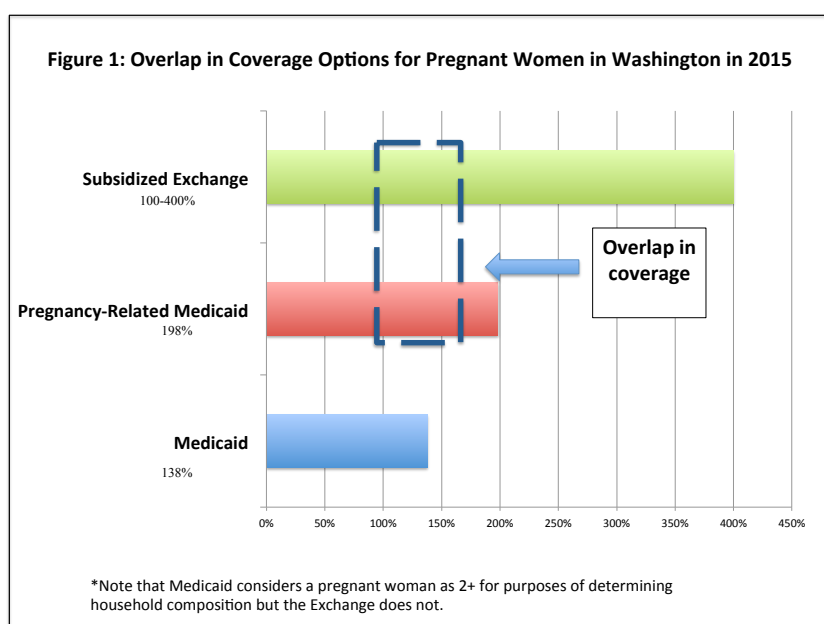
The analysis compared King County OB/GYN provider networks for the insurance carriers certified to sell 2016 QHPs on the Washington Health Benefit Exchange to Medicaid's, finding an average overlap amount of 67.4% of listed providers with carrier's

ranging from 45.8% to 81.9% of overlap. These findings raise concerns relating to women's access to consistent maternal care over the course of pregnancy during a churn event, while underscoring the need to address the challenges around churn and narrow networks. Policy-makers and regulators can begin to address such challenges by creating and enforcing substantive network adequacy standards, providing consumers with information on accessing out-of-network providers while ensuring recourse for consumers impacted, and lastly by strengthening and enforcing requirements that ensure provider directory information is current, accurate and actionable.

I. INTRODUCTION

Before the Affordable Care Act (ACA), pregnant women in Washington State who earned under 185% of the federal poverty level (FPL) qualified for pregnancy-related Medicaid (now Washington Apple Health for Pregnant Women) during their pregnancy and in the two months post-partum. Since this coverage was time-limited, many women lost health insurance coverage after their post-partum period because they did not qualify for any other coverage.

However, with the ACA's passage in 2010, coverage options for Washington women have been greatly expanded: first, through the expansion of the state's Medicaid program – Washington Apple Health (WAH) – which now provides coverage for individuals and families with household incomes at or below 138% of the federal poverty level (FPL);¹ second, through the premium subsidies and cost-sharing reductions for Qualified Health Plans (QHPs) sold on the Washington State Health Benefit Exchange (HBE) available to individuals with incomes up to 400% of the FPL who are ineligible for Medicaid.^{2,3} Women with incomes above 138% to 198% FPL who become pregnant while covered under a QHP remain eligible and may switch over to Apple Health for Pregnant Women (hereafter also called WAH) during and two months following the pregnancy as illustrated in Figure 1.⁴ While these new coverage opportunities under



¹ Patient Protection Affordable Care Act, 42 U.S.C. § 2001 (2012). The Affordable Care Act established an income disregard equal to five percentage points of the FPL disregard “for the purposes of determining income eligibility” for individuals whose eligibility is based on MAGI.

² *Id.* §1401.

³ *Healthplanfinder*, WASH. HEALTH BENEFIT EXCHANGE, www.wahealthplanfinder.org (last visited Feb. 29, 2016). It is worth noting that on Healthplanfinder, women need to report that they are pregnant before being able to assess eligibility for coverage on the HBE. Once doing so, if their income falls below 198% FPL, they are automatically directed to Medicaid plans.

⁴ In particular, Apple Health for Pregnant Women provides “categorically needy” coverage to pregnant women with countable income at or below 193% of the FPL (plus the 5% disregard) without regard to citizenship or immigration status. Once enrolled, the “individual is covered regardless of any change in income through the end of the month after the 60th day after the pregnancy end date (e.g., pregnancy ends June 10, health care coverage continues through August 31). Women receive this post-partum coverage regardless of how the pregnancy ends. Women who apply for Pregnancy Medical after the baby’s birth may not receive postpartum coverage, but they may qualify for help paying costs related to the baby’s birth if they submit the application within three months after the month in which the child was born.” *Eligibility Overview Washington Apple Health (Medicaid) Programs*, WASH. STATE HEALTH CARE AUTH. (Apr. 2015), available at http://www.hca.wa.gov/medicaid/publications/documents/22_315.pdf.

the ACA improve access to health insurance, this overlap in eligibility for pregnant women can lead to challenges related to “insurance churn.”

Churn is used to describe situations where individuals have a change in their health insurance coverage as a result of eligibility changes, including receiving other insurance, changes in income, changes in household size, pregnancy or aging out of an eligibility category.⁵ As discussed above, when individuals have such a change, they must report it to the marketplace to ensure that their eligibility determination is accurate. Reported changes can affect the household members’ eligibility for WAH, advanced premium tax credits (APTC) and cost-sharing reductions (CSRs).

The resulting disruptions or breaks in coverage caused by churn, a problem with which Medicaid has long struggled, exposes individuals to financial liability as well as challenges in accessing health care or maintaining continuity of care with their providers.⁶ Numerous studies show that coverage disruptions adversely affect both access to health care and services and health status regardless of the reasons underlying changes in insurance status.⁷ While not as detrimental as losing coverage completely, even changes in insurance type cause problematic delays in access for those seeking care.

The aforementioned challenges such individuals face upon churning are likely compounded by the increasing prevalence of narrow networks. During the transition to new health plans and new marketplaces under the ACA, many insurers responded by revamping their approach to network design, offering lower premiums in exchange for more limited access to health care providers, known as narrow networks.⁸ On one hand, narrow networks may offer value to many consumers as long as lower premiums costs are coupled with meaningful access to a reasonable array of providers. Potentially, the flexibility insurers have to contract selectively might result in driving higher quality care by allowing insurers to build networks of providers satisfying certain quality and efficiency measures. On the other hand, however, the narrowing of

⁵ In January 2016, the HBE and Washington Health Care Authority (HCA) released data focusing on those who churned between WAH and QHP coverage within the exchange. Between April 2014 and March 2015, over 30,000 individuals throughout the state moved between coverage programs – about 8.5% of the QHP population and .7% of the WAH population. Here in King County over 10,000 individuals churned once and almost 700 churned at least twice, most with incomes between 151-200% of the FPL. *Churn Between Washington Apple Health and Qualified Health Plans: A Data Analysis*, WASH. HEALTH BENEFIT EXCHANGE AND WASH. HEALTH CARE AUTH. (Jan. 2016), available at http://www.wahbexchange.org/wp-content/uploads/2015/12/HBE_EN_160112_Medicaid_QHP_Churn_Analysis.pdf [hereinafter WA Churn Report].

⁶ Pamela Farley Short and Deborah R. Graefe, *Battery-Powered Health Insurance? Stability In Coverage Of The Uninsured*, 22 HEALTH AFFAIRS 244 (2003).

⁷ See Leighton Ku & Donna Ross, *Staying covered: the importance of retaining health insurance for low-income families*, THE COMMONWEALTH FUND (Dec. 2002); Sharon Long et. al., *How Well does Medicaid Work in Improving Access to Care?*, 40 HEALTH SERV. RES. 39 (2005); Julia Prentice & Steven Pizer, *Delayed Access to Health Care and Mortality*, 42 HEALTH SERV. RES. 44 (2007); Shana Lavareda et. al., *Switching health insurance and its effects on access to physician services*, 46 MED. CARE 1055 (2008).

⁸ *Hospital networks: Configurations on the exchanges and their impact on premiums*, MCKINSEY & CO. 2 (Dec. 2013), available at http://healthcare.mckinsey.com/sites/default/files/Hospital_Networks_Configurations_on_the_Exchanges_and_Their_Impact_on_Premiums.pdf.

networks may jeopardize continuity of care for consumers while exposing them to often significant financial costs of out-of-network care.

Moreover, as consumers make decisions about which plan to choose, they may lack sufficient information to make informed decisions about potential consequences of their choice of plan and its overall costs. This is particularly true when consumers do not receive accurate and timely information about the providers participating in a specific network. Despite the federal and state requirements that insurance providers make provider directories available for consumers, these are often neither current nor accurate.⁹ This is troublesome because consumers may be required to pay significant fees to cover visits to providers, who despite being listed in the directory, might be considered out-of-network by the health plan carrier. As a result, individuals who churn between WAH and a QHP are placed at risk of both financial and health care consequences. Pregnant women are particularly vulnerable to these challenges given that acuity and time-sensitive nature of their medical condition.

Ultimately, much is still unknown about the practical impact of narrowing networks and network adequacy for women who may churn due to the eligibility overlap on their access to health care. This capstone report, conducted in collaboration with Northwest Health Law Advocates (NoHLA), seeks to better understand this impact within the construct of access to OB/GYN providers; first, by examining both the federal and state legal landscapes around network adequacy; second, by exploring to what extent providers are shared across WAH and QHP networks by conducting a comparison analysis of King County OB/GYN providers covered by carriers using online provider directories; and third, by providing recommendations to address the challenges and findings.

II. BACKGROUND

The eligibility overlap for pregnant women became a priority issue for NoHLA during the first ACA enrollment period in October 2013. At the time, both law and federal guidance left it unclear as to whether Washington women even had a real choice between staying in their QHP or being forced to switch to WAH upon pregnancy. In particular, under section 36B(c)(2)(B) of the Internal Revenue Code, as implemented at 26 C.F.R. 1.36B-2(a)(2), individuals were not eligible to receive advanced payment of premium tax credit (APTC) to support enrollment on a QHP for any month which the individual was considered eligible for “minimum essential coverage,” or (MEC). Section 5000A(f) of the Code defined MEC to encompass coverage provided either by Medicaid or CHIP programs, including full-scope Medicaid coverage for “qualified pregnant women” eligible under section 1902(a)(10)(A)(i)(III) of the Act, coverage for pregnant women eligible under section 1931 of the Act, and coverage for pregnant women under CHIP provided in accordance with section 2112 of the Act. Per final regulations issued by the IRS, however, MEC excluded coverage of pregnancy-related services for pregnant women

⁹ See e.g., *Covered California Open Enrollment 2013-2014: Lessons Learned*, COVERED CA. 29-30 (Oct. 2014), available at <https://www.coveredca.com/PDFs/10-14-2014-Lessons-Learned-final.pdf>; *Network Adequacy in Maryland: A Report of Provider Directories and Women’s Access to Health Care Services*, MD. WOMEN’S COMM’N FOR HEALTH CARE REFORM 3 (Nov. 2015), available at http://static1.1.sqspcdn.com/static/f/481003/26671500/1447430672827/2015+Report_Coalition+OB-GYN+Network+Adequacy+_FINAL_11+13+15.pdf?token=a7DkeEy4mb4yjXPuROhpoVfbW1s%3D.

eligible under section 1902(a)(10)(A)(i)(IV) or 1902(a)(10)(A)(ii)(IX) of the Act (not full-scope coverage).¹⁰

Thus, individuals eligible for full scope pregnancy coverage were not considered eligible for APTCs associated with QHP enrollment, including eligible pregnant women in Washington as it provides full-scope pregnancy related Medicaid coverage. Because of higher income eligibility standards applicable in many states for pregnant women under Medicaid or CHIP, it would not be uncommon for women to be eligible for Medicaid only for the duration of their pregnancy, but otherwise eligible for APTC and CSR for enrolling in a QHP.

To this end, in November 2014, Health and Human Services (HHS) and the Internal Revenue Service (IRS) issued guidance clarifying that in states that offer full-scope pregnancy-related Medicaid, like Washington, women who are enrolled in QHP coverage when they become pregnant may either stay in their QHP and continue receiving APTC and CSR or switch to pregnancy-related Medicaid coverage for the duration of the pregnancy and post-partum period and not face a tax penalty.¹¹ If they leave the QHP and decide to switch to WAH, however, their coverage will end two months after delivery unless their income and household size allows continuation onto another Apple Health program.¹² Therein lies the challenge NoHLA now seeks to examine, which is the impact on pregnant women of switching from a QHP onto WAH and vice versa in terms of access to providers, particularly in the context of narrow networks and inadequate provider directories.

¹⁰ 26 C.F.R. § 1.5000A-2(b)(1)(ii) (2012).

¹¹ Letter from the Department of Health and Human Services, SHO#14-002 (Nov. 7, 2014), *available at* <http://medicaid.gov/federal-policy-guidance/downloads/sho-14-002.pdf>; Internal Revenue Services Notice 2014-17, Eligibility for Minimum Essential Coverage under Pregnancy-Based Medicaid and CHIP Programs (Nov. 7, 2014), *available at* <http://www.irs.gov/pub/irs-drop/n-14-71.pdf>.

¹² Why a woman would choose to switch insurance coverage likely comes down to the differences between what each type of coverage offers, providers who are covered under the plan, and convenience. Below are the differences in coverage between Apple Health for Pregnant Women and QHPs.

Apple Health for Pregnant Women includes prenatal, labor and delivery, plus:

- No monthly premiums, copays or deductibles
- Maternity Support Services including health education and counseling for the mother and child
- Dental Coverage and a full range of other health services
- Assistance with transportation to doctor's appointments
- Access to family planning and pregnancy termination services
- Newborn child will be automatically enrolled in Apple Health for Kids coverage for 12 months

If she chooses to stay covered under a QHP purchased through Healthplanfinder, typically coverage includes prenatal, labor and delivery, plus:

- Premiums, copays, and deductibles still apply (Costs of services vary by plan)
- Some coverage of alternative providers (acupuncture, massage therapists, etc.)
- Most but not all plans include pregnancy termination services
- Adult dental and some other services are not included. Separate dental insurance is offered in Healthplanfinder for children
- Depending on the plan, additional services may be provided.

III. NETWORK ADEQUACY: A FEDERAL AND STATE LEGAL OVERVIEW

The most favorable cost sharing arrangements offered by a health plan apply only when enrollees use providers in the plan's network. Network design features differ among plans, but narrow networks are referred to as those where insurers seek to offer lower premiums by limiting the number and choice of providers available to plan enrollees.¹³ These narrow network plans are particularly attractive to consumers who are willing to trade off provider choice for lower premiums and reduced out-of-pocket payments. However, recent anecdotal reports from both patients and providers alike suggest that narrower networks leave such patients vulnerable to coverage discrepancies and the resulting financial burden of out-of-network care.¹⁴

Even though narrow networks have been around long before the ACA, they have recently come under the spotlight as QHPs available on the FFM and state-based exchanges now predominately feature narrower provider networks.¹⁵ Today, narrow networks—which are available to 92% of the population covered through the exchanges—make up almost half of all exchange networks available nationwide and 60% of networks in the largest city in each state.¹⁶

Insurers can use narrow networks to lower premiums in various ways. They can both directly exclude high-cost providers from the network while also directing patients to high-value providers. As for the latter mechanism, they can use the market power of networks to negotiate lower reimbursement levels with participating providers in exchange for greater volume, thereby keeping prices low. They can segment their network into tiers, with higher cost-sharing for the higher tiers, resulting in a de facto narrowing of the network for price conscious consumers. All of these strategies are designed to control the costs of individual plans offered on the ACA marketplaces.

To date, most of the work summarizing the narrow networks network among plans offered on the Health Insurance Marketplace has been limited to hospital networks. McKinsey & Co. recently categorized the network size of plans on the 2015 marketplaces by the proportion of participating hospitals in a rating area.¹⁷ They found 39% of networks in plans offered in the marketplace to be “narrow,” defined as a network with fewer than 70% of hospitals in a rating area. This is a valuable though incomplete characterization of narrow networks, because it

¹³ Laura Summer, *Research Insights – Health Plan Features: Implications of Narrow Networks and the Trade-Off between Price and Choice*, ACADEMYHEALTH (Dec. 2014), available at <http://academyhealth.org/files/HCFO/RIBrief0315.pdf>.

¹⁴ See e.g., Chad Terhune et al., *Obamacare doctor networks to stay limited in 2015*, L.A. TIMES (Sep. 28, 2014), available at <http://www.latimes.com/business/la-fi-0928-obamacare-doctors-20140928-story.html#page=2>. Consumers who receive care from health care providers not in their plan's network face costs beyond the deductible, copayments, or other cost-sharing that they would have had to pay if they received care from in-network providers. These extra costs could include a higher deductible, other additional cost-sharing, or the entire bill for the services that the out-of-network provider delivers.

¹⁵ Noam Bauman, et al., *Hospital Networks: Updated national view of configurations on the exchanges*, McKinsey Center for U.S. Health System Reform (June 2014), available at <http://healthcare.mckinsey.com/hospital-networks-updated-national-view-configurations-exchanges>.

¹⁶ *Id.*

¹⁷ *Id.* at 1.

considers hospital participation only – it does not help consumers understand which non-hospital providers are covered under that plan.

The McKinsey study surveyed consumers across both state and federal exchanges and found that overall they did not seem to understand the differences among plan options with regard to hospital network configurations and the impact of choosing one over another.¹⁸ Of those newly insured with a QHP, 44% reportedly did not know their plan’s hospital network configuration. In light of these results, it is highly likely that many patients may not realize, for example, if an in-network hospital has out-of-network physicians providing care. Indeed, one study predicts that three million patients will experience unexpected medical costs due to care received out-of-network each year.¹⁹ The negative impact of this issue is compounded because most plans do not have an out-of-pocket maximum for out-of-network care, leaving patients vulnerable to possible medical bankruptcy.²⁰

More recently, Haeder, et al., looked at quality of hospitals covered under health plans offered through Covered California (the state’s exchange). The study found that such plans have narrower hospital networks than commercial insurance plans, but do not appear to have lower-quality, as measured by fourteen quality indicators.²¹ Additionally, the study found that narrower networks only marginally restrict geographic access as measured by the percentage of people per Marketplace region residing within a fifteen-mile radius of a hospital.²² Nevertheless, people in certain areas may be confronted with considerable distances to the nearest hospital, although this is often the case for commercial plans as well. Nonetheless, the study concluded that overall access to services remains an important issue to be addressed both inside and outside of the ACA’s exchanges.²³

With regard to access to care, a study released by the Robert Wood Johnson Foundation examined stakeholder perspectives in seventeen states with state-run health insurance exchanges and documented substantial access problems related to mental health and substance use services. The researchers noted that, while access to such services is not a new problem, it is a continuing concern and state governments do not seem likely to act on the concern.²⁴

¹⁸ *Id.* at 2. This is up from 19% from 2014.

¹⁹ Kelly Kyanko et al., *Out-of-Network Physicians: How Prevalent are Involuntary Use and Cost Transparency?*, 48 HEALTH SERV. RES. 1154, 1166 (2013).

²⁰ *Id.* at 1167.

²¹ Simon Haeder et al., *California Hospital Networks are Narrower in Marketplace than in Commercial Plans but Access and Quality are Similar*, 34 HEALTH AFFAIRS 741 (2015). The quality indicators used were developed by the Agency for Healthcare Research and Quality (AHRQ), which are reported by all California Hospitals; Leapfrog Hospital Survey; as well as data from the Joint Commission’s “Top Performers Ranking.”

²² *Id.* at 746.

²³ *Id.* at 747.

²⁴ Sabrina Corlette et al., *Narrow provider networks in new health plans: Balancing affordability with access to quality care*, GEO. UNIV. HEALTH POL. INST., available at <http://www.urban.org/sites/default/files/alfresco/publication-pdfs/413135-Narrow-Provider-Networks-in-New-Health-Plans.PDF> (May 2014).

Ultimately, what determines a narrow network and whether it is adequate? While the ACA provided a national standard for network adequacy, this definition has been difficult to put into practice. Many states, including Washington, have therefore created their own regulations around network adequacy. The following sections provide an overview of both federal and Washington's network adequacy regulations for QHPs and Medicaid managed care.

A) Qualified Health Plan Network Adequacy Requirements

While states historically regulated the health insurance industry and continue to play a primary role in setting and enforcing network rules, the ACA set forth the first federal standard for network adequacy in the commercial insurance market for plans offered through the law's insurance marketplaces. Section 1311 of the ACA tasks the Secretary of the Department of Health and Human Services (HHS) with establishing the first federal standard for network adequacy among QHPs to be sold on health insurance exchanges (whether federal, state, or jointly-run).²⁵ At minimum, the criteria must include requirements that plans seeking QHP certification "ensure a sufficient choice of providers...[and] provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers."²⁶

To implement this statutory provision, HHS issued regulations on the minimum network adequacy requirements, requiring QHPs to provide a network "sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay."²⁷ However, it provides no further clarification on what the terms "sufficient" or "unreasonable delay" mean, thereby leaving the implementation of specific standards either to insurers or to the states. Indeed, in the preamble to the final rule, HHS acknowledged its intention to leave the network adequacy standard broad to allow exchanges "significant flexibility to apply this standard to QHPs in a manner appropriate to the State's existing patterns of care" in light of the fact "that network adequacy standards should be appropriate to States' particular geography, demographics, local patterns of care, and market conditions."²⁸ In fact, HHS rejected public comments that called for more comprehensive language such as "reasonable proximity of providers to enrollees' home or workplaces, ongoing monitoring process, and out-of-network care when in-network care is unavailable."²⁹ This rejection has likely left individuals in diverse areas with having to travel unreasonably far from their homes or workplaces to reach in-network providers. This is particularly important for communities of color and other underserved groups, who may depend on public transportation, friends, or family members to travel to medical appointments and thus can only travel a limited distance to obtain care.

²⁵ Patient Protection Affordable Care Act, 42 U.S.C. § 1311(c)(1)(B) (2012).

²⁶ *Id.* § 1311(c)(1)(B) and (C). The rule also details that the network adequacy standards must be consistent with the provisions of section § 2702 (c) of the Public Health Services Act, which allows the plan to limit enrollment eligibility to those who live, work, or reside in the service area and deny enrollment to eligible individuals if the issue does not have capacity to meet responsibilities of current enrollees and issue coverage to new individuals.

²⁷ 45 C.F.R. § 156.230 (2012).

²⁸ 76 Fed. Reg. 41,866, 41,893 (proposed July 15, 2011) (codified as 45 C.F.R. §§ 155-56 (2012)).

²⁹ Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18,310, 18,419 (proposed Mar. 27, 2012).

Another provision of HHS' minimum network adequacy rules is the standard that QHP networks include essential community providers ("ECPs") who serve predominately low-income, medically underserved individuals.³⁰ The inclusion of ECPs was a response to concerns that insurers would avoid serving low-income neighborhoods.³¹ Specifically, QHPs must maintain provider networks that have a "sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP's service area."³²

In developing the language for the final rules, HHS considered many comments about the standard initially proposed in 45 CFR §155.1050. Many commenters supported state flexibility to facilitate exchanges with network adequacy standards that reflect local conditions, such as patterns of care, geography, demographics, etc.³³ Others suggested that HHS establish a national, uniform standard, such as adopting the National Association of Insurance Commissioners' (NAIC) Managed Care Plan Network Adequacy Model Act (Model I-74-1).³⁴ Ultimately HHS fashioned the final rules to allow states considerable latitude in structuring their standards as long as they are sufficient to meet the final rules.³⁵

In states that operate their own marketplaces, it is up to the state to define the additional specific standards, if any, that a health plan must meet. After the ACA's passage, Washington was among the first states to significantly revise its network adequacy standards applicable to individual or small-group health plans. Prompted by consumer complaints about narrower networks, and overriding the complaints of certain insurers and hospitals regarding the speed of the implementation, the OIC finalized new network adequacy rules in April 2014.³⁶ Like the federal standard, Washington requires a QHP to ensure its network "is sufficient in numbers and types of providers and facilities to assure that all health plan services to covered persons will be

³⁰ 42 U.S.C. § 18031.

³¹ Sally McCarty & Max Farris, *Issue Brief: ACA Implications for State Network Adequacy Standards*, ROBERT WOOD JOHNSON FOUND. 1 (2013), available at <http://www.rwjf.org/en/library/research/2013/08/aca-implications-for-state-network-adequacy-standards.html>.

³² 45 C.F.R. § 156.235(a) (2013).

³³ *Plan Management Function: Network Adequacy White Paper*, NAT'L ASS'N OF INSURANCE COMM'RS (June 2012), available at http://www.naic.org/documents/committees_b_related_wp_network_adequacy.pdf.

³⁴ *Id.* at 3.

³⁵ 42 U.S.C. § 18031.

³⁶ Concerns around network adequacy in Washington were particularly heightened after the OIC initially decided not to permit five health insurers to participate in the HBE for the 2014 benefit year because of their inability to meet state and federal network adequacy standards. However, after several carriers appealed and revised their applications, in fall 2013 the OIC approved their applications to offer exchange coverage. In October 2013, Seattle Children's Hospital, which had been excluded from most of the plans offered on the exchange, sued the OIC to reverse two of these approvals, alleging that the agency failed to ensure adequate network coverage in several exchange plans. Ultimately, these two insurance carriers subsequently agreed to add the hospital to their network plans for 2015, and the lawsuit was withdrawn. Not. and Mot. To Withdraw In re Seattle Children's Hospital Appeal of OIC's Approvals of HBE Plan Filings, No. 13.0293 (Wash. Ins. Comm'n Sept. 5, 2014).

accessible without unreasonable delay.”³⁷ The network must also satisfy the ECP standard as outlined by the federal standard.

While incorporating the federal minimum standard, the new rules also impose more detailed and concrete requirements, including the following:³⁸

- Distance standards: Plans must show that 80% of the enrollees have providers a specified distance from their home or workplace. The distance varies by type of provider and whether the area is urban or rural. Children’s and consumer advocates in Washington are concerned that the distance standards included for commercial plans are not as strict as Medicaid, and will want to continue to monitor these standards in particular.
- Ratios: The ratio of primary care providers to enrollees in an issuer’s service area must meet or exceed the average ratio for the state for the prior plan year.
- Wait time limits: Enrollees must have access to an appointment with their primary care provider within 10 business days of requesting one (other than preventive care) and within 15 days for a non-urgent specialist visit. Urgent appointments must be available within 48 hours (or 96 if prior authorization is required).
- Essential Health Benefits: Each network must include licensed providers to cover all essential health benefits services and treatment, per WAC 284-43-878. The state’s prior rules referred to the state’s basic health plan as the source of services covered (which will continue to be the standard for plans other than individual and small group).
- Spot Contracting: The rules limit so-called “spot contracting” to fill holes or gaps in the network.

In December 2015, the OIC revised these rules (referred to by the OIC as Phase 2 network access rules).³⁹ The new rules clarify standards for maintenance of sufficient provider networks and individual provider and facility contracting.

Lastly, both federal and state guidance require that QHPs share provider directories for online publication and provide a directory to potential enrollees upon request, which should include which providers are or are not accepting new patients.⁴⁰ Notably the federal guidelines previously had no requirement for how often directories must be updated by insurers.⁴¹ WAC 284-43-200 filled this gap and requires QHPs on Healthplanfinder, Washington state’s insurance

³⁷ Wash. Admin. Code 284-43-200(1).

³⁸ Wash. Admin. Code 284-43-200.

³⁹ Rev. Code Wash. 34.05.360.

⁴⁰ 45 C.F.R. § 156.230(b).

⁴¹ In response to concerns about network transparency, CMS began requiring QHPs on the federally-facilitated exchanges in 2016 to make accurate and complete provider network directories available to the exchange for publication online and updated monthly. The listed information must include whether the provider is accepting new patients, as well as the provider’s location, contact information, specialty, medical group and any institutional affiliations. All health insurance issuers are required to make it easy for consumers to determine which providers participate in particular networks and plans. 45 C.F.R. 156.230(b); Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016; Final Rule, 79 Fed. Reg. 10750, 10830 (Feb. 27, 2015); Final 2016 Letter to Issuers in the Federally-facilitated Marketplaces, Center for Consumer Information and Insurance Oversight (CCIIO), 24 (Feb. 20, 2015).

exchange, to accurately update provider directories on a monthly basis and make them available for online publication.⁴² Additionally, each directory must clearly identify which providers participate in which network. Per WAC 284-43-200, the OIC monitors compliance of these network adequacy requirements, and the HBE will decertify QHPs of issuers that do not adhere to the standards.⁴³

B) Medicaid Managed Care Network Adequacy Requirements

Medicaid managed care plans such as managed care organizations (MCOs) must meet a combination of federal and state requirements.⁴⁴ Federal Medicaid law requires that each Medicaid managed care plan ensure that all services covered under the State plan are available and accessible to managed care enrollees.⁴⁵ Federal regulations also require Medicaid managed care plans to assure and document to the state their capacity to serve the health care needs of their enrollees.⁴⁶ Documentation must demonstrate that the participating plans offer a range of primary, preventive and specialty services.⁴⁷ In addition, the rules require that plans maintain a provider network sufficient in number, type and geographic distribution, but do not establish detailed and specific time and distance standards or provider to enrollee ratios, rather deferring to each Marketplace or state to develop specific standards.⁴⁸

On June 1, 2015, the Centers for Medicare and Medicaid Services (CMS) published its long awaited Medicaid managed care proposed rules.⁴⁹ In addition to the above requirements, the proposed rules would also require states to establish network adequacy standards that ensure access to all contractual services, that is, all services included in managed care contract. In contrast to existing rules, the proposed rules do stipulate time and distance standards – but only for specified provider types, including OB/GYN services, primary care (adult and pediatric, separately), pharmacy, pediatric dental, and other services when it is in the best interest of the program to set such standards.⁵⁰ CMS requested comments on whether a different type of standard, such as provider-to-patient ratios, should be used, as well as whether standards should be set for pediatric and adult behavioral health care and family planning services (which are

⁴² Wash. Admin. Code 284-43-204.

⁴³ Wash. Admin. Code 284-43-230.

⁴⁴ Though Medicaid is available both as managed care and Fee-For-Service (FFS), this report focuses on managed Medicaid only for several reasons. Pre-ACA, managed Medicaid accounted for the majority (~65%) of Medicaid beneficiaries in WA state, and under Medicaid expansion this trend will continue with the majority of new enrollees being assigned to or choosing managed Medicaid. Additionally, there is substantial overlap between the population of MCO-contracted and FFS-contracted providers in King County.

⁴⁵ 42 U.S.C. § 1396u-2(b)(5); 42 C.F.R. § 438.206(a) (requiring states to ensure that services are available to enrollees in Medicaid managed care organizations (“MCOs”), Prepaid Inpatient Health Plans (“PIHPs”) and Prepaid Ambulatory Health Plans (“PAHPs”)); *id.* § 438.207(b) (requiring the State to ensure adequate network adequacy in Medicaid managed care plan contracts).

⁴⁶ 42 C.F.R. § 438.207(a).

⁴⁷ *Id.* § 438.207(b)(1).

⁴⁸ *Id.* § 438.207(b)(2).

⁴⁹ 80 Fed. Reg. 31097.

⁵⁰ *Id.*

covered by special statutory free choice guarantees permitting access to out-of-network care).⁵¹ CMS further requested comments on “approaches to measuring enrollee’s [sic] timely access to covered services and to evaluating whether managed care plans networks are compliant with such standards . . . and the value of requiring some or all of these mechanisms for ensuring that access standards are being met.”⁵²

Consistent with the ACA’s rules on Marketplaces and QHPs, the Medicaid managed care rules ultimately leave the state with the primary responsibility of administering and monitoring its Medicaid managed care program. State rules tend to be more specific than those for private plans due to concerns about more vulnerable populations and weaker access because of low reimbursement rates to providers.⁵³ States often require plans to contract with certain providers, like Federally Qualified Health Centers and, if they cover long-term care benefits, certified nursing facilities. Medicaid standards also reflect fears that providers often make Medicaid patients wait longer for care than patients with more generous insurance.⁵⁴ To address this, some states have implemented “in-office wait time” standards that require plans to monitor the time that beneficiaries wait to receive care once they arrive at a provider’s location.⁵⁵

In Washington, the current network standards for Medicaid managed care programs are set forth in the WAH 2015 Managed Care Contract template between the HCA and each carrier.⁵⁶ The contract requires that each carrier maintain and monitor an appropriate provider network to serve enrollees. If the network of participating providers is deemed insufficient by HCA to meet the medical needs of enrollees however, the carrier will provide contracted services for non-participating providers at the in-network cost to enrollees.⁵⁷ Additionally, the rules require carriers to conduct a quarterly quality assurance review, through outreach phone calls and emails, of 25% of individual providers within the primary care, pediatric and obstetrical provider network to verify that the provider is contracted with the carrier, has correctly listed contact information, and is or is not accepting new WAH patients.⁵⁸ Lastly, like QHPs, carriers are required under the state’s Medicaid managed care rules to share provider directories for online publication that are to be updated at least quarterly or whenever there is a significant change in the network that might affect a service area.⁵⁹

Ultimately, these extensive revisions to its network adequacy rules made Washington a leader in network access regulation of both QHPs and Medicaid managed care plans. However, there remain many concerns that the rules are insufficient to ensure access to care, particularly for populations subject to churning. For this reason, a comparison analysis using the construct of

⁵¹ *Id.*

⁵² *Id.*

⁵³ *Network Adequacy & Exchanges*, NAT’L COMM. FOR QUALITY ASSURANCE (Feb. 11, 2013), http://www.ncqa.org/Portals/0/Public%20Policy/Exchanges&NetworkAdequacy_2.11.13.pdf.

⁵⁴ *Id.*

⁵⁵ *Id.*

⁵⁶ *Washington Apple Health 2015 Managed Care Contract*, WASH. STATE HEALTH CARE AUTH., http://www.hca.wa.gov/medicaid/healthyoptions/Documents/2015-16_apple_health_redline_amdmts1-4.pdf (last visited Feb. 29, 2016).

⁵⁷ *Id.* Section 6, *Access to Care and Provider Network*, at 94.

⁵⁸ *Id.*

⁵⁹ *Id.*

access to OB/GYN providers in King County was conducted to begin understanding how churning between programs, given the potential constraints of narrow networks, impacts pregnant women who fall within the coverage eligibility overlap.

III. ANALYSIS OF OVERLAP IN ACCESS TO OB/GYNs BETWEEN WAH AND QHPs

A) Methodology

In order to assess what extent providers are shared across WAH and QHP networks, a comparison was conducted examining OB/GYN providers covered under WAH versus under each QHP in King County, Washington.⁶⁰

Information for providers accepting Medicaid was generated by the Health Care Authority of Washington, to which all Medicaid plans report the providers with whom they contract. This sheet provided the name of every provider accepting WAH managed care plans, along with address, specialty, etc. To generate the lists for the overlap analysis, information for all practicing OB-GYNs accepting each WAH managed care plans offered in 2016 was included.

The HBE does not offer provider listings for each plan offered, but rather links consumers to carrier websites (though it does not check the accuracy of such links, relying on the carriers to update links as needed).⁶¹ As such, information for providers accepting coverage by a QHP was created using each plan's online provider directory. For 2016, the HBE approved the following insurance carriers to sell QHPs in King County through *Washington Healthplanfinder*: BridgeSpan, Coordinated Care, Group Health Cooperative, LifeWise, Molina, Premera BlueCross, Regence BlueShield, and UnitedHealthcare.

The provider lists from which these data were gathered were not uniform in their formats and coding. Additionally, the ease in use of each provider directory depended in large part on the carrier. Most directories were easy to locate after searching by carrier under "Washington provider directory," and all were accessible to the public. Many carriers called their directory "Find a Doctor" (though they included ARNPs). Fortunately, all of these directories allowed the user to specify the specialty of the provider (OB-GYN) to determine how many accept insurance from the QHP as well as which providers were accepting new patients. Most could be organized by specific location, zip code, or city (only one by county), as well as by distance from that specific point. Some directories could be filtered by plan type though most did not specify among the bronze, silver, or gold plans. It was often difficult to determine which providers in the directory corresponded to plans offered on the exchange, because often there was no option to filter by plan or network. When the site did allow the user to select the specific plan or network offered on the Exchange, the results were filtered accordingly.

⁶⁰ The comparison focused on King County because it is the most populous county in Washington, with the highest number of health plans offered on the Exchange and OB/GYN providers.

⁶¹ Some states exchanges, such as Maryland's, run their own online provider directory based on information submitted by each health plan participating in Maryland Health Connection, available at <https://providersearch.crisphealth.org/>.

Once the provider lists were gathered from each QHP and WAH, each networks' list of providers was automatically cross-checked using excel to determine the amount of overlap between the programs.⁶² "Overlap" is used to represent the percentage of OB-GYN providers covered under a QHP that are also covered under WAH.

B) Results & Discussion

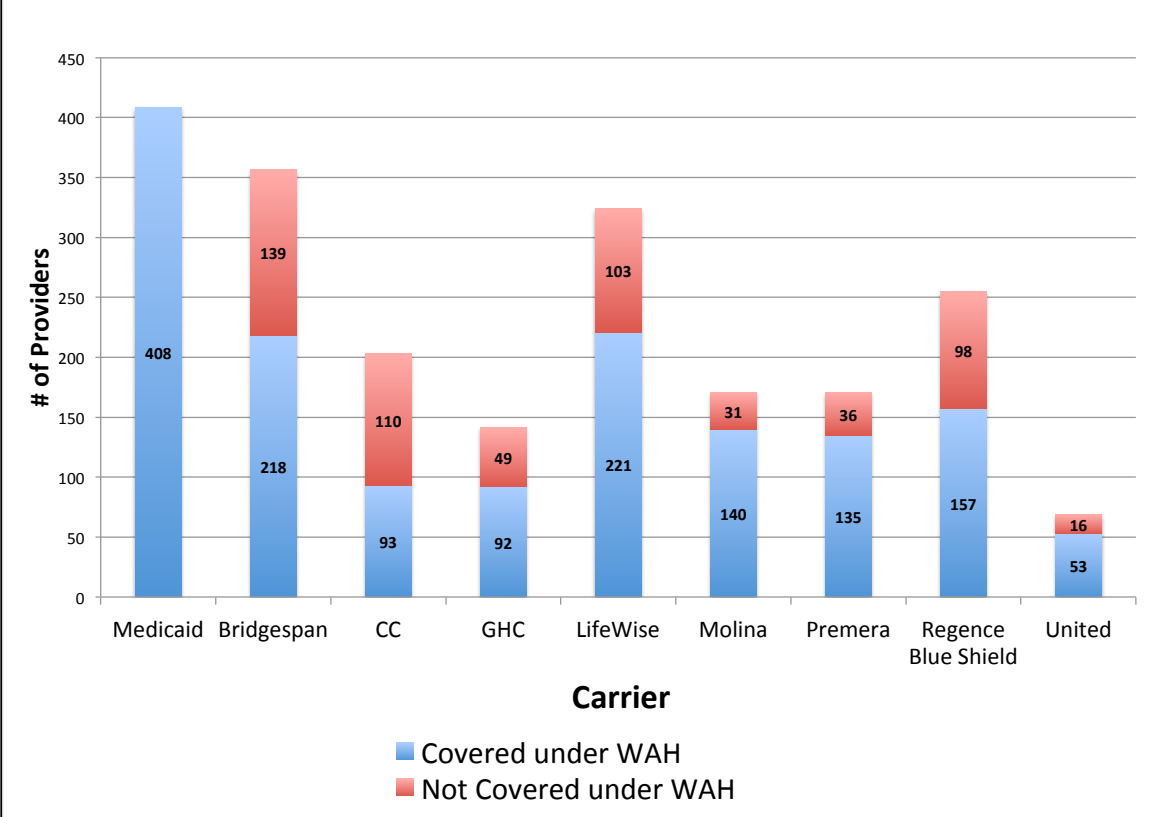
In total, the dataset consisted of 2099 provider names gathered from the various directories. Table 1 provides a summary of how many OB-GYN providers are covered by each program in King County, how many are covered/not covered by WAH, and the overlap percentage of providers covered/not covered by WAH. As can be seen in Table 1 and Figure 2, all of the plans share OB-GYN providers with WAH to varying degrees. The average overlap amount is 67.4% among the eight plans offering QHPs on the HBE in 2016.

Table 1: Overall 2015 Carrier Data Summary and Overlap Percentages for King County

Plan	OB-GYN Providers	# on WAH	% on WAH	# NOT on WAH	% NOT on WAH
Medicaid	408	408	100.0%	n/a	n/a
Bridgespan	357	218	61.1%	139	38.9%
Coordinated Care	203	93	45.8%	110	54.2%
GHC	141	92	65.2%	49	34.8%
LifeWise	324	221	68.2%	103	31.8%
Molina	171	140	81.9%	31	18.1%
Premera	171	135	78.9%	36	21.1%
Regence BS	255	157	61.6%	98	38.4%
United	69	53	76.8%	16	23.2%

⁶² Specifically, "CountIf statements" in excel were used to compare lists of providers across each network. This counts all of the times a specific value (in this case a provider name) shows up. This was done across all networks to determine the number of occurrences for each provider. Then the results from each network were compared to the WAH providers.

Figure 2: 2015 King County OB-GYN Provider by Carrier Covered/Not Covered under WAH



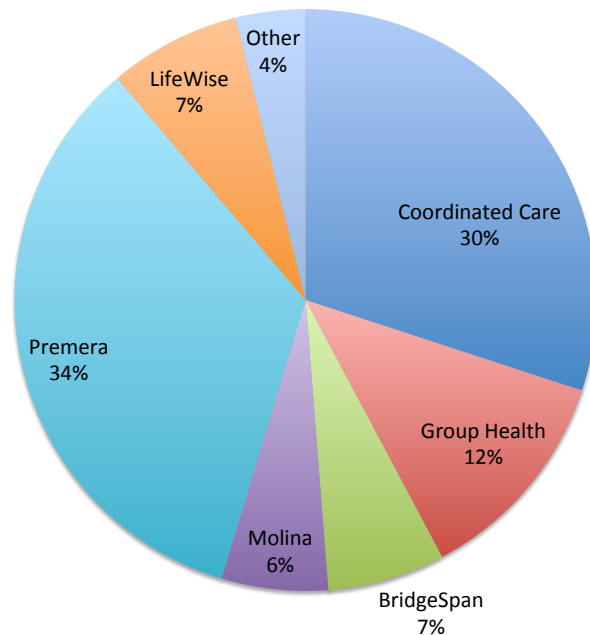
Accounting for the distribution of women enrolled across carriers in 2015 King County QHPs (Table 2 & Figure 3), the low overlap rate (45.8%) of the second biggest carrier, Coordinated Care, becomes troubling. In contrast, the largest carrier Premera, which covered around 35% of women in 2015, has a much better overlap rate of 78.9%. Thus, the challenges pregnant women, and consumers in general, could face in maintaining provider continuity upon churning vary by plan.

Table 2. Distribution of Women by Carrier in 2015 QHPs in King County

Carrier	Women Enrolled ⁶³
Coordinated Care	7946
Group Health	3224
BridgeSpan	1726
Molina	1567
Premera	9024
LifeWise	1942
Other (Plans not offered in 2016)	1025
Total:	26454

⁶³ Email from Joan Altman, Legislative & External Affairs Manager, Washington Health Benefit Exchange, to Andrea Frey (Feb. 3, 2016) (on file with author).

Figure 3: Distribution of Women by Carrier in 2015 QHPs in King County

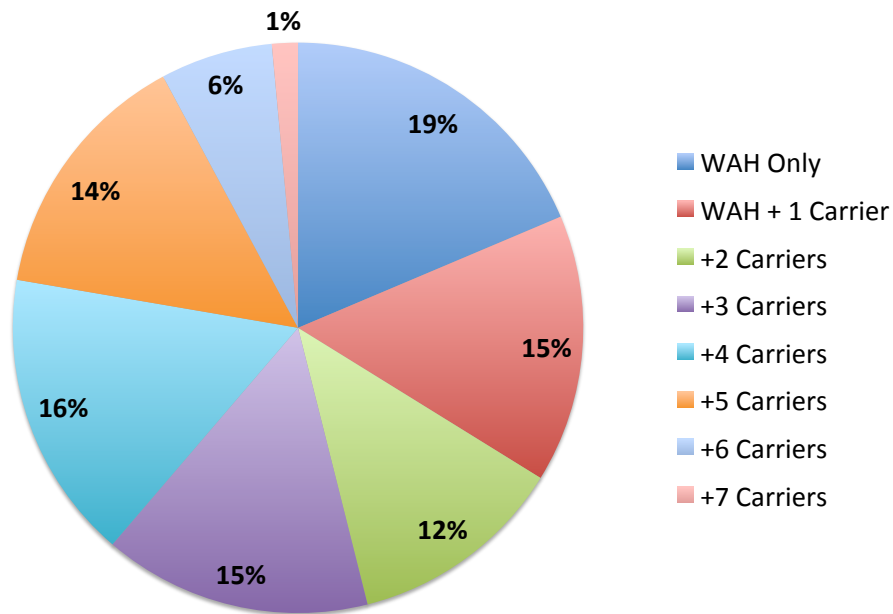


*Note that "Other" includes Moda and Community Health Plan of Washington Plans, which is not offered in 2016.

Moreover, from the HBE and HCA's 2016 Washington churn report, we know that statewide only 19% of individuals moving from WAH to QHPs who were enrolled in a plan offered by carriers on both WAH and the Exchange chose to stay with the same plan.⁶⁴ Thus, the deleterious affects of churn on access to providers might be heightened if a woman were to switch for example from a Premera WAH plan to a Coordinated Care QHP given the disparities in overlap by carrier. And just because there might overlap with WAH by one QHP carrier does not necessarily imply that the same overlapping providers are contracted with another QHP carrier. That said, many of the providers have contracts with multiple QHPs in addition to WAH, as Figure 4 shows.

⁶⁴ WA Churn Report, *supra* note 7 at 15. Note that this data is at the state level. Future research on churn by county, while needed, was not included in the report.

Figure 4: Percentage of 2015 King County OB-GYN Providers by Number of Carriers in addition to WAH



While these numbers only show a part of the picture within the construct of access to OB-GYNs in King County, they do begin the process of better understanding how pregnant women churning between programs may be affected, particularly in the context of narrow networks. No matter which carrier a woman switches to upon churning, on average only 67.4% of her original plan's providers would be available to her on the new plan. As such, pregnant women are certainly subject to possible care disjuncture when moving between health plans upon churning, and with it the potential harmful health effects of discontinuous care during pregnancy, due to the size and composition of an insurer's provider network. Moreover, even if a woman elects to continue receiving care from the original plan's providers not in the new plan's network, she would most likely face significant costs beyond the deductible, copayments, or other cost-sharing that they would have had to pay if they received in-network care. These extra costs could include a higher deductible, other additional cost-sharing, or the entire bill for the services that the out-of-network provider delivers. As a result, women who churn between WAH and a QHP are placed at significant risk of both financial and health care consequences. While having insurance is a critical first step to meeting people's health care needs, these results demonstrate that health coverage alone does not necessarily guarantee access to appropriate care.

C) Limitations

One potential limitation of this analysis is that the underlying data on providers may contain erroneous or missing information, which would affect the overlap calculations. Here in

Washington, the Public Health – Seattle & King County (PHSKC) and the University of Washington Department of Health Services partnered in 2013 to begin evaluating the implementation and impact of the Affordable Care Act (ACA) in King County.⁶⁵ During the course of the study, PHSKC reported hearing from many stakeholder groups that the provider directories of both Medicaid managed care plans and commercial plans are largely inaccurate.⁶⁶ The anecdotal evidence around MCOs' inaccuracy was confirmed by a mystery shopper survey conducted by the project team, which found that in December 2013, only 37% of PCPs had an accurate phone number listed on an MCO website directory.⁶⁷ By April 2014, the accuracy rate had fallen significantly to 31%.⁶⁸ The vast majority of inaccurate phone numbers were inaccurate for one of two reasons – the named provider was not at the clinic or the clinic did not offer primary care.⁶⁹

Additionally, for the directories where providers could not be filtered by specific networks or plans offered on the HBE, all listed OB-GYN providers' information was gathered and subsequently used in the analysis. Consequently, total numbers of such carrier's contracted providers may appear more extensive than in actuality.

Lastly, the analysis was based on provider data in King County only and therefore may not be applicable outside of the county given that both insurance and provider markets differ by locale.

⁶⁵ Public Health – Seattle & King County & University of Washington Department of Health Services, Final Report: Quality Assurance and Evaluation of the Affordable Care Act in King County, Washington (presented Oct. 30, 2014), available at <http://www.kingcounty.gov/healthservices/health/data/~media/health/publichealth/documents/healthreform/QAEvaluationACApresentation.ashx>.

⁶⁶ *Id.* at 62.

⁶⁷ *Id.*

⁶⁸ *Id.*

⁶⁹ Note that this is not limited to Washington. For example, Covered California, the California exchange, has had to take down its provider list multiple times because of consumer complaints that the list was inaccurate. A 2015 study performed by the Maryland Women's Coalition for Health Care Reform to assess the accuracy of the information in the provider directory linked from the Maryland Health Connection website found that over 30% of providers listed were deemed entirely inaccessible to women purchasing a QHP because they could not be reached due to bad or missing information (such as no phone number, incorrect office listing, and provider left office or retired). Covered California ultimately determined that it was not able to provide consumers with reliable and accurate information and decided to link to each health insurance company's online provider directory instead. The exchange will reassess its opportunity to launch an accurate, combined provider directory. *Covered California Open Enrollment 2013-2014: Lessons Learned*, COVERED CAL. 29-30 (Oct. 2014), available at <https://www.coveredca.com/PDFs/10-14-2014-Lessons-Learned-final.pdf>; *Network Adequacy in Maryland: A Report of Provider Directories and Women's Access to Health Care Services*, MD. WOMEN'S COMM'N FOR HEALTH CARE REFORM 3 (Nov. 2015), available at http://static1.1.sqspcdn.com/static/f/481003/26671500/1447430672827/2015+Report_Coalition+OB-GYN+Network+Adequacy+_FINAL_11+13+15.pdf?token=a7DkeEy4mb4yjXPuROhpoVfbW1s%3D. See also *Directory Assistance: Maintaining Reliable Provider Directories for Health Plan Shoppers*, CALIFORNIA HEALTHCARE FOUND. (Sep. 2015), available at <http://www.chcf.org/publications/2015/09/directory-assistance-provider>.

IV. GOING FORWARD: CONCLUSION & RECOMMENDATIONS

This report examines access to care from OB-GYN providers for pregnant women who may be subject to churning in King County, Washington. As discussed, women who fall above 138% up to 198% of FPL may face significant challenges when seeking pregnancy-related services and care. The following suggestions for future analysis and policy recommendations would not address all of the complexities of churn in the context of narrow networks, but they would substantially assist in understanding the real impact on women while also substantially improving the ability of consumers to identify in-network OB-GYNs and stay with their preferred providers if churn occurs. More accurate provider directories would also empower women and consumers across Washington to make informed decisions, not only about their initial purchase of coverage, but also their ability in accessing care when and where they need it.

A) Suggestions for Future Analysis

Additional research questions that warrant further exploration to better understand churn between WAH and QHPs should focus on the key drivers of churn and how those that do churn are impacted, including:

- Conduct qualitative surveys and analysis focused on the experiences churn populations like pregnant women face. This would help us understand the effects of churning as well as provide an overview of the steps needed to reduce the impacts of moving between programs. This research could focus on providers, benefit packages, premiums, and customer service.
 - For example, HCA could take advantage of the surveys consumers need to complete in order to renew or disenroll in a WAH plan to ask why consumers no longer need coverage and how they will be covered going forward (if at all). Such questions would inform both researchers and policy-makers the reasons behind why an individual might churn.
- Analysis of the accuracy of the provider directories through surveying providers (from each plan's directory) throughout Washington state would help determine whether policy actions must be taken in order to ensure that enrollees are able to access up-to-date and accurate information about which providers are offered and available under each plan.
- Additional analysis about provider networks state-wide, and across the care spectrum, would help to better understand the impacts churning has on enrollees overall.
- A comprehensive assessment of plan networks, focused on specialty areas that are either high volume (e.g., obstetrics/gynecology) or high impact (e.g., oncology), would help evaluate whether health plans throughout the state have enough in-network hospitals and providers available to members so that all services will be accessible without an unreasonable delay.

B) Policy Recommendations

i) Churn & Network Adequacy Standards

The findings of this report suggest policymakers, carriers, providers and advocates have several opportunities to help consumers who experience churn events in the context of narrow

networks. These recommendations, while not exhaustive, would assist consumers in making informed health insurance choices and minimize the challenges faced by the churn populations:

- The HBE should raise awareness and educate consumers about challenges around narrow networks and their right to access out-of-network care at in-network cost-sharing levels if a carrier does not have an in-network provider available without unreasonable delay or travel as required by WAC 284-43-200. Increasing health literacy during the shopping experience and beyond would assist consumers in making the best insurance decisions for both their health and financial needs.
- The HBE and OIC should both identify ways to improve consumer education and outreach. Individuals need accurate information regarding network options in order to make a meaningful choice about which plan is right based on preferences, family, and medical needs. For example, the OIC could require plans to disclose whether they follow broad, narrow, or ultra narrow designs. Additionally, for consumers who do move between WAH and QHP coverage, the HBE should provide additional support, including outreach through email or telephone calls when an individual churns, to ensure that they transition to their new coverage successfully. For example, an HBE representative might call consumers to see whether they are having any issues transition and let them know about the provider directories to make sure consumers receive in-network care.
- The OIC should create and enforce quantitative standards that ensure access to care in a timely manner. A potentially helpful resource for creating these standards is the model language developed by the National Association of Insurance Commissioners.⁷⁰
- The HCA should consider requiring WAH plans to allow enrollees to continue receiving maternity care from out-of-network providers and not pay out-of-network fees throughout the pregnancy and two months postpartum period. This would apply only to out-of-network providers who were rendering services at the time of the enrollees' transition to new plans.
- Lastly, the OIC must be sure to follow through with enforcement of its network adequacy rules. If it determines a plan has failed to meet the standards, appropriate enforcement action should then be taken to ensure compliance in the long run.

ii) Provider Directories & Consumer Rights

Consumers rely on the information they find in the provider directories to make decisions about which plan to enroll in and where to seek care and therefore need accurate, up-to-date information about which providers are in a plan's network. Inaccuracies in the directories can lead to interruptions or delays in necessary care for consumers. This is particularly problematic for pregnant women, given that their condition is time-sensitive, as well as underserved communities, who may have less experience using health insurance and navigating challenges relate to determining whether or not providers are in a plan's network. As such, it is critical that health plans provide this information so that consumers can understand their options for care and avoid unintentionally visiting costly out-of-network providers. Recommended steps that could be taken to address inaccuracies in provider directories include:

⁷⁰ National Association of Insurance Commissioners, Managed Care Plan Network Adequacy Model Act (Oct. 15, 2015).

- Similar to the Medicaid managed care rules, the OIC should require QHP carriers to quarterly, or in the event of a significant network change, assess the accuracy and completeness of 25-50% of their directories; for example, by verifying whether providers have an active network contract, are accepting new patients, and have current contact information listed.
 - The OIC and HCA should require that these updates are organized by specialty and reported to both organizations, which can take enforcement actions against the carrier in the event that it's network does not meet the state's adequacy standards, particularly for specialty types (either QHPs or Medicaid managed care).
- Both OIC and HCA should require directories be filterable by specific plans offered on the Exchange in which consumers can narrow provider search results.
- The OIC, HBE, HCA, and carriers should take steps to ensure that consumers have an appropriate recourse to address inaccurate listings that impact their ability to access care in a timely manner.
 - The OIC and HCA could even consider establishing penalties like New York's that include "payment of restitution to consumers who paid more than they should have because they received services from providers erroneously listed as in-network."⁷¹
- Since regulators rely primarily on consumer complaints as indicia of network adequacy issues, both the OIC and HBE should be sure to fully inform consumers about the HBE or OIC's complaint process.

⁷¹ *A.G. Schneiderman Announces Settlements Requiring Health Insurers to Publish Accurate Provider Directories*, N.Y. STATE OFFICE OF THE ATT'Y GEN. (Jan. 19, 2012).