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Employee Benefit Plan Review

The "Ghost Network" Problem: The Key Questions Employers Can Ask to Avoid Little-Known Benefits Risk

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A recent federal district court decision highlights a little known but significant risk faced by employers with welfare benefit plans that rely on medical provider and facility networks supplied by insurance carriers or third-party administrators (TPAs). In *Orrison v. Mayo Clinic*, the U.S. District Court for the District of Minnesota held that an employee adequately stated a claim against the employer plan administrator for maintaining an inaccurate database of medical providers. The decision means employer plan administrators may face possible liability in relying on the provider networks and related directories offered by insurance carriers and TPAs.

This article discusses what companies need to know about this decision, and what questions they should ask to monitor their plan's network.

The Facts

In the *Mayo Clinic* case,[1] an employee used an online search tool maintained by the TPA to find an available "in-network" mental health provider for her son. She alleged that the online tool returned no results for a provider in her local geographic area. As a result, she took her son out of network to receive services, for which she incurred additional healthcare costs. However, an in-network provider was apparently available but unknown to her because the database of network providers was allegedly inaccurate.

Although the court concluded that the employee did not allege sufficient facts regarding the TPA's directory verification protocol, it held that she stated a claim regarding deficiencies in the provider directory under a provision of the Employee Retirement Income Security Act (ERISA) requiring plans to publish and maintain accurate network provider directories.[2]

The Importance of Provider Networks

Employers necessarily rely on carriers and TPAs to supply provider networks because most employers are not in the business of contracting with providers and facilities to provide employee benefits. Relying on those entities is an efficient strategy for administering self-funded welfare plans, but as the *Mayo Clinic* decision makes clear, doing so comes with risks because the sufficiency and accuracy of those networks are sometimes unclear. In addition, the insurance carriers and TPAs hold the relevant information about the providers in their network, which leaves employers unsure

about the accuracy of the provider directory.

Studies have pointed to the common problem of so-called "ghost networks"[3] where insurance companies list providers "in network" that no longer have contracts to provide negotiated services or that no longer provide services in a listed geographic area. Most people rely on directories when searching for or selecting a healthcare provider or facility.[4] Misleading provider directories can leave plan participants with a false impression about the coverage they will receive.

Congress recently amended ERISA to address the issue of ghost networks by requiring plans and insurance companies offering group health insurance coverage to make available a database of their contracted providers, including their names, addresses, specialties, telephone numbers, and digital contact information.[5] More importantly, the statute requires plans and insurance companies to verify and correct the information listed in their provider directories every 90 days.[6]

Relatedly, plan administrators could face financial consequences for flawed directories where a participant obtains medical services from an out-of-network provider after receiving information from a plan directory that improperly lists the provider as in-network. In those cases, the plan participant cannot be charged any cost-sharing or out-of-pocket maximum greater than what she would have paid for the same service from an in-network provider. As the plan administrator, the employer might be held accountable for any charges the participant incurred based on directory errors.[7]

The *Orrison v. Mayo Clinic* case raises a related concern. The employer argued that the network accuracy requirements under ERISA are only directed at situations where the employee obtains services from an out-of-network provider based on the provider directory incorrectly listing the provider as in-network. However, the court rejected that narrow reading of the statute, holding that the plain text requires accurate directories generally and makes no distinction for databases that are underinclusive rather than overinclusive. Thus, plan administrators may face liability for directory errors that incorrectly include or exclude relevant providers from the provider directory.

Possible Liability for Employers

What is the nature of network accuracy liability? Although insurance companies should bear ultimate responsibility for making sure their directories are accurate, the statute also imposes the duty on the group health plan.[8] Despite the obligation imposed on the *plan*, the plan administrator arguably has a duty to ensure that the plan is administered in compliance with the law.

This is a significant point because the insurance carrier supplying the provider network to a self-funded plan will likely argue that the statutory requirement in that context is imposed on the plan, not the insurance carrier. The argument turns on the statutory requirement that health insurance issuers offering group health plans provide accurate network directories. In self-funded plan arrangements, the insurance carrier is arguably not offering group health insurance since the employer bears the financial risk of coverage.[9]

Another possible basis for liability rests with the plan administrator's duty to convey complete and accurate information about the plan.[10] When an employer communicates with its employees about a plan, fiduciary responsibilities come into play.[11] Relatedly, directory errors might be imputed to the plan administrator relying on the insurance company as an agent of the plan.[12]

Although the *Mayo Clinic* decision shows the availability of a cause of action relating to network accuracy violations, the employer may have a defense to the usual claims for equitable relief under ERISA. The statute provides a legal remedy and money damages to address directory errors when participants go out of network. This is important because equitable relief is not available when the plaintiff has a legal remedy.[13]

Relatedly, the relevant statutes support the participant or the employer looking to the insurance carrier and provider to compensate the participant for any out-of-network costs or balance billing. However, those defenses may not be available in situations like in *Mayo Clinic* because in that case the provider was not incorrectly listed as in-network.

Some Relevant Questions to Ask

Although plan administrators have available defenses to consider in these types of cases, it is best to avoid the problem of directory errors at the outset. This can be done by assessing (and continuing to monitor) the insurance carrier's or TPA's verification system and history of compliance with the directory accuracy requirements.

- When assessing whether an insurance company's network directory is accurate, the employer should at minimum request its verification protocol to determine whether the carrier complies with the statute. The plan administrator should make sure the administrative services agreement with the insurance carrier or TPA contains performance standards addressing network directory accuracy and verification protocols.
- It is also notable that HHS has in the past conducted "secret shopper" calls to providers listed in the directories of insurance companies to assess the accuracy of their directories. It is unclear whether those surveys will continue. However, it is worth asking the insurance company for the results of any secret shopper surveys conducted, either

by state or federal government entities, within the last two years to determine whether it had any directory accuracy problems.

- The plan administrator should also ask the insurance carrier whether any state insurance agencies in the past two years issued any deficiency findings relating to directory accuracy. That information will help the plan administration evaluate the insurance carrier's provider network, the accuracy of its directories, and whether the plan will be getting the bargained for services that the insurance carrier promises.

Notes

1. Civil No. 24-1124, 2025 WL 2688798 (D. Minn. Sept. 19, 2025).
2. Public Law No. 116-260, Div. BB, Title I, § 116(b) (Dec. 27, 2020) (29 U.S.C. § 1185i).
3. Abigail Burman, Laying Ghost Networks to Rest, 40 Yale L. & Pol'y Rev. 78, 108 (2021).
4. See 87 Fed. Reg. 61018 (Health and Human Services) (Oct. 7, 2022).
5. 29 U.S.C. § 1185i(a)(1), (6).
6. 29 U.S.C. § 1185i(a)(2).
7. 29 U.S.C. § 1185i(b)(1)-(2). Providers must reimburse the participant for any out-of-network cost sharing paid to the provider if the participant uses the provider based on incorrect directory information. See 42 U.S.C. § 300gg-139(b). Nor is the participant subject to balance billing. See 42 U.S.C. §§ 300gg-111(b)(1)(A), 300gg-132(a).
8. 29 U.S.C. § 1185i(a)(1).
9. See 29 U.S.C. § 1191b(b)(1) (defining health insurance coverage).
10. Killian v. Concert Health Plan, 742 F.3d 651, 665 (7th Cir. 2013).
11. Bins v. Exxon Co., 220 F.3d 1042, 1053 (9th Cir. 2000).
12. Sullivan-Mestecky v. Verizon Communication, 961 F.3d 91, 104 (2d Cir. 2020).
13. Grasso v. Express Scripts, 809 F.3d 1033, 1040 (8th Cir. 2016).

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