



Report to the Ranking Member,
Committee on Finance, United States
Senate

February 2016

PROVIDER NETWORKS

Comparison of Child- Focused Network Adequacy Standards between CHIP and Private Health Plans

GAO Highlights

Highlights of [GAO-16-219](#), a report to the Ranking Member, Committee on Finance, United States Senate

Why GAO Did This Study

Federal funding for CHIP expires at the end of fiscal year 2017. Any state with insufficient federal CHIP funding is required to have procedures to enroll eligible children in QHPs certified by HHS as comparable to CHIP, if any such QHPs are available. Little is known about how provider networks offered in QHPs compare with those in CHIP plans.

GAO was asked to review the inclusion of pediatric providers, including children's hospitals—where many children access pediatric specialists—in CHIP and QHP networks. This report examines (1) federal and selected state CHIP and QHP network adequacy standards, (2) the extent to which selected issuers of CHIP plans and QHPs include children's hospitals and otherwise help ensure access to pediatric specialists, and (3) how CMS and selected states monitor CHIP plan and QHP compliance with adequacy standards. GAO selected five states—Alabama, Massachusetts, Pennsylvania, Texas, and Washington—that varied based on whether the state or CMS operated the exchange on which QHPs were offered, as well as in the number of children in CHIP and in the state overall. GAO then selected issuers of the largest CHIP plan and QHP in the states' largest county, based on the most recently available enrollment data, and at least one children's hospital in each state. GAO reviewed federal and state laws and regulations and interviewed officials from CMS, the selected states, issuers, and children's hospitals. GAO findings on selected states and entities are not generalizable.

View [GAO-16-219](#). For more information, contact Katherine Iritani at (202) 512-7114 or iritanik@gao.gov.

February 2016

PROVIDER NETWORKS

Comparison of Child-Focused Network Adequacy Standards between CHIP and Private Health Plans

What GAO Found

Broad federal provider network adequacy standards apply to health plans in the joint federal-state State Children's Health Insurance Program (CHIP) and to qualified health plans (QHP)—private health plans offered on health insurance exchanges. These standards measure the adequacy of the networks of physicians, hospitals, and other providers participating in each plan. The five selected states GAO reviewed had one or more specific network adequacy standards, including:

- All five states required CHIP plans and QHPs to adhere to specific and quantitative standards for travel time or distance for the proximity of network providers' locations to enrollees' residences; some had both.
- Three selected states required CHIP plan and QHP networks to follow provider capacity or availability standards, including, for example, specific limits on appointment wait times.
- Two selected states required CHIP plan and QHP networks to follow specific provider-to-enrollee ratios.

More of the five states that GAO reviewed had child-focused network adequacy standards for CHIP plans than for QHPs. For CHIP plans, four of the five states had specific requirements for pediatric provider types, but, for QHPs, two of the five selected states had requirements for pediatric provider types.

Nearly all of the 19 selected issuers that GAO interviewed stated that they included at least one children's hospital in their CHIP and QHP networks. Most of the issuers noted they included more than one. One of the selected issuers—a QHP-only issuer—informed GAO that it did not include any children's hospitals, but noted having an arrangement with another hospital to provide certain pediatric services. Officials from most of the nine selected children's hospitals GAO interviewed raised concerns around not being included in all plan networks and the potential effect of this on children's access to specialty care they may need. Officials from the selected issuers also noted challenges recruiting certain types of pediatric specialists related to geographic location and compensation.

The Centers for Medicare & Medicaid Services (CMS)—the federal agency that oversees CHIP and QHPs—monitors state oversight of network adequacy for CHIP plans and is responsible for directly monitoring QHPs' network adequacy in states with federally facilitated exchanges. For CHIP, CMS officials told GAO they review state contracts and plans to assure compliance with access requirements, and, for QHPs, they monitor network adequacy through an annual certification process as well as other types of review. Officials from most of the five selected states told GAO they also monitored issuers' network adequacy compliance, but the frequency of monitoring varied. For example, three of the five selected states told GAO they require CHIP plan issuers to submit certain provider network information when the plan and network are established, then quarterly or annually thereafter. Officials from most of the selected states told GAO that they rely primarily on complaints, network changes, and other concerns to prompt the frequency with which they monitor QHPs' network adequacy. The Department of Health and Human Services (HHS) provided technical comments on a draft of this report that GAO incorporated, as appropriate.

Contents

Letter		1
	Background	6
	Federal Network Adequacy Standards Are Broad for Both CHIP Plans and QHPs, and Selected States Are More Focused on Pediatric Providers for CHIP Plans Than for QHPs	9
	Nearly All Selected Issuers Included at Least One Children’s Hospital in Their Networks, but Many Expressed Challenges Recruiting Certain Specialists	16
	CMS Monitors State Oversight of Network Adequacy for CHIP Plans and Directly Monitors Adequacy for QHPs in Federally Facilitated Exchanges; Selected States’ Monitoring Varied	18
	Agency Comments	24
Appendix I	Selection Criteria for States, Issuers, and Children’s Hospitals	26
Appendix II	GAO Contact and Staff Acknowledgments	30
Tables		
	Table 1: Selected States and Characteristics	27
	Table 2: Total Number of Issuers and Selected Issuers in Selected Counties, by Type of Issuer	29
Figure		
	Figure 1: Benefit Year 2015 State Children’s Health Insurance Program (CHIP) and Qualified Health Plan (QHP) Network Adequacy Standards Specific to Pediatric Provider Types for Selected States	15

Abbreviations

CHIP	State Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
FFE	federally facilitated exchange
HHS	Department of Health and Human Services
MACPAC	Medicaid and CHIP Payment and Access Commission
NAIC	National Association of Insurance Commissioners
PPACA	Patient Protection and Affordable Care Act
QHP	qualified health plan

This is a work of the U.S. government and is not subject to copyright protection in the United States. The published product may be reproduced and distributed in its entirety without further permission from GAO. However, because this work may contain copyrighted images or other material, permission from the copyright holder may be necessary if you wish to reproduce this material separately.



February 5, 2016

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate

Dear Senator Wyden:

The State Children’s Health Insurance Program (CHIP), a joint federal-state program established in 1997 to provide health coverage to certain low-income children, currently finances health insurance for over 8 million children whose household incomes are too high for Medicaid eligibility but may be too low to afford private insurance.¹ Since the inception of CHIP, the percentage of children without health insurance coverage has decreased by more than half, from 13.9 percent in 1997 to 5.5 percent in 2014.² Over the course of the program, Congress has enacted legislation authorizing continued funding for CHIP. Most recently, the Medicare Access and CHIP Reauthorization Act of 2015 appropriated federal CHIP funding to states through fiscal year 2017.³

Since January 2014, federal subsidies have been available to qualifying individuals to offset the cost of private health insurance purchased through health insurance exchanges—marketplaces where eligible individuals may compare and select among qualified health plans (QHP) offered by participating private issuers—established under the Patient Protection and Affordable Care Act (PPACA).⁴ PPACA directed each state to establish the exchange itself (referred to as a state-based

¹Medicaid is a joint federal-state program that finances health insurance coverage for low-income and medicallyneedy individuals, including children. States administer their CHIP programs under broad federal requirements and programs vary in the services covered and the costs to individuals and families. For example, states can administer their CHIP programs through managed care, fee-for-service arrangements, or both.

²The uninsured rate for children varies considerably among states. See M. E. Martinez and R. A. Cohen, *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, 2014* (National Center for Health Statistics, June 2015).

³Pub. L. No. 114-10, § 301(a), 129 Stat. 87, 154 (2015).

⁴Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010).

exchange) or cede the responsibility to the Department of Health and Human Services (HHS) (referred to as a federally facilitated exchange (FFE)).⁵ The federal government and states each play a role in overseeing CHIP and the exchanges, including oversight of the CHIP plans, the QHPs, and the adequacy of provider networks—that is, the networks of physicians, hospitals, and other providers that contract with the issuer of the CHIP plan or QHP.⁶

PPACA also requires that, if a state's federal CHIP funding is insufficient to cover all CHIP-eligible children, the state must establish procedures to ensure that eligible children who are not covered by CHIP are screened for Medicaid eligibility. By law, any state with insufficient federal CHIP funding is required to have procedures to facilitate the enrollment of children found ineligible for Medicaid in QHPs certified by HHS as comparable to CHIP, if any such QHPs are available. The Secretary of HHS in November 2015 reported there were no QHPs comparable to CHIP.⁷ Children transitioning from CHIP to exchange coverage may be eligible for federal subsidies established through PPACA to offset the cost of insurance purchased through the exchanges by eligible families. In contrast to the more than 8 million children enrolled in CHIP, HHS

⁵HHS's Centers for Medicare & Medicaid Services (CMS), which is tasked with overseeing the establishment of exchanges, refers to exchanges as marketplaces.

⁶An issuer is an insurance company, insurance service, or insurance organization that is required to be licensed to engage in the business of insurance in a state.

⁷CHIP regulations require that, for children found ineligible for CHIP either at the time of initial application or during a follow-up eligibility determination, the state must screen the child for Medicaid eligibility and, if ineligible for Medicaid, the state must then screen for potential eligibility for other insurance affordability programs, including subsidized coverage in a QHP. 42 C.F.R. § 457.350 (2014). Children eligible for subsidized coverage in a QHP may enroll in the QHP of their choosing, regardless of whether it has been certified by the Secretary of Health and Human Services as comparable to CHIP. In November 2015, CMS issued a report comparing cost-sharing and benefits in CHIP plans to the second lowest cost silver plan in the largest rating area in each state in which at least a portion of the CHIP child population was enrolled in a CHIP program separate from Medicaid. Based on this comparison, the Secretary did not certify any QHPs as comparable to CHIP coverage. See Department of Health and Human Services, Centers for Medicare & Medicaid Services, *Certification of Comparability of Pediatric Coverage Offered by Qualified Health Plans* (Baltimore, MD: November 25, 2015).

estimated that QHPs covered fewer than 1 million children in 2015, comprising about 8 percent of total QHP enrollment.⁸

Access to care from pediatric providers—including those practicing in and outside of children’s hospitals—is important for children, given that they have different health care needs than adults. Further, receiving regular preventive care and vaccinations at a young age are a key factor in an individual’s long-term health. Based on an analysis of the National Survey of Children’s Health, the Medicaid and CHIP Payment and Access Commission (MACPAC) reported that approximately one-quarter of children likely to be covered by CHIP reported having special health care needs.⁹ Even the majority of CHIP enrollees who are relatively healthy may need occasional access to pediatric specialists, many of whom provide services at children’s hospitals. More than two-thirds of CHIP enrollees received coverage through states’ CHIP programs that were administered separately from their Medicaid programs in fiscal year 2013, and most of these children (80 percent) were enrolled in managed care plans.¹⁰ In general, in both CHIP managed care plans and QHPs, enrollees’ choice of providers is largely limited to providers within the CHIP plan and QHP networks. MACPAC has raised concerns about whether the provider networks used by QHPs are adequate to address the health care needs of children.¹¹ To date, however, little is known

⁸Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Health Insurance Marketplaces 2015 Open Enrollment Period: March Enrollment Report* (March 10, 2015). QHP coverage is generally purchased for a calendar year, known as the benefit year.

⁹Medicaid and CHIP Payment and Access Commission, *Report to Congress on Medicaid and CHIP* (Washington, D.C.: March 2015). MACPAC is a non-partisan federal agency that provides policy and data analysis and makes recommendations to Congress, HHS, and the states on issues related to Medicaid and CHIP.

¹⁰Medicaid and CHIP Payment and Access Commission, *CHIP Enrollment by State, FY 2013* (March 2014) and Medicaid and CHIP Payment and Access Commission, *Child Enrollment in Separate CHIP Programs by State and Managed Care Participation, FY 2013* (March 2014).

States can administer CHIP as a separate program, include CHIP-eligible children in their Medicaid program, or do both. In 2015, 42 states operated separate CHIP programs (2 states had a separate CHIP program only and 40 states covered CHIP-eligible children through both a separate program and an expansion of their Medicaid program). The other 9 states covered CHIP-eligible children through an expansion of their Medicaid program.

¹¹Medicaid and CHIP Payment and Access Commission, *Report to Congress on Medicaid and CHIP* (Washington, D.C.: March 2015).

about any differences in the inclusion of children’s hospitals and other pediatric providers in the networks of CHIP and QHPs.

Because Congress will be deciding whether to extend CHIP funding beyond fiscal year 2017, you asked us to examine the inclusion of pediatric specialists and children’s hospitals in provider networks in CHIP and QHPs. In this report, we examine:

1. federal and state provider network adequacy standards CHIP plans must meet, particularly for pediatric providers, and how these compare to standards for QHPs;
2. the extent to which selected issuers of CHIP plans and QHPs include children’s hospitals in their networks and otherwise help to ensure access to pediatric specialists; and
3. how the federal government and selected states monitor CHIP plan and QHP compliance with provider network adequacy standards.

To address all three objectives, we reviewed relevant laws, regulations, and guidance documents to obtain information on network adequacy standards and monitoring responsibilities at the federal level, and interviewed knowledgeable officials from HHS’ Centers for Medicare & Medicaid Services (CMS).¹² Additionally, to obtain a broad perspective on network adequacy for pediatric providers, we interviewed officials from 10 organizations, including the National Association of Insurance Commissioners (NAIC), research organizations, and stakeholder organizations representing consumers, issuers, and providers.

In addition, we selected five states—Alabama, Massachusetts, Pennsylvania, Texas, and Washington—that administer the majority of their CHIP programs separately from their Medicaid programs and cover children ages 0 to 18 in these separate programs. These states varied in the type of health insurance exchange (i.e., state-based exchange or FFE), the size of their CHIP program, and their overall child population, among other characteristics.¹³ In these five states, we reviewed documents such as state laws and contracts between the states and

¹²CMS is the federal agency responsible for overseeing CHIP and health insurance exchanges.

¹³For 2015, Massachusetts and Washington had their own state-based exchanges, while Alabama, Pennsylvania, and Texas had FFEs.

selected issuers of CHIP plans. We also interviewed or obtained information in writing regarding network adequacy requirements and monitoring from knowledgeable officials from state agencies that administer the CHIP program and departments of insurance in each state, as well as exchanges in the two state-based exchange states. For the most populous county in each selected state, we selected issuers and children's hospitals from which to obtain information. We selected issuers of the largest CHIP plan and largest QHP in the selected county, based on the most recently available enrollment data. For QHPs, we selected issuers based on total county enrollment in each issuer's silver plan with the lowest premium for 2014 or 2015.¹⁴ Where possible, within each state we selected at least one issuer that offered: (1) only a CHIP plan, (2) only QHPs, and (3) both a CHIP plan and QHPs. We also selected at least one children's hospital in each state. In total, we interviewed or obtained information regarding the inclusion of children's hospitals and providers in networks from representatives of 19 selected issuers of CHIP plans and QHPs and nine selected children's hospitals.¹⁵ Our findings on state network adequacy standards and plan inclusion of children's hospitals and pediatric specialists, as well as on state monitoring of compliance with network adequacy standards, are not generalizable to all states, issuers, or children's hospitals, but provided us with valuable insight on these issues. See app. I for more details on the selection criteria for the states, issuers, and children's hospitals we included in our review.

We conducted this performance audit from December 2014 through February 2016 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform our work to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

¹⁴QHP issuers must offer coverage that meets one of four metal tier levels—bronze, silver, gold, and platinum—that correspond to plans' actuarial value. We focused our selection on silver level plans because reduced cost-sharing is available for eligible individuals enrolled in these plans.

¹⁵Most of the selected issuers offered CHIP plans and QHPs that were managed care plans that used provider networks, with the exception of one—Alabama's sole CHIP plan, which is a fee-for-service plan that used a provider network.

Background

Through CHIP, states provide health insurance coverage for children in families whose household incomes are too high to qualify for Medicaid. CHIP is funded jointly by the federal government and states. States administer CHIP under federal standards, and the state programs may vary, for example, in the services covered, costs to individuals and families, and eligibility standards.¹⁶ Specifically, CHIP income eligibility standards vary across states, with most states' upper income eligibility levels between 200 and 300 percent of the federal poverty level and the highest eligibility level being 400 percent of the federal poverty level. PPACA requires states to maintain their current eligibility levels for children in CHIP and Medicaid through fiscal year 2019. Thus, under current law, some states could choose to eliminate or scale back coverage for children in their CHIP and Medicaid programs beginning in fiscal year 2020, even if federal funds for these programs are available.

PPACA required the establishment of exchanges by January 1, 2014, to allow consumers to compare individual health insurance options available in each state and enroll in coverage. As of June 2015, 17 states had established state-based exchanges and 34 states had FFEs.¹⁷ The exchanges include certified QHPs offered in the states by the participating issuers of coverage. QHPs are required to meet certain benefit design, consumer protection, and other standards. Issuers may offer multiple QHPs and may also offer other health insurance products outside of the exchange, such as a CHIP managed care plan, Medicare Advantage plan, Medicaid managed care plan, or other commercial insurance products.¹⁸

¹⁶States typically cover a broad array of services in their CHIP programs, for example, routine check-ups, immunizations, emergency services, and certain dental services. CHIP premiums and cost-sharing may not exceed minimum amounts as defined by federal law.

¹⁷The Henry J. Kaiser Family Foundation, *State Health Insurance Marketplace Types, 2015*, accessed October 29, 2015, <http://kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/>.

¹⁸The National Academy for State Health Policy found overlap between issuers offering CHIP plans and QHPs in benefit year 2015. Specifically, in the 25 states included in the study, 5 states had complete overlap of issuers offering plans in both separate CHIP and the states' exchanges, 16 states had partial overlap, and 4 states had no overlap. See National Academy for State Health Policy, *Alignment Between Separate Children's Health Insurance Program (CHIP) and Marketplace Issuers by State, 2015* (2015).

While the CHIP program was created to address the health care needs of children in low-income families, QHPs offered through the exchanges established by PPACA are intended to target a broader population. Specifically, PPACA contained a number of provisions that were intended to make coverage more available and affordable for individuals seeking coverage in the private individual and small group health insurance markets.¹⁹ Some of these provisions established new rules that limit how much issuers can vary the premiums they charge certain individuals or groups, as well as prohibiting issuers from denying coverage based on an individual's health status, among other things. With the introduction of QHPs in 2014, researchers have found that issuers have increasingly employed cost-containment tools—such as creating narrow networks that include a smaller group of providers and hospitals—as well as by tiering networks—that is, creating several networks of differing levels of coverage that reflect different arrangements of out-of-pocket costs that may be incurred by an enrollee.²⁰

The federal government and states each play a role in overseeing CHIP, CHIP plans, exchanges, and QHPs:

- **CHIP.** CMS is the federal agency responsible for overseeing states' implementation and administration of their CHIP programs, including establishing federal standards for these programs and ensuring that

¹⁹For example, individuals or families seeking exchange coverage may be eligible for the health insurance premium tax credit and for cost-sharing subsidies established through PPACA. Eligibility for the premium tax credit is limited to individuals with household incomes between 100 and 400 percent of the federal poverty level. Eligibility for the cost-sharing subsidies, which aim to reduce out-of-pocket costs for deductibles, co-payments, and other costs, is generally for individuals and families with household incomes between 100 and 250 percent of the federal poverty level that choose silver-level plans. To be eligible for these subsidies, an individual cannot be eligible for public insurance such as Medicaid or CHIP (except for a child in a state with insufficient federal CHIP funds for eligible children) or affordable employer-sponsored health insurance that provides a minimum value.

²⁰See, for example, S. Corlette, J. Volk, R. Berenson, and J. Feder, *Narrow Provider Networks in New Health Plans: Balancing Affordability with Access to Quality* (Washington, D.C.: Urban Institute, May 2014). When tiering a network, an issuer assigns in-network providers into distinct tiers whereby enrollee cost-sharing increases progressively from tier to tier as the network becomes more expansive. For example, a QHP could have two provider tiers within its network—a preferred tier, with the lowest level of enrollee cost-sharing, and a general tier, with a higher level of cost-sharing—with all other providers considered out-of-network, which has the highest level of enrollee cost-sharing.

states take steps to adequately oversee issuers' compliance with these standards. At the state level, state agencies such as the Medicaid agencies or departments of health or social services are responsible for administering CHIP programs and overseeing CHIP plans. For CHIP programs operated through the use of managed care, the relevant state agencies contract with managed care organizations to provide services to CHIP enrollees. State departments of insurance may also play a role in overseeing CHIP plans, to the extent these plans are subject to state insurance rules.

- **QHPs.** Regardless of the exchange type, CMS has direct oversight responsibilities for the PPACA exchanges, as CMS is responsible for certifying state exchanges for operation and directly operating the FFE. In addition, CMS is responsible for establishing minimum QHP certification requirements that all QHPs must meet in order to participate in an exchange. In the FFE states, CMS oversees compliance with these requirements; in the states with state-based exchanges, the states are responsible for ensuring the plans comply. Federal regulations require that all exchanges have procedures to annually certify QHPs to ensure they are in compliance with exchange requirements.²¹

While we and others have reported on CHIP enrollees' experiences with access to health care compared to those with private insurance or without insurance and comparisons of other aspects of CHIP and QHPs, little is known about whether the provider networks used by QHPs are adequate to address the health care needs of children or how CHIP networks compare with those of QHPs. Specifically, we reported in November 2013 that survey data indicated that CHIP enrollees reported comparably positive responses regarding their ability to obtain care when compared with responses for enrollees with private insurance, but that approximately 18 percent of CHIP enrollees reported difficulties seeing a specialist.²² We also reported in February 2015 that coverage of services by selected CHIP plans in five selected states was generally comparable to that of the selected QHPs, with the notable exceptions of pediatric dental and certain enabling services such as translation and

²¹45 C.F.R. § 155.1075 (2014).

²²See GAO, *Children's Health Insurance: Information on Coverage of Services, Costs to Consumers, and Access to Care in CHIP and Other Sources of Insurance*, [GAO-14-40](#) (Washington, D.C.: Nov. 21, 2013).

transportation services, which were covered more frequently by the CHIP plans.²³ However, as noted by MACPAC in its March 2015 report, little has been reported on the provider network differences among CHIP, Medicaid, and QHPs.²⁴ HHS' Assistant Secretary for Planning and Evaluation contracted for studies looking at provider networks in CHIP, Medicaid, and qualified health plans in six urban areas; but, as of November 2015, HHS had not published the studies.

Federal Network Adequacy Standards Are Broad for Both CHIP Plans and QHPs, and Selected States Are More Focused on Pediatric Providers for CHIP Plans Than for QHPs

At the federal level, broad network adequacy standards apply to CHIP plans and QHPs. At the state level, most of the five states we reviewed required CHIP plans to adhere to network adequacy standards that related specifically to pediatric provider types. The selected states required QHPs to follow fewer pediatric provider-specific standards.

Broad Federal Network Adequacy Standards Apply to CHIP Plans and QHPs

Broad federal network adequacy standards apply to CHIP plans and QHPs. States that administer their CHIP programs through managed care plans must adhere to federal requirements governing CHIP managed care organizations, while QHPs in both state-based exchanges and FFEs are also subject to federal requirements for provider network adequacy. Specifically:

- Federal law requires that CHIP managed care plans provide assurances that, within their service areas, they have the capacity to

²³See GAO, *Children's Health Insurance: Coverage of Services and Cost to Consumers in Selected CHIP and Private Health Plans in Five States*, [GAO-15-323](#) (Washington, D.C.: Feb. 25, 2015).

²⁴Medicaid and CHIP Payment and Access Commission, *Report to Congress on Medicaid and CHIP* (Washington, D.C.: March 2015).

serve their expected enrollment; that they maintain an adequate number, mix and distribution of providers; and that they offer an appropriate range of services and access to preventive and primary care services for the expected population.²⁵ Because CHIP managed care plans primarily cover children, these plans are thus required to include a sufficient network of pediatric providers.

- Federal regulations require QHPs to maintain networks that are sufficient in number and types of providers in order to ensure that all services are accessible to enrollees without unreasonable delay.²⁶ Regulations also require that QHP networks include “essential community providers” to ensure reasonable and timely access to a broad range of providers for low-income and medically underserved individuals.²⁷

CMS has established more specific network adequacy criteria applicable to QHPs participating in the FFE, which CMS operates.²⁸ For example, in its annual certification guidance to QHP issuers in FFE states for benefit years 2015 and 2016, CMS instructed issuers to submit a list of providers and their geographic locations so that CMS could determine whether an issuer met the “reasonable access” standard—that is, that the issuer maintains networks that are sufficient in number and types of providers in

²⁵See 42 U.S.C. § 1396u-2(b)(5). See also CMS, SHO # 09-008 (Baltimore, M.D.: Aug. 31, 2009). In addition, federal law and regulations require states to provide a description of how the state will assure access to covered services and “appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee’s medical condition.” 42 C.F.R. § 457.495(c) (2014). Federal law also requires CHIP plans to cover the cost of out-of-network care if in-network providers cannot meet enrollee needs. 42 U.S.C. § 1396u-2(b)(6).

²⁶See 45 C.F.R. § 156.230(a) (2014).

²⁷See 45 C.F.R. § 156.235(a) (2014). Essential community providers are defined as providers that serve predominantly low-income, medically underserved individuals.

²⁸In its annual QHP certification guidance, CMS provides specific operational and technical guidance to issuers participating in the FFE. See Center for Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services, *2015 Letter to Issuers in the Federally-facilitated Marketplaces* (Washington, D.C.: March 14, 2014); and Center for Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services, *Final 2016 Letter to Issuers in the Federally-facilitated Marketplaces* (Washington, D.C.: Feb. 20, 2015). State-based exchanges are responsible for providing such guidance to issuers participating in the state-based exchanges.

order to ensure that all services are accessible to enrollees without unreasonable delay. CMS also noted that it considers a QHP network to meet the essential community provider requirement when:

- The network includes at least 30 percent of available essential community providers in the QHP's service area and
- The network covers at least one provider in each essential community provider category in each county where an essential community provider in that category is available.²⁹

For QHPs participating in the FFE, CMS specified that essential community provider categories include, but are not limited to: federally qualified health centers, Indian Health providers, and hospitals. None of these specified categories are specific to pediatric providers.

CMS is considering changes to CHIP plan and QHP network adequacy requirements. With regard to the CHIP program, CMS issued a proposed rule in June 2015 that, if finalized as proposed, would amend current Medicaid and CHIP managed care regulations to reduce variation in how states evaluate and define network adequacy.³⁰ With regard to QHPs in FFE states, CMS issued a proposed rule in December 2015 that, if finalized as proposed, would allow states in which an FFE operates to select a quantifiable network adequacy standard—such as a travel time or distance standard for the proximity of network providers' locations to enrollees' residences—applicable to QHPs in that state. If the state does not adopt such a standard or does not review QHP network adequacy, a

²⁹See Center for Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services, *2015 Letter to Issuers in the Federally-facilitated Marketplaces* (Washington, D.C.: March 14, 2014), 19; and Center for Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services, *Final 2016 Letter to Issuers in the Federally-facilitated Marketplaces* (Washington, D.C.: Feb. 20, 2015), 25. Issuers that do not satisfy the 30 percent guideline are required to include as part of their QHP applications a narrative describing how the issuer's provider network provides an adequate level of service for low-income and medically underserved enrollees.

³⁰See 80 Fed. Reg. 31,097 (June 1, 2015) (proposing to amend 42 C.F.R. parts 438 and 457). For example, the proposed rule, if finalized, would require states to establish minimum time and distance standards for the proximity of certain types of network providers' locations to enrollees' residences, such as primary care providers and specialists (adult and pediatric). CMS solicited comments on whether the agency should include CHIP plan standards for additional pediatric provider types, such as children's hospitals or child and adolescent behavioral health providers, among other things.

default federal standard imposing specific time and distance requirements would apply to QHPs in the state.³¹ CMS indicated that the agency followed proposed changes to the NAIC network adequacy model in considering modifications to the QHP network adequacy standards.³²

Selected States Also Had Network Adequacy Standards, but Held CHIP Plans More Often Than QHPs to Pediatric-Specific Standards

³¹See 80 Fed. Reg. 75,549 (Dec. 2, 2015) (proposing to amend 45 C.F.R. part 156). According to CMS, this proposed change is intended to recognize the traditional roles that states have in developing and enforcing network adequacy standards. The proposed rule proposes other changes related to network adequacy, including, for example, the establishment of a justification process when issuers are unable to meet the network adequacy standards for reasons such as the availability of providers, and requirements for notification of provider termination to enrollees and continuity of care in certain circumstances.

³²CMS used the NAIC 1996 network adequacy model as the basis for the PPACA exchange network adequacy standards. See National Association of Insurance Commissioners, *Managed Care Plan Network Adequacy Model Act #74* (Washington, D.C.: October 1996). Since 1996, NAIC has made available to states this model act for network adequacy. NAIC updated its model act in November 2015 after convening a group of state insurance regulators and other interested parties to provide input on the update. The revised model act includes options for how network adequacy, or sufficiency, may be determined through various types of quantitative standards, but does not suggest specific quantitative benchmarks. The revised model act also suggests that issuers and states ensure that the network is sufficient to provide covered services to covered individuals, including adults and children, without unreasonable travel or delay.

Overall Network Adequacy
Standards in Selected States

The five selected states we examined had one or more specific network adequacy standards for CHIP plans and QHPs.³³ These standards included the following:

- **Provider-to-enrollee ratios** or quantitative standards for a minimum number of providers per enrollee or set of enrollees. Two of the selected states—Massachusetts and Washington—required CHIP plan networks to follow specific provider-to-enrollee ratios. For instance, in Massachusetts, managed care plans in which CHIP children are enrolled must include one primary care provider for every 200 enrollees. These same two states also required at least some QHPs to have a minimum provider-to-enrollee ratio for certain provider types, such as primary care providers. These primary care providers may include, but were not exclusive to, pediatric primary care providers.
- **Travel time or distance standards** for the proximity of network providers' locations to all or some proportion of enrollees' residences; such standards may differ for rural and urban areas. All five states required CHIP plans to adhere to specific and quantitative travel time standards, travel distance standards, or both. For example, Alabama required that, for 90 percent of enrollees, one hospital must be available within 30 miles of enrollees' homes, and two behavioral health providers must be available within 10 miles of enrollees' homes in urban areas or 45 miles in rural areas. All five selected states also had specific quantitative travel time or distance standards for QHPs for certain provider types, such as primary care providers. These primary care providers may include, but were not necessarily exclusive to, pediatric primary care providers.

³³In three of the five selected states, at least some CHIP plans were subject to network adequacy standards that are generally applicable to managed care plans in the state, including QHPs, as well as network adequacy standards specifically applicable to CHIP plans. In contrast, CHIP plans in Massachusetts and Washington were only subject to CHIP-specific standards established by the state agency responsible for overseeing CHIP. In some states, certain standards apply only to specific plan types. For example, certain standards adopted by Alabama's Department of Public Health only apply to health maintenance organizations. While Alabama's only CHIP plan as of the time of our review was not a health maintenance organization, those standards would apply to any CHIP plans in the future that are health maintenance organizations. In another example, Massachusetts has separate network adequacy standards that apply to ConnectorCare QHPs—a subset of the lowest-cost silver QHPs—but do not apply to other QHPs.

Specific Network Adequacy Standards for Pediatric Provider Types in Selected States

- **Capacity or availability standards**, which may include requirements that a certain number or proportion of providers are accepting new patients or may require specific limits on appointment wait times. Three of the selected states—Massachusetts, Texas, and Washington—required CHIP plan networks to follow provider capacity or availability standards. Washington, for example, required CHIP plans to ensure that non-emergency, routine primary care be available within 10 days. These same three states also required QHPs to take into account the capacity or availability of network providers.

While federal network adequacy standards for QHPs do not impose requirements specifically related to pediatric providers, individual states may adopt such requirements. For CHIP plans, most selected states had specific requirements for pediatric provider types, but, for QHPs, only two states had specific requirements for pediatric provider types. (See fig. 1.) Specifically, four of the selected states—Alabama, Massachusetts, Texas, and Washington—required CHIP plans to meet certain pediatric provider standards. This was particularly true for travel time and distance standards, as well as capacity or availability standards. For example, Texas required CHIP plans to include in their networks one age-appropriate primary care provider within 30 miles of enrollees' homes for 90 percent of enrollees, and Alabama required CHIP plan networks to provide access to two pediatric primary care providers within a 20-mile radius of enrollees' homes for 90 percent of enrollees. In addition, Texas required CHIP plans to make preventive health service appointments for children available within a timeframe that is in accordance with standards set by a national pediatric provider group. For QHPs, fewer of the selected states had adopted standards related to pediatric provider types than for CHIP plans. Specifically, two of the five selected states—Texas and Washington—had QHP standards containing requirements specific to pediatric provider types.³⁴ For example, Washington required QHP issuers to demonstrate that 80 percent of the covered children in a given service area have access to a pediatrician within 30 miles of their homes for an urban area or 60 miles for a rural area and to pediatric specialty services within 60 miles of their homes for an urban area and 90 miles for a rural area. In another example, Texas required that QHP issuers provide routine care for children within two months of the request.

³⁴In addition to having network adequacy standards that are specific to pediatric provider types, Washington required the inclusion of school-based health centers as an essential community provider category that QHPs must cover.

Figure 1: Benefit Year 2015 State Children’s Health Insurance Program (CHIP) and Qualified Health Plan (QHP) Network Adequacy Standards Specific to Pediatric Provider Types for Selected States

Selected state	Pediatric standards for					
	Children’s Health Insurance Program (CHIP) plans			Qualified Health Plans (QHP)		
	Provider to enrollee ratios	Time and distance criteria	Capacity or availability	Provider to enrollee ratios	Time and distance criteria	Capacity or availability
Alabama		✓				
Massachusetts	✓		✓			
Pennsylvania						
Texas		✓	✓			✓
Washington		✓			✓	

Source: GAO analysis of state standards. | GAO-16-219

Note: Some standards apply only to specific plan types or to specific programs.

Nearly All Selected Issuers Included at Least One Children's Hospital in Their Networks, but Many Expressed Challenges Recruiting Certain Specialists

Eighteen of 19 selected issuers that offered CHIP plans, QHPs, or both, in the most populous counties of the five selected states reported including at least one children's hospital in their provider networks for their CHIP plans and QHPs.³⁵ Most of them—16 of the 18—reported including more than one children's hospital. Representatives from one QHP-only issuer told us they did not include a children's hospital in their QHP network, but they instead provide access to children's pediatric services—such as neonatal intensive care and general pediatric surgery—through an agreement with four hospitals that treat children but are not limited to children. All of the selected issuers of CHIP plans and QHPs told us they had a policy to allow for enrollees to obtain case-by-case exceptions when certain services or providers are unavailable in-network.³⁶

Officials representing some of the children's hospitals we spoke with, however, raised concerns around not being included in all plan networks and the potential effect on children's access to specialty care they may need. Representatives from all nine selected children's hospitals we contacted in the selected states told us that their hospitals are currently included in networks of many—but not all—CHIP plans and QHPs that are offered in the selected counties. Representatives from five of the nine children's hospitals located in four different states noted concerns about some aspects of network inclusion that could affect access for children who need specialty care through their hospitals. Specifically:

- Representatives from three of these five children's hospitals told us that, in some QHPs that have tiered networks, their hospitals are included in tiers that are associated with higher enrollee cost-sharing.
- Representatives from two of these five children's hospitals told us they were concerned about their future inclusion in CHIP and QHP networks, explaining that their hospital's inclusion in networks could

³⁵Although we selected QHP issuers based on total county enrollment in each issuer's silver plan with the lowest premium for 2014 or 2015, we asked each selected issuer about the inclusion of children's hospitals in the networks of their QHPs offered in the selected county.

³⁶Enrollees may need to obtain pre-authorization before they access services from out-of-network providers. Representatives from Washington's Office of the Insurance Commissioner told us that they are scrutinizing the pre-authorization process more closely and requiring issuers to submit data on denied pre-authorizations because they are concerned that pre-authorization may be affecting access to care.

vary from year to year. A representative from one of these two children's hospitals also noted that the fundamental network adequacy issue for the pediatric population is the small percentage of children with complex health care needs, which typically account for a large percentage of pediatric medical costs.

- Representatives from three of these five children's hospitals noted that when their hospitals are not in a CHIP or QHP network, treating CHIP or QHP enrollees at their facilities increases the administrative burden placed on the hospitals as they have to arrange case-by-case exceptions with plan issuers.

The selected issuers that offered both CHIP plans and QHPs told us they had the same or similar provider networks for their CHIP plans and QHPs. For example, one issuer told us that in 2014 its Medicaid and CHIP plan networks were different in that some Medicaid providers did not initially join QHP networks. However, the issuer told us there was an increase in the number of Medicaid providers willing to join QHP networks in 2015. Representatives from another issuer told us they had one provider network for all plans, including CHIP plans and QHPs.

All of the 19 selected issuers we contacted indicated that pediatric specialists are included in each of their networks. However, many expressed challenges recruiting certain types of pediatric specialists. Many of the challenges related to location or compensation as well as reflecting provider availability nationwide:

- **Location.** Representatives from four issuers—one QHP issuer, two issuers of CHIP plans, and one issuer of both a CHIP plan and QHP—in two states told us that it is difficult to recruit and retain pediatric behavioral health providers. These representatives further noted that this problem is not specific to their county or state, but related to a nationwide shortage of children's behavioral health providers. In addition, representatives from four issuers of CHIP plans in three states told us that recruiting specialists in metropolitan counties is generally not as difficult as recruiting specialists in rural counties, and difficulties recruiting specialists in rural counties is a problem affecting all of their insurance plan networks, not just CHIP plans.
- **Compensation.** Representatives from one issuer of a CHIP plan told us that some specialists generally require significantly higher compensation than CHIP plans typically pay, making it difficult for the issuer to recruit certain pediatric specialists—such as cardiologists,

cardiovascular surgeons, neurologists, neurosurgeons, and urologists—to its network. In addition, the issuer noted that these specialists are difficult to contract with due to the limited number of providers practicing in these specialties.

CMS Monitors State Oversight of Network Adequacy for CHIP Plans and Directly Monitors Adequacy for QHPs in Federally Facilitated Exchanges; Selected States' Monitoring Varied

States have primary responsibility for administering CHIP and for overseeing CHIP plan compliance with network adequacy standards, and CMS monitors these state oversight activities. CMS officials reported conducting certain monitoring activities for QHPs to assess the adequacy of provider networks in FFE states. Officials from most of the selected states' CHIP agencies and departments of insurance reported monitoring issuers' compliance with state CHIP and QHP standards, but states' frequency of monitoring varied.

CMS Monitored State Oversight of CHIP Network Adequacy through Contract and State Plan Reviews, and Directly Monitored Adequacy for QHPs in Federally Facilitated Exchange States

Federal Monitoring of CHIP Network Adequacy

CMS officials told us that the agency monitors the oversight activities of states, which have primary responsibility for administering CHIP and for overseeing CHIP plan compliance with network adequacy standards, primarily by reviewing state contracts with plan issuers and requiring certain assurances from states and issuers. Federal law requires states to establish standards for access to care under CHIP managed care plans to ensure that covered services are available within reasonable timeframes and in a manner that ensures both continuity of care and

adequate primary care and specialized services capacity; states must also provide assurances to CMS that these standards are met. These standards may include, for example, provider-to-enrollee ratios, travel time or distance standards, and capacity or availability standards. CMS monitors states' CHIP oversight activities in the following ways:

- **Reviews state contracts with issuers of CHIP plans.** Since July 1, 2009, CMS has required states to submit for CMS review all new, extended, renewed, or amended CHIP managed care contracts that states enter with managed care organizations to ensure these contracts comply with federal requirements, including those relating to access to care.³⁷
- **Requires states to develop and implement plans that include access standards.** States must operate their CHIP programs in accordance with a CMS-approved state CHIP plan that must include a description of the methods the states use to ensure the quality and appropriateness of care provided under the plan.³⁸ Each state that contracts with managed care organizations to provide CHIP benefits also must develop and implement a Quality Assessment and Improvement Strategy, which must include access to care standards that ensure covered services are available within reasonable timeframes and in a manner that ensures continuity of care and adequate primary care and specialized services capacity.³⁹ CMS is required to monitor the development and implementation of this plan.⁴⁰ In addition, each contract that a state enters into with a managed care organizations to provide CHIP benefits must include a requirement for an annual external independent review to ensure the

³⁷See Centers for Medicare & Medicaid Services, SHO # 09-008 (Baltimore, M.D.: Aug. 31, 2009).

³⁸See 42 C.F.R. § 457.495 (2014).

³⁹42 U.S.C. § 1397cc(f)(3), 1396u-2(c).

⁴⁰42 U.S.C. § 1396u-2(c)(1)(C).

Federal Monitoring of QHP
Network Adequacy

plan's quality and timeliness of, and access to, covered items and services under the contract.⁴¹

CMS officials told us that they are not aware of any concerns about children enrolled in CHIP not having access to pediatric specialists, and that they think states make a concerted effort in establishing provider networks for their CHIP plans for children to ensure sufficient pediatricians and pediatric specialists.

In contrast with its indirect oversight role over CHIP plans, CMS is responsible for directly monitoring QHPs' compliance with QHP certification standards in FFE states.⁴² CMS officials reported using three types of monitoring activities to assess the adequacy of QHPs' provider networks in FFE states—through the annual QHP certification process, comprehensive issuer compliance reviews, and post-certification reviews, as follows:

- **Annual QHP certification process.** CMS conducts an annual certification process of QHPs in FFE states. CMS officials told us that during this process they assess QHPs' provider networks using the "reasonable access" standard in order to identify networks that potentially fail to provide access without unreasonable delay, as required by federal regulations.⁴³ CMS officials told us they do not assess QHP networks for their adequacy of pediatric providers or pediatric specialists because there have not historically been network adequacy concerns with these types of providers. During the certification process, CMS officials told us they analyze issuers' QHP

⁴¹42 U.S.C. § 1396u-2(c)(2)(A). If finalized, CMS's proposed regulation to amend current Medicaid and CHIP managed care requirements would establish additional CHIP managed care plan oversight activities. The proposed rule would require states to establish monitoring systems to address specific aspects of their CHIP and Medicaid managed care programs, including network management, and to submit to CMS an annual program assessment report on various aspects of their CHIP and Medicaid managed care programs, including network adequacy. See 80 Fed. Reg. at 31,296 (proposing to amend 42 C.F.R. § 457.1230).

⁴²At the time of our review, Massachusetts and Washington had their own state-based exchanges, while Alabama, Pennsylvania, and Texas had FFEs. As discussed above, however, in a December 2015 proposed rule, CMS has proposed to rely on state reviews of QHP network adequacy in states in which the FFE operates. If the state chooses not to review network adequacy, CMS would do so. See 80 Fed. Reg. 75,549 (Dec. 2, 2015) (proposing to amend 45 C.F.R. part 156).

⁴³See 45 C.F.R. § 156.230(a) (2014).

provider network data on the providers and types of providers in the networks for each service area using a computerized geographic mapping and analytics tool. CMS compares the QHPs' network data against internal CMS metrics, including time and distance standards for certain provider categories that have historically raised network adequacy concerns—hospitals, mental health, oncology, primary care, and dental.⁴⁴ According to CMS officials, 17 QHP issuers were flagged as having potential network adequacy concerns during the certification process for benefit year 2015, resulting in CMS communicating with the issuers through an iterative process to obtain more information. CMS officials reported that these issuers either provided what CMS officials deemed to be a reasonable justification for the lack of providers, such as a lack of available providers in a specialty or patterns of care that reasonably justify the lack of providers, or they provided CMS with data to indicate they included additional providers in their networks since their initial data submission. CMS officials said that, for benefit years 2014 and 2015, all issuers ended up providing adequate information about their networks to be able to attain QHP certification.

- **Comprehensive issuer compliance reviews.** CMS officials reported monitoring QHPs' compliance with provider network standards in FFE states through comprehensive issuer compliance reviews, though network adequacy is only one of many elements in these reviews. During a compliance review, CMS reviews an issuer's policies and procedures related to CMS's internally established availability and accessibility standards and also reviews issuers' compliance with other federal standards, such as QHPs' rates, benefit design, and marketing. CMS officials reported that for benefit year 2014 they

⁴⁴In its annual guidance to issuers for benefit years 2014, 2015, and 2016, CMS indicated the provider types on which the agency would focus its review; however, CMS did not include the specific quantitative standards it would use. For benefit year 2017, however, CMS has proposed establishing a quantitative standard for QHPs participating in the FFE. See Center for Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services, *Affordable Exchanges Guidance: Letter to Issuers on Federally-facilitated and State Partnership Exchanges* (Washington, D.C.: April 5, 2013), 6; Center for Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services, *2015 Letter to Issuers in the Federally-facilitated Marketplaces* (Washington, D.C.: March 14, 2014), 17; Center for Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services, *Final 2016 Letter to Issuers in the Federally-facilitated Marketplaces* (Washington, D.C.: Feb. 20, 2015), 22; and 80 Fed. Reg. 75,549 (Dec. 2, 2015) (proposing to amend 45 C.F.R. part 156).

conducted compliance reviews of 21 issuers; for benefit year 2015, CMS reported having conducted such reviews of 30 issuers.⁴⁵

- **Post-certification reviews.** CMS officials reported that they also conduct post-certification reviews, which focus on a specific topic and may be conducted for a sample of issuers or for all issuers, depending on the focus of the review. For example, prior to the start of benefit year 2015, officials said they reviewed all certified QHP issuers' websites to make sure the links to their provider directories were compliant with CMS network adequacy standards—that is, that the links worked and were easily accessible.

In addition to these monitoring activities, CMS officials told us they also receive and respond to consumer complaints about QHPs. According to officials, when a complaint of that nature reaches CMS, the agency will follow up with the consumer on an ad hoc basis. While officials reported that they have heard anecdotally of problems with network adequacy from advocacy groups, they were not aware of any complaints specific to pediatric providers.

Most Selected States Monitored CHIP and QHP Network Adequacy, but the Frequency of Monitoring Varied

Selected States' Monitoring of CHIP Network Adequacy

Officials from CHIP agencies in three of the five selected states—Massachusetts, Texas, and Washington—told us they regularly monitor CHIP plan issuers' compliance with the states' CHIP network adequacy standards, but the frequency with which they reported doing this varied. Specifically:

- CHIP officials from these three states told us they require CHIP plan issuers to submit certain provider network information at the time the plan and network are established and then quarterly or annually thereafter. For example, in Washington, issuers must demonstrate the

⁴⁵According to CMS, there were 182 QHP issuers (excluding stand-alone dental and Small Business Health Options Program plans) in 2014 and 231 of these issuers in 2015.

ability to service 80 percent of the eligible CHIP population in a given service area. Washington CHIP officials told us that issuers must submit information at least quarterly on all of their providers in each service area; this information is entered into a computerized geographic access program that assesses the locations of providers in relation to all potential CHIP enrollees in a service area and measures the results against the state's distance standards. The officials said they specifically focus on an issuer's network inclusion of 17 provider types, 6 of which they deem to be "critical" for CHIP and Medicaid, including hospitals, pharmacies, primary care providers, pediatric primary care providers, obstetricians, and behavioral health providers. Additionally, issuers must annually report information to the state CHIP agency, such as their provider-to-enrollee ratios and provider utilization ratios.

- In contrast, CHIP officials in the other two selected states—Alabama and Pennsylvania—told us they assess CHIP plan issuers' compliance with state network adequacy standards at the time the network is established and then on an ad hoc basis thereafter. For example, officials from Pennsylvania told us they would request network information if they received a complaint about the network or if a provider group or hospital left the network.
- CHIP officials in all five states also told us that they track any consumer complaints received about CHIP plan provider networks.

Selected States' Monitoring of
QHP Network Adequacy

Officials from most of the selected states—Massachusetts, Pennsylvania, Texas, and Washington—told us that they rely primarily on complaints,

network changes, and other concerns to prompt the frequency with which they monitor QHPs' network adequacy.⁴⁶ For example:

- Department of insurance officials from Texas— an FFE state—noted that QHP issuers must re-submit provider network information when there is a material change to the network, and, if the updated network is no longer adequate, the issuer must also submit an access plan and a request for a waiver in order to continue to offer QHPs in that service area.
- Department of insurance officials from Pennsylvania—another FFE state—told us that if they receive an access complaint about a QHP, staff will investigate and alert CMS to the problem.
- Department of insurance officials from one FFE state—Alabama—told us that they do not assess or monitor QHP provider networks, nor do they track consumer complaints.

Officials from the departments of insurance in Massachusetts, Pennsylvania, and Washington told us that, as of mid-2015, they had received very few or no complaints about QHPs' provider networks in 2014 and in 2015.

Agency Comments

We provided a draft of this report to the Secretary of Health and Human Services. HHS provided technical comments that we incorporated as appropriate.

⁴⁶One of these states—Massachusetts—conducts more regular reviews of network adequacy for a subset of the lowest-cost silver QHPs. In addition, Massachusetts officials noted that network adequacy review is a part of a biennial managed care accreditation process, but the state does not have its own quantitative standards against which to measure adequacy. Overall, however, what we found is consistent with the results of a 2014 survey of state regulators conducted by the consumer representatives of the NAIC that found few states conduct regular monitoring of provider networks outside of the initial establishment of a network and when they receive a complaint. See Health Management Associates, *Ensuring Consumers' Access to Care: Network Adequacy State Insurance Survey Findings and Recommendations for Regulatory Reforms in a Changing Insurance Market* (November 2014). In FFE states, CMS is responsible for directly monitoring QHPs' compliance with certification standards, though states departments of insurance, which license health plans in the respective states, oversee compliance with state insurance requirements. At the time of our review, Massachusetts and Washington had their own state-based exchanges, while Alabama, Pennsylvania, and Texas had FFEs.

As agreed with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution of it until 30 days from the report date. At that time, we will send copies to the Secretary of Health and Human Services, and other interested parties. In addition, the report will be available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or iritanik@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix II.

Sincerely yours,

A handwritten signature in black ink that reads "Katherine Iritani". The signature is written in a cursive style with a large, looped initial "K".

Katherine M. Iritani
Director, Health Care

Appendix I: Selection Criteria for States, Issuers, and Children’s Hospitals

This appendix describes the methodology we used to select states, issuers, and children’s hospitals to address our objectives to examine: (1) federal and state provider network adequacy standards State Children’s Health Insurance Program (CHIP) plans must meet, particularly for pediatric providers, and how these compare to standards for qualified health plans (QHP); (2) the extent to which selected issuers of CHIP plans and QHPs include children’s hospitals in their networks and otherwise help to ensure access to pediatric specialists; and (3) how the federal government and selected states monitor CHIP plan and QHP compliance with provider network adequacy standards.

State selection

We selected five states that administered CHIP separate from their Medicaid program for the majority of their CHIP enrollees, and covered children ages 0 to 18 in their separate CHIP programs—Alabama, Massachusetts, Pennsylvania, Texas, and Washington. The five selected states varied in the type of health insurance exchange where QHPs are sold (i.e., federally facilitated exchange or state-based exchange); the size of their child population, the number of children enrolled in their separate CHIP program as of 2013; the estimated number of children enrolled in a QHP for 2015, and the 2014 CHIP upper income eligibility standard.¹ (See table 1.)

¹Officials from the Centers for Medicare & Medicaid Services (CMS) provided the estimated number of children enrolled in QHPs for 2015, based on plan selection data. See Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Health Insurance Marketplaces 2015 Open Enrollment Period: March Enrollment Report* (March 10, 2015), 48. CMS officials told us they have “effectuated” data—i.e., the number of individuals that actually paid their QHP premiums for coverage in 2015—but they did not have this readily available at the state level broken down by age. States administer CHIP under federal requirements, and the state programs vary; for example, states have broad discretion in setting their CHIP income eligibility standards, and eligibility varies across states.

Appendix I: Selection Criteria for States, Issuers, and Children’s Hospitals

Table 1: Selected States and Characteristics

Selected state	Type of exchange ^a	Total state child population ^b	Number of children enrolled in separate CHIP program ^c	Number of children enrolled in a QHP ^d	CHIP upper income eligibility standard (percent of the federal poverty level) ^e
Alabama	FFE	1,123,367	113,490	5,141	312
Massachusetts	SBE	1,408,050	79,606	7,870	300
Pennsylvania	FFE	2,760,380	267,073	28,263	314
Texas	FFE	6,924,908	1,034,613	120,204	201
Washington	SBE	1,584,900	44,073	5,947	312

Source: U.S. Department of Health and Human Services (HHS), Office of the Assistant Secretary for Planning and Evaluation; HHS, Centers for Medicare & Medicaid Services (CMS); U.S. Census Bureau; The Henry J. Kaiser Family Foundation, *State Health Insurance Marketplace Types, 2015*; Medicaid and CHIP Payment and Access Commission analysis of CHIP Statistical Enrollment Data System from CMS as of March 4, 2014. | GAO-16-219.

^aFFE stands for federally facilitated exchange; SBE stands for state-based exchange. Reflects type of exchange in 2015.

^bPopulation data for children aged 17 and younger for 2013.

^cNumber of children includes those aged 18 and younger for fiscal year 2013.

^dNumber of children includes those aged 17 and younger as of February 22, 2015. CMS officials provided the estimated number of children enrolled in QHPs for 2015, based on plan selection data.

^eStandard as of October 1, 2014. Most states’ State Children’s Health Insurance Program (CHIP) upper income eligibility levels are between 200 and 300 percent of the federal poverty level, with the highest eligibility level being 400 percent of the federal poverty level. Individuals with household income up to 400 percent of the federal poverty level may be eligible for federal subsidies when purchasing qualified health plans (QHP).

Issuer selection

Within each selected state, we identified the most populous county (based on 2013 U.S. Census data) from which we selected a set of issuers of CHIP plans and QHPs.² To do this, we obtained data on 2014 or 2015 enrollment for all CHIP plans and QHPs offered in each selected county, as well as QHP 2014 or 2015 premium data, from officials at the Centers for Medicare & Medicaid Services (CMS) and agencies in each selected state that administer CHIP, departments of insurance, and exchanges (in the two state-based exchange states).³ From a total of 37 issuers of CHIP plans and QHPs that offered plans in the five selected counties, we selected 19—4 issuers that only offered a CHIP plan, 8

²By selecting issuers that provided services in the most populous county in each state, we increased the likelihood that pediatric specialists and children’s hospitals (which are generally located in larger urban areas) would be located in those counties.

³We requested the most recently available enrollment and premium data from the various entities. The CHIP enrollment data, and QHP enrollment and premium data, we received were as of December 2014 through May 2015.

issuers that only offered QHPs, and 7 issuers that offered both a CHIP plan and QHPs.

The 19 issuers we selected included issuers of the largest CHIP plan and largest QHP in each selected county, based on enrollment for benefit year 2014 or 2015, in order to obtain information on issuers who cover a large share of CHIP and QHP enrollees.⁴ Because QHP issuers offered more than one QHP in a given county, we selected QHP issuers based on total county enrollment in each issuer's silver plan with the lowest premium for 2014 or 2015.⁵ Where possible, within each state we selected at least one issuer that offered: (1) only a CHIP plan, (2) only QHPs, and (3) both a CHIP plan and QHPs. The CHIP plans and lowest-cost silver plans offered by the 19 selected issuers provided coverage to at least 73 percent of enrollment in CHIP managed care plans and at least 84 percent of enrollment in lowest-cost silver QHPs in each selected county. See table 2 for the selected counties and the number of issuers that offered CHIP plans, QHPs, or both in each county.

⁴Most of the selected issuers offered CHIP plans and QHPs that were managed care plans that used provider networks, with the exception of one—Alabama's sole CHIP plan, which is a fee-for-service plan that used a provider network.

⁵QHP issuers must offer coverage that meets one of four metal tier levels—bronze, silver, gold, and platinum—that correspond to plans' actuarial value. We focused our selection on silver level plans because reduced cost-sharing is available for eligible individuals enrolled in these plans. Sixty-nine percent of QHP enrollees in the 37 states using the healthcare.gov platform chose a silver-level plan in 2015, according to an Assistant Secretary for Planning and Evaluation (ASPE) enrollment report. See Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Health Insurance Marketplaces 2015 Open Enrollment Period: March Enrollment Report* (March 10, 2015), 12.

Appendix I: Selection Criteria for States, Issuers, and Children’s Hospitals

Table 2: Total Number of Issuers and Selected Issuers in Selected Counties, by Type of Issuer

Selected county (state)	Total number of issuers	Number of selected issuers that offered:			Total number of selected issuers
		CHIP only	QHP only	CHIP and QHP	
Jefferson (AL)	2	0	1	1	2
Middlesex (MA)	11 ^a	0	1	2	3
Philadelphia (PA)	5	2	0	1	3
Harris (TX)	9	1	3	1	5
King (WA)	10	1	3	2	6
Total	37	4	8	7	19

Source: Centers for Medicare & Medicaid Services (CMS); and officials from state agencies overseeing the State Children’s Health Insurance Program (CHIP), state-based exchanges, and qualified health plans (QHP). | GAO-16-219.

Note: Within each of the five selected states, we selected issuers of the largest CHIP plans and QHPs based on 2014 or 2015 enrollment in the largest county. We selected QHP issuers based on total enrollment in each issuer’s silver plan with the lowest premium for 2014 or 2015 in the largest county in each selected state.

^aAccording to exchange officials, one of these issuers offered plans that were only available in a limited number of zip codes within the county.

Children’s hospital selection

In four of the five states, we selected a set of hospitals in each selected county whose mission was to primarily serve children—referred to as children’s hospitals.⁶ In the fifth selected state, the selected county did not have a children’s hospital, so we contacted children’s hospitals in a neighboring county. We contacted a total of nine children’s hospitals—at least one in each selected state—and interviewed or received written information from all of them.

⁶We selected children’s hospitals from a list provided by the Children’s Hospital Association. We excluded from our selection specialty hospitals that historically have not billed third party payors for their services (so their experience with provider networks in QHPs and how they compare to CHIP would be limited) and we included only hospitals that primarily serve children.

Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact

Katherine M. Iritani, 202-512-7114 or iritanik@gao.gov

Staff Acknowledgments

In addition to the contact named above, Kim Yamane, Assistant Director; Sandra George; Kate Nast Jones; Laurie Pachter; and Nina Verevkina made key contributions to this report.

GAO's Mission

The Government Accountability Office, the audit, evaluation, and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through GAO's website (<http://www.gao.gov>). Each weekday afternoon, GAO posts on its website newly released reports, testimony, and correspondence. To have GAO e-mail you a list of newly posted products, go to <http://www.gao.gov> and select "E-mail Updates."

Order by Phone

The price of each GAO publication reflects GAO's actual cost of production and distribution and depends on the number of pages in the publication and whether the publication is printed in color or black and white. Pricing and ordering information is posted on GAO's website, <http://www.gao.gov/ordering.htm>.

Place orders by calling (202) 512-6000, toll free (866) 801-7077, or TDD (202) 512-2537.

Orders may be paid for using American Express, Discover Card, MasterCard, Visa, check, or money order. Call for additional information.

Connect with GAO

Connect with GAO on [Facebook](#), [Flickr](#), [Twitter](#), and [YouTube](#).
Subscribe to our [RSS Feeds](#) or [E-mail Updates](#).
Listen to our [Podcasts](#) and read [The Watchblog](#).
Visit GAO on the web at www.gao.gov.

To Report Fraud, Waste, and Abuse in Federal Programs

Contact:

Website: <http://www.gao.gov/fraudnet/fraudnet.htm>

E-mail: fraudnet@gao.gov

Automated answering system: (800) 424-5454 or (202) 512-7470

Congressional Relations

Katherine Siggerud, Managing Director, siggerudk@gao.gov, (202) 512-4400, U.S. Government Accountability Office, 441 G Street NW, Room 7125, Washington, DC 20548

Public Affairs

Chuck Young, Managing Director, youngc1@gao.gov, (202) 512-4800, U.S. Government Accountability Office, 441 G Street NW, Room 7149, Washington, DC 20548

