

Assessing Consumer Experiences Navigating Provider Networks in Pennsylvania ACA Marketplace Plans Using a Secret Shopper Survey

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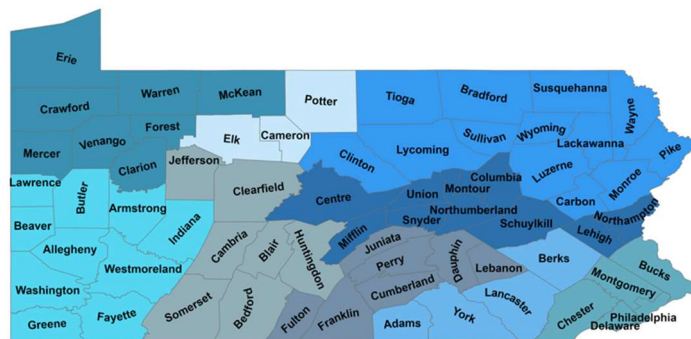
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Executive Summary

The vast majority of Americans, including consumers in the Affordable Care Act (ACA) Marketplaces, receive their insurance coverage through managed care arrangements.¹ Consumers are highly incentivized to seek care solely from within their provider network.^{1,2} Because of the restrictions imposed by managed care arrangements, consumers and regulators have an interest in carriers establishing and maintaining provider networks that are adequate to serve consumer needs including, but not limited to, the number and types of providers, their geographic distribution, and potentially other characteristics so that beneficiaries can access appropriate medical care when needed.³ At the same time, consumers rely on accurate provider directories to make choices about their health plan selections at the time of plan purchase as well as to identify suitable providers when seeking care.⁴ However, a growing literature has identified several problems with both network adequacy and provider directories.^{3,5-9}

To better understand the experiences of consumers of ACA Marketplace plans in Pennsylvania, a large-scale secret shopper survey was fielded from March 20, 2023, to August 18, 2023. Data was collected for all eight carriers participating in the 2023 ACA market and across a variety of specialists for adults (cardiology, dermatology, endocrinology, gastroenterology, neurology, obstetrics-gynecology, primary care, psychiatry, psychology) and children (general pediatrics and pediatric mental health services from psychiatrists and psychologists). Overall, data were collected for 7,753 simulated patients with callers making 28,161 unique phone calls.

The secret shopper survey results showed that consumers in the Pennsylvania ACA Marketplace may experience substantial challenges when navigating the provider networks established by the eight carriers serving them. While almost 80% of simulated patients were able to secure an appointment eventually, 20% of the simulated patients were not able to find a medical provider despite making calls to ten uniquely listed providers. At the unique call level, just over 1 in 5 calls led to an appointment. Mental health patients struggled in particular to secure appointments. Despite most simulated patients eventually being able to secure an appointment, consumers often had to invest substantial resources to obtain these appointments including contacting almost three unique providers on average and spending almost 30 minutes making calls. Across all outcomes analyzed, the analyses identified substantial differences across specialty, carrier, region, and, to a limited degree, caller rurality. Even when successful in securing an appointment, simulated patients on average had to wait more than 60 days (median 41 days) and drive almost 30 minutes (median 18 minutes) to see their medical provider across all specialties. Unsurprisingly, rural patients had to travel particularly long distances. In addition to often only reaching an answering machine (which prevented the verification of providers), inaccurate provider directories were the primary contributor to access challenges, with almost 50% of calls experiencing inaccurate phone numbers, specialty information, or network status. In addition, 15% of calls experienced provider capacity issues in the form of providers not willing or able to accept new patients into their practice or not offering new appointments. Mental health patients were particularly affected by capacity issues. Lastly, it is worth noting that across all outcomes analyzed there were also not unsubstantial percentage of outliers present. That is, between 5% and 25% of simulated patients experienced challenges well

above the overall average and median. For example, while 75% of simulated patients had to travel less than 33 minutes to see a provider, 5% had to travel in excess of 86 minutes. Similarly, 3 in 4 simulated patients were able to secure an appointment within 86 days but appointments were scheduled more than 139 days from the date of the call for 10% of simulated patients.

Overall, the findings suggest persistent barriers to maintaining, verifying, and updating provider directories as well as establishing and maintaining adequate provider networks. In combination, both issues may impose substantial challenges for patient access including delayed access to care, seeking inappropriate levels of care, and increased likelihood of experiencing out-of-pocket costs. However, not all consumers are likely to be equally affected by the burdens identified here. The findings also indicate that carriers may take different approaches to network maintenance and adequacy verification, with variation in staffing, resources, administrative capacity, and institutional knowledge that could affect the frequency and accuracy of these efforts.¹⁰ Ultimately, the findings may indicate that current approaches to network adequacy regulation and enforcement may not fully protect consumers from experiencing delays and barriers to care. Lastly, given that many of the carriers surveyed participate in multiple insurance markets, it seems also likely that many other Pennsylvanians experience similar access challenges.

Introduction

The vast majority of Americans, including consumers in the Affordable Care Act (ACA) Marketplaces, receive their insurance coverage through managed care arrangements.¹ Consumers are highly incentivized to seek care solely from within their provider network.^{1,2} Because of the restrictions imposed by managed care arrangements, consumers and regulators have an interest in carriers establishing and maintaining provider networks that are adequate to serve consumer needs including, but not limited to, the number and types of providers, their geographic distribution, and potentially other characteristics so that beneficiaries can access appropriate medical care.³ The most obvious way for consumers to learn about their network is via provider directories.⁵ Insurance carriers publish these consumer-facing provider directories both online and in print. Provider directories typically contain important information such as contact information and provider specialty.⁴ This information is then used by consumers to make choices about their health plan selections at the time of plan purchase as well as to identify suitable providers when seeking care.

A growing literature has identified several problems with both network adequacy and provider directories.^{3,5-9} These problems included diverse regulatory standards which often lack empirical grounding¹¹ as well as lack of enforcement.^{12,13} Concerns about inadequate provider networks are not new and received substantial attention during the initial managed care revolution.¹⁴ However, given the growth of managed care products as well as the narrowing of provider networks over time concerns remain prominent today.^{9,15-24} As a result, regulators have employed various measures to ensure adequate access to care.^{5,11,13,25-29} However, empirical analyses of these measures have found consistent challenges for consumers.³⁰⁻³⁴

With regard to provider directories, analyses have identified substantial errors ranging from incorrect contact information to inaccurate in-network designations.^{3,5-9} These errors are ubiquitous and have been found across specialties and markets.^{20,21,30,33,35-42} Errors in provider directories are more than mere nuisances and may contribute to delayed or forgone care³⁴, exacerbate health inequities,^{17,34,39} and compromise the effectiveness of existing network adequacy regulations.^{3,5,12,43} State and federal regulators have increasingly become aware of inaccuracies in provider directories as well as the detrimental effects on consumers. In response, they have imposed requirements upon carriers to increase accuracy, although these vary widely in their scope and content.^{13,44-46} Despite the growing attention, high rates of inaccuracies persist nationwide, even in states with the most stringent regulatory standards like California.^{31-33,38} At the federal level, the *No Surprises Act of 2021*, which went into effect in 2022, requires carriers to update and verify provider directories every 90 days at minimum, and to develop a protocol for removing providers that cannot be verified.^{13,47} While adequate enforcement has been identified as a substantial challenge, the effect of state and federal regulations on improving provider directory inaccuracies remains underexplored.^{12,13} As a result, questions have emerged about the extent to which provider directory inaccuracies persist despite these policies.

To better understand the experiences of consumers of ACA Marketplace plans in Pennsylvania, a large-scale secret shopper survey was fielded from March 20, 2023, to August 18, 2023. Data was collected for all eight carriers participating in the 2023 ACA market and across a variety of specialists

for adults (cardiology, dermatology, endocrinology, gastroenterology, neurology, obstetrics-gynecology, primary care, psychiatry, psychology) and children (general pediatrics and pediatric mental health services from psychiatrists and psychologists). Overall, data were collected for 7,753 simulated patients with callers making 28,161 unique phone calls.

Background on the ACA Market in Pennsylvania

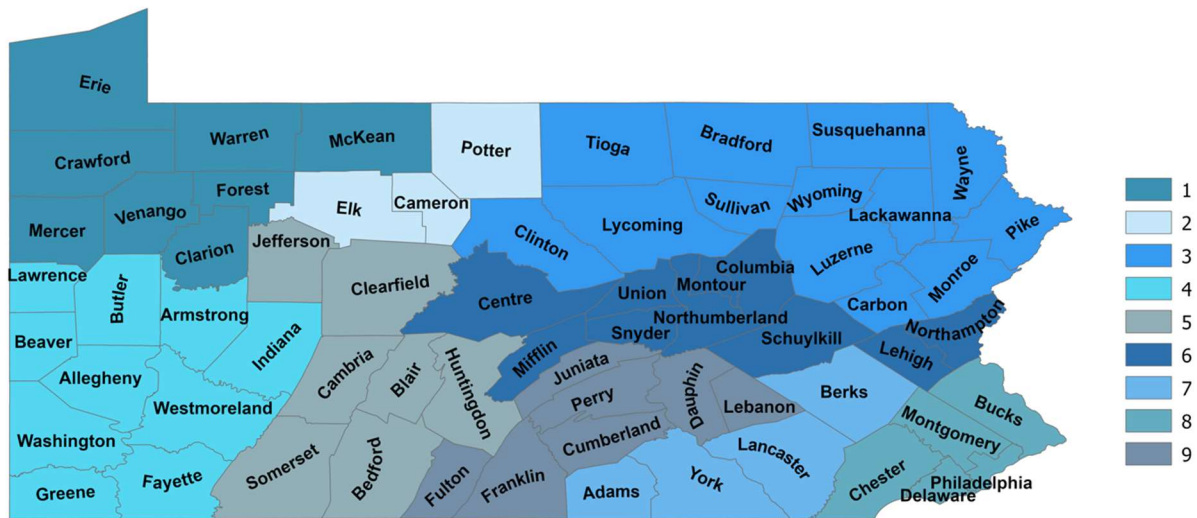


Figure 1: Affordable Care Act Rating Areas in Pennsylvania

Pennsylvania’s ACA consumers are served by the state-based marketplace known as Pennie®, which was established pursuant to Act 42 of 2019 and started offering coverage for the 2021 Plan Year. Pennsylvania’s 67 counties are divided into nine rating areas. For Plan Year 2023, Pennsylvanians were offered insurance plans by eight different carriers (Ambetter, Capital BlueCross, Cigna, Geisinger, Highmark BlueCross BlueShield, Independence Blue Cross, Oscar, UPMC) in the individual market. However, with the exception of Highmark, UPMC, and partially Geisinger, carriers tended to focus on specific regions of the state. Two carriers, IBC and Cigna, only sold products in one rating area.

Data and Data Collection

Data for the analyses were collected from March 20, 2023, to August 18, 2023, using an extensive secret shopper survey developed to closely align with consumer experiences navigating ACA provider networks. In each case, callers were assigned a variety of information including, for example, a real home address, names for themselves and for a simulated patient, and insurance plan. Callers were also assigned to one of five common, non-emergency medical conditions for each specialty. After assignment, callers searched for the medical provider of the assigned specialty closest to their home address. Callers then contacted the geographically closest provider at the number listed in the online provider directory and asked for the next available appointment. During

the call, callers sought to verify the accuracy of the providers' contact information, network status, and specialty. Because the callers presented on behalf of a simulated patient, phone calls were terminated once any inaccuracy was identified, as would be common for real consumers. If unsuccessful in securing an appointment, callers contacted the next-closest provider listed in the provider directory for their assigned simulated patient. Callers repeated this process until securing an appointment or for a maximum of ten attempts. Overall, data were collected for 7,753 simulated patients with callers making 28,161 unique phone calls. Because this approach can be time-intensive, not all simulated patients could be completed, as callers had to abandon simulated patients at the end of the day or when their work time had expired. Callers were able to secure an appointment or complete ten attempts for 3,856 simulated patients. All data were collected in a secure, online data management system that also automatically tracked the time required for each simulated patient to complete the appointment search process. To avoid congesting medical services, no actual appointments were scheduled.

To ensure representativeness of the analyses from a consumer perspective, calls were distributed across ACA market regions proportional to ACA enrollment in the nine Pennsylvania regions. Within each region, calls were evenly distributed among all carriers serving the specific region.

Table 1: Distribution of simulated patients and phone calls, by region

	Simulated Patients	Unique Calls Made
Region 1	345	1,042
Region 2	42	124
Region 3	717	2,479
Region 4	1,485	5,034
Region 5	300	980
Region 6	689	2,468
Region 7	880	3,188
Region 8	2,808	11,210
Region 9	487	1,636
Overall	7,753	28,161

Table 2: Distribution of simulated patients and phone calls, by caller rurality

	Simulated Patients	Unique Calls Made
Non-Rural Addresses	6,311	23,526
Rural Addresses	1,442	4,635
Overall	7,753	28,161

Data were collected for all eight carriers participating in the ACA market for a variety of specialists for adults (cardiology, dermatology, endocrinology, gastroenterology, neurology, obstetrics-gynecology, primary care, psychiatry, psychology) and children (general pediatrics and pediatric mental health services from psychiatrists and psychologists). Calls were evenly distributed across specialties with slightly fewer calls for child psychiatrists and child psychologists due to a later data collection start date.

Table 3: Distribution of simulated patients and phone calls, by carrier

	Simulated Patients	Unique Calls Made
Ambetter	1,113	4,455

Capital Blue Cross (CBC)	381	1,435
Cigna	712	2,703
Geisinger	617	1,654
Highmark	1,580	5,339
Independence Blue Cross (IBC)	670	2,561
Oscar	1,121	4,596
UPMC	1,559	5,418
Overall	7,753	28,161

Analyses below were conducted at the simulated-patient- and call-level, as appropriate.

Results

Successful Appointments

Appointments by Simulated Patient¹

Overall, 79.7% of simulated patients (N=3,072) were able to eventually obtain an appointment, with the remainder unable to obtain an appointment after completing ten phone calls (N=784). Success rates ranged from 41.2% for psychology to 96.9% for dermatology (p<0.001). Simulated patients particularly struggled with mental health appointments. Here, success rates ranged from a low of 41.2% for psychiatry appointments to a high of 56.2% for pediatric psychiatry. Differences across carriers ranged from 73.1% for Oscar to 87.1% for Geisinger (p<0.001), whereas regional differences ranged from 75.8% in Region 8 to 90.0% in Region 2. However, regional differences were statistically indistinguishable. Moreover, rural patients were slightly more successful than non-rural patients in securing appointments (82.1% vs 79.1%, p=0.042).

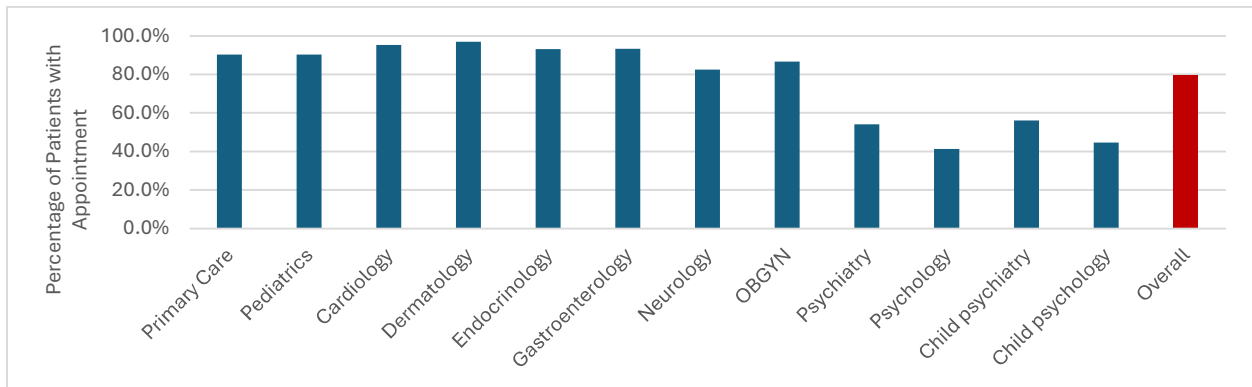


Figure 2: Percentage of simulated patients with appointment, by specialty

¹ Data in this section is restricted to simulated patients (N=3,856) who were either able to obtain an appointment (N=3,072) or were able to complete all ten calls without securing an appointment (N=784).

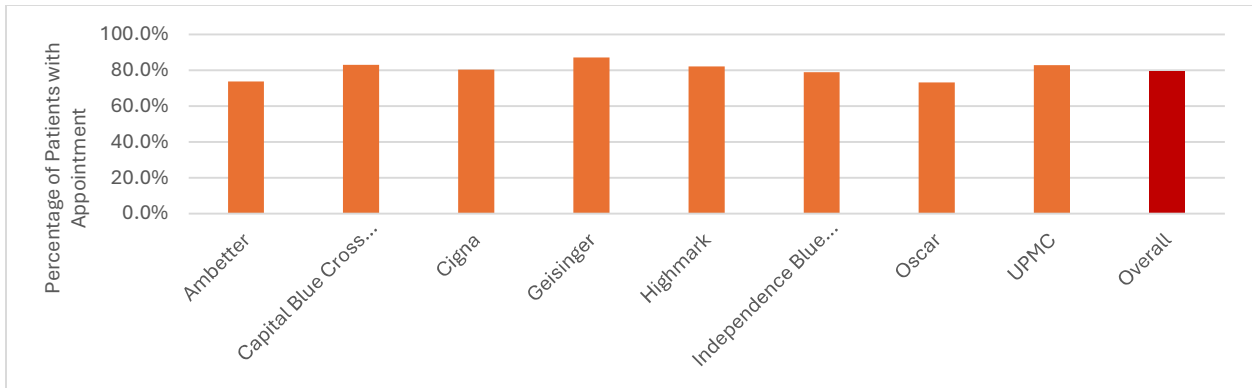


Figure 3: Percentage of simulated patients with appointment, by carrier

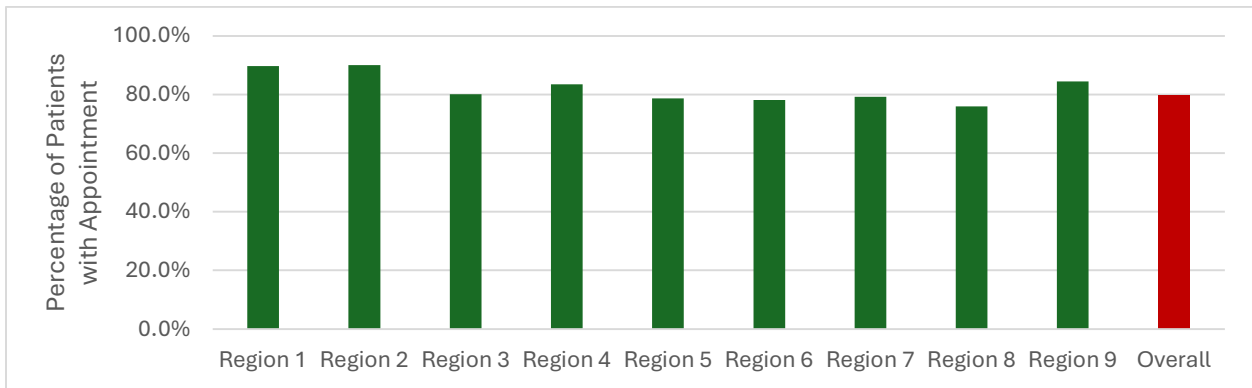


Figure 4: Percentage of simulated patients with appointment, by region

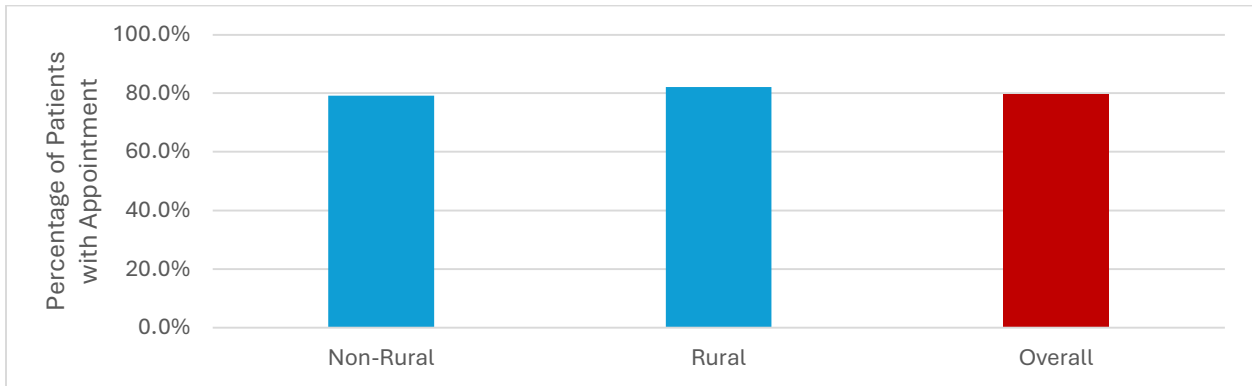


Figure 5: Percentage of simulated patients with appointment, by caller rurality

Appointments by Unique Call²

At the call level, callers were able to secure appointments on 21.6% of unique calls. Differences across specialties ranged from 9.2% of calls for child psychology to 37.7% for dermatology ($p < 0.001$). Success rates for all mental health specialties were low and, in all cases, did not exceed 10%, ranging from 9.2% for child psychiatry to 9.8% for psychiatry. For carriers, differences ranged from 15.9% for Oscar to 28.4% for UPMC ($p < 0.001$). Regional differences ranged from 18.6% in

² Data in this section is restricted to calls (N=14,240) where callers were able to connect with a staffer to verify information. Failure to connect was primarily due to reaching an answering machine or unwillingness of medical office staff to provide any information.

Region 8 to 29.4% in Region 4 ($p < 0.001$), with rural callers slightly more successful than their non-rural counterparts (24.3% vs. 21.1%, $p < 0.001$).

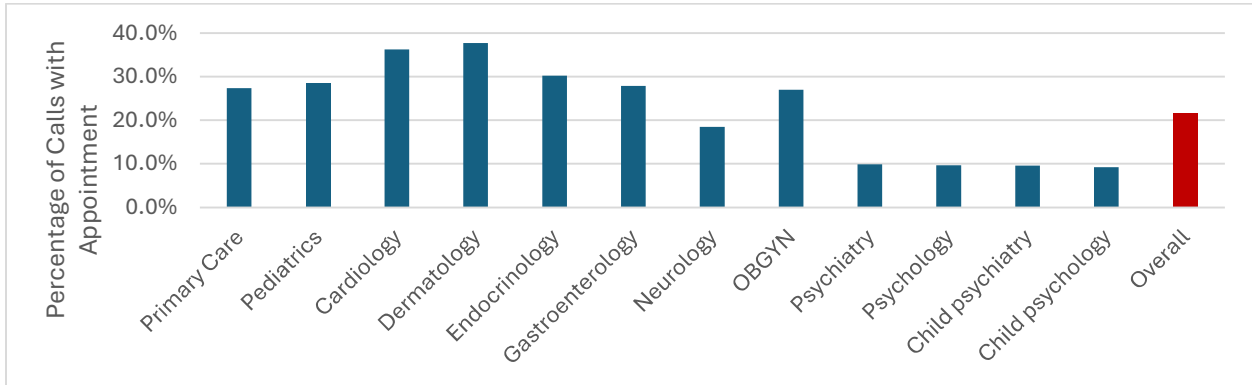


Figure 6: Percentage of calls with appointment, by specialty

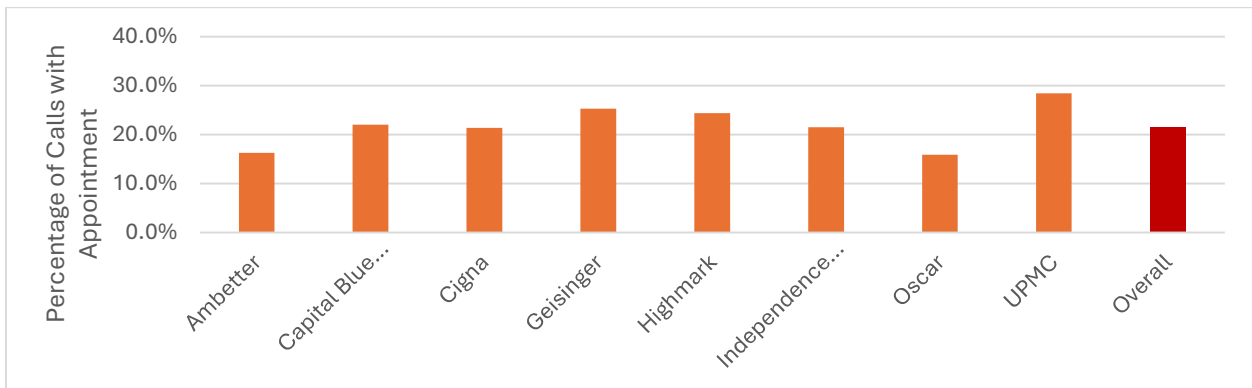


Figure 7: Percentage of calls with appointment, by carrier

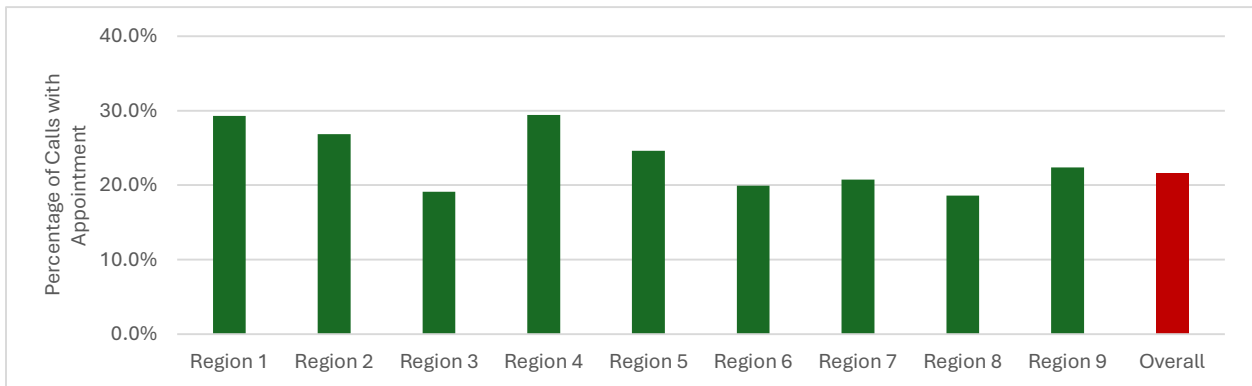


Figure 8: Percentage of calls with appointment, by region

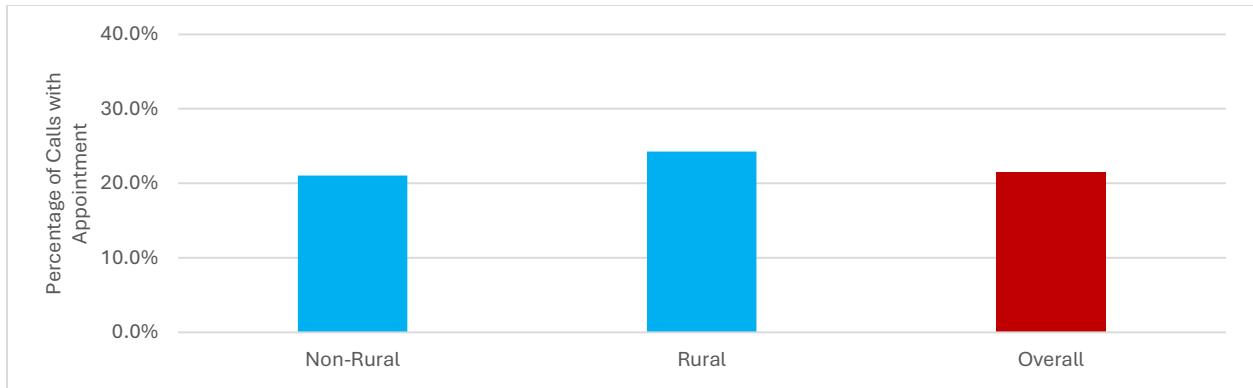


Figure 9: Percentage of calls with appointment, by caller rurality

Time to Appointments³

Callers able to secure an appointment on average had to wait 60.3 days to see a medical provider for their non-emergency medical conditions from the date of their call. Differences ranged from a low of 39.9 days for pediatric appointments to a high of 91.8 days for endocrinology appointments ($p < 0.001$). Differences across carriers ranged from 55.5 days for Ambetter to 70.4 days for Geisinger ($p = 0.003$). Wait times were lowest in Region 8 and longest in Region 1 (58.3 vs 67.0 days, $p = 0.041$). Differences between rural and non-rural callers were indistinguishable (63.1 vs. 59.7 days, $p = 0.120$).

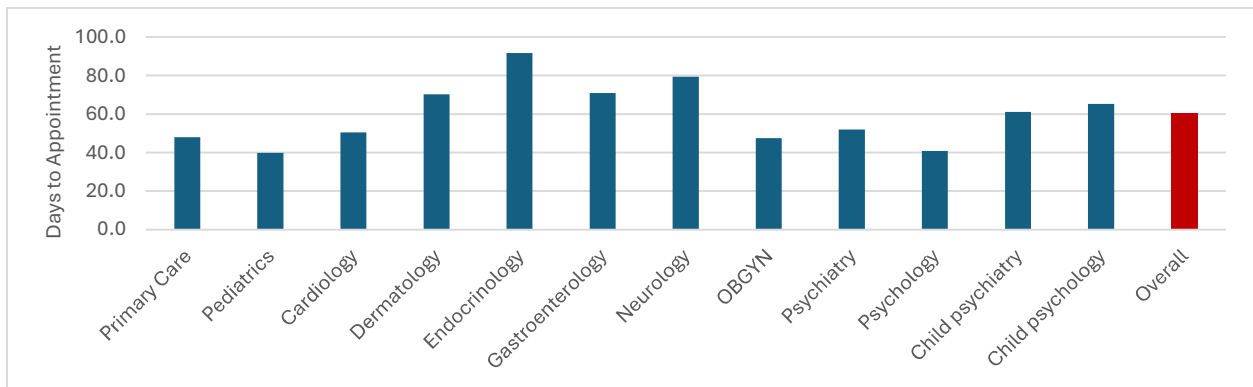


Figure 10: Average time to appointment in days, by specialty

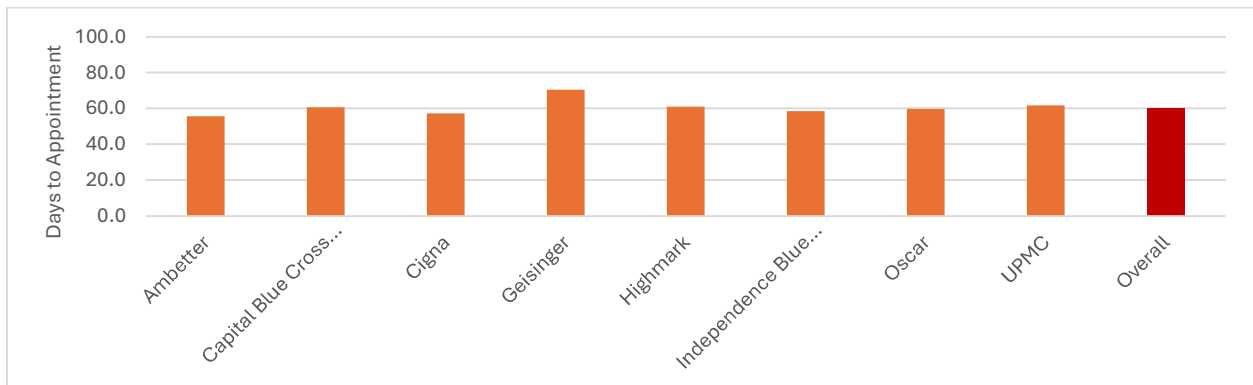


Figure 11: Average time to appointment in Days, by Carrier

³ Data in this section is restricted to simulated patients (N=3,072) who were able to obtain an appointment.

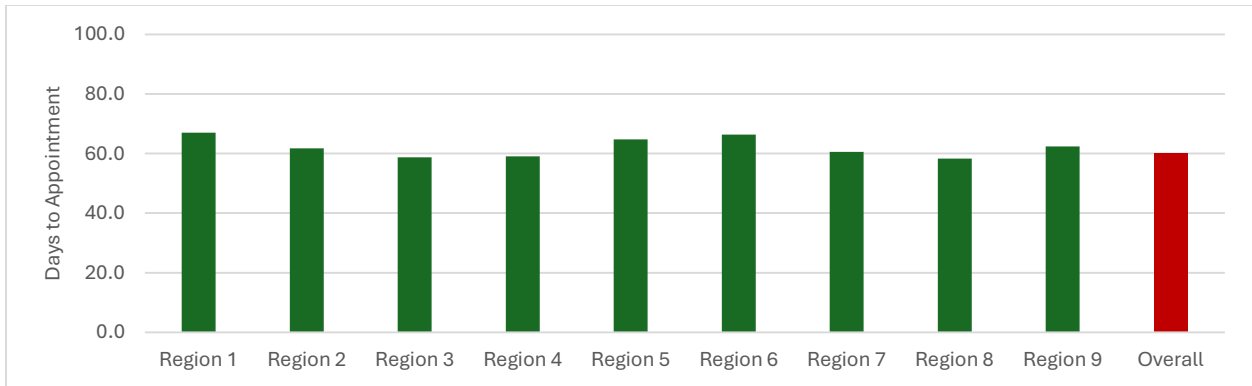


Figure 12: Average time to appointment in days, by region

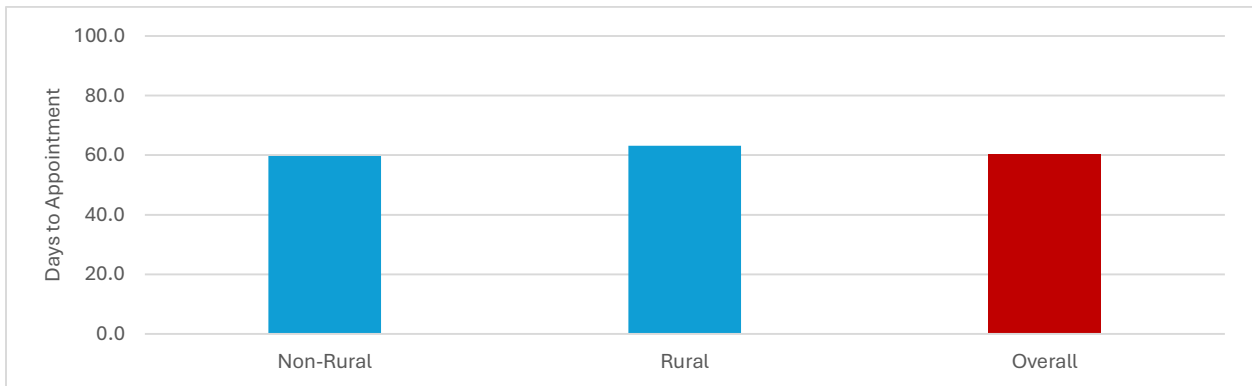


Figure 13: Average time to appointment in days, by caller rurality

Travel Time to Appointments⁴

Across all callers who were able to secure an appointment, simulated patients on average would have been required to travel 27.9 minutes to their appointment, ranging from 17.2 minutes for primary care appointments to 37.4 minutes for child psychiatry appointments ($p < 0.001$). Travel times were longest for Geisinger and shortest for IBC (41.9 vs 14.3 minutes, $p < 0.001$). Differences were at least partially attributable to regional differences and rurality, with travel times lowest in Region 8 and highest in Region 2 (18.1 vs. 77.9 minutes, $p < 0.001$), and rural callers having to travel an additional 14.4 minutes (25.3 vs. 39.7 minutes, $p < 0.001$) on average.

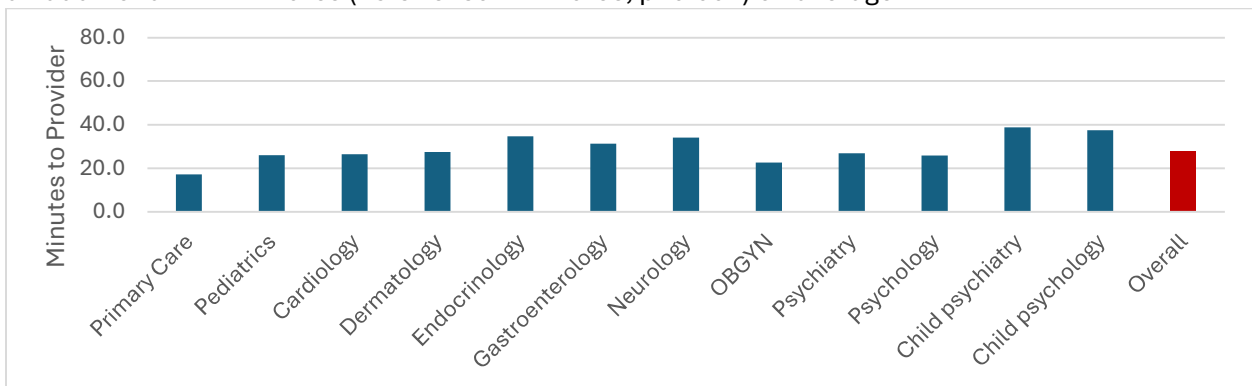


Figure 14: Average travel time to appointment in minutes, by specialty

⁴ Data in this section is restricted to simulated patients (N=3,072) who were able to obtain an appointment.

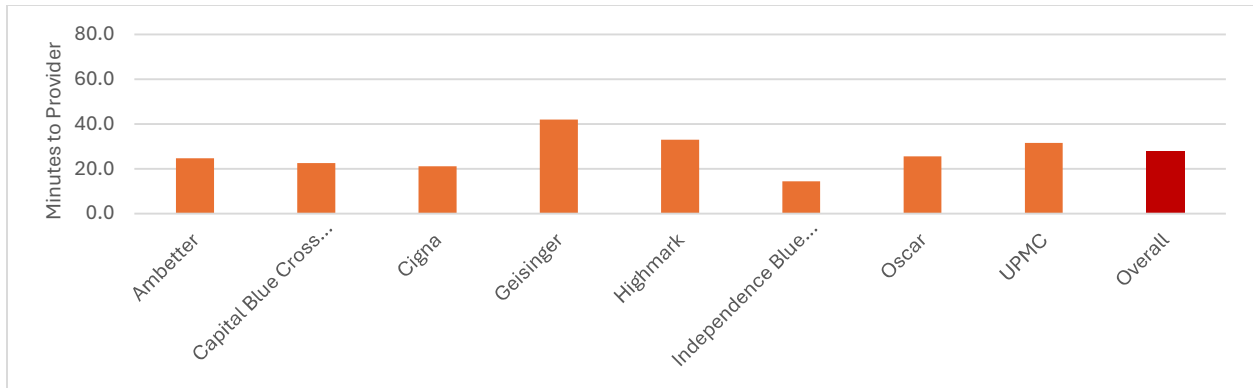


Figure 15: Average travel time to appointment in minutes, by carrier

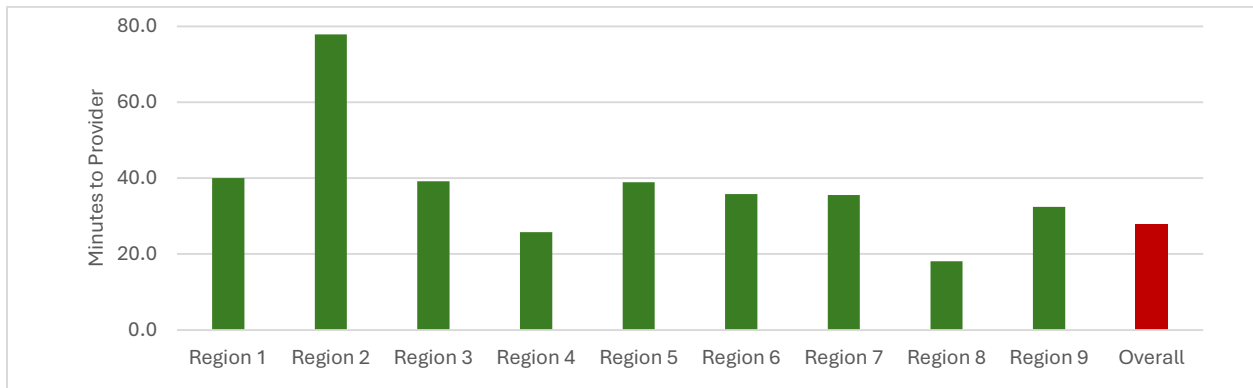


Figure 16: Average travel time to appointment in minutes, by region

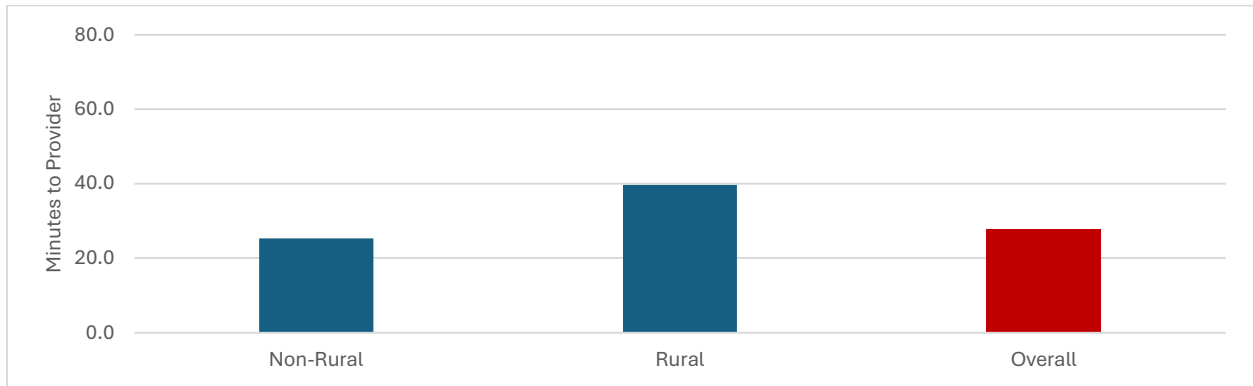


Figure 17: Average travel time to appointment in minutes, by caller rurality

Call Experience

Number of Calls⁵

Overall, callers needed to make 2.7 calls to secure an appointment. Across specialties, the number of calls required to obtain an appointment ranged from a low of 2.3 calls for dermatology to a high of 3.4 calls for child psychiatry ($p < 0.001$). The analyses identified consistent differences between general medical and mental health specialties, with all mental health specialties requiring more than three calls to secure an appointment. As illustrated further below, both capacity and provider

⁵ Data in this section is restricted to simulated patients (N=3,072) who were able to obtain an appointment.

directory errors were important contributors to these differences. Differences across carriers ranged from 2.1 calls for Geisinger to 3.0 calls for CBC ($p=0.001$). Regional differences ranged from 2.4 calls in Region 5 to 2.8 calls in Region 8 ($p=0.069$). The data also indicate small differences between rural and non-rural callers (2.4 vs. 2.7 calls, $p=0.001$).

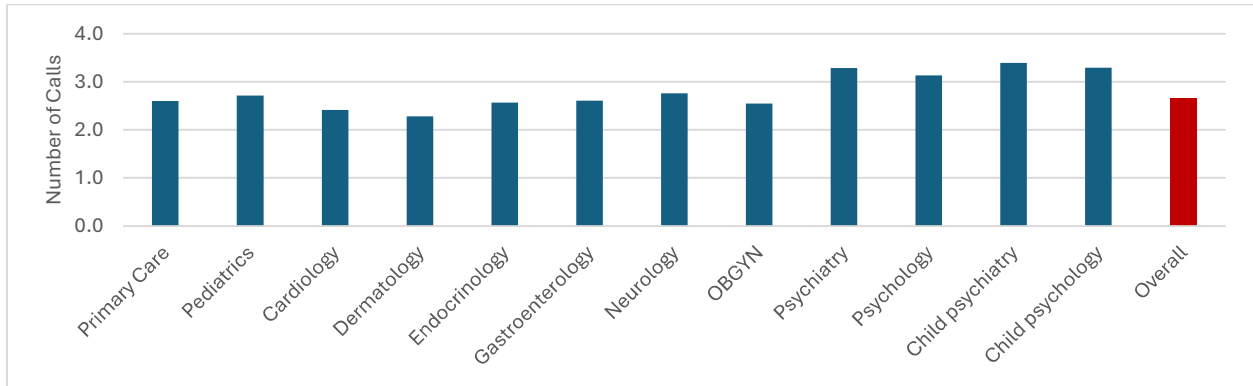


Figure 18: Average number of calls to appointment, by specialty

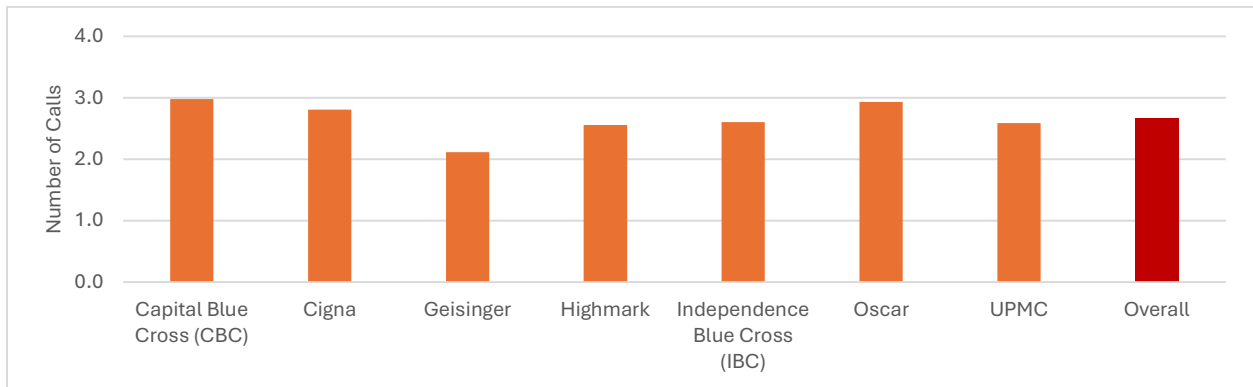


Figure 19: Average number of calls to appointment, by carrier

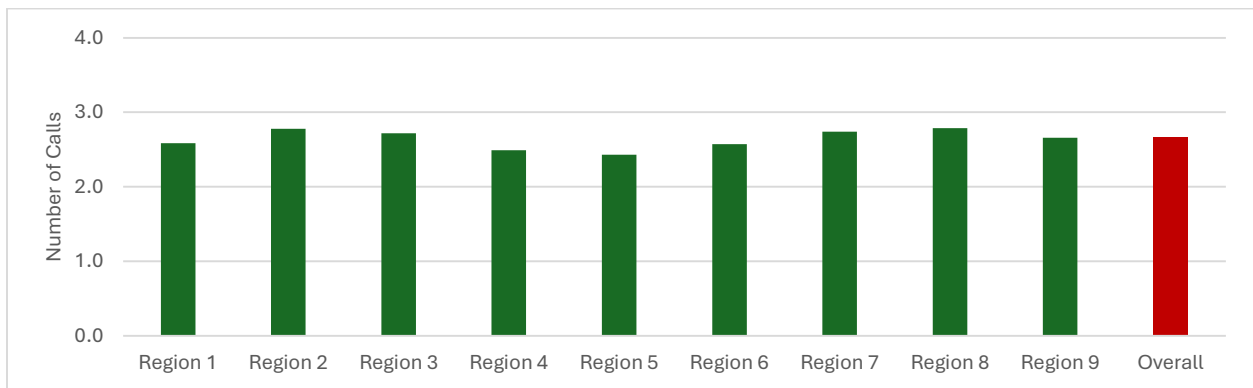


Figure 20: Average number of calls to appointment, by region

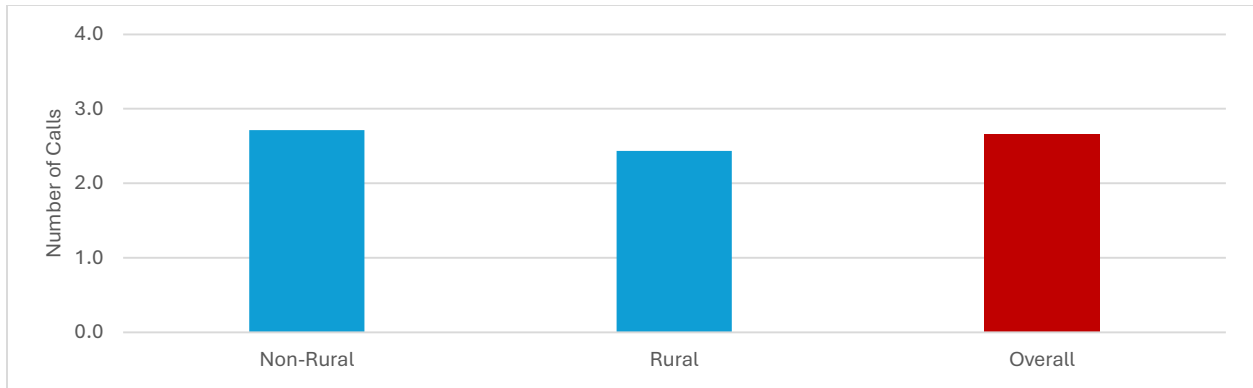


Figure 21: Average number of calls to appointment, by caller rurality

Time Spent Calling⁶

Successful callers spent an average of 28.9 minutes making calls until securing an appointment. Calls were shortest for cardiology appointments (26.2 minutes) and longest for child psychology appointments (35.1 minutes, $p < 0.001$). Moreover, calls for mental health specialties were consistently longest. Across carriers, calls ranged from 25.7 minutes for Geisinger to 33.6 minutes for CBC ($p = 0.042$). Call efforts were shortest in Region 2 and longest in Region 8 (23.0 vs. 29.4 minutes, $p = 0.021$). Rural callers spent 2.3 fewer minutes making calls (27.0 vs 29.3 calls, $p = 0.032$).

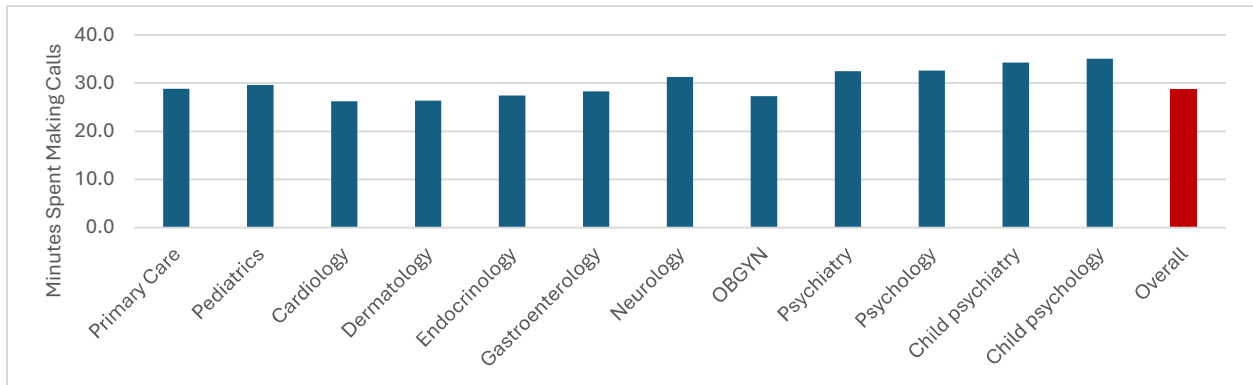


Figure 22: Average number of minutes spent calling to appointment, by specialty

⁶ Data in this section is restricted to simulated patients (N=3,072) who were able to obtain an appointment. Additionally, a small number of simulated patients were not included in the analyses here due to apparent data entry errors by callers related to the duration of calls (N=155) by indicating excessively long calls. This left leaving an analysis sample of N=2,917. Eliminating these data points may potentially bias the estimates here downward. That is, search costs may be larger than identified here.

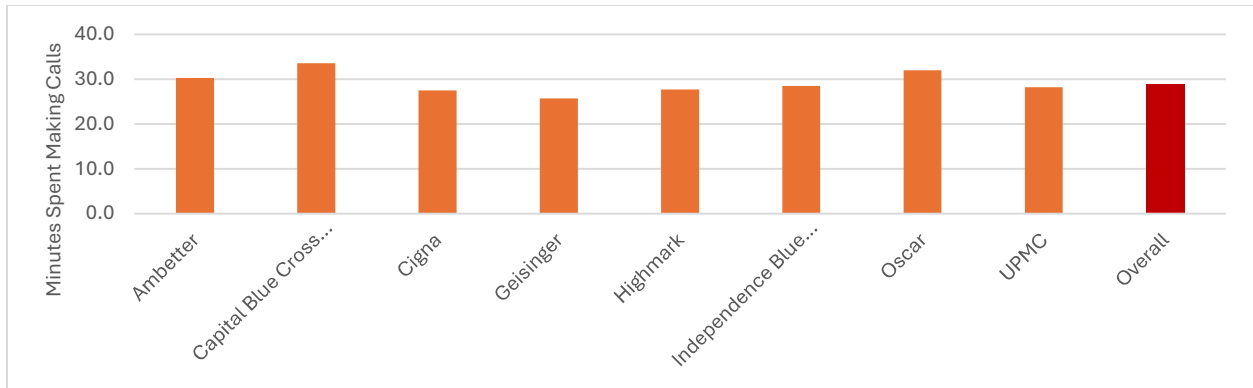


Figure 23: Average number of minutes spent calling to appointment, by carrier

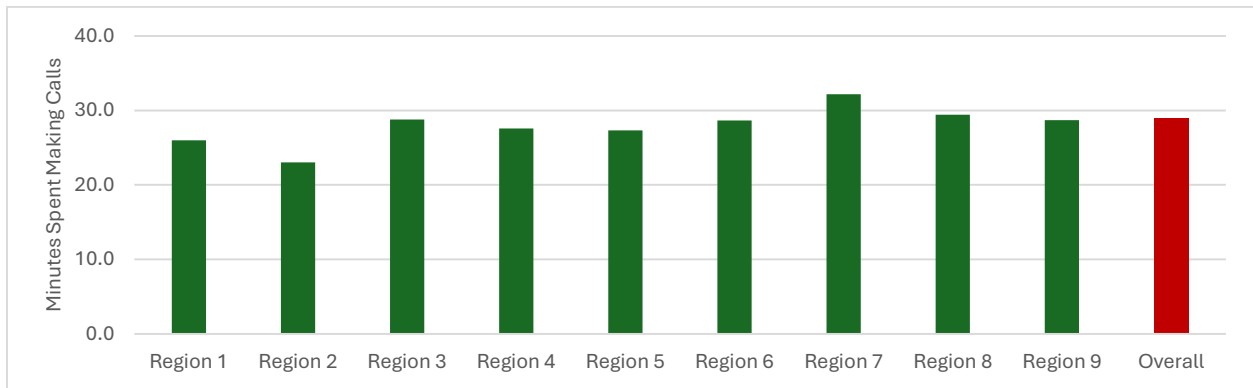


Figure 24: Average number of minutes spent calling to appointment, by region

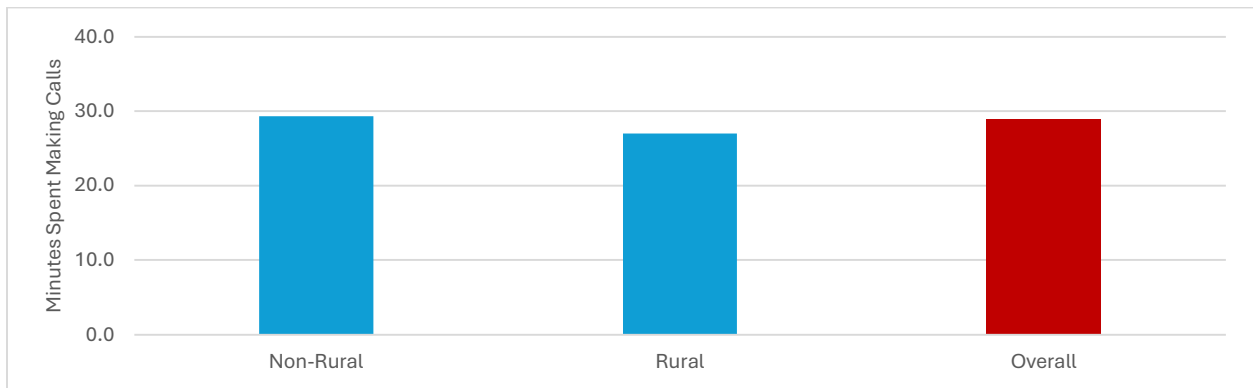


Figure 25: Average number of minutes spent calling to appointment, by caller rurality

Challenges Encountered by Callers

Simulated patients experienced a number of problems when seeking to secure appointments. As noted above, in a number of cases, callers only reached an answering machine or experienced unwillingness of medical office staff to provide any information, making further assessment of these providers impossible in terms of the accuracy of provider directory information or ability to secure an appointment. Beyond these limitations, the most common problems experienced by callers were inaccuracies present in provider directories including errors related to phone numbers, specialty, and network status. Moreover, callers also experienced provider capacity issues in the form of providers refusing to schedule additional appointments or allowing new patients into their practice.

Overall Directory Errors⁷

Overall, 47.0% of calls experienced provider directory inaccuracies related to phone numbers (33.6%), specialty (8.9%), and network status (5.0%).⁸ Inaccuracies were lowest for dermatology and highest for neurology (32.4% vs. 55.1%, $p < 0.001$). Differences between carriers ranged from 33.8% for UPMC to 57.9% for Oscar ($p < 0.001$). Regional differences ranged from 35.1% in Region 4 to 53.2% in Region 8 ($p < 0.001$), whereas rural callers experienced fewer inaccuracies than non-rural callers (41.7% vs. 48.0%, $p < 0.001$).

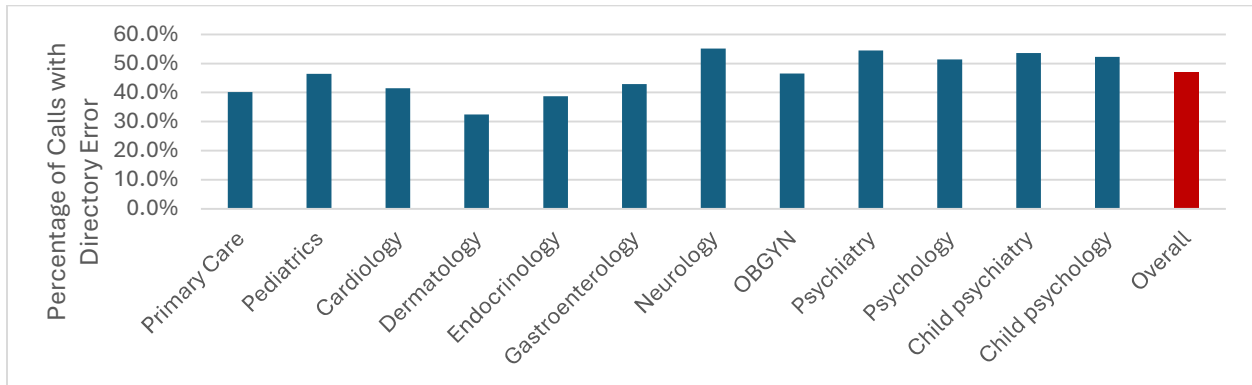


Figure 26: Percentage of calls with any directory error, by specialty

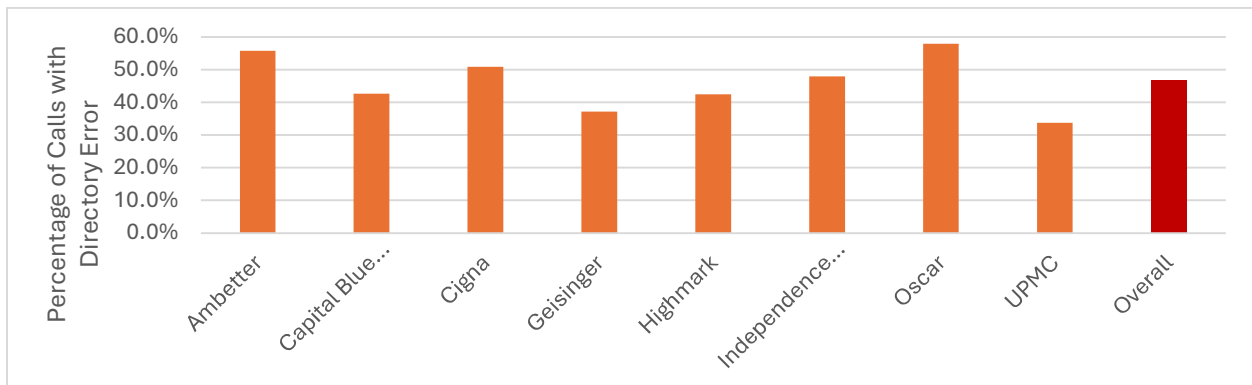


Figure 27: Percentage of calls with any directory error, by carrier

⁷ Data in this section is restricted to calls (N=14,240) where callers were able to connect with a staffer to verify information. Failure to connect was primarily due to reaching an answering machine or unwillingness of medical office staff to provide any information. Analyses presented combined errors related to incorrect phone numbers, specialty, and network status.

⁸ Individual inaccuracies do not add to 47.0% because in rare cases callers were able to document multiple inaccuracies at the same time.

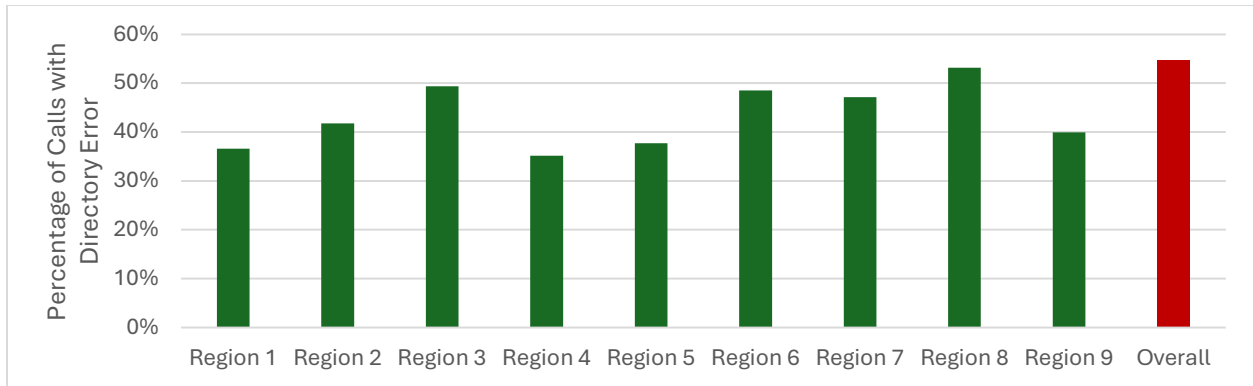


Figure 28: Percentage of calls with any directory error, by region

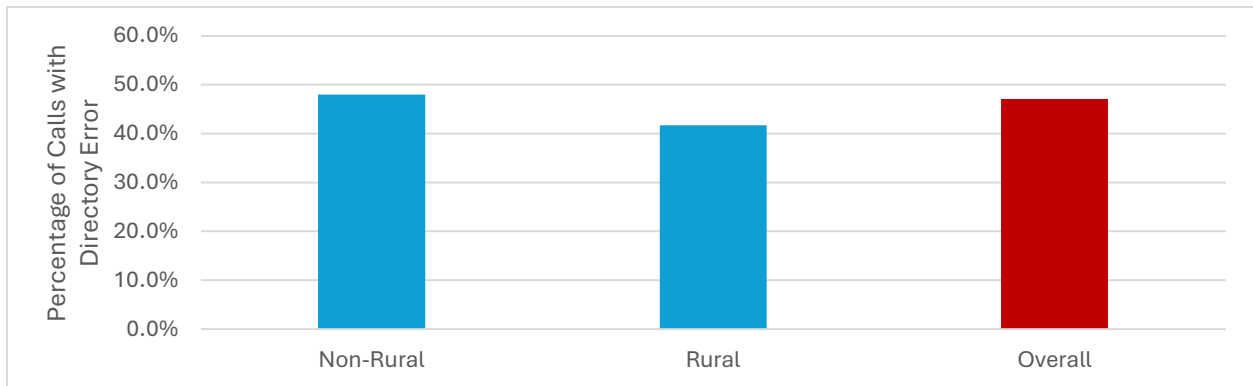


Figure 29: Percentage of calls with any directory error, by caller rurality

Capacity Problems⁹

Provider capacity issues in the form of providers not accepting new patients (12.7%) or offering new appointments (2.3%) were experienced by 15.0% of callers. Differences by specialty ranged from 5.5% for cardiology to 24.2% for psychology ($p < 0.001$). Capacity issues were particularly prevalent for mental health specialties. At the carrier level, differences ranged from 12.8% for Cigna to 19.3% for CBC ($p < 0.001$). Regional differences ranged from 13.4% in Region 2 to 18.2% in Region 9; whereas rural callers experienced issues in 15.2% of calls and non-rural callers experienced issues in 15.0% of calls. However, in both cases, the differences were not statistically significant ($p = 0.165$ and $p = 0.439$).

⁹ Data in this section is restricted to calls (N=14,240) where callers were able to connect with a staffer to verify information. Failure to connect was primarily due to reaching an answering machine or unwillingness of medical office staff to provide any information. Analyses presented combined data for cases where providers did not accept new patients into their practices as well as cases where providers did not schedule any new appointments.

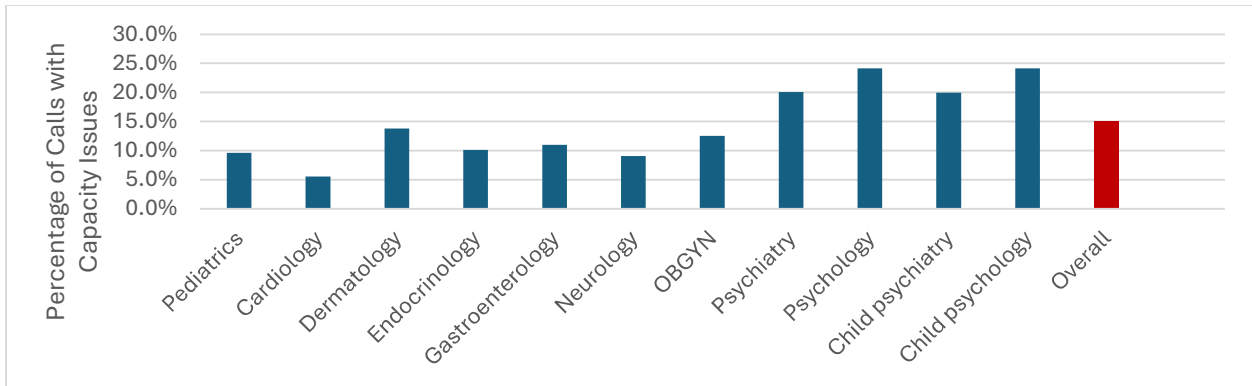


Figure 30: Percentage of calls experiencing provider capacity issues, by specialty

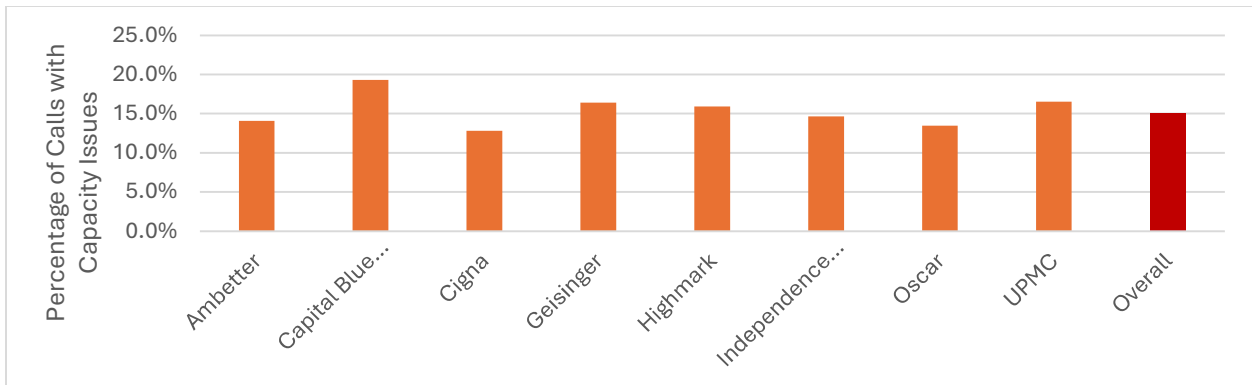


Figure 31: Percentage of calls experiencing provider capacity issues, by carrier

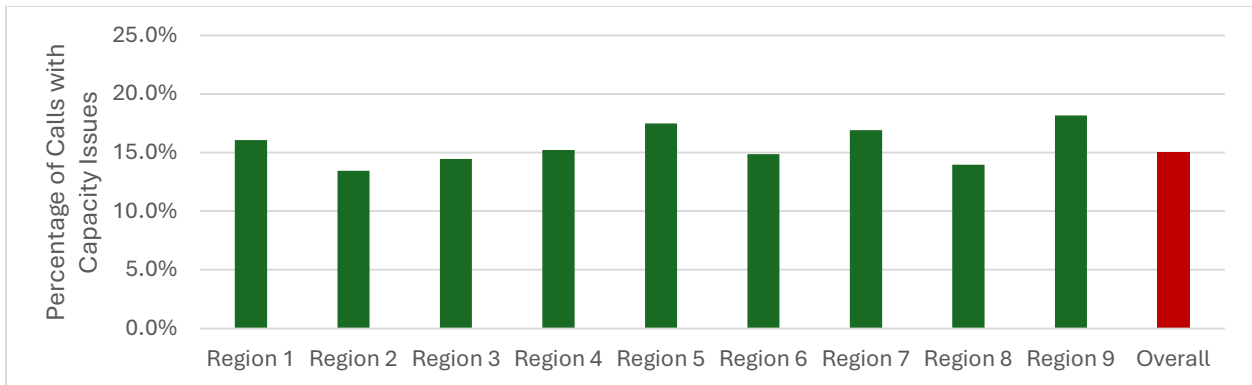


Figure 32: Percentage of calls experiencing provider capacity issues, by region

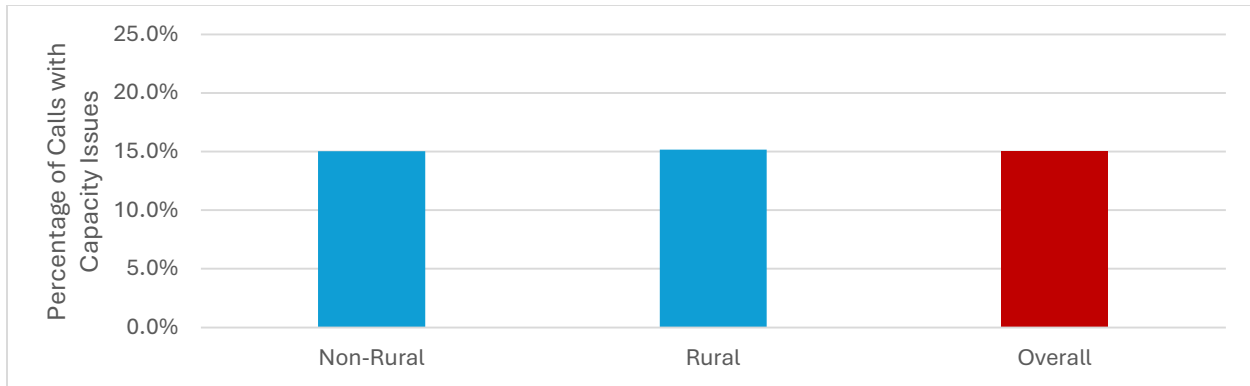


Figure 33: Percentage of calls experiencing provider capacity issues, by caller rurality

Discussion

Based on the findings from a large-scale secret shopper survey for 7,753 simulated patients with callers making 28,161 unique phone calls, consumers that were in the 2023 Pennsylvania ACA Marketplace experienced substantial challenges when navigating the provider networks established by the eight carriers serving them. While almost 80% of simulated patients were able to eventually secure an appointment, this also means that 20% of patients were not able to find a medical provider despite making ten calls. At the individual call level, just over 1 in 5 calls led to an appointment. Mental health patients struggled in particular to find a provider. Although most simulated patients were ultimately able to secure appointments, consumers often had to invest substantial resources to obtain these appointments, making on average nearly three calls and spending almost 30 minutes to do so. Across these outcomes, the analyses identified substantial differences across specialty, carrier, region, and, to a limited degree, caller rurality. Even when successful in securing an appointment, simulated patients had to wait more than 60 days and drive almost 30 minutes to see their medical provider. Unsurprisingly, rural patients had to travel particularly long distances. In addition to often only reaching an answering machine, inaccurate provider directories were the primary contributor to access challenges with almost 50% of calls experiencing inaccurate phone numbers, specialty information, or network status. In addition, 15% of calls experienced provider capacity issues, such as providers being unwilling or unable to accept new patients into their practice or not offering new appointments at the time of the call. Mental health patients were particularly affected by limited provider capacity. Lastly, it is worth noting that across all outcomes analyzed there were also not unsubstantial percentage of outliers present. That is, between 5% and 25% of simulated patients experienced challenges well above the overall average and median. For example, while 75% of simulated patients had to travel less than 33 minutes to see a provider, 5% had to travel in excess of 86 minutes. Similarly, 3 in 4 simulated patients were able to secure an appointment within 86 days but appointments were scheduled more than 139 days from the date of the call for 10% of simulated patients.

Overall, the findings indicate that both inaccurate provider directories as well as inadequate provider networks are important contributors to the access challenges ACA Marketplace consumers experience. Contributing factors to persistent inaccuracies may include inadequate administrative

capacity to verify and update provider directory information.⁴⁰ The differences in findings across carriers may be an indication that carriers may take different approaches to network maintenance and adequacy verification, with variation in staffing, resources, administrative capacity, and institutional knowledge that could affect the frequency and accuracy of these efforts.¹⁰ Differences in rates of corrective action across carriers suggest potential administrative, operational, and health information technology levers that may facilitate more accurate and timely verification.¹² Providers participating in insurance networks may also experience challenges initiating and responding to different processes, documentation, and timelines for directory requests from multiple carriers despite their affirmative obligation to do so.⁴⁷ While network adequacy cannot fully be assessed until higher degrees of network accuracy are achieved, the findings here also indicate that inadequate provider capacity makes an important contribution to the access challenges consumers experience. This not only includes cases where providers were not able to offer appointments to callers but also includes the substantial wait and travel times documented. The travel and wait times identified, in combination with the findings related to provider directory accuracy, may also indicate that many provider networks, at least in certain areas of the Commonwealth, may not meet the expectations of policymakers and consumers regarding access to care.

Overall, the access challenges identified via the secret shopper survey may make it difficult for many consumers to navigate the health care system, resulting in delayed access to care, seeking inappropriate levels of care, and increased likelihood of out-of-pocket costs.⁴⁴ In addition, if consumers select plans based on faulty information, inaccuracies may also prevent consumers from selecting plans that fit their needs and accessing their preferred providers with potential implications for continuity of care, as well. Moreover, the substantial burdens identified in terms of the number of calls and minutes spent on the phone or travel to providers may also be prohibitive for some consumers. Ultimately, the findings may indicate that current approaches to network adequacy regulation and enforcement may not protect consumers from experiencing delays and barriers to care. Lastly, given that many of the carriers surveyed participate in multiple insurance markets, it also seems likely that many other Pennsylvanians experience similar access challenges.

Policy Recommendations

By identifying important contributors to access challenges, the survey findings indicate several opportunities for positive policy changes. In terms of improving provider directory accuracy, the differential findings for carriers may indicate different administrative procedures and resource commitments on the part of carriers. To increase transparency, carriers could be required to share their provider verification procedures as well as resource commitments with the Insurance Department. Suppressing providers from provider directories who fail to pass proper verification procedures until they can be fully verified would also incentivize both providers and carriers to ensure accurate provider information. In addition, carriers could be required to suppress providers from their provider directories if they have failed to submit an in-network bill over a designated period of time. Stronger fines and penalties for non-complying carriers and providers could also provide better incentives to minimize inaccuracies. A centralized state provider registry that maintains

accurate contact, specialty, and network information across carriers could offer an efficient long-term technical solution. This registry would also facilitate network verification by regulators. While noting that the networks status of providers for which callers only reached an answering machine could not be verified, the large number of cases where this was the case may also indicate the need to explore alternative scheduling tools to make it easier for consumers to obtain appointments.

In terms of barriers related to network capacity and adequacy, the findings related to provider directory inaccuracy as well as those related to travel and wait time may indicate the need to revisit existing regulatory standards and enforcement approaches. This includes questions about how inaccuracies in networks may affect compliance with existing standards. Most broadly, an all-stakeholder conversation on what standards are feasible and acceptable for different specialties and areas of the Commonwealth may be needed. This may also include an assessment of what capacity ceilings exist, what trade-offs exist between increasing standards, and how existing resources can be utilized more efficiently. The findings also highlight the need to specifically focus on securing more adequate access to mental health providers. Lastly, it is worth re-emphasizing that, ultimately, assessments of network adequacy require reasonably accurate information about provider networks.

Irrespective of any specific policy changes, comprehensive annual secret shopper surveys could be put in place to assess carrier compliance to existing requirements as well as to assess changes over time. Findings from these surveys could be shared publicly as well as be made part of the information provided to Pennie consumers during their enrollment process. Moreover, raising awareness about consumers' ability to file complaints against carriers as well as facilitating the complaint process and prominently publicizing these data would further encourage carriers to improve procedures. Lastly, resources for consumers in the form of patient advocates could help mitigate existing access challenges until long-term solutions can be implemented.⁹

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