BerryDunn

Wisconsin Individual Health Insurance Market:

Network Adequacy

Final Report
Submitted to the
Wisconsin Office of the Commissioner of Insurance
Contract # 145CAP-M22-IN220937-01

September 2023

This report was prepared by
Donna Friedsam, Dina Nash, Jennifer Elwood, and Tyler Brannen
BerryDunn Health Analytics Practice Group

Rachel Cissne-Carabell, Darcy Paskey, Mary Kay Rodriguez, and Jennifer Stegall, of the Wisconsin Office of the Commissioner of Insurance, provided ongoing guidance, review, and comments in preparation of this report.

This publication was supported by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $689,458.16 with 100% funded by CMS/HHS and $0 and 0% funded by non-government source(s). The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, CMS/HHS or the U.S. Government.

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List of Acronyms

ACA	Affordable Care Act
AODA	Alcohol and Other Drug Abuse
ACS	American Community Survey (U.S. Census)
APCD	All-Payer Claims Database
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CEAC	Counties with Extreme Access Considerations
CMS	Centers for Medicare and Medicaid Services
CM/CNM	Certified Midwife/Certified Nurse Midwife(ves)
DHHS	U.S. Department of Health and Human Services
ECP	Essential Community Provider
DHS	Wisconsin Department of Health Services
FFE	Federally-Facilitated Exchanges – also known as the "Marketplace"
FQHC	Federally Qualified Health Center
FTE	Full Time Equivalent
FY	Fiscal Year
GAO	U.S. Government Accountability Office
HHS	U.S. Department of Health and Human Services
HMO	Health Maintenance Organization
HPSA	Health Professional Shortage Area
MCO	Managed Care Organization
MH/SUD	Mental Health/Substance Use Disorder
NCQA	National Committee on Quality Assurance
NAIC	National Association of Insurance Commissioners
NP	Nurse Practitioner
NPI	National Provider Identifier
OB/GYN	Obstetrics and Gynecology
OCI	Office of the Commissioner of Insurance (Wisconsin)
PA	Physician Assistant
PY	Plan Year
PPR	Provider Participation Rate
QHP	Qualified Health Plan - ACA Compliant
QTT	Qualified Treatment Trainee
RELD	Race, Ethnicity, Language, and Disability
SAC	Substance Abuse Counselor

Terms and Terminology

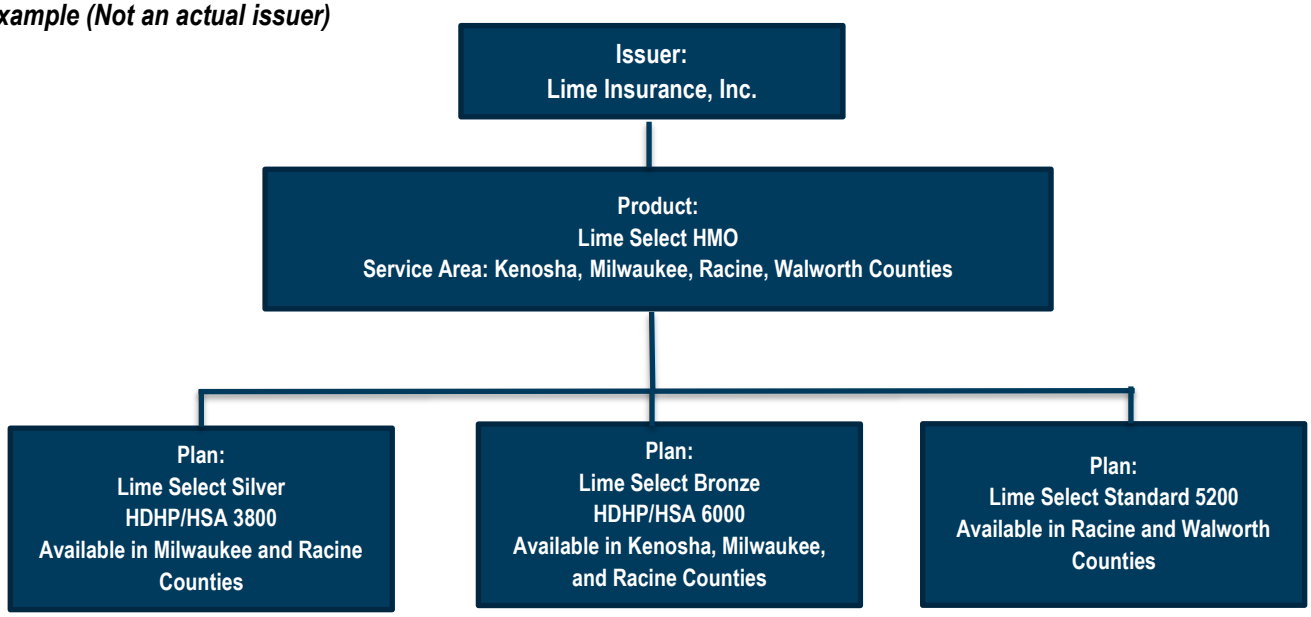
The health insurance sector uses a variety of terms, some of which seem interchangeable. Some terms that seem similar are distinct from one another but may become conflated within discussions. This report limits use of terms to "issuer" to refer to health insurance issuers and insurers, and "product" to refer to the specific benefit package available to consumers, including the service area and provider network. A product may include multiple "health plans" or "plans" (defined below). A plan may either be a Qualified Health Plan (QHP) as certified by the Affordable Care Act (ACA) Health Insurance Marketplace (the "Marketplace") or an ACA compliant plan offered only off the Marketplace.[1]

The following narrative provides more detail about these definitions and the context for why this report adopts the use of the terms "issuers" and "products" and instances where the report refers to "health plans" and "plans."

Product vs. Plan

The Code of Federal Regulations, at 45 CFR §144.103, provides the complete federal definitions of "product" and "plan."[2] This OCI report adopts the following usage: the product defines the benefit coverages and network type (such as health maintenance organization (HM0), preferred provider organization, exclusive provider organization, point of service) and the plans within a product define the cost-sharing structure, service area, and provider network. A product will have several plans associated with it as options for consumers to purchase. The service areas for all plans offered within a product constitutes the total service area of the product.

Example (Not an actual issuer)



Qualified Health Plan (QHP)

CMS provides the following definition for a Qualified Health Plan:[3] an insurance plan that is certified by the Health Insurance Marketplace®, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements under the ACA. All QHPs meet the ACA requirement for having health coverage, known as "minimum essential coverage."

Any plan available through the Marketplace must be certified as a QHP. Once certified, a QHP may also be available off-Marketplace, purchased through a broker or directly from the issuer.[4] However, consumers can only qualify for the ACA's premium tax credits and/or cost-sharing subsidies by purchasing a QHP through the federal Marketplace or a state health insurance marketplace. In addition, other ACA compliant health plans are offered off-Marketplace only. These plans are not titled "Qualified Health Plan" because they have not been certified by CMS.

Insurer, Carrier, and Issuer

Wisconsin Statutes § 600.03 (27)[5] define an "insurer" as any person or association of persons conducting an insurance business as a principal, and includes, but is not limited to, fraternals, cooperative associations organized under s.85.981, insurers operating under subch. I of ch. 616, and risk retention groups. The National Association of Insurance Commissioners (NAIC) also defines an insurer as an entity "authorized to write property and/or casualty insurance under the laws of any state."[6]

The term "carrier" lacks official reference in the ACA or in Wisconsin state law related to health insurance. The Federal Employee Health Benefits Program, Part 1602.170-1 defines carrier as follows:[7] "Carrier means a voluntary association, corporation, partnership, or other nongovernmental organization which is lawfully engaged in providing, delivering, paying for, or reimbursing the cost of health care services under group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, including a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services, in consideration of premiums or other periodic charges payable to the carrier." HealthInsurance.org states that "the terms insurer, carrier, and insurance company are generally used interchangeably."[8]

The ACA relies on use of the term "issuer" – a term this OCI report adopts due to its application to the ACA and its specificity to the individual health insurance market. The federal Code of Federal Regulations 45 CFR §144.103 defines issuer as follows:[9]

> **Issuer** means an insurance company, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a State and that is subject to State law that regulates insurance (within the meaning of section 514(b)(2) of ERISA). This term does not include a group health plan.

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[1] The Health Insurance Marketplace®, also known as the "Marketplace" or "exchange," is operated by the federal government and available to Wisconsin residents. It provides health plan shopping and enrollment services for consumers through websites (HealthCare.gov), call centers, and in-person help. https://www.healthcare.gov/glossary/health-insurance-marketplace-glossary/

[2] 45 CFR §144.103 Definitions, Requirements Relating to Health https://www.ecfr.gov/current/title-45/section-144.103

[3] Healthcare.gov https://www.healthcare.gov/glossary

[4] HealthInsurance.org. What is a qualified health plan? https://www.healthinsurance.org/glossary/qualified-health-plan/

[5] Wisconsin Statutes https://docs.legis.wisconsin.gov/statutes/statutes/600.pdf

[6] NAIC. Glossary of Insurance Terms. https://content.naic.org/consumer_glossary

[7] Federal Employee Health Benefits Acquisition Regulation Part 1602 – Definitions of Words and Terms https://www.acquisition.gov/fehbar/part-1602-definitions-words-and-terms

[8] HealthInsurance.org https://www.healthinsurance.org/glossary/carrier/

[9] 45 CFR §144.103 Definitions, Requirements Relating to Health https://www.ecfr.gov/current/title-45/section-144.103

I. Executive Summary

Network adequacy refers to an issuer's ability to deliver covered benefits within its offered products and health plans, by providing reasonable access to enough in-network primary care and specialty providers, and to all services included under the terms of the contract.[1,2] The federal Affordable Care Act (ACA) requires products sold through the Marketplaces (also known as "Exchanges") to be certified as Qualified Health Plans (QHPs) and meet network adequacy standards that ensure consumers have access to needed care without "unreasonable delay."[3]

Wisconsin, in 2022, had 14 issuers with 23 products offered in the individual health insurance market.[i] Thirteen issuers offered 21 products certified as QHPs on the Marketplace. This report assesses the 23 products against existing network adequacy benchmarks and standards, including the following:

- Provider networks at a plan-level across counties and at a county-level across products
- Adherence with Centers for Medicare & Medicaid Services (CMS) standards for various specialties
- Members-to-provider ratios
- Access to behavioral health and primary care providers (including telehealth access), and obstetrics and gynecology (OB/GYN) physicians
- Percentage of providers in a specific provider category accepting new patients

The purpose of this report is to help regulators and other interested parties better understand network adequacy in the ACA compliant individual health insurance market and help these parties determine whether there is a need to pursue related regulatory changes or policy initiatives.

Issuers design provider networks to assure access and member choice but may limit provider participation to control utilization, improve the quality of care, minimize adverse risk selection, and reduce costs. Several factors may contribute to inadequate networks, including provider shortages, challenges in contracting with providers, and geography.[4] To help ensure that Marketplace QHPs serve members' needs, the ACA requires that QHPs maintain a provider network "sufficient in numbers and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay."[5]

Measuring Network Adequacy

Examples of quantitative standards for measuring network adequacy include the following:

- Maximum time or distance for enrollees to travel to providers
- Maximum wait times to schedule an appointment with a provider
- Enrolled-population (members)-to-provider ratios
- Number or percentage of essential community providers (ECPs) included in network[ii]

This report's analysis relies on two primary sources of data collected from issuers for two different plan years:

- 2023 Issuer Data Call: BerryDunn collected primary data, conducting an insurance issuer data call through the Wisconsin Office of the Commissioner of Insurance (OCI). The data call occurred in February through

[i] The number of issuers referenced treats WPSIC and WPS Health Plan under a single issuer (WPS).
[ii] ECPs are providers who serve predominately low-income, medically underserved individuals. See 45 C.F.R. § 156.235(c) (2022).

March 2023, receiving responses from all 14 issuers that offer products in Wisconsin's individual health insurance market. Data are reported for 23 separate products and reflect PY 2022 experience.

- CMS Plan Year (PY) 2023 Rate Filing Data: Wisconsin OCI provided BerryDunn with the network adequacy data that issuers of QHPs on the Marketplace had reported to CMS in filing for QHP certification. CMS receives rate filing data from 13 of Wisconsin's 14 individual market issuers, as one of the issuers in Wisconsin's individual market (WPS) does not offer plans on the ACA Marketplace.[iii] Data reflect issuers' expectations as filed in 2022 in anticipation of PY 2023.

Several measurement challenges affect the assessment of network adequacy. The application of time and distance standards and the counting of available providers requires the enumeration of the service population and the available providers within a geographic service area. However, the use of county boundaries as a unit of analysis may often not reflect an area's health care use patterns and needs. This approach may underestimate certain residents' access to health care when crossing county boundaries – particularly in non-metropolitan areas.[6] In metropolitan counties, the county-based provider count may overestimate access for county residents, and some portion of those county providers serve residents crossing county borders from other counties for services.

As well, the measure of members-to-provider ratios cannot rely on a simple count of contracted providers.[7] Many providers contract with, and serve patients from multiple products and plans, may practice at multiple locations (that may be widely dispersed in rural areas), or may practice part-time. These factors reduce the actual available provider capacity for a specific plan's enrolled members. For this reason, anticipating provider demand and supply, as well as workforce planning calculations, occurs in full-time equivalents (FTEs).[8,9]

QHPs Networks Relative to CMS Network Adequacy Standards

Issuers of QHPs report using National Committee on Quality Assurance (NCQA) standards to measure and evaluate compliance with wait time standards, and some reported also applying standards set by BadgerCare and the Supplemental Security Income (SSI) Contract with the Wisconsin Department of Health Services. Two issuers of QHPs answered that they do not currently have methods that evaluate compliance and did not provide answers for how they plan to evaluate compliance against the wait time standards CMS plans to implement for PY 2025.

CMS requires issuers of QHPs to report data to indicate the degree to which their products' networks attain CMS access standards. Issuers of QHPs report from a range of preset reasons regarding why they are not meeting the CMS standard for access. The reasons fall into three general categories: 1) contracting challenges with existing providers, 2) provider shortages in the region, and 3) networks being developed. Most Wisconsin issuers of QHPs report experiencing each of these reasons and identify these challenges for up to 40 of Wisconsin's 72 counties.

Wisconsin QHPs may more frequently fall short of achieving the CMS standard for pediatric and OB/GYN services due to the CMS definition requiring the presence of pediatrians and OB/GYNs. However, many of Wisconsin's non-metropolitan counties rely on family practice physicians to provide pediatric and prenatal services. Family physicians and general practitioners — along with physician assistants and licensed nurse practitioners—often provide care for children in rural counties, whereas pediatricians are predominantly concentrated in metropolitan areas.[10,11,12] Rural

[iii] Reference to 14 issuers here reflects all individual market insurers offering ACA compliant plans and treats WPS Health Plan and WPSIC as one issuer (WPS). The reference to 13 issuers reflects the issuers that offered QHPs through the ACA Marketplace. This count excludes WPS, which did not offer its products through the Marketplace for PY 2023.

family physicians are more likely than their urban counterparts to provide obstetrical deliveries, newborn care, and pediatric care.[13]

CMS access standards require that QHPs demonstrate that 90% of their enrolled members in the counties that they reside have access to specific services. Issuers of QHPs self-report to CMS on the degree to which their networks attain these access standards. Table 1 displays that issuers issuing QHPs most often fall short of the CMS standard at the county level for pediatric primary care and for OB/GYN services.

Table 1. Number of Issuers Not Meeting CMS Access Standard and Number of Counties Where Average Across Issuers Does Not Meet CMS Access Standard

Specialty	Number of Issuers (Out of 13 Reporting)	Number (%) of Counties (Out of 72)
Adult primary care	8	9 (13%)
Pediatric primary care	12	52 (72%)
OB/GYN	11	34 (47%)
Clinical behavioral health services	9	20 (28%)

Provider Networks at a Plan and County-Level

Members-to-Provider Ratios

Providers often contract with multiple issuers, might work in multiple geographies, and might work part time. Therefore, a meaningful measure of provider availability requires a calculation based on FTEs rather than on a simple head count of contracted providers. With that caveat, this report provides the average ratios of members-to-providers within regions, based on the number of contracted providers reported by each issuer for each product and the reported number of the plans' enrolled members in those regions. Although these figures do not represent the level of available providers for the population, the number of contracted providers relative to the enrolled population does provide a view of the relative breadth of the products' networks. At the region-level, the northern region stands apart due to its high members-to provider ratio across all provider types.

Essential Community Providers

The 2023 issuer data call asked issuers to select from a list of Wisconsin Federally Qualified Health Centers (FQHCs) to indicate the FQHCs where their products currently hold existing contracts. This exercise provided an initial view of the extent to which issuers engaged with ECPs in the areas where products have members enrolled. Most issuers report contracts with FQHCs, while three out of 23 products have no in-network FQHCs in counties where the plans have enrolled members.

Providers Accepting New Patients as Reported and Compared to Provider Directory

Regulators evaluate plans against quantitative network adequacy standards using network directory data, which can often contain errors.[14] This report assesses the number of providers that issuers identify as accepting new patients within their products and how this compares to the provider directory. Three issuers, accounting for four products, show few or no claims for new patient visits by providers for three or more provider types among providers designated as accepting new patients. These results may indicate occurrences where (1) new members have challenges accessing providers; (2) these products have a stable enrolled population with relatively few new enrollees needing services; or (3) providers who are designated as accepting new patients may not actually be available.

Access to High-Priority Services and Specialists

Primary Health Care

QHP issuer data reported to CMS indicate shortfalls in meeting the CMS access standards for both adult and pediatric primary care services, with eight issuers falling below the standard for adult primary care, and 12 issuers falling below for pediatric primary care. However, all 14 issuers responding to the OCI data call reported "no known access issues" due to provider capacity deficiencies. Issuers frequently commented "no member complaints/appeals received." These responses contradict the quantitative data presented and stand contrary to Wisconsin's reported widespread primary care provider shortages.

Two issuers asserted issues with the CMS method for measuring pediatric primary care access. They note that CMS does not allow family practice physicians to count toward meeting network adequacy for Primary Care - Pediatrics, although CMS does allow count of family practice for meeting Primary Care - Adult network adequacy. Similarly, CMS does not allow count of physician assistants or nurse practitioners in assessing network adequacy for Primary Care – Pediatrics, but these providers do count toward meeting network adequacy for Primary Care – Adult.

Obstetrics/Labor and Delivery Services

Data reported to CMS by issuers of QHPs indicate shortfalls in meeting CMS access standards for OB/GYN services, with 11 issuers of QHPs falling below the standard. However, issuers' responses to the 2023 data call indicate a heavy reliance on family practice physicians and certified nurse midwives (CNMs) to provide these services, rather than only on OB/GYN providers. The inclusion of these other providers, along with comments by some of the issuers, suggest that members' access exceeds the level represented by the CMS standard.

Mental Health and Substance Use Disorder (MH/SUD) Services

Issuers of QHPs reported data to CMS that indicate shortfalls in meeting the CMS access standards for outpatient behavioral health services, with nine issuers falling below the standard. In the issuer data call, issuers also frequently reported challenges in filling behavioral health network panels, more so than other service types. However, the issuers' reported challenges may understate those faced by enrolled members, given other state and national reports about widespread shortages in the workforce for behavioral health services.

- Eight of the 14 issuers reported known capacity or access issues with behavioral health generally.
- Five of the 14 issuers identified challenges with access to crisis behavioral health services.
- Five of the 14 issuers addressed the availability/access to providers beyond inpatient services.
- Four of the 14 issuers identified challenges in access for Alcohol and Other Drug Abuse (AODA) services.

Coverage for Telehealth Services

Telehealth holds promise in augmenting network adequacy by overcoming barriers in mobility, transportation, and geography.[15] The measure of network adequacy may account for how telehealth might enhance access, while also assessing risk for reduced access to necessary in-person providers. All 14 issuers reported paying for telehealth services, with some slight variation related to coverage for audio services alone without video.

Accessibility: Race, Ethnicity, Language, Disability (RELD) Data

The 2023 issuer data call asked whether the issuers collect data about the race, ethnicity, language, and disability needs of their members and the languages available among their contracted providers. Ten of the 14 issuers reported using RELD data to identify disparities in quality of care and target quality improvement interventions. Twelve issuers reported collecting data from providers about their spoken languages, and two reported they do not collect such data. All issuers emphasized that providers reporting of this information is voluntary.

II. Introduction and Background

A. Project Scope

The Wisconsin Office of the Commissioner of Insurance (OCI) received federal funding from the U.S. Centers for Medicare and Medicaid Services (CMS), to better understand health insurance accessibility and to increase individual market enrollment. OCI engaged BerryDunn to conduct analyses and prepare three reports focused on Wisconsin's individual health insurance market:

- Report 1: Affordable Care Act (ACA) Compliant Comprehensive Coverage and the Uninsured
- Report 2: Short-Term Limited Duration Plan (STLDP) Analysis
- Report 3: Network Adequacy Analysis

This document serves as Report #3, addressing the following aims:

- Assess Qualified Health Plans (QHPs) against existing federal network adequacy benchmarks and standards.
- Measure provider networks at a plan-level across counties and at a county-level across products.
- Assess adherence to CMS standards for various specialty types, analyze members-to-provider ratios, and determine whether telehealth is available. Specialty types include behavioral health and primary care providers, and obstetrics and gynecology (OB/GYN) physicians.
- Identify percentage of providers in a specific provider category that is accepting new patients.

The purpose of this report is to help regulators and other interested parties to better understand network adequacy in the individual health insurance market and to help these parties determine whether there is a need to pursue related regulatory changes or policy initiatives.

B. Background on Network Adequacy

B1. General Background

Network adequacy refers to an issuer's ability to deliver the covered benefits by providing reasonable access to enough in-network primary care and specialty physicians, and all health care services included under the terms of the contract.[16,17] The federal ACA requires that health plans participating as QHPs in the Marketplaces (also known as Exchanges) meet network adequacy standards and ensure consumers have access to needed care without "unreasonable delay."[18]

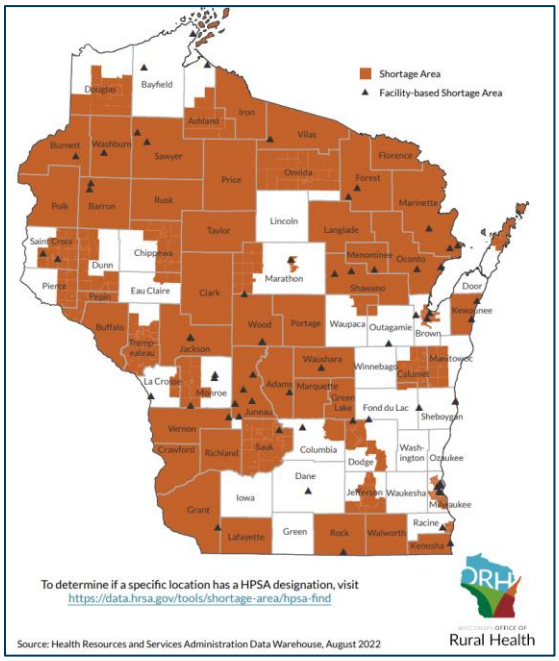
Health insurance issuers are generally able to define and adjust the number and required qualifications of providers in their networks.[19] Product networks are a key factor that determine whether and how patients get needed care, as claims for out-of-network services may be denied altogether or covered at a reduced rate. Issuers design provider networks to assure access and member choice but may limit provider participation to control utilization and reduce costs. In doing so, concern exists that networks may become too narrow, overly restricting enrollees' options in choosing or finding providers.

Several other factors may contribute to inadequate networks, including provider shortages, challenges in contracting with providers, and geography.[20] Wisconsin has federally designated Health Professional Shortage Areas (HPSA) in counties statewide for primary care, dental, and behavioral health services.[21] Federal regulations define HPSA designation as having a population-to-provider ratio that meets or exceeds a certain threshold. For primary care

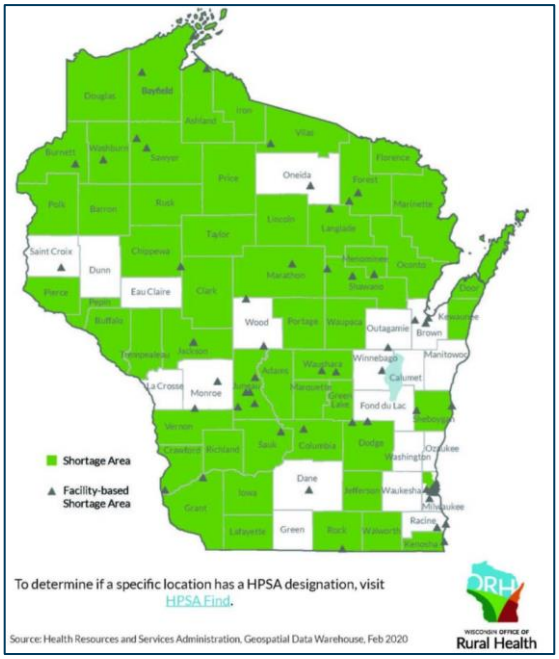
geographic designations, the population-to-provider ratio must be at least 3,500-to-1 or, for areas with unusually high needs, 3,000-to-1.[22] Approximately 1.6 million Wisconsin residents (27%) live in areas designated with primary care and dental provider shortages, and 2.8 million (48%) live in areas with designated mental health provider shortages.[23] The maps in Figure 1 display the widespread shortages throughout the state.[24] The Wisconsin Department of Health Services identifies a ratio of 2,000 population to 1.0 full-time equivalent (FTE) primary care physician for removing the primary care physician shortage, but notes this threshold is "not an optimal ratio to meet the need for primary care for the general population."[25]

Figure 1. Wisconsin HPSA Maps, 2022

Primary Health Care



Mental Health Care



B2. Network Adequacy Standards and Enforcement

The ACA provided federal oversight of network adequacy in commercial health insurance by requiring QHPs offered through the Marketplace to ensure a sufficient choice of providers and to provide information to enrollees and prospective enrollees regarding availability of in-network and out-of-network providers.[26] The ACA directs the U.S. Department of Health and Human Services to develop criteria to certify health plans sold in Marketplaces. These criteria aim to ensure each plan:

- provides a sufficient choice of providers;
- includes "essential community providers (ECPs)" that predominately serve lower-income and medically underserved individuals and communities; and
- provides information to enrollees and prospective enrollees regarding availability of in-network and out-of-network providers.

To help ensure that Marketplace-offered plans serve the needs of enrollees, the ACA requires that plans maintain a provider network "sufficient in numbers and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay." The federal

government certifies QHPs offered in federal marketplace states, including in Wisconsin. Issuers continually update their service model as regulatory standards have evolved over the past decade.

Beginning with the 2018 plan year (PY), CMS ended direct federal oversight of the adequacy of QHP networks, deferring to states' interpretation and oversight of network adequacy standards and reliance on accreditation by private organizations or the issuer's attestation. The HHS Notice of Benefit and Payment Parameters for 2019 final rule provided clear authority to the states to determine network adequacy in their QHP certification reviews. In its QHP certification standards, CMS expanded the states' role in the QHP certification process for Federally-Facilitated Exchanges (FFEs) and continued deference to the states' reviews of network adequacy.

Since 2021, CMS has returned to expanding its federal oversight role. For PY 2023, CMS announced new network adequacy standards through regulations and guidance, plans for its own evaluation of the adequacy of provider networks for QHPs offered through the FFEs, and plans to adopt quantitative time and distance standards and appointment wait time standards.[27] At this time, the standards do not include minimum provider-to-member ratios.

The CMS Notice of Benefit and Payment Parameters for 2024 delays the application of the appointment wait time standards until PY 2025.[28] In PY 2025, QHPs will be required to attest to meeting appointment wait time standards. HHS expects to rely on issuers' attestations of compliance with the standard.

Also in the 2024 rule, CMS finalized changes to strengthen network adequacy and ECP standards – focusing on access to care for low-income and medically underserved consumers. The 2024 rule establishes two additional major ECP categories starting in PY 2024 -- Mental Health Facilities and Substance Use Disorder Treatment Centers -- and adds rural emergency hospitals as a provider type in the "Other ECP" category. CMS retains the overall 35% threshold for ECP provider participation and extends the 35% threshold to two major ECP categories: FQHCs and Family Planning Providers.

Federal network adequacy standards, and measures for "sufficient" and "accessible," shape issuers' service areas, plans, and provider contracting approaches. The recently augmented federal standards challenge issuers anew in expanding their contracting practices, describing barriers to attaining such contracts, and otherwise addressing the needs of vulnerable populations. As well, issuers previously demonstrated adherence to federal standards via attestation. Now, they must provide quantitative data to CMS and provide a justification if an issuer does not meet one or more of the standards.

B3. Measures and Metrics for Network Adequacy

The regulation of network adequacy can involve the use of various quantitative standards, as well as other oversight activities.[29] Examples of quantitative standards include the following:

- Maximum time or distance for enrollees to travel to providers
- Maximum wait times to schedule an appointment with a provider
- Minimum ratios of providers to enrolled population
- Number or percentage of ECPs included in network[iv]

[iv] ECPs are providers who serve predominately low-income, medically underserved individuals. See 45 C.F.R. § 156.235(c) (2022).

Apart from federal CMS standards, states apply differing network adequacy standards, which vary across types of coverage.[30] The National Association of Insurance Commissioners (NAIC) has developed a Health Benefit Plan Network Access and Adequacy Model Act,[31] that lacks quantitative standards. Instead, it offers a framework for a qualitative review and state specific quantitative requirements. Officials from the 50 states and the District of Columbia, responding to a survey conducted by the U.S. Government Accountability Office (GAO), reported varying actions to oversee the adequacy of individual and group health plans' provider networks.[32] (Figure 2) Officials from 44 states reported using at least one standard, such as time and distance or wait times, to assess network adequacy. Officials from 32 states reported reviewing health plans' provider networks prior to approval of the plan for sale, and officials from 23 states reported reviewing plans upon changes to the network.

Wisconsin statute § 609.22 sets forth access standards for defined network plans,[v] which include health maintenance organizations and preferred provider plans.[33] A defined network is required to adhere to the following:

- Include a sufficient number, and sufficient types, of qualified providers to meet the anticipated needs of its enrollees, with respect to covered benefits, as appropriate to the type of plan and consistent with normal practices and standards in the geographic area.
- Develop an access plan to meet the needs of its enrollees who are members of underserved populations.

A defined network plan that is not a preferred provider plan must adhere to the following:

- Ensure each enrollee has adequate choice among participating providers and that the providers are accessible and qualified.
- Provide telephone access during business and evening hours to ensure that enrollees have adequate access to routine health care services and provide 24-hour telephone access for emergency care, or authorization for care.

Administrative rule, Ins 9.32, adds some detail to the requirements in Wis. Stat. § 609.22, but does not set quantitative standards.[34] A defined network plans that is not a preferred provider plan must adhere to the following:

- Provide covered benefits by plan providers with reasonable promptness (defined as usual community standards), with respect to geographic location, hours of operation, waiting times for appointments in provider offices, and after-hours care.
- Have sufficient number and provider types to adequately deliver all covered services based on enrollee demographics and health status.
- Provide 24-hour nationwide toll-free telephone access for its enrollees to the plan or participating provider for authorization for care.

A preferred provider plan must adhere to the following:

- Provide covered benefits by participating providers with reasonable promptness consistent with normal practices and standards in the geographic area.
    - Geographic availability shall reflect the usual medical travel times within the community.
    - This does not require the issuer to offer geographic availability of a choice of participating providers.

[v] Wis. Stat. § 609.01(1b) defines a defined network plan as "a health benefit plan that requires an enrollee of the health benefit plan, or creates incentives, including financial incentives, for an enrollee of the health benefit plan, to use providers that are managed, owned, under contract with, or employed by the insurer offering the health benefit plan." This includes Health Maintenance Organizations and Preferred Provider Plans. https://docs.legis.wisconsin.gov/statutes/statutes/609/01/1b

- Provide sufficient number and type of participating providers to adequately deliver services based on enrollee demographics and needs, including at least one primary care provider and a participating provider with expertise in obstetrics and gynecology accepting new enrollees.

In Wisconsin and most other states, oversight generally has relied on an initial attestation of compliance by the issuer and monitoring for complaints.[35] Regulators also rely on product and health plan provider directory data. Wisconsin regulations state that "Insurers offering a defined network plan shall make current provider directories available to enrollees upon enrollment, and no less than annually, following the first year of enrollment."[36] However, provider network directories are often outdated or inaccurate, such that apparent compliance with current network adequacy standards may not reflect actual access.[37,38]

Figure 2. GAO Survey of State Officials: Standards Used to Oversee Network Adequacy

Table 2: Types of Quantitative Standards State Officials Reported Using to Oversee Provider Network Adequacy for Individual and Group Health Plans, January 2019 through December 2021

Description of quantitative standard	Number of states that used quantitative standard	Examples of quantitative standards
Maximum travel time or distance		
Measures the time or distance an enrollee would have to travel to reach a provider location to determine whether providers are geographically accessible to plan enrollees.	26	Require that enrollees have access to a primary care provider within 30 miles or 30 minutes of their home.
Number or percentage of essential community providers (ECPs) included in a network		
Measures how many providers are in the network who serve predominately low income, medically-underserved individuals.	19	Require that 35 percent of the ECPs in a service area must be included in the network.
Provider-to-enrollee ratio by specialty		
Measures the number of providers and enrollees in a network to determine how many providers by specialty are available in a service area.	15	Require that there is one primary care physician for every 1,500 enrollees.
Maximum appointment wait time		
Measures the amount of time for an enrollee to schedule an appointment to determine how much actual capacity network providers have to provide services to enrollees.	10	Require that enrollees be able to secure a specialist appointment within 45 days of their request.
Other quantitative standard		
Other quantitative standards.	12	Require that a certain percentage of providers are accepting new patients.

Source: GAO survey of officials from state departments of insurance and literature reviewed. | GAO-23-105642

Notes: Network adequacy refers to a health plan's ability to deliver the benefits promised to enrollees by providing reasonable access to in-network providers. Officials from 50 of 51 states provided information in response to our survey.

Time/Distance Standards

Time/distance standards help determine whether participating providers are geographically accessible to plan enrollees. Time/distance standards measure geographic proximity, but not the breadth of a network. A 2021 GAO survey reported 26 states specifying the maximum amount of time and/or distance an enrollee must travel to access covered services.[39]

The CMS 2023 Letter to Issuers in the FFEs provides the full list of specialties and facilities for which the proposed time/distance standards apply starting in plan year 2023, and details on geographic types.[40] At least 90% of enrollees must live within the maximum distance of at least one provider of each type. The standards vary by five county designations: 1) Large Metro County, 2) Metro County 3) Micro County, 4) Rural County, and 5) Counties with Extreme Access Considerations (CEAC). For the 2024 plan year, CMS will evaluate QHPs for compliance with network adequacy standards based on the designated time and distance standards.

Appointment Wait Times

CMS final notice to issuers for PY 2024[41] confirms plans to adopt appointment wait time standards beginning with PY 2025, focusing on three provider specialties:

- Behavioral Health: 10 business days
- Primary Care (routine): 15 business days
- Specialty Care (non-urgent): 30 business days

Issuers will be required to attest that 90% of contracted providers meet the wait time standard; CMS will conduct compliance reviews in response to enrollee complaints and via random audits. The 2021 GAO survey reports 10 states using wait time standards.[42]

Members/Enrollees per Provider Ratios

To date, CMS has not applied a members-to-provider ratio standard for the federal marketplace, nor has it proposed one for 2024. The 2021 GAO survey reported 15 states with standards prescribing ratios of maximum enrollees per provider.[43] Among states that specify required ratios, the examples displayed in Table 2 reflect how the requirements vary.[44]

Table 2. Example Enrolled Members-to-Provider Ratio Requirements Among States

	Primary Care Enrolled Members : Provider	OB/GYN Enrolled Members : Provider	MHSUD Enrolled Members : Provider
California	2,000:1		
Colorado	1,000:1	1,000:1	1,000:1
Connecticut	2,000:1		
Delaware	2,000:1		
Illinois	1,000:1	2,500:1	5,000:1
Maine	2,000:1		
Montana	2,500:1		
New Mexico	1,500:1		
South Carolina	2,000:1		
West Virginia	500:1	1,000:1	

Network Breadth/Provider Participation Rate

"Network Breadth" refers to the number and range of provider types in a geographic area available for consumers to choose within a plan. CMS offers states the opportunity to participate in a pilot, measuring and displaying network breadth information for QHPs on the FFE.[45] This measure compares each network's number of contracted providers to the number of specific providers and facilities included across all QHP networks available in a county. The analysis uses QHP provider and facility data submitted during the plan year certification process. The Network Breadth pilot began in PY 2017 with four states – Maine, Ohio, Tennessee, and Texas.[46] Only Tennessee and Texas are slated as Network Breadth pilot states for PY 2024.[47]

Network breadth ratings focus on inclusion of hospitals, adult primary care, and pediatric primary care with a separate classification for each of the three categories. CMS calculates the percentage of providers in a plan's network compared to the total number of providers in QHP networks available in a county based on a time and distance calculation. To calculate network breadth, CMS divides the number of each QHP's servicing providers at the issuer, network, county, and specialty combination level by the total number of all available QHP servicing providers

for that county, including ECPs. The resulting number yields the Provider Participation Rate (PPR), classified as follows:

- Basic: Fewer than 30% of available providers
- Standard: 30% − 69% of available providers
- Broad: 70% or more of available providers.

Essential Community Providers (ECPs)

In addition to other network standards, QHPs are required to contract with a minimum number of ECPs in their service area.[48] These include community health clinics, Ryan White HIV/AIDS Program providers, and other specified providers that serve predominately low-income and medically underserved individuals. In 2017, FFE plans were required to contract with at least 30% of available ECPs, with the threshold then reduced to 20% of available ECPs beginning in 2018. For 2023, CMS requires QHPs to meet a threshold of 35% of available ECPs. The higher federal standards challenge issuers anew in expanding their contracting practices, describing barriers to attaining such contracts, and otherwise addressing the needs of vulnerable populations.

Other Standards

In 2023, CMS begin requiring QHPs to report data on whether network providers offer telehealth services, as CMS considers how telehealth availability might be incorporated into network adequacy standards.[49] QHP issuers must also conduct an annual QHP Enrollee Experience Survey and report the data to CMS.[50] The survey includes questions about timely access to care, patient/provider communication capacity, and patient ratings of their doctors and of the care provided. Results inform a star-rating system for QHPs, and aggregated results are posted publicly.[51]

B4. Other Federal and State Laws and Regulations

CMS is moving toward aligning network adequacy standards for QHPs with those it requires for Medicaid and Medicare managed care organizations (MCOs).[52,53] Federal rules have long required states to establish and enforce network adequacy standards for MCOs, while providing states flexibility to define those standards.[54] A state that contracts with an MCO to deliver Medicaid services must develop and enforce network adequacy standards, with federal expectations of states defined under 42 CFR § 438.68.[55] At a minimum, a state must develop quantitative network adequacy standards for the following provider types, if covered under the contract:

- Primary care, adult and pediatric
- OB/GYN
- Behavioral health (MH/SUD), adult and pediatric
- Specialist (as designated by the state), adult, and pediatric
- Hospital
- Pharmacy
- Pediatric dental

Further 42 CFR § 438.206 requires that state contracts with MCOs include specific standards for timely access.[56] Under 42 CFR § 438.207, state Medicaid programs must ensure that MCOs provide supporting documentation that demonstrates the capacity to serve the expected enrollment in its service area in accordance with the state's standards for access to care.[57] State's Medicaid MCOs use varying standards that include time and distance, provider-to-enrollee ratios, and appointment wait times.[58] Table 3 displays examples of network adequacy requirements included in the FY23 Wisconsin Medicaid managed care contract.[59]

Table 3. Network Adequacy Standards, Wisconsin Medicaid Managed Care Contract, State Fiscal Year 23

Specialty/Facility	Members-to-Provider Ratio		Appointment Wait Times	Distance/Drive Times	
	High Density* Counties	All Other Counties	All Counties	High Density* Counties	All Other Counties
Primary Care	100:1	No standard	30 days	20 miles/30 minutes	20 miles/60 minutes
OB/GYN	No standard	No standard	30 days 2 weeks for high risk prenatal	20 miles/30 minutes	30 miles/60 minutes
Behavioral Health/MHSUD	900:1(psychiatrist sand psychologists)	No standard	90 days psychiatric 30 days non-psychiatric	35 miles/60 minutes	35 miles/60 minutes
Hospital	No standard	No standard	No standard	20 miles/30 minutes	35 miles/60 minutes

*High density counties: Brown, Dane, Kenosha, Milwaukee, Racine, Ozaukee, Washington, Waukesha

B5. Accuracy of Provider Network Directories

Regulators may evaluate plans against quantitative network adequacy standards using network directory data, which often contain errors.[60] Plans offered on the FFE are required to include directory links showing providers' location, contact information, provider specialty, and whether they are accepting new patients. Issuers are required to update directories at least monthly. As part of its annual compliance review, CMS selects a small sample of issuers and reviews a machine-readable provider directory to verify accuracy. The most recent report found inaccuracies in all directories examined in 2020, with similar compliance problems observed in prior years.[61]

As of 2022, the federal No Surprises Act requires health insurance issuers, including QHP issuers, to maintain accurate provider directories and requires providers to regularly update issuers about any changes in their information.[62] Issuers must verify and update directories at least every 90 days and, on an ongoing basis, post any changes within two business days.[63]

B6. Measurement Challenges

Defining Geographic Service Areas

The application of time and distance standards, and the counting of available providers, requires the enumeration of the service population and the available providers within a geographic service area. However, the use of county boundaries as a unit of analysis may often not reflect an area's health care use patterns and needs. A measure of available providers in the county where individuals live have differing results. For non-metropolitan counties, this approach may underestimate certain residents' access to health care based on the likelihood of residents crossing county boundaries — particularly in non-metropolitan areas.[64] In metropolitan counties, the county-based provider count may overestimate access for county residents, and some portion of those county providers serve residents migrating in from other counties for services. In effect, some providers may appear in under- or over-supply in adjacent counties, although these providers are serving natural travel and health care service access patterns of residents.

Counting Providers

The measure of members-to-provider ratios cannot rely on a simple head count of contracted providers.[65] Many providers contract with and see patients from multiple products and health plans, might practice at multiple locations (that may be widely dispersed in rural areas), or might practice part-time. These factors will reduce the actual available provider capacity for a specific plan's enrolled members. For this reason, planning for provider demand and supply, and staffing need calculations, occurs in FTEs.[66,67] Federal methods for measuring HPSAs exclude the time that providers are not engaged in patient care activities, and require that provider counts be expressed as FTEs.[68] The State of California, in conducting its annual MediCal network certification, looks at National Provider Identifiers (NPIs) across all plans with which each provider is contracted, and allocates FTEs accordingly.[69]

III. Data and Methods

A. Data Sources

This analysis relies on two primary sources of data collected from issuers:

- 2023 Issuer Data Call: BerryDunn collected primary data, conducting an insurance issuer data call with OCI. The data call occurred in February-March 2023, requiring, and receiving responses from all 14 issuers that offer products in Wisconsin's individual health insurance market.[70] Data are reported for 23 separate products and reflect PY 2022 experience.
- CMS PY 2023 Rate Filing Data: OCI provided BerryDunn the network adequacy data that issuers of QHPs had reported to CMS in filing for QHP certification. CMS received rate filing data from 13 of Wisconsin's 14 individual market issuers, reflecting 21 QHPs offered through the Marketplace. One of the issuers in Wisconsin's individual market (WPS) does not offer plans on the ACA Marketplace and is not subject to CMS network adequacy oversight. Data reflect issuers' expectations as filed in 2022 in anticipation of PY 2023.

Literature and published reports also supplement these data sources, as cited throughout the report.

B. Data Constraints and Limitations

The data reported depend on the quality of information provided by the issuers in responding to the OCI data call. In some cases, the responses were incomplete or inconsistent, requiring multiple iterations, questions, and clarifications. The data also depend on the accuracy of information that issuers provide to CMS in their QHP rate filings. The data call and CMS rate filing templates provided specific instructions. However, it is possible that each issuer may have varied in their interpretations of instructions in ways that affected their reported counts. The data provided by the issuers were not subject to audit.

IV. Analysis

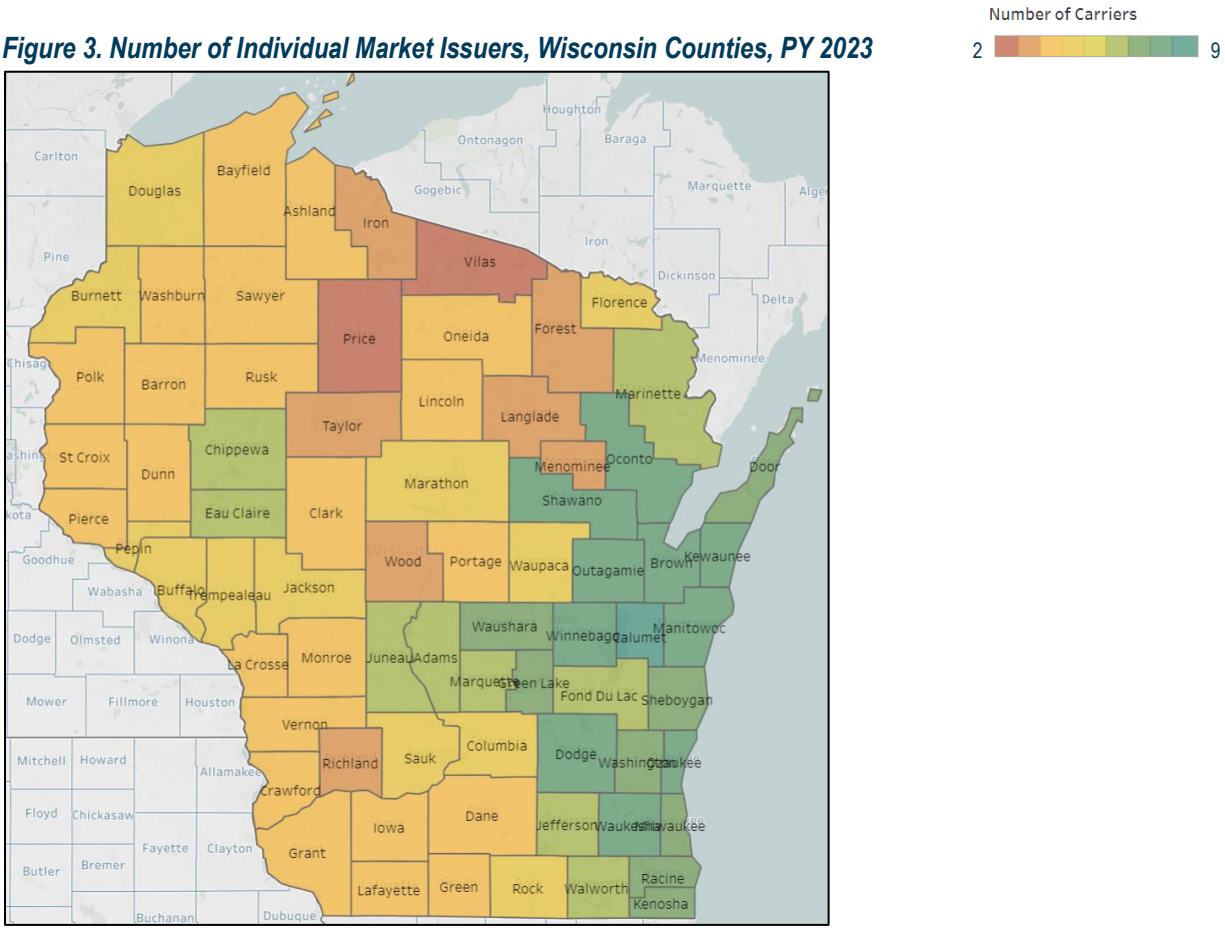
This section presents data for each of the following elements:

A. Issuer and Product Service Areas and Membership by County
B. QHP Networks: Monitoring and Reporting
C. Provider Networks at County/Region Level Across Products
D. Provider Networks Across Products
E. Providers Accepting New Patients, as Reported and Compared to Provider Directory
F. Access to High Priority Services and Specialties
   - Primary Health Care
   - Obstetrics/Prenatal and Labor and Delivery Services
   - Mental Health and Substance Use Disorder Services
G. Telehealth Services
H. Accessibility: Race, Ethnicity, Language, Disability (RELD) Data

A. Issuer and Plan Service Areas and Membership by County

The number of issuers offering individual market plans ranges from two to nine in each Wisconsin county for PY 2023.[71] (Figure 3) This report relies on PY 2022 issuer network adequacy data reported in early 2023, at which point 14 issuers offered 23 products with ACA compliant plans in the individual health insurance market.

Figure 3. Number of Individual Market Issuers, Wisconsin Counties, PY 2023

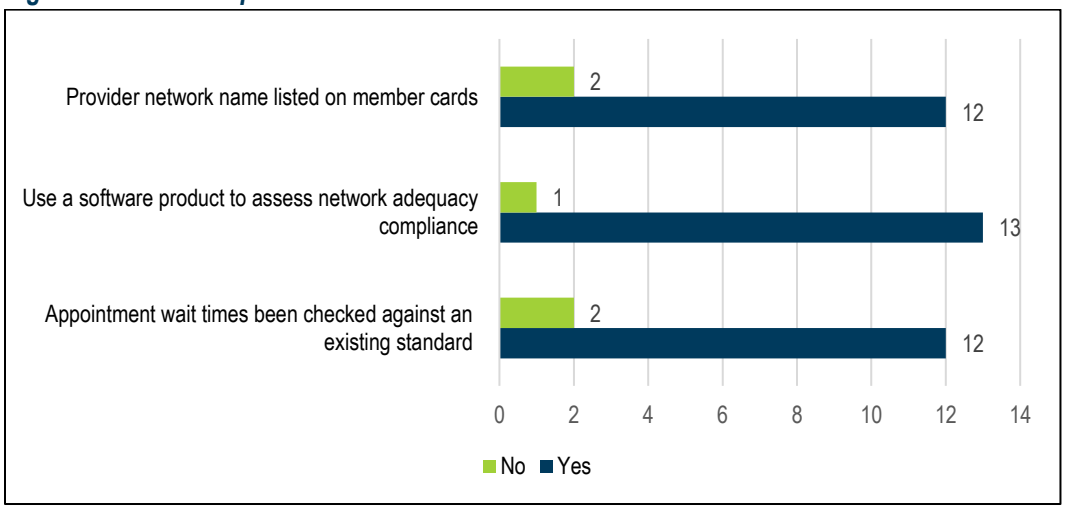


Several issuers offer multiple product options. Appendix A. Products: Reported Enrolled Membership by County, PY 2022 provides maps of each product with its reported enrollment by county for PY 2022. Each product has members concentrated in specific counties, with a few members in outlying counties. The counties with a few outlier members will affect measures of network adequacy if measured at the county level; this may not indicate insufficiency for network adequacy at the product level. For this reason, county-level assessment of network adequacy in this analysis often focuses on counties where products have a concentration of members.

B. QHP Networks: Monitoring and Reporting

Figure 4 displays issuers' practices of interest to OCI. Most reported listing the provider network on member cards, using a software product to assess network adequacy compliance, and checking wait times against an existing standard. Of those that reported using a software product, 10 use Quest Analytics, and three use GeoAccess.

Figure 4. Issuers' Reported Administrative Practices



Issuers identified several methods for evaluating compliance and vary in which services/provider specialties they measure. Reported methods include the following:

- Survey sent to in-network clinics with questions pertaining to all specialties.
- Primary care, behavioral health, OB/GYN: providers self-report their appointment wait times via quarterly provider roster review process.
- Annual survey sample of in-network providers; primary care providers, behavioral health providers, and high volume and high impact specialists.
- Annual survey to entire network requesting data on appointment access, based on NCQA guidelines. Questions address both routine, non-urgent, and urgent services for primary care and new patient, established patient, and urgent appointment access for specialty care.
- Statistical sample of primary care and behavioral health providers surveyed via telephone for NCQA analysis.
- Survey High-Impact Specialties of behavioral health and hematology/oncology providers and High-Volume Specialty of cardiovascular disease providers.
- Use Dial America to evaluate time and distance standards.
- Use Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Health Insurance and Oversight System (HIOS) data for member perspective data.

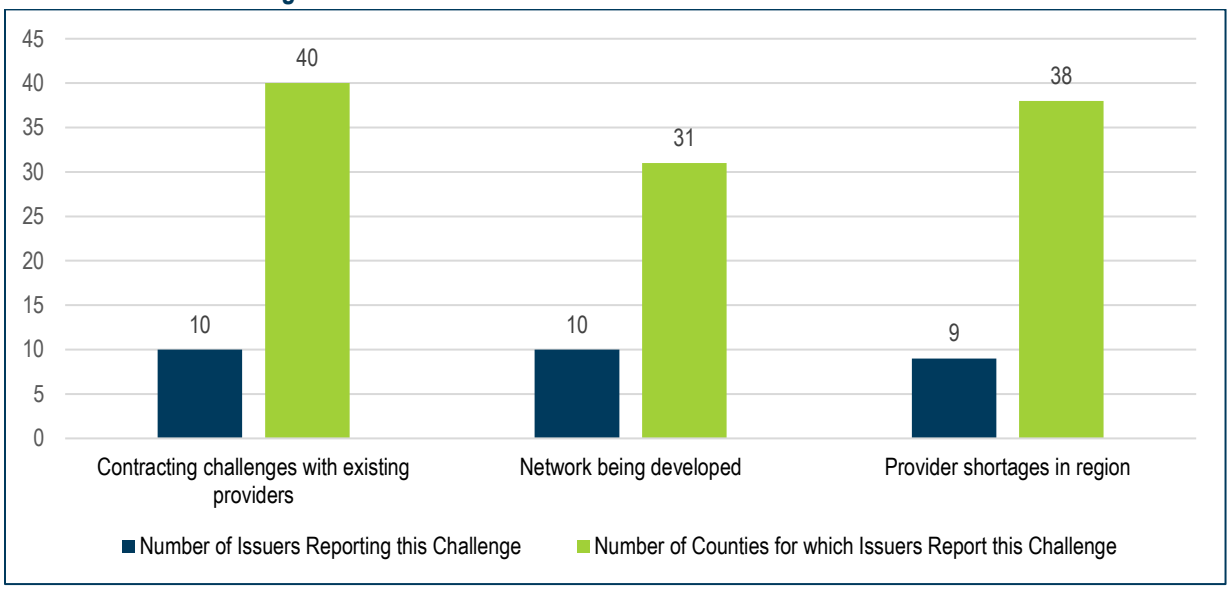
- Use measures from the CAHPS surveys covering access to primary care (both routine appointments and appointments for minor illness/injury) and access to specialty appointments. Compare Marketplace CAHPS survey results against historical data and local and national benchmark data to evaluate performance.

CMS requires QHP issuers to report data to indicate the degree to which their products' networks attain CMS access standards. Sections IVC and IVD of this report present the issuers' data specific to their QHPs, while this section provides context for viewing those data. CMS asks issuers to report from a range of preset reasons about why they are not meeting the CMS standard for access. These preset reasons include those identified in Table 4, which this report combines into three reason groups. Figure 5 displays the number of issuers reporting each reason, and the number of counties attributed to each reason: 10 Wisconsin issuers reported experiencing each reason in some counties where they enroll members. In total, the issuers identify these challenges for up to 40 of Wisconsin's 72 counties.

Table 4. CMS Access Shortfall Reason Codes and Reason Group Assigned for OCI Study

CMS Reason Options	Reason Group – Assigned for OCI Study
All providers/facilities of this specialty type within the time and distance standards of this county contract exclusively with another organization.	Contracting challenges with existing providers
Good faith contract offer(s) for upcoming plan year rejected by provider.	
The issuer's provider network is under development	Network being developed
Insufficient number of providers/facilities of this specialty type are currently practicing within the time and distance standards of this county.	Provider shortages in region
No providers of this specialty type are currently practicing within the time and distance standards of this county.	

Figure 5. Primary Reason Category for CMS Unmet Standard by Number of Issuers Reporting and Number of Counties Where Challenge Identified



Specific comments made by issuers in their CMS QHP filings, pertaining to provider network limits and provider or health system negotiation and pricing challenges, include the following:

- *Some provider systems have been unresponsive to our requests to negotiate with us.*
- *There have been certain provider groups that we cannot contract with due to exclusivity arrangements or the fact that they may be [owned by an integrated system that owns its own health plan] which can pose challenges.*
- *The primary issues exist in counties where one clinic/hospital system predominates the available providers in the regional area.*
- *Certain rural systems, needed for adequate networks in several Wisconsin counties, have asserted their market power through negotiation or through a lack of willingness to negotiate.*

Additionally, Wisconsin issuers' QHPs may more frequently fall short on achieving the CMS standard for pediatric and OB/GYN services due to the CMS definition, which requires the presence of pediatricians and obstetricians-gynecologists. Family physicians and general practitioners — along with physician assistants and licensed nurse practitioners — often provide care for many rural children, whereas pediatricians are predominantly concentrated in metropolitan areas.[72,73,74] Rural family physicians are more likely than urban family physicians to provide obstetrical deliveries, newborn care, and pediatric care.[75] Similarly in Wisconsin, many non-metropolitan counties rely on family practice physicians to provide pediatric and prenatal services. Members will travel farther distances for more specialized care, when needed. Section IV,E, below, discusses these matters in further detail as they affect primary care and obstetrics services.

C. Provider Networks at County/Region Level Across Products

C1. Attainment of CMS Access Standards

CMS access standards require that 90% of QHPs' enrolled members have access to specific services in the counties in which the members reside. Issuers of QHPs self-report to CMS regarding the degree to which their networks attain these access standards. Table 5 displays the number of counties where the rates of access do not meet the CMS 90% standard when averaging the access rates of issuers with members in those counties.

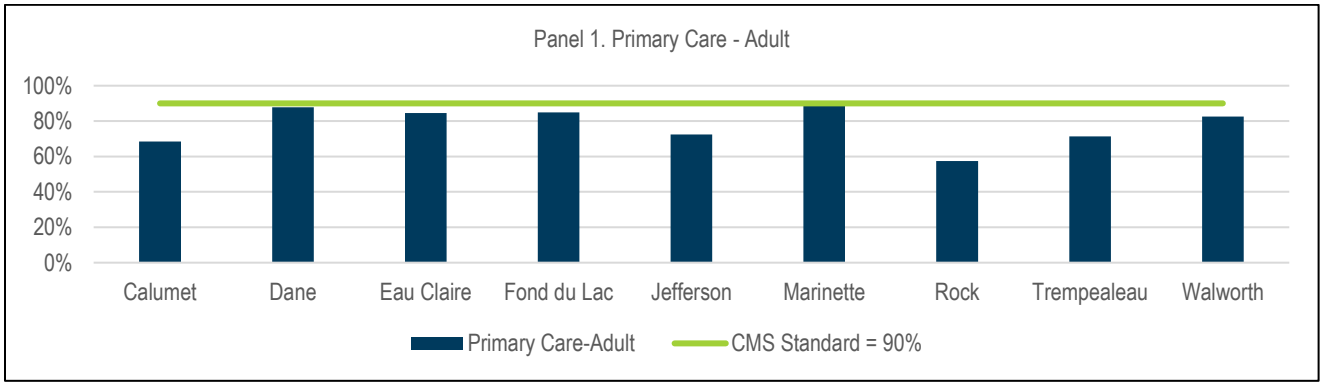
Table 5. Number of Counties Where Issuers' Average Do Not Meet CMS Standard

Specialty	Number (%) of Counties
Adult primary care	9 (13%)
Pediatric primary care	52 (73%)
OB/GYN	34 (47%)
Clinical behavioral health services	20 (28%)

Note that nearly three-quarters of Wisconsin counties fall short of the CMS access standard for pediatric primary care. This reflects CMS strict criterial for inclusion of providers that qualify for counting toward meeting that access standard. Similarly, about half of Wisconisn counties fail to meet the CMS access standard for OB-GYN services.

Figure 6, panels 1 through 4, display the counties where QHP access rates reported by issuers average below 90%, for adult and pediatric primary care, OB/GYN, and outpatient behavioral health service providers. Fewer counties fall short in Primary Care – Adult. More counties showing shortfalls in other specialties may reflect, in part, CMS exclusion of family practice and other providers in the count for Primary Care – Pediatrics and for OB/GYN.

Some counties stand out with consistent shortfalls across specialties. Five counties — Calumet, Eau Claire, Fond du Lac, Jefferson, Rock — show access shortfalls across the four specialties measured, with Calumet and Rock showing the most substantial shortfalls. Many of the other counties may show access shortfalls in pediatric primary care or OB/GYN — again, likely due to CMS provider inclusion criteria — but show better access in adult primary care and outpatient behavioral health. Figure 6. Counties below 90% Average Access Across QHPs, by Specialty



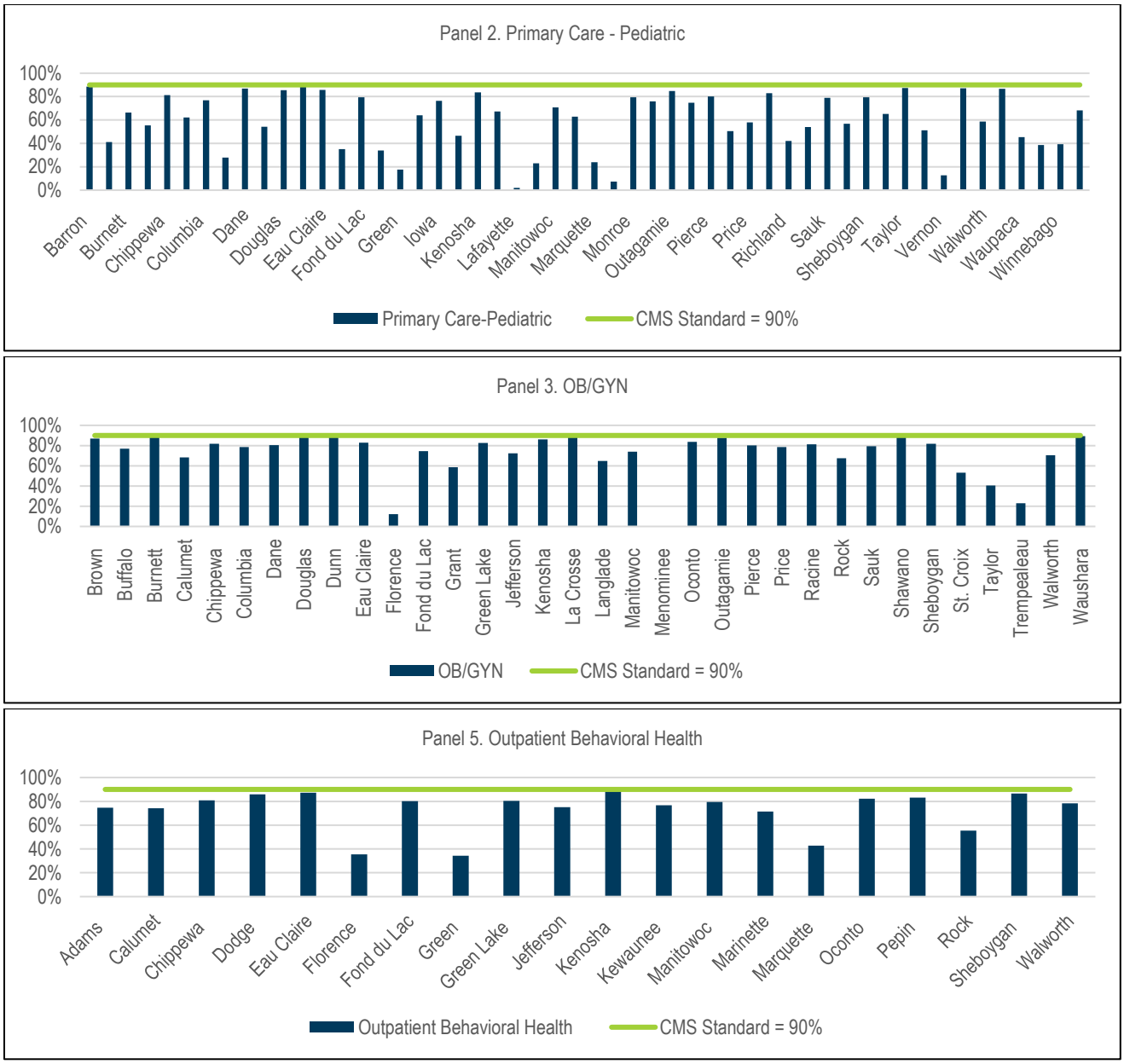


Figure 7 displays the counties that show shortfalls for both adult primary care and outpatient behavioral health.

Section IV.F reviews access to these specialties and issuers' submitted data in more detail. Figure 8 displays the average of reported QHP access by county type, metropolitan, micropolitan, rural, and Counties with Extreme Access Considerations (CEACs).[vi] This shows that, on average, the QHPs are not meeting the CMS standards for the four specialty types reviewed regardless of county type. For rural counties, access appears substantially lower for pediatric primary care and OB/GYN; this may reflect rural areas' more frequent use of family practice physicians for these services – again noting CMS exclusion of family practice physicians toward meeting these access standards.

[vi] CMS defines Counties with Extreme Access Considerations (CEAC) "for any population size with a population density of less than 10 persons per square mile." 42 CFR 422.116. https://www.ecfr.gov/current/title-42/section-422.116. Only Florence County is designated a CEAC in Wisconsin.

Figure 6. Counties below 90% Average Access Across QHPs, by Specialty

Figure 7. Counties below 90% Average Access Across QHPs for both Adult Primary Care and Outpatient Behavioral Health Services

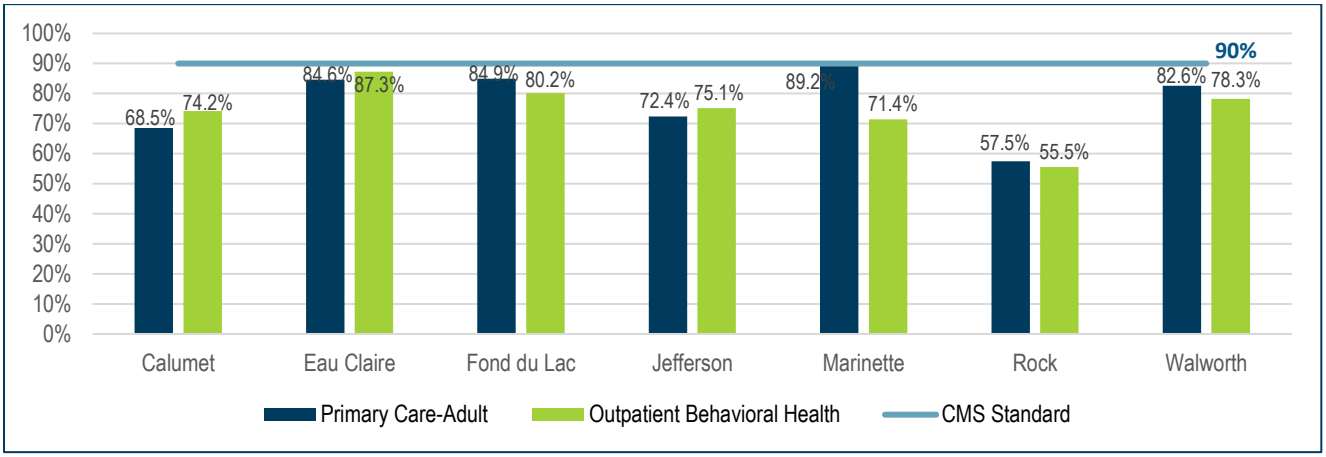
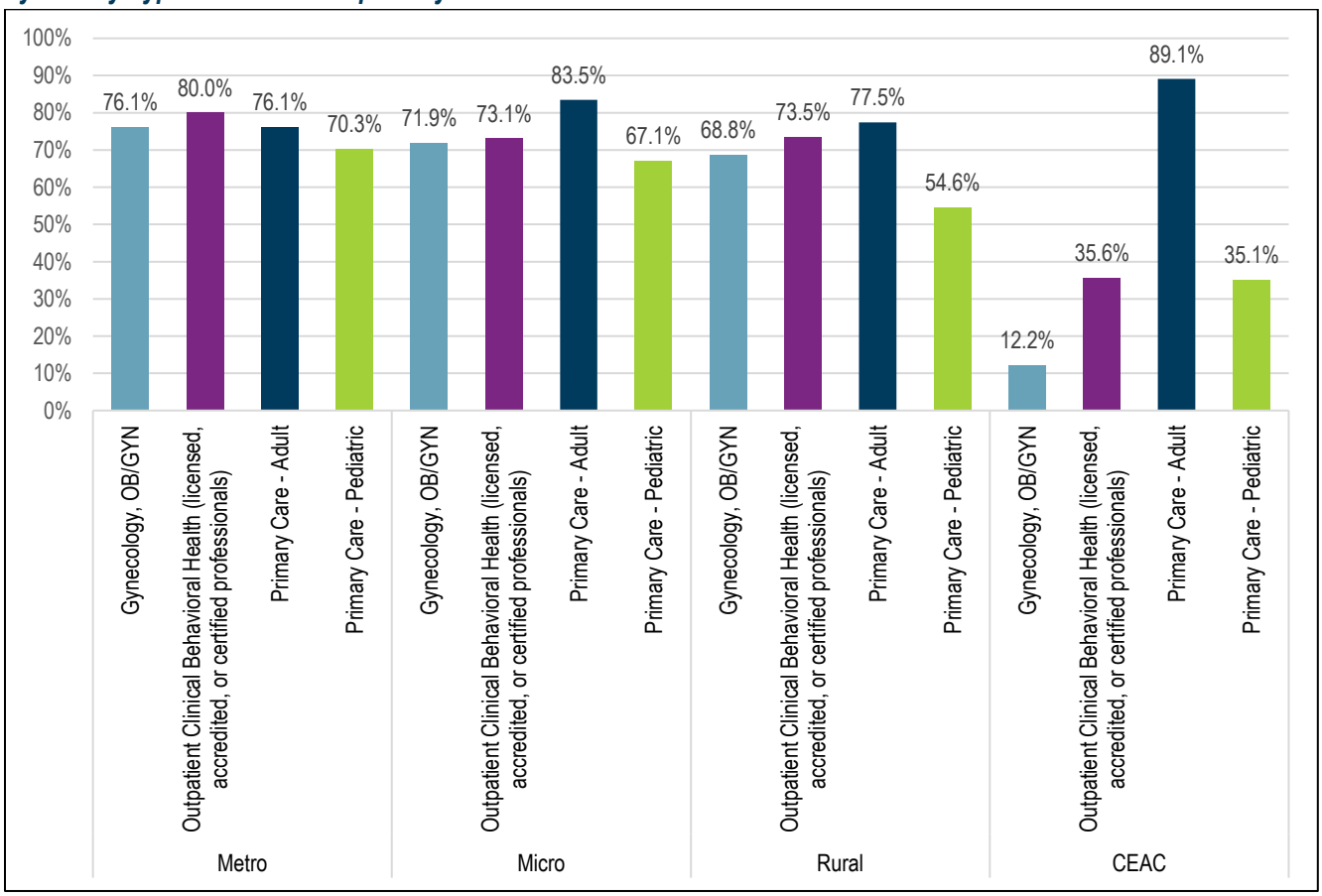


*Figure 8. Average of Actual Percentage with Access (90% Required to Pass CMS Standard) by County Type and Provider Specialty**



*Florence County is the only Wisconsin CEAC

C2. Members-to-Provider Ratios

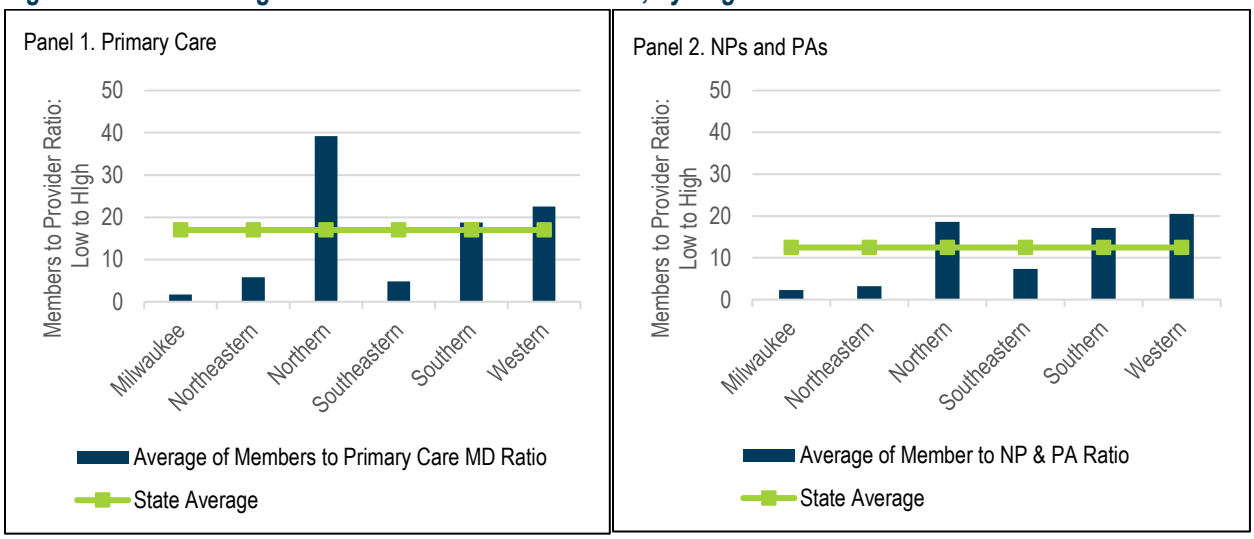
The 2021 GAO report indicated that 15 states set guidelines for the maximum number of members per provider, with wide variation in acceptable ranges. As noted, the members-to-provider ratio provides a measure of provider availability to a product's enrolled population. Providers often contract with multiple issuers, may work in multiple geographies, and may work part-time; a meaningful measure of provider availability requires a calculation based on the full-time-equivalence rather than a simple head count of contracted providers.

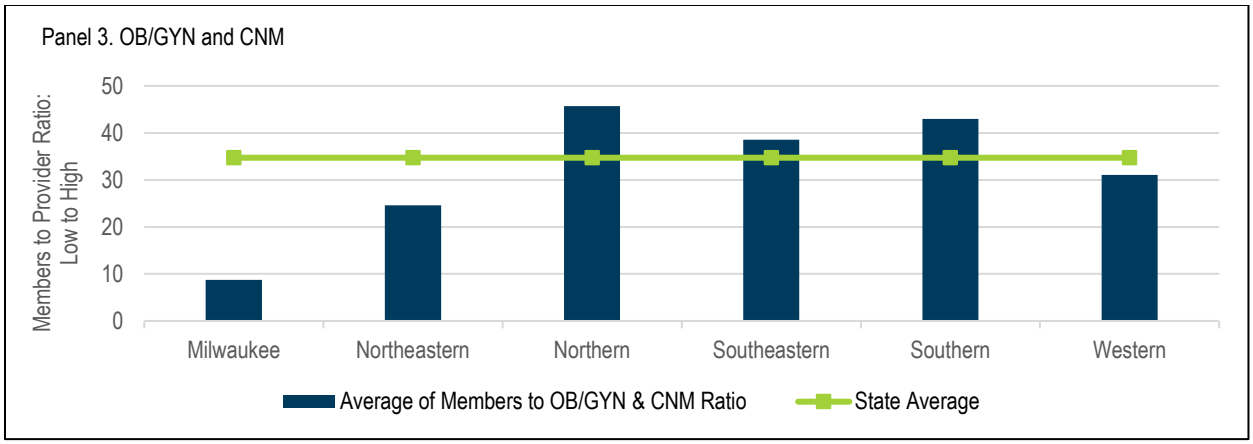
With that caveat, this report presents comparison among regions of the average ratios of members to providers within regions, based on the number of contracted providers reported by each product issuer relative to the number of enrolled members in those regions. Although these figures do not represent the level of available providers for the population, the number of contracted providers relative to the enrolled population does provide a view of the relative breadth of the products' networks. For this reason, the data presented (in Figure 9) support comparison among regions but do not display the absolute numbers (on the y-axis).

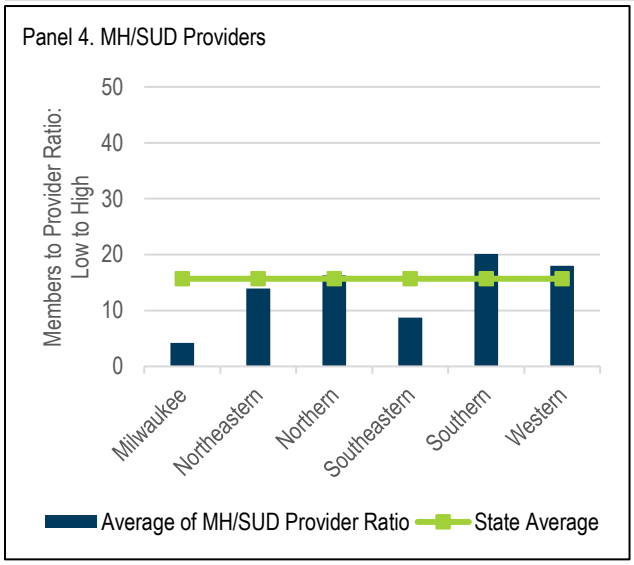
In this measure, regions with a lower members-to-provider ratio may have better access, indicating more providers are contracted in the network to provide care for the enrolled population. Regions with a high members-to-provider ratio would indicate fewer providers are contracted to provide care for the enrolled population.

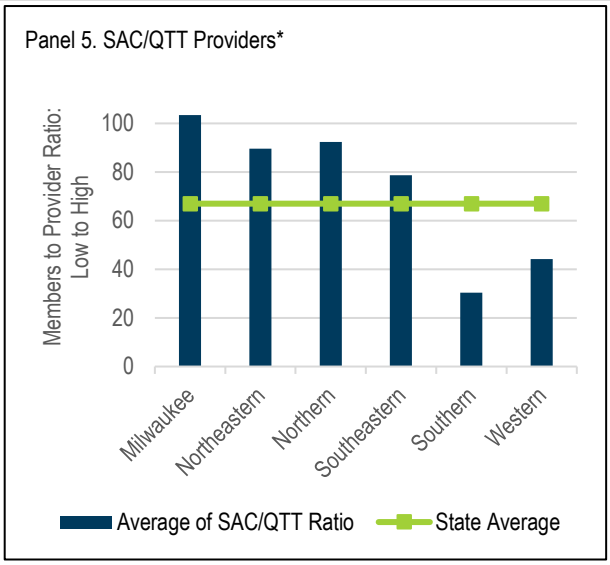
At the region level, the northern region stands apart for its high members-to-provider ratio across all provider types.

Figure 9. Plans' Average of Members-to-Provider Ratios, by Region









*SAC refers to Substance Abuse Counselor and QTT refers to Qualified Treatment Trainee

D. Provider Networks Across Products

D1. Attainment of CMS Access Standards

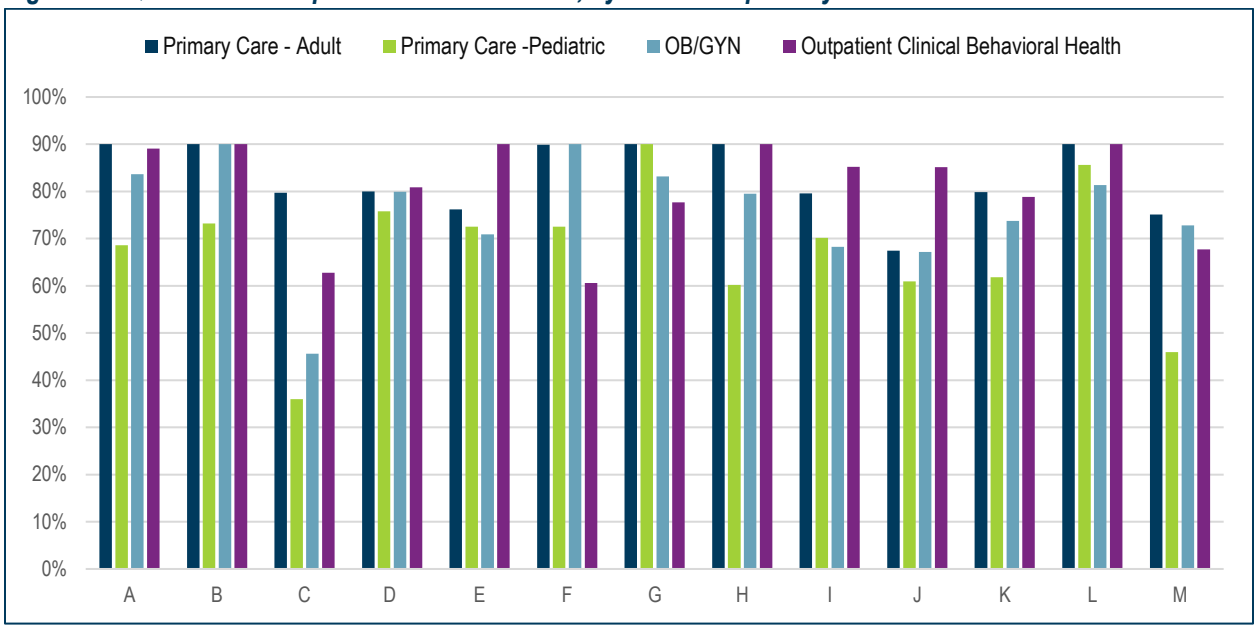
CMS access standards require that QHP issuers demonstrate that 90% of QHP enrolled members have access to specific services. Issuers self-report to CMS regarding the degree to which their networks attain these access standards. Table 6 displays the number of issuers that *do not* meet the CMS 90% standard.

Table 6. Number of QHP Issuers Not Meeting CMS Standard

Specialty	Number of QHP Issuers Out of 13
Adult primary care	8
Pediatric primary care	12
OB/GYN	11
Clinical behavioral health services	9

Most QHP issuers come close to meeting the CMS standard, although some show consistent and larger shortfalls across specialties. (Figure 10)

Figure 10. QHP Issuers' Reported Member Access, by Provider Specialty



D2. Members-to-Provider Ratios

As noted above, states that set guidelines for the maximum number of members per provider have wide variation in acceptable ranges. As noted, providers often contract with multiple health issuers, may work in multiple geographies, and may work part-time; a meaningful measure of provider availability requires a calculation based on the full-time-equivalence rather than on simple head count of contracted providers.

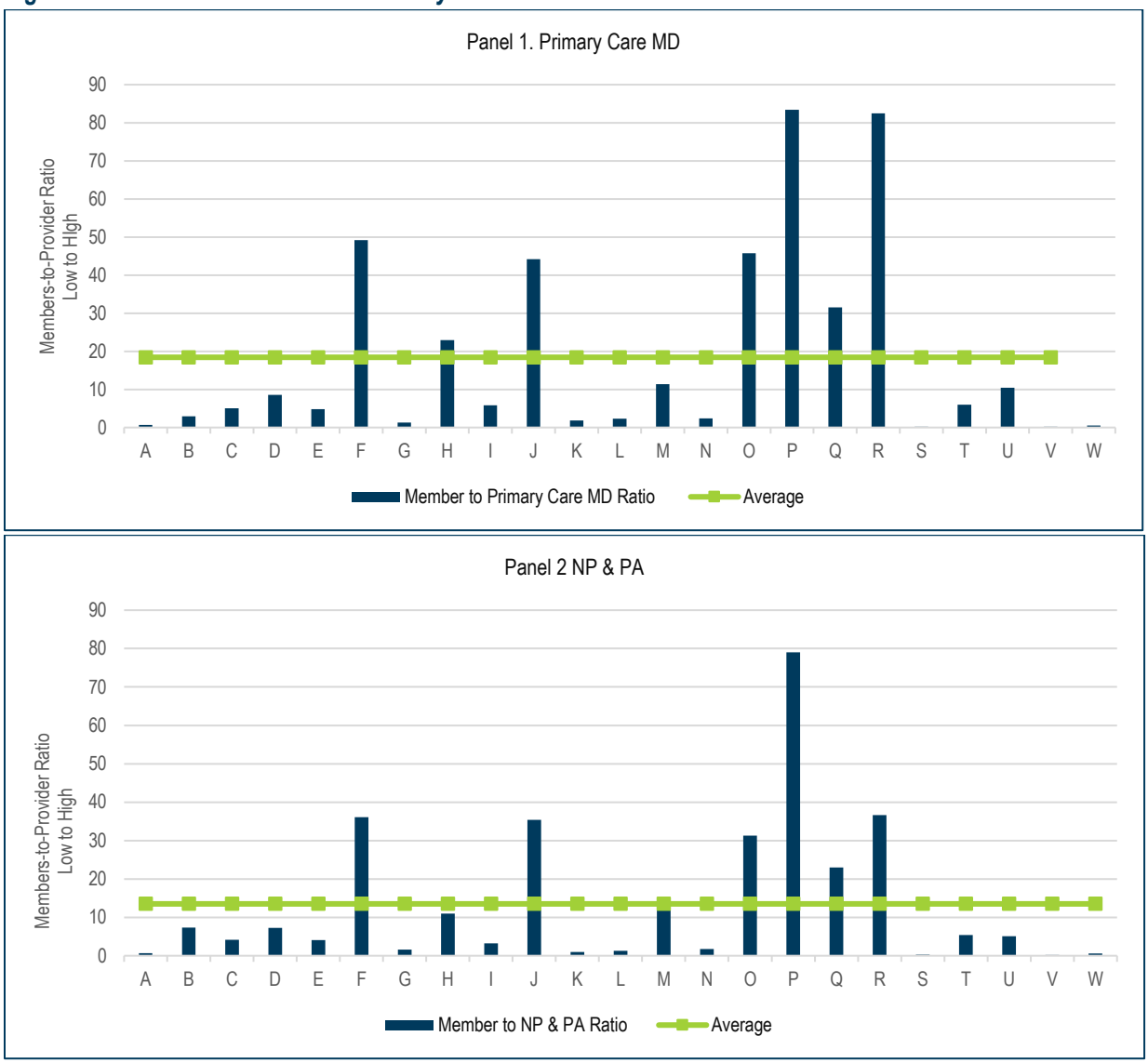
With that caveat, this report presents the members-to-provider ratios, based on the number of contracted providers for each product reported by each issuer. Although these figures do not represent the level of available providers for the population, the number of contracted providers relative to the enrolled population does provide a view of the relative breadth of the products' networks.

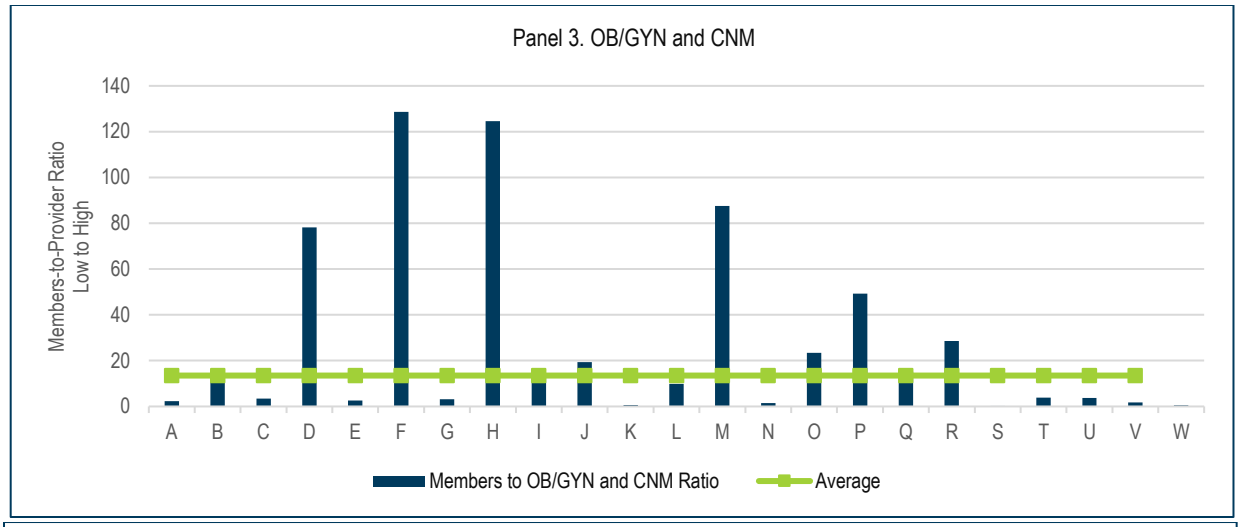
In this measure, a lower number of members per provider is better, indicating more providers are contracted in the network to provide care for the enrolled population. A high members-to-provider ratio would indicate fewer providers are contracted to provide care for the enrolled population.

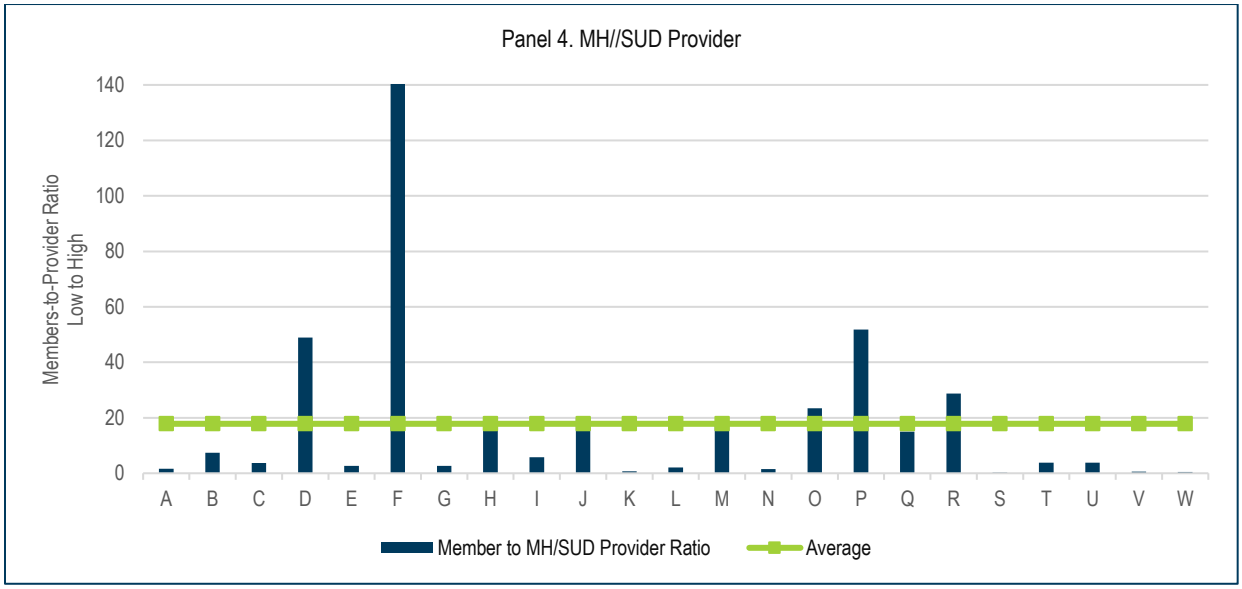
Figure 11 shows that five products – labeled F, J, O, P, and R – generally show highest members-to-provider ratios for primary care providers. Five products — labeled D, F, H, M, and P — exhibit narrow networks with large members-to-provider ratios for OB/GYN providers. For MH/SUD providers, product labeled F stands out for its very high members-to-provider ratio relative to other issuers, likely indicating significant access restrictions. Most other products show similar ratios, although others show ratios above the statewide average. Products labeled D, F, and M also show very limited use of SAC/QTT providers relative to their plans' enrolled membership. Issuer of product labeled F reports no use of SAC/QTT providers.

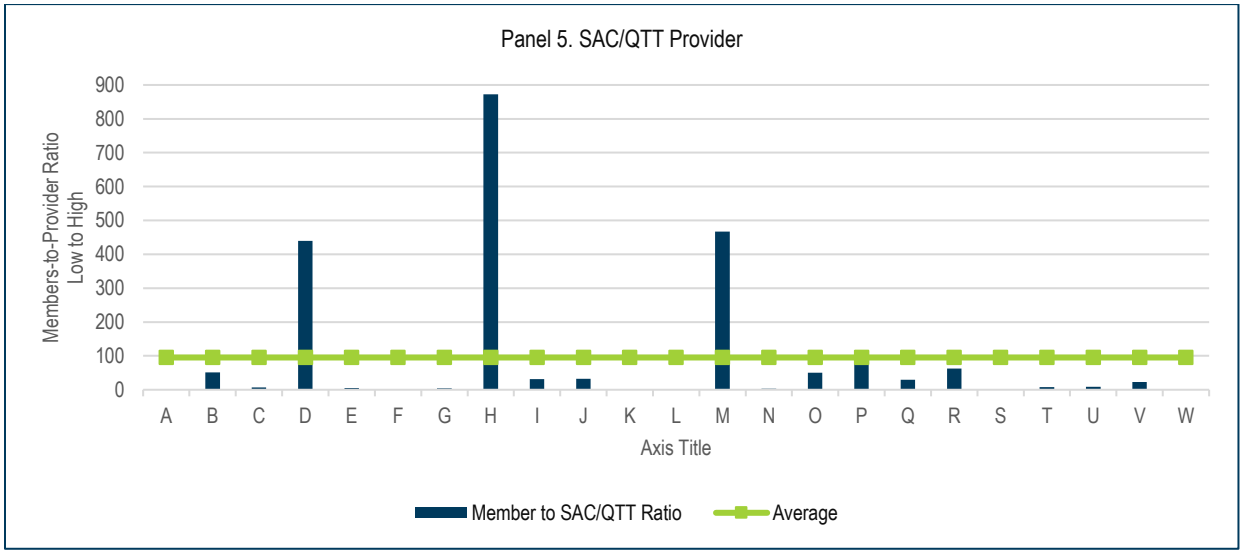
Here again, as noted in Section C2, these figures allow comparison among products for their relative members-to-providers ratios, reflecting the number of providers the issuers have contracted within their networks relative to their enrolled membership. A low members-to-provider ratio suggests better access. But the absolute numbers reported in the ratio here are not based on FTE counts and so do not reflect the true level of access internally within products.

Figure 11. Members-to-Provider Ratios by Product









Note: Product labeled F is the only one with the issuer reporting no use of either SACs or QTTs.

D3. Access to Essential Community Providers

CMS network standards require that QHP issuers contract with a minimum number of available ECPs in their service area.[76] CMS requires QHP issuers to offer a contract in good faith to at least one ECP in each of the eight ECP categories, where available, in each county in the plan's service area. ECP categories include FQHCs, Ryan White HIV/AIDS Program Providers, Family Planning Providers, Indian Health Care Providers, Inpatient Hospitals, Mental Health Facilities, Substance Use Disorder Treatment Centers, and Other ECP Providers. The Other ECP category includes Rural Health and Rural Emergency Hospitals.[77]

A complete review of products' and plans' inclusion of ECPs is outside the scope of this current network adequacy study. However, the 2023 issuer data call did ask issuers to select from a limited list of Wisconsin FQHCs where their products have existing contracts. This exercise provides an initial view of the extent to which issuers engage with ECPs in the areas where products have members enrolled.

Most issuers reported product offerings with FQHCs, (Figure 12) while three out of 23 products had no contracts with FQHCs in counties where the products have enrolled members. Issuers that show no FQHC contracts for products in counties where the products have members (blue bar in Figure 13 is at zero) may merit particular attention. Even though a few of those products (labeled M, V, and W) reported contracting with FQHCs (Figure 12), those contracted FQHCs the product issuers identified are outside of the counties where the issuers' products have enrolled members.

Figure 12. Issuer Reported Contracts Reported from Listed FQHCs by Product

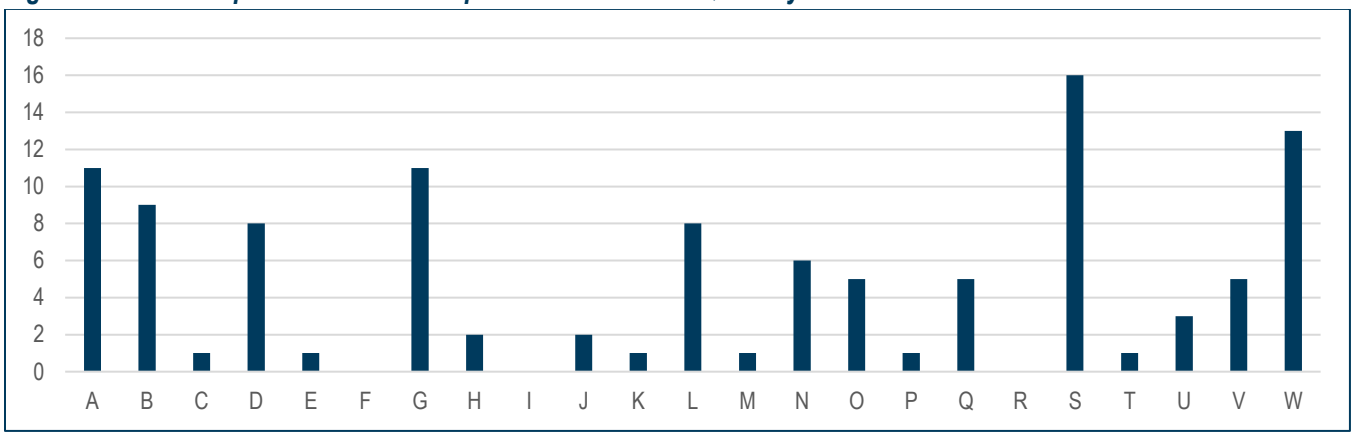
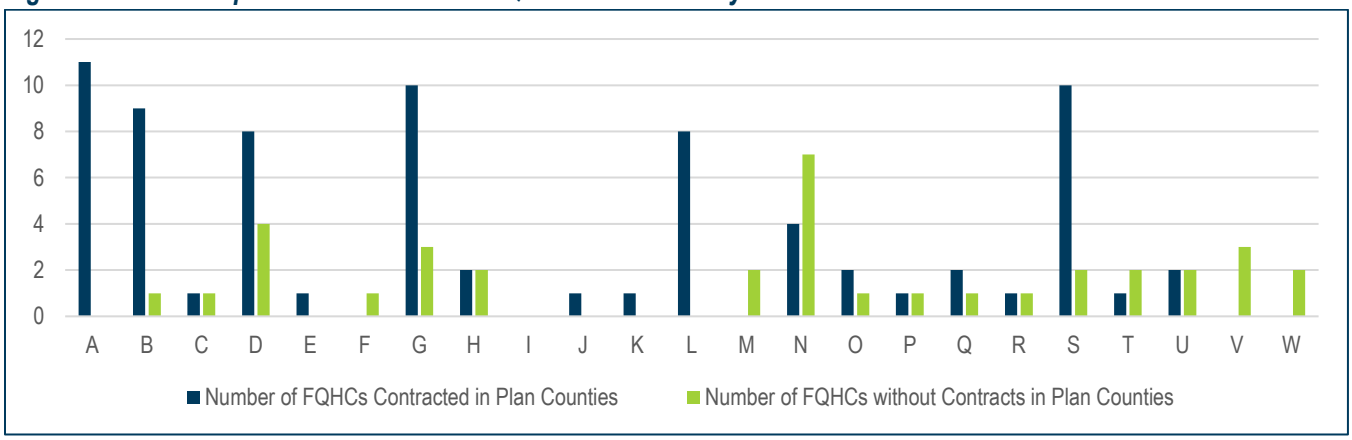


Figure 13. Issuer Reported Contracts with FQHCs in Counties by Product



E. Providers Accepting New Patients, as Reported and Compared to Provider Directory

Section II.B explains that regulators evaluate plans against quantitative network adequacy standards using network directory data, which may often contain errors.[78] This report's analysis used issuers' self-reported data to assess the number of providers accepting new patients, and how this compares to the provider directory.

The analysis involved the following measures:

- Number of providers in each specialty
- Number of providers reported in the provider directory as accepting new patients
- Number of new patient claims for providers designated as accepting new patients

A few issuers reported some new patient claims attached to providers who were accepting new patients but had not been listed in their provider directories as accepting new patients. This report's analysis includes these additional providers in the "accepting new patients" provider group, to avoid overstating the number of new patient claims attached to providers designated as accepting new patients. From this, we derived the rate of new patient claims per provider. Providers designated as accepting new patients would, as a group, be expected to show claims for new patients, and would therefore show a non-zero rate of claims per provider.

Table 7 displays the results for new patient claims per provider and highlights products with a new claims rate at or near zero for three or more provider types. These results are not conclusive but may indicate occurrences where (1) new plan members have challenges accessing providers; (2) these products have a stable enrolled population with relatively few new enrollees needing services; or (3) providers who are designated as accepting new patients may not actually be available.

This information — assessing the degree to which providers named in a product network are actually available — may be validated using claims data, rather than relying on issuers' self-reported data. For example, the New Hampshire Insurance Department (NHID) analyzes claims from the state's all-payer claims database (APCD) for validating provider service delivery. NHID determines the number of all available providers in a county and the share of available providers in each plan's network, measuring provider availability for core specialties, such as adult primary care providers.[79] NHID then compares this provider list to directory data, to correct directory errors. Marketplace consumers can compare QHP hospital networks on the NHID site[80] and hospital networks in state-regulated health plans.[81]

Table 7. Number of New Patient Claims per Provider, by Product, PY 2022

Gray - near or at zero for three or more provider types

Issuer Product	Family Practice/General Practice Physicians	General Internal Medicine Physician	Pediatrician	Nurse Practitioner	Physician Assistant	OB/GYN Physician	Nurse Midwife	Psychiatrist	Psychologist (PhD)
A	0.45	0.22	0.12	0.09	0.10	0.19	0.04	0.17	0.10
B	0.78	0.39	0.28	0.00	12.45	0.95	0.00	0.48	0.42
C	1.08	0.49	0.22	0.60	0.88	1.13	0.13	0.23	0.15
D	2.02	1.37	0.34	0.77	1.47	3.96	*	3.05	2.23
E	0.31	1.67	0.08	0.16	0.15	0.47	0.00	0.25	0.00
F	**	**	**	**	**	**	**	**	**
G	0.19	0.10	0.05	0.13	0.14	0.23	0.07	0.18	0.21
H	1.06	0.43	0.56	1.12	1.73	1.43	1.00	0.74	1.02
I	0.18	1.80	0.00	0.19	0.12	0.09	0.50	0.13	0.00
J	3.41	8.18	1.25	1.52	1.40	2.67	1.64	0.48	0.40
K	0.47	0.53	0.01	0.16	0.07	0.14	0.00	0.01	0.02
L	0.87	0.30	0.13	0.15	0.25	0.41	0.05	0.24	0.10
M	1.46	3.07	1.50	0.44	0.46	2.24	1.08	0.12	0.06
N	*	*	0.09	0.16	0.27	*	0.17	0.71	0.31
O	2.08	4.64	1.27	1.43	1.45	1.67	0.25	0.25	4.07
P	6.91	1.02	0.58	1.32	1.72	0.90	0.50	0.84	0.17
Q	1.94	2.11	0.34	1.17	1.41	2.46	0.68	0.71	0.58
R	2.87	3.27	0.69	2.20	3.15	2.15	0.00	0.70	2.56
S	0.03	0.01	0.00	0.00	0.00	0.02	0.00	0.00	0.00
T	0.42	0.74	0.07	0.19	0.17	0.17	0.00	0.27	0.08
U	0.96	0.98	0.39	0.74	0.42	0.59	0.07	0.16	0.14
V	0.04	0.04	0.00	0.02	0.03	0.04	0.02	0.01	0.01
W	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Across all Plans	**0.75**	**0.50**	**0.12**	**0.26**	**0.37**	**0.66**	**0.14**	**0.37**	**0.27**

* Claims for patient visits reported, but product issuer reported no providers in provider directory designated as accepting new patients

** Excluded due to anomalies in reported data

F. Access to High Priority Services and Specialists

F1. Primary Health Care

Primary care physicians generally include physicians who practice under the specialties of family medicine, general internal medicine, general pediatrics,[82,83] and may also include OB/GYN.[84] The shortage of supply of these provider types has been well documented.[85] Wisconsin has federally designated primary care HPSAs in counties statewide.[86,87] Federal regulations define primary care HPSA designation with a population-to-provider ratio of at least 3,500-to-1 or, for areas with unusually high needs, 3,000-to-1.[88] One estimate reported that Wisconsin would need an additional 150 physicians to remove existing shortage designations,[89] while the Wisconsin Council of Medical Education and Workforce reported a 2020 deficit of 100 primary care physicians.[90] Physician count, however, will underrepresent primary care access, as both rural and non-rural areas increasingly rely on nurse practitioners and physician assistants to provide primary care.[91,92,93]

As noted, the issuers' product data reported to CMS do indicate shortfalls in meeting the CMS access standards for both adult and pediatric primary care services, with eight issuers falling below the standard for adult primary care, and 12 issuers falling below for pediatric primary care. (Figure 14)

Figure 14. Issuers' Reported Access Relative to CMS Access Standard, Primary Care

Issuer Data Call Responses

The issuers' responses to the 2023 data call yield a different reported view of primary care network adequacy. Despite CMS access shortfalls, and Wisconsin's reported widespread primary care provider shortages, all 14 issuers reported "no known access issues" due to provider capacity deficiencies. Issuers frequently commented "no member complaints/appeals received." However, one issuer commented that "wait time for appointment access is beyond 30 days for the majority of primary care providers nationally." Another issuer noted: "The health care industry has experienced a growing provider shortage and our contracted health systems are not immune to that. We are experiencing increased difficulty making sure our members continue to have access to an adequate number of primary care providers due to availability."

Focusing specifically on pediatric primary care services, most issuers also report no known access issues. One issuer noted again a more than 30-day wait time for appointment access for most pediatric providers across the nation. In addition, two issuers asserted problems with the CMS method for measurement of pediatric care access:

- CMS does not allow family practice physicians to count toward meeting network adequacy for Primary Care - Pediatrics, although CMS does allow family practice physicians to count toward meeting Primary Care - Adult network adequacy. Similarly, CMS also does not allow count of physician assistants or primary care nurse practitioners in assessing network adequacy for Primary Care – Pediatrics, but these providers do count toward meeting network adequacy for Primary Care – Adult.
- Pediatric specialists are limited in a predominantly rural service area. Practices are often staffed with family medicine specialists to see patients of all ages.

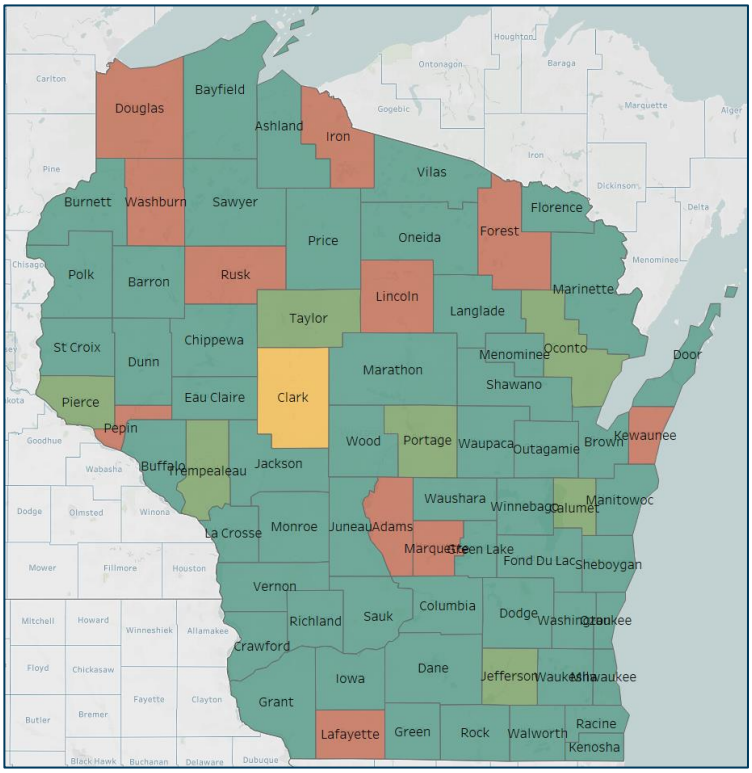
Section IV.C, above, addresses these measurement concerns in more detail.

F2. Obstetrics/Prenatal and Labor and Delivery Services

Areas with limited access to prenatal care and labor and delivery services may be referred to as a "maternity care desert."[94] The March of Dimes defines this as any county in the United States without a hospital or birth center offering obstetric care and without an obstetrician, family physician who delivers babies, or a CNM/CM.[95] Figure 15 displays Wisconsin county access ratings for 2023 by the March of Dimes, showing relatively strong access to services in the state, with a few areas of weakness. Details include the following:

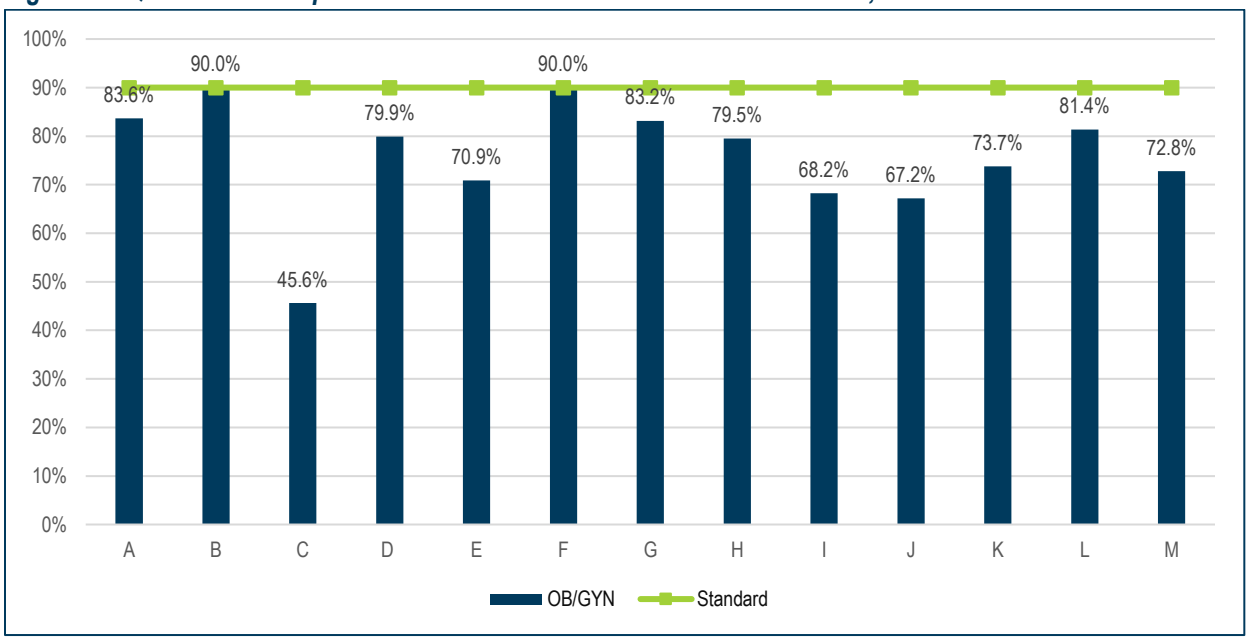
- Eleven Wisconsin counties (15.3%) are considered maternity care deserts, compared to 32.6% of U.S. counties.
- On average, women in Wisconsin travel 7.1 miles to the nearest birthing hospital.
- Only 3.1% of women in Wisconsin had no birthing hospital within 30 minutes, compared to 9.7% in the U.S.
- In rural areas across Wisconsin, 31.6% of women live farther than 30 minutes from a birthing hospital compared to 2.1% of women living in urban areas.
- Women living in counties with the highest travel times could travel up to 31.4 miles and 38.5 minutes, on average, to reach their nearest birthing hospital.
- Under normal traffic conditions, there are no women who live farther than 60 minutes from their nearest birthing hospital.
- Wisconsin had a 2.2% decrease in the number of birthing hospitals between 2020 and 2019.

Figure 15. Wisconsin Maternity Care Access, by County, as Ranked by March of Dimes, 2023



Constraints in available facilities and workforce may challenge issuers in assuring access to obstetric services for their members. As noted, the issuers' data reported to CMS do indicate shortfalls in meeting the CMS access standards for OB/GYN services, with 11 QHP issuers falling below the standard. (Figure 16)

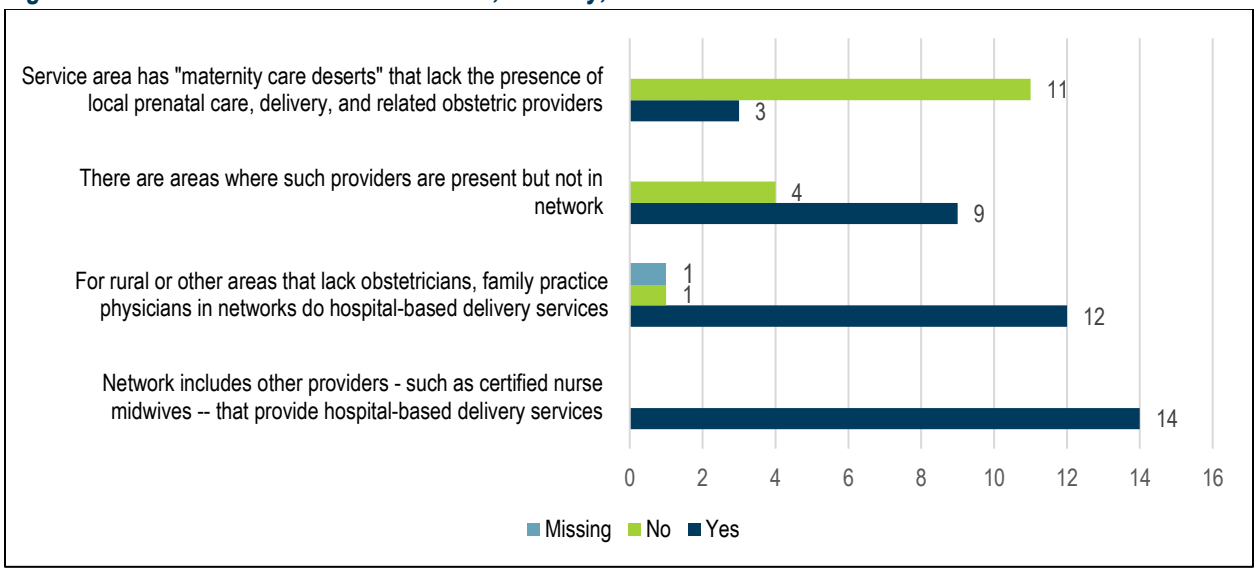
Figure 16. QHP Issuers' Reported Access Relative to CMS Access Standard, OB/GYN



Issuer Data Call Responses

The issuers' responses to the 2023 data call yield a more nuanced view of obstetrics services network adequacy. Many issuers (11 out of 14) report their service area does not have "maternity care deserts," and 12 out of 14 issuers also reported that family practice physicians provide hospital-based delivery services for rural and other areas that lack obstetricians. (Figure 17)

Figure 17. Presence of Local Prenatal Care, Delivery, and Related Obstetric Providers

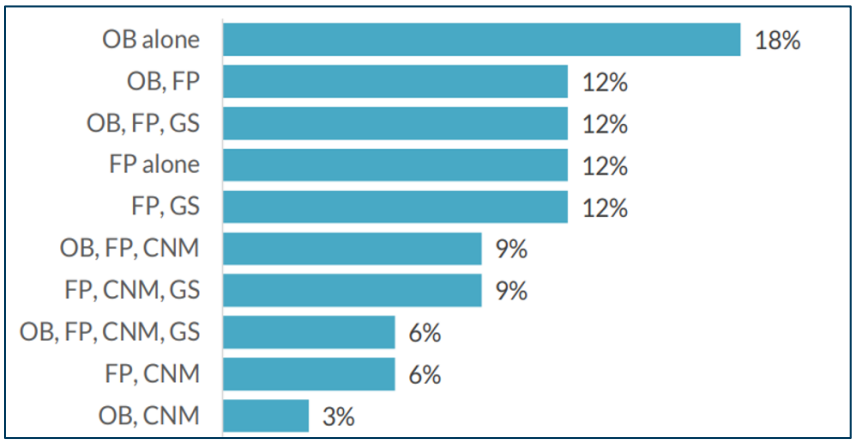


These findings echo those from the Wisconsin Office of Rural Health in its 2019 Survey of Rural Hospitals, which reports the following:[96]

- 99% of women of child-bearing age live within a 30-minute drive of a hospital that provides obstetric delivery services.
- 70% of rural hospitals that deliver babies use more than one type of provider to provide obstetric care. The most frequent combinations are obstetricians working with family physicians, obstetricians working with family physicians and general surgeons, and family physicians with general surgeons.
- Family physicians attend deliveries in 79% of hospitals (12% alone and 67% in combination with other providers).
- Obstetricians/gynecologists attend deliveries in 60% of hospitals (18% alone and 42% in combination with other providers).
- General surgeons attend deliveries in 39% of hospitals.
- CNMs attend deliveries in 33% of hospitals.

Rural hospitals reported that only 18% of deliveries occurring in their hospitals rely on an obstetrician alone, although an obstetrician may be involved in about half of deliveries, along with other providers. Most deliveries (88%) involve a family practice physician and/or a certified nurse midwife. (Figure 18)

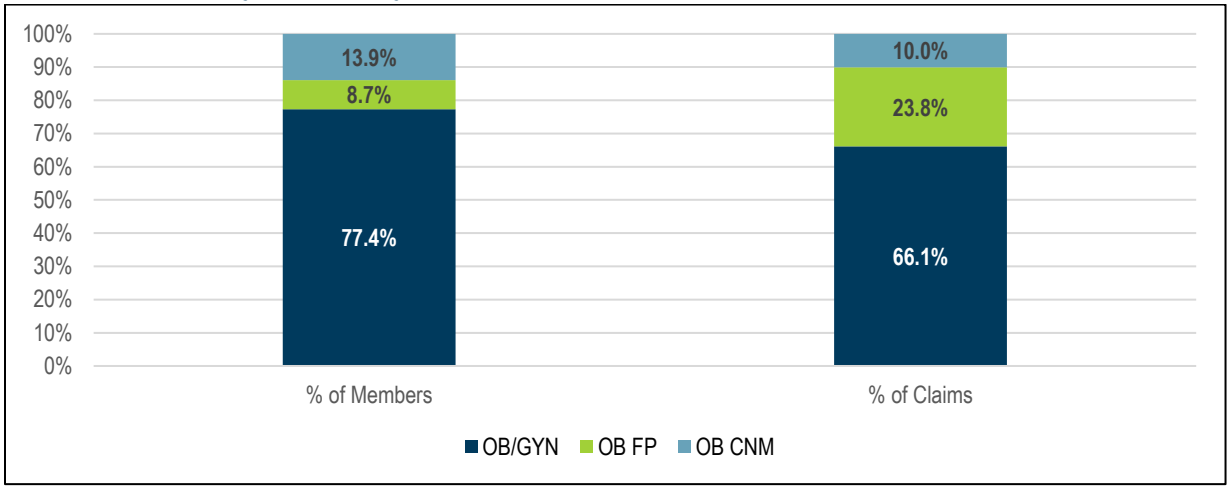
Figure 18. Percentage of Rural Hospitals by Type(s) of Providers Attending Deliveries, as Reported by the Wisconsin Office of Rural Health



The OCI 2023 issuer data call asked about the use of providers by pregnant members, and the percentage of claims by provider type. (

Figure 19) Health issuers statewide reported that OB/GYNs provided obstetric services to 77.4% of pregnant members, and OB/GYNs accounted for 66.1% of obstetric service claims. Family practice physicians provided obstetrics services to 8.7% of pregnant members, while family practice physicians accounted for 23.8% of claims; CNMs provided obstetric services to 13.9% of pregnant members, and CNMs accounted for 10% of claims.

Figure 19. Obstetric Services: Percentage of Pregnant Members and Percentage of Claims by Provider Type (Obstetricians, Family Practice Physicians, and CNMs) Statewide



The use of different obstetrics providers varies somewhat by region. (Figure 20) Members of products in the Southeastern Region much more frequently use an OB/GYN for obstetrics services, while members in the Western region more frequently use CNMs and family practice physicians. This variation may reflect the workforce composition of the region. It may also reflect characteristics and needs of the population and the policies of the local hospitals pertaining to admitting and delivery privileges of provider types.

The distribution among providers for obstetrics service claims follow a somewhat similar pattern across regions. (
Figure 21) However, in the Western region, where family practice physicians reported care for 59.1% of pregnant members, they account for 72.4% of claims, while CNMs, with 28.9% of pregnant members, account for 17.3% of claims. This may reflect differing needs of the patient bases or differing practice/care patterns of the provider types. It may also reflect billing patterns or practices in that region, such that CNMs manage patient care but bill under an affiliated family practice physician.

Figure 20. Obstetrics Services: Percentage of Pregnant Members Using Obstetricians, Family Practice Physicians, and CNMs, by Region

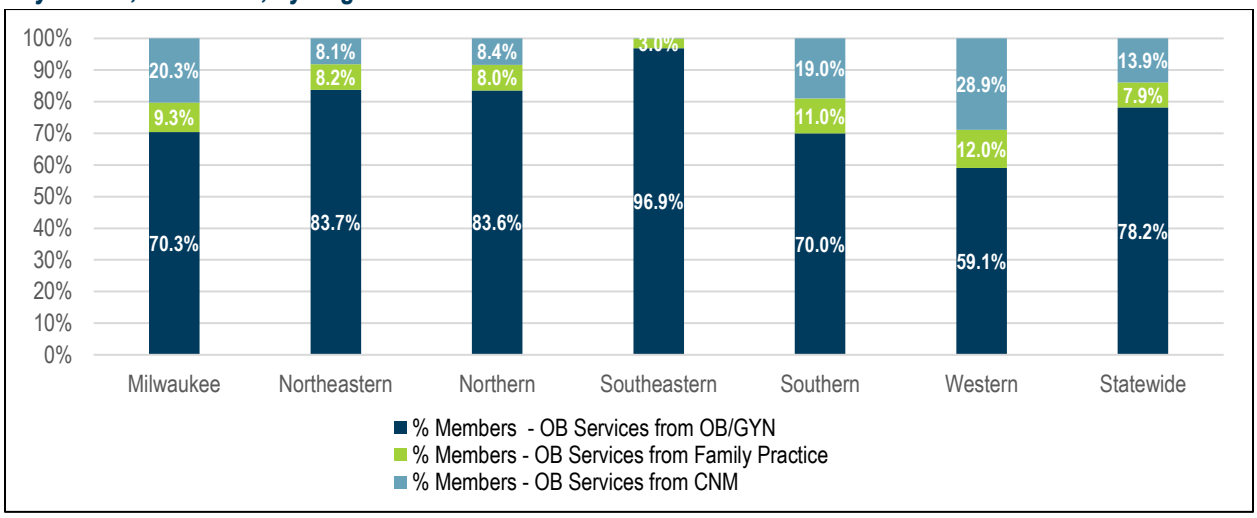
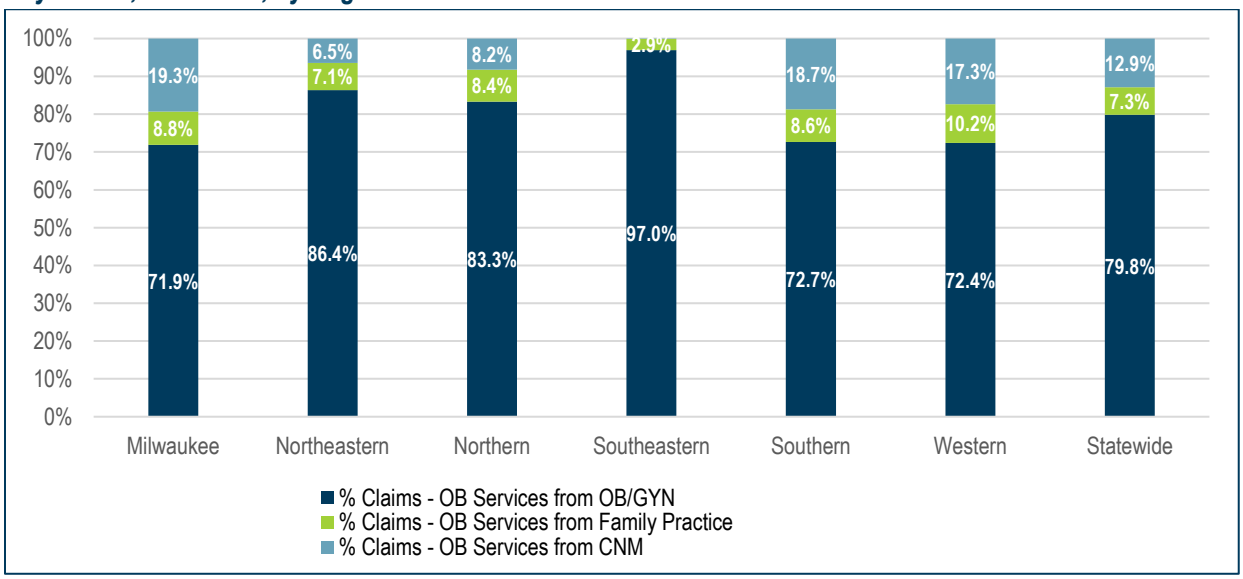


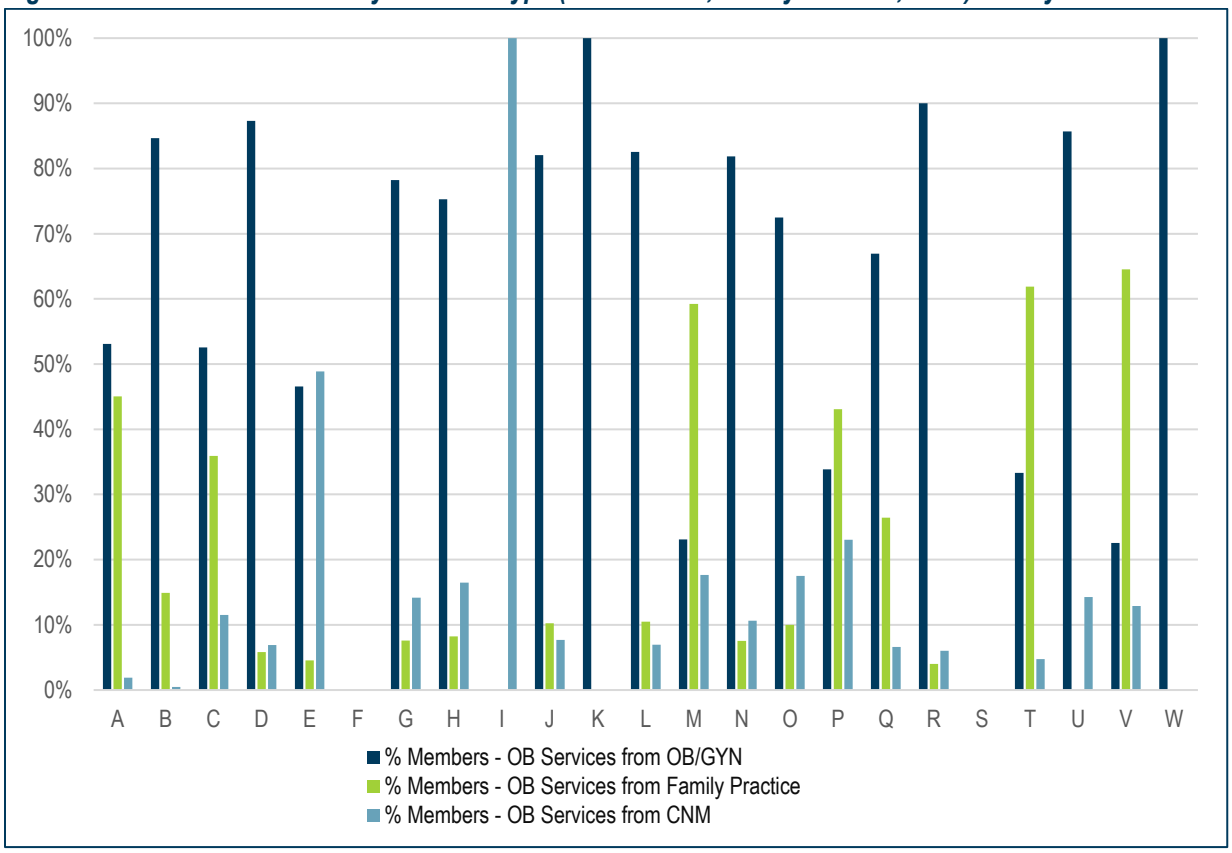
Figure 21. Obstetrics Services: Percentage of Pregnant Member Claims for Obstetricians, Family Practice Physicians, and CNMs, by Region



Most issuers report that pregnant members are most frequently served by OB/GYNs. (Figure 22) Issuers of four products — labeled M, V, P, and T — report pregnant members more frequently served by family practice physicians

than by OB/GYNs. Issuer of product labeled E reports pregnant members are most frequently served by CNMs; Issuer of product labeled I reports 100% of its pregnant members are served by CNMs, which likely represents an anomaly in the issuer's data report.

Figure 22. Obstetrics Services by Provider Type (Obstetrician, Family Practice, CNM) and by Product



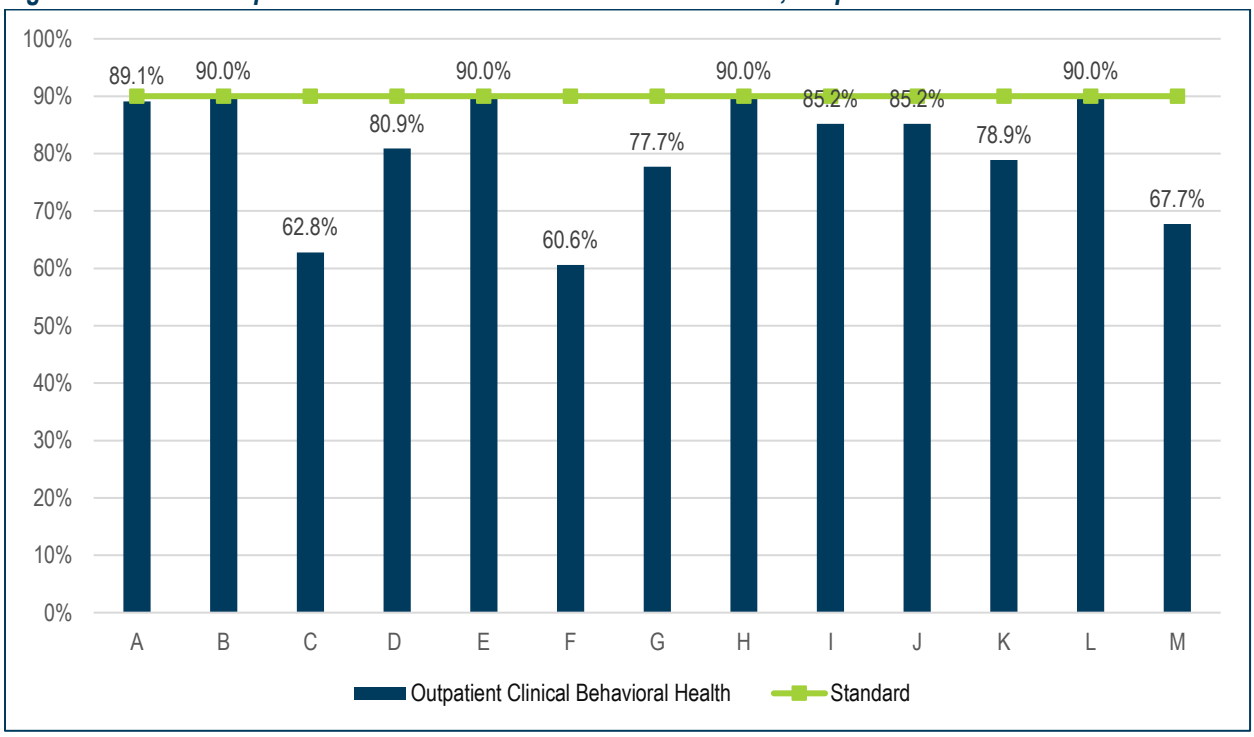
F3. Mental Health and Substance Use Disorder Services

A report by Mental Health America, for 2022, ranked Wisconsin 35th nationally for mental health workforce availability, with a population-to-provider ratio of 470-to-1.[97] States' ratios range from best workforce supply at 150-to-1 (Massachusetts) to least access at 920-to-1 (Alabama). In this report, the term "mental health provider" includes psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, and advanced practice nurses specializing in mental health care. The same report ranks Wisconsin better on the composite Access Ranking, at fourth out of all states nationally.[98] This other measure includes access to insurance, quality and cost of insurance, access to special education, access to treatment, and mental health workforce availability. This high ranking for Wisconsin likely counterbalances the state's workforce challenges with its relatively strong access to insurance coverage.

A 2019 study conducted for the Wisconsin Department of Health Services described gaps and barriers in MH/SUD services.[99] The key service gaps highlighted across data sources included shortages in child and geriatric psychiatrists; shortages in mental health inpatient beds and residential facilities for treating substance use; inadequacies of the medical transportation system; a need for improving crisis stabilization services in the community; shortages in medication-assisted treatment providers and clinics; long waitlists across the service array; shortages in competent translation services; and the need to provide wraparound services, particularly for consumers with families. Workforce/facility shortage was noted as the most frequent barrier for mental health outpatient services, and shortage of detoxification and SUD-specific inpatient/residential services was noted as the most frequent barriers for SUD services.

As noted, the issuers' data reported to CMS indicates shortfalls in meeting the CMS access standards for outpatient behavioral health services, with nine issuers falling below the standard.

Figure 23. Issuers' Reported Access Relative CMS Access Standard, Outpatient Behavioral Health



Issuer Data Call Responses

The issuer data call asked several questions about access to MH/SUD services and, specifically, where they faced challenges due to provider capacity deficiencies. Here, issuers reported challenges more frequently than for other service types. However, the issuers' reports regarding network adequacy and access to mental health service may understate the challenges faced by enrolled members.

Asked generally about such access issues, eight of the 14 issuers reported known capacity or access issues. Comments include the following:

- *Anecdotally, we can note that by and large our access issues are minimal. One noteworthy area that we have heard member feedback around is locating a psychiatrist. We infrequently receive out-of-network authorization requests for behavioral health care due to the size of our network; however, there have been a few exceptions that we have made for residential treatment — mostly when members are unable to return to the service area. We have heard that prescribing providers are sometimes hard to find or hard to get into see quickly due to the national shortage.*
- *Challenges include wait times for new appointments and lack of intermediate care options (residential, Intensive Outpatient Services, Partial Hospitalization Programs) that treat co-occurring mental health and substance use.*
- *Accessing a behavioral health therapist or psychiatrist can take up to nine weeks. This is only for routine, non-urgent members. Members experiencing urgent/emergent concerns of an acute nature are able to see a provider sooner.*
- *Our largest clinic is at capacity. We continue to recruit for providers.*
- *We have seen long wait times with behavioral health specialists for members needing higher levels of expertise (complex prescribing, children, substance counseling services). Wait for psychiatrist intake can be several months.*
- *This is an industry-wide issue, with a lack of providers specializing or being available to treat behavioral health/mental health/substance use disorders.*
- *Mental health services are in high demand, and not all providers in our network are able to meet standards set for appointment availability due to increased demand.*

The 2023 issuer data call also asked specifically about access to crisis behavioral health services. Here, only five of 14 issuers identified challenges. The others noted no known access issues. Comments included the following:

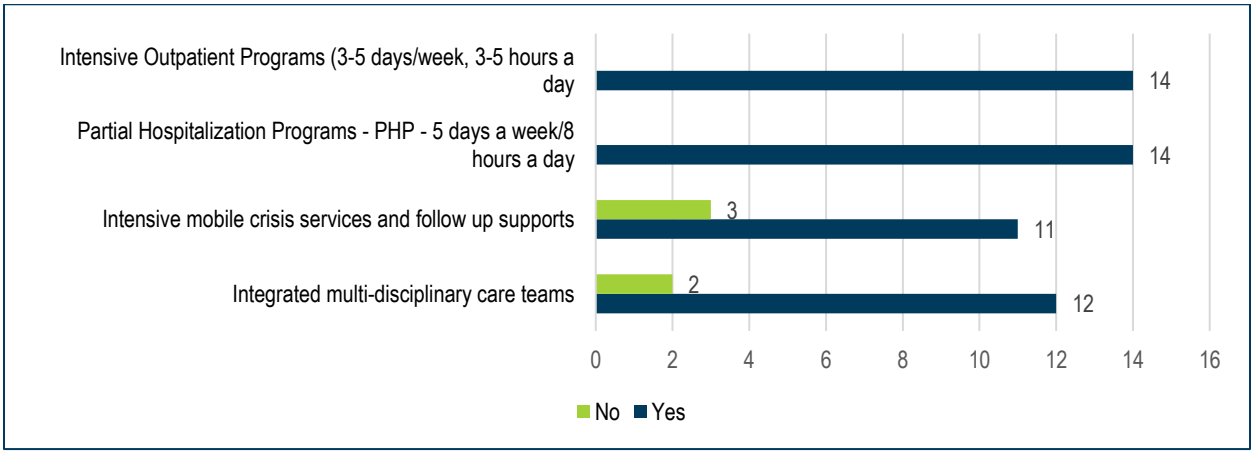
- *We have three in-network crisis resource centers for our members to access and a large amount of in-network providers that are crisis-based. We are currently seeking out additional contracts with crisis behavioral health providers.*
- *There is a lack of community-based 24-hour services to support Emergency Department diversion (crisis observation beds).*
- *Marketplace members are often ineligible for County programs due to income requirements. Limited resources in northern counties for crisis services. Milwaukee County has only one crisis center, causing access issues.*
- *At the time of crisis, there are often no beds available to treat members. In these times, we will look for providers outside of the plan's network that can accept and care for the member.*
- *Mental health care services, including crisis services, are in high demand. Not all providers in our network are able to meet standards set for appointment availability due to increased demand.*

Five of the 14 issuers responded when asked about the availability/access to providers beyond inpatient services, assuring continuity of care.

- *Our provider network offers services along the care path as outlined by a provider for a member. Intensive Outpatient Services, Partial Hospitalization Programs, Residential.*
- *We have active service agreements with several agencies that provide Intensive Outpatient Services, Partial Hospitalization Programs, Residential, and Inpatient levels of care for members. Additionally, our plan has its own Intensive Outpatient level of care.*
- *We rely on telehealth.*
- *Our plan will coordinate with providers and the member to transition care outside of inpatient services to ensure continuing outpatient care. If no providers are available in network, we will assist the member with finding a provider outside of the plan's network that will accept and treat the member.*
- *If a member or provider or facility calls in asking for assistance in locating providers, we provide them with the affiliated providers in network. If a provider calls and requests continuation of services with a non-affiliated provider, the case is reviewed taking in the member specific situation and a determination is made. Services may be covered with a non-affiliated provider for continuity of care.*

However, when issuers were asked separately whether their members have access to specific components of MH/SUD services, most reported a range of available services. Three issuers – Anthem Compcare, Aspirus, and MercyCare – reported no provisions for intensive mobile crisis services and follow-up supports. Aspirus and MercyCare also reported no provisions for multi-disciplinary teams.

Figure 24. Available MH/SUD Specialty Services



Only four of 14 issuers identified known challenges in access for alcohol and other drug abuse (AODA) services. The others noted no known access issues. Challenges noted include the following:

- Extensive wait times for new appointments.
- Increased state licensing requirements to deliver substance use services.
- Limited number of credentialed treatment providers.
- Shortage of available beds to treat members.
- High demand for mental health services, including AODA services.
- Inability for some networks to meet standards set for appointment availability.

Issuers were asked about approaches to address MH/SUD challenges and ensure access for members. Eight of the 14 issuers identified strategies to address capacity issues. Their responses shared several themes:

- Conducting active recruiting.
- Expanding telehealth options for mental health services.
- Working with Behavioral Health agencies in the community and regularly establishing service contracts to provide more options for members.
- Engaging care coordination and intensive case management for SUD and serious mental illness (SMI).
- Covering behavioral health integration services delivered in primary care settings.
- Paying for services delivered by out-of-network providers.

G. Telehealth Services

Telehealth holds promise in augmenting network adequacy by overcoming barriers in mobility, transportation, and geography.[100] Telehealth may include synchronous audio-visual and audio-only telehealth, along with asynchronous forms such as remote patient monitoring and e-visits. Measures of network adequacy may account for how telehealth may enhance access (for those with reliable internet service), while also assessing risk for reduced access to necessary in-person providers.

All 14 issuers reported paying for telehealth services, with some slight variation related to coverage for audio services alone without video. (Figure 25) Three issuers report that they do not pay for audio alone; one issuer did not provide an answer to this question. Figure 26, Panels 1 through 7, display the relative volume of telehealth claims by different provider types, as reported by the 14 issuers for each of the 23 individual market products. Overall, providers of mental health services — psychiatrists, psychologists, clinical social workers — show a higher average rate of telehealth claims per provider. A few plans show a substantially higher rate of telehealth claims per provider for primary care services relative to the average across all plans.

Figure 25. Issuers' Reported Payment for Telehealth Services

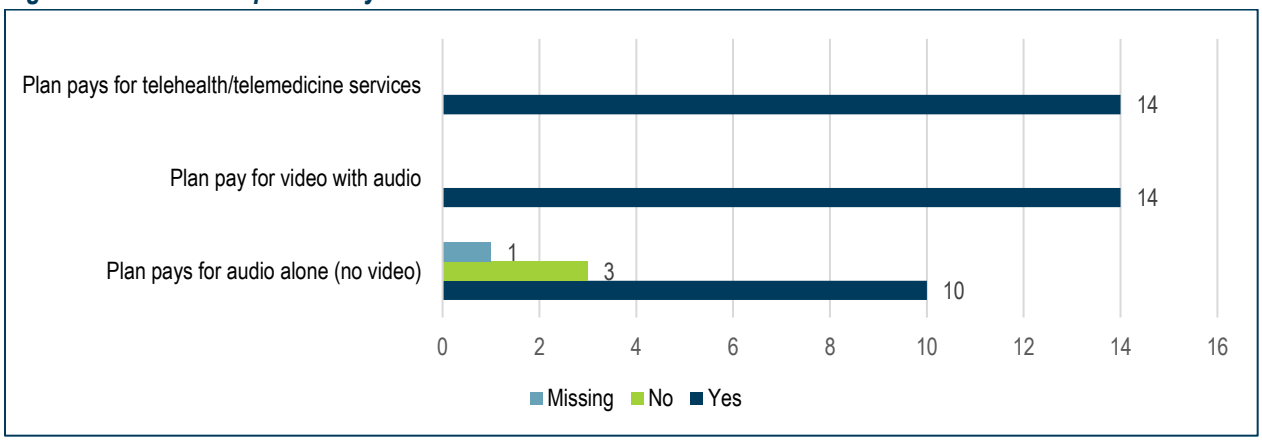
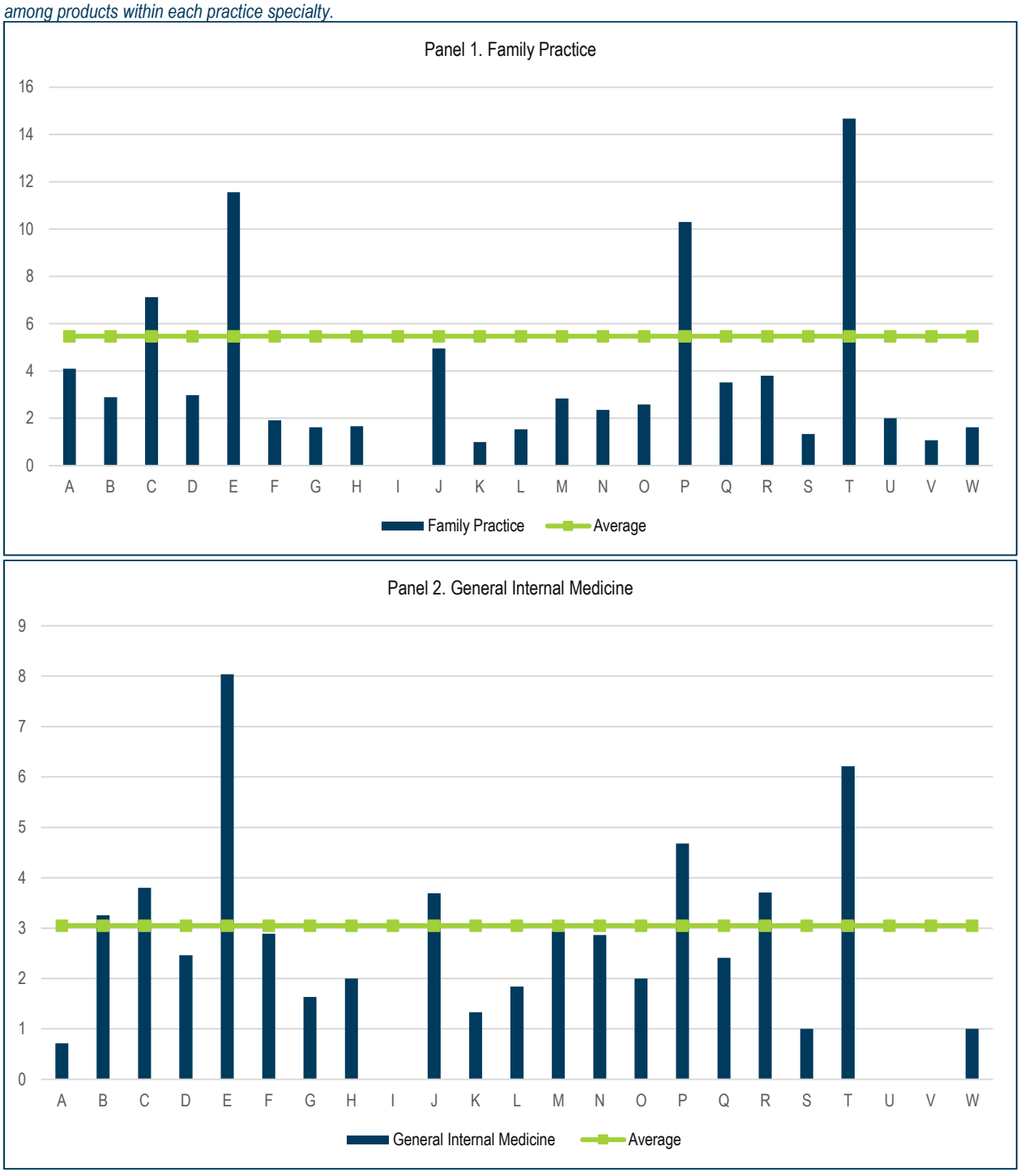
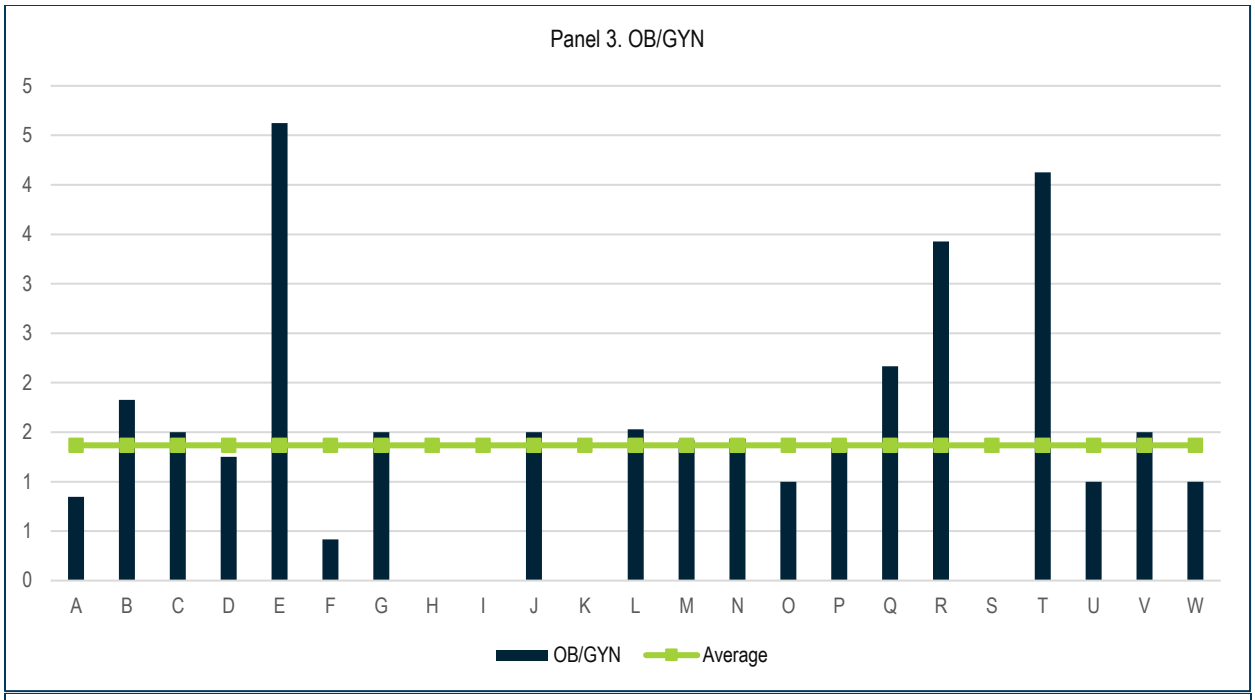
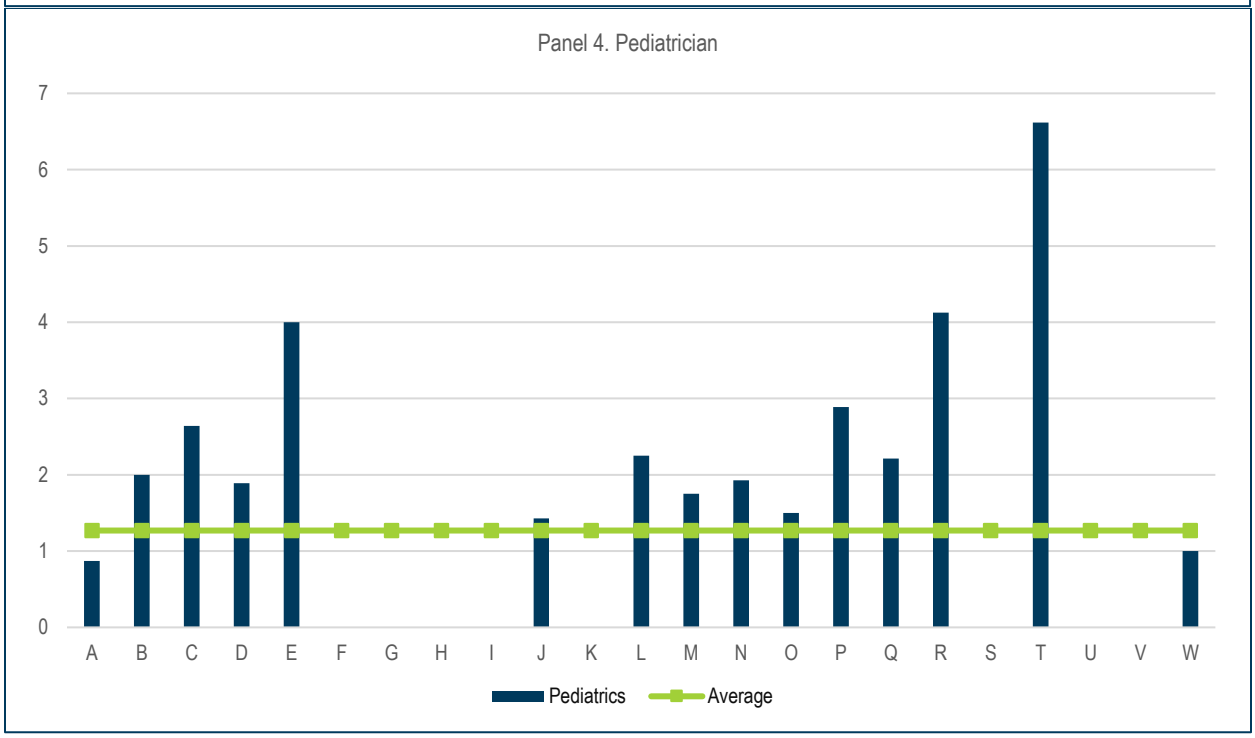


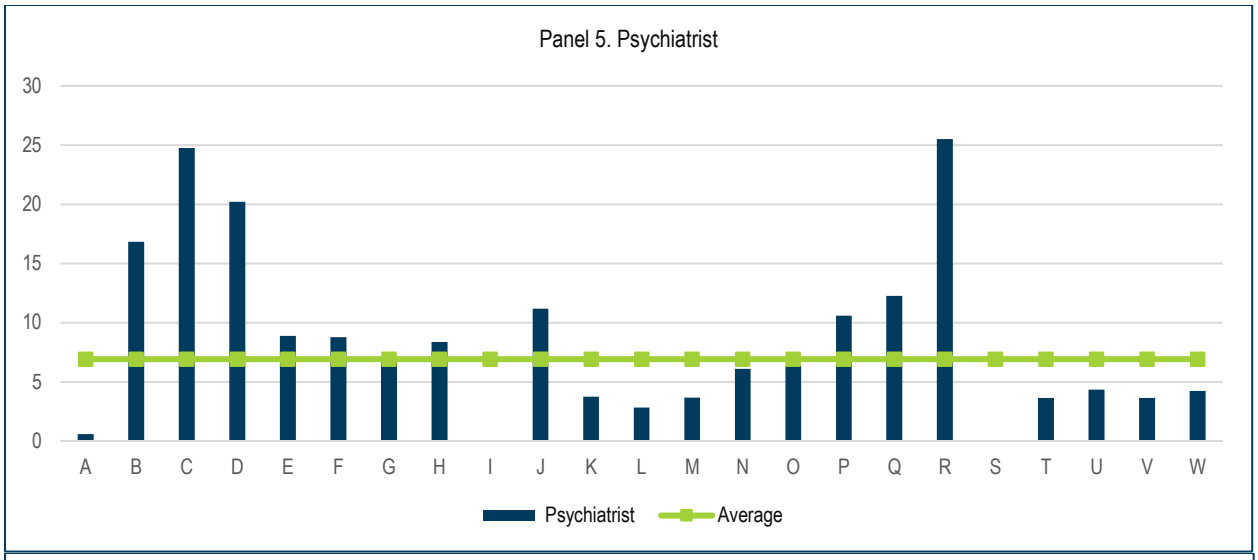
Figure 26. Telehealth Claims per Provider Type, by Product, and Average Across Products (Unweighted)

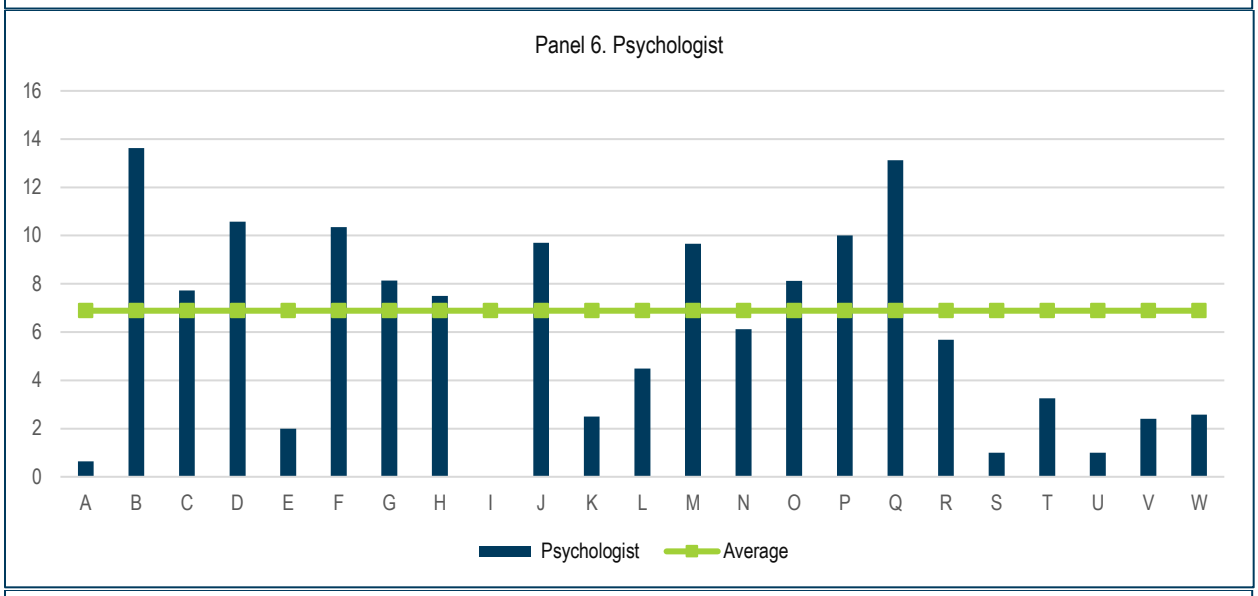
Note: Vertical scales in Panels 1 through 7 differ, due to different volume of telehealth provision among specialties. Graphs support comparison among products within each practice specialty.

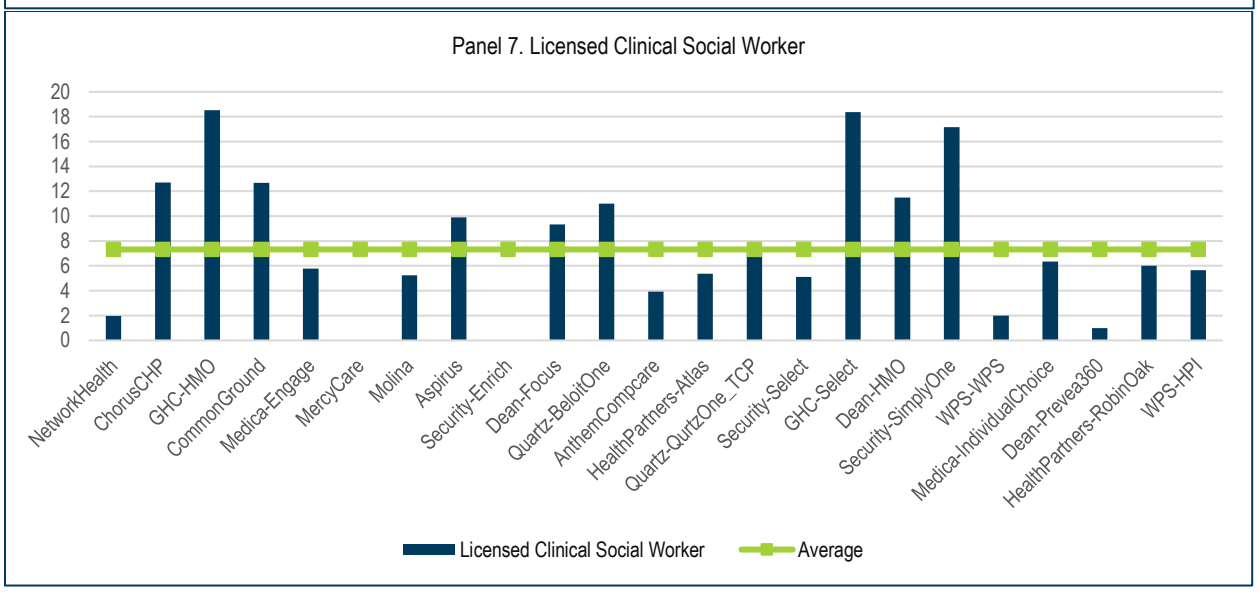



Panel 3. OB/GYN
5
5
4
4
3
3
2
2
1
1
0
A B C D E F G H I J K L M N O P Q R S T U V W
OB/GYN
Average


Panel 4. Pediatrician
7
6
5
4
3
2
1
0
A B C D E F G H I J K L M N O P Q R S T U V W
Pediatrics
Average


Panel 5. Psychiatrist
30
25
20
15
10
5
0
A B C D E F G H I J K L M N O P Q R S T U V W
Psychiatrist
Average


Panel 6. Psychologist
16
14
12
10
8
6
4
2
0
A B C D E F G H I J K L M N O P Q R S T U V W
Psychologist
Average


Panel 7. Licensed Clinical Social Worker
20
18
16
14
12
10
8
6
4
2
0
NetworkHealth
ChorusCHP
GHC-HMO
CommonGround
Medica-Engage
MercyCare
Molina
Aspirus
Security-Enrich
Dean-Focus
Quartz-BeloitOne
AnthemCompcare
HealthPartners-Atlas
Quartz-QurtzOne_TCP
Security-Select
GHC-Select
Dean-HMO
Security-SimplyOne
WPS-WPS
Medica-IndividualChoice
Dean-Prevea360
HealthPartners-RobinOak
WPS-HPI
Licensed Clinical Social Worker
Average

H. Accessibility: Race, Ethnicity, Language, Disability (RELD) Data

The NCQA finalized changes to its 2022 Health Plan Accreditation program to include diversity, equity, and inclusion standards.[101] Similarly, the Alliance of Community Health Plans developed a health equity framework.[102] The U.S. HHS provides implementation guidance on such data collection.[103] Uses of these data include assessment of health insurance and product enrollment patterns,[104] to address health and health care disparities,[105] and to promote health care quality improvement.[106]

The issuers report the following steps underway to collect patient RELD data:

- *Request members voluntarily provide the information through the enrollment process.*
- *Currently collect this information on enrollment applications, health risk assessments, data feeds from the Wisconsin health information exchange, and data feeds from clinically integrated provider systems.*
- *Collect RELD data through 834 files and allow members to update RELD information (as well as gender identity, sexual orientation, pronouns) via member portal, member app, or by contacting the call center.*
- *For our members who purchase individual and family coverage in the Federally Facilitated Marketplace, if they complete RELD information, that information is passed onto us. Disability status is assessed by care coordination staff interactions with members.*
- *Point of service collection methods to collect data on race, ethnicity, and language. Additionally, implementing processes to incorporate RELD data from Wisconsin-Medicaid and ACA/FFM enrollment data files.*
- *We do not collect race/ethnicity or language information during the application process. We use the US Census data. For language, we use what is sent via interpreter services both from customer service and in person at time of office visit to determine the need.*
- *The Enrollment Department does not collect race, ethnicity, and language from members. Disability would only be included for members who have both commercial/plus Medicare plans.*

Ten of the 14 issuers reported using RELD data to identify disparities in quality of care and to appropriately target quality improvement interventions. The issuers that reported not using the data in this manner provided the following comments:

- *Request for member to voluntarily provide the information through the enrollment process.*
- *Due to the voluntary nature of REL status, we have not collected enough data to use to develop meaningful interventions.*
- *We only began uploading the FFM data in December so are still in the early stages of evaluating the data.*

Issuers were also asked whether they collect data about race, ethnicity, and languages spoken among their contracted providers. Twelve issuers reported collecting such data, and two reported not doing so. All emphasized that providers reporting this information is voluntary. Comments included the following:

- *We have these data classifications only if the provider has submitted the details to us. We have several initiatives planned for later this year to outreach to providers to enhance these indicators. Across all of our networks, we are lacking in race and ethnicity data.*
- *Race, ethnicity, and language capabilities are self-reported and currently we only have approximately 16% of practitioners that self-report.*
- *We do not collect race and ethnicity data on providers but do ask them to identify languages spoken other than English.*

V. Conclusion

Health insurance issuers, under network adequacy standards, aim to provide enough in-network primary care and specialty care providers to assure reasonable access to the health care services outlined in the contract.[107,108] The federal ACA mandates that issuers offering QHPs in the Marketplace meet network adequacy standards to ensure consumers have access to needed care without unreasonable delays.

For the 2024 plan year, CMS will evaluate QHPs for compliance with network adequacy standards based on designated time and distance standards. CMS final notice to issuers for PY 2024 also confirms plans to adopt appointment wait time standards beginning with PY 2025, focusing on primary care, specialty care, and behavioral health services.[109] CMS is also strengthening network adequacy and ECP standards, focusing on access to care for low-income and medically underserved consumers.

CMS now requires more rigorous data reporting by issuers for demonstrating adherence to network adequacy standards. Wisconsin issuers appear only partially prepared to meet these reporting expectations. Issuers vary widely in their methods for measuring provider numbers, time and distance to providers, and appointment wait times. Reported data often rely on provider attestation. Methods are available to confirm provider reported data, including the accuracy of provider directories, along with available FTE capacity of contracted providers. But such confirmation may require comparing provider data against other administrative data sources, such as submitted claims.

Many issuers' products have challenges meeting CMS network adequacy standards for some services and many geographic regions. Wisconsin's QHPs, based on reported data, appear strong in the adequacy of their primary care networks, but variation does exist across geographic regions. Some weaknesses emerge in their performance for pediatric primary care and for access to obstetric services. However, CMS definitions for access to pediatric and obstetric services may not fully capture access to these services. Counting the use of family practice physicians, nurse practitioners, and other providers, particularly in rural areas, yields a different result.

Access to providers for MH/SUD services presents a challenge for most issuers and plans, reflecting statewide shortages in this workforce. While many issuers identified these challenges, several did not. Such reporting gaps may merit further exploration by OCI — for MH/SUD and all services included in health plan contracts — to assure that all issuers sufficiently monitor their members' access challenges, that the issuers support members in navigating such workforce capacity limits, and that issuers address the need for improvement.

In recent years, telehealth has expanded its role in the provision of health care services and its potential to address barriers in access to providers.[110] Issuers now report telehealth service capacity of its providers. The degree to which issuers pay for various levels of telehealth service will incent its provision and will support members in using these services. At the same time, telehealth may be a barrier for members with limited internet service, technical ability, or comfort. In measuring network adequacy, it will be important to assure that the offering of telehealth does not replace members' access to needed in-person services.

Finally, NCQA and CMS continue to promote the collection of race, ethnicity, language, and disability data to monitor and assure access.[111,112] Wisconsin issuers report progress, along with barriers, in collecting and using such data to promote quality and equity in service delivery. Progress will occur with the support and expectations of federal and state agencies along with national accrediting bodies.

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https://mhanational.org/sites/default/files/2022%20State%20of%20Mental%20Health%20in%20America.pdf

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[99] Vigna, A.J., Connor, T. The 2019 Behavioral Health Gaps Report for the State of Wisconsin. Madison, WI: University of Wisconsin Population Health Institute, October2020. https://uwmadison.app.box.com/s/gbdrrm4ktk2ljwm80kac9rrk3zksyi02

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[101] NCQA's Health Equity Accreditation Programs. https://www.ncqa.org/programs/health-equity-accreditation/

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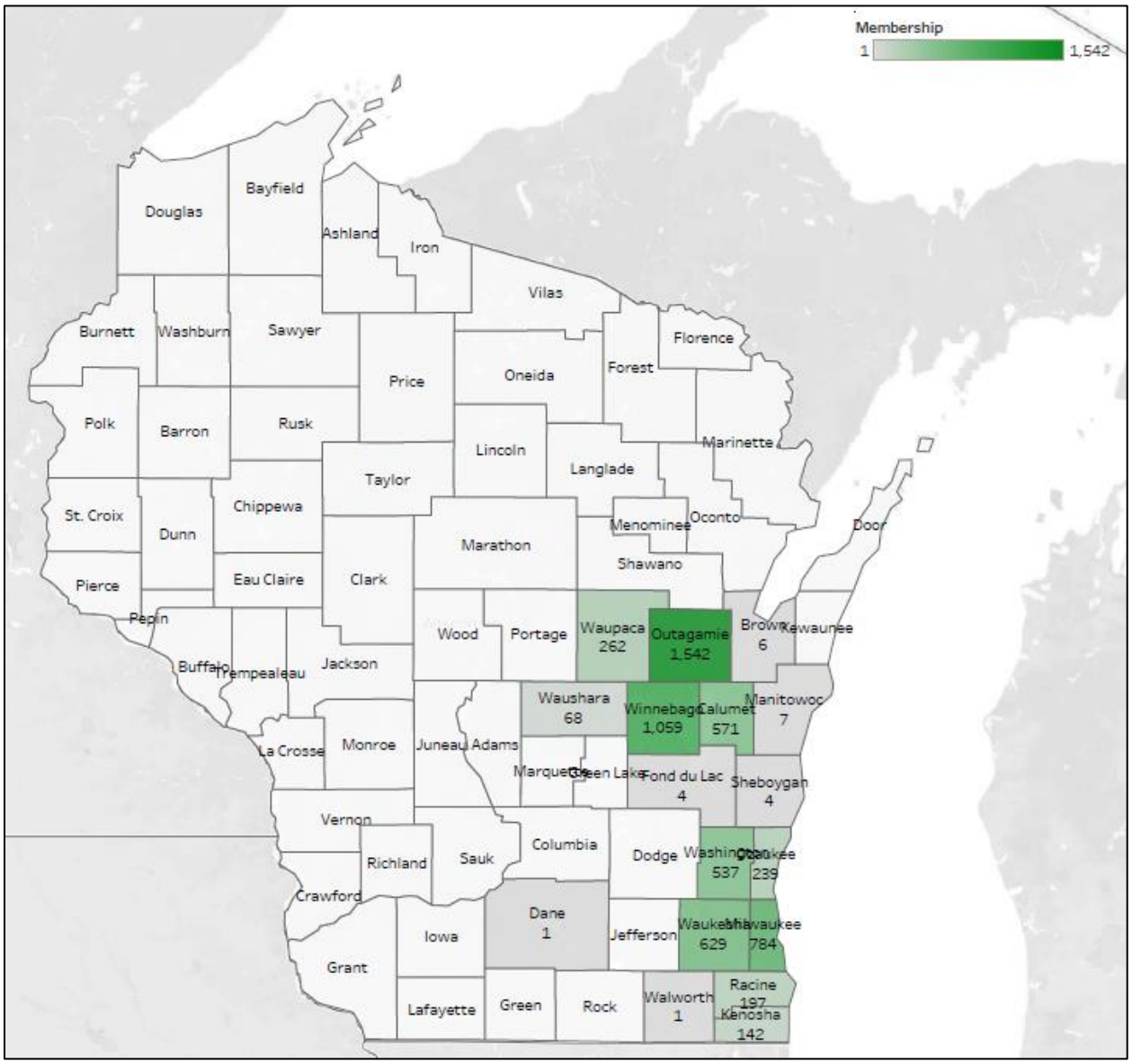
[111] *Op. cit*. NCQA's Health Equity Accreditation Programs.

[112] Op. cit. *CMS. Inventory of Resources for Standardized Demographic and Language Data Collection.*

VII. Appendix A. Products: Reported Enrolled Membership by County, PY 2022

A



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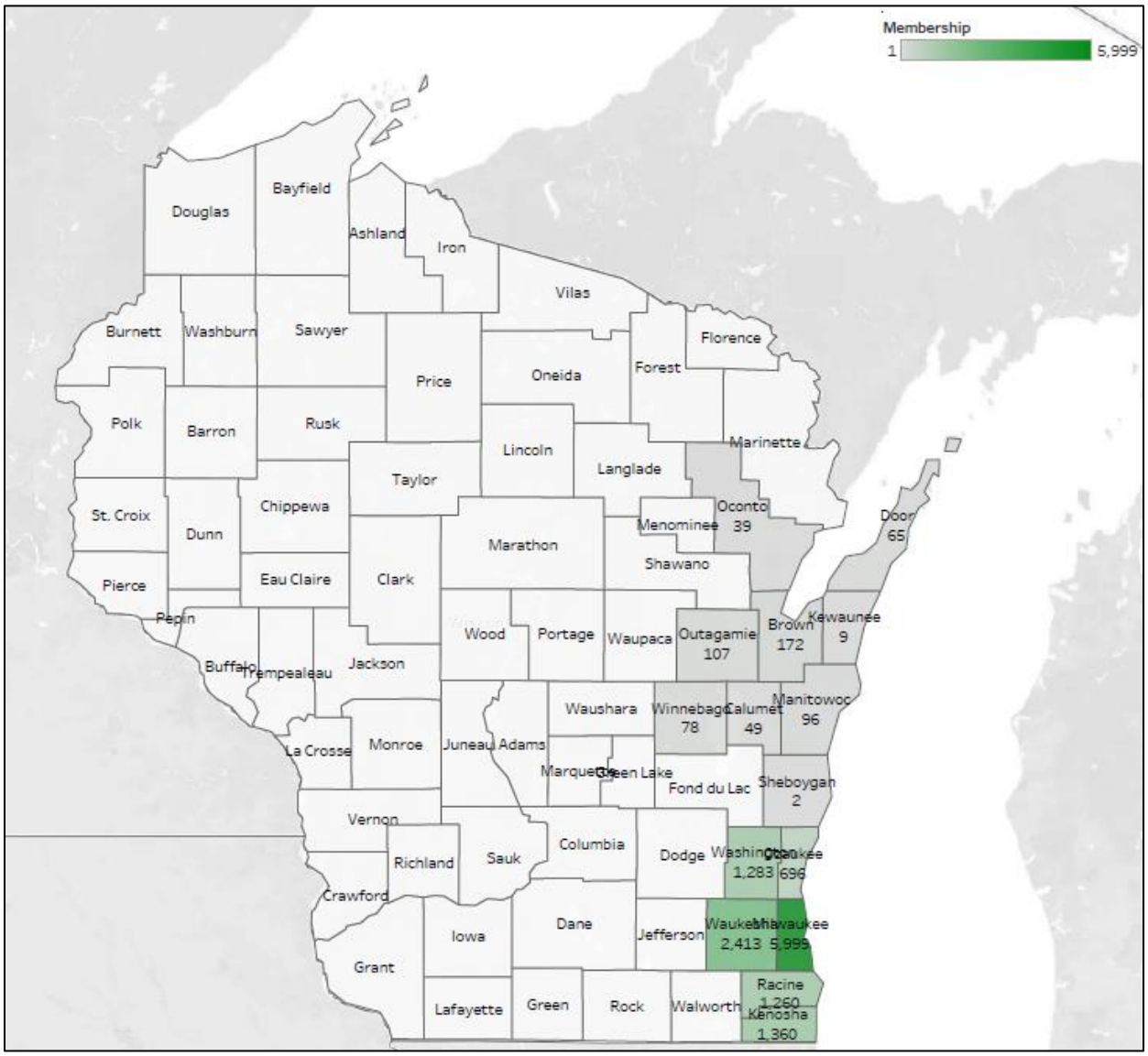
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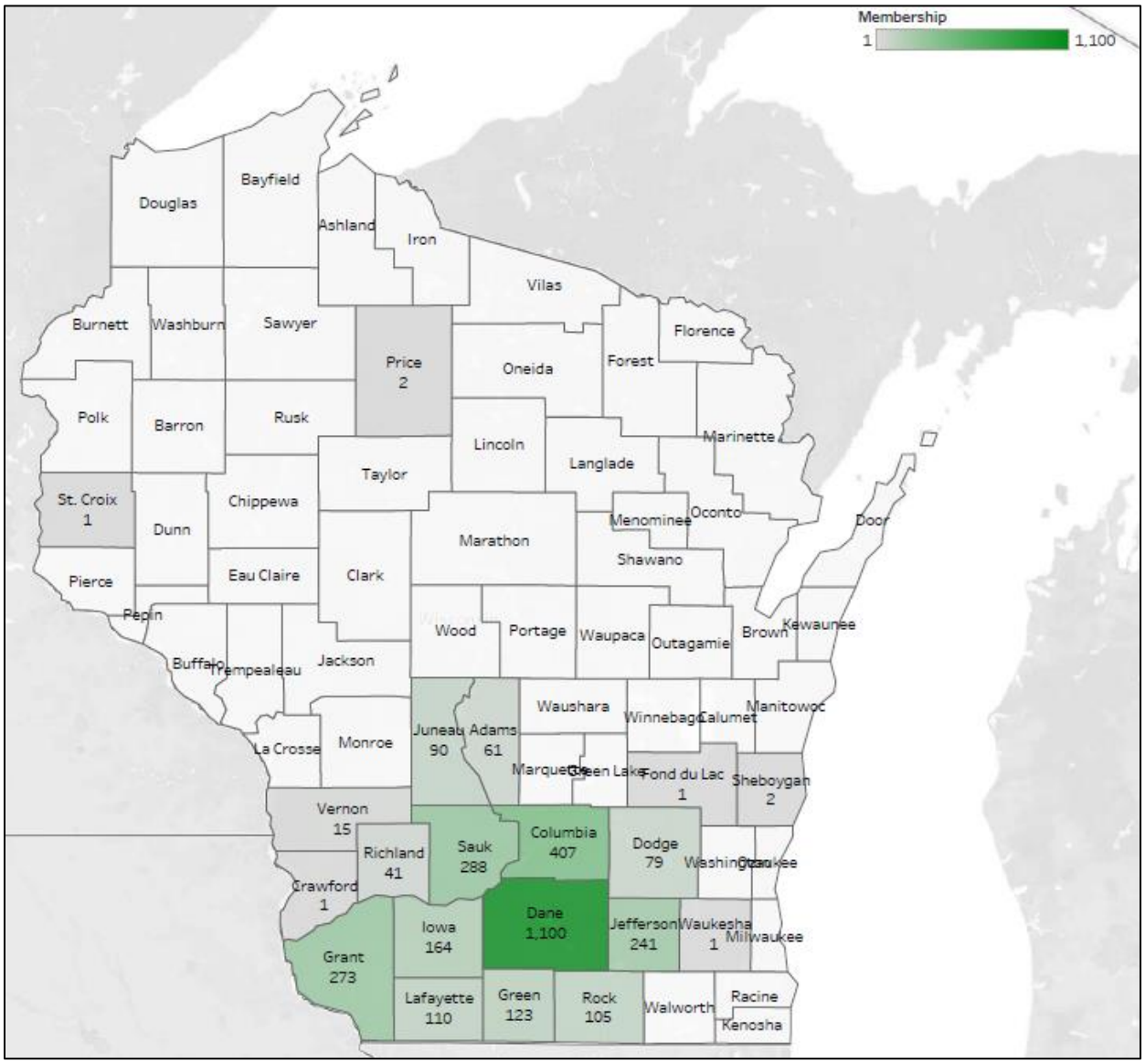
Bayfield
Ashland
Iron
Vilas
Florence
Burnett
Washburn
Sawyer
Price
Oneida
Forest
Polk
Barron
Rusk
Lincoln
Langlade
Marinette
Taylor
St. Croix
Dunn
Chippewa
Oconto
39
Door
65
Menominee
Marathon
Shawano
Pierce
Eau Claire
Clark
Pepin
Wood
Portage
Waupaca
Outagamie
107
Brown
172
Kewaunee
9
Buffalo
Trempealeau
Jackson
Waushara
Winnebago
78
Calumet
49
Manitowoc
96
La Crosse
Monroe
Juneau
Adams
Marquette
Green Lake
Fond du Lac
Sheboygan
2
Vernon
Columbia
Dodge
Washington
1,283
Ozaukee
696
Richland
Sauk
Crawford
Dane
Jefferson
Waukesha
2,413
Milwaukee
5,999
Iowa
Grant
Racine
1,260
Lafayette
Green
Rock
Walworth
Kenosha
1,360

c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Douglas
Bayfield
Ashland
Iron
Vilas
Florence
Burnett
Washburn
Sawyer
Price
2
Oneida
Forest
Polk
Barron
Rusk
Lincoln
Langlade
Marinette
St. Croix
1
Dunn
Chippewa
Taylor
Menominee
Oconto
Door
Marathon
Shawano
Pierce
Eau Claire
Clark
Pepin
Wood
Portage
Waupaca
Outagamie
Brown
Kewaunee
Buffalo
Trempealeau
Jackson
Waushara
Winnebago
Calumet
Manitowoc
La Crosse
Monroe
Juneau
90
Adams
61
Marquette
Green Lake
Fond du Lac
1
Sheboygan
2
Vernon
15
Richland
41
Sauk
288
Columbia
407
Dodge
79
Washington
Ozaukee
Crawford
1
Iowa
164
Dane
1,100
Jefferson
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Milwaukee
Grant
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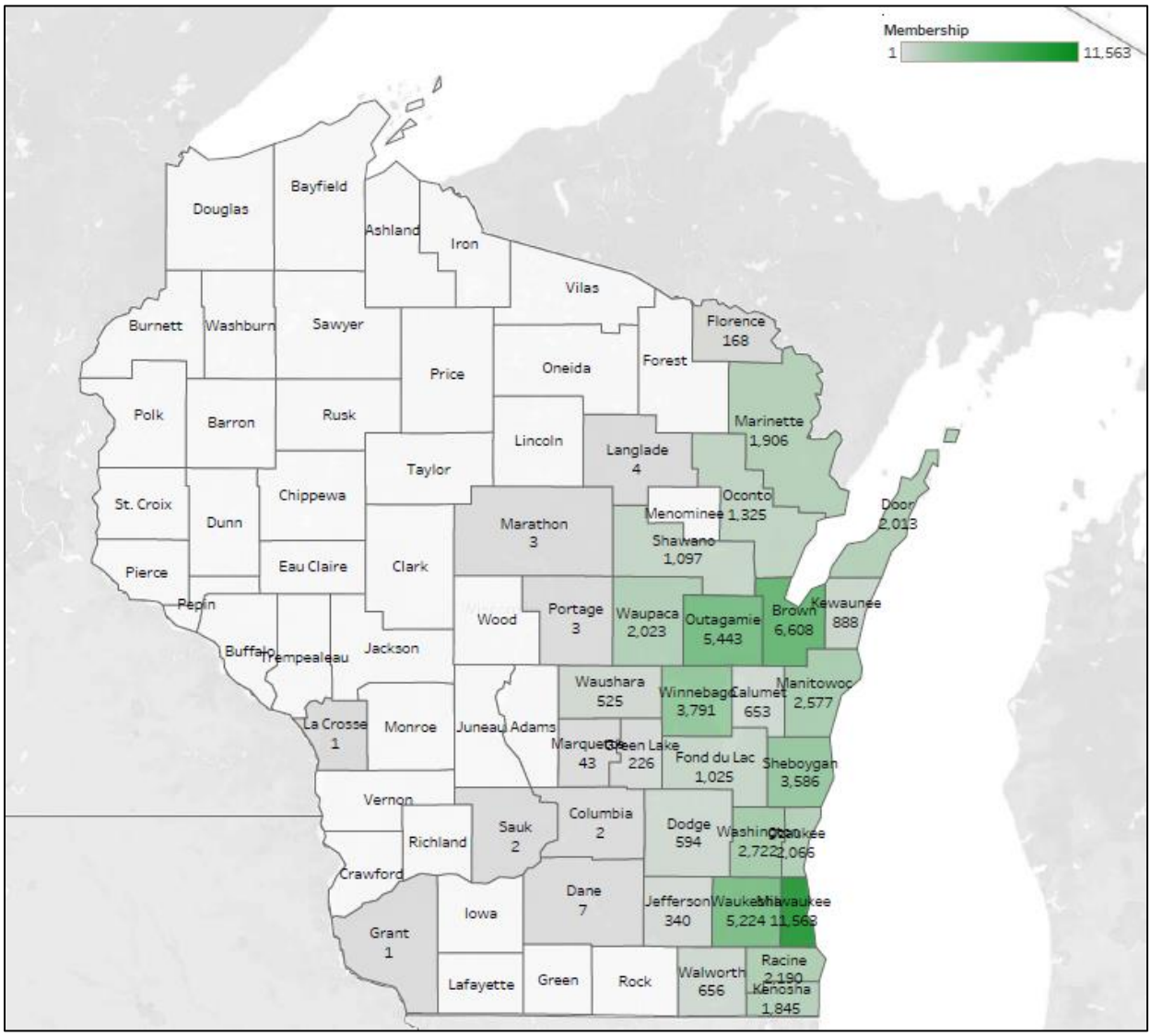
Lafayette
110
Green
123
Rock
105
Walworth
Racine
Kenosha

D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Florence
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Burnett
Washburn
Sawyer
Price
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Forest
Marinette
1,906
Polk
Barron
Rusk
Lincoln
Langlade
4
Taylor
St. Croix
Dunn
Chippewa
Marathon
3
Oconto
1,325
Menominee
Door
2,013
Shawano
1,097
Pierce
Eau Claire
Clark
Pepin
Wood
Portage
3
Waupaca
2,023
Outagamie
5,443
Brown
6,608
Kewaunee
888
Buffalo
Trempealeau
Jackson
Waushara
525
Winnebago
3,791
Calumet
653
Manitowoc
2,577
La Crosse
1
Monroe
Juneau
Adams
Marquette
43
Green Lake
226
Fond du Lac
1,025
Sheboygan
3,586
Vernon
Columbia
2
Dodge
594
Washington
2,722
Ozaukee
2,066
Richland
Sauk
2
Crawford
Dane
7
Jefferson
340
Waukesha
5,224
Milwaukee
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Iowa
Grant
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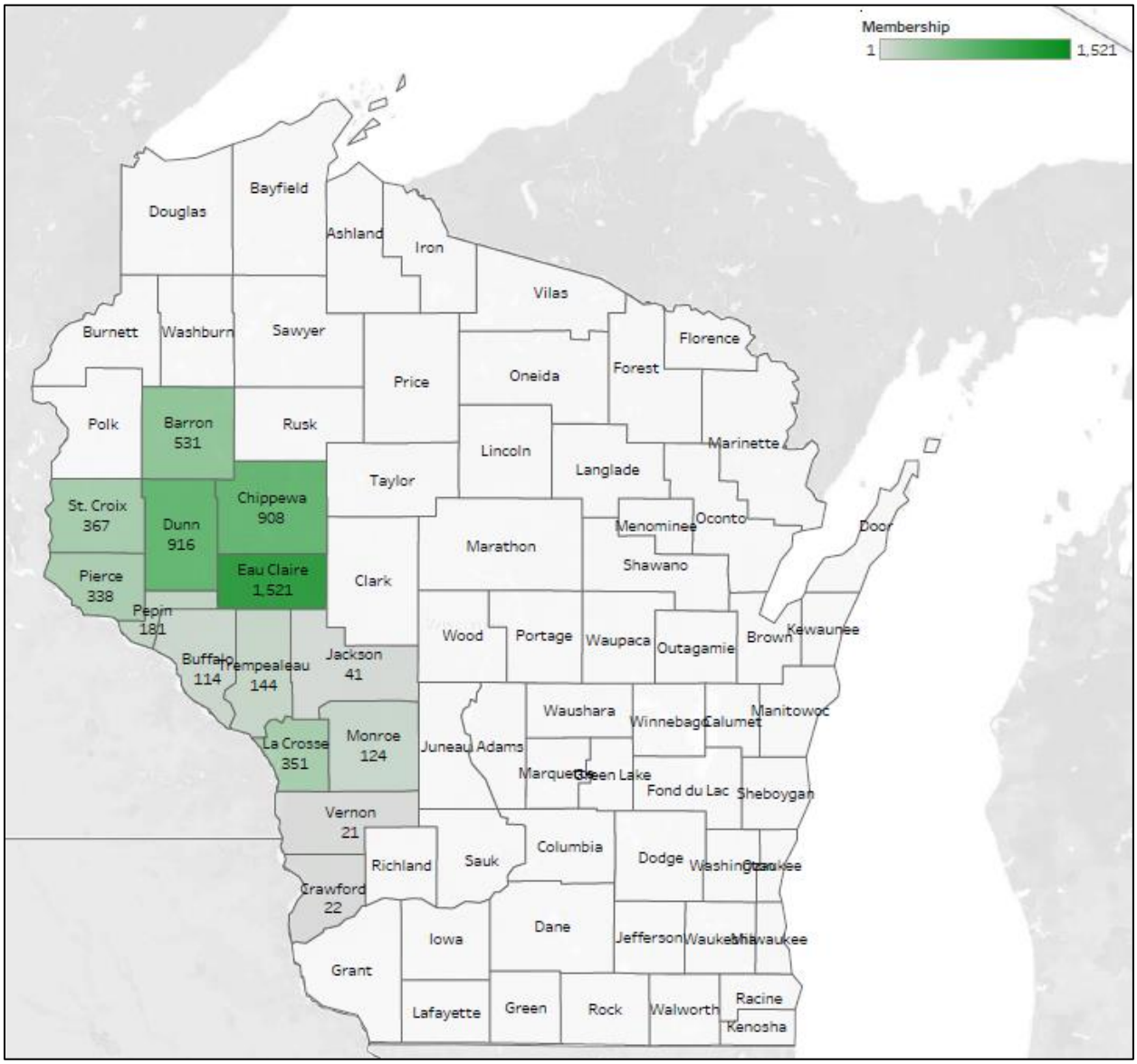
Lafayette
Green
Rock
Walworth
656
Racine
2,190
Kenosha
1,845

E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Bayfield
Ashland
Iron
Vilas
Burnett
Washburn
Sawyer
Price
Oneida
Forest
Florence
Polk
Barron
531
Rusk
Lincoln
Langlade
Marinette
Taylor
St. Croix
367
Dunn
916
Chippewa
908
Menominee
Oconto
Door
Marathon
Shawano
Pierce
338
Eau Claire
1,521
Clark
Pepin
181
Wood
Portage
Waupaca
Outagamie
Brown
Kewaunee
Buffalo
114
Trempealeau
144
Jackson
41
Waushara
Winnebago
Calumet
Manitowoc
La Crosse
351
Monroe
124
Juneau
Adams
Marquette
Green Lake
Fond du Lac
Sheboygan
Vernon
21
Columbia
Dodge
Richland
Sauk
Crawford
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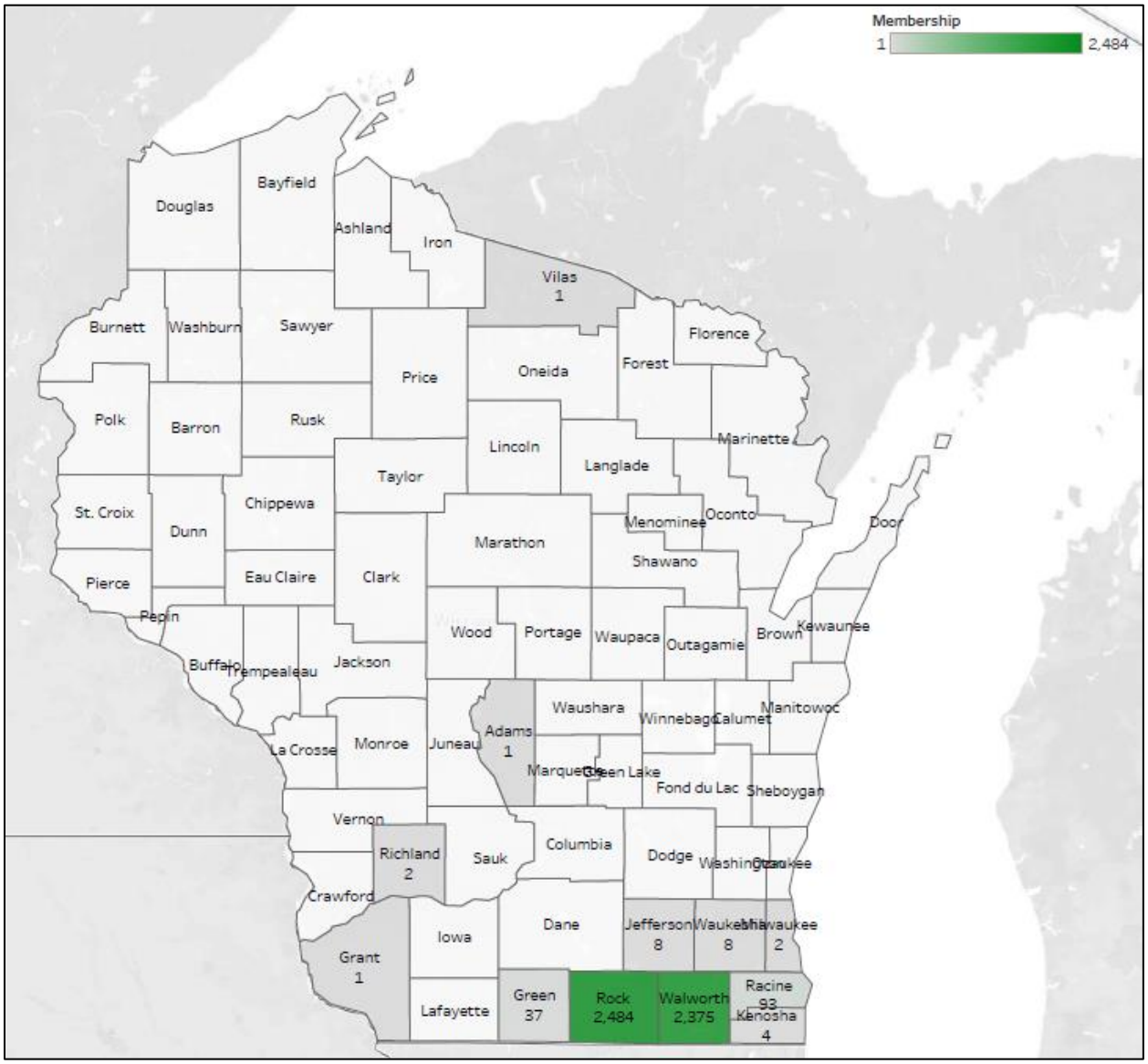
Iowa
Dane
Jefferson
Grant
Lafayette
Green
Rock
Walworth
Racine
Kenosha

F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Bayfield
Ashland
Iron
Vilas
1
Burnett
Washburn
Sawyer
Price
Oneida
Forest
Florence
Polk
Barron
Rusk
Lincoln
Langlade
Marinette
Taylor
St. Croix
Dunn
Chippewa
Marathon
Menominee
Oconto
Door
Shawano
Pierce
Eau Claire
Clark
Pepin
Wood
Portage
Waupaca
Outagamie
Brown
Kewaunee
Buffalo
Trempealeau
Jackson
Waushara
Winnebago
Calumet
Manitowoc
La Crosse
Monroe
Juneau
Adams
1
Marquette
Green Lake
Fond du Lac
Sheboygan
Vernon
Richland
2
Sauk
Columbia
Dodge
Crawford
Iowa
Dane
Jefferson
8
Waukesha
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Grant
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Lafayette
Green
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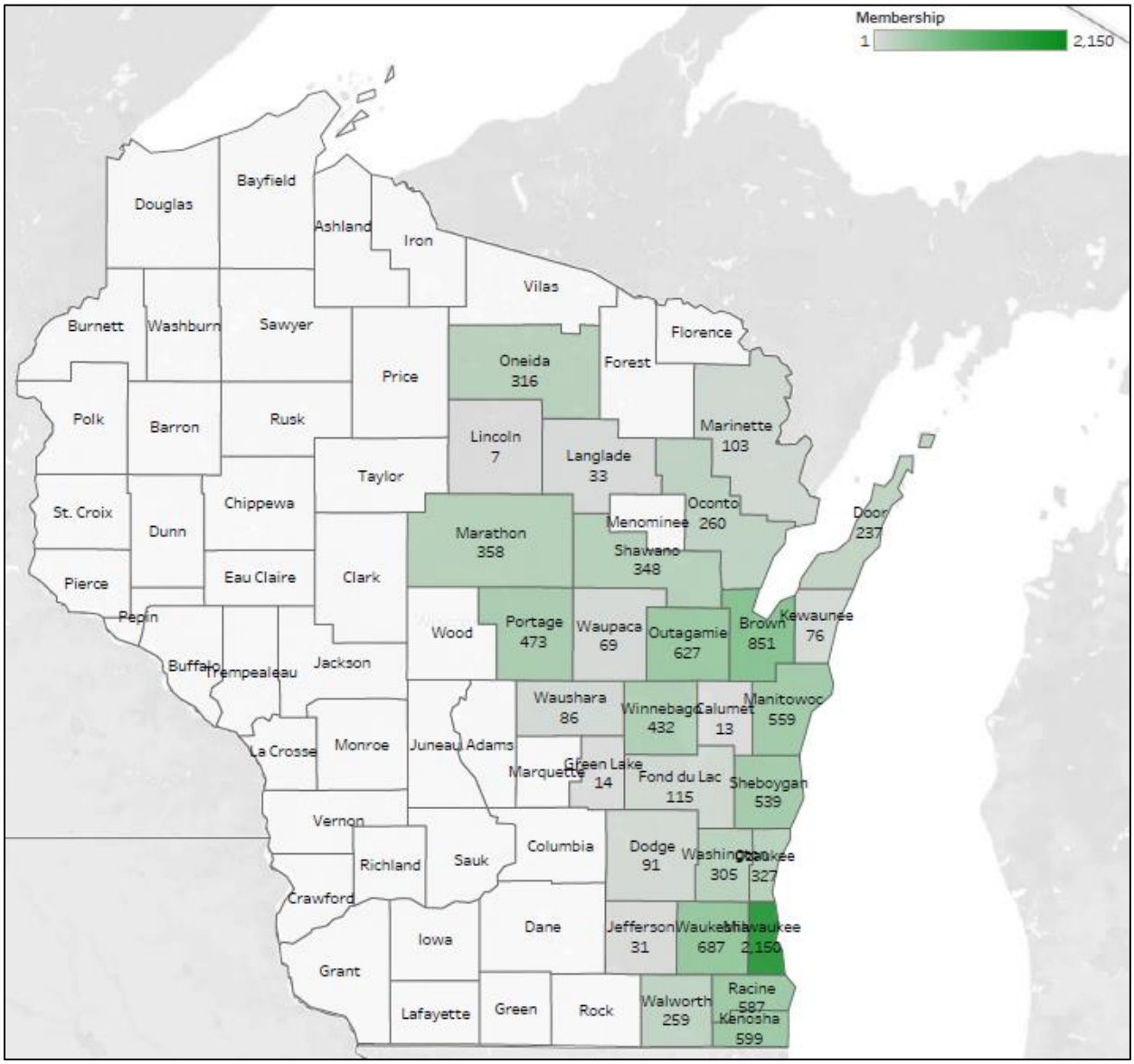
Rock
2,484
Walworth
2,375
Racine
93
Kenosha
4

G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Bayfield
Ashland
Iron
Vilas
Florence
Burnett
Washburn
Sawyer
Price
Oneida
316
Forest
Polk
Barron
Rusk
Lincoln
7
Langlade
33
Marinette
103
Taylor
St. Croix
Dunn
Chippewa
Oconto
260
Door
237
Menominee
Marathon
358
Shawano
348
Pierce
Eau Claire
Clark
Pepin
Wood
Portage
473
Waupaca
69
Outagamie
627
Brown
851
Kewaunee
76
Buffalo
Trempealeau
Jackson
Waushara
86
Winnebago
432
Calumet
13
Manitowoc
559
La Crosse
Monroe
Juneau
Adams
Marquette
Green Lake
14
Fond du Lac
115
Sheboygan
539
Vernon
Columbia
Dodge
91
Washington
305
Ozaukee
327
Richland
Sauk
Crawford
Dane
Jefferson
31
Waukesha
687
Milwaukee
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Iowa
Grant
Lafayette
Green
Rock
Walworth
259
Racine
587
Kenosha
599

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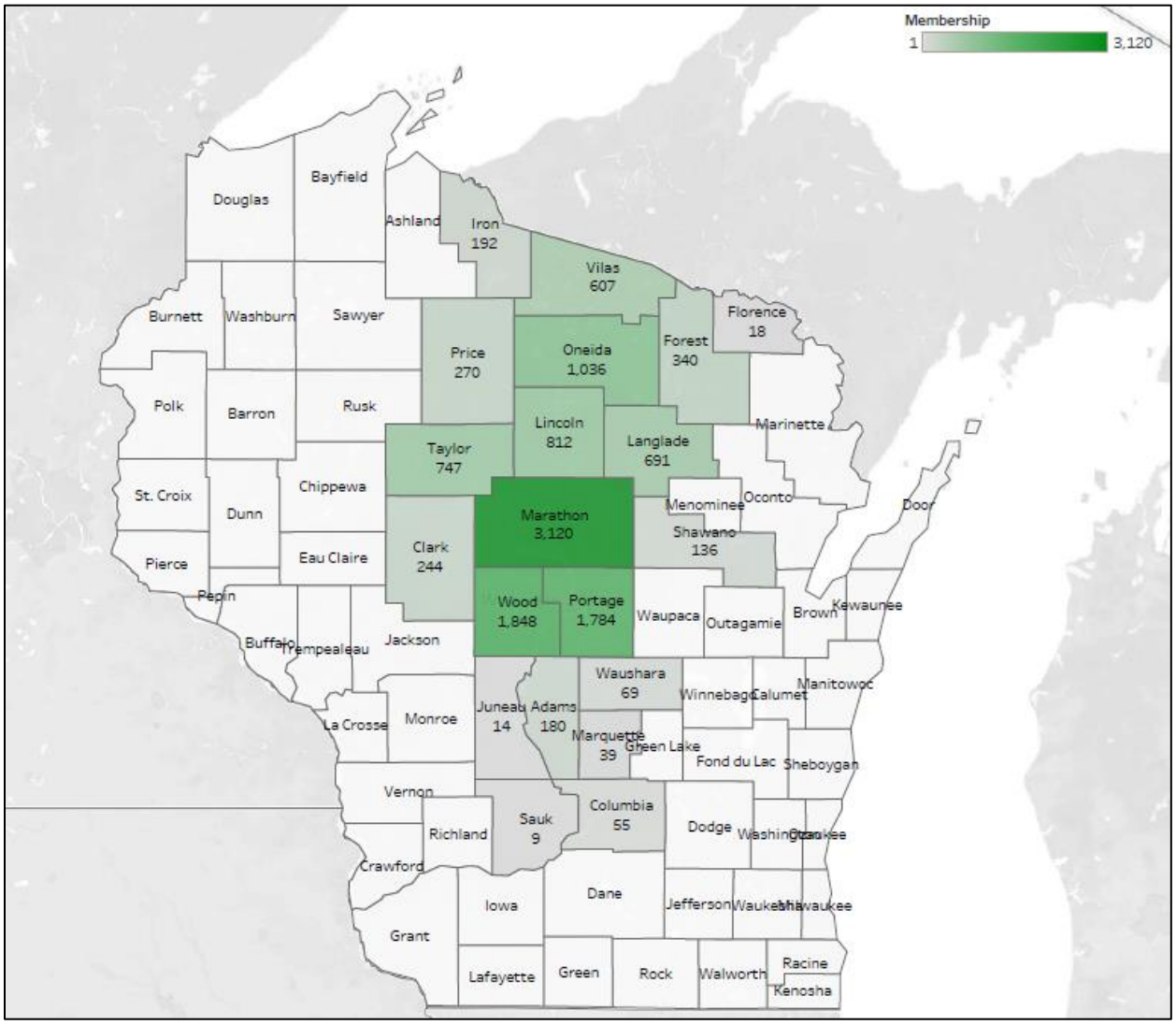
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Ashland
Iron
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Vilas
607
Florence
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Burnett
Washburn
Sawyer
Price
270
Oneida
1,036
Forest
340
Polk
Barron
Rusk
Lincoln
812
Langlade
691
Marinette
Taylor
747
St. Croix
Dunn
Chippewa
Marathon
3,120
Menominee
Oconto
Door
Shawano
136
Pierce
Eau Claire
Clark
244
Pepin
Wood
1,848
Portage
1,784
Waupaca
Outagamie
Brown
Kewaunee
Buffalo
Trempealeau
Jackson
Waushara
69
Winnebago
Calumet
Manitowoc
La Crosse
Monroe
Juneau
14
Adams
180
Marquette
39
Green Lake
Fond du Lac
Sheboygan
Vernon
Columbia
55
Sauk
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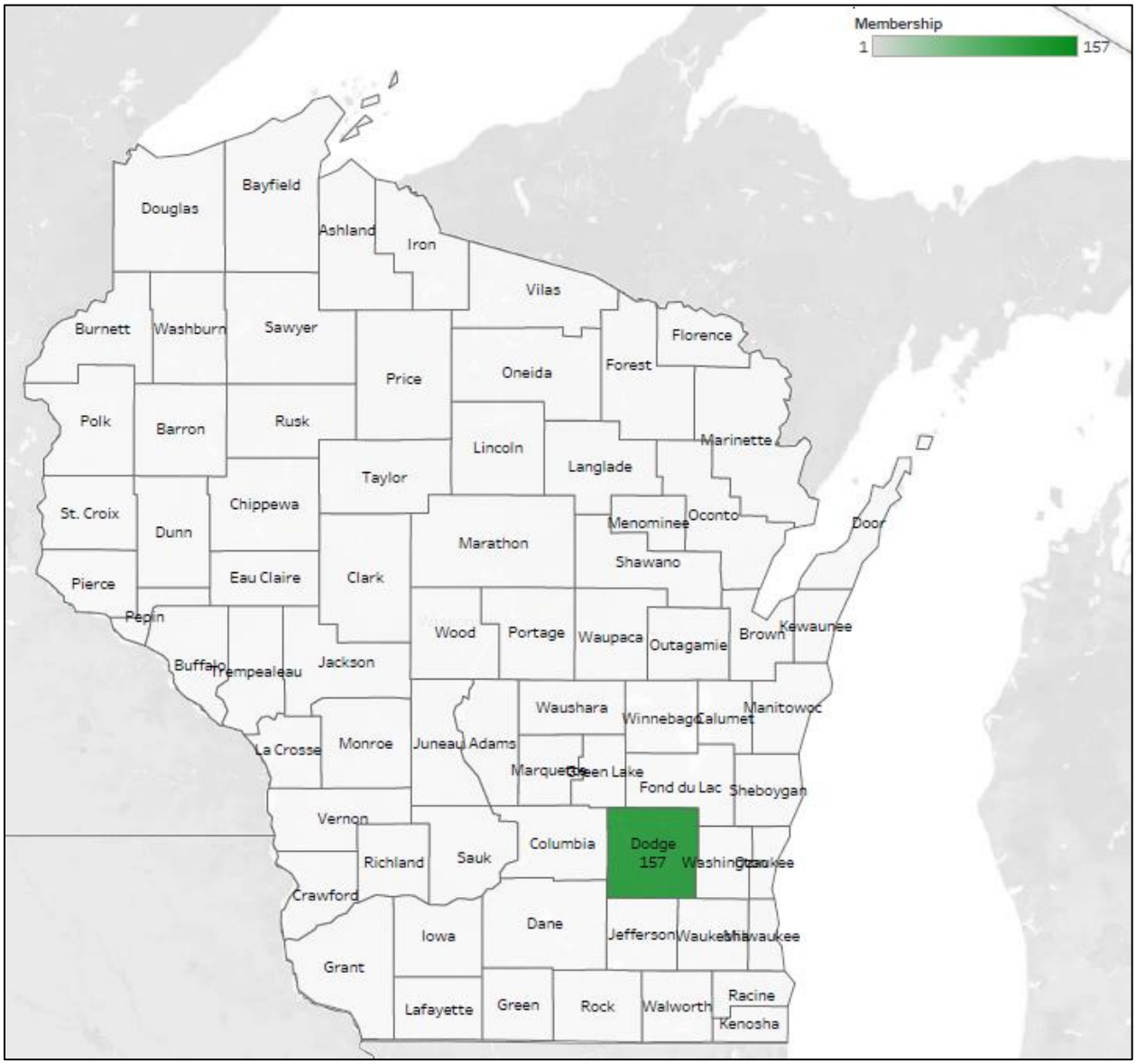
Dodge
Richland
Crawford
Dane
Iowa
Jefferson
Grant
Lafayette
Green
Rock
Walworth
Racine
Kenosha

I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Bayfield
Ashland
Iron
Vilas
Florence
Burnett
Washburn
Sawyer
Price
Oneida
Forest
Polk
Barron
Rusk
Lincoln
Langlade
Marinette
Taylor
St. Croix
Dunn
Chippewa
Marathon
Menominee
Oconto
Door
Shawano
Pierce
Eau Claire
Clark
Pepin
Wood
Portage
Waupaca
Outagamie
Brown
Kewaunee
Buffalo
Trempealeau
Jackson
Waushara
Winnebago
Calumet
Manitowoc
La Crosse
Monroe
Juneau
Adams
Marquette
Green Lake
Fond du Lac
Sheboygan
Vernon
Columbia
Dodge
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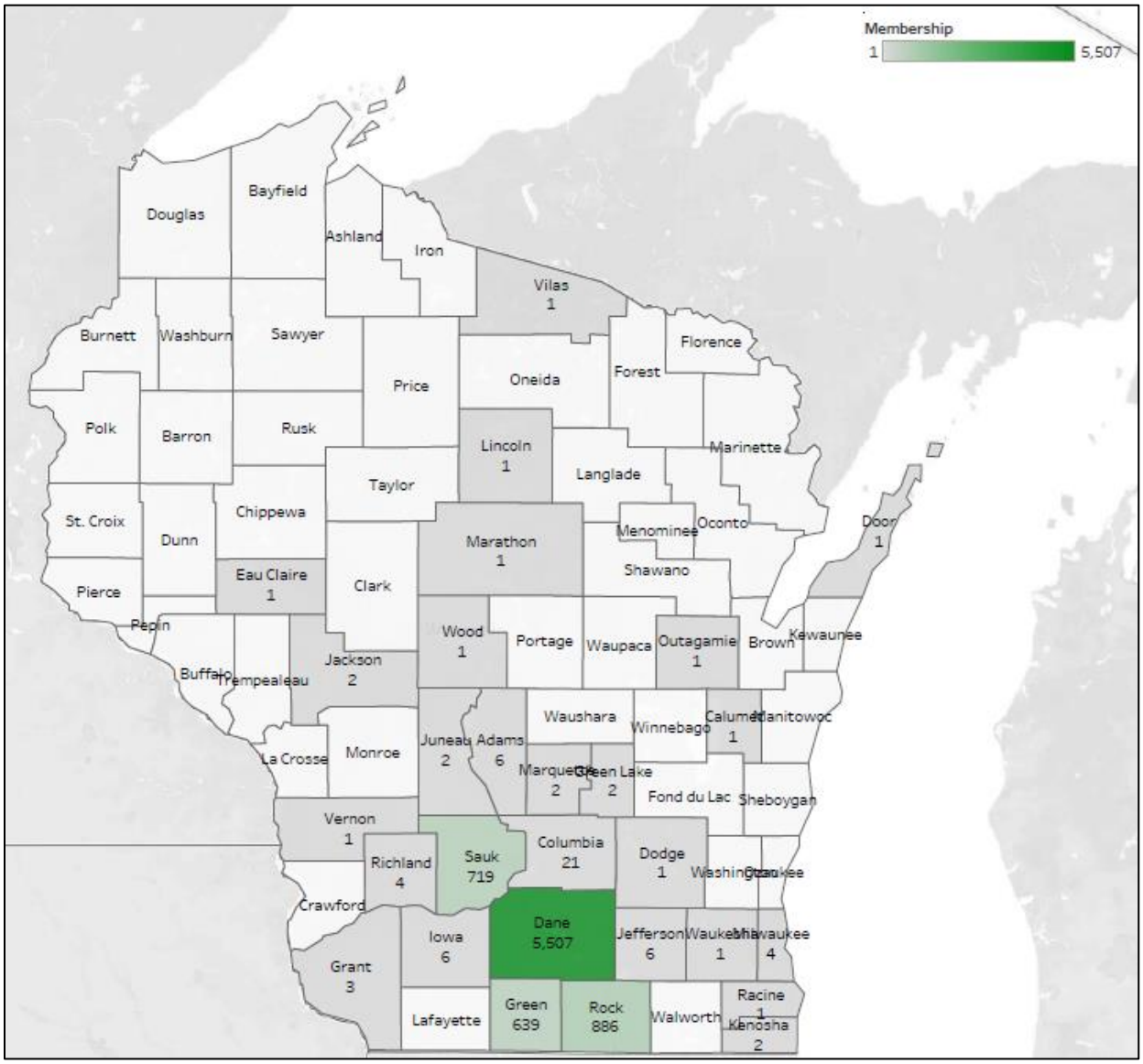
Richland
Sauk
Crawford
Dane
Iowa
Jefferson
Grant
Lafayette
Green
Rock
Walworth
Racine
Kenosha

J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Bayfield
Ashland
Iron
Vilas
1
Burnett
Washburn
Sawyer
Price
Oneida
Forest
Florence
Polk
Barron
Rusk
Lincoln
1
Langlade
Marinette
Taylor
St. Croix
Dunn
Chippewa
Marathon
1
Menominee
Oconto
Door
1
Shawano
Pierce
Eau Claire
1
Clark
Pepin
Wood
1
Portage
Waupaca
Outagamie
1
Brown
Kewaunee
Buffalo
Trempealeau
Jackson
2
Waushara
Winnebago
Calumet
1
Manitowoc
La Crosse
Monroe
Juneau
2
Adams
6
Marquette
2
Green Lake
2
Fond du Lac
Sheboygan
Vernon
1
Richland
4
Sauk
719
Columbia
21
Dodge
1
Washington
Ozaukee
Crawford
Dane
5,507
Iowa
6
Jefferson
6
Waukesha
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Milwaukee
4
Grant
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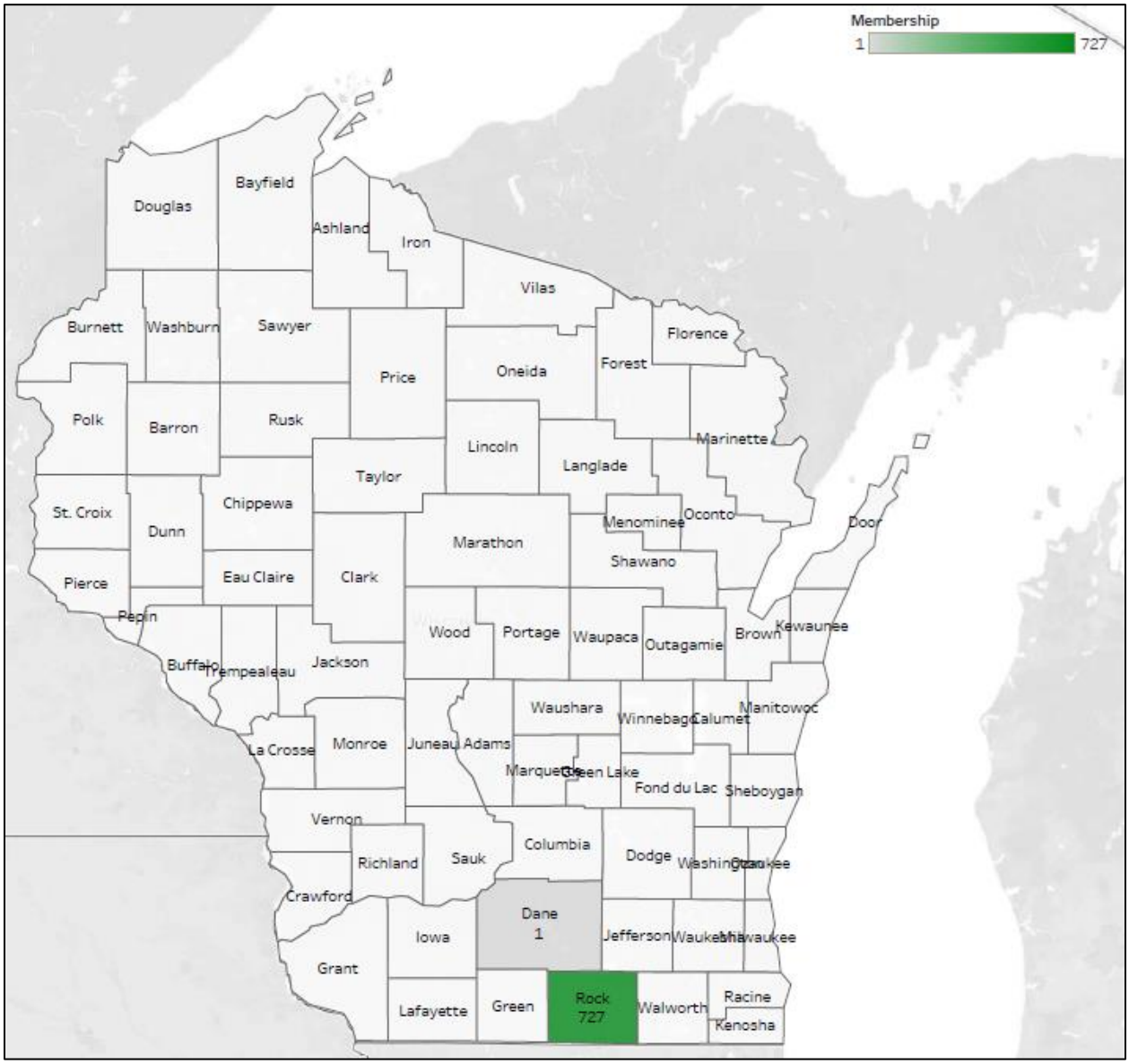
Lafayette
Green
639
Rock
886
Walworth
Racine
1
Kenosha
2

K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Bayfield
Ashland
Iron
Vilas
Florence
Burnett
Washburn
Sawyer
Price
Oneida
Forest
Polk
Barron
Rusk
Lincoln
Langlade
Marinette
Taylor
St. Croix
Dunn
Chippewa
Marathon
Menominee
Oconto
Door
Shawano
Pierce
Eau Claire
Clark
Pepin
Wood
Portage
Waupaca
Outagamie
Brown
Kewaunee
Buffalo
Trempealeau
Jackson
Waushara
Winnebago
Calumet
Manitowoc
La Crosse
Monroe
Juneau
Adams
Marquette
Green Lake
Fond du Lac
Sheboygan
Vernon
Richland
Sauk
Columbia
Dodge
Crawford
Dane
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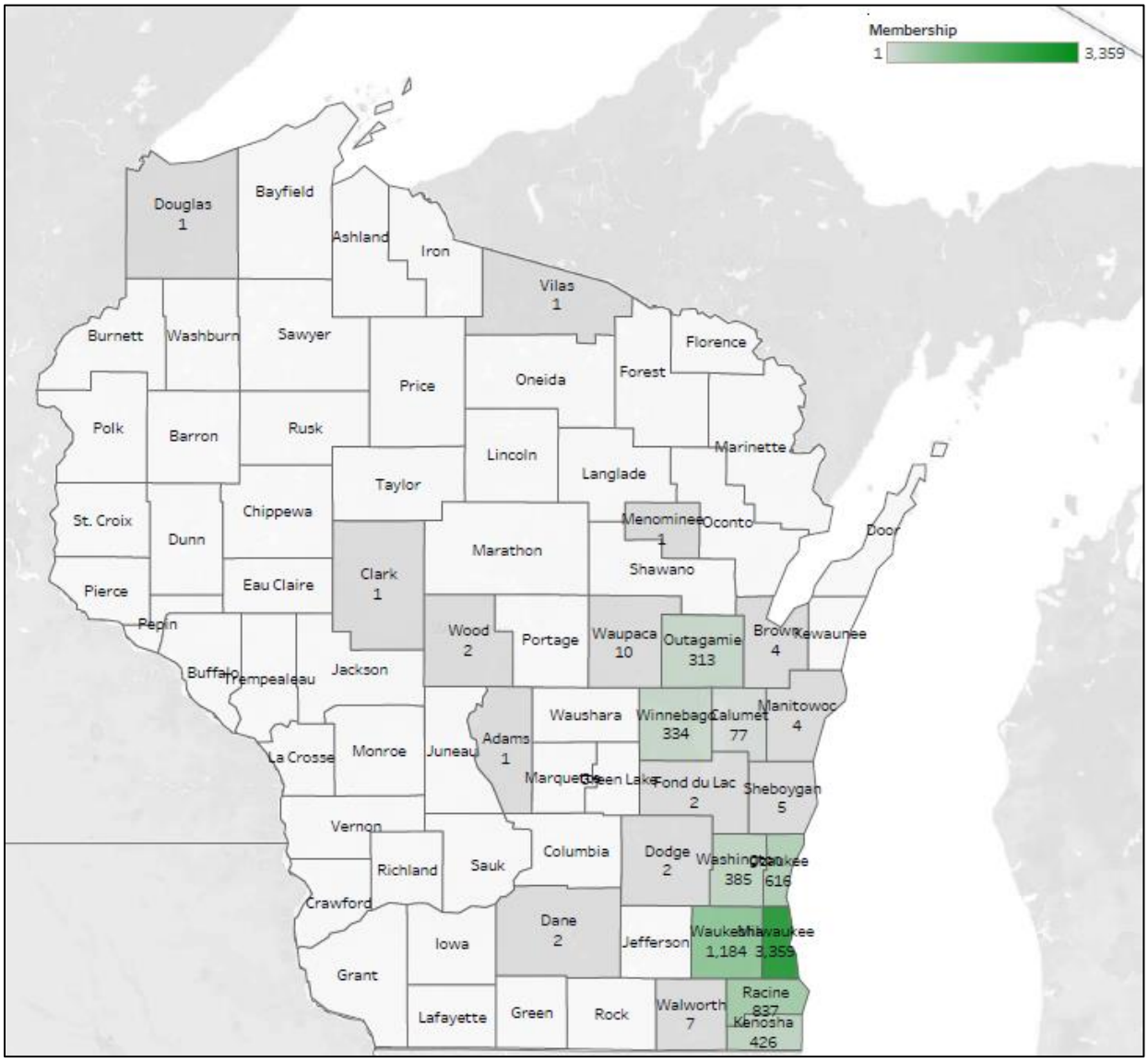
Iowa
Jefferson
Grant
Lafayette
Green
Rock
727
Walworth
Racine
Kenosha

L


Membership
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Bayfield
Ashland
Iron
Vilas
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Burnett
Washburn
Sawyer
Price
Oneida
Forest
Florence
Polk
Barron
Rusk
Lincoln
Langlade
Marinette
Taylor
St. Croix
Dunn
Chippewa
Marathon
Menominee
1
Oconto
Door
Clark
1
Shawano
Pierce
Eau Claire
Pepin
Wood
2
Portage
Waupaca
10
Outagamie
313
Brown
4
Kewaunee
Buffalo
Trempealeau
Jackson
Waushara
Winnebago
334
Calumet
77
Manitowoc
4
La Crosse
Monroe
Juneau
Adams
1
Marquette
Green Lake
Fond du Lac
2
Sheboygan
5
Vernon
Columbia
Dodge
2
Washington
385
Ozaukee
616
Richland
Sauk
Crawford
Dane
2
Jefferson
Waukesha
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Grant
Lafayette
Green
Rock
Walworth
7
Racine
837
Kenosha
426

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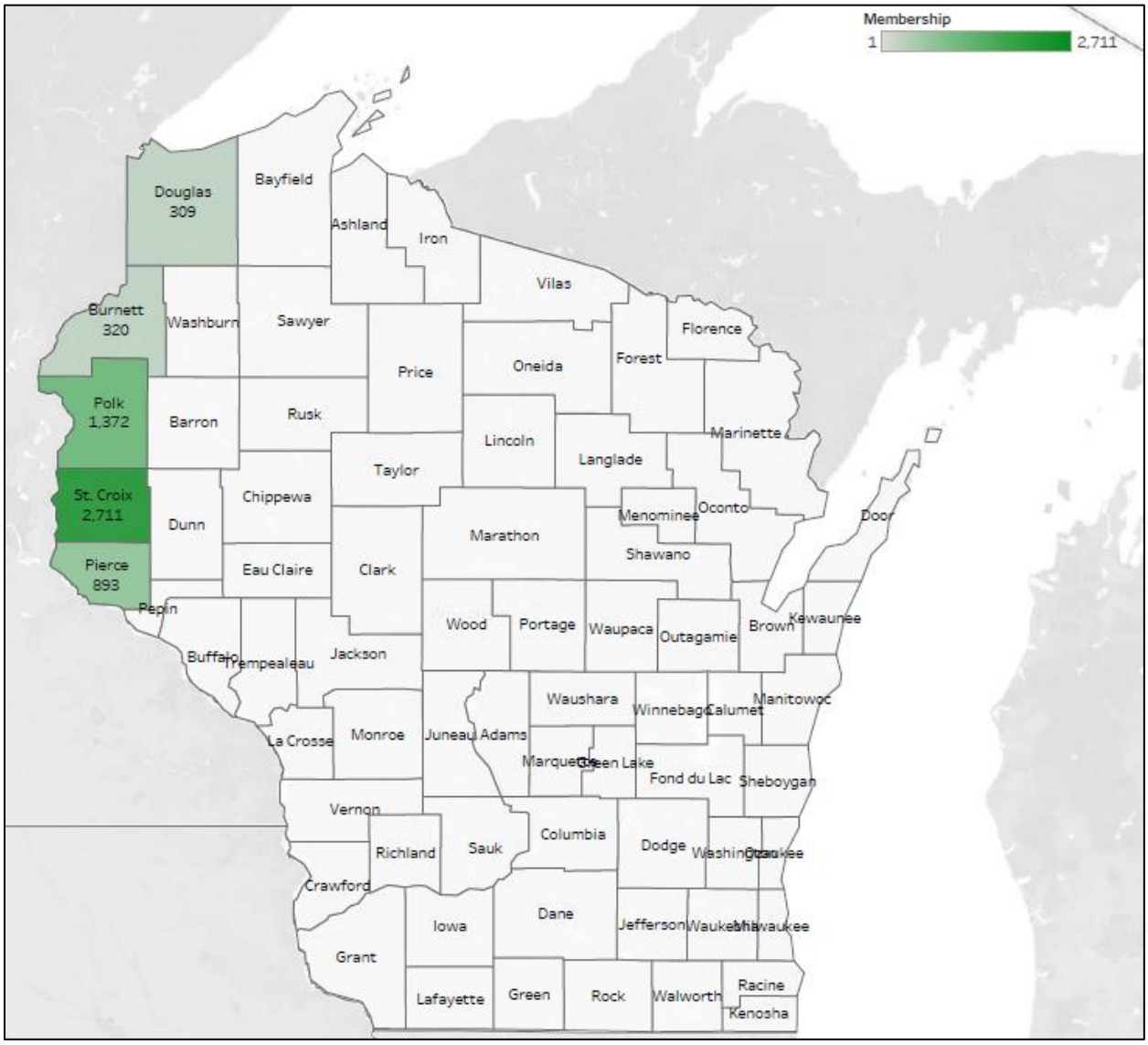
Membership
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2,711
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Bayfield
Ashland
Iron
Vilas
Florence
Burnett
320
Washburn
Sawyer
Price
Oneida
Forest
Polk
1,372
Barron
Rusk
Lincoln
Langlade
Marinette
Taylor
St. Croix
2,711
Chippewa
Dunn
Marathon
Menominee
Oconto
Door
Shawano
Pierce
893
Eau Claire
Clark
Pepin
Wood
Portage
Waupaca
Outagamie
Brown
Kewaunee
Buffalo
Trempealeau
Jackson
Waushara
Winnebago
Calumet
Manitowoc
La Crosse
Monroe
Juneau
Adams
Marquette
Green Lake
Fond du Lac
Sheboygan
Vernon
Columbia
Dodge
Richland
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Crawford
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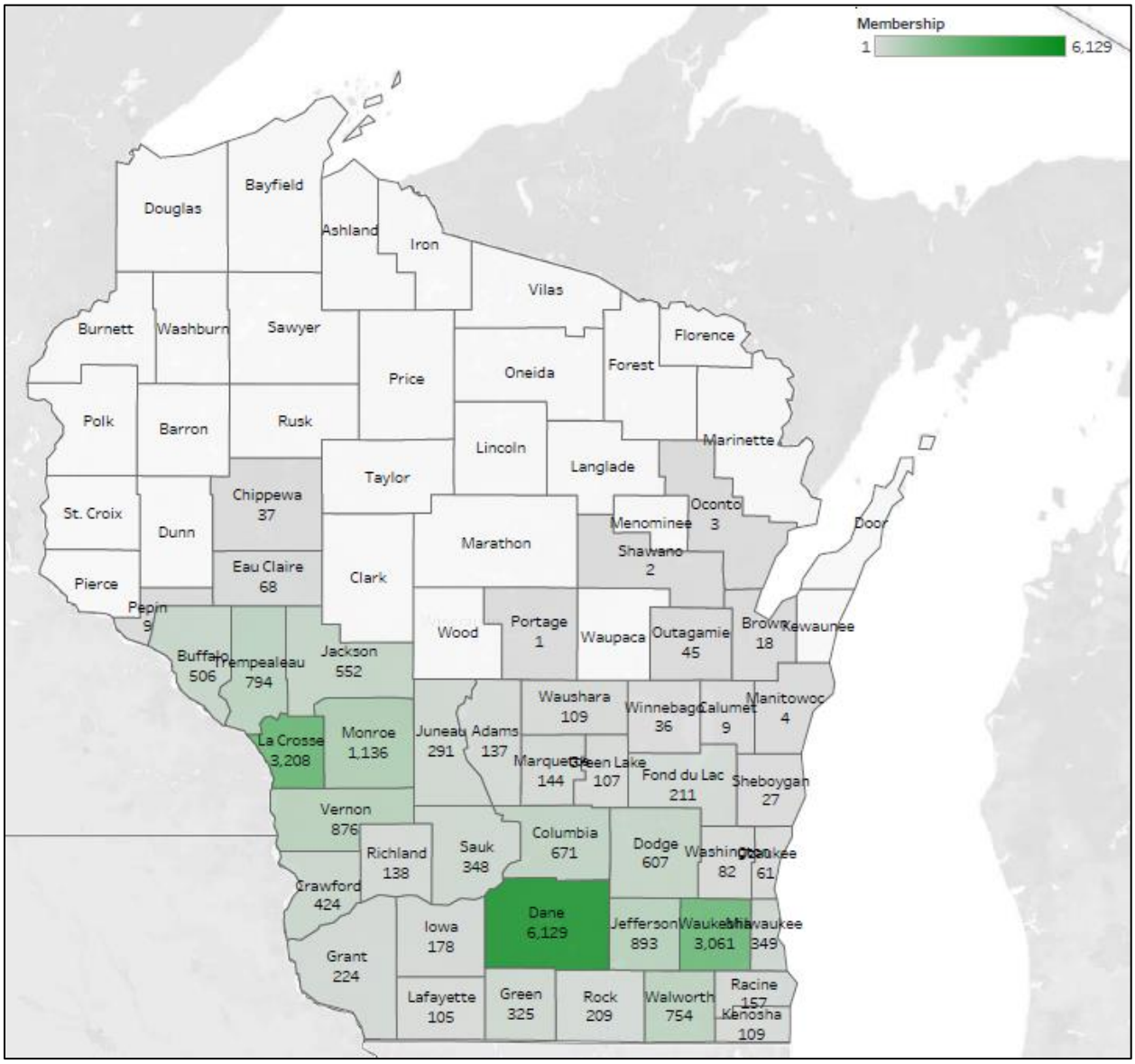
Iowa
Jefferson
Grant
Lafayette
Green
Rock
Walworth
Racine
Kenosha

N


Membership
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6,129
Douglas
Bayfield
Ashland
Iron
Vilas
Florence
Burnett
Washburn
Sawyer
Price
Oneida
Forest
Polk
Barron
Rusk
Lincoln
Langlade
Marinette
Taylor
St. Croix
Chippewa
37
Oconto
3
Door
Dunn
Menominee
Marathon
Shawano
2
Pierce
Eau Claire
68
Clark
Pepin
9
Wood
Portage
1
Waupaca
Outagamie
45
Brown
18
Kewaunee
Buffalo
506
Trempealeau
794
Jackson
552
Waushara
109
Winnebago
36
Calumet
9
Manitowoc
4
La Crosse
3,208
Monroe
1,136
Juneau
291
Adams
137
Marquette
144
Green Lake
107
Fond du Lac
211
Sheboygan
27
Vernon
876
Richland
138
Sauk
348
Columbia
671
Dodge
607
Washington
82
Ozaukee
61
Crawford
424
Dane
6,129
Jefferson
893
Waukesha
3,061
Milwaukee
349
Iowa
178
Grant
224
Lafayette
105
Green
325
Rock
209
Walworth
754
Racine
157
Kenosha
109

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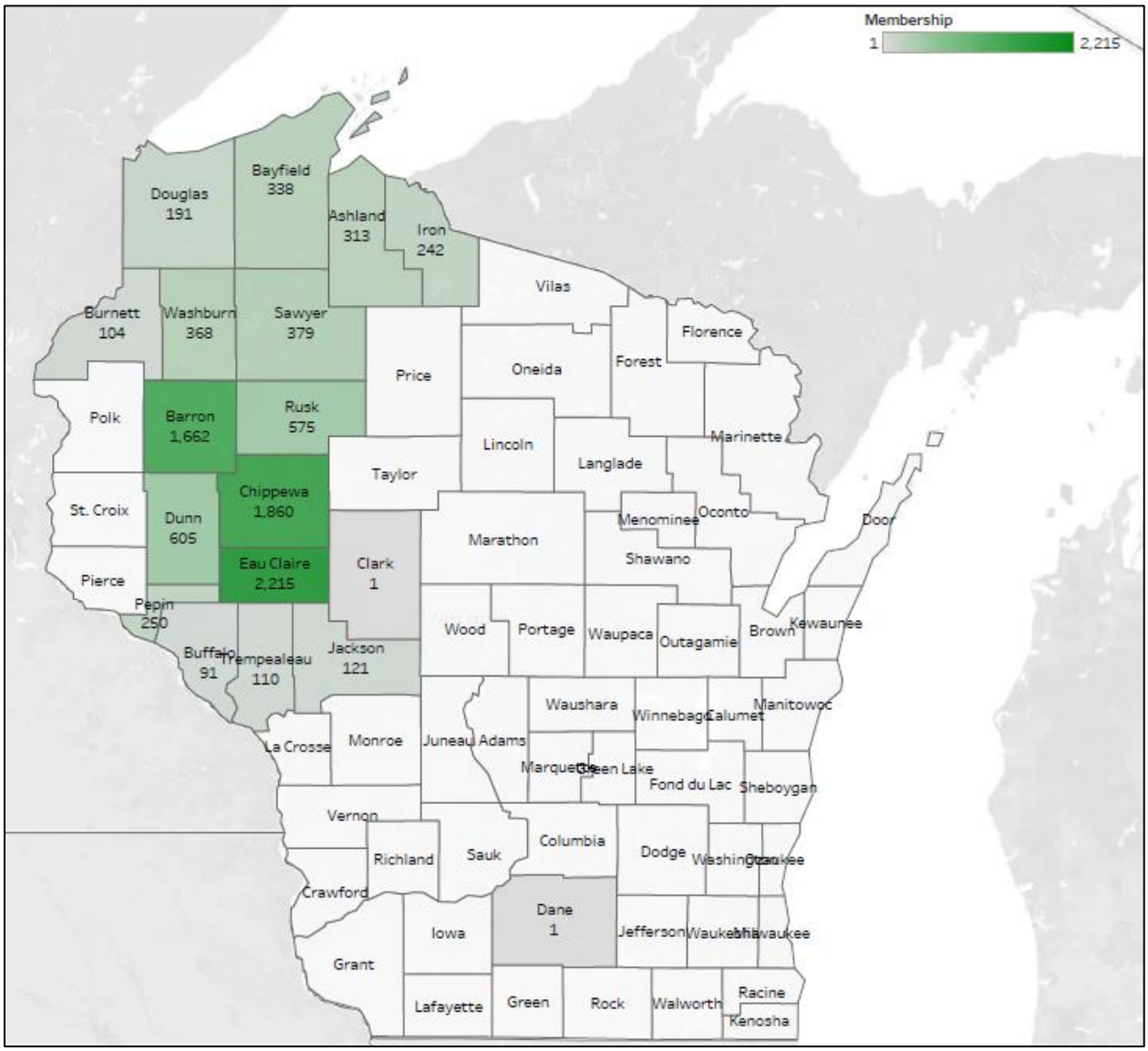
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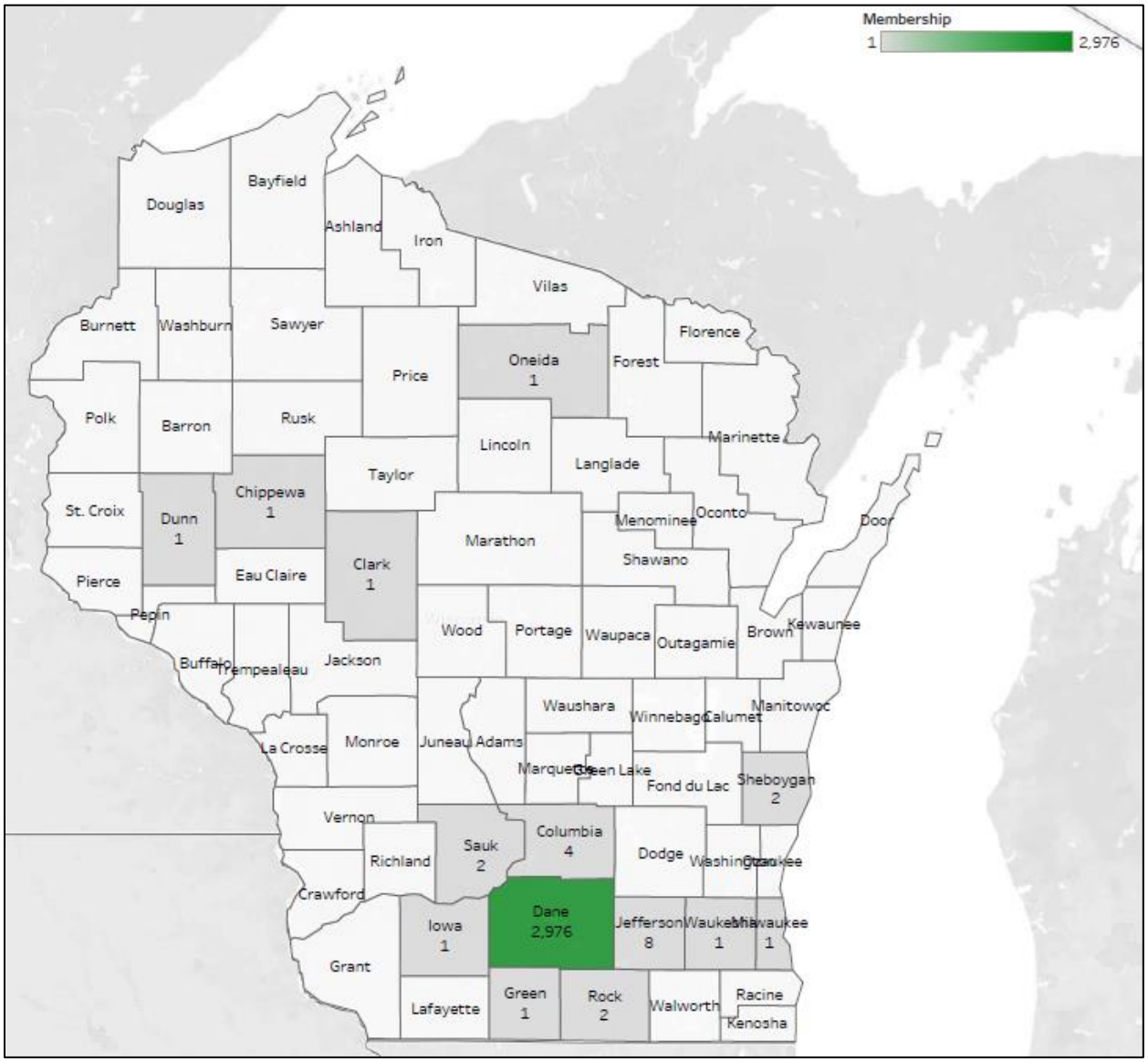
2,215
Douglas
191
Bayfield
338
Ashland
313
Iron
242
Vilas
Florence
Burnett
104
Washburn
368
Sawyer
379
Price
Oneida
Forest
Polk
Barron
1,662
Rusk
575
Lincoln
Langlade
Marinette
Taylor
Chippewa
1,860
St. Croix
Dunn
605
Marathon
Menominee
Oconto
Door
Shawano
Pierce
Eau Claire
2,215
Clark
1
Pepin
250
Wood
Portage
Waupaca
Outagamie
Brown
Kewaunee
Buffalo
91
Trempealeau
110
Jackson
121
Waushara
Winnebago
Calumet
Manitowoc
La Crosse
Monroe
Juneau
Adams
Marquette
Green Lake
Fond du Lac
Sheboygan
Vernon
Richland
Sauk
Columbia
Dodge
Crawford
Dane
1
Iowa
Jefferson
Grant
Lafayette
Green
Rock
Walworth
Racine
Kenosha

P


Membership
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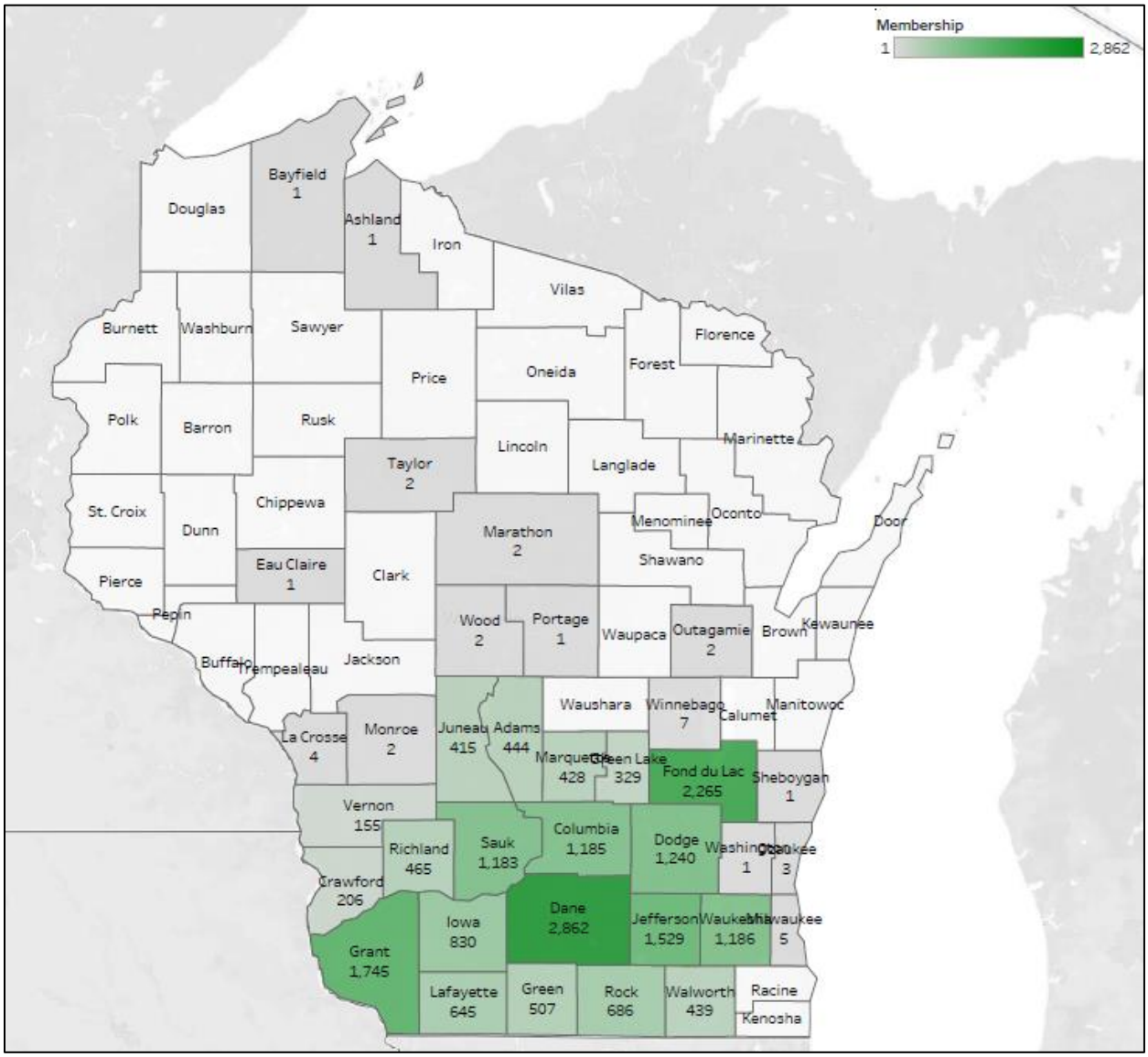
Douglas
Bayfield
Ashland
Iron
Vilas
Florence
Burnett
Washburn
Sawyer
Price
Oneida
1
Forest
Polk
Barron
Rusk
Lincoln
Langlade
Marinette
Taylor
St. Croix
Dunn
1
Chippewa
1
Menominee
Oconto
Door
Marathon
Clark
1
Shawano
Pierce
Eau Claire
Pepin
Wood
Portage
Waupaca
Outagamie
Brown
Kewaunee
Buffalo
Trempealeau
Jackson
Waushara
Winnebago
Calumet
Manitowoc
La Crosse
Monroe
Juneau
Adams
Marquette
Green Lake
Fond du Lac
Sheboygan
2
Vernon
Columbia
4
Sauk
2
Dodge
Richland
Crawford
Dane
2,976
Iowa
1
Jefferson
8
Waukesha
1
Milwaukee
1
Grant
Lafayette
Green
1
Rock
2
Walworth
Racine
Kenosha

Q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Iron
Vilas
Florence
Burnett
Washburn
Sawyer
Price
Oneida
Forest
Polk
Barron
Rusk
Lincoln
Langlade
Marinette
Taylor
2
St. Croix
Dunn
Chippewa
Marathon
2
Menominee
Oconto
Door
Pierce
Eau Claire
1
Clark
Shawano
Pepin
Wood
2
Portage
1
Waupaca
Outagamie
2
Brown
Kewaunee
Buffalo
Trempealeau
Jackson
Waushara
Winnebago
7
Calumet
Manitowoc
La Crosse
4
Monroe
2
Juneau
415
Adams
444
Marquette
428
Green Lake
329
Fond du Lac
2,265
Sheboygan
1
Vernon
155
Richland
465
Sauk
1,183
Columbia
1,185
Dodge
1,240
Washington
1
Ozaukee
3
Crawford
206
Dane
2,862
Jefferson
1,529
Waukesha
1,186
Milwaukee
5
Iowa
830
Grant
1,745
Lafayette
645
Green
507
Rock
686
Walworth
439
Racine
Kenosha

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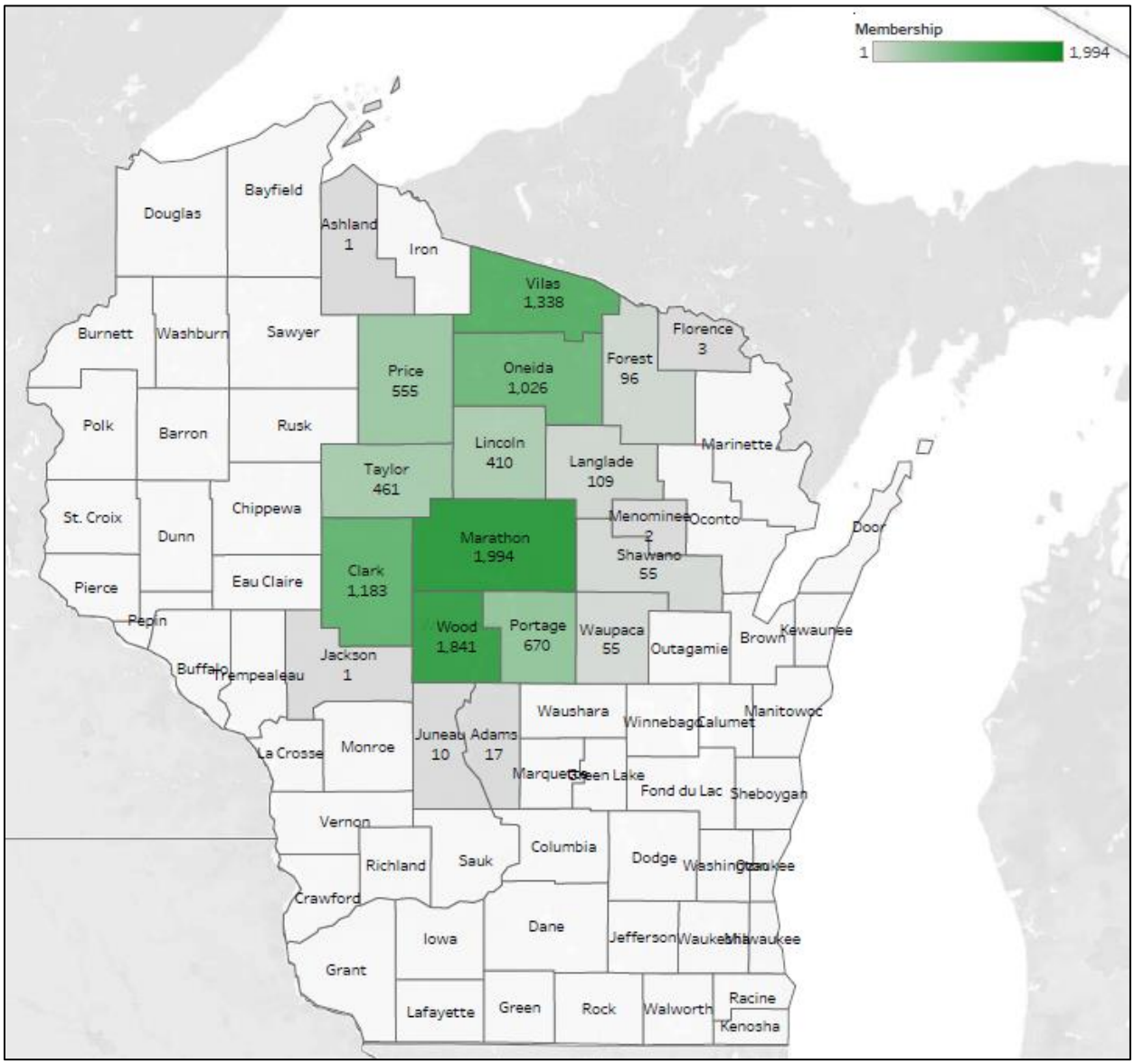
Membership
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Douglas
Bayfield
Ashland
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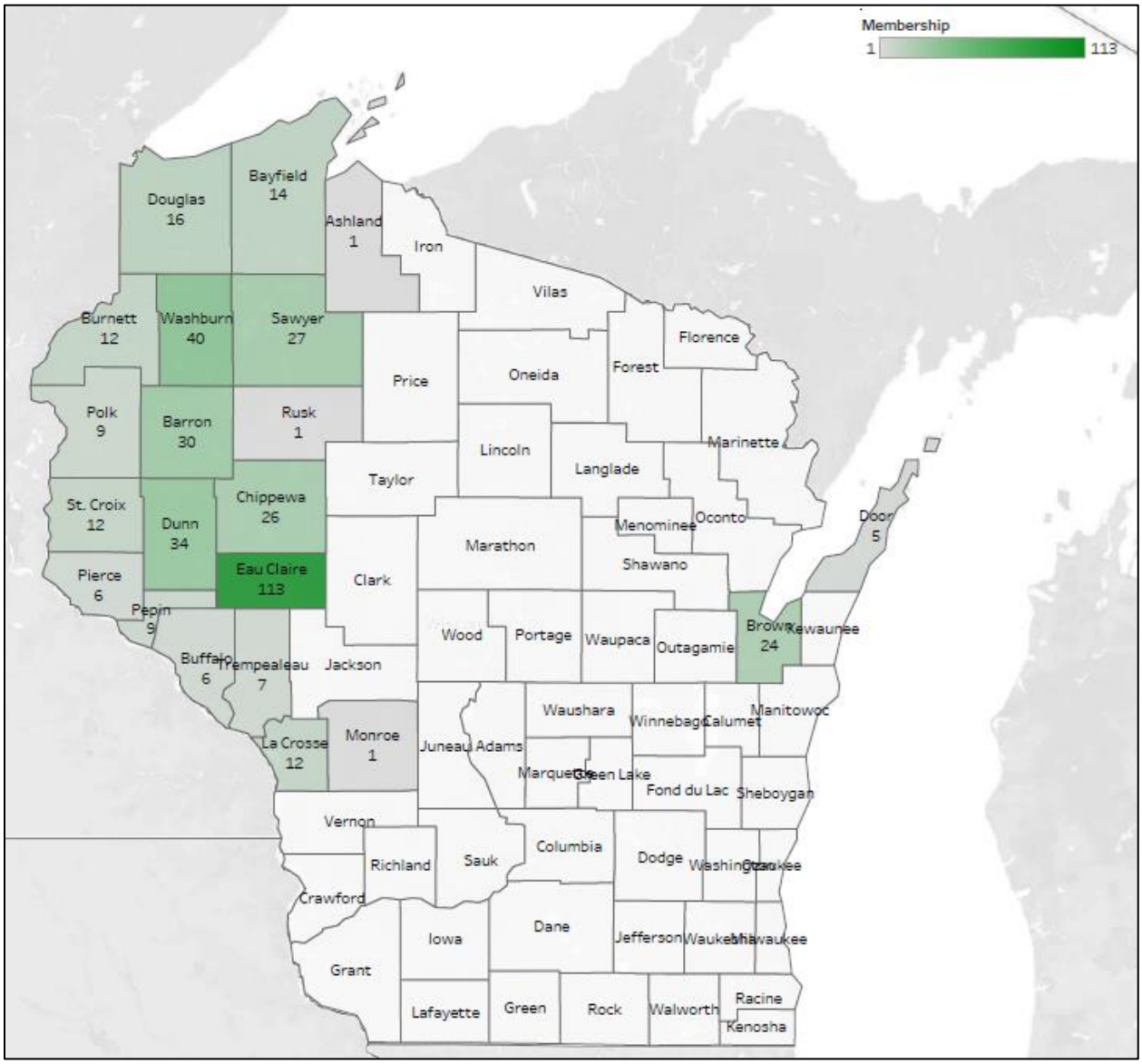
Iron
Vilas
1,338
Florence
3
Burnett
Washburn
Sawyer
Price
555
Oneida
1,026
Forest
96
Polk
Barron
Rusk
Lincoln
410
Langlade
109
Marinette
Taylor
461
St. Croix
Dunn
Chippewa
Marathon
1,994
Menominee
2
Oconto
Door
Shawano
55
Pierce
Eau Claire
Clark
1,183
Pepin
Wood
1,841
Portage
670
Waupaca
55
Outagamie
Brown
Kewaunee
Buffalo
Trempealeau
Jackson
1
Waushara
Winnebago
Calumet
Manitowoc
La Crosse
Monroe
Juneau
10
Adams
17
Marquette
Green Lake
Fond du Lac
Sheboygan
Vernon
Richland
Sauk
Columbia
Dodge
Crawford
Iowa
Dane
Jefferson
Grant
Lafayette
Green
Rock
Walworth
Racine
Kenosha

S


Membership
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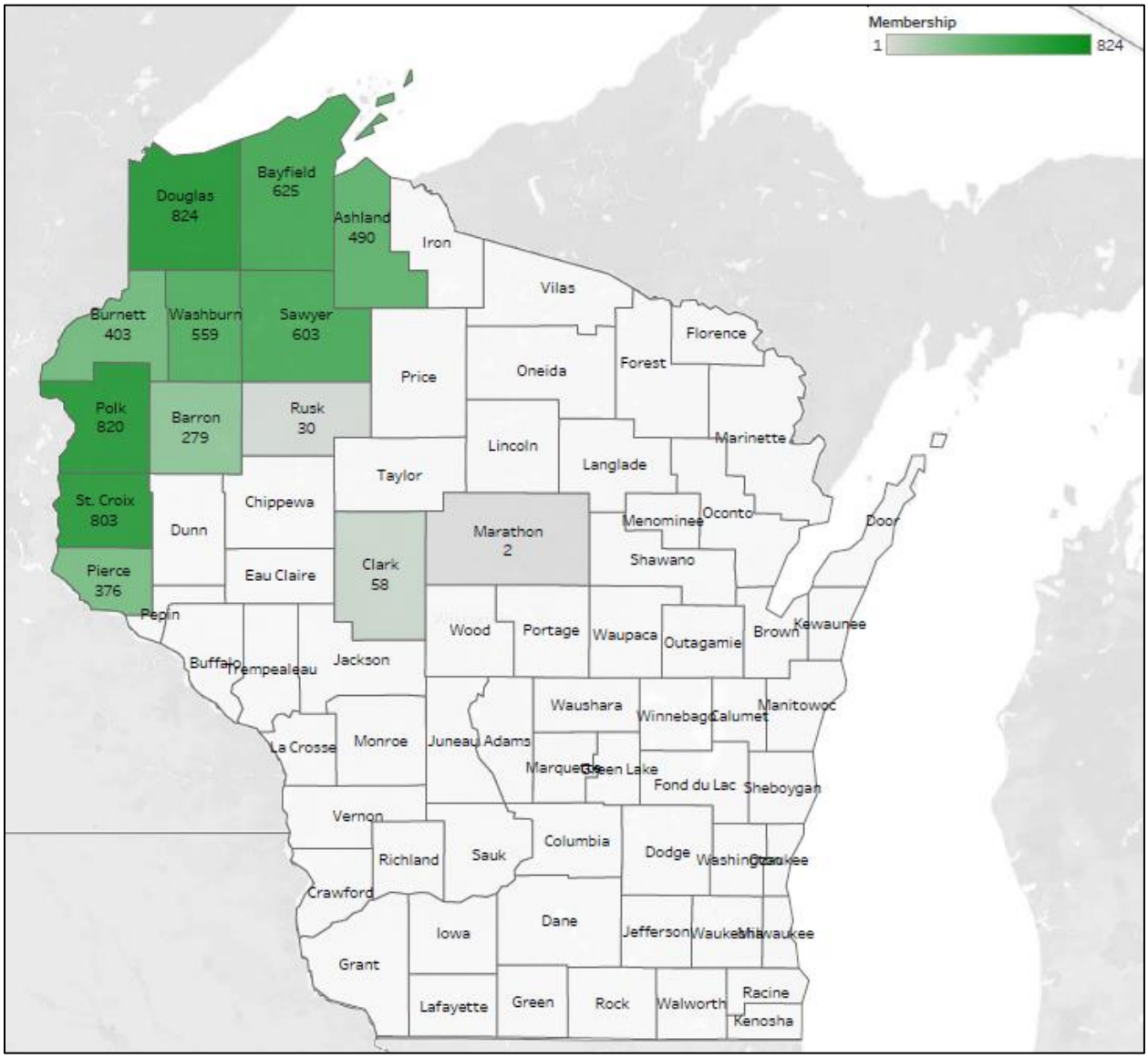
113
Douglas
16
Bayfield
14
Ashland
1
Iron
Vilas
Florence
Burnett
12
Washburn
40
Sawyer
27
Price
Oneida
Forest
Polk
9
Barron
30
Rusk
1
Lincoln
Langlade
Marinette
Taylor
St. Croix
12
Dunn
34
Chippewa
26
Menominee
Oconto
Door
5
Marathon
Pierce
6
Eau Claire
113
Clark
Shawano
Pepin
9
Wood
Portage
Waupaca
Outagamie
Brown
24
Kewaunee
Buffalo
6
Trempealeau
7
Jackson
Waushara
Winnebago
Calumet
Manitowoc
La Crosse
12
Monroe
1
Juneau
Adams
Marquette
Green Lake
Fond du Lac
Sheboygan
Vernon
Richland
Sauk
Columbia
Dodge
Crawford
Iowa
Dane
Jefferson
Grant
Lafayette
Green
Rock
Walworth
Racine
Kenosha

T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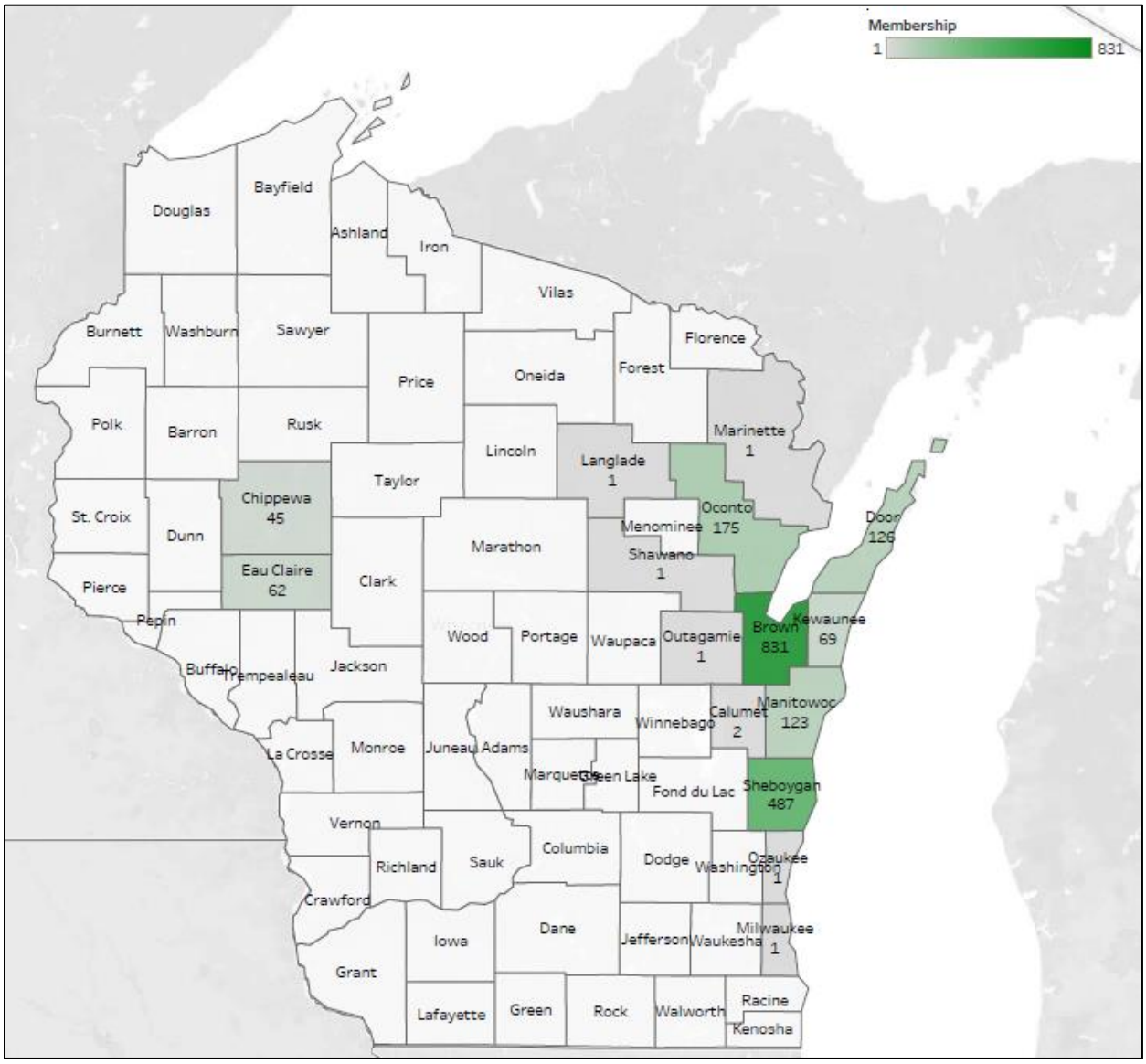
Douglas
824
Bayfield
625
Ashland
490
Iron
Vilas
Florence
Burnett
403
Washburn
559
Sawyer
603
Price
Oneida
Forest
Polk
820
Barron
279
Rusk
30
Lincoln
Langlade
Marinette
Taylor
St. Croix
803
Chippewa
Dunn
Marathon
2
Menominee
Oconto
Door
Shawano
Pierce
376
Eau Claire
Clark
58
Pepin
Wood
Portage
Waupaca
Outagamie
Brown
Kewaunee
Buffalo
Trempealeau
Jackson
Waushara
Winnebago
Calumet
Manitowoc
La Crosse
Monroe
Juneau
Adams
Marquette
Green Lake
Fond du Lac
Sheboygan
Vernon
Richland
Sauk
Columbia
Dodge
Crawford
Dane
Jefferson
Iowa
Grant
Lafayette
Green
Rock
Walworth
Racine
Kenosha

U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Bayfield
Ashland
Iron
Vilas
Florence
Burnett
Washburn
Sawyer
Price
Oneida
Forest
Polk
Barron
Rusk
Lincoln
Langlade
1
Marinette
1
Taylor
Chippewa
45
St. Croix
Dunn
Marathon
Menominee
Oconto
175
Door
126
Shawano
1
Eau Claire
62
Clark
Pierce
Pepin
Wood
Portage
Waupaca
Outagamie
1
Brown
831
Kewaunee
69
Buffalo
Trempealeau
Jackson
Waushara
Winnebago
Calumet
2
Manitowoc
123
La Crosse
Monroe
Juneau
Adams
Marquette
Green Lake
Fond du Lac
Sheboygan
487
Vernon
Richland
Sauk
Columbia
Dodge
Washington
Ozaukee
1
Crawford
Iowa
Dane
Jefferson
Waukesha
Milwaukee
1
Grant
Lafayette
Green
Rock
Walworth
Racine
Kenosha

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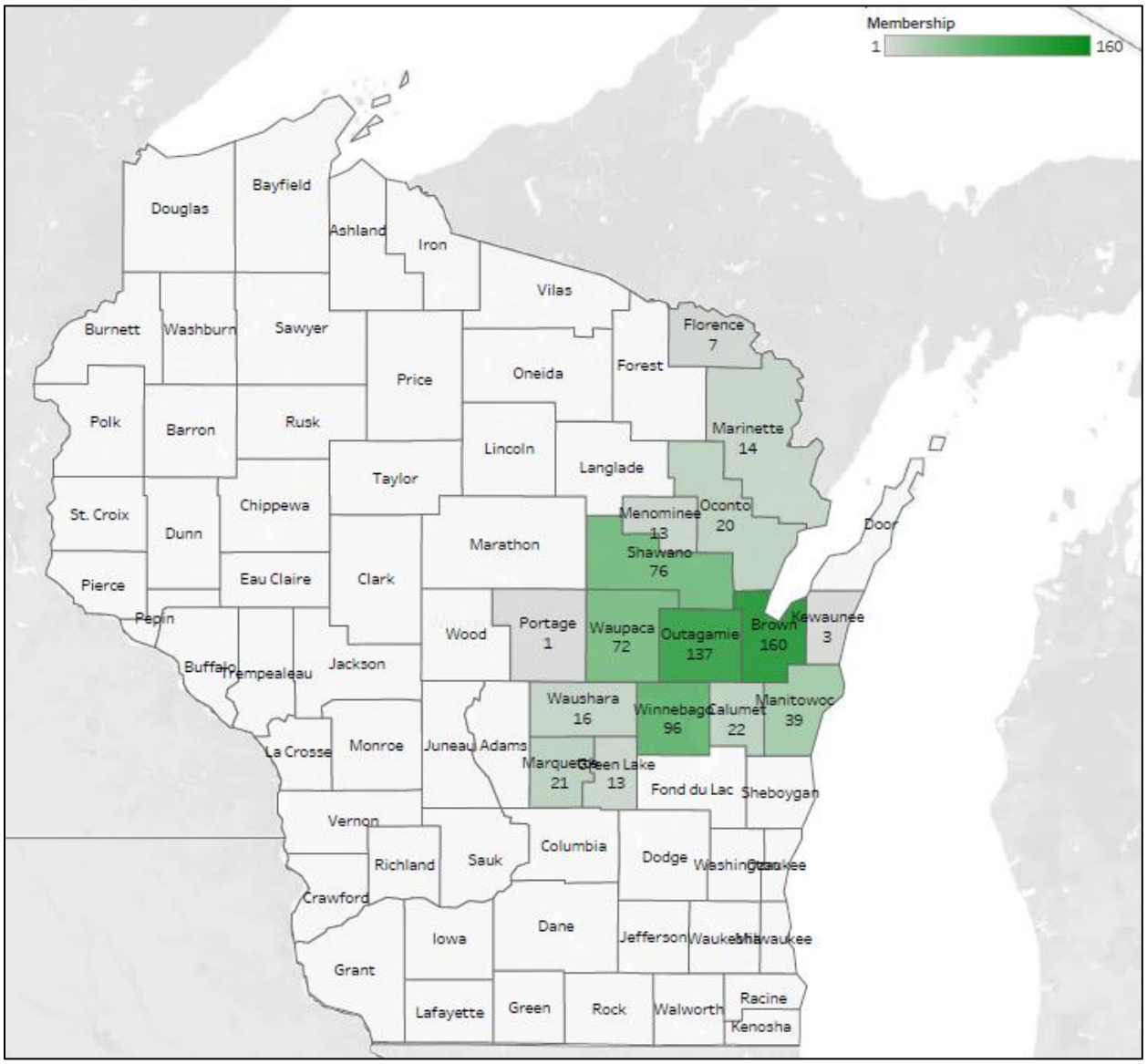
Membership
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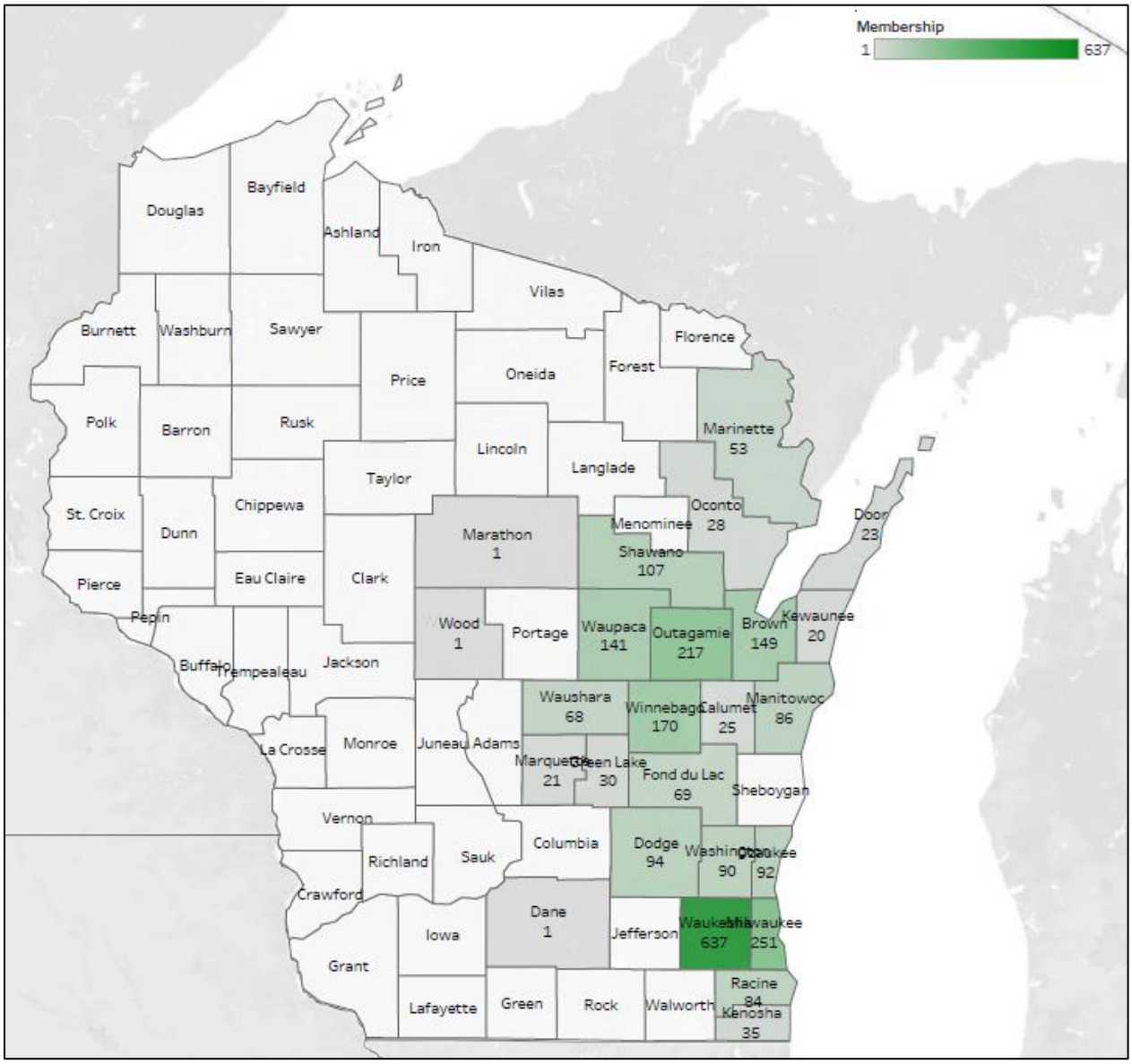
160
Douglas
Bayfield
Ashland
Iron
Vilas
Florence
7
Burnett
Washburn
Sawyer
Price
Oneida
Forest
Marinette
14
Polk
Barron
Rusk
Lincoln
Langlade
Taylor
St. Croix
Dunn
Chippewa
Menominee
13
Oconto
20
Door
Marathon
Shawano
76
Pierce
Eau Claire
Clark
Pepin
Wood
Portage
1
Waupaca
72
Outagamie
137
Brown
160
Kewaunee
3
Buffalo
Trempealeau
Jackson
Waushara
16
Winnebago
96
Calumet
22
Manitowoc
39
La Crosse
Monroe
Juneau
Adams
Marquette
21
Green Lake
13
Fond du Lac
Sheboygan
Vernon
Columbia
Dodge
Richland
Sauk
Crawford
Dane
Jefferson
Iowa
Grant
Lafayette
Green
Rock
Walworth
Racine
Kenosha

W


Membership
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Douglas
Bayfield
Ashland
Iron
Vilas
Florence
Burnett
Washburn
Sawyer
Price
Oneida
Forest
Polk
Barron
Rusk
Lincoln
Langlade
Marinette
53
Taylor
St. Croix
Dunn
Chippewa
Marathon
1
Menominee
Oconto
28
Door
23
Shawano
107
Pierce
Eau Claire
Clark
Pepin
Wood
1
Portage
Waupaca
141
Outagamie
217
Brown
149
Kewaunee
20
Buffalo
Trempealeau
Jackson
Waushara
68
Winnebago
170
Calumet
25
Manitowoc
86
La Crosse
Monroe
Juneau
Adams
Marquette
21
Green Lake
30
Fond du Lac
69
Sheboygan
Vernon
Columbia
Dodge
94
Washington
90
Ozaukee
92
Richland
Sauk
Crawford
Dane
1
Jefferson
Waukesha
637
Milwaukee
251
Iowa
Grant
Racine
84
Lafayette
Green
Rock
Walworth
Kenosha
35