



December 2022

PRIVATE HEALTH INSURANCE

State and Federal Oversight of Provider Networks Varies

Accessible Version

Why GAO Did This Study

The majority of Americans—or about two-thirds of individuals in the United States—receive their health coverage through private health plans. Health plans establish provider networks—the doctors, other providers, and facilities with which a plan contracts—to provide medical care to their enrollees. A provider network can be inadequate if the network has an insufficient number of providers or facilities to provide care to health plan enrollees. Inadequate networks can affect enrollees' ability to access care in a reasonably timely manner.

The Consolidated Appropriations Act, 2021, includes a provision for GAO to review the adequacy of provider networks in individual and group health plans. This report describes (1) state, CMS, and DOL oversight of the adequacy of provider networks; and (2) what is known about the adequacy of individual and group health plans' provider networks.

For this report, GAO (1) reviewed CMS and DOL guidance and reports; (2) conducted a survey and received responses from 49 states and the District of Columbia about oversight practices and any issues states experienced with network adequacy; (3) interviewed officials from CMS, DOL, selected states, and stakeholders, such as the American Medical Association; and (4) reviewed available literature that assessed provider network adequacy.

GAO provided a draft of this report to the Department of Health and Human Services and DOL. Both agencies provided technical comments, which were incorporated as appropriate.

View [GAO-23-105642](#). For more information, contact John E. Dicken at (202) 512-7114 or DickenJ@gao.gov.

PRIVATE HEALTH INSURANCE

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What GAO Found

Provider network adequacy refers to a health plan's ability to deliver the benefits promised to enrollees by providing reasonable access to a sufficient number of in-network providers. Inadequate networks can make it more likely that enrollees obtain care from out-of-network providers, which can be more expensive. State agencies and the Departments of Health and Human Services and Labor (DOL) each have responsibilities for overseeing private health plans, including, in some cases, certain requirements related to the adequacy of provider networks. These oversight practices varied.

- Officials from 45 of the 50 states (including the District of Columbia) that responded to GAO's survey reported they took varying actions to oversee the adequacy of individual and group health plans' provider networks. For example, officials from 32 states reported they review health plans' provider networks prior to approval of the plan for sale, and officials from 23 states reviewed plans when there were changes to the network. Officials from 44 states reported in GAO's survey that they used at least one standard to assess the adequacy of networks. Examples of standards include a maximum time or distance to a provider or a maximum wait time to see a provider.
- The Centers for Medicare & Medicaid Services (CMS) within the Department of Health and Human Services oversees the adequacy of provider networks for most qualified health plans (QHP) offered on the federally facilitated exchanges. CMS's oversight actions include annual and targeted reviews of QHP networks in addition to reviews of provider directories—listings of a plan's in-network providers and facilities. For example, as part of the agency's annual review of QHPs for plan year 2023, CMS officials told GAO they compare issuer data on their provider networks against CMS's network adequacy standards.
- DOL does not have authority or standards to enforce network adequacy for private employer-sponsored group health plans generally, but DOL conducts reviews of compliance with mental health and substance use disorder parity requirements. DOL enforces these requirements by conducting reviews to ensure that limitations on mental health and substance use disorder benefits are no more restrictive than limitations on medical/surgical benefits.

While there is no comprehensive information on the overall adequacy of provider networks, states and CMS identified issuers that were not in compliance with network adequacy standards. Information also indicated other potential limitations in access to certain provider specialties like mental health and pediatrics. States and stakeholders also reported interrelated factors that may contribute to inadequate networks—provider shortages, challenges in contracting with providers, and geography. These interrelated factors were consistent with the literature. For example, provider shortages can contribute to inadequate networks. This can be particularly challenging in rural areas because such shortages limit the number of available providers with which an issuer can contract.

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Abbreviations

CMS	Centers for Medicare & Medicaid Services
DOL	Department of Labor
ECP	essential community providers
QHP	qualified health plan

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December 15, 2022

Congressional Committees

The majority of Americans receive their health coverage through private health plans, either by purchasing health coverage directly or receiving coverage through their employer. In 2020, about 216.5 million people—or about 66.5 percent of individuals in the United States—had coverage through private health plans, according to the U.S. Census Bureau.¹ Health plans establish provider networks—the doctors, other health care providers, and facilities with which a plan contracts—to provide medical care to their enrollees. Providers who contract with an enrollee’s health plan are known as “in-network.” The adequacy of a health plan’s provider network refers to the plan’s ability to deliver the benefits promised to enrollees by providing reasonable access to in-network providers.

Health plans with provider networks that are narrower—that is, more limiting in the number of in-network providers available to enrollees—have become more prevalent in recent years due, in part, to pressure to lower health care costs.² By contracting with a narrower network, health plans may be able to select providers who accept lower payment rates in exchange for participating in the network. These plans may offer value to consumers if coverage pairs a lower premium with a provider network that provides access to quality health care. However, stakeholders and researchers have raised concerns that a provider network can be inadequate if

- the network has an insufficient number of providers or facilities to provide care to patients enrolled in the health plan,
- too few providers who are taking new patients, or

¹In general, those who obtain private health coverage do so in the individual or group market. The individual market includes plans purchased directly from an insurer both on and off the health insurance exchanges (markets that operate within each state where eligible individuals and small employers can compare and select among qualified insurance plans offered by participating issuers). The group market—which includes small and large groups—is largely made up of employer-sponsored plans.

²See, for example, Giovannelli, J., K. Lucia, and S. Corlette. “Health Policy Brief: Regulation of Health Plan Provider Networks,” *Health Affairs* (July 2016) and Hall, M.A. and P.B. Ginsburg, *A Better Approach to Regulating Provider Network Adequacy* (Washington, D.C.: The Brookings Institution, 2017).

- too few providers who have an available appointment within a reasonable time or distance.

Stakeholders and researchers have noted that an inadequate network can affect enrollees' ability to reasonably access in-network providers in a timely manner.³ For example, the American Medical Association has reported that inadequate networks could result in patients experiencing interruptions in care, delayed care, and undue harm.⁴ Additionally, inadequate networks make it more likely that patients will need to obtain care from out-of-network providers, which can be considerably more expensive than in-network care.⁵

States, the Centers for Medicare & Medicaid Services (CMS)—an agency within the Department of Health and Human Services—and the Employee Benefits Security Administration—an agency within the Department of Labor (DOL)—each have responsibilities for overseeing private health plans, including, in some cases, certain requirements related to the adequacy of provider networks. Which entity or agency has oversight responsibility depends on the type of coverage, such as group or individual health plans, whether it is sold on a health insurance exchange, and whether the plan is self-funded or fully insured.⁶ States are generally responsible for overseeing individual health plans and some group health plans sold in their state, including those sold by health insurance companies (known as issuers).⁷ CMS is generally responsible for

³Providers who do not have a contract with an enrollee's health plan are referred to as "out-of-network."

⁴American Medical Association, *Improving the Health Insurance Marketplace: Network Adequacy* (American Medical Association, 2015).

⁵See Giovannelli, Lucia, and Corlette, "Regulation of Health Plan Provider Networks," 2, and Hall and Ginsburg, *A Better Approach*, 2-3.

⁶Group health plans may be self-funded, fully insured, or a mix of the two. Self-funded plans are plans for which the employer pays for employee health care benefits directly, bearing the risk of covering medical benefits generated by beneficiaries. Fully insured plans are plans for which the employer purchases coverage from a state-regulated issuer. See 42 U.S.C. § 300gg-91; 45 C.F.R. § 146.145 (2022).

⁷See 42 U.S.C. § 300gg-22(a). However, states have limited authority to oversee employer-sponsored plans, particularly those that are self-funded. See 29 U.S.C. § 1144. An issuer is an insurance company, insurance service, or insurance organization that is required to be licensed to engage in the business of insurance in a state.

overseeing qualified health plans (QHP).⁸ DOL is generally responsible for overseeing private employer-sponsored group health plans.⁹

The Consolidated Appropriations Act, 2021, includes a provision for us to review the adequacy of provider networks in individual and group health plans.¹⁰ This report describes

1. state, CMS, and DOL oversight of the adequacy of provider networks, and
2. what is known about the adequacy of individual and group health plans' provider networks.

To examine state, CMS, and DOL oversight of the adequacy of provider networks for individual and group health plans, we administered a survey to all 50 states and the District of Columbia (hereafter referred to as "states").¹¹ We asked states to report information on how they oversaw provider network adequacy from January 2019 through December 2021, such as any actions taken to review provider networks and standards used to assess provider network adequacy. We conducted the survey in May 2022 and received responses from 50 of the 51 states.¹² We did not independently verify the information reported by the states in the survey, but we reviewed responses and followed up with state officials when

⁸See 42 U.S.C. § 18031(c)(1). CMS is responsible for establishing requirements applicable to QHPs offered on health insurance exchanges and for overseeing such plans in certain states/exchanges. QHPs are offered for sale on health insurance exchanges, which may be operated as a state-based exchange, a federally facilitated exchange, or a state-based exchange using the federal platform for limited functions, such as eligibility and enrollment functions.

⁹The Department of the Treasury and the Department of Health and Human Services also have responsibility for certain federal laws applicable to private health insurance. For example, the Department of Health and Human Services, DOL, and the Department of the Treasury develop and jointly issue regulations under parallel provisions, consistent with the tri-agency memorandum of understanding that implements section 104 of the Health Insurance Portability and Accountability Act of 1996. 64 Fed. Reg. 70,164 (Dec. 15, 1999); Pub. L. No. 104-191, § 104, 110 Stat. 1936, 1978.

¹⁰Pub. L. No. 116-260, div. BB, tit. I, § 109(c), 134 Stat. 1182, 2859 (2020).

¹¹For purposes of our report, we did not include Medicare, Medicaid, or non-federal government plans overseen by the Department of Health and Human Services in our review.

¹²One state (Indiana) did not provide information in response to the survey. For some questions, a few states did not respond.

reported information appeared inconsistent or needed clarification. We interviewed representatives and reviewed documentation from the National Association of Insurance Commissioners to provide additional national context to state responses.¹³

We also interviewed officials from state departments of insurance in six selected states to illustrate aspects of, and variations in, state oversight of provider network adequacy.¹⁴ We selected states based on criteria including variation in geographic location, population size, adoption of regulation related to provider network adequacy, and health insurance exchange type. We also reviewed documentation from these states related to their oversight of network adequacy, such as guidance provided to issuers related to types of information or data issuers must submit for network adequacy reviews.

Additionally, we reviewed relevant laws, regulations, and federal agency reports and guidance to examine how CMS and DOL oversee the adequacy of provider networks within their purview. For example, we reviewed CMS's instructions to issuers for QHP certification and DOL's enforcement manual. We also interviewed officials from CMS and DOL on their provider network adequacy oversight activities. Lastly, we interviewed representatives from four stakeholder organizations—American Medical Association, America's Health Insurance Plans, the Business Group on Health, and the National Association of Insurance Commissioners—about oversight of provider networks. We selected these organizations to identify a range of perspectives from stakeholders that represent the insurance industry, medical providers, and state departments of insurance.

To describe what is known about the adequacy of provider networks, we conducted a literature review to identify relevant studies published in peer-reviewed journals, government reports, and association, nonprofit, or research institute publications from January 2015 through March 2022.

¹³The National Association of Insurance Commissioners is a voluntary association of the chief insurance regulators from all 50 states, the District of Columbia, and five U.S. territories. The National Association of Insurance Commissioners coordinates the regulation of multistate insurers, develops standards for state insurance regulation, and publishes model laws, regulations, and guidelines that state regulators can use as resources for developing their laws and regulations. In addition, they provide a forum for states to share information and state-developed tools, as well as to discuss issues with federal regulators.

¹⁴The six selected states were Connecticut, Maryland, Michigan, New Mexico, Texas, and Washington.

Stakeholders we interviewed also provided recommendations on literature related to the adequacy of provider networks. As a result, we identified and reviewed 29 relevant studies. (See app. I for more details about the methodology of our literature review.) We also used information from sources in the methodology described above. For example, we collected and analyzed information from the survey and through interviews with officials from the six selected states, CMS, DOL, and stakeholder organizations related to network adequacy, including any factors that may contribute to inadequate networks. We also collected and analyzed information on noncompliance with network adequacy standards and complaints about the adequacy of provider networks. We synthesized the information from these sources to describe what is known about the adequacy of provider networks.

We conducted this performance audit from January 2022 to December 2022 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

The majority of Americans receive their health coverage through private health plans, according to the U.S. Census Bureau. In general, those who obtain coverage through private health plans do so in the individual or group market. The individual market includes plans purchased directly from an issuer both on and off the health insurance exchanges. Health insurance exchanges are markets that operate within each state through which eligible individuals and small employers can compare and select among health plans—known as QHPs—offered by participating issuers.¹⁵

¹⁵Each state may operate its own exchange (known as a state-based exchange) or elect to use the federally facilitated exchange. In 2022, the 18 states that operated state-based exchanges were: California, Colorado, Connecticut, District of Columbia, Idaho, Kentucky, Maine, Maryland, Massachusetts, Minnesota, Nevada, New Jersey, New Mexico, New York, Pennsylvania, Rhode Island, Vermont, and Washington. In 2022, three additional states—Arkansas, Oregon, and Virginia—operated state-based exchanges on the federal platform, which is an arrangement in which the state administers its own exchange but relies on CMS for limited functions, such as eligibility and enrollment functions. In 2022, the remaining 30 states elected to use the federally facilitated exchange, which includes four states that performed their own plan management functions.

The group market—which includes small and large groups—is largely made up of employer-sponsored plans.

Provider networks are the doctors, hospitals, pharmacies, and other health care providers with which a health plan contracts to provide medical services to its enrollees for an agreed-upon rate. Providers and other entities who contract with an enrollee’s health plan are known as “in-network” providers. Providers who do not have a contract with an enrollee’s health plan are referred to as “out-of-network” providers. It is often more expensive for enrollees to go to out-of-network providers. For example, a health plan may require higher cost sharing—either in the form of co-payments or coinsurance—for enrollees who use out-of-network providers. Network adequacy refers to a health plan’s ability to provide enrollees the benefits promised in the plan by providing reasonable access to in-network providers. A network may be inadequate if the network has an insufficient number of providers or facilities to provide care to health plan enrollees, too few providers who are taking new patients, or too few providers who have an available appointment within a reasonable time or distance.

Standards Used to Assess Provider Network Adequacy

State and federal agencies may use standards to assess provider network adequacy. This might include assessing issuer provider network data against standards to make a determination as to whether a given network is adequate. These standards are generally described as quantitative or qualitative. Quantitative standards are measurable. Examples of quantitative standards include (1) minimum ratios of providers to enrolled population, (2) maximum time or distance for enrollees to travel to providers, (3) maximum wait times to schedule an appointment with a provider, and (4) the number or percentage of essential community providers (ECP) included in network.¹⁶ Qualitative standards describe a subjective standard for adequacy, such as a network with sufficient choice and types of provider to assure that all services will be accessible without unreasonable delay, which could accommodate differences in geographic accessibility and population dispersion.

¹⁶In general, ECPs are providers who serve predominately low-income, medically underserved individuals. See 45 C.F.R. § 156.235(c) (2022).

Oversight of Provider Network Adequacy by States and Federal Agencies

States, CMS, and DOL each have responsibilities for overseeing private health plans, including, in some cases, certain requirements related to the adequacy of provider networks. Which entity or agency has oversight responsibilities depends on the type of coverage, such as group or individual health plans, whether it is sold on a health insurance exchange, and whether the plan is self-funded or fully insured. Self-funded plans are plans for which the employer bears the risk of covering medical benefits for its beneficiaries, while fully insured plans are plans for which the issuer bears the risk.

- **States.** States are generally responsible for overseeing health insurance sold by issuers (1) in the individual market, where individuals purchase private health insurance plans directly from an issuer or through an exchange; and (2) in the group market, where a plan sponsor (typically an employer) purchases coverage from an issuer. In 2020, the estimated enrollment in these state-regulated markets was 13.7 million enrollees in the individual market, 11.9 million enrollees in the small group market (coverage offered by small employers), and 41.5 million enrollees in the large group market (coverage offered by large employers).¹⁷ State oversight of health insurance applies only to fully insured health plans offered by state-licensed issuers. Self-funded plans, which are financed directly by the plan sponsor, are generally not subject to state law or oversight.
- **CMS.** CMS is responsible for establishing requirements that QHPs must meet in order to be offered on federal and state health insurance exchanges, as well as for ensuring QHP compliance with these requirements in certain states.¹⁸ This includes establishing criteria to

¹⁷Federal law defines a small employer as having an average of 1 to 50 employees during the preceding calendar year; however, states may apply this definition based on an average of 1 to 100 employees. See 42 U.S.C. §§ 300gg-91(e)(4), 18024(b)(2). The estimated enrollment numbers for state-regulated small group and large group markets are from CMS's Medical Loss Ratio data. These estimates are from fully insured plans only and do not include enrollment data for self-funded plans, which is how most large employers provide at least some of their employee health benefits.

¹⁸See 42 U.S.C. § 18031. Federal law authorizes states to oversee compliance with federal QHP requirements and provides that, in states that fail to substantially enforce such requirements, the Department of Health and Human Services is responsible for doing so. See 42 U.S.C. § 300gg-22(a).

ensure a sufficient choice of providers in QHPs.¹⁹ For the plan year 2023 and for future years, CMS guidance states it will include an assessment of network adequacy as part of the annual certification reviews of QHPs offered in most states with a federally facilitated exchange.²⁰ In addition, CMS guidance states it will conduct annual compliance reviews of a selection of QHPs during each plan year to ensure ongoing compliance with certification requirements. Further, the Consolidated Appropriations Act, 2021, requires issuers of private health plans, including QHPs, to establish a process to regularly update and verify the accuracy of information in provider directories—listings of a plan’s in-network providers and facilities—for plan years beginning in or after 2022, among other things.²¹ CMS, in coordination with DOL and Department of the Treasury, is responsible for implementing and overseeing compliance with these new requirements.

- **DOL.** DOL’s Employee Benefits Security Administration is generally responsible for overseeing private employer-sponsored group health plans under the Employee Retirement Income Security Act of 1974, as amended.²² This includes both fully insured plans (where the employer purchases coverage from a state-regulated issuer) and self-funded plans (where the employer pays for employee health care

¹⁹See 42 U.S.C. § 18031(c). The Department of Health and Human Services’ regulations generally require QHPs with a provider network to 1) include a sufficient number and geographic distribution of ECPs, 2) include sufficient numbers and types of providers to ensure all services are accessible without unreasonable delay, and 3) make their provider directories available online, among other things. See 45 C.F.R. § 156.230 (2022).

²⁰A plan year is the 12-month period of benefits coverage for a health plan. This 12-month period may not be the same as the calendar year. CMS conducted network adequacy reviews for QHPs sold on the federally facilitated exchange for plan years 2015 through 2017 but deferred to others, such as states or issuer attestation, for plan years 2018 through 2022. In May 2022, the Department of Health and Human Services issued a final rule indicating the agency will conduct network adequacy assessments as part of annual QHP certification reviews for most federally facilitated exchange states starting with certifications for plan year 2023. See 87 Fed. Reg. 27,208, 27,322-37 (May 6, 2022). States, rather than the Department of Health and Human Services, are to conduct these reviews for certain of the four federally facilitated exchange states performing plan management functions, the 18 state-based exchange states, and the three state-based exchange states using the federal platform for eligibility and enrollment functions. In 2020, the estimated enrollment in QHPs was 10.3 million, representing about 75 percent of the total enrollees in the individual market.

²¹Pub. L. No. 116-260, div. BB, tit. I, § 116, 134 Stat. 1182, 2878 (2020) (codified as amended at 42 U.S.C. § 300gg-115).

²²See 29 U.S.C. § 1002 et seq.

benefits directly, bearing the risk for covering medical benefits generated by beneficiaries). In fiscal year 2021, there were about 137 million enrollees in private employer-sponsored group health plans.²³ The Employee Retirement Income Security Act of 1974, as amended, does not include federal network adequacy standards for employer-sponsored group plans. However, DOL shares responsibility with states, the Department of Health and Human Services, and the Department of the Treasury for overseeing compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended.²⁴ This act requires that coverage for mental health and substance use disorder treatment is no more restrictive than coverage for medical/surgical treatment.²⁵ Generally, this means that the financial requirements or treatment limitations imposed on mental health and substance use disorder benefits—such as copayment amounts, number of annual visits allowed, or preauthorization of services—must be in parity with those imposed on medical/surgical benefits. However, the act does not impose specific network adequacy requirements on plans or issuers. Additionally, DOL, along with CMS and the Department of the Treasury, also has responsibility for implementing the requirement in the Consolidated Appropriations Act, 2021, for private health plans to establish a process to regularly update and verify the accuracy of provider directory information.²⁶

²³Department of Labor, Employee Benefits Security Administration, Fact Sheet: FY2021 MHPAEA Enforcement (Washington, D.C.).

²⁴Pub. L. No. 110-343, div. C, tit. V, subtit. B, §§ 511-12, 122 Stat. 3765, 3881-3893 (codified as amended at 26 U.S.C. § 9812, 29 U.S.C. § 1185a, and 42 U.S.C. § 300gg-26). These parity requirements generally apply to plans in the group and individual markets, although only indirectly to small group health plans. For more information, see GAO, *Mental Health and Substance Use: State and Federal Oversight of Compliance with Parity Requirements Varies*, [GAO-20-150](#) (Washington, D.C.: Dec. 13, 2019).

²⁵Specifically, this act requires that financial requirements and treatment limitations applicable to mental health and substance use disorder benefits be no more restrictive, as designed and in operation, than similar requirements or limitations applicable to medical/surgical benefits.

²⁶Pub. L. No. 116-260, div. BB, tit. I § 116, 134 Stat. 1182, 2878 (2020) (codified in relevant part, as amended, at 29 U.S.C. § 1185i).

Practices for Overseeing the Adequacy of Provider Networks Varied among State and Federal Agencies

Nearly all states reported reviewing the adequacy of individual and group health plans' provider networks and reported oversight actions varied. CMS's oversight of network adequacy includes annual reviews and other targeted reviews of most QHPs offered on the federally facilitated exchange. DOL officials told us the department's oversight of the adequacy of provider networks for private employer-sponsored group health plans is limited to reviews of mental health and substance use disorder parity.

Nearly All States Reported Reviewing Plans for Network Adequacy; Oversight Actions Varied

Officials from nearly all states that responded to our survey reported taking actions to oversee the adequacy of individual and group health plans' provider networks. The reported actions states took to oversee provider network adequacy varied, and most states took multiple actions. Further, the standards states reported using to assess network adequacy included different quantitative or qualitative standards.

Officials from 45 out of 50 states responding to our survey of state insurance departments took actions to oversee the adequacy of individual and group health plans' provider networks from January 2019 through December 2021.²⁷ For example, officials from 32 states reported in our survey that they reviewed plans for provider network adequacy prior to approving the plans to be sold in the state, and officials from 36 states reviewed plans during an annual review process. Officials from most states reported taking multiple actions, though the specific actions varied among states. Table 1 summarizes and provides examples of the type of actions states took.

²⁷Although officials from five states reported that they did not take any steps to oversee provider network adequacy, these states may have requirements related to network adequacy. For example, officials from one of these states reported requiring issuers to attest to network standards. Officials from another state reported requiring issuers to cover services as in-network when there are no providers available in an area. Officials from one state did not provide information in response to our survey.

Letter

Table 1: Types of Actions Reported by State Officials to Oversee Provider Network Adequacy for Individual and Group Health Plans, January 2019 through December 2021

Description of action taken to oversee provider network adequacy	Number of states that took action	Examples of actions state officials reported
Reviewed plans prior to approval for sale		
Review issuer documentation and data before they approve the issuer's plans for sale to enrollees.	32	Require issuers to submit information on the location and number of providers in network and the expected number of enrollees in order to obtain a certificate of authority to sell their plan in the state.
Reviewed plans during an annual review process		
Review issuer documentation and data on an annual cycle.	36	Require issuers to submit multiple reports each year to verify the adequacy of their network(s), including an access plan, which is a narrative story of the network documenting any changes from year to year.
Reviewed plans when there were changes to networks		
Review when the composition of an issuer's network changes.	23	Review issuers' networks when there is a material change to the composition of a network, such as termination of a portion of providers from the network, or if an issuer adds a network.
Conducted market conduct examinations that included a review of provider network adequacy		
Broad, routine review of issuers' compliance with state and federal health insurance laws.	11	Examine issuers' policies and procedures for contracting with providers, copies of those contracts, and the issuer's annual network adequacy survey.
Conducted random audits or other random reviews or examinations		
Random audit of network adequacy.	9	Conduct random audits on specific items, such as rural access to oral surgeons or of all hospital contracts.
Conducted targeted examinations when there were concerns about the adequacy of a plan's provider network		
Examine specific items in response to identified concerns.	13	Review identified patterns of complaints or information originating from regular market conduct examinations.
Took other actions		
Other oversight actions.	15	Other actions included meeting with carriers when complaints were received, reviewing networks twice per year, communicating monthly to discuss known network issues with issuers, and conducting outreach to providers regarding difficulties contracting with issuers.

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

Note: 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. Although officials from five states reported that they do not take any steps to oversee provider network adequacy, these states may have requirements related to network adequacy. For example, officials from one of these states reported requiring issuers to attest to network standards. Officials from another state reported requiring issuers to cover services as in network when there are no providers available in an area.

Officials from most states reported in our survey that they reviewed plans both prior to approving the plans for sale and after sale, but some states only conducted oversight of provider network adequacy after receiving a complaint or did not report taking any actions related to network adequacy.²⁸ Specifically:

- Officials from 30 states reported reviewing plans for network adequacy both prior to approval for sale and after sale, such as during a market conduct or targeted examination or an annual review.
- Officials from 12 states reported not reviewing plans for network adequacy prior to approval for sale but did review plans during an examination or annual review after sale.
- Officials from two states reported only reviewing plans for network adequacy prior to approval for sale.
- Officials from one state reported only reviewing plans for network adequacy when a complaint was received, and then working directly with the carrier to address the complaint.
- Officials from five states reported not taking any actions to oversee provider network adequacy.

The standards that states used also varied among the 44 states that reported using at least one standard to assess network adequacy from January 2019 through December 2021. Network adequacy standards are generally described as quantitative—that is, measurable and can be applied objectively—or qualitative—broadly defining access to sufficient or reasonable health care.²⁹ When using qualitative standards, states review a network and make a determination as to whether a network provides sufficient access to covered services. (See fig. 1.) One study we reviewed noted that it is challenging to identify one standard for assessing network adequacy as the types of standards measure different things.³⁰

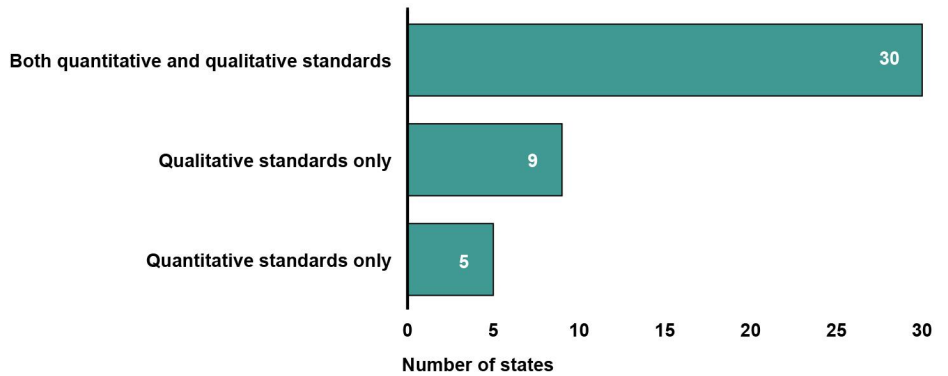
²⁸State reviews of network adequacy after sale may include reviewing plans during an annual review process, reviewing plans when there were changes to networks, conducting market conduct examinations that included a review of provider network adequacy, conducting random audits or other random reviews or examinations, or conducting targeted examinations when there were concerns about the adequacy of a plan's provider network.

²⁹Hall and Ginsburg, *A Better Approach*, 6-7, and J. B. Wishner and J. Marks, *Ensuring Compliance With Network Adequacy Standards: Lessons from Four States* (Washington, D.C.: Urban Institute, March 2017).

³⁰See Hall and Ginsburg, *A Better Approach*, 8.

Therefore, the study noted, it is generally necessary to use multiple standards to better assess network adequacy.

Figure 1: Number of States Whose Officials Reported Using Specific Types of Provider Network Adequacy Standards, January 2019 through December 2021



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

Data table for Figure 1: Number of States Whose Officials Reported Using Specific Types of Provider Network Adequacy Standards, January 2019 through December 2021

	Number of states
Both quantitative and qualitative standards	30
Qualitative standards only	9
Quantitative standards only	5

Note: 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.

Use of quantitative standards. Officials from 35 states reported using at least one quantitative provider network adequacy standard from January 2019 through December 2021 and officials from 27 states reported using more than one quantitative standard. Table 2 describes the types of quantitative standards states reported using.

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.

Officials we interviewed from four of the six selected states in our review reported using standards broken out by provider type or geography. For example, officials from one state we interviewed told us they measured travel distance for enrollees to providers for 36 different provider types and used different mileage requirements for rural, urban, and suburban zip codes. Officials from another state we interviewed told us they used a wait time standard with different requirements for primary care providers and specialty providers.

Use of qualitative standards. Officials from 39 states we surveyed reported using at least one qualitative provider network adequacy standard from January 2019 through December 2021 to determine whether a network provides sufficient access to covered services and

seven states reported using more than one qualitative standard. Table 3 describes the types of qualitative standards states reported using.

Table 3: Types of Qualitative Standards State Officials Reported Using to Oversee Provider Network Adequacy for Individual and Group Health Plans, January 2019 through December 2021

Description of qualitative standard	Number of states that used qualitative standard	Examples of qualitative standards
Sufficient choice and timely access		
Network should have a sufficient choice of providers to ensure services are accessible without unreasonable delay.	28	Require that issuers describe how they determine and measure adequacy for their networks and self-monitor their compliance.
Other qualitative standard		
Other qualitative standards.	18	Require provider network accreditation from an accreditation organization or require diversity in provider networks to address the needs of all enrollees, including, for example, those with limited English proficiency or from diverse cultural backgrounds.

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. Officials from one state reported use of network adequacy accreditation from the National Committee for Quality Assurance or the Utilization Review Accreditation Commission as a qualitative standard.

Officials we interviewed from one state noted that they only used qualitative standards because in their initial years of network adequacy reviews they found that quantitative standards, such as requiring two providers within 30 miles to deliver a particular service, were limiting and arbitrary given geographic barriers in the state.

In addition to the variation in the use of provider network adequacy standards, the application of standards to health plan types varied as well. Most states applied network adequacy standards to QHPs and small group plans. A smaller majority of states also applied network adequacy standards to non-QHP individual health plans and to large group health plans. See table 4.

Table 4: State Official Reported Application of Provider Network Adequacy Standards by Health Plan Type, January 2019 through December 2021

Health plan type to which states applied standards	Number of states
Qualified health plans (QHP)	42
Non-QHP individual health plans	32
Small group health plans	41
Large group health plans	31

Source: GAO survey of state departments of insurance. | 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 a response to our survey. For purposes of our report, non-QHP individual health plans does not include short-term limited duration plans and small and large group health plans do not include Association Health Plans or limited-scope plans.

In addition to taking actions to oversee provider network adequacy, officials from 12 states reported in our survey that they conducted systematic reviews of provider directories—listings of a plan’s in-network providers and facilities—from January 2019 through December 2021. Officials from states we interviewed reported various approaches for their provider directory reviews. For example, officials from one state commented that they review issuers’ directories on an annual basis to confirm that the required information, such as phone numbers and addresses of providers, is included. Officials from another state reported conducting a review in which they made cold calls to a random sample of providers in an issuer’s directory to confirm it was possible to schedule an appointment.

Officials from most states we interviewed and surveyed reported several key challenges related to overseeing network adequacy, such as experiencing difficulties with data collection, lacking software or staff to review network adequacy data, and accounting for telehealth in network adequacy reviews.³¹ For example, officials from one state we interviewed explained that determining standardized measurement methodologies for each network adequacy standard has been a challenge. In the first few years of their oversight, state officials saw that issuers were measuring appointment wait time data differently from one another, which made comparing across issuers challenging. In response to our survey, officials

³¹Available research we reviewed also indicated challenges in overseeing network adequacy. For example, two articles indicated that determining the most effective standards to use when reviewing network adequacy can be a challenge. In another example, an article indicated that inaccurate provider directories may complicate the oversight for states who use that information to determine whether issuers are meeting standards for their plan networks.

from one state reported that they lack data on the universe of providers in their state, including information related to the location of practices. Officials from another state we interviewed reported a similar issue and said it can pose a challenge when reviewing data for certain quantitative standards.

CMS's Oversight of Network Adequacy Includes Annual Reviews and Other Targeted Reviews of Qualified Health Plans

CMS oversees provider network adequacy for most QHPs offered on the federally facilitated exchange through annual certification reviews, annual compliance reviews, targeted reviews conducted in response to complaints, and provider directory reviews.³²

- **Annual certification reviews.** In these annual certification reviews to assess the adequacy of QHP networks, CMS officials told us they compare QHP issuer data on the issuer's provider network against network adequacy standards, which include quantitative time and distance standards.³³ For example, CMS reviews data to confirm the QHP's provider network includes a primary care provider within 10 minutes and 5 miles for potential enrollees in a large metro county.³⁴ It also reviews data on the issuer's QHP network to ensure that, in general, issuers have contracted with at least 35 percent of the

³²In 2022, 30 states used the federally facilitated exchange, including four states that perform their own plan management functions and may perform evaluations of provider network adequacy as part of QHP certification reviews beginning with plan year 2023 if certain criteria are met. See 87 Fed. Reg. 27,208, 27,323 (May 6, 2022).

³³See 45 C.F.R. § 156.230 (2022).

³⁴CMS told us street addresses for potential enrollees are compiled into a population sample data file. Data are based on U.S. Census data. For each county, an eligible population sample is identified based on age and income requirements for consumers to qualify for health coverage through the exchange. The population data file is used to measure provider access to potential enrollees in that county and certify provider networks offered by QHPs meet network adequacy standards.

available ECPs in their plan's service area, among other things.³⁵ CMS completed its certification review for plan year 2023 in fall 2022.³⁶

QHP issuers are required to complete and submit a template to CMS that provides information on their networks, including data on individual providers and facilities, for the certification review. CMS officials use the issuer-submitted data to obtain provider locations and compare those against sample QHP potential enrollee population data. Officials said they use software to estimate driving time and distance between provider and potential enrollee locations and compare those estimates against the time and distance standards for each QHP to determine if the standard is met.

CMS officials told us that if an issuer does not meet the network adequacy standards, issuers have two options to address the noncompliance—(1) add more contracted providers to their network or (2) identify in a justification form the reasons why the issuer will need additional time to meet the standards. Officials told us that an issuer may need additional time to meet standards when, for example, additional contracting is needed or the given standard is not achievable in a certain area due to a provider shortage.³⁷

Additionally, CMS officials stated that the agency will coordinate with state departments of insurance for cases when a QHP issuer is not in compliance with the network adequacy standards during the certification review process. This coordination with state departments of insurance is conducted on an ad-hoc basis as of July 2022, but the agency is developing a formalized process for state coordination, according to CMS officials. As part of the informal coordination, state departments of insurance have access to information on the actions issuers in their state took to address noncompliance with network adequacy standards. CMS has also developed a work group with state departments of insurance to discuss trends in network adequacy

³⁵In addition to contracting with at least 35 percent of the available ECPs in their plan's service area, QHP issuers generally must also offer contracts in good faith to participate in the plan's provider network to (1) at least one ECP in each of the six ECP categories set forth in regulation, such as federally qualified health centers, in each county in the service area and (2) all available Indian health care providers in the plan's service area. See 45 C.F.R. § 156.235 (2022).

³⁶Certification reviews occur prior to CMS approving a plan to be sold on the federally facilitated exchange.

³⁷According to officials, CMS provides the issuer a justification form that identifies the noncompliance for their plan's network. If needed, the issuer will update the form to provide justification of why the issuer will need more time to address noncompliance.

and certification review activities, according to CMS officials. For example, CMS learned through this work group that states wanted a better understanding of how the network adequacy review conducted as part of the CMS QHP certification process worked. As a result, CMS officials told us they provided additional information to the states to make the review process more transparent.

- **Annual compliance reviews.** In addition to certification reviews, CMS conducts annual compliance reviews of a sample of QHPs. These reviews focus on a variety of things, such as the plans' enrollment and complaint resolution processes. CMS issues a report when the annual compliance review is completed. In 2019 and 2020, the compliance reviews included an assessment of the accuracy of QHPs' provider directories and inclusion of ECPs in networks.³⁸ For example, CMS reviewed a selection of plans' provider directories to determine if the directories were available to enrollees online and in hard copy and to determine if the demographic and other information listed in the directories—such as identifying providers that are not accepting new patients—are accurate.³⁹
- **Targeted reviews.** According to officials, CMS will conduct formal, targeted monitoring in response to complaints beginning in plan year 2023, although officials informally assisted state departments of insurance with complaints related to network adequacy from January 2019 through December 2021. This informal CMS assistance consisted of coordination and advice from CMS to states, typically at the request of states. For example, after a state request, CMS could coordinate discussions of a complaint between the state department of insurance and issuer to identify a resolution, CMS officials told us.

³⁸According to CMS officials, the agency has conducted compliance reviews annually since 2014. See Centers for Medicare & Medicaid Services, The Center for Consumer Information and Insurance Oversight, *2019 Plan Year Federally Facilitated Exchange Issuer Compliance Review Summary Report* (Baltimore, MD.: Dec. 29, 2020) and Centers for Medicare & Medicaid Services, The Center for Consumer Information and Insurance Oversight, *2020 Plan Year Federally Facilitated Exchange Issuer Compliance Review Summary Report* (Baltimore, MD.: Dec. 30, 2021). As of August 2022, the 2020 annual compliance review summary report is the most recent report.

³⁹CMS conducts its compliance reviews during a plan year for a select number of QHP issuers. For plan year 2019, CMS selected 22 issuers for compliance reviews of plans certified in plan year 2019. For plan year 2020, CMS modified the compliance review process due to the COVID-19 pandemic. They conducted full compliance reviews of seven QHP issuers and modified compliance reviews for 15 other QHP issuers for plans certified in plan year 2020. See Centers for Medicare & Medicaid Services, *2019 Plan Year Compliance Review Summary Report*, 2020, and Centers for Medicare & Medicaid Services, *2020 Plan Year Compliance Review Summary Report*, 2021.

CMS officials told us the agency plans to conduct targeted monitoring of network adequacy in QHPs offered on the federally facilitated exchange beginning in plan year 2023, as CMS has resumed oversight of provider network adequacy for these QHPs. According to officials, these targeted reviews will originate from complaints received by CMS from consumers, state or federal representatives, or state departments of insurance, and this targeted monitoring will be separate from the annual certification process. For example, if a complaint is received, CMS officials will review it and may work with the issuer and state department of insurance to resolve the issue using a compliance model the agency is developing, officials told us. If a resolution cannot be identified, agency officials said the agency could take enforcement actions against the issuer.

- **Provider directory reviews.** In addition to reviewing provider directories for a sample of plans during annual compliance reviews, CMS also reviews provider directories to ensure compliance with CMS regulations.⁴⁰ Specifically, CMS compares issuer data submitted to the agency to the issuers' online provider directories and other data sources to assess the accuracy of the data provided by issuers. According to CMS, the agency uses the information from these assessments to develop best practices on how issuers of QHPs can improve the accuracy of provider directories, such as having issuers encourage providers to make timely notification of changes to demographic and directory data.

CMS officials noted there are several challenges related to the oversight of provider network adequacy. For example, officials told us that oversight of provider network adequacy is challenging because reviews are point-in-time analyses and provider networks are constantly changing. Additionally, ongoing monitoring and enforcement of network adequacy standards across all federally facilitated exchange issuers is resource-

⁴⁰See 45 C.F.R. § 156.230(b) (2022). For example, QHP issuers are required to make available provider directory information in a specified format and also submit this information to the Department of Health and Human Services, in a format and manner and at times determined by the Department of Health and Human Services. See Department of Health and Human Services, Centers for Medicare & Medicaid Services, The Center for Consumer Information and Insurance Oversight, *Machine-Readable Provider Directory Review Summary Report Plan Years 2017-2021* (Baltimore, MD.: March 22, 2022). Additionally, in an August 2021 frequently asked questions document, CMS noted it plans to undertake rulemaking to implement the provider directory requirements established under the Consolidated Appropriations Act, 2021. See 42 U.S.C. § 300gg-115. CMS has not issued any rules implementing the requirements for plans to establish a process to update and verify the accuracy of provider directory information, among other things, as of November 2022.

intensive, given the additional need to verify issuer reports of barriers beyond the issuer's control, such as provider shortages and geographic barriers. Officials told us that the agency is working to automate and streamline as many parts of the review process for the 2023 plan year as possible, but there is still a large amount of data to be reviewed in a short period of time.

DOL's Oversight of Private Employer-Sponsored Group Plans Is Limited to Reviews of Mental Health and Substance Use Disorder Parity

DOL officials told us the department's oversight of provider network adequacy for private employer-sponsored group plans is limited to reviews of mental health and substance use disorder parity. DOL officials told us that federal law does not provide the agency with authority to review, or standards to assess, provider network adequacy generally.

DOL officials told us the department may address network adequacy as part of mental health and substance use disorder parity requirements. Officials told us these requirements are not related to assessing the actual provider network but instead to comparing various aspects of mental health and substance use disorder coverage to medical/surgical coverage. This comparison is to ensure that limitations on mental health and substance disorder benefits are no more restrictive than limitations on medical/surgical benefits. According to officials, DOL can compare the designs of mental health and substance use disorder provider networks and medical/surgical provider networks but cannot specifically assess the adequacy of individual networks against standards. For example, officials told us that if DOL identified that a medical/surgical provider had no appointments available within a certain waiting period, DOL would not have authority to address that network adequacy concern as it is outside the context of mental health and substance use disorder parity.

Additionally, DOL officials told us their oversight of network adequacy includes reviews of provider directories in the context of mental health and substance use disorder parity. According to DOL, officials review the accuracy of provider directories for mental health and substance use disorder providers because inaccurate directories can be a significant barrier in accessing this care. DOL officials told us that these reviews originate from specific concerns DOL has regarding a plan or an issuer, rather than through complaints. Separately, DOL, together with CMS and the Department of the Treasury, plans to undertake rulemaking to

implement the more generally applicable provider directory requirements established under the Consolidated Appropriations Act, 2021, according to an August 2021 frequently asked questions document.⁴¹

Available Information Showed Cases of Inadequate Networks and Contributing Factors

While there is no comprehensive information on the extent to which networks are adequate, available information from states and CMS identified issuers that were not in compliance with network adequacy standards.⁴² These examples include the following.

- Officials from some states we surveyed identified issuers that were noncompliant with network adequacy standards for their provider networks from January 2019 through December 2021. Specifically, officials from 18 states responding to our survey identified cases of noncompliance with network adequacy standards during this time. For example, officials from one state reported that some of the most common areas of network adequacy noncompliance found during this time included issuers' failure to establish a network that meets time and distance and primary care provider-to-enrollee ratio standards. Officials from another state reported cases where issuers were not compliant with appointment wait time standards. Additionally, officials from six states reported cases in which issuers were noncompliant because their plans did not have certain required specialty providers in their networks. For example, officials from one state reported cases

⁴¹Pub. L. No. 116-260, § 116, 134 Stat. 1182, 2878 (2020). See Departments of Labor, Health and Human Services, and the Treasury, *FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021* (Washington, D.C.: Aug. 20, 2021).

⁴²DOL officials told us they do not assess provider networks against any federal network adequacy standards as they have no authority to do so. Therefore, DOL did not identify noncompliance with network adequacy standards during this time. However, officials told us they were conducting 21 investigations as part of their oversight of mental health and substance use disorder parity, as of September 2022. Specifically, officials told us these investigations assess whether there is parity between the treatment limitations applicable to mental health and substance use disorder and medical/surgical care benefits. An investigation does not necessarily indicate that a network is inadequate.

in which an issuer's plan did not have sufficient pediatricians and obstetrician-gynecologists.⁴³

- CMS identified 243 out of 375 issuers that were not in compliance with network adequacy standards as part of the agency's certification review of QHPs on the federally facilitated exchange for plan year 2023, as of August 2022.⁴⁴ CMS officials told us that these issuers were in the process of submitting updated data or justification forms to address the noncompliance. Officials told us that noncompliance may not indicate that an issuer has not met a network adequacy standard but instead that they did not complete the paperwork correctly when first submitted. Further, this review of network adequacy standards is a new process for issuers and CMS expects fewer issuers will be noncompliant as issuers become more familiar with the process. CMS officials told us that all issuers certified as QHPs in September satisfied the network adequacy requirements by either meeting the network adequacy standards or providing an acceptable justification as to why they were unable to meet the standards in certain cases, such as provider shortages.⁴⁵

Available information from state officials we surveyed and CMS did not always identify specific cases of inadequate networks but instead

⁴³A case of noncompliance does not always indicate that a network is inadequate. For example, officials from one state reported in our survey that an issuer was not compliant because the issuer did not submit the appropriate administrative forms.

⁴⁴CMS officials told us that the issuers included those that offer medical qualified health plans (173), stand-alone dental plans (192), and both QHPs and stand-alone dental plans (20). CMS did not assess the adequacy of provider networks for QHPs on the federally facilitated exchange as part of their annual certification reviews from January 2019 through December 2021.

⁴⁵CMS officials told us that QHP issuers that submitted justifications for any unmet network adequacy standards are required to conduct and report to CMS their ongoing efforts through CMS's recently launched Essential Community Providers and Network Adequacy Post-certification Compliance Monitoring program to monitor for new providers who may enter their service area that can potentially fill any such provider specialty gaps. CMS officials told us they launched this program in November 2022. Separate from the annual QHP certification review, CMS found non-compliance with the ECP standard as part of its annual compliance review for plan year 2020. Specifically, two of the seven selected issuers did not make contract offers to ECPs, as required. QHP issuers are required to offer contracts in good faith to at least one ECP in each ECP category in each county in the service area where an ECP in that category is available and provides medical or dental services covered by the issuer plan type. For plan year 2020, CMS modified the compliance review process due to the COVID-19 pandemic. They conducted full compliance reviews of seven QHP issuers and modified compliance reviews for 15 other QHP issuers. See Centers for Medicare & Medicaid Services, *2020 Plan Year Compliance Review Summary Report*, 2021.

indicated other potential limitations related to access to in-network providers, in some cases identified through enrollee complaints. Enrollee complaints have been an important tool to monitor network adequacy because complaints are a reflection of enrollees' actual experiences with their networks, according to one article we reviewed, CMS officials, and officials from some states. Complaints on their own, however, might be of limited use in evaluating adequacy, given that many enrollees do not make complaints because they do not understand their rights to complain or do not know to whom they should complain. State officials responding to our survey and CMS officials we interviewed reported they received complaints related to provider networks from January 2019 through December 2021 that could indicate a potential problem with network adequacy.⁴⁶ Complaints may come from enrollees, providers, and other stakeholders, such as legislators, according to officials. State and CMS experiences with complaints from January 2019 through December 2021 included the following.⁴⁷

- Officials from 35 states we surveyed reported receiving complaints about provider networks from January 2019 through December 2021. However, these complaints represented a low percentage of all complaints received by these states, averaging 4.4 percent. For example, officials from one state reported that they received complaints that enrollees did not have access to a certain type of provider, including some subspecialties in behavioral health, which could indicate a problem with the adequacy of the enrollee's provider network.
- CMS officials told us they received complaints about network adequacy during this time period. However, officials did not know the number of complaints received because the agency does not track the number of complaints specifically about network adequacy. One of the complaints they received related to the termination of a contract that would have left a good number of enrollees unable to access basic care, according to officials.

⁴⁶DOL officials told us they do not specifically track complaints related to network adequacy separate from their oversight of mental health and substance use disorder parity because they rarely receive network adequacy complaints that pertain to medical/surgical benefits.

⁴⁷Not all patient complaints received by states and CMS relate to network adequacy. Some complaints received focus, for example, on specific enrollee preferences—such as enrollees who complained a provider did not offer a specific specialty knee replacement.

Inaccurate provider directories may also indicate potential limitations in access to in-network providers. Literature we reviewed noted inaccurate provider directories can misrepresent the breadth of an enrollee's network and make it difficult, costly, and time consuming to access an in-network provider.⁴⁸ CMS has found inaccuracies in provider directories for QHPs as part of their annual compliance reviews and as part of their review of provider data files. For example, in CMS's annual compliance review for plan year 2020, CMS found that all seven QHP issuers selected for the review had at least one issue with provider directories, such as information for a provider's specialty or status of accepting new patients.⁴⁹

As part of its review of provider data, CMS consistently identified differences between provider network data submitted by QHP issuers and secret shopper review results for plan years 2017 through 2021.⁵⁰ For example, CMS confirmed that no more than 47 percent of the selected providers listed in the provider data files for QHPs contain accurate, up-to-date, and complete contact, location, specialty, and accessibility information, during these 5 years. However, the results vary when comparing the data to other public databases.⁵¹

Additionally, we identified literature that indicated potential limitations related to access to in-network providers.⁵² Specifically, fifteen studies reviewed provider networks for certain provider specialties, including mental health, and identified limitations that could affect an enrollee's ability to access in-network specialists. Ten of these studies focused on networks within the individual health insurance market, particularly on the exchanges. Some of these studies examined provider networks more

⁴⁸Burgman, A., "Laying Ghost Networks to Rest: Combatting Deceptive Health Plan Provider Directories," *Yale Law & Policy Review*, vol. 40, no. 78 (2021).

⁴⁹Centers for Medicare & Medicaid Services, *2020 Plan Year Compliance Report*, 2021.

⁵⁰The provider network data submitted by issuers is known as machine-readable data, which are provider directory information made available to CMS in a specified format and at times determined by CMS. For the secret shopper review, reviewers called providers using the contact information published in select issuers' data files to determine whether (1) the phone number was active and reached a live person and (2) the phone number published connected with a valid provider's office.

⁵¹Centers for Medicare & Medicaid Services, The Center for Consumer Information and Insurance Oversight, *Machine-Readable Provider Directory Review Summary Report Plan Years 2017-2021* (March 22, 2022).

⁵²Literature we reviewed did not include assessments of networks against standards to identify the full extent of inadequate networks.

broadly across different plan types, such as across exchanges and other private health plans, and identified limitations in networks that may affect access to care. Examples include the following.

- One study found that residents in most Arizona counties had no outpatient neurosurgeons available within their QHP network from the third quarter of 2016 to the second quarter of 2019. The study noted that this was despite guidelines from medical associations that recommend at least one neurosurgeon per 100,000 people. Specifically, several counties with such a population lacked access to neurological care or did not have neurosurgical facilities included on the QHPs offered in Arizona.⁵³
- One study compared networks for mental health and primary care services in exchange plans across the U.S. The study found that provider networks for mental health care in 2016 were far narrower than those for primary care because of lower rates of network participation by mental health care providers. Specifically, compared to primary care networks, provider participation in mental health networks was low with only 42.7 percent of psychiatrists and 19.3 percent of non-physician mental health care providers participating in any network.⁵⁴
- One study found that in June and July of 2015 less than 30 percent of new patients in either exchange plans or comparable commercial plans in California were able to schedule an appointment with the physician they initially selected.⁵⁵ While the study also found that new patients in commercial plans fared somewhat better than those in exchange plans with respect to getting appointments and appointment wait times, these differences were relatively small and often statistically insignificant.

Similar to the literature we reviewed, officials from 10 states responding to our survey and all stakeholders we interviewed reported that enrollees

⁵³Potla, S., T.S. Cole, C.B. Mulholland, and L.M. Tumialán, "Access to Neurosurgery in the Era of Narrowing Insurance Networks: Statewide Analysis of Patient Protection and Affordable Care Act Marketplace Plans in Arizona," *World Neurosurgery*, vol. 149 (May 2021).

⁵⁴Zhu, J.M., Y. Zhang, and D. Polsky, "Networks in ACA Marketplaces Are Narrower for Mental Health Care Than For Primary Care," *Health Affairs*, vol. 36, no. 9 (Sept. 2017).

⁵⁵Commercial plans are managed and administered by a private company rather than by a state or the federal government. Haeder, S.F., D.L. Weimer, and D.B. Mukamel, "Secret Shoppers Find Access to Providers and Network Adequacy Lacking for Those in Marketplace and Commercial Plans," *Health Affairs*, vol. 35, no.7 (July 2016).

may experience challenges in accessing certain in-network provider specialties. For example, officials from these 10 states reported that certain provider types were limited in the state's provider networks. State officials and stakeholders most commonly cited mental health or behavioral health providers when discussing challenges enrollees had in accessing in-network specialists. Other specialties mentioned by one of these states and one of these stakeholders included pediatrics and obstetrics and gynecology.

Literature we reviewed, officials from some states we interviewed and surveyed, and stakeholders we interviewed identified several interrelated factors that may contribute to inadequate networks. These factors included (1) provider shortages that limit the number of available providers for any given network, (2) issuers' challenges in contracting with available providers, and (3) geography, such as large rural areas, that may affect an enrollee's access to providers. These factors are described in more detail below.

Provider shortages. Literature we reviewed, officials from 16 states we surveyed, and all stakeholders we interviewed, indicated that provider shortages can affect network adequacy. The literature, state officials responding to our survey, and stakeholders noted provider shortages may contribute to inadequate networks because shortages limit the number of available providers that can be included in a network. Three studies, officials from nine of the states, and all stakeholders noted that provider shortages may be more prevalent in certain specialties or in rural areas of a state.⁵⁶ Mental and behavioral health providers were the most commonly cited specialists for which there are provider shortages.

For example, one study noted that advocates they interviewed identified an inadequate number of appropriate behavioral health providers, such as pediatric psychiatrists, as a potential barrier to receiving behavioral health care in exchange plans in New Jersey. The study noted that these shortages meant that enrollees had to wait extended periods of time or

⁵⁶See, for example, Wong, C.A., K. Kan, Z. Cidav, R. Nathenson, and D. Polsky. "Pediatric and Adult Physician Networks in Affordable Care Act Marketplace Plans," *Pediatrics*, vol. 139, no.4 (April 2017), and Haeder, S.F., D. Wimer, and D.B. Mukamel, "A Consumer-Centric Approach to Network Adequacy: Access to Four Specialties in California's Marketplace," *Health Affairs*, vol. 38, no. 11 (Nov. 2019).

travel long distances for appointments and, in some cases, go without care.⁵⁷

Similarly, one stakeholder noted that there are many consequences for an inadequate provider network for mental health and substance use disorder care, including increased risk of harm, mental health crises, overdose events, and even death. Some of the literature, state officials, and stakeholders reported several other specialties for which there were provider shortages, including pediatric specialists, obstetricians and gynecologists, and emergency care providers.

Provider contracting challenges. Four articles we reviewed, officials from nine states we surveyed or interviewed, and three stakeholders we interviewed indicated that issuers' challenges in contracting with available providers can affect network adequacy.⁵⁸ When issuers and providers do not agree to a contract, the number of available in-network providers may not be adequate. Three studies and officials from three states we surveyed indicated that these challenges with contracting were often in specialty fields, particularly in mental health.⁵⁹ This literature, these state officials, and two stakeholders cited several reasons why providers may be less likely or unwilling to contract with issuers, including lower provider compensation and the consolidation of hospitals or provider groups.⁶⁰ For example, officials from three states we surveyed or interviewed reported that concerns about reimbursement rates can contribute to a provider's decision not to contract with an issuer. Similarly, two studies discussed reluctance of some mental health providers to participate in an issuer's network because they may receive lower payment as an in-network

⁵⁷Jacobi, J.V. and T.A. Ragone, *Access to Behavioral Health Services in Marketplace Plans in New Jersey: The Puzzle of Parity* (Newark, New Jersey: Seton Hall University School of Law, 2016).

⁵⁸See, for example, Ahn, S., S. Corlette, and K. Lucia, *Can Telemedicine Help Address Concerns with Network Adequacy? Opportunities and Challenges in Six States* (Washington, D.C.: Urban Institute, 2016), and Zhu, J.M., Y. Zhang, and D. Polsky, "Networks in ACA Marketplaces Are Narrower for Mental Health Care Than For Primary Care," *Health Affairs*, vol. 36, no. 9 (Sept. 2017).

⁵⁹See Wong, Kan, Cidav, Nathenson and Polky, "Pediatric and Adult Physician Networks," 5; Ahn, Corlette, and Lucia, "Telemedicine and Network Adequacy," 5; and Zhu, Zhang, and Polsky, "Narrower for Mental Health Care," 1628.

⁶⁰This is consistent with our findings in a March 2022 report on challenges consumers with coverage face in accessing mental health care services. See GAO, *Mental Health Care: Access Challenges for Covered Consumers and Relevant Federal Efforts*, [GAO-22-104597](#) (Washington, D.C.: Mar. 29, 2022).

provider compared to an out-of-network provider.⁶¹ One of the studies also noted that an issuer may eliminate expensive providers from their networks to reduce costs.⁶² Additionally, two stakeholders and officials from two states we surveyed reported that consolidation of hospitals or provider groups can lead to inadequate networks. For example, officials from one state reported in our survey that if large hospital systems consolidate and choose not to contract with a particular issuer because they can increase their revenue by remaining out-of-network, that issuer's network may then become inadequate if there are no other available providers. One of the stakeholders explained that such consolidation reduces competition, increases rates, and incentivizes providers to stay out-of-network.

Geography. Three articles we reviewed, officials from several states we surveyed, and most stakeholders we interviewed indicated that large rural areas or areas with physical barriers may contribute to inadequate networks. For example, officials from 11 states reported in our survey that rural areas can affect network adequacy in their states because availability of, and access to, in-network providers in those rural areas can be limited. Officials from one of these states noted that there are no psychiatrists practicing in some of their rural counties, which requires enrollees to travel some distance for appointments. Officials from another state we surveyed reported that, when a specialist is not available in a rural area, enrollees are referred to urban centers where those providers are more available. This may mean enrollees experience longer travel times or distances. Similarly, one study we reviewed and three stakeholders we interviewed noted instances in which rural areas can affect network adequacy.⁶³ For example, the study noted that, in 2017, access to in-network providers for certain specialties in California's health insurance exchange were more available in large metropolitan areas than in rural areas. One of these stakeholders noted that a network may include rural areas where there is not a hospital with which to contract, limiting access to in-network care. In addition to rural areas, officials from one state we surveyed and one stakeholder reported that significant land barriers—including mountain passes and significant water barriers—can

⁶¹See Jacobi and Ragone, *Puzzle of Parity*, and Zhu, Zhang, and Polsky, "Narrower for Mental Health Care," 1628.

⁶²Wong, Kan, Cidav, Nathenson and Polky, "Pediatric and Adult Physician Networks," 5.

⁶³Haeder, Weimer, and Mukamel. "A Consumer-Centric Approach to Network Adequacy," 1924.

make it hard to ensure a provider is within a certain time or distance requirement.

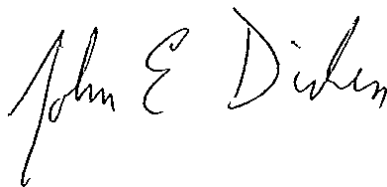
Officials from some of the states we surveyed and stakeholders we interviewed described ways these factors are interrelated. For example, officials from seven states we surveyed and two stakeholders we interviewed reported that provider shortages can be particularly challenging in rural areas, and that these shortages limit the number of available providers with which an issuer can contract. Officials from one state we surveyed noted that an issuer may be limited in the actions it can take to broaden networks if there are no local providers available.

Agency Comments

We provided a draft of this report to the Department of Health and Human Services and DOL. Both agencies provided technical comments, which we incorporated as appropriate.

We are sending copies of this report to the appropriate congressional committees, the Secretaries of Health and Human Services and Labor, and other interested parties. In addition, the report will be available at no charge on GAO's website at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or at DickenJ@gao.gov. Contact points for our Office of Congressional Relations and Office of Public Affairs can be found on the last page of this report. Other major contributors to this report are listed in appendix II.



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Director, Health Care

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Appendix I: Literature Review Scope and Methodology

To examine what is known about the adequacy of provider networks, we conducted a literature review to identify relevant studies published in peer-reviewed journals, government reports, and association, nonprofit, or research institute publications from January 2015 to March 2022.¹ We searched multiple databases for research published in relevant peer-reviewed journals; publications from associations, nonprofits, and think tanks; and government sources, including APA PsycInfo®, BIOSIS Previews®, EBSCO, Embase®, EMCare®, Harvard Think Tank Search, MEDLINE®, PAIS International, ProQuest Biological & Health Science Professional, SciSearch®, Scopus, WorldCat. Key search terms included “network adequacy,” “provider network,” “private health insurance,” “network” and “network oversight.” After excluding duplicates, we identified and reviewed 131 abstracts.

For those abstracts we found relevant, we obtained and reviewed the full study and selected 27 that were relevant to (1) reviewing the adequacy of provider networks, including those for certain specialty areas or health plan types; (2) factors that may contribute to network adequacy; (3) information on the oversight of provider networks, including potential challenges in assessing network adequacy; or (4) provider directories. We also identified two relevant studies through recommendations from interviews with selected stakeholders. As a result, we reviewed a total of 29 relevant studies. See below for a complete list of the studies we reviewed.

Studies GAO Reviewed

Ahn, Sandy, Sabrina Corlette, and Kevin Lucia. “Can Telemedicine Help Address Concerns with Network Adequacy? Opportunities and Challenges in Six States.” *Urban Institute*, 2016.

¹We selected this timeframe to reflect the current state of network adequacy and how it has evolved since 2015, a year after coverage began through the health insurance exchanges established under the Patient Protection and Affordable Care Act.

Burman, Abigail. "Laying Ghost Networks to Rest: Combatting Deceptive Health Plan Provider Directories." *Yale Law & Policy Review*, vol. 40, no.78 (2021): 78-148.

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Busch, Susan H., and Kelly Kyanko. "Assessment of Perceptions of Mental Health vs Medical Health Plan Networks Among US Adults with Private Insurance." *JAMA Network Open*, vol. 4, no. 10 (2021): e2130770.

Busch, Susan H., and Kelly A. Kyanko. "Incorrect Provider Directories Associated With Out-Of-Network Mental Health Care And Outpatient Surprise Bills." *Health Affairs*, vol. 39, no. 6 (2020): 975-983.

Colvin, Jeffrey D., Matt Hall, Cary Thurm, Jessica L. Bettenhausen, Laura Gottlieb, Samir S. Shah, Evan S. Fieldston et al. "Hypothetical Network Adequacy Schemes for Children Fail to Ensure Patients' Access to In-Network Children's Hospital." *Health Affairs*, vol. 37, no. 6 (2018): 873-880.

Dorner, Stephen C., Carlos A. Camargo Jr, Jeremiah D. Schuur, and Ali S. Raja. "Access to In-Network Emergency Physicians and Emergency Departments Within Federally Qualified Health Plans in 2015." *Western Journal of Emergency Medicine*, vol.17, no. 1 (2016): 18-21.

Dossani, Rimal H., Piyush Kalakoti, Anil Nanda, Bharat Guthikonda, and Luis M. Tumialán. "Is Access to Outpatient Neurosurgery Affected by Narrow Insurance Networks? Results From Statewide Analysis of Marketplace Plans in Louisiana." *Neurosurgery*, vol. 84, no. 1 (2019): 50-59.

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Hall, Mark A., and Paul B. Ginsburg. *A Better Approach to Regulating Provider Network Adequacy*. Washington, D.C.: The Brookings Institution, 2017.

Jacobi, John V., and Tara Adams Ragone. *Access to Behavioral Health Services in Marketplace Plans in New Jersey: The Puzzle of Parity*. Newark, NJ: Seton Hall University School of Law, 2016.

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Jumah, Fareed, Tania Atanassova, Bharath Raju, Michael S. Rallo, Vinayak Narayan, Richard Menger, Rimal Hanif Dossani, Gaurav Gupta, and Anil Nanda. "Do Narrow Networks Affect the Delivery of Outpatient Care in Neurosurgery?: A Statewide Analysis of Marketplace Plans in New Jersey." *World Neurosurgery*, vol. 141 (2020): e213-e222.

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Public Consulting Group, *State of Colorado Division of Insurance Network Adequacy Landscape Analysis and Review – Plan Year 2015. Individual Market and Small Group Market*. Boston, Mass.: 2015.

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Zhu, Jane M., Yuehan Zhang, and Daniel Polsky. "Networks in ACA Marketplaces Are Narrower for Mental Health Care Than for Primary Care." *Health Affairs*, vol. 36, no. 9 (2017): 1624-1631.

Appendix II: GAO Contact and Staff Acknowledgments

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Staff Acknowledgments

In addition to the contact named above, Kristi Peterson (Assistant Director), Amy Leone (Analyst-in-Charge), Alison Granger, and Hannah Grow made key contributions to this report. Leia Dickerson, Cynthia Khan, Laurie Pachter, Jenny Rudisill and Ethiene Salgado-Rodriguez also made important contributions.

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