December 2022

PRIVATE HEALTH INSURANCE

State and Federal Oversight of Provider Networks Varies

GAO Highlights

Highlights of GAO-23-105642, a report to congressional committees

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.

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.