

November 10, 2021

The Honorable Jessica Altman
Co-Chair
The Honorable Ricardo Lara
Co-Chair
Workstream 5, Special Committee on Race and Insurance
National Association of Insurance Commissioners
444 North Capitol Street NW, Suite 700
Washington, DC 20001-1512

Sent via email to: Jolie Matthews at: JMatthews@naic.org

Re: AMA comments on Provider Network Paper Outline

Dear Commissioners Altman and Lara:

On behalf of the American Medical Association (AMA) and our physician and student members, I write to state our appreciation for the work of the National Association of Insurance Commissioners' (NAIC) Special Committee on Race and Insurance—Workstream 5 (Workstream 5), and to offer our perspective on the collection and use of physician race and ethnicity information (REI) in provider networks and provider directories.

Attached, please find several suggested edits to the outline for the proposed paper on provider networks. Additionally, we are attaching a literature review on race concordant care prepared by the AMA that also includes some high-level takeaways from the literature and potential implications of policy supporting race concordant care. We thought this document may be useful to you as you embark on the drafting of this paper. Lastly, below we respectively offer additional thoughts on Workstream 5's work as it relates to this initiative.

Health care stakeholders, including patients, are increasingly expressing interest in including physician REI in provider directories and as a component of network adequacy requirements to advance health equity and ensure culturally competent care. The AMA recognizes and understands that there are many reasons why patients may want to consider REI when choosing a physician. Presumably this could help patients (1) identify and connect with physicians with whom they may relate; and (2) select products/plans that can help them accomplish their health goals.

There is some early and limited research that shows patients have better experiences leading to better health outcomes when working with a physician to whom they relate. For example, “concordance” studies have shown better birth outcomes for Black newborns when they are cared for by Black physicians ([Greenwood et al., 2020](#)). Somewhat contradictory research shows, however, that patient-provider race concordance is not always a significant predictor of health outcomes for historically minoritized patients (see review by [Meghani et al., 2009](#)).

Since the research in this area is inconclusive, we suggest that racial concordance should not be used to bypass the more fundamental equity questions:

- Why do care experiences and clinical outcomes vary by a provider's race/ethnicity?
- What work is necessary to improve outcomes and satisfaction for minoritized patients seen by non-rationally concordant doctors?

The AMA's historical experience with racial data in physician directories must be acknowledged. In the early decades of the 20th century, the AMA listed Black physicians as "colored" in its national physician directory and was slow to remove the designation in response to protests from the National Medical Association and the harm the designation was inflicting. We need to acknowledge that there are real dangers in including clinician REI in provider directories, especially if the problems associated with patient-facing data of this nature are not addressed, resulting in the rebuilding and reinforcement of racist structures. To avoid these consequences, the following must be considered:

- Historically, designation of a physician's race has been used as a tool to discriminate and exclude physicians. Absent careful planning and communication, this initiative could be viewed as a modern-day attempt to do the same.
- Relatedly, displaying REI in provider directories could expose minoritized physicians to discrimination from enrollees and others with access to the directories.
- Physicians, patients, and equity advocates should be cautious of payers collecting and using this information for purposes other than its originally stated purpose. For example, payers could draw inappropriate inferences and discriminate against certain populations, potentially leading to fewer insurance options in specific geographic areas or reduced access for certain populations.

As the NAIC continues its work to examine the role of provider REI in network adequacy determinations and provider directories, we ask that you consider the following:

- If plans do not currently collect data on their contracted physicians' REI, this could provide an opportunity for plans to (1) ensure their networks are appropriately diverse and align with their patient population; and (2) establish a benchmark to measure improvement in diverse physician networks over time. In addition, plans' collection of network physicians' REI could help regulators hold insurers accountable for creating diverse networks that meet the needs of their enrollees. This could be accomplished without making REI available in patient-facing directories.
- Providing and displaying REI, even if voluntary and at the discretion of the physician, does not ensure that providers will be fully protected from harm. For example, physicians that opt out (or fail to opt in) may be less likely to be selected by patients for various reasons, including implicit and explicit bias. Thus, strong safeguards would need to be implemented to avoid coercive pressure on providers to share their REI information.

We also ask that you consider establishing the following guardrails in any regulatory guidance or models for state regulators:

- Use of these data by the payer should be limited and transparent to the physician. Insurers should clearly communicate to the physician not only what the information will be used for, but also what it will not be used to accomplish.

- Insurers should implement mechanisms to evaluate whether the initiative benefits or harms both physicians and patients over time. For example, insurers should consider conducting pilot studies to evaluate potential for harm.
- Insurers should directly engage with patients and physicians via qualitative means such as focus groups, key informant interviews, etc. These can help to inform other evaluation methods.
- Findings should be made available to participants and shared among any planning partners.
- Insurers should have processes to quickly adjust the program in real-time as necessary.
- Insurers should provide anti-racial bias training to all of its contracted providers at no cost and consider offering positive incentives for course completion.
- Insurers should consider other ways to support diversification and health equity, such as heavily investing in funding/supporting pathway programs, from elementary education to residency/fellowship programs.
- Insurers should use standardized race and ethnicity categorizations.

Finally, we offer several questions that may be posed by regulators to insurers related to the use of REI in network building and provider directories to evaluate existing safeguards related to the data collection/publication and effectiveness of these efforts:

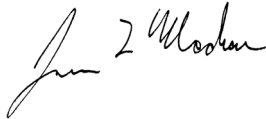
- Does an insurer already have this information about network physicians, or would it be new data? If already collecting, how has it been used?
- What data categories/classification will an insurer use to capture REI? (Of note, the AMA is currently working with the Association of American Medical Colleges (AAMC) and Accreditation Council of Graduate Medical Education (ACGME) to identify a standard classification for clinician race and ethnicity data to be used in health care to facilitate meaningful research in health equity.)
- What other tactics are being contemplated to ensure diverse options for culturally competent patient care? For example:
 - What else is an insurer doing to promote diversity within its networks and support for historically/currently marginalized clinicians?
 - What metrics will an insurer use to evaluate the diversity of its networks (e.g., comparison of the demographic composition of its member population within a certain metropolitan statistical area (MSA) to the demographics of contracted physicians within the same MSA?)
 - What is an insurer doing to educate physicians in its networks about cultural and racial sensitivity, non-discrimination, and equity?
 - Has an insurer explored other avenues intended to connect patients with physicians they relate—for example, giving physicians the opportunity to highlight any patient populations they would like to work with, have experience with, or specialize in?
- How will an insurer respond to harassment or other forms of discrimination non-white physicians may experience from patients?
- How will an insurer measure the potential benefits/harms of this initiative? How will an insurer measure whether stated goals of this initiative are accomplished?
 - Harms can be explicit (e.g., non-white clinicians receiving discriminatory messages from the public) or subtle (e.g., non-white clinicians suddenly experiencing unexplained cancellations). An insurer should consider how it will document and evaluate a range of responses to its initiative.
 - Intersectionality is critical to evaluation strategy. Patients select physicians for a variety of reasons, not only race or ethnicity. Insurers should develop a strategy to determine

whether benefits and harms are linked to REI vs. (or in addition to) other factors. Relatedly, insurers should ensure holistic review and evaluation prior to implementing changes to its initiative.

- How will an insurer communicate requests to physicians to provide their REI?
- Has the insurer reached out to the National Medical Association, the National Hispanic Medical Association, and organizations representing Asian Americans, Pacific Islanders, and Native physicians about the initiative? If so, what feedback have they shared?
- Are non-white physicians in an insurer's network prepared to take on additional patients who may seek them out as a result of this initiative?
- Will members/prospective members be informed of the inclusion of REI in the provider directory? If so, what will be the content of these communications?

Thank you for the opportunity to engage with you on this important issue. We are happy to answer any questions about the attached documents or any issues raised in this letter and look forward to working with you on these critical issues. Please contact Emily Carroll, Senior Legislative Attorney, AMA Advocacy at emily.carroll@ama-assn.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Jim L Madara".

James L. Madara, MD

Attachments