

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:

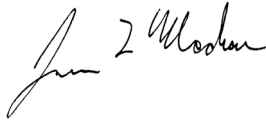
- Does an insurer already have this information about network physicians, or would it be new data? If already collecting, how has it been used?
- What data categories/classification will an insurer use to capture REI? (Of note, the AMA is currently working with the Association of American Medical Colleges (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

Race Concordant Care Briefing Book

Prepared by Maria Yerstein, MD

1: Research Findings

- 1.1 Communication
- 1.2 Healthcare Utilization
- 1.3 Health Outcomes
- 1.4 Summary
- 1.5 Key Points

2: Potential Implications of Policy Supporting Racially Concordant Care

3: References

1. Research Findings

There have been many studies examining health care inequities through the lens of concordance, which can be defined as a similarity, or shared identity, between physician and patient based on a demographic attribute, such as race, sex, or age.[1] The concept of concordance is difficult to study because one parameter of identity, such as race, does not occur in isolation, but instead with many other parameters, such as age, gender, education level, etc. Moreover, some categories, such as race and ethnicity, are fundamentally social constructs. Race, for example, describes an arbitrarily organized combination of physical traits, geographic ancestry, language, religion and a variety of other cultural features.

The ways in which concordance matters is unclear: one study showed that race and sex were not predictors of perceived patient-physician similarity, but that age, education, and physicians' patient-centered communication were.[1]

Most concordance studies have examined racial and ethnic concordance, particularly between Black patients with Black versus White providers, and others have included gender and language concordance. Racial and ethnic categories are presented as the researchers designated them.

1.1 Communication:

Black Patients

- One systematic review examining 6 studies found that racial concordance improved patient satisfaction but had no effect on quality of communication.[2]
 - o Quality includes concepts such as interpersonal exchange, fairness, respect, physicians' attention to patient concerns and ability to explain things clearly, as well as more objective measures such as time spent asking questions of patient, time spent explaining biomedical concepts, etc.
 - o Satisfaction parameters included concepts of overall satisfaction, being accessible, listening to patient concerns, explaining medical concepts, etc.
- A large registry review (22,440 patients between 2002-2007) found no relationship between race concordance and patient reported ratings of provider communication.[3]
- Simulated clinical scenario studies:
 - o One study showed that when giving a sample of Black women a variety of clinical vignettes with a variety of different providers, they consistently chose White men as being most trustworthy as compared to Black men or women.[4]

- Of note, this likely reflects internalized racism and oppression—i.e., “conscious and unconscious acceptance of a racial hierarchy in which Whites are consistently ranked above people of color.”[5]
- Another showed that Black patients were more likely to be information-seeking after an interaction with a Black provider. [6]
- Another demonstrated that Black patients had reduced “self-reported and physiological indicators of pain” when they had a Black provider and previous experiences of discrimination were predictive of a greater reduction in pain scores.[7]

Hispanic Patients

- One study looking at a patient registry from 1994 found that Hispanics with Hispanic physicians were more likely than those with non-Hispanic physicians to be very satisfied with their health care overall.[8] Please note, in this study from 1999, patients and physicians were divided into categories of White, Black, and Hispanic.
- Another study compared non-Hispanic men and women to Hispanic men and women in a patient registry from 2009-2011 and found that for Hispanic women, ethnic concordance had no significant association with overall satisfaction with their care, and Hispanic men were actually likely to be less satisfied with some aspects of their medical care when they were ethnically concordant with their provider [9]

Female Patients

- One study showed that female physicians report improved rapport when treating female patients.[10]
- Another study showed that female patients report worse communication with female doctors [3]

1.2 Healthcare Utilization

Financial

- One study showed that language concordance between the primary care provider and patient has been shown to reduce total utilization of services, with significant reductions in ED visits, specialist visits, and inpatient visits. [11]
- Another study showed that racial concordance (White, Black, Asian-American, and Hispanic) was associated with increased total healthcare utilization.[12] Hispanic was used as a racial, not an ethnic, category.
- A third study showed that healthcare expenditures were lower among non-Hispanic White, non-Hispanic Black, Asian, and Hispanic patients with concordant clinicians than those with discordant clinicians. [13]

Preventative Services

- One study showed that in accessing preventative care, Black men are more likely to do so when they have a Black physician.[14]
- Another showed that for cancer screenings, racial and ethnic concordance actually lowered screening rates for Hispanic patients as compared to non-Hispanic Black and White patients, but increased rates for similarly gendered dyads.[15]

- Another study showed that women may be more likely to access cancer screenings and mammographies, but no more likely to access pap smears, with female providers. [3]

1.3 Health Outcomes

- One study demonstrated that racial concordance between pediatrician and newborn improves mortality rates for Black newborns by 30%; importantly, White newborns did not have increased or decreased mortality when cared for by Black pediatricians.[16]
- In a simulated clinical scenario, patients were grouped into categories of non-Hispanic Black/African American, Hispanic white, or non-Hispanic white; non-Hispanic White and Hispanic White patients, as compared to non-Hispanic Black patients, did not demonstrate any changes in perceived pain based on concordance of the provider; they also did not report significant experiences of discrimination.[7]
- A review of 27 studies found that the data was inconclusive on whether concordance improved health outcomes.[17]

1.4 Summary of Research

- There is an overall paucity of research on the potential benefits and risks of concordant care by race, ethnicity, gender, language, and other factors, from which to draw firm conclusions.
- Racially and ethnically concordant care may improve patient satisfaction for Black patients but may not improve quality of care. For non-Hispanic White and Hispanic patients, racially and ethnically concordant care does not seem to have an effect on patient satisfaction.
- Racially concordant care may increase utilization of preventative services and decrease total cost of care.
- For health outcomes, there is limited evidence that Black patients may experience some improved outcomes around specific health indicators when in a racially concordant dyad.

1.5 Key Learnings from Research:

- Concordance is a multidimensional concept, and factors such as concordant age, education level, and physician's patient-centered communication may be more important for patient satisfaction than race.
- Racial concordance seemed to provide the greatest benefit to Black patients who reported the highest levels of discrimination.
- Much more research is needed to draw meaningful conclusions.

2. Potential Advantages of Racially Concordant Care:

- May lead to improved patient satisfaction for Black patients

Potential Disadvantages of Racially Concordant Care:

- Risk for exacerbating racial segregation in healthcare and between patient-provider populations
- Potentially distracts from core responsibility and duty of all physicians (especially White physicians) to develop and provide culturally competent and equitable care to diverse populations

- Potential for inadvertently exacerbating inequities by race and other factors given limited evidence around benefits and near- and long-term risks for communities and populations
- Underrepresentation of Black, Hispanic, indigenous, and other historically marginalized groups among physicians and other providers poses a structural concern and barrier.
 - o For example, physicians may feel coerced to care for patients that ‘look like them’ or who self-identify similarly, putting them at risk for burnout in attempting to accommodate patients who are not being adequately served by other providers.
 - o Please note data below which demonstrates disparities between physicians and the general populations by racial and ethnic categories. Data is given in the categories the studies provided.

2018: Practicing Physicians and self identified racial/ethnic category[18]	2019: U.S. Census Data for general population racial/ethnic categories[19]
56.2% White	60.0% non-Hispanic White
17.1% Asian	5.6% non-Hispanic Asian
5.8% Hispanic	18.4% Hispanic
5.0% Black or African American	12.4% non-Hispanic Black
13.7% Other	

3. References

1. Street RL, O’Malley KJ, Cooper LA, Haidet P. Understanding concordance in patient-physician relationships: personal and ethnic dimensions of shared identity. *Ann Fam Med.* 2008 Jun;6(3):198–205.
2. Shen MJ, Peterson EB, Costas-Muñiz R, Hernandez MH, Jewell ST, Matsoukas K, et al. The Effects of Race and Racial Concordance on Patient-Physician Communication: A Systematic Review of the Literature. *J Racial Ethn Health Disparities.* 2018 Feb;5(1):117–40.
3. Jerant A, Bertakis KD, Fenton JJ, Tancredi DJ, Franks P. Patient-provider sex and race/ethnicity concordance: a national study of healthcare and outcomes. *Med Care.* 2011 Nov;49(11):1012–20.
4. Wiltshire J, Allison JJ, Brown R, Elder K. African American women perceptions of physician trustworthiness: A factorial survey analysis of physician race, gender and age. *AIMS Public Health.* 2018;5(2):122–34.
5. Johnson, Robin N. *The Psychology of Racism: How Internalized Racism, Academic Self-Concept, and Campus Racial Climate Impact the Academic Experiences and Achievement of African American Undergraduates.* , 2008. Print.
6. Alsan M, Stanford FC, Banerjee A, Breza E, Chandrasekhar AG, Eichmeyer S, et al. Comparison of Knowledge and Information-Seeking Behavior After General COVID-19 Public Health Messages and Messages Tailored for Black and Latinx Communities : A Randomized Controlled Trial. *Ann Intern Med.* 2021 Apr;174(4):484–92.
7. Anderson SR, Gianola M, Perry JM, Losin EAR. Clinician-Patient Racial/Ethnic Concordance Influences Racial/Ethnic Minority Pain: Evidence from Simulated Clinical Interactions. *Pain Med.* 2020 Nov 1;21(11):3109–25.

8. Saha S, Komaromy M, Koepsell TD, Bindman AB. Patient-physician racial concordance and the perceived quality and use of health care. *Arch Intern Med*. 1999 May 10;159(9):997–1004.
9. Oguz T. Is Patient-Provider Racial Concordance Associated with Hispanics' Satisfaction with Health Care? *Int J Environ Res Public Health*. 2018 Dec 24;16(1):E31.
10. Gross R, McNeill R, Davis P, Lay-Yee R, Jatrana S, Crampton P. The association of gender concordance and primary care physicians' perceptions of their patients. *Women Health*. 2008;48(2):123–44.
11. Chandrashekar P, Zhang R, Leung M, Jain SH. Impact of Patient-Physician Language Concordance on Healthcare Utilization. *J GEN INTERN MED* [Internet]. 2021 Aug 3 [cited 2021 Sep 14]; Available from: <https://link.springer.com/10.1007/s11606-021-06998-w>
12. LaVeist TA, Nuru-Jeter A, Jones KE. The association of doctor-patient race concordance with health services utilization. *J Public Health Policy*. 2003;24(3–4):312–23.
13. Jetty A, Jabbarpour Y, Pollack J, Huerto R, Woo S, Petterson S. Patient-Physician Racial Concordance Associated with Improved Healthcare Use and Lower Healthcare Expenditures in Minority Populations. *J Racial Ethn Health Disparities*. 2021 Jan 5;
14. Alsan M, Garrick O, Graziani G. Does Diversity Matter for Health? Experimental Evidence from Oakland. *American Economic Review*. 2019 Dec 1;109(12):4071–111.
15. Malhotra J, Rotter D, Tsui J, Llanos AAM, Balasubramanian BA, Demissie K. Impact of Patient-Provider Race, Ethnicity, and Gender Concordance on Cancer Screening: Findings from Medical Expenditure Panel Survey. *Cancer Epidemiol Biomarkers Prev*. 2017 Dec;26(12):1804–11.
16. Greenwood BN, Hardeman RR, Huang L, Sojourner A. Physician-patient racial concordance and disparities in birthing mortality for newborns. *Proc Natl Acad Sci U S A*. 2020 Sep 1;117(35):21194–200.
17. Meghani SH, Brooks JM, Gipson-Jones T, Waite R, Whitfield-Harris L, Deatrick JA. Patient-provider race-concordance: does it matter in improving minority patients' health outcomes? *Ethn Health*. 2009 Feb;14(1):107–30.
18. Diversity in Medicine: Facts and Figures 2019 | AAMC [Internet]. [cited 2021 Sep 14]. Available from: <https://www.aamc.org/data-reports/workforce/report/diversity-medicine-facts-and-figures-2019>
19. Census - Table Results [Internet]. [cited 2021 Sep 15]. Available from: <https://data.census.gov/cedsci/table?q=race%20ethnic&d=ACS%201-Year%20Estimates%20Data%20Profiles&tid=ACSDP1Y2019.DP05&hidePreview=true>

Comments are being requested on this draft document on or before Nov. 4, 2021. Comments should be sent by email only to Jolie Matthews at jmatthews@naic.org.

**National Association of Insurance Commissioners (NAIC)
Special Committee on Race and Insurance – Workstream 5 (Health)
White Paper on Provider Networks**

1. The role of the insurance sector in increasing diversity and cultural competency in networks
 - a. Discussion of the goal of more diverse and culturally competent networks
 - i. Discussion of key populations to consider
 - ii. Discussion of research that shows connection between these factors and outcomes, maternal health as an example.
 1. Acknowledge somewhat contradictory research showing that patient-provider race concordance is not always a significant predictor of health outcomes for minoritized patients (see review by Meghani et al 2009).
 - iii. Define/explain cultural competency; what is its relationship (if any) to cultural concordance?
 - iv. Discussion on systemic factors, such as whether demographically concordant care is/should be necessary for culturally competent care.
 1. Why are patients from historically marginalized populations receiving sub-par care?
 2. What other actions are needed to ensure that patients from historically marginalized populations receive quality care from all providers, regardless of demographics or cultural concordance, including the responsibility of all physicians and other health care providers to develop and provide culturally competent and equitable care to diverse populations.
 - b. Recognition that others have key roles, but insurance sector can contribute significantly to this goal
 - i. Provider education, recruitment, etc
 - ii. Role of state licensing boards
 - c. Role of insurance companies
 - i. Provider credentialing
 - ii. Network construction
 - iii. Leveraging provider directories to connect policyholders to diverse and culturally competent care
 - d. Role of insurance regulators
 - i. Network adequacy as a tool
 - ii. Provider directory oversight
2. Network Adequacy
 - a. Background and Legal Landscape
 - i. Affordable Care Act requires adequate networks
 - ii. NAIC network adequacy model – a brief description and history
 - iii. What have been the barriers to adequate networks to date?

- i. Should networks be required to include FQHCs? Are the current ECP requirements sufficient?
 - 1. Reimbursement
 - 2. Should NAIC further explore FQHC challenges with PBM actions relative to the 340B program?

6. Conclusion and discussion of recommended next steps

DRAFT