Milbank Memorial Fund

Fact Sheet

Evaluating the Effectiveness of Policies to Improve Primary Care Access for Underserved Populations

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For More Information

Read the set of five fact sheets summarizing the evidence on policy initiatives in each dimension of primary care access. Or read the complete report, *The Effectiveness of Policies to Improve Primary Care Access for Underserved Populations: An Assessment of the Literature.*

GEORGETOWN UNIVERSITY McCourt School of Public Policy
CENTER ON HEALTH INSURANCE REFORMS

Part 4: Removing Financial Barriers to Primary Care

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Having health insurance coverage has a tremendous impact on an individual's ability to obtain primary care services. Policies that facilitate enrollment in comprehensive health insurance plans and reduce out-of-pocket obligations can play a critical role in increasing access to primary care.

The Affordable Care Act's expansion of Medicaid eligibility has proven to be one of the most effective levers to boost access to primary care. States that adopted Medicaid expansion have benefited from reduced preventable hospitalizations, a key measure of primary care access. States with the highest Medicaid income eligibility thresholds and Medicaid payment rates have even lower rates of preventable hospitalizations. For many underserved communities, safety net providers like federally qualified health centers (FQHCs) are an essential source of affordable primary care (See Part 2 for more on FQHCs).

This fact sheet summarizes the state of evidence supporting additional policy interventions to make primary care more affordable and accessible.

Primary care is a critical tool to prevent illness and death and improve equitable distribution of health in populations. However, access to this important source of care is lacking, especially for many underresourced communities, such as communities of color and those in rural areas. Attempts to improve access to primary care for these populations can be divided into five interrelated dimensions:1) improving availability of primary care clinicians; 2) accessibility of primary care services geographically; 3) accommodation of primary care services in terms of appointment availability and hours; 4) affordability; and 5) acceptability in terms of comfort and communication between patient and clinician.

Making Primary Care Services Available with Minimal to No Cost Sharing.

Even $1 to $5 in cost sharing can lead to reduced utilization of preventive and primary care, and policies that reduce premium and cost-sharing amounts are likely to improve access to primary care. Yet, from 2009 to 2018, health insurance deductibles and individual out-of-pocket spending have increased at more than twice the rate of growth in wages in that period.

- ***What Has Been Attempted?*** Value-based insurance design (VBID) reduces cost sharing for services like primary care or generic prescription drugs that provide high value for patients. As of 2017, five states required standardized benefit plans in the Affordable Care Act (ACA) marketplaces to provide non-preventive primary care visits as a pre-deductible service. Several large

employers, some state Medicaid programs, some state employee plans, and the Centers for Medicare and Medicaid Services (for Medicare Advantage plans) have also implemented VBID programs to boost the use of primary care services.

- ***How Has It Worked?*** Enrollment in VBID plans is associated with an increase in primary care visits for patients with diabetes and a general reduction in hospitalization and inappropriate ER visits. The Connecticut state employee health plan saw a 75% increase in primary care visits after implementing a VBID program in 2011. An evaluation of the first three years of the Medicare Advantage VBID program found that it increased utilization of targeted high-value primary care services like diabetes monitoring. Despite the positive impacts, these programs tend to face barriers, like administrative burdens and enrollee pushback when increasing cost sharing for low-value services, which can prevent expansion.

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Using Network Adequacy to Improve Access. Network adequacy refers to a health plan's ability to provide reasonable access to benefits by ensuring there are sufficient number and type of health care clinicians in a plan's network. When networks are inadequate, plan members may end up paying higher costs for out-of-network providers.

- ***What Has Been Attempted?*** Medicare Advantage, Medicaid, and the ACA all include a requirement that plan enrollees have access to an adequate network of providers.

  In the commercial market, most states lack quantitative standards for access to primary care services such as minimum ratios of primary care providers to enrolled population, maximum time or distance for enrollees to travel to a primary care provider, or maximum wait times to secure an appointment. In the few states with quantitative standards. insurance regulators often lack the capacity or authority to conduct robust oversight and enforcement. Further, quantitative standards often fail to take into account which providers are accepting new patients.

  Conversely, Medicare Advantage plans are required to cover a certain number of provider types within specified distance and travel time requirements, and most state Medicaid managed care plans also face network adequacy requirements specific to travel time or distance for primary care providers.

- ***How Has It Worked?*** Research indicates that current network adequacy standards for Medicare Advantage, Medicaid managed care, and commercial plans have done little to improve access to primary care.

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A 2021 analysis of Medicare Advantage found substantial racial/ethnic disparities in access to wider Medicare Advantage networks for primary care among Hispanic and Asian enrollees. A 2014 Office of the Inspector General report on the availability of Medicaid managed care providers found that more than half of providers could not offer appointments to enrollees, and primary care providers were less likely to offer an appointment than specialists. The report also raised questions about both the enforcement and adequacy of state Medicaid managed care network adequacy standards.

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