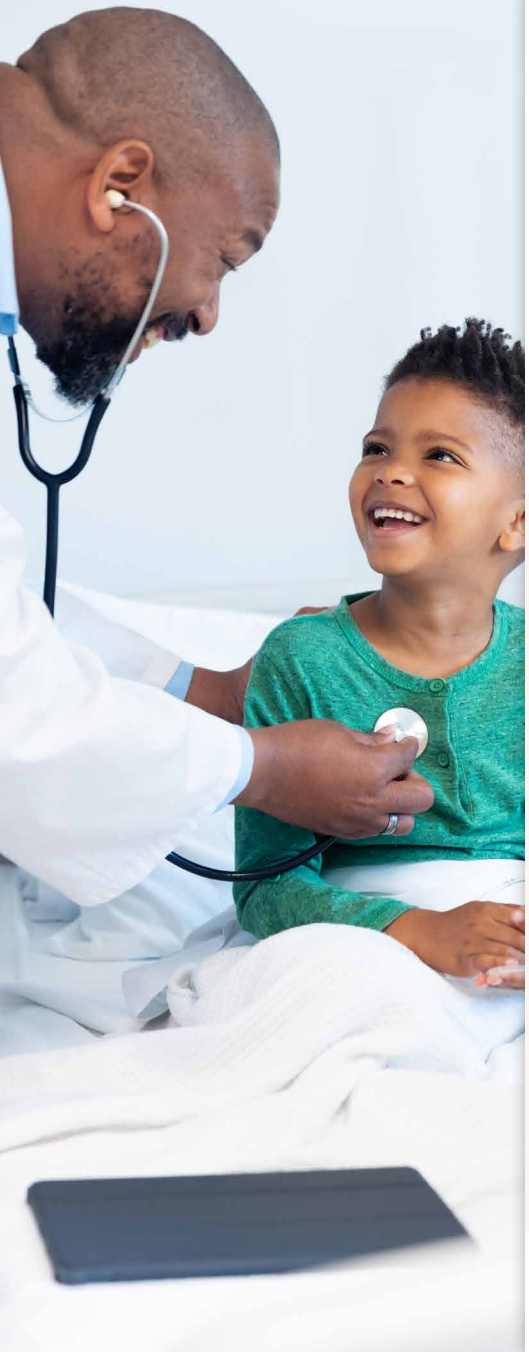
UNITED STATES of CARE

UNITED SOLUTIONS *for* CARE

EXPANDING PATIENTS' ACCESS *to High-Quality, Cost-Effective Services*

Informed by listening to thousands of people across the country, USofCare's United Solutions for Care agenda represents a set of four goals and twelve targeted and achievable solutions to help us build a fairer health care system. The policy principles outlined here respond to one of those twelve solutions: reducing or eliminating out-of-pocket costs, and one way to do this is by ensuring people's low- or no-cost access to high-quality, cost–effective services.



Our health care system should provide people with access to proven, cost-effective services that maintain and improve overall health, although it often falls short in achieving this balance. More can and should be done to ensure that people have access to such "high-value" services and care. Reducing or eliminating out-of-pocket costs for patients and pursuing other policies to incentivize access to high-value services, including primary and preventive services and some specialty care, can increase access and improve health outcomes for patients.

Advancing these policies is part of the broader movement towards "patient-first care" (also known as value-based care) that aims to shift incentives within the health care system to better align with patient needs. This includes moving away from unnecessary or "low-value" care – such as an overreliance on imaging services or diagnostic tests – that does little to improve people's health outcomes and collectively costs patients billions of dollars annually.

Federal and State Action to Encourage People to Receive Services that Balance Cost and Quality

Colorado (HB 1232, 2021): Established the "Colorado Option" standardized plan option and provides enrollees with "first-dollar, pre-deductible coverage for certain high-value services" including primary care visits and services that disproportionately benefit communities of color, such as low-cost diabetes care.

Rhode Island (HB 5929, 2021): Requires private insurers subject to state regulation to cover perinatal doula services, aligning them with state Medicaid requirements that also cover perinatal doula services.

Inflation Reduction Act (H.R. 5376, 2022): Establishes a $2,000 cap on Medicare beneficiaries' out-of-pocket spending and limits cost-sharing for insulin products to no more than $35 per month. Many states, as well as private insurers, have also capped insulin costs.

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Policy Recommendations to Increase Access to High-Quality, Cost-Effective Services

Policymakers on both the state and federal levels have a broad array of options available to them to create policies that increase access to high-quality, cost-effective services, including policies that incorporate the following principles:

Promote Plan Coverage of High-Quality, cost-effective Services

Insurers should broadly identify ways to implement value-based insurance design (V-BID) principles and other policy levers to leverage cost-sharing arrangements that shift the system toward greater patient uptake of high-quality, cost-effective services. To promote access to these services, policymakers should:

- **Require plans to provide certain high-quality, cost-effective benefits with limited or no cost-sharing.** Policymakers should require plans to provide certain services with zero or reduced out-of-pocket costs as part of a mandated standardized plan option or by adding to other benefit design requirements. Policymakers should prioritize services that reduce health disparities and, if allowing cost-sharing, emphasize predictable cost structures like copays over coinsurance to better help patients budget for care.
- **Strengthen network adequacy requirements.** Network adequacy standards outline how health plans must provide access to providers to ensure patients have reasonable access to covered benefits. Policymakers on both the state and federal levels should expand upon existing requirements governing marketplace plans with more rigorous standards, such as maximum appointment wait-times and minimum provider-to-enrollee ratios, and robust enforcement to ensure compliance.

Increase Access to Providers

High-quality, cost-effective coverage relies on providers available to deliver it to patients. To ensure people have access to the providers they need, policymakers should:

- **Establish reimbursement policies that promote primary care delivery and access.** Payment models should move away from volume-based fee-for-service toward alternative payment models, such as prospective payments, that pay primary care providers a set amount for a given period to incentivize delivery of high-value, cost-effective services. Initiatives such as primary care investment targets, in which thresholds are established for insurers to increase and measure primary care spending, can rebalance spending toward underfunded primary care.
- **Remove undue restrictions on non-physician providers.** Increasing the number of nurse practitioners, physician assistants, and other providers have been shown to expand access to high-quality, cost-effective care, particularly in rural or underserved areas. These providers should be allowed to practice at the top of their license to ensure patients have access to timely, appropriate care.
- **Expand access to safety net care.** Certain providers deliver elevated levels of high-quality, cost-effective essential physical and mental health care services to underserved populations. Plans should be required to contract with a higher percentage of Essential Community Providers (ECPs) than required by federal law to ensure communities have access to regular sources of care while also simplifying the ECP certification process and properly ensuring adequate reimbursement to allow ECPs to remain in the community. Policymakers should also include more providers and provider types in plan networks that have been proven to decrease health disparities, such as doulas and community health workers, and implement culturally responsive care to promote health equity.