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**NAIC Special (EX) Committee on
Race & Insurance
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“Of all the forms of inequality, injustice in health care is the most shocking and inhumane.”

Dr. Martin Luther King, Jr.



DC Health Link: ACA State-Based Online Health Insurance Marketplace

- DCHBX: Private-public partnership (private Executive Board) responsible for DC Health Link – DC’s Affordable Care Act online health insurance marketplace
- Last state to start IT build, **1 of 4 state marketplaces opened for business on time** (& stayed open) Oct 1, 2013
- **100,000 people** (private health insurance): 83,000+ people with job-based coverage (5,300+ District small businesses covered; 11,000 Congress -- Members and designated staff in district offices and on the Hill) paying over \$520 million annually in premiums (invoiced and collected by DCHBX and paid to 3 United Healthcare insurers, 2 Aetna insurers, Kaiser Permanente, and CareFirst Blue Cross Blue Shield); 15,000 to 20,000 residents with individual coverage paying over \$100 million annually in premiums
- **Cut uninsured rate in half** since DC Health Link opened for business. Near universal coverage with more than 96% of DC residents covered
 - ✓ DC ranks **#2** in U.S. for lowest uninsured
- **157 small group health plans and 25 individual and family health plans in 2022**



Our Journey: Social Justice, Health Disparities, Health Equity

- Pandemic data shining the light on race and ethnicity
- George Floyd's murder
- **ACTIONS:** External (today's slides) and internal (not in slides)



Health Disparities

Compared to White Americans with COVID-19 in the U.S. (2021):

- Black Americans were **hospitalized at 3.3** times the rate and **died at 1.8 times** the rate;
- Latinos were **hospitalized at 3.8** times the rate and **died at 1.3 times** the rate; and
- American Indian or Alaska Natives are **hospitalized at 3.7** times the rate and **died at 1.4 times** the rate.

These pandemic inequities reflect a long history in the U.S. of racism, inferior treatment, discrimination and mistreatment of people of color in the health care system.

We believe it is critical to be part of the solution to help end systemic discrimination and injustice.



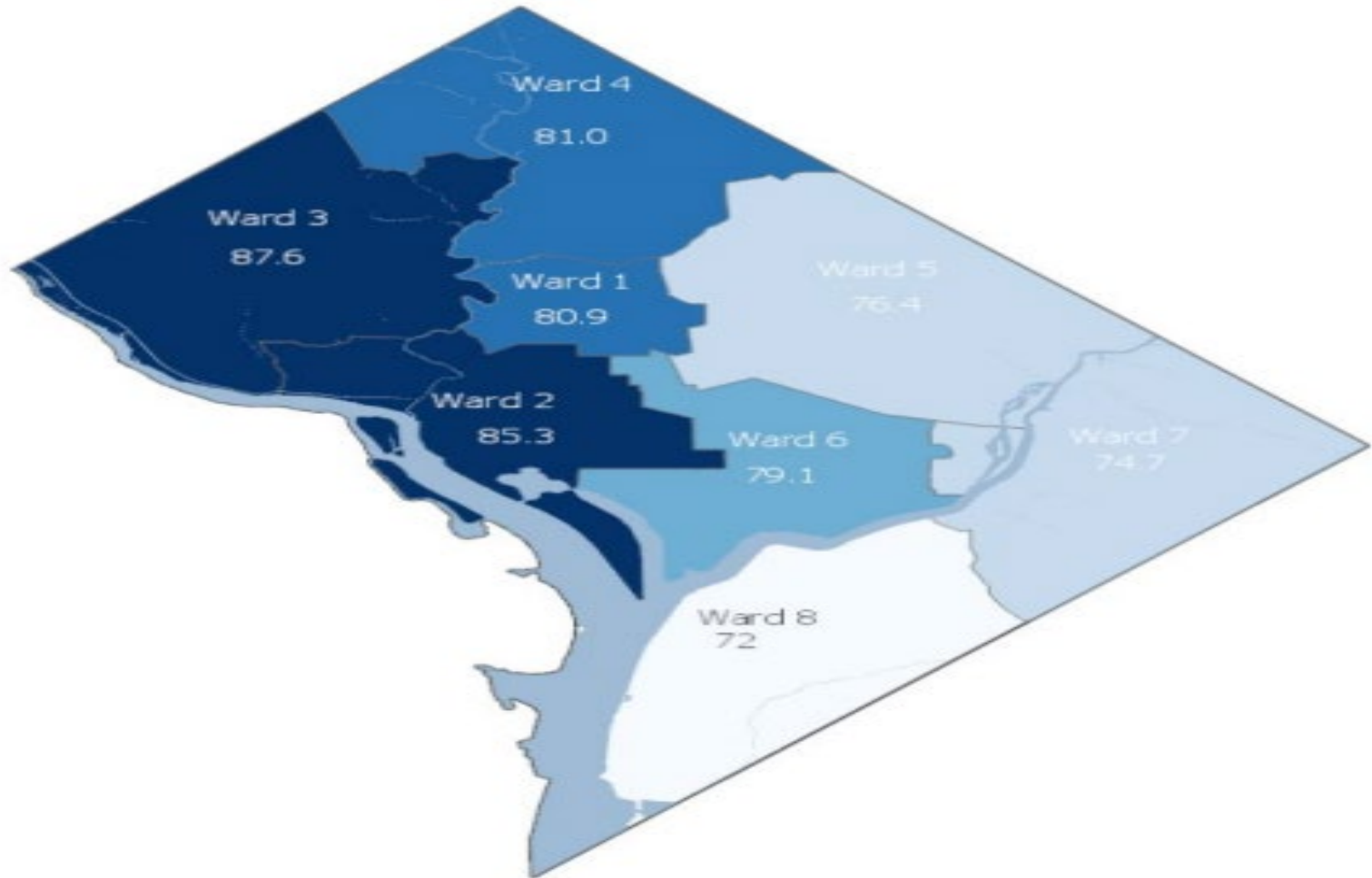
A few examples of documented bias & outcomes

In addition to the pandemic: Studies show 3rd year medical students and while in residency believe that black skin is thicker than white skin, that black people have a stronger immune system than white people – NONE of that is true – race bias impacts how you diagnose and treat your patients.

An example of bias and treatment outcome:

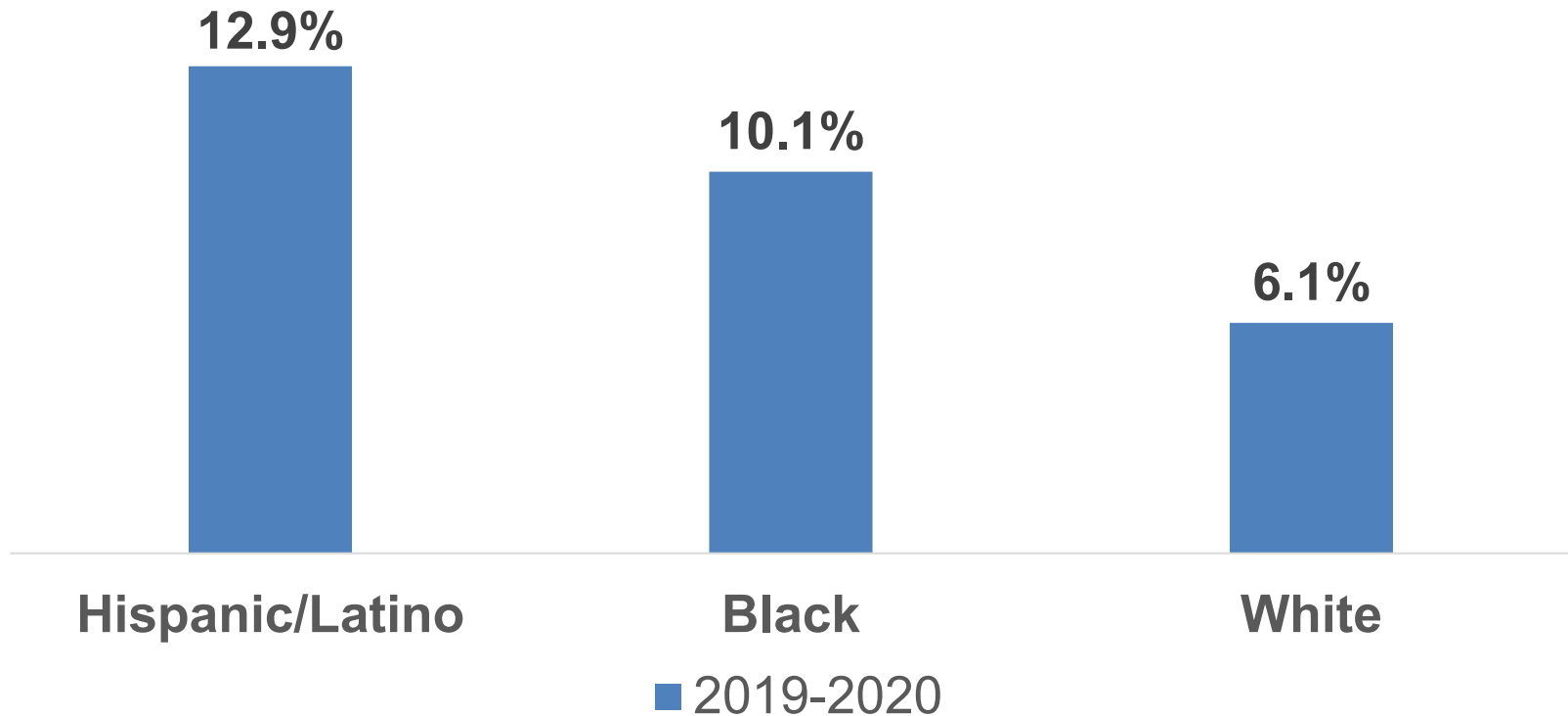
- Information from a health plan: a black patient who went to the ER was treated for drug overdose by the ER treating physician who erroneously assumed a drug overdose instead of a severe episode of sickle cell.

Life Expectancy by Ward 2011-2015 (nearly 16 years life expectancy difference)



Source: DC Health Equity Report, February 2019

Many DC Residents Could Not See a Doctor Because of Cost



Source: DC Health, BRFSS Annual Report, 2020.

<https://dchealth.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/DC%20BRFSS%202020%20Annual%20Health%20Report.pdf>



DC's State-Based Marketplace: Addressing Social Justice and Health Disparities

- ✓ **HBX Executive Board created** a working group on Social Justice and Health Disparities. More needs to be done to help address discrimination, racism, and health disparities. The Board asked the new working group to focus on 3 areas to help identify ways HBX can help.
- ✓ **WG Members:** Commissioner Woods and other DCHBX Board Members, all DC Health Link insurers (United Healthcare, Aetna, Kaiser Permanente, and CareFirst Blue Cross Blue Shield), the DC hospital association, Physician association, Children's hospital, patient/consumer advocates, brokers, and experts. Facilitated and staffed by Dr. Dora Hughes (now Chief Medical Officer at CMMI/CMS). Dr. Hughes' work supported by SHVS/RWJF. Chaired by HBX Board Chair & Vice Chaired by former Director of Office of Minority Health at CMS.
- ✓ **Goal:** Do not displace or replace important work City agencies, community leaders, providers and payors are already doing. Identify specific solutions within HBX authority that HBX can implement with the health plans.
- ✓ **HBX Board adopted unanimous recommendations of the working group** in July 2021.



Year 1 (July 2021 – July 2022)

- ✓ **Immediate Plan Design Changes for 2023 plan year:** updated standard plan design to cover Type 2 Diabetes with no cost sharing in individual and small group standard plans. Type 2 diabetes disproportionately impacts communities of color in DC.
 - **No deductibles, no co-insurance, no copays for physician visits, lab work, eye exams and foot exams, supplies and insulin/Rx.**
 - **Applies to Type 2 Diabetes and not to other conditions, e.g., high blood pressure.**
- ✓ **Lessons:**
 - **Need clinical expertise** (Type 2 Diabetes based on federal work)
 - Heavily relied on health plan clinicians
 - DISB grant collaboration to help fund future research and analysis
 - **Need more flexibility from CMS for AV issues/barriers**
 - **Using value-based design** including low value services produce almost no savings
 - New “zero value” services recommendations from researchers may help to off-set cost.



Highlights of additional standard plan design changes for Plan Year 2024 and beyond:

Coverage changes for \$0 cost sharing for conditions disproportionately impacting communities of color in DC:

- pediatric population – mental and behavioral health services (2024 plan year);
- adult population – cardiovascular disease, cerebrovascular disease, mental health, and HIV, as well as cancer of the breast, prostate, colorectal and lung/bronchus.



Insurance Commissioners can Help!

- ✓ **AV barrier:** more flexibility is necessary from CMS. State regulators could help by weighing in like the NAIC did with fixing “family glitch.”
 - Actuarial impact for Type 2 Diabetes was .03-.05 to AV but CMS changes to AVC and allowable de minimis range forced us to increase cost-sharing.
 - AV is the most significant barrier.
- ✓ **In individual states market-wide reach:** state-based marketplace coverage design is for the ACA on-line marketplace. Insurance regulators should consider coverage design changes to apply market-wide, e.g., apply to large group health insurance plans and those outside ACA on-line marketplaces.
- ✓ **NAIC** should consider developing a process/approach/resources. This will help states developing or updating their standard plans to cover with zero cost sharing conditions that disproportionately impact communities of color.



Additional Year 1 (July 2021 – July 2022) Outcomes

- ✓ **Health plans prohibit race adjusted GFR for network providers.**
 - If you are black, the GFR (measures kidney function) score gets adjusted upward so it looks like your kidneys function better than they actually do. The Adjusted GFR is a racist practice resulting in African American people getting delayed medical intervention for kidney disease and delays (or not qualifying for) kidney transplants.
- ✓ **Health plans** review clinical algorithms and diagnostic tools for biases and inaccuracies and address/update.
 - Internal plan AI and tools; external and internal medical guidelines (e.g. C-sections – maternal mortality); external AI and software (e.g. scheduling software)



13 clinical diagnostic tools that use race adjustment:

1. American Heart Association Get with the Guidelines- Heart Failure
2. Society of Thoracic Surgeons Short-Term Risk Calculator
3. eGFR **UPDATED to no longer include race adjustment**
4. Kidney Donor Risk Index (KDRI)
5. Vaginal Birth after Cesarean Risk Calculator **UPDATED to no longer include race adjustment**
6. STONE Score
7. UTI Calculator **UPDATED to no longer include race adjustment**
8. Rectal Cancer Survival Calculator
9. National Cancer Institute Breast Cancer Risk Assessment Tool
10. Breast Cancer Surveillance Consortium Risk Calculator
11. Osteoporosis Risk SCORE
12. Fracture Risk Assessment Tool FRAX
13. Pulmonary-function tests



Additional actions:

- Insurance Commissioners (NAIC) should consider ways to impact clinical guidelines
- DCHBX is reconvening its Social Justice and Health Disparities Working Group to provide advice on working with medical associations to encourage updates to clinical guidelines that continue to use race adjustment



Highlights of additional future actions (health plans):

Where and who is in networks:

- Provide scholarships for STEM students & medical school students of color in the District.
- Provide incentives to practice in underserved areas.
- Conduct network reviews.

Data collection:

- Collect member level data on race, ethnicity & language.
- Identify disparities in care by race, ethnicity & language and conduct equity audits.
- Update medical management vendor contracts requiring assessment of how vendors perform caring for diverse populations.

Bias and other requirements:

- Require bias/cultural competency training in provider contracts.
- Obtain the NCQA Multicultural Health Care distinction*.



Commonwealth Fund Blog on state-based marketplaces coverage design and diabetes (August 22):

<https://www.commonwealthfund.org/blog/2022/using-health-insurance-reform-reduce-disparities-diabetes-care>

DCHBX Standard plans details for plan year 2023 (Diabetes coverage summary starts on page 8):

https://hbx.dc.gov/sites/default/files/dc/sites/hbx/page_content/attachments/Standard%20Plans%20Advisory%20Group%20Report%20PY2023%2007052022.pdf

July 2022 (Year 1) report to DCHBX Executive Board on Implementation:

https://hbx.dc.gov/sites/default/files/dc/sites/hbx/event_content/attachments/SJWG%20Slides%20July%2013%202022%20Year%20One%20DRAFT.pdf

DCHBX Executive Board Social Justice and Health Disparities Working Group Report, Consensus Recommendations, and Deliberations:

<https://hbx.dc.gov/page/social-justice-health-disparities-2021-meeting-materials>