



May 14, 2021

Commissioner David Altmaier, Co-Chair
Director Dean Cameron, Co-Chair
NAIC Special (EX) Committee on Race and Insurance
National Association of Insurance Commissioners
444 North Capitol Street NW, Suite 700
Washington, D.C. 20001-1512

Submitted via email: Kay Noonan, KNoonan@NAIC.org

RE: NAIC Special (EX) Committee on Race and Insurance 2021 Charges

Dear Commissioner Altmaier and Director Cameron:

On behalf of our member plans, America's Health Insurance Plans (AHIP) ¹ would like to thank you for the opportunity to comment on the [2021 Proposed Charges](#) released by the Special (EX) Committee on Race and Insurance. AHIP commends the NAIC for taking concrete steps to reduce healthcare disparities and promote health equity. Every American deserves access to high-quality care. For far too long, discrimination and systemic racism have served as barriers to health equity for minority and underserved communities. ***Health insurance providers know that ending these barriers is the key to an equitable health care system.***

On April 9, AHIP offered [preliminary comments](#) to the 2021 Proposed Charges, and with this letter, we offer further remarks to the proposed NAIC work.

Special (EX) Committee on Race and Insurance Proposed Charge B: Coordinate with existing groups such as the Big Data and Artificial Intelligence (EX) Working Group and the Casualty Actuarial and Statistical (C) Task Force and encourage those groups to continue their work in predictive modeling, price algorithms and artificial intelligence (AI), with a particular focus on how race is impacted.

Artificial Intelligence (AI) leveraging and applying machine learning has many benefits and is predicted by many to become commonplace in the coming years. Advanced analytics and predictive algorithms, a subset of AI, are currently in use within healthcare to enhance clinical decision support, improve health care quality, and detect fraud. However, because AI is built upon available data and a series of mathematical and computational assumptions, it risks perpetuating and possibly magnifying existing biases. Thus, it is critical that users are vigilant in assessing, identifying, and mitigating unintended consequences, such as disadvantaging certain individuals or groups/categories of consumers. Regardless of whether the user is an insurer or another type of business, users should strive to prevent harmful impacts based on race, ethnicity, sexual orientation and gender identity (SOGI), disability, socioeconomic status, geographic regions, and other unchanging characteristics and legally protected classifications.

¹ America's Health Insurance Plans (AHIP) is the national association whose members provide coverage for health care and related services to hundreds of millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities, and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access, and well-being for consumers.

Currently, however, there is no consensus on how bias should be defined and/or measured. We are committed to working with relevant stakeholders, developers, and/or vendors to eliminate biases in algorithms and AI. AHIP recently joined the Consumer Technology Association (CTA), which has convened more than 60 organizations – from global tech brands to startups and health care industry leaders –in developing a new [ANSI-accredited standard](#) that identifies the core requirements and baselines to determine trustworthy AI solutions in health care. This standard, part of CTA's initiative on AI in health care, is the second in a series of standards focused on implementing medical and health care solutions built on AI. The first step in identifying bias is the transparency of the data and methodologies used. We strongly recommend that the NAIC collaborate with these industry-driven efforts as a part of the work of this workstream.

Special (EX) Committee on Race and Insurance Proposed Charge C/Workstream One: Continue research and analysis to develop specific recommendations on action steps that state insurance regulators and companies can take to improve the level of diversity and inclusion in the industry, including: 1. Seeking additional engagement from stakeholders to understand the efficacy of diversity-related programs, how companies measure their progress and what state insurance regulators can do to support these efforts. 2. Collecting input on existing gaps in available industry diversity-related data.

To achieve greater health equity, America's diversity must be reflected at all levels within health care organizations. AHIP and our member plans believe that promoting organizational diversity, equity and inclusion is an imperative and must be part of every organization's DNA. We believe companies have a civic duty and corporate responsibility to their communities, and we believe that inclusiveness is a critical component of that responsibility. We are committed to DEI by: increasing company vigilance to interview, hire, and promote candidates from diverse communities; expanding and growing supplier diversity across the industry; and deploying or updating unconscious bias and conscious inclusion training to improve accountability and impact within organizations.

AHIP believes in the importance of cultural competency and cultural humility training, tailored to different populations and communities, to ensure our staff and member organizations approach each individual with empathy, respect, care, and concern for each individual's well-being. We also believe developing effective implicit bias and anti-racism training methods, topics, and standards will help promote culturally competent and equitable care for our beneficiaries.

AHIP recently conducted a series of interviews with prominent leaders in health care to better understand the role health insurance providers must play in improving health equity. These conversations lay the foundation for the work we all must do to fight racism and discrimination, both in health care and beyond. AHIP member plans have been engaged and continue every day to do this vital work. More details of specific companies and actions are available at AHIP's [Health Equity Spotlight](#). AHIP and our member plans will continue to listen—and to act—to promote organizational policies and practices that advance diversity, equity, and inclusion while also collaborating with other public and private partners to address upstream inequities.

Special (EX) Committee on Race and Insurance Proposed Charge G/Workstream Five: Consider enhanced data reporting and record-keeping requirements across product lines to identify race and other sociodemographic factors of insureds. Consider a data call to identify resources and products sold in specific ZIP codes to identify barriers to access.

Standardizing data collection and reporting on race, ethnicity, language, disability, and sexual orientation and gender identity data will ensure we better understand our consumers' identities which will help inform more appropriate care interventions. It will also facilitate aggregation, measurement, reporting, and interoperable sharing of data—which will help health insurance providers to identify and address disparities. We want to better understand our populations so that they may receive more appropriate care. However, we ask that the NAIC, regulators and policymakers consider the current barriers to collecting these data, including the important cultural sensitivity of personal agency.

AHIP members believe that direct data is the most accurate and reliable type of data on race and ethnicity, but such data can be challenging for health plans to collect or obtain. We believe there are four main pathways to the collection of this data: 1) collection at enrollment; 2) surveying members or other outreach methods; 3) obtaining the data from providers as part of a claim or from the Electronic Health Record (EHR), and 4) obtaining data from employers or government agencies that collect this data. Key challenges with data collection at enrollment include:

- **Statutory Barriers:** Several states such as Maryland, California, New Jersey, and New Hampshire have or at one point had laws barring the collection of race and ethnicity data on applications for insurance over concerns of this data being used to determine eligibility for benefits. In addition, state policymakers are currently contemplating legislation that would further impede health insurance providers' ability to collect data. For example, Colorado has pending legislation, SB21-169, which would prohibit the use of certain protected class information "in any insurance practice."
- **Regulatory Barriers:** Policies and procedures required by governing agencies (e.g., the state-level Departments of Insurance) make it difficult to revise enrollment forms so that health plans can collect racial and ethnic data.
- **Employer Health Plan Sponsor Barriers:** Many employers may be hesitant to update enrollment forms or to ask employees to provide this data for insurance enrollment. Additionally, some employers do not allow insurers to reach out to their employees to collect demographic data.
- **HIPAA Transaction Standards:** The HIPAA-prescribed 834 enrollment transaction form does not require the inclusion of demographic codes leading to incomplete data provided to insurers. Claims data is similarly limited by the HIPAA-prescribed 837 claims transaction forms that do not require the use of demographic codes.
- **Negative Member Response to Data Collection:** Survey data is often met by negative member reaction and response to such data collection. There may be a perception of potential discrimination for benefit eligibility, distrust, and lack of understanding of the purpose of the collection. Other considerations include difficulties in successful outreach due to issues such as churn and changes in address.
- **Interoperability Challenges:** Electronic Health Record (EHR) data is not routinely shared with plans unless attached to claims. Interoperability issues may also impede the sharing

of data between plans and providers given lack of data standards and the use of different codification structures.

- Community Trust: Underscoring all these challenges is the need to address issues of trust among consumers about the collection and sharing of potentially sensitive data between clinicians with health insurance providers.

Indirect data, such as census data, is more feasible to collect, but this data may be less accurate. This data may also lack validity with consumers and other stakeholders who distrust this data and fear it could mask disparities. The feasibility of indirect data collection could be improved if software vendors that support the accreditation and measurement process were required to load a standardized methodology into their programs to ensure that health plans and health care organizations use the same methodology for indirect data estimations. This will improve accuracy and allow for better apples-to-apples comparisons across the health care system.

We believe in the importance of collecting this data and its utility in identifying and eliminating health disparities. We stand ready to work with the NAIC, along-side of consumers, policymakers, providers, and employers to help stakeholders understand why this data is being collected, how it will be used, and the need to remove policy and operational barriers to better understand healthcare disparities. We also encourage the NAIC to join us in developing frameworks, guidance, and best practices to help health plans collect race/ethnicity data at scale in patient-centered and respectful ways. We state this with understanding the importance of earned trust by individuals and the cultural legacies that will continue to make this a long term but important undertaking.

Special (EX) Committee on Race and Insurance Proposed Charge H: Continue research and analysis related to insurance access and affordability issues, including:

H.3 (Workstream Five): Measures to advance equity through lowering the cost of health care and promoting access to care and coverage, with specific focus on measures to remedy impacts on people of color, low income and rural populations, and historically marginalized groups, such as the LGBTQ+ community, individuals with disabilities, and Alaska Native and other Native and Indigenous people.

H.4 (Workstream Five): Examination of the use of network adequacy and provider directory measures (such as provider diversity, language, and cultural competence) to promote equitable access to culturally competent care.

H.5 (Workstream Five): Conduct additional outreach to educate consumers and collect information on health and health care complaints related to discrimination and inequities in accessing care.

AHIP supports promoting diverse provider networks that reflect the communities we serve so that our enrollees can find providers that meet their preferences and needs and to assure that the people we serve receive culturally competent and patient-centered care. An important component in achieving that goal is to make it easy for consumers to know and understand provider/practitioner demographic diversity and diversity of staff and roles on the care team. However, many consequential systemic barriers have resulted in a long-standing lack of diversity within the health care workforce and pipeline that regrettably have been over a century in the making. AHIP is committed to working with other relevant stakeholders, including the educational

system, to address the insufficient numbers of diverse individuals within the workforce pipeline. We support policies and programs that facilitate and incentivize people of diverse backgrounds to enter the health care workforce, including loan repayment and scholarship programs like the National Health Service Corps and Nurse Corps.

Additionally, we recognize that obtaining and displaying provider demographic data will help consumers find someone who they feel comfortable seeing for care. However, we also want to be mindful of providers' concerns of possible discrimination by patients if their private information is publicly displayed. We, therefore, are committed to exploring the best ways to communicate the diversity of our provider networks while protecting providers' personal information.

Enhanced training on cultural competency, cultural humility, unconscious bias, and anti-racism that leads to actionability and accountability can promote empathy, respect, and understanding amongst our provider networks to ensure everyone is treated with respect regardless of racial or demographic harmony between our providers and our consumer members. Promoting diverse provider networks that reflect the communities we serve and disclosing provider demographics will allow our beneficiaries to find providers that meet their preferences and needs to receive culturally competent and patient-centered care. AHIP and our members are committed to working with providers, insurance regulators and those who regulate health professionals to explore the best ways to identify and communicate the diversity of our provider networks while protecting providers' personal needs and preferences.

Special (EX) Race and Insurance Committee Proposed Charge I: Direct NAIC and Center for Insurance Policy and Research (CIPR) staff to conduct necessary research and analysis, including:

I.3 (Workstream Five): Aggregation of existing research on health care disparities and collection of insurance responses to the COVID-19 pandemic and its impact across demographic populations.

Over the last year, the COVID-19 crisis has ravaged the physical and economic health of communities across the country. Disadvantaged communities and communities of color have experienced higher rates of infection and death from COVID-19. They also are suffering greater economic harm. More than ever, we need to take sustained action to improve health equity.

The COVID-19 crisis has unmasked and shined a spotlight on the health inequities that have long existed. Throughout the pandemic, Americans have seen the profound and disproportionate impact of COVID-19 on communities of color. Although racial and ethnic information is currently available for only about 35% of the total deaths in the U.S., even this limited sample shows that Black Americans and other historically underserved groups are experiencing COVID-19 infection and death rates that are far higher than the overall proportion of these populations in America. For example, while Black Americans represent only about 13% of the population in the states reporting racial/ethnic information, this population accounts for about 34% of the total number of COVID-19 deaths in those states.² Asian Americans and Latinx Americans also show elevated impacts in some regions. Moreover, at the national level, Pacific Islander, Latinx, Indigenous, and

² <https://coronavirus.jhu.edu/data/racial-data-transparency>

Black Americans all have COVID-19 death rates of double or more that of White and Asian Americans.³

Since the beginning of the COVID-19 crisis, health insurance providers have innovated, built new service delivery models, and partnered with service providers and the communities we serve to deliver critical resources to people experiencing greater health and social needs during this challenging time. Recognizing the inequities exposed during the COVID-19 crisis, AHIP has launched several initiatives with our health insurance provider members to respond to these challenges. To build upon these actions and take the commitment of health insurance providers even further, AHIP and the Blue Cross Blue Shield Association (BCBSA), in collaboration with the Biden Administration, launched the national Vaccine Community Connectors pilot initiative. This is a concerted, coordinated effort to vaccinate two million seniors age 65+ in communities that are most at-risk, vulnerable, and underserved, such as Black and Hispanic communities. The initiative focuses on expanding vaccinations for those who may have difficulty signing up for appointments or getting to vaccine administration sites, such individuals who are home-bound, who have disabilities, and those who lack transportation options.

As vaccine supplies expand and registrations have become more available, health insurance providers are using our combined expertise, data, and insights and working with their partners to:

- Identify seniors 65+ who are vulnerable to COVID-19 and who live in areas where vaccination rates are most inequitable.
- Work with partners in the community to educate seniors on the safety, efficacy, and value of COVID-19 vaccines.
- Contact those seniors who are eligible to get a vaccine through multiple channels to:
 - Facilitate vaccine registration and appointment scheduling.
 - Answer their questions about vaccines.
 - Help them to understand when, where, and how they can receive vaccines and remind them about any required second doses.
 - Coordinate services to help overcome barriers that may stand between them and getting vaccinated, including transportation.
- Work with federal, state, and local leaders to deliver vaccines to underserved communities and closely collaborate with other vaccination partners, for example pharmacies.
 - Track progress to ensure that those who need vaccinations the most are receiving them.

As America reaches the COVID-19 “vaccine wall,” in which more vaccines are available than Americans who demand appointments, health insurance providers are taking multifaceted approaches to improve vaccine uptake. New data and [survey results](#) continue to inform the work that AHIP and its member plans are doing to partner for vaccine delivery, vaccination coordination and education on safety and efficacy of vaccinations.

³ <https://www.apmresearchlab.org/covid/deaths-by-race>

Proposed New Charges to the Health Insurance and Managed Care (B) Committee, the Mental Health Parity and Addiction Equity Act (B) Working Group, the Health Innovations (B) Working Group and the Market Regulation and Consumer Affairs (D) Committee:

New health equity charges have been proposed for the Health Insurance and Managed Care (B) Committee, the Market Regulation and Consumer Affairs (D) Committee and (B) Committee Working Groups. As previously stated, health insurance providers are committed to improving health equity in our communities, and we are proud to serve Americans of every age, gender, gender identity, race, creed, color, sexual orientation, and health status, working with partners and community leaders across the entire health care system. To that end, we support coordinated, collaborative discussions with partners across the entire health care system to address the urgent national imperative that stands in front of all of us – to improve the health care system so that every American has an equal opportunity to thrive.

In closing, we express our ongoing appreciation for the NAIC's willingness and commitment to undertake this critically important work. We stand ready and committed as well to work together with you to address these vital issues in a meaningful and productive way in pursuit of real movement and real change.

Sincerely,



Matthew Eyles
President and Chief Executive Officer
America's Health Insurance Plans