

November 4, 2021

Commissioner Jessica Altman, Co-Chair
Commissioner Ricardo Lara, Co-Chair
Special Committee on Race and Insurance
National Association of Insurance Commissioners
444 North Capitol Street NW, Suite 700
Washington, D.C. 20001-1512

Submitted electronically to: Jolie Matthews (jmatthews@naic.org)

Dear Commissioners Altman and Lara:

The Blue Cross Blue Shield Association (BCBSA) appreciates the opportunity to provide comments on the NAIC Special (EX) Committee on Race and Insurance (Special Committee), Workstream 5 draft outline for its white paper on provider networks. As the health care partner to one in three Americans, BCBSA believes everyone should have access to high-quality health care regardless of race, ethnicity, sex, gender identity, sexual orientation, age or location.

BCBSA is a national federation of 35 independent, community-based and locally operated Blue Cross and Blue Shield (BCBS) companies (Plans) that collectively provide health care coverage for one in three Americans. For more than 90 years, Blue Cross and Blue Shield companies have offered quality health care coverage in all markets across America – serving those who purchase coverage on their own as well as those who obtain coverage through an employer, Medicare and Medicaid.

BCBSA shares the Special Committee's goal of promoting equitable access to high-quality care through improving access to culturally competent care and strengthening the diversity of the American health care workforce. We appreciate Workstream 5's approach by pursuing a white paper to examine how the various methods and tools available to all stakeholders—providers, industry and regulators—can lead to collaborative, interdisciplinary solutions to increase access to culturally competent health care and promote workforce diversity. As Workstream 5 begins its work on this white paper, we offer the following comments and suggested edits to the outline.

The role of the insurance sector in increasing access to cultural competent care and strengthening provider diversity

As with other key stakeholders, BCBSA recognizes the role insurers can play in helping increase access to health care providers with culturally competent and implicit bias training. To meaningfully address existing barriers in access to diverse providers and providers offering linguistically and culturally competent care, we need to focus on the root causes: a lack of diversity within our health care system and health education pipelines; limited availability of providers in areas that are predominantly communities of color or communities where English is not the primary language spoken; and the critical need to promote cross-cultural and implicit bias training within health professions.

The numbers on provider diversity are stark. Latinos make up more than 18% of the U.S. population, but just 6% of physicians. Black Americans make up more than 13% of the U.S. population, but account for fewer than 5% of the physicians. Additionally, between 1978 and 2008, Black Americans, American

Indians and Latinos together made up only 12% of graduates of U.S. medical schools. For mental and behavioral health, provider diversity is similarly stark. Latinos are just 7% of psychologists. Black Americans account for only 3% of psychologists. Similarly, while collectively making up nearly 33% of the U.S. population, according to a Johns Hopkins [study](#), only 10.4% of practicing psychiatrists are Black, Latino or Native American.

Across our system, BCBS Plans are taking action to help address our nation's workforce diversity challenges, in addition to helping promote access to culturally competent and implicit bias trainings for health care professionals. For example,

- Blue Cross Blue Shield of Illinois has launched the Institute for Physician Diversity (IPD), a strategic partnership academic medical centers, teaching hospitals and not-for-profit associations designed to achieve greater racial and ethnic diversity in the physician workforce. The IPD will work with hospitals and academic medical centers to accelerate the recruitment of medical students, resident physicians, and clinical faculty who are underrepresented in medicine.
- Blue Cross Blue Shield of Michigan (BCBSM) is working collaboratively with its network providers to create awareness of unconscious bias in health care to help address health and health care disparities. BCBSM introduced unconscious (implicit) bias education to the 40 physician organizations that participate in the statewide [Physician Group Incentive Program \(PGIP\)](#).
- To support health care workers in identifying and addressing their own implicit biases, **Blue Cross and Blue Shield of North Carolina** (BCBSNC) helped March of Dimes launch its national Breaking Through Bias in Maternity Care program in North Carolina. The program's curriculum covers structural racism in the U.S., strategies to mitigate bias in maternity care and approaches to building a culture of equity in workplaces and communities.

The role of the regulator in increasing access to culturally competent care and strengthening provider diversity

BCBSA appreciates the Special Committee's emphasis on action; however, focusing on network adequacy standards, particularly in communities already facing provider shortages, may not help improve access to culturally competent care. Instead, BCBSA urges NAIC to consider other tools beyond network adequacy and provider directories to achieve the Special Committee's aims. As noted above, there are more foundational and root cause issues that must/should be prioritized in order to meaningfully and sustainably advance health equity and address our nation's health disparities. Developing solutions to help address workforce shortages and diversity should be priorities of regulators seeking to meaningfully advance health equity.

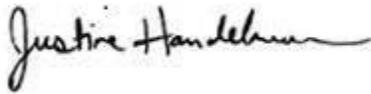
We recommend the NAIC consider how to facilitate and work in partnership with the federal government, state legislators and state agencies on the following steps to help alleviate expected workforce shortages, support development of a diverse next generation of health care practitioners, and promote workforce retention in underserved and rural communities:

- Collect, analyze and publish health care workforce supply data to inform strategies for workforce development and retention. To address the current health care workforce shortages, which have been exacerbated by the pandemic, it is necessary to have accurate and timely data to understand the true scope of the issue.
- Increase financial support for initiatives such as pipeline programs that improve the diversity of the health care workforce.

- Consider how financial incentives for health care organizations to hire and retain culturally competent health care providers and organizational leaders from underrepresented groups, with a particular focus on hiring those individuals from the health organization's community which will help build trust within the health care system.
- Promote culturally competent care by emphasizing the need for cross-cultural and implicit bias training. These trainings should be required for all health care practitioners at all levels, and state officials can institute requirements for providers to do continuing education in these areas in order to maintain their licenses.
- Improve access to care for patients and increase the efficiency for providers and health plans to use technologies like telehealth to expand access to patients and beneficiaries. BCBSA supports the efforts of state and federal agencies to remove arbitrary restrictions that dictate how, when and where a provider can treat patients, including geographic and originating site requirements which are not evidence-based or have no impact on quality of care. We also support increased investment in broadband and telehealth infrastructure to connect rural and underserved communities.

In addition to these comments, BCBSA has provided redlines to the draft outline. We appreciate the NAIC's thoughtful consideration of these important issues, and we look forward to continued dialogue as you finalize the outline and draft the white paper. If you have any questions or want additional information, please contact Randi Chapman at Randi.chapman@bcbsa.com or 202.826.5156.

Sincerely,

A handwritten signature in cursive script that reads "Justice Handelman".

Senior Vice President
Office of Policy and Representation

cc: Commissioner Jessica Altman
Commissioner Ricardo Lara

BCBSA Redlines and Comments 11/4/21

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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
 - iii. Define/explain cultural competency
 - b. Recognition that others have key roles, but insurance sector can contribute significantly to this goal
 - i. Federal government initiatives and other existing efforts
 - ii. Provider education, recruitment, etc.
 - iii. Role of state licensing boards
 - iv. Providers (including hospitals and large provider organizations)
 - c. Role of insurance companies
 - i. Current programs and best practices (workforce investment, training collaborations with MODs)
 - ii. Provider credentialing
 - iii. Network construction
 - iv. 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
 - iii. Collect, analyze and publish health care workforce supply data by state to inform strategies for workforce development and retention. Accurate and timely data is necessary to understand and effectively address the full scope of the issue.
 - iv. Work with state legislators and federal government partners to increase financial support for initiatives such as pipeline programs that improve the diversity of the health care workforce
 - v. Institute requirements tied to licensure for providers to do continuing education training in cross-cultural and implicit bias training
 - vi. Work with state legislators and federal government partners to expand access for patients by removing arbitrary restrictions that dictate how, when and where a provider can treat patients, including geographic and originating site requirements which are not evidence-based or have no impact on quality of care.

Commented [CR1]: Please see [BCBSA's 2021 Health of America report on Racial Disparities in Maternal Health](#). This study examines variations in many of these severe maternal morbidity rates, as well as the most common risk factors for those events, between white, Black and Hispanic communities.

Commented [CR2]: Please note, Plans rely on data from state medical boards to obtain data for credentialing.

Commented [CR3]: BCBSA Plans examine and refine contracting strategies on an ongoing basis to ensure the maximum access to quality and affordable care for members and continue to be committed to compliance with network adequacy and provider directory requirements.

Commented [CR4]: BCBSA understands the need to ensure that all network-based health plans provide consumers with appropriate access to the care they need. Many consumers understand the importance of finding a plan that includes their health care providers in-network. Because of this, provider networks are an important competitive factor for health plans, and most health plans are careful to ensure their networks meet the needs of consumers in their market, including cultural needs.

2. Network Adequacy
 - a. Background and Legal Landscape

- ~~i.~~ Affordable Care Act requires adequate networks requirements and demonstration process
- ~~ii.~~ NAIC network adequacy model – a brief description and history, including discussion of how demographic differences inform and member expectations
- b. Examples ~~/~~ potential strategies and challenges for network adequacy review to be a tool for states to increase patient access to diverse, culturally competent care
- c. Address shortage in provider workforce – particularly of providers of color – and the need to increase the pipeline of diverse providers, as well drawing upon non-physician health care providers as a means of increasing access to culturally competent care
- d. Brief history of FQHCs, including legal parameters around their operation
- e. Overview of ACA essential community provider (ECP) requirements, including discussion of scope and impact
- f. Potential industry data call for further information on FQHCs in provider networks
- g. Public Policy considerations
 - i. Should networks be required to include FQHCs? Are the current ECP requirements sufficient?
 - 1. Reimbursement
 - ~~b-2.~~ Should NAIC further explore FQHC challenges with PBM actions relative to the 340B program?

Commented [CR5]: In the discussion of implementation of the decision in *City of Columbus, et al. v. Cochran*. (See page 24264 of the [2022 Final NBPP](#), published in the Federal Register on May 5, 2021), wherein the court vacated the extension of the elimination of federal reviews of network adequacy of certain QHPs, CMS said HHS would need to “set up a new network adequacy review process, and issuers will need sufficient time before the applicable plan year to assess that their networks meet the new regulatory standard, submit network information, and have the information reviewed by applicable regulatory authorities in order for their plans to be certified as QHPs.”

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Commented [CR6]: Moved up from below

- 3. Data collection and provider directories
 - a. Current state of regulatory oversight of provider directories
 - i. No Surprises Act – impact on provider directories
 - b. Should demographic data and/or information on cultural competency be collected and shared in provider directories? National Plan & Provider Enumeration System (NPPEs)
 - i. Background and historical resistance to including demographic data
 - c. Provider hesitancy to publicize widely certain demographic data
- 4. How can Telehealth opportunities improve provider access?
 - a. Brief description of telehealth
 - b. Telehealth data
 - i. Discussion of federal and state telehealth flexibility initiatives during COVID
 - ii. Literature review of telehealth usage during COVID; focus on race and demographic information
 - iii. Potential industry data call for further information on insurer implementation of telehealth policies
 - iv. *(Note for consideration: perhaps CIPR could be helpful)*
 - c. Public Policy considerations
 - i. Cost and value-based payment to support expansion of telehealth
 - ~~i.~~ Reimbursement
 - ii. Audio-only versus Audio-Visual, including privacy protections and safeguards around fraud/abuse for audio only modalities
 - iii. Telehealth-only or gatekeeper networks
 - ~~iv-1.~~ What role can insurers play in providing resources to members for telehealth accessibility, (i.e. are providing phones risk-based or an inappropriate rebate?)

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~~5.—What role for FQHCs in an adequate network?~~

- ~~a.—Brief history of FQHCs, including legal parameters around their operation~~
- ~~b.—Overview of ACA essential community provider (ECP) requirements, including discussion of scope and impact~~
- ~~c.—Potential industry data call for further information on FQHCs in provider networks~~
- ~~d.—Public Policy considerations~~
 - ~~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?~~

~~6.5.~~ Conclusion and discussion of recommended next steps

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