

May 14, 2021



Commissioner David Altmaier, Co-Chair
Director Dean Cameron, Co-Chair
Special Committee on Race and Insurance
National Association of Insurance Commissioners
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Submitted electronically to: Kay Noonan (knoonan@naic.org)

Dear Commissioner Altmaier and Director Cameron:

The Blue Cross Blue Shield Association (BCBSA) appreciates the opportunity to provide comments on the proposed charges for 2021 to the Special (EX) Committee on Race and Insurance (Special Committee) and related charges to other committee groups. BCBSA supports the continued efforts of the Special Committee to advance diversity and inclusion and address racial disparities that disadvantage people of color and historically underrepresented communities.

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.

As we stated in our preliminary comments to the proposed charges, BCBSA believes everyone should have access to high-quality health coverage and care regardless of race, ethnicity, national origin, sex, gender identity, sexual orientation, religion, education level, age, geography or disability. We affirm the need to recognize the negative impact of long-standing structures of racism and discrimination, underlying bias and social factors on the health and well-being of many Americans. To that end, every BCBS company across the country, and in Puerto Rico, has launched at least one local initiative to address health disparities.

Our health equity policy recommendations outlined in our Issue Brief, [Addressing Health Disparities and Inequities in Communities of Color](#), align with the Special Committee's proposed 2021 charges and efforts to promote improved access to quality, affordable coverage and culturally competent care. As the Special Committee works to finalize the proposed 2021 charges, we offer the following comments and recommendations.

Data

BCBSA agrees that availability of accurate and quality data is essential in improving health outcomes in vulnerable communities. In our [December 2020 letter](#) to the Special Committee, we raised the importance of NAIC support for health industry-led efforts, such as the [HL7 Gravity Project](#) - a multi-

industry effort to reduce current barriers to the integration of efforts to integrate social risk data into clinical decision making to improve health outcomes, while supporting appropriate safeguards and privacy protections for the use of sensitive consumer information.

In order to continue improving the quality and accuracy of necessary data to drive health equity, the availability of accurate and quality race and ethnicity (R/E) data is key to improving health equity outcomes in all communities across the country. However, today, there are no national industrywide standards in the health sector to facilitate consistent R/E data collection and appropriate use, leading to challenges around the accuracy, quality and consistency of the data collected. Compounding the challenges are the many overlapping and complex federal and state laws governing R/E data collection and use in the health care sector. For instance:

- At the federal level, the collection and use of R/E data are guided by Section 1557 of the Affordable Care Act (ACA), the Health Insurance Portability and Accountability Act (HIPAA), and Section 5 of the Federal Trade Commission (FTC)'s Unfair Deceptive Practices Act (UNDP) as well as the Civil Rights Act of 1964.
- At the state level, collection and use of R/E data are guided by individual state privacy laws, insurance regulations and Unfair and Deceptive Practices/Insurance Practices (UNDP/UNIP) laws, which guide and may restrict how R/E data are collected and used by the health care entities.

Adding to the complexity is the lack of collection and appropriate use standardization around R/E data sets as R/E data come from different sources (i.e., provider records, employer records, member-provided information and imputation algorithms) and are collected using varying standards, which has an impact on the accuracy, consistency and completeness of the data.

We ask the Special Committee to reflect these challenges in two specific ways: First, in undertaking initial steps be mindful of the complex and overlapping nature of current federal and state legal and regulatory restrictions around R/E data collection and use. Any initial data calls to implement health equity programs will be challenged by these restrictions. Second, conduct a study to review current legal and regulatory barriers to appropriate and secure collection and use of R/E data for the purposes of supporting health equity efforts. Given the inconsistencies in data collection methods today, unless and until a national health industry standard can be developed and implemented across the industry, we will continue to face existing data accuracy and quality challenges. BCBSA is also reviewing ways the health sector can better support such efforts, and we stand ready to assist the Special Committee in meeting our shared goals of achieving health equity.

In the appendix to this letter, we provide charts that illustrate the federal and state laws that regulate how R/E data may be collected and used by the healthcare insurance industry today.

Provider Diversity and Linguistically & Culturally Competent Care

We share the Special Committee's goal of promoting equitable access to high-quality care through improving the racial and ethnic diversity of providers, in addition to addressing language diversity needs and cultural competency challenges. 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 percent of the U.S. population, but just 6 percent of physicians.¹ Black Americans make up more than 13 percent of the U.S. population, but account for fewer than five percent of the physicians.² Additionally, between 1978 and 2008, 88 percent of graduates of U.S. medical schools were white or Asian. Black Americans, American Indians and Latinos together made up the remaining 12 percent.³

BCBS 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. However, focusing on network standards in communities with provider shortages may not help improve access to culturally competent care. Instead, BCBSA urges NAIC to consider opportunities to inform patients of the providers currently available (e.g., considering how best to identify these providers, evaluating whether identifying them by race or ethnicity, for example, has any negative unintended impacts for the providers themselves). Within this process, we recommend the NAIC consider how to facilitate 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 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 health care practitioners at all levels and state regulators can institute requirements for providers to do continuing education in these areas in order to maintain their licenses. For example, the American Medical Association's graduate medical education competency program helps residents recognize patients' cultural, professional, and biological differences, which can lead to more effective diagnosis, treatment and management.⁴
- 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

¹ <https://labusinessjournal.com/news/2020/mar/17/2020-diversity-inclusion-diversity-health-care-key/>

² <https://labusinessjournal.com/news/2020/mar/17/2020-diversity-inclusion-diversity-health-care-key/>

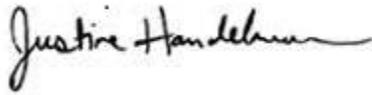
³ https://www.washingtonpost.com/national/health-science/even-as-the-us-grows-more-diverse-the-medical-profession-is-slow-to-follow/2018/09/21/6e048d66-aba4-11e8-a8d7-0f63ab8b1370_story.html

⁴ <https://www.sciencenews.org/article/black-newborn-baby-survival-doctor-race-mortality-rate-disparity>

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.

BCBSA and a broad range of other stakeholders have provided input into the development of the workstream reports on race and insurance. We appreciate the NAIC's thoughtful consideration of those previous comments in developing the reports. We look forward to partnering with the Special Committee as you continue to seek industry input and technical expertise on this important topic. 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 black ink that reads "Justice Handelman". The signature is written in a cursive, flowing style.

Senior Vice President
Office of Policy and Representation

cc: Commissioner Jessica Altman
Commissioner Ricardo Lara

APPENDIX

Federal and State Laws and Regulations on the Collection and Use of Race and Ethnicity (R/E) Data by the Health Insurance Industry	
FEDERAL	STATE
<ul style="list-style-type: none"> • ACA: <u>May</u> collect R/E data using OMB/HHS standard categories for federally funded programs, subject to anti-discrimination laws under the Civil Rights Act. • Considered PHI and subject to HIPAA and HHS/OCR enforcement • Subject to Unfair Deceptive Acts/Practices (UDAP) laws and subject to FTC enforcement • Subject to the Civil Rights Act of 1964 – for government funded programs with DOJ enforcement 	<ul style="list-style-type: none"> • State Insurance Codes: Many states specifically prohibit R/E data collection on health insurance applications (CA, PA, TX, etc.) • Some states also require strict use purpose if plans collect R/E data (MD) • State privacy laws also strictly regulate R/E data: e.g. R/E data is considered “sensitive data” under CA law (CCPA) • State Unfair Deceptive Insurance Practices/Acts (UDIP/UDAP) apply in collection and use of R/E data and State AGs enforce. • Some states also allow private right of action/class action

Federal and State Regulations on R/E Data Collection and Use	
Collection of R/E Data	Allowable Uses – State and Federal Laws
<ul style="list-style-type: none"> • Must be voluntary – self identified, cannot mandate for government funded/supported programs, silent for private plans • OMB/HHS provides R/E data category standards for government funded programs, no industry standards for private sector • Many states specifically prohibit collection of R/E data in insurance applications (CA, PA, etc.) 	<ul style="list-style-type: none"> • ACA allows use of R/E data for the purposes of addressing health inequity only <ul style="list-style-type: none"> • Once collected, requires data to be made available publicly • Requires reporting to HHS Office of Minority Health, CDC, and CMS • Considered PHI, subject to HIPAA requirements • Unfair deceptive acts/practices under federal or state laws <ul style="list-style-type: none"> • Prohibit use of R/E data for insurance underwriting or eligibility purposes • Need to show clear/transparent use purpose of R/E data