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Health Innovations (B) Working Group
San Diego, California
December 11, 2021

The Health Innovations (B) Working Group of the Health Insurance and Managed Care (B) Committee met in San Diego, CA, Dec. 11, 2021. The following Working Group members participated: Andrew R. Stolfi, Chair, and TK Keen (OR); Laura Arp, Co-Vice Chair, and Martin Swanson (NE); Nathan Houdek and Jennifer Stegall, Co-Vice Chairs (WI); Andria Seip (IA); Julie Holmes (KS); Robert Wake (ME); Cynthia Amman (MO); Jon Godfread (ND); Maureen Belanger (NH); Paige Duhamel (NM); David Buono and Shannen Logue (PA); Chris Herrick (TX); Tanji J. Northrup (UT); Molly Nollette (WA); and Joylynn Fix (WV). Also participating were: Lori K. Wing-Heier (AK); David Altmaier and Chris Struk (FL); Weston Trexler (ID); Stephanie McGee (NV); and Glen Mulready (OK).

1. Heard a Presentation on Health Plan Efforts to Address Health Disparities

Commissioner Stolfi reviewed the changes the Working Group received from the Special (EX) Committee on Race and Insurance. He said the Working Group plans to evaluate existing research on the health disparities impacts of telehealth and alternative payment models and hear from stakeholders on these topics.

Dr. John Lumpkin (Blue Cross and Blue Shield of North Carolina—BCBS NC) described his organization's work to develop a health equity index score. He shared a statement from BCBS NC that says, "[n]o community can truly be healthy until racism no longer exists." He said North Carolina counties can be divided into tiers based on their economic distress. He said a health equity index can provide accountability to measure what works. He said BCBS NC's index measures both racial and economic disparities and currently shows a summary score for overall equity of 87%. He said the index score would be used to support BCBS NC's priorities of improved data on race, ethnicity, and language; improve maternal care; increase behavioral health access; and increase immunizations and wellness visits. He described an example of work to improve maternal health, particularly for Black Americans.

Commissioner Stolfi asked how other states can develop similar health equity index scores. Dr. Lumpkin said health insurance plans cannot do it alone, and states should work with a range of stakeholders to develop coordinated measures. Commissioner Stolfi asked what strategies BCBS NC has used to collect data. Dr. Lumpkin said the biggest challenge in developing the index was that race and ethnicity data are not readily available. He said some data is self-reported by enrollees, and other data is calculated, but the best data is reported by consumers. Commissioner Stolfi asked what state insurance regulators can do to support industry efforts to reduce health disparities. Dr. Lumpkin said there must be an open partnership between state insurance regulators and regulated plans.

Dr. Darrell Gray (Anthem) presented on the company's efforts to improve health equity. He said Anthem has an integrated approach to whole health that includes physical, behavioral, social, and pharmacy health and incorporates consumers, communities, and associates. He described the difference between equality and equity, and he said Anthem's approach to equity is data-driven, inclusive, and nimble. He stressed the importance of addressing a variety of needs, including upstream (poverty, racism, and discrimination), midstream (housing, transportation, and violence), and downstream (chronic disease, poor nutrition, and poor mental health). He said Anthem is working to develop a Whole Health Index that includes measures of global health, social drivers, and clinical quality. He described three steps for identifying social needs, coordinating social care, and creating social interventions. He said health-related social needs contribute to 70–80% of clinical outcomes, while clinical care contributes only 20%.

Ms. Seip asked in what markets Anthem is applying its social interventions. Dr. Gray said the company's goal is to deploy them across all public and private markets in which it operates. Mr. Houdek asked what length of time the company expects to move from the first step of identifying social needs to the third step of creating social interventions. Dr. Gray said it varies greatly by the type of need, the population, and the insurance market being served. Commissioner Stolfi asked how state insurance regulators can support industry efforts to reduce health disparities. Dr. Gray said assisting with data definition and collection efforts would be helpful since the company does not have complete self-reported data on race and ethnicity or sexual orientation and gender identity. He said New York has been able to get better data on race and ethnicity in its individual market through updates to collection practices in its state-based exchange.

2. Heard a Presentation on the Health Disparities Impacts of Telehealth and Alternative Payment Models

Kelly Edmiston (NAIC) presented the findings of research he conducted with the Center for Insurance Policy and Research (CIPR) colleagues on the health disparities impacts of the rise in telehealth services and the move to alternative payment models. He said the key take-away is that both telehealth and alternative payment models have the potential to improve health and reduce disparities, but they must evolve to do so because they are not there yet. He said prior to the pandemic, the share of claims delivered through telehealth was minimal, grew enormously early in the pandemic, and has since declined but not to pre-pandemic levels. He said telehealth can provide greater access to culturally competent care based on language, race, or gender. He said telehealth is especially effective for chronic conditions, which disproportionately affect vulnerable populations. He said the potential of telehealth is limited by restricted access to broadband connections. He said telehealth requires significant upfront costs, and uncertainty in payment policies can limit needed investments.

Mr. Edmiston said alternative payment models seek to reduce the incentive to overtreat and the disincentive to treat underserved populations, which occurs because underserved or vulnerable populations may need more low-margin care. He said value-based payment models are intended to reduce the cost of care without reducing quality or improve quality without increasing cost. He said research has not shown value-based payments to be effective in reducing disparities, despite the potential to do so. He said models can include social risk factors, but they are not currently sophisticated enough due to data limitations.

Mr. Keen asked whether any single telehealth technology platform has emerged and whether it allows medical records to be easily exchanged between patients and providers. Mr. Edmiston said the fast adoption of electronic health records is a good sign for telehealth. He said there are multiple models that exist for telehealth, and some have higher sales than others. He said basic digital literacy is more important than the technology used. Ms. Seip asked whether alternative payment models that incorporate social determinants of health have better outcomes than those that do not. Mr. Edmiston said research on Medicare Advantage showed small effects of accountable care organizations overall, and the measurement of social determinants is not adequate yet to reach a conclusion. Mr. Trexler asked whether payment parity rules are related to the needed investments in telehealth. Mr. Edmiston said some states have added parity requirements since the pandemic, and they may be temporary. He said this may limit providers' willingness to make investments. Mr. Trexler asked whether telehealth could result in lower health care costs overall. Mr. Edmiston said telehealth use has leveled off in the last year and is likely here to stay. Mr. Wake said telehealth is different from in-person health care. He said Maine imposed temporary payment parity during the pandemic because telehealth needed to substitute for in-person care, but it does not always need to be a substitute. He said in cases where different services are provided through telehealth, payment parity is not appropriate because it is one-size-fits-all. He said telehealth providers need equity in payments, not equality. Ms. Arp asked about the age distribution of patients who use telehealth. Mr. Edmiston said consumers who use telehealth tend to be older than those who do not, and non-white populations are less likely to use it. He said urban consumers are more likely to use it, potentially due to a lack of broadband access in rural areas. Ms. Arp said state insurance regulators could look at telehealth as a bonus, requiring in-person networks to be adequate while offering access to more culturally competent or specialized providers through telehealth.

3. Discussed Other Matters

Commissioner Stolfi said NAIC staff would ask the Working Group what questions the presentations raised and how else members would like to dig into the issues highlighted. In addition, NAIC staff would ask members how they want to move toward developing recommendations related to race and insurance work.

Having no further business, the Health Innovations (B) Working Group adjourned.

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