

NAIC Consumer Representatives Comments

Draft: 10/6/21

Comments are being requested on this draft document on or before Nov. 4, 2021. Comments should be sent by email only to Jolie Matthews at jmatthews@naic.org.

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, linguistically, and clinically 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 and culturally and linguistically appropriate services
 - b. Recognition that others have key roles, but insurance sector can contribute significantly to this goal
 - i. Provider education, recruitment, etc
 - ii. Role of state licensing boards
 - c. Role of insurance companies
 - i. Provider credentialing
 - ii. Network construction
 - iii. Translation and interpretation services for populations that do not use English as a first language or who need written English available in accessible formats
 - iv. Leveraging provider directories to connect policyholders to diverse and culturally competent care
 - v. Intersection of equity and payment reform (e.g., effect of alternative payment models on disparities in access and outcomes)
 - vi. Measurement of quality, inclusive of cultural competency, and reporting to consumer
 - d. Role of insurance regulators
 - i. Network adequacy as a tool
 - ii. Provider directory oversight
 - iii. Consumer information and transparency
 - iv. Complaints, market conduct exams, and enforcement
2. Network Adequacy
 - a. Background and Legal Landscape
 - i. Affordable Care Act requires adequate networks, inclusion of essential community providers in networks, and nondiscrimination under Section 1557
 - ii. NAIC network adequacy model – a brief description and history
 - b. Describe current gaps in adequate networks, especially those that may be felt more acutely by diverse enrollees
 - c. Examples/potential strategies for network adequacy review to be a tool for states to increase patient access to diverse, culturally competent care
3. Data collection and provider directories

Commented [KK1]: We did not include these in our comments, but the consumer reps have already identified resources that could be helpful to this process, both generally and on specific issues in the outline. We look forward to assisting with this process and can share those resources upon request. Thank you!

Commented [KK2]: We encourage the term "provider" to be construed broadly (to include, for instance, certified professional midwives) and not limited to only physicians

Commented [KK3]: To adequately serve those with limited English proficiency and comply with federal nondiscrimination requirements, insurers and providers must provide meaningful access to LEP individuals, including through translation and interpretation services. Health care providers have their own independent requirements to provide these services. But insurers can use network design and reimbursement policies to promote access. For instance, some FHQCs that serve immigrant populations have those capabilities in-house.

Commented [EE4]: Improving User eXperience of provider directory websites is critical for enabling lower-knowledge consumers to make effective use of them.

Commented [KK5]: Some of the challenges associated with alternative payment models are discussed in this resource from the American Academy of Actuaries Health Equity Work Group:

https://www.actuary.org/sites/default/files/2021-09/Health_Equity_Provider_Contract_Network_Develop_09_2021.pdf

Commented [EE6]: Insurers have internally adopted many measures of quality, both internal uses such as benchmarking providers and external ones such as NCQA accreditation or CMS requirements. However, nearly none of this quality data makes it to provider directories, much less to other entities for analysis and linking.

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- a. Current state of regulatory oversight of provider directories
 - i. No Surprises Act – impact on provider directories
 - ii. CMS Transparency Rules (Provider Directory and Patient Access APIs)
 - iii. General interoperability efforts from ONC, including CURES Act
 - b. Should demographic data and/or information on cultural competency, languages spoken, and accessibility 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. Discussion of opportunities and challenges for using telehealth to advance health equity
 - iv. Potential industry data call for further information on insurer implementation of telehealth policies
 - v. (Note for consideration: perhaps CIPR could be helpful)
 - c. Public Policy considerations
 - i. Reimbursement
 - ii. Audio-only versus Audio-Visual
 - iii. Telehealth-only or gatekeeper networks
 - iv. What role can insurers play in providing resources to members for telehealth accessibility, i.e. are providing phones risk-based or an inappropriate rebate?
5. What role for FQHCs and other safety net providers in an adequate network?
- a. Overview of ACA essential community provider (ECP) requirements, including discussion of scope and impact
 - b. Brief history of FQHCs, including legal parameters around their operation
 - c. Potential industry data call for further information on ECPs (including FQHCs) in provider networks
 - d. Public Policy considerations
 - i. Are the current ECP requirements sufficient? Should networks be required to include FQHCs and other safety net providers?
 1. Reimbursement
 2. Should NAIC further explore FQHC challenges with PBM actions relative to the 340B program?
6. Conclusion and discussion of recommended next steps

Commented [KK7]: We do not understand this emphasis and are not convinced that this is based on more than anecdotal reports. In any event, this concern is already captured in the bullet point immediately above (3)(b)(i) and we recommend removing this from the outline. There are also existing models for these efforts in, for instance, directories of behavioral health providers where this information is routinely included (and is both voluntary and popular).

We also note an early suggestion from CMS in the preamble to the [third 2022 notice of benefit and payment parameters](#) that CMS may require the collection and disclosure of demographic and other information about providers: "HHS agrees that adequacy metrics supporting equitable access for all consumers should be a high priority. For future rulemaking, HHS is carefully considering standards that promote health equity (for example, provider directory requirements to include information about the race/ethnicity, language(s) spoken, accessibility, and office hours of in-network providers)."

Commented [KK8]: This may already be intended, but we recommend an explicit discussion of tele-mental/behavioral health services.

Commented [KK9]: Rachel Klein and Karen Siegel gave a presentation at the Consumer Liaison meeting in August on "Regulatory Possibilities for Promoting Equity Through Telehealth" - much of that information could be reflected here on the promises of telehealth and how to realize those promises for health equity.

Commented [KK10]: We do not see a need to limit this discussion to FQHCs to the exclusion of other key providers (such as community health centers, Ryan White providers, Title X family planning programs, Indian Health Services providers, etc.). We recommend that this section be framed around essential community providers with additional focus on FQHCs as a subset of those providers (versus the current framing that focuses primarily on FQHCs). We rearranged some of the content consistent with that recommendation.