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November 4, 2021

Commissioner Jessica K. Altman, Co-Chair
Commissioner Ricardo Lara, Co-Chair
Special (EX) Committee on Race and Insurance – Workstream 5 (Health)
National Association of Insurance Commissioners (NAIC)

Attn: Jolie H. Matthews, Senior Health and Life Policy Counsel, NAIC

Re: Comments on Exposure Draft of *White Paper on Provider Network* Outline

Dear Commissioners Altman and Lara:

On behalf of the American Academy of Actuaries¹ Health Equity Work Group (HEWG), we appreciate the opportunity to offer comments on the exposure [draft](#) of the outline for the *White Paper on Provider Networks*, dated October 6, 2021 and exposed by the NAIC’s Special (EX) Committee on Race and Insurance—Workstream 5 (Health) on October 14, 2021.

As evidenced by the approach outlined in the draft this white paper is to look at provider networks in the context of addressing health equity concerns as they relate to historically underrepresented and marginalized groups. We hope our suggestions will assist you in identifying areas where there may be a need for further exploration. This includes an examination of the current measures of network adequacy and how they may impact access to care by historically marginalized and underrepresented communities, as well as the impact of network selection, provider reimbursement, and provider incentives on these communities.

Please find our redlined edits and comments in Attachment A.

Thank you for the opportunity to provide input on the outline for the *White Paper on Provider Networks*. We welcome the opportunity to speak with you in more detail and answer any questions you have regarding these comments or on other topics related to health equity. If you do have any questions or would like to discuss further, please contact Matthew Williams, the Academy’s senior health policy analyst, at williams@actuary.org.

¹ The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

Sincerely,

Annette V. James, MAAA, FSA, FCA
Chairperson, Health Equity Work Group
American Academy of Actuaries

CC: Brian R. Webb, Assistant Director, Life and Health Policy and Legislation, NAIC

Attachment A

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. Goals of this paper:
 - a. Furthering equity in health insurance coverage by increasing diversity and cultural competency in networks by:
 - i. Examining access to care by underserved communities
 - ii. Seeking solutions to improve access to diverse and culturally competent networks.

2. 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. Provider education, recruitment, etc.
 - ii. Role of state licensing boards
State health exchanges certifying ACA health benefit plans
- c. Role of insurance companies
 - i. Provider credentialing
 - ii. Network construction
 - iii. Leveraging provider directories to connect policyholders to diverse and culturally competent care
- d. Role of the Centers for Medicare and Medicaid Services (CMS)
 - i. Exchange qualified health plans
 - ii. Medicare Advantage
 - iii. Medicaid
- e. Role of state insurance regulators
 - i. Network adequacy as a tool
 - ii. Provider directory oversight

3. Review of access to care by category such as:
 - a. Race/ethnicity
 - b. Geography (rural vs. urban)
 - c. Socioeconomic status

Commented [A1]: Consider adding an introductory section that provides context for the white paper as part of the focus on health equity.

Commented [A2]: Consider moving this item up. It seems that this section of the report should define cultural competency earlier on.

- d. Language
- e. Provider specialty
- f. Age
- g. Employment status
- h. Housing status
- i. Highest level of education

2.4 Network Adequacy

- a. Is the definition of network adequacy consistent with health equity goals?
 - i. Current measures of network adequacy
 - ii. Inequity of the current network adequacy measures and the populations left behind
 - iii. Equitable measures of network adequacy
 - iv. Transitioning to a more equitable measure of network adequacy

a-b Background and Legal Landscape

- i. Affordable Care Act requires adequate networks
 - 1. Use of narrow or select networks and their impact on equity
 - ii. NAIC network adequacy model – a brief description and history

b-c Examples/potential strategies for network adequacy review to be a tool for states to increase patient access to diverse, culturally competent care

3-5 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

4-6 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. Access to telehealth by category such as:
 - i. Race/ethnicity

Commented [A3]: Many insurers only offer “select” or “narrow” networks on ACA Exchanges – should the impact of this strategy be explored?

Commented [A4]: We recommend that the telehealth section include an acknowledgement of the impact of disparate access (rural, economic, language, provider specialty, age, privacy). It is not clear if this issue is intended to be addressed here (item (b)(ii) or if it needs a separate section (see item c. below)

- ii. Geography (rural vs. urban)
- iii. Socioeconomic status
- iv. Language
- v. Provider specialty
- vi. Age
- vii. Employment status
- viii. Housing status
- ix. Highest level of education

e-d. 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?
- v. Interstate issues
 - 1. Credentialing
 - 2. Prescriptions
 - 3. Patient protections

5-7. 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?

8. Alignment of Provider reimbursement and incentives with health equity goals

- a. Networks in low-income areas
- b. Networks in rural areas

6-9. Conclusion and discussion of recommended next steps

Commented [A5]: Providers serving a lower income or racial/ethnic minority population may have fewer resources or resource wealth as compared to their counterparts serving more privileged communities. Reimbursement rates tend to be lower in racial/ethnic minority communities and lower income communities. Additionally, provider incentives may not encourage providers to serve underrepresented and under-resourced communities. Also, over the past 20 years there have been significant community hospital closures – many situated in lower income regions.