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ADVANCING EQUITY THROUGH HEALTH INSURANCE COVERAGE

EXAMPLES FROM THE STATES



ACKNOWLEDGMENTS



ABOUT UNITED STATES OF CARE

United States of Care (USofCare) is a non-partisan non-profit working to ensure everyone has access to quality, affordable health care regardless of health status, social need, or income. By putting the needs of people at the forefront of our research and policy solutions, we can create a health care system that works for people.

In May 2022, USofCare released a set of twelve concrete and achievable aims, known as our [United Solutions for Care](#), to help us build a better and more equitable health system. These twelve solutions are derived from four goals for the health care system that continuously rose to the top when talking to people around the country about what works and what is lacking in their health care. The menu of policy solutions laid out in this resource align with what we know people need and want from the health care system. Using these policy solutions to advance equity through health insurance coverage, we can tackle our shared health care challenges — through solutions that people of every demographic tell us will bring them peace of mind and make a positive impact on their lives.

Waxman

| OUTCOMES THAT MATTER |

ABOUT WAXMAN STRATEGIES

Waxman Strategies is a mission-driven consulting firm chaired by former Congressman Henry Waxman that uses advocacy, communications, and campaigns to advance policy solutions. Our Health Practice envisions a society in which all people and communities have what they need to become and stay healthy. From conducting and compiling targeted policy research, to crafting compelling advocacy campaigns in partnership with key stakeholders, to working directly with decision makers in Congress, the executive branch, and the states to shape health policy, we provide full-service support to organizations that share our belief that everyone deserves equitable, high-quality, affordable, and accessible health care.

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INTRODUCTION

At United States of Care (USofCare), listening to people’s needs and experiences with the health care system is at the core of what we do. From our listening, it is clear that inequities in the health care system persist and the solutions to tackling these issues must start with first understanding who the health care system is not serving and addressing those gaps.

The Affordable Care Act’s (ACA) expansion of health insurance coverage, including through state and federally facilitated exchanges (or marketplaces), has helped increase equity in coverage rates across people of different races, ethnicities, and additional demographic statuses. The ACA decreased the uninsured rate across all people in the United States, with the greatest decrease among people of color. Between 2013 and 2018, the uninsured rate for Black adults decreased from 24% to 14% and for Hispanic adults, it decreased from 40% to 30%.¹ Increasing access to insurance can help people obtain the health care they need, ultimately leading to better health outcomes. However, despite gains in access to coverage, people across the country continue to experience inequities in access to care and health outcomes.

With millions of diverse members, health insurance plans can make important progress toward improving health equity, ensuring that their enrollees have a fair opportunity to be as healthy as possible. Insurance plans establish networks of providers and health care facilities that are available to enrollees seeking care. The breadth, training, and composition of those networks can significantly impact people’s ability to attain care that meets their health needs. Insurance plans also require different levels of cost-sharing, such as deductibles and copayments, for services. When these amounts are high, they may hinder access to care for enrollees, and amplify existing disparities. However, when these and other features of plans are tailored with equity in mind, they can help to address disparities, and importantly, avoid exacerbating them.

States have the opportunity to make real progress by pursuing legislation, regulation, and other policies to ensure health insurance coverage is increasing health equity and reducing disparities through approaches to costs, plan design, provider networks, and more.

While policy change to the health insurance system alone is insufficient in addressing health inequities, these efforts can make an important impact, especially when combined with actions to address health equity from state and federal agencies, lawmakers, providers, community partners, and additional stakeholders.

This paper presents a menu of policy options for states to consider to advance health equity through health insurance coverage. These policy solutions target insurance coverage through health insurance exchanges, public health insurance options (referred to as “public options” throughout this resource), and state insurance markets more broadly. The following policy options showcase steps that certain states have taken to date, but do not represent a comprehensive list of all policies that states have enacted, considered, or tested. Instead, they intend to provide a broad sample of approaches for policymakers to consider from states that are diverse in their geographies, political landscapes, and insurance market sizes. These policies are not mutually exclusive and can be used

in combination with each other to increase their impact toward achieving health equity through health insurance coverage. Although this paper specifically highlights actions that states have taken in health insurance exchanges, public options, and private insurance markets, states can also look to Medicaid and CHIP program policies that have been especially focused on addressing health equity and disparities for additional examples of how to advance equity across all types of health insurance coverage.²

Furthermore, some of the states featured in this guide are long-standing leaders in advancing equity through insurance markets. California, for example, has wide-reaching requirements regarding equity for all health insurance plans participating in its exchange and a law guaranteeing language access to health care consumers, which applies to the state's entire insurance market. On the other hand, some of the featured states have taken more initial and foundational steps worthy of replication, especially in combination with other approaches.

By presenting an array of options, we intend to provide state leaders with policy ideas for advancing equity through health insurance coverage that will best suit their state's unique needs. Importantly, states that have prioritized driving equity through insurance coverage, whether through a public option or through their entire state-regulated markets, often enact many of the following policies together in combination for maximum impact.

POLICY OPTIONS FOR ADVANCING EQUITY THROUGH HEALTH INSURANCE COVERAGE

The following examples include a range of options that states can consider to advance equity through health insurance coverage based on features like plan design, network considerations, data collection, and more. All featured models are currently used by states that are diverse in their geographies, market sizes, and political landscapes. The policy options are applicable to state health insurance exchanges, public options, and/or private health insurance markets more broadly, as indicated.

ENGAGING DIVERSE COMMUNITY STAKEHOLDERS

Engaging community members, especially those who have been traditionally marginalized by the health care system, is critical to understanding people's priorities and needs to create effective and meaningful policy.

Collaborating with diverse stakeholders to understand perspectives and challenges, establish equity goals, and develop strategies and policies to achieve those goals is important to ensuring equitable access to coverage and care. It is for this reason that states have sought to establish robust processes for stakeholder engagement in developing and implementing policies to drive equity through health insurance coverage.

COLORADO

The law that established the Colorado Option (the state's public option) mandates that the Division of Insurance incorporate stakeholder input when creating standards for participating health insurance plans. The law specifically requires engagement from a diverse range of stakeholders, including:

- Physicians
- Health care industry representatives
- Consumer representatives
- Individuals who represent health care workers or work in health care
- Individuals working in or representing diverse communities with regards to race, ethnicity, immigration status, age, ability, sexual orientation, gender identity, or geographic area³

To implement these requirements, the Division of Insurance held meetings to gather information on the experiences of diverse residents, providers of all types, and advocates. Stakeholders were also asked to share ideas for how to structure the Colorado Option's plans and provider networks.

The Division took many steps to make it easier for people to participate in the meetings, such as:

- Holding meetings during evening hours so people who work standard business hours could attend⁴
- Implementing measures to ensure meetings were accessible to people with diverse communication needs, such as ASL interpretation, Spanish language interpretation, and translation of meeting slides into Spanish⁵
- Holding a specific meeting to focus on the perspectives and needs of rural communities
- Including call-in options so that people who do not have internet access, have limited bandwidth, or who prefer phone to video could participate⁶

Colorado law also requires the Governor to appoint an advisory board to consult with the Insurance Commissioner in the implementation of the Colorado Option. The eleven members of the board must be demographically diverse, including with regards to race, ethnicity, immigration status, age, ability, sexual orientation, gender identity, and geography. Notably, the law requires the Governor to work to ensure that the board is composed of at least one-third people of color and that both rural and urban populations are represented. The Governor must also work to ensure that among appointees are those who:

- Have faced barriers to health access, including people of color, immigrants, and Coloradans with low incomes
- Have purchased coverage through the Colorado Option
- Represent consumer advocacy organizations
- Have health equity expertise, among other characteristics⁷



DISTRICT OF COLUMBIA

It is a top priority of the District of Columbia's health insurance exchange, the DC Health Benefit Exchange (DCHBX), that diverse stakeholders, residents, and community groups be engaged in the development, implementation, and operation of exchange policies and practices. For setting and revising policy for the DCHBX, the exchange forms advisory working groups comprised of the following stakeholders:

- People who use exchange coverage
- Advocates for people with certain health conditions
- Advocates for lower-income health insurance enrollees
- Brokers who help people purchase exchange coverage
- Clinicians including those who serve lower-income and medically underserved people
- Insurers
- Others whose involvement is critical to a high-functioning health insurance exchange that meets the needs of DC residents

These stakeholders prepare policy recommendations, including policies for how the exchange and participating plans will address "social justice and health disparities" for consideration. The Standing Advisory Board and the DCHBX Executive Board review the policies proposed by the advisory working groups and vote on whether the exchange will implement them.⁸

In 2022, the DCHBX standard plan working group was active and focused on changes to plan designs for 2024 that would reduce cost-sharing for certain services that are associated with health disparities, including mental health services for children and adolescents.⁹

MAKING COVERAGE AND CARE MORE AFFORDABLE

Addressing affordability so that cost is not a barrier for people to obtain needed care is a high priority for many policymakers working on health insurance issues. To address premium affordability, some states are pursuing public options with new tools like authority to set benchmarks for lowering premiums in future plan years, or the ability to set provider reimbursement rates to lower underlying costs and thereby decrease pressure for premium growth.¹⁰ In other states, health insurance exchanges and regulators use tools like increased financial assistance for exchange enrollees or enhanced rate review to make premiums more affordable.¹¹

Policies to decrease the cost of premiums are important for health equity. For example, even though the U.S. uninsured rate has decreased over time, especially for Black and Hispanic people, Black and Hispanic people are still more likely to be uninsured than White people.¹² Policies like those described here to lower insurance premiums can make it easier for people historically underserved by the health care system to attain health insurance coverage, a critical element of accessing necessary health care services and achieving health equity.

However, even once people are enrolled in coverage, cost-sharing requirements such as deductibles and copayments can still be prohibitive, leading to financial anxiety and people skipping or postponing needed care.¹³ High-cost sharing associated with services to treat conditions that are particularly prevalent in populations underrepresented by the health care system can contribute to inequities.¹⁴ If people avoid a health care service because it costs too much, their condition may only worsen. For conditions that are associated with disparities, these high costs can increase the burden already felt due to inequities in the health care system. The ramifications of these affordability issues are also seen in how populations accrue medical debt. For example, in the U.S., Black people are more likely than non-Black people to hold medical debt. In fact, Black households that have insurance carry medical debt at a rate comparable to non-Black households who do not have insurance.¹⁵

“Every time I see a doctor I have to pay. I’m paying \$1000 or more per month; I pay a little over two-hundred dollars per week whenever I go to the doctor.”
-Black woman living in Denmark, South Carolina

To decrease the barrier that costs can create, even for those with health insurance, some states have implemented policies to eliminate or minimize cost-sharing associated with “high-value” services that are vital to maintaining health.

To address existing disparities, states have defined services associated with conditions that disproportionately impact underrepresented populations as “high-value” and are working to reduce the cost-sharing burden of these services for consumers.



COLORADO

Insurers participating in the Colorado Option (the state's public option) must offer standardized bronze, silver, and gold metal level plans that cover certain high-value services with \$0 or minimal cost-sharing. These include the following services identified as particularly important to reducing health disparities with \$0 cost-sharing:

- Diabetic supplies, such as constant glucose monitoring
- Prenatal and postnatal visits
- Mental health and substance use disorder visits
- Sick visits to primary care providers
- Diabetes self-management education (\$5 copayment applies)¹⁶



MASSACHUSETTS

The Massachusetts Health Connector (the state's health insurance exchange) has implemented policies to eliminate cost-sharing in ConnectorCare (plans for people earning under 300% of the federal poverty level, or less than \$40,770 for an individual) for high-value services that may be particularly important for addressing disparities in the state. These services include medications needed for the treatment of the following four select chronic conditions disproportionately affecting communities of color:

- Diabetes
- Asthma
- Coronary artery disease
- Hypertension

Services also include \$0 cost-sharing mental health and substance use disorder visits and primary care sick visits.¹⁷

CONNECTING PEOPLE TO A BROADER ARRAY OF PROVIDERS

Insurers can vary in the types of providers they contract with to deliver care to enrollees, especially in the range of non-physician providers they include in provider networks. By including a wider array of provider types in networks, such as non-physician providers focused on a holistic approach to mental and maternal health care, insurers can support equity by including additional providers that understand and can meet the cultural and other specific needs of diverse enrollees. This broader array of providers can also fill gaps in geographic areas where there may not be enough physicians or facilities relative to the number of health plan enrollees, therefore increasing access to care in underserved regions.¹⁸

For example, doulas are non-physician providers who are proven to contribute to significant improvements in maternal health outcomes. In fact, the American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine report that doula care during pregnancy is one of the most effective tools for improving labor and delivery outcomes.¹⁹ A 2017 review of

clinical trials, which included nearly 16,000 women from 17 high- and middle-income countries, found that doula care led to a 39% reduction in cesarean births, shorter labor by an average of 41 minutes, and a 31% decrease in negative birth experiences.²⁰

Doula care is especially important for addressing systemic racism and mistreatment during pregnancy.

One U.S.-based survey found that 27.2% of women of color (defined as Black, Indigenous, Hispanic, and Asian women) with low socioeconomic status (SES) reported mistreatment during pregnancy compared to 18.7% of White women with low SES. Doulas can help prevent mistreatment and provide support to pregnant people by advocating for their personal care preferences and helping to combat interpersonal and institutional racism that occurs frequently in the maternal health care context.²¹

“I found a doula after going to a class - it was the only class available in this area. The doula I found was the person running the class. We were somewhere about an hour from here. There are no options for doulas around here; I have searched.”

-Black woman living in St. Matthews, South Carolina

By expanding access to diverse provider types through health insurance plans, states can increase the number of providers available to health plan enrollees, including in underserved geographies, while increasing access to culturally responsive providers.²² Some states have implemented requirements that health insurance plans expand access to specific provider types, such as non-physician reproductive and mental health care providers, as part of their efforts to eliminate health disparities. In implementing these standards, states should consider how to support diverse providers with issues such as credentialing requirements and reimbursement rates, which can determine the ease with which they can participate in health insurance networks.



MASSACHUSETTS

As part of efforts to address disparities in mental health disorder incidence and access to behavioral health care by race, ethnic group, and LGBTQ+ status, the Massachusetts Health Connector (the state's health insurance exchange) requires participating health insurance plans to contract with state-designated Community Behavioral Health Centers (CBHCs).²³ The Connector also encourages participating plans to incorporate recovery coaches and certified peer specialists into covered treatment for substance use disorders (SUD). In addition, the exchange requires that insurers enhance their gender affirming care case management expertise to help address inconsistent or unclear access to care for transgender enrollees.²⁴



Rhode Island requires every state-regulated health insurance plan to provide coverage for perinatal doula services that are within the doula’s professional competence, as defined by the state’s doula certification standard. Rhode Island defines a doula as “a trained professional providing continuous physical, emotional, and informational support to a pregnant individual, from antepartum, intrapartum, and up to the first twelve (12) months of the postpartum period.” Insurers cannot require supervision, signature, or referral by another health care provider for a doula to be reimbursed for perinatal services unless the plan requires the same for other categories of providers.²⁵

ENSURING ACCESS TO ESSENTIAL COMMUNITY PROVIDERS

As defined by federal regulations, essential community providers (ECPs) serve predominantly low-income, medically underserved individuals and include:

- Federally Qualified Health Centers (FQHCs) and FQHC look-alikes
- Ryan White HIV/AIDS Program Providers
- Family Planning Providers
- Indian Health Care Providers
- Inpatient Hospitals²⁶
- Other ECP providers including:²⁷
 - Substance Use Disorder Treatment Centers
 - Community Mental Health Centers
 - Rural Health Clinics
 - Black Lung Clinics
 - Hemophilia Treatment Centers
 - Sexually Transmitted Disease Clinics
 - Tuberculosis Clinics²⁸

These providers and facilities provide a wide array of care that is specifically situated to meet the needs of underserved and high-need populations that may experience health disparities. For example, ECPs often provide language access services and coordination of health and social services, and are frequently located in lower-income communities.²⁹ These features of ECPs make their inclusion in health plan networks important to advancing health equity.

For plan year 2023 and beyond, federal rules require all plans participating in the federally facilitated exchange to contract with at least 35% of ECPs in their service areas based on the federal ECP definition, an increase from the previous 20% requirement.³⁰

Some states have implemented state-level standards for health insurance plans to include ECPs in provider networks that exceed federal standards to ensure a wide variety of providers are available to serve populations with diverse, unmet, and complex health needs.



ARKANSAS

Arkansas has expanded its definition of an ECP to include school-based health centers. These provide primary and behavioral health care and related services to children and adolescents and are more likely to be located in lower-income, underserved communities where disparities persist.³¹ Insurers participating in the state's health insurance exchange must submit a list of school-based providers included in their exchange plan networks. Health insurers that participate in the exchange must offer a contract to at least one school-based provider in each county in the insurer's service area, where a school-based provider is identifiable, available, and meets insurer certification and credentialing standards.³²



CONNECTICUT

Insurers in Access Health CT (the state's health insurance exchange) must contract with at least 50% of FQHCs in Connecticut, and 50% of the non-FQHC providers on the exchange's ECP list.³³ This exceeds the federal threshold for ECP inclusion by 15% and places a special emphasis on contracting with FQHCs across the state.

TRAINING PROVIDERS TO BE CULTURALLY RESPONSIVE

Providers and patients each hold their own racial, ethnic, gender, sexual orientation, language, ability, and additional identities, which can influence their beliefs, practices, and biases, including about health and medicine. Patients' identities and backgrounds impact their experience of the health system and interactions with providers. Providers' internalized cultural exposures, including systemic racism and implicit biases, can negatively impact patient interactions and care. For example, one study showed that nearly 50% of U.S. medical students reported hearing negative comments about Black patients by an attending or resident physician. Students who reported hearing these negative comments demonstrated more characteristics of implicit racial bias in year four than they did in year one of their program.³⁴

Targeted efforts to train providers in cultural responsiveness are important to ensure that care for diverse patients is appropriate, well-received, and effective, especially in the context of the systemic racism that is embedded in our society.

State policymakers have taken steps to require or encourage training in cultural responsiveness for providers and health plan staff in an effort to support effective relationships with diverse patients that will improve care delivery and ultimately health equity.

“When seeking health care services, having an advocate from someone's own culture is huge and makes all the difference.”

-White woman living in Oakland, California



COLORADO

Providers participating in health insurance plan networks for the Colorado Option (the state’s public option), as well as their front office staff and health insurance plan customer service staff who assist enrollees in these plans must complete anti-bias, cultural competency, or similar training annually. Insurers must provide the state’s Division of Insurance information on the trainings that insurance plan staff receive using a standard reporting form. Insurers must also collect information on the trainings that providers and office staff receive using a standard form created by the state’s Division of Insurance.

All applicable health insurance plan staff must have completed the training requirements prior to the start of open enrollment for plan year 2023. At least 50% of each insurer’s Colorado Option providers and provider front office staff must complete training by January 1, 2023, with at least 90% completing training by January 1, 2025.

Insurers are also required to submit a summary of the trainings offered to customer service representatives, including the subject matter and duration of the training(s), and the total number and percentage of customer service representatives who completed training in the past 12 months. This information must be included in the insurers’ network access plans, which must be filed with the Division of Insurance when insurers create or make material changes to a provider network. The access plans must also include a description of the type of training reported by providers and provider front office staff, and the number and percentage of providers and provider front office staff who completed training in the past 12 months.³⁵



NEW MEXICO

As part of their application for licensure, state-regulated health insurance plans in New Mexico must submit to the state’s Division of Insurance a plan for approval of how they will address the cultural and linguistic diversity of their covered populations. At a minimum, these plans shall address any guidelines or training regarding the cultural and linguistic needs of covered persons that the health insurance plans will utilize with their own staff and providers within their networks.³⁶

ENSURING ACCESSIBLE COMMUNICATION WITH PROVIDERS AND HEALTH INSURANCE PLANS

For care to be truly accessible, people must be able to communicate with insurers and providers in their preferred language. Accessible communication for people who are deaf, blind, and have speech and communication disorders is also essential to delivering equitable health care. Health is a complex and personal topic, and people must be able to communicate with and understand their providers in their language and method of comfort. Barriers in understanding can lead to adverse outcomes, such as poor adherence to treatments, increased medical complications, or forgoing care altogether.³⁷

“Interactions between doctors and disabled patients are often fraught, unproductive, and traumatizing for the patient.”

-White woman living in Kansas City, Missouri

Access to professional interpretation and accessibility services is proven to improve outcomes for people in health care settings.

For example, a 2017 study found a decrease in readmissions for patients with limited English proficiency (LEP) that corresponded to an increase in access to professional interpreter services.³⁸

For people who are deaf or hard of hearing, access to interpreter services has been shown to increase receipt of necessary preventive care.³⁹ To advance equity in health care access and outcomes, some states have enacted specific language and accessibility standards that health insurance plans must follow.



CALIFORNIA

State-regulated health insurance plans must offer qualified interpretation services to enrollees with limited-English proficiency (LEP) at no cost during all points of contact, including when an enrollee is accompanied by a family member or friend who can provide interpretation services. Insurers must develop and implement Language Assistance Programs that address:

- Standards for assessing enrollees' language needs
- Standards for providing language assistance services
- Standards for staff training
- Standards for compliance monitoring

Enrollee Assessment Standards

Insurers must develop a demographic profile for each enrollee, including preferred spoken and written language and race and ethnicity, and insurers must survey the linguistic needs of individual enrollees. Obtaining this information enables insurers to calculate their threshold languages (those spoken by at least 3,000 or 5% of enrollees) and report them to state regulators. These threshold calculations determine the languages the plan must focus on for certain targeted accessibility efforts, as described in the next section.

Providing Language Assistance Services

Insurers' Language Assistance Programs (LAPs) must include all points of contact where enrollees may need language assistance services, insurers' processes to inform enrollees of language services, and how enrollees can access language services at no cost. They must also include a process to identify enrollee language needs, inform enrollees of interpretation services, and facilitate individual enrollee access to language services at all points of contact. Additionally, LAPs must include processes that insurers will use for providing notices of language assistance services with all vital plan documents and enrollment materials. LAPs must also include processes that insurers will use to provide statements in English and threshold languages about the availability of language assistance in other materials like brochures, newsletters, and marketing regularly sent to plan enrollees.

LAPs must also include the range of interpretation services that will be provided to enrollees as appropriate for the particular point of contact. The range may include, but is not limited to:

- Arranging for the availability of bilingual plan or provider staff who are trained and competent in the skill of interpreting.
- Hiring staff interpreters who are trained and competent in the skill of interpreting.
- Contracting with an outside interpreter service for trained and competent interpreters.
- Arranging formally for the services of voluntary community interpreters who are trained and competent in the skill of interpreting.
- Contracting for telephone, videoconferencing, or other telecommunications-supported language interpretation services.

Offers of qualified interpreters to enrollees and, if applicable, subsequent refusal must be documented in medical records or plan files.

Staff Training Standards

Insurers must implement a system to provide training regarding their LAP to all staff who have routine contact with enrollees with LEP. The training shall include:

- The health insurance plan's policies and procedures for language assistance.
- Working effectively with enrollees with LEP.
- Working effectively with interpreters in person and through video, telephone, and other media, as applicable.
- Understanding the cultural diversity of the plan's enrollee population and sensitivity to cultural differences relevant to delivery of health care interpretation services.

Compliance Monitoring Standards

Every insurer shall monitor its LAP, including delegated programs, and make modifications as necessary to ensure compliance.⁴⁰ California laws and regulations also require that health plans ensure health care services are accessible to those who are blind and deaf or hard of hearing.⁴¹



NEW MEXICO

Health insurers in New Mexico must provide interpreters for limited English proficient (LEP) individuals and interpretive services for patients who qualify under the Americans with Disabilities Act (ADA), such as people with disabilities that impact their hearing, vision, speech, and communication. Such interpretive services must be made available to providers' offices at no cost to the provider.⁴²

COLLECTING ENROLLEE DATA TO ADVANCE HEALTH EQUITY

Implementing systems to collect demographic data from people using the health care system is key to assessing needs and closing gaps in care and identifying and addressing health disparities.

Health insurance plans that collect enrollee data can help improve outcomes related to chronic disease, maternal and infant mortality, and lower life expectancies for populations who are traditionally marginalized by the health care system.

By identifying health disparities between populations based on demographics or geography, policymakers and insurers can tailor interventions to drive equity and improve outcomes.⁴³

However, when health insurers and policymakers lack demographic data about enrollees, it is impossible to identify health and health care disparities or assess whether interventions intended to address disparities are effective.

Although communities that have been historically marginalized by the U.S. health care system can be understandably hesitant to provide demographic information, states are working to adopt voluntary, transparent processes that protect and disaggregate personal data used to address health disparities. Some states have adopted standards that require health insurance plans to collect enrollee demographic data as part of efforts to address health and health care disparities.



CALIFORNIA

Covered California (the state's health insurance exchange) is phasing in requirements for all participating health insurance plans to collect self-reported race, ethnicity, and preferred spoken and written language data for at least 80% of enrollees by plan year 2025. The exchange is also working with plans to expand self-reported data collection to include disability status, sexual orientation, and gender identity. The exchange intends to proceed with efforts to stratify measures by income for disparities identification and monitoring purposes.⁴⁴



WASHINGTON

For plan year 2023, The Washington Health Benefit Exchange (the state's health insurance exchange) will require participating insurers to collect self-reported race and ethnicity data from 70% of enrollees. The exchange will support participating insurers in achieving this metric by sharing race and ethnicity information provided by enrollees on exchange applications through enrollment files. Insurers are required to report enrollee demographic data as part of the Quality Improvement Strategy (QIS) form from the exchange, described in more depth on page 17.⁴⁵

COLLECTING PROVIDER DEMOGRAPHIC DATA

A provider network that reflects the demographics of an insurance plan's enrollees can promote health equity and help reduce health disparities.

Research shows that alignment between the demographic characteristics of patients and health care providers is correlated with improved patient and provider communication, patient satisfaction, and patient health outcomes.⁴⁶ Having a provider with a shared cultural identity, sexual orientation, gender, and additional shared demographic backgrounds can help people feel more comfortable when obtaining medical services and sharing their health concerns. Furthermore, people from different cultural groups describe pain and distress differently, so providers who understand culturally-specific terms, expressions, or metaphors may be better able to accurately diagnose and treat diverse patients, ultimately improving health outcomes.⁴⁷

Insurers can utilize provider demographic data, together with enrollee demographic data, as a baseline to help align the demographics of provider networks with those of enrollees. Some states have implemented requirements for insurers to assess the demographics of their provider networks and expand the diversity of their provider networks, starting with the collection of data on provider demographics.

COLORADO

As required under Colorado law, insurers participating in the Colorado Option (the state's public option) must develop provider networks that reflect the diversity of their enrollees, in terms of race, ethnicity, gender identity, and sexual orientation.⁴⁸ The Colorado Option's requirements for diverse provider networks rely upon provider data collection and closely align with the public option's standards for enrollee data collection.⁴⁹

Under the Division of Insurance's provider data collection requirements for the Colorado Option, insurers must develop materials for network providers and their front office staff to voluntarily report their demographic data. Within these materials, insurers must highlight the intended uses of the data, including that data will be used to "improve racial health equity, reduce health disparities for covered persons who experience higher rates of health disparities and inequities, and to provide aggregate information about the diversity of the providers in the carrier's network." To reduce the burden on network providers and office staff, insurers must request demographic information when collecting information to build provider directories. Insurers are also responsible for including information about how the data will be shared. Insurers are required to report their data collection methods and the voluntary demographic information they receive from network providers and office staff in the aggregate only to protect respondents' identities.⁵⁰



DISTRICT OF COLUMBIA

Insurers participating in the DC Health Benefit Exchange (the District of Columbia’s health insurance exchange) are required to conduct a review of their provider networks to establish baselines for race, ethnicity, and primary language of their providers. After the review, health insurance plans must establish a 5-year plan to increase the diversity of their provider networks.⁵¹

IMPROVING HEALTH OUTCOMES FOR ENROLLEES

To advance equity, insurers can collect data to measure and monitor enrollee health outcomes, and partner with policymakers and providers to achieve improvements over time. This is especially important for health conditions that are associated with disparities.

Policymakers can also establish incentives, such as through alternative payment models, to motivate both insurers and providers to increase their focus on driving improved health outcomes over time, including for populations that experience disparities in health and health care access. While alternative payment models are currently more widespread in Medicare and Medicaid, they are tools policymakers and health insurers in any insurance market can consider to drive equity. In fact, the Affordable Care Act requires health insurance exchanges to implement payment structures that provide increased reimbursement for improved outcomes such as reduced health and health care disparities through a “Quality Improvement Strategy” (QIS) that each participating insurer must develop.⁵² Federal guidance encourages insurers to either select “reducing health and health care disparities” as a QIS goal or to address the reduction of health and health care disparities as part of the activities within another goal, such as improving patient safety or preventing hospital readmissions. The Centers for Medicare and Medicaid Services (CMS) require health insurance plans seeking to participate on an exchange to submit information on disparities efforts within their QIS activities.⁵³

The states below have implemented requirements that health insurance plans measure specific health outcomes and disparities to be improved over time. They have also established various payment incentives to help reduce disparities.



CALIFORNIA

Covered California (the state’s health insurance exchange) requires health insurance plans to collect data on metrics related to several health conditions commonly associated with health disparities as a condition of participation on the exchange. Participating insurers must report specified health condition and disparities data for their enrollee population and develop disparity reduction strategies and targets in collaboration with the exchange.⁵⁴

Specifically, for measurement years 2023-2025, insurers must submit the following Healthcare Effectiveness Data and Information Set (HEDIS) patient-level data files with race and ethnicity indicators to monitor disparities for plan enrollees:

1. Controlling High Blood Pressure
2. Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control
3. Colorectal Cancer Screening
4. Childhood Immunization Status (Combo 10)
5. Depression Screening & Follow-Up for Adolescents & Adults
6. Pharmacotherapy for Opioid Use Disorder
7. Prenatal Depression Screening and Follow-Up
8. Postnatal Depression Screening and Follow-Up

Insurers must modify the measures over time, with stakeholder input, to track disparities in care and health outcomes in additional areas, including behavioral health. The exchange will also work with public purchaser partners to assess and monitor disparities across populations in the state.

Insurers must also work with the exchange to review performance on disparities measures using data from the exchange's "Healthcare Evidence Initiative (HEI)," which requires insurers to submit data including medical claims data. HEI measures required for submission regarding disparities include:

1. Comprehensive Diabetes Care (CDC): Hemoglobin A1c (HbA1c) Testing
2. Ambulatory Emergency Room (ER) Visits[©] per 1,000
3. Adult Preventive Visits[©] per 1,000
4. Breast Cancer Screening (BCS)
5. Proportion of Days Covered: Three Rates by Therapeutic Category
6. Diabetes All Class (PDC-DR)
7. RAS Antagonists (PDC-RASA)
8. Statins (PDC-STA)

Covered California is currently beginning the process of developing standards for health insurance plans that want to participate on the exchange in plan year 2024. As part of that process, the exchange is discussing how to update both the HEDIS and HEI measures that health insurers must submit.⁵⁵

Additionally, Covered California is phasing in requirements, depending on how long insurers have participated in the exchange, for insurers to meet specific disparity-reduction targets based on the measures above. Insurers must submit disparity reduction intervention proposals based on a template provided by the exchange and report progress toward their targets to the exchange. The disparity reduction intervention proposals must include baseline measures for disparity identification, an analysis of the root cause of disparities, and the insurer's intervention design levels, strategies, and modes. The timeline for implementation and evaluation and the proposed improvement target must be included as well. As a condition of offering plans on the exchange,

insurers must participate in learning activities and meetings specified by the exchange to help them meet these requirements.⁵⁶

Covered California has established “Quality Transformation Initiatives” to set financial incentives for health insurers that participate in the exchange to improve health care quality and to reduce health disparities. Insurers that fail to meet specified benchmarks must make payments to the Quality Transformation Fund, which finances Covered California’s quality-related operations and activities. These payments can be as high as 4% of premiums. The exchange intends to incorporate health disparities reduction targets into these models in 2025 or 2026, tying payments to the reduction of disparities once stratified race and ethnicity benchmarks are established based on the data collection described above. Covered California is also working to align the measures tied to financial incentives for participating health insurers with other major purchasers, including the state’s Medicaid program, the state’s employee health plan, and federal programs such as Medicare.⁵⁷

WASHINGTON

The Washington Health Benefit Exchange (the state’s health insurance exchange) requires insurers’ Quality Improvement Strategies (QIS) to tie payments to providers or enrollees to measures of performance. Specifically, insurers must establish payments to providers based on meeting specific quality indicators in patient care or establish payments to enrollees based on making certain health care choices or exhibiting behaviors associated with improved health. As required by both federal and state QIS standards, the goal of the QIS, and therefore the performance measures to which payments are tied, must either be focused on or incorporate disparity reduction.

Regardless of the goals an insurer chooses for its QIS, insurers must report data on health and health care disparities to the Washington Health Benefit Exchange (WAHBE) based on a WAHBE standardized form. The form solicits data on the following clinical measures, stratified by race and ethnicity:

- Cervical Cancer Screening
- Plan All-Cause Readmissions
- Antidepressant Medication Management

Insurers are encouraged to adopt Breast Cancer Screening into their QIS as well, but this measure is not currently required. Insurers may monitor and track progress on additional quantitative measures to analyze progress toward their QIS goals.⁵⁸

IMPROVING INFORMATION ABOUT IN-NETWORK PROVIDERS

In 2020, more than half of U.S. patients used health insurance plan provider directories to select a physician.⁵⁹ At the state and federal level, ongoing policy work has focused on efforts to improve the accuracy of provider directory information.⁶⁰ In addition to ensuring that all health insurance enrollees and people shopping for insurance coverage have up-to-date and accurate access to provider network information, it is important that provider directories are accessible regardless of any identity an enrollee holds. Provider plan directories that meet the needs of diverse populations can help drive health equity.

Provider directories are an important tool for helping enrollees and people shopping for coverage identify providers who will meet their needs for culturally responsive providers.

For example, some jobs may not offer time off to go to appointments, and people may rely on directories to identify providers and facilities that are open outside of traditional business hours. Others may search provider directories for information about the languages providers speak or the accessibility of facilities for people with disabilities. Some states have implemented requirements for health insurance plan provider directories to include key information about providers' ability to serve the needs of diverse enrollees.

“Car insurance is so easy, but health insurance is not. How do you figure out which doctors take your insurance? The list of doctors in-network provided to us was only for one group of providers, and as a result, it took a month to get an appointment.”
-Hispanic woman living in Houston, Texas



State-regulated health insurance plans in Arkansas must make their online provider directories available in Spanish. Directories must indicate hours of operation for providers, including part-time or full-time operation, as well as after-hours availability, as reported by providers. Directories must also include the ability to filter providers by each category of Essential Community Provider. Finally, directories must indicate providers who participate in the state's Patient-Centered Medical Home program, which provides a local point of access to care that proactively looks after patients' health on a "24-7" basis and supports coordinated, customized care with a focus on prevention and chronic disease management.⁶¹

Health insurers participating in the Colorado Option (the state’s public option) must include several elements designed to ensure their provider directories meet the needs of all enrollees. The provider directories, both printed and online, shall include the following information about in-network providers and their front office staff:

- Providers who are multilingual or employ multilingual front office staff, including the languages spoken by providers and their front office staff
- If the provider offers extended and/or weekend hours
- The accessibility of the provider's office and examination rooms for persons with disabilities

The provider directories must also include information regarding the following services and processes for interacting with the insurance plan:

- Availability of translation and interpreter services in languages other than English for individuals with limited English proficiency
- Accessibility services for people with disabilities and the procedures for requesting such services from the insurer⁶²

ADDRESSING BIAS IN CLINICAL ALGORITHMS & TOOLS

Clinical algorithms and tools guide provider decision-making regarding diagnosis and treatment of people’s health conditions across the health care system. Although algorithms are designed to make clinical decision-making more reliable, they can be built upon biased assumptions about different populations and data sets that do not represent diverse patients. As a result, they can lead to inappropriate care— or even denial of services— for patients with underrepresented identities, unless bias is addressed and eliminated.⁶³

For example, the clinical kidney function score glomerular filtration rate (GFR) is often adjusted upwards for Black patients. This means that a low GFR demonstrating kidney failure risk in a non-Black patient would be treated as a healthy, functioning kidney for a Black patient, indicating no need for intervention. This is a biased result that leads Black patients to receive delayed kidney interventions compared to non-Black patients. The National Kidney Foundation therefore recommends the replacement of this diagnostic tool with “a substitute that is accurate, representative, unbiased, and provides a standardized approach to diagnosing kidney diseases.”⁶⁴

There are several other common health conditions where diagnostic tools and medical guidelines include race, such as predictors for obstetric care, pulmonary function, cancer, and dermatological conditions.⁶⁵

The following states have implemented policies that are designed to identify and address bias in clinical algorithms and tools.



DISTRICT OF COLUMBIA

The District of Columbia Health Benefit Exchange (the District of Columbia’s health insurance exchange) passed a resolution stating that participating health insurance plans should conduct an assessment of their clinical management algorithms and provide a report on the outcomes to the exchange. Health insurance plans must assess algorithms that may introduce bias into clinical decision-making or influence access to care, quality of care, or health outcomes for racial and ethnic minorities. Plan reports on the algorithms provided to the DC Health Benefit Exchange (DCHBX) are considered proprietary and confidential and will be used for informational purposes to identify the types and prevalence of algorithms that are found to potentially bias care for diverse populations.⁶⁶

According to DCHBX, within the first year of implementing this policy, participating plans conducted an assessment of their use of 13 clinical diagnostic tools that cover a wide range of conditions. One plan confirmed it does not use any of the 13 clinical diagnostic tools in decision-making.⁶⁷ The 13 diagnostic tools were selected for assessment based on a systematic review by Harvard University researchers, who identified these tools as utilizing race adjustment and having the potential to perpetuate or even amplify race-based health inequities.⁶⁸ As a result of the assessment, the health insurance plans are now undergoing a process to modify their practices pertaining to the use of biased clinical diagnostic tools with algorithm developers, medical directors, and other experts internal and external to the health insurance plans. Participating health insurance plans are now also engaging in ongoing monitoring of clinical diagnostic tools for bias.⁶⁹

DCHBX also enacted a resolution in July 2021 stating that within a year, insurers should prohibit the use of race in estimating glomerular filtration rate (GFR) by their network hospitals, laboratories, and other providers.⁷⁰

Adoption of this National Kidney Foundation guideline to prohibit the use of race in assessing kidney function is a recognition that race is a social construct and is not a biological predictor that should be used to approximate kidney function.⁷¹

Currently, DCHBX is working with health insurance plans to phase out the use of race in GFR in accordance with the resolution.⁷²



CALIFORNIA

Covered California (the state’s health insurance exchange) requires participating health plans to assess clinical algorithms for bias and take steps to improve or suspend the use of biased algorithms. It also requires plans to implement procedures to prevent future use of biased algorithms. The exchange provides guidance to participating plans on how to meet these requirements by recommending they utilize the Chicago Booth Center for Applied Artificial Intelligence Algorithmic Bias Playbook to implement best practices.⁷³ The Playbook provides the

health care industry with a four-step process for addressing bias in algorithms. These steps include:

- Creating an inventory of algorithms
- Screening for bias
- Retraining biased algorithms (or throwing them out)
- Setting up structures to prevent bias in future algorithms⁷⁴

REQUIRING HEALTH EQUITY ACCREDITATION FOR HEALTH INSURANCE PLANS

Most health insurance plans rely on the National Committee for Quality Assurance (NCQA) for accreditation to assess their structures and processes.⁷⁵ The NCQA now offers the opportunity for health plans to specifically receive accreditation for health equity efforts. This accreditation creates standards and infrastructure for many of the elements through which health insurance plans can advance health equity, including data collection, language access, and improving health outcomes.

Obtaining the NCQA Health Equity Accreditation can demonstrate that an insurer has taken several steps to advance health equity and is continuing to engage in those efforts.⁷⁶

Some states are requiring or encouraging health insurance plans to obtain the NCQA Health Equity Accreditation.



CALIFORNIA

Health insurance plans participating in Covered California (the state's health insurance exchange) must achieve NCQA Health Equity Accreditation by the end of 2023. Insurers must submit evidence of Health Equity Accreditation or create and submit a work plan to achieve the Accreditation by the end of 2023. Plans with current NCQA Multicultural Health Care Distinction (a recognition that is not as comprehensive as Accreditation) must submit evidence of the Distinction and submit a work plan to transition to Accreditation at the expiration of the Distinction's term.⁷⁷



DISTRICT OF COLUMBIA

The Executive Board of the DC Health Benefit Exchange (the District of Columbia's health insurance exchange) passed a resolution stating that participating health plans should obtain the NCQA Multicultural Health Care Distinction.⁷⁸ In an update on progress towards the exchange's social justice and health disparities goals, the DC Health Benefit Exchange (DCHBX) staff note that the NCQA has now updated from a Multicultural Health Care Distinction to a full Health Equity Accreditation. DCHBX indicates it may need to update its resolution to reflect this new NCQA Accreditation.⁷⁹

CONCLUSION

Inequities in health outcomes and access to care rob people of the quality of life they deserve and are costly for our health care system and communities. Health insurers cover millions of people across every state, in health insurance exchanges, in burgeoning public options, and more broadly. Insurers have a critical role to play in stemming health and health care disparities. Policymakers and regulators can work with insurers to implement measures that will advance health equity through insurance coverage using this guide as a menu of options.

States can adopt the policies in this paper to address health disparities, adapting the approaches to serve their states' unique needs, populations, and insurance markets.

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- ⁷⁷ Covered California, Attachment 1 To Covered California 2023-2025 Individual Market QHP Issuer Contract: Advancing Equity, Quality, And Value, op. cit.
- ⁷⁸ DC Health Benefit Exchange Authority, Resolution on Social Justice Disparities Working Group Recommendations, op. cit.
- ⁷⁹ DC Health Benefit Exchange Authority, Insurers' implementation of HBX Executive Board's Resolution Adopting Recommendations from the HBX Executive Board's Social Justice and Health Disparities Working Group, op. cit.