Leveling Up

A Role for Health Plans in Improving Health Equity in New York

United Hospital Fund
Improving Health Care for Every New Yorker

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Executive Summary

Anniversaries of seminal works on inequities in the U.S. health care system keep piling up lately, but progress toward equity has been distressingly slow. This disparity was underscored by the outsized impact of the COVID-19 pandemic on Black and Latine Americans, who died at twice the rate and were hospitalized at three and four times the rate of white Americans. Still, the COVID toll, along with the demand for justice that followed the tragic murder of George Floyd just months after the pandemic took hold, has engendered a renewed focus on health equity. This report surveys the efforts of health plans in New York and other states—and the regulators and policymakers who set the rules for plans—to highlight specific and wide-ranging opportunities to improve health equity.

Making progress on health equity will certainly require an all-hands-on-deck approach—government, educators, artists, activists and community-based organizations, employers, researchers, health care providers and systems, and foundations all have important contributions to make. But health plans are uniquely situated to play a critical role in eliminating health care disparities and addressing the underlying drivers of inequity.

For starters, health plans are large employers in their communities: they control vast resources through premium payments by government, individuals, and employers; they invest those premium dollars; and they spend billions of dollars on goods and services. Major health plans providing comprehensive health coverage in New York in 2020 reported about $50 billion in revenue, $15 billion in invested assets, and $6.5 billion in administrative expenses, including $2.8 billion in salaries and hundreds of millions more on auditing, actuarial and other consulting services, marketing and advertising, and equipment. Viewed one way, health plans are the stewards of these vast resources, including the estimated $93 billion spent annually in *excess* direct medical costs attributable to racial disparities.

This review follows the "river" of interventions health plans are positioned to make—upstream, mid-stream, and downstream—with examples from New York and other states, across Medicaid, Medicare, and commercial insurance. The areas of opportunity highlighted in this report include diversity, equity, and inclusion efforts among insurers; insurer investments and procurement programs in communities; provider networks and consumer information; benefit design; utilization review; the employer-sponsored insurance market; data needs; and reporting and transparency.

New York policymakers, regulators, and health plans face many daunting tasks in the effort to build a more equitable health care system, not the least of which is scrambling to fill huge voids in the data needed to guide and measure progress, a

problem identified decades ago. But New York also has some valuable assets in its work toward equity, including a longstanding commitment to coverage, engaged state agencies, strong advocates, and a pending Medicaid waiver that (if successful) could bring important resources and infrastructure into the game.

The task at hand is best described as "leveling up": encouraging investment by insurers to improve economic opportunities and address community needs; exporting a positive intervention from one market segment to another, and from one health plan to another. Alignment and focus will be critical; policymakers and regulators must also look for opportunities to emphasize how urgent the need for change is. As a group of Black leaders noted in a recent opinion piece on how best to plot a course back from the pandemic: "Everyone keeps saying 'We can't wait for things to get back to normal,' and we say, 'We're not going back to normal. We died in normal.'"

Introduction

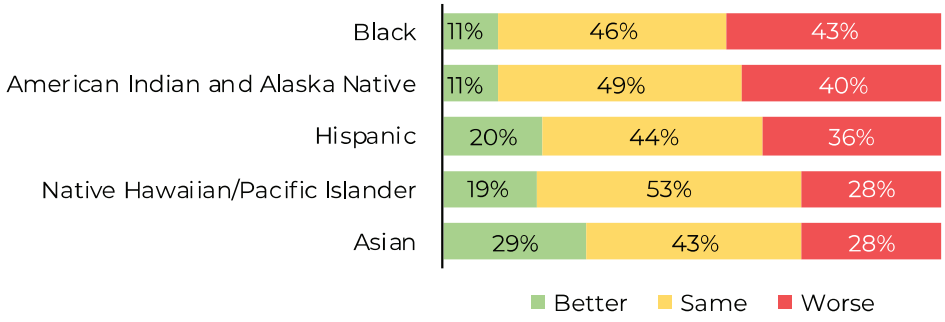
Decades of warnings and the shameful path to now

This year marks the 20th anniversary of the publication of the landmark Institute of Medicine report *Unequal Treatment*,[1] which found that even after access and socioeconomic factors are accounted for, "race and ethnicity remain significant predictors of the quality of health care received," and analyzed a series of potential interventions. And almost 40 years have passed since the Department of Health and Human Services released the landmark Heckler report,[2] which concluded that over 60,000 excess deaths occur each year because of health disparities. Action plans, roadmaps, frameworks, and guides on how to tackle the problem abound[3] as well. But while the importance of social drivers of health on well-being is now far better understood than it used to be[4] and care has generally improved, significant disparities persist[5]—even as these anniversaries of past calls for action on the shameful inequities of the U.S. health care system keep piling up. This report highlights notable health equity initiatives underway by health plans in New York and other states to map out the range of opportunities to improve health equity.

Since 2000, according to the 2021 National Healthcare Quality and Disparities report (see figure below), disparities have narrowed for only about 8% of measures for American Indian and Alaska Native populations, 2% of measures for Asian populations, 3% for Black populations, 4% for Hispanic populations, and 10% for Native Hawaiian/Pacific Islander populations. More than 43% of quality measures were worse for Black groups in 2021, when compared to white groups, since 2000. The slow pace of change was underscored by the starkly disparate impact of the COVID-19 pandemic on Black and Latine Americans (who died at twice the rate[6] and were hospitalized at three and four times the rate of white Americans),[7] whose deaths and suffering provide a kind of silent rebuke: *you were supposed to do something about this.*

2021 NATIONAL HEALTHCARE QUALITY AND DISPARITIES REPORT, AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

Percentage of quality measures for which racial/ethnic groups experienced better, same, or worse quality of care compared to white patients, most recent data year...



But this deadly interval—along with the murder of George Floyd and other Black Americans that followed just months after the COVID-19 lockdown—has focused renewed energy on achieving health equity and addressing the social determinants of health by all sectors of society.

Health plans are just one player in the effort to improve health equity, but an important one, since they straddle the "river" of equity interventions—upstream, downstream, and midstream—touching all aspects of health care delivery. They enroll and engage members, execute state and federal policy initiatives, craft benefit packages, credential and contract with the provider networks on whom equity relies, and compile enrollment and encounter data. Because of government, employer, and individual premium payments, health plans bring enormous resources and leverage to bear. In some ways, insurers are the stewards of those funds and the health outcomes they produce, including, regrettably, the estimated $93 billion spent annually in *excess* medical care costs ascribed to racial inequity.[8]

First, A Look in the Mirror

Some plans' equity efforts start at home

Key Takeaways

Some insurers actively pursue internal diversity, equity, and inclusion programs and publish the results, so they can be held accountable.

A survey of California insurers found that 20% had no women on their boards and 35% had no racial or ethnic diversity on their boards.

Action Option

New York could weigh the benefits of requiring insurers to publicly report on the diversity of their boards of directors and senior management.

In the wake of the tragic murder of George Floyd and the social unrest that followed, the National Association of Insurance Commissioners (NAIC) was prompted to examine the insurance industry's own legacy of racism, which includes redlining (typically associated with banking institutions) and a range of discriminatory underwriting and pricing practices.[9] Among its sensible first steps was establishing workgroups to examine the diversity of both insurers and regulators, and to develop approaches to improve equity in insurance markets.[10]

Many insurers were spurred to action as well, including Connecticut-based Cigna, which reported over $1.7 billion in health insurance premiums for New York in 2020, mostly from the commercial group market.[11] The company's 2021 report on its health equity activities features a scorecard, to be issued annually, that highlights "aspirational goals" and provides detailed breakdowns and salary ranges for employees and directors based on several dimensions: gender, race, ethnicity, LGBTQ+ identification, and military service.[12] A New York plan made a similar commitment. In a preface to the initial 2021 diversity report for Excellus BCBS,[13] a nonprofit that operates in 31 counties upstate, the company's director of diversity, equity, and inclusion notes that "my job is to disrupt the status quo—and I'm in the right industry to do just that. Health care is historically a white, straight, male-led, and conservative industry." The report highlights Excellus's own DEI program, setting out the steps it is taking toward inclusion and equity goals, and provides a detailed breakdown of its nearly 4,000-member workforce by gender, race, ethnicity, and age; in 2021, the company reported a 17% increase in employees of color compared to 2020. In 2021, Excellus also appointed a vice president of health equity and community investments,[14] who guides regional community investment strategies, working in tandem with regional advisory boards.[15]

As part of its Insurance Diversity Initiative,[16] the California Department of Insurance conducts an annual survey of diversity on insurer boards of directors and publishes its results. A 2020 presentation that included 260 responding insurers reported that 20% had no women on their boards, and 35% had no racial or ethnic diversity on their boards, signaling that there is still room for improvement.[17] New York's Department of Financial Services issued a regulation in 2021 requiring insurers to report diversity data on their boards and senior management, but has yet to publish the results of the inquiry.[18]

Investing in Communities to Address Social Needs

Ensuring "giving back to the community" isn't an empty catchphrase

Key Takeaways

Many health plans make investments to help meet the social needs of their communities, but these investments should be viewed in the context of the considerable resources health plans command.

Action Option

One option for New York would be to formally incorporate an assessment of community investment opportunities focused on health disparities or health equity into the review of transactions or applications requiring regulatory approval.

When BlueCross BlueShield (BCBS) insurers in western New York and Pennsylvania announced plans to join forces in June 2020,[19] it hardly seemed worth noticing. Consolidation among insurers has been commonplace for decades,[20] particularly intra-BlueCross plan activity. This particular affiliation, involving Highmark BCBS and HealthNow BCBS, was notable because state regulators at the Departments of Financial Services (DFS) and Health (DOH) made agreement contingent[21] on the new combined companies making a $10 million commitment to "improve racial and health inequities in western New York and Northeastern NY"—the first time such an equity-based proviso was included in the process. The Highmark/HealthNow affiliation provides a useful illustration of the role health plan investment can play in improving health equity and addressing social determinants of health—and how state regulators and policymakers can seize on opportunities to propagate such efforts.

Experts agree that community involvement at every stage of health equity efforts is a key element of success.[22] As part of its approval of the Highmark/HealthNow agreement, the $10 million investment plan announced by DFS and DOH requires the insurer to "consult with legislators and representatives of local constituencies, health care providers and community organizations, and in good faith take their feedback into account prior to making such expenditures." By the end of the year, Highmark announced[23] its first round of $2.67 million in awards, including free office space in its own headquarters and a $1.5 million grant to the Buffalo Center for Health Equity to "support organization capacity building and a program targeting communities with the greatest health disparities, including a blood pressure control pilot project in partnership with the American Medical Association." The Center[24] works closely on health equity issues with local organizations, such as the University of Buffalo Community Health Equity Research Institute.[25] It focuses on five zip codes in East Buffalo where residents suffer from much higher rates of poverty, chronic disease, and premature death.

Highmark's other grants address more specific social needs and are more typical of those made routinely by most health plans. A $370,000 grant to Buffalo Go Green[26] will support a mobile unit to provide meals, cooking demonstrations, and health and wellness programming. A $300,000 grant to the Whitney M. Young, Jr. Health

Center[27] in Albany will help the center expand its mobile health unit program and hire a social health engagement specialist.

New York health plans have long provided this type of community support, something of a fixture in the state's unusual health insurance marketplace—a mix of national for-profit plans, provider-sponsored plans, and nonprofit plans in New York City and upstate with roots in the communities that supply the enrollment. For example, Highmark BCBS competitor Independent Health Association (IHA), an HMO formed in Buffalo in the early 1980s, focuses on "bringing health and wellness to the areas with the greatest health needs"[28] through the plan and a foundation it created. Many health plans have established foundations to target their giving, often in conjunction with employee volunteers. IHA's projects involve healthy food and nutrition, as well as promoting physical activity through a medically oriented gym, youth soccer, and other programs. The company estimated that it contributed more than $25 million in community investments in 2020, through direct expenditures and in-kind contributions such as employee volunteers.

Health plans' investments do lift up communities, but they are also a relatively inexpensive marketing tool; it's important to view these contributions in the context of the resources that health plans command

Excellus BCBS, headquartered in Rochester, perennially one of the poorest cities in the U.S.,[29] provides a range of support for community programming in addition to its internal efforts. In 2021, the company announced $388,000 in "health equity awards"[30] to nonprofit groups undertaking initiatives to provide home visits for young mothers, assist domestic violence survivors, and improve nutrition "for people of color and immigrants." The company also awards multiyear grants focused on improving health equity and launched a maternal health equity initiative in July 2022.[31] [32] As part of its community commitment, another regional nonprofit, Albany-based Capital District Physicians Health Plan (CDPHP), created a bicycle-sharing program in partnership with the local transit agency,[33] and opened a pharmacy when a long-tenured community drugstore closed. CDPHP also partners with local nonprofits on a variety of programs to meet members' housing[34] and nutrition[35] needs. Housing assistance is a priority at MetroPlus, which is sponsored by the New York City Health + Housing Corporation. The plan assesses members' housing needs through all care management programs, and partners with a range of city agencies and nonprofits to tap local and federal resources to help members transition from homeless shelters to permanent housing.[36]

Health plans' financial support takes many forms and is no doubt important to the communities being invested in, but they are also a useful and relatively inexpensive marketing tool; some health plans have special portals for requests for community golf outings in support of charitable causes. It is important to view these contributions in the context of the resources health plans command. Excellus BCBS

is one of the largest insurers in the state, with revenues of over $6 billion in 2020.[37] And the IHA report[38] of $25 million in community investments includes more than $16 million in required surcharges and taxes paid through New York's Health Care Reform Act, which assesses all insurers and self-funded employers to support a range of state health initiatives.[39]

Some local leaders in western New York argued that the $10 million commitment by Highmark BCBS was not enough, citing much larger charitable asset set-asides by insurers undergoing full-blown mergers recently.[40] Highmark officials responded that its affiliation differed, and that the equity awards were in addition to ongoing community support that would bring its total to $70 million over 10 years. Still, it did not go without notice that Highmark BCBS also acquired the naming rights to the Buffalo Bills football stadium in 2021; although the terms of the deal were not disclosed, newspaper accounts indicated that the Bills' owners were seeking $4 million annually for the rights.[41] Schenectady-based MVP Health also got into the naming rights game in 2021 with its successful bid for the former Times Union Center arena in Albany. That $2 million annual contract does include something of an equity component, including establishing a year-round farmers market at the facility and improvements to a public recreation area.[42] The company also launched an innovative nutrition program for neighborhoods with poor food access, purchasing about 20 coolers for convenience stores and arranging for a local nonprofit to stock them with vegetables at wholesale prices.[43]

Investments Further Upstream

Partnerships for housing and other capital needs

Some insurers, typically large national plans operating in multiple states, invest in both services and the capital needs of communities; this section looks at some of these broader approaches to health equity followed by large plans, particularly housing assistance. While large insurers generally are posting significant profits[44] and Medicare Advantage plans have come under fire of late for a range of unsavory practices,[45] many of the carriers have made substantial commitments to the communities they do business in.

Key Takeaways

In 2020, major New York insurers operating in public and private markets reported almost $16 billion in invested assets and over $45 billion in revenue.

Some insurers are working with government and local partners to meet communities' capital needs, such as affordable housing.

Action Option

New York could evaluate whether creating a structure to facilitate these upstream investments would advance equity goals, and revisit how it regulates health plan investments and expenses to reduce disincentives.

Humana, Inc., a plan based in Louisville with a modest presence in New York's Medicare Advantage market, has a thoughtful approach to population health and health equity.[46] Housing is one of the company's focus points, and in addition to underwriting supportive services and legal services to prevent eviction in some of its markets, it also invests in affordable housing. In September 2021, Humana announced a $25 million investment to increase affordable housing supplies in several states, not including New York.[47] The investment was channeled through three separate syndicators, which will work with other investors and developers to identify potential sites for rehabilitation or new construction. The syndicators have access to low-income housing tax credits,[48] a federal program administered by states that allows investors to deduct a portion of the funding they provide from taxes they owe; New York has also authorized a companion state credit.[49]

UnitedHealthcare, another national insurer and an active participant in New York's public and private insurance markets through several subsidiaries, followed a similar approach, announcing over $1 million in grants to New York nonprofits in 2020 through its Medicaid managed care plan. These grants supported a range of community initiatives for improved nutrition and behavioral health; a $750,000 grant in 2023 will help federally-qualified health centers hire and train community health workers.[50] UnitedHealthcare's reported $500 million commitment to affordable housing in recent years[51] includes supportive housing projects in Long Island and the Bronx, the latter a partnership with New York State agencies and Enterprise Community Partners, a community reinvestment expert that helped manage distribution of the low-income housing tax credits. United also recently announced a $10 million commitment over 10 years to a special public/private investment fund targeting social needs in the Appalachian region.[52]

Many intermediaries like Enterprise maintain a presence in New York, and these organizations, like community development financial institutions,[53] help spur affordable housing development and address other social needs—such as access to primary care, child care, and nutritious food. Such organizations fill a niche created by the complexity and wide range of tax credits and other incentives aimed at promoting a social good: they use their financial and technical expertise to leverage private and public investment and to navigate and maximize low-income housing tax credits, new market tax credits,[54] and other federal and state funding. The Local Initiative Support Corporation is another intermediary of this sort. It operates the Healthy Futures Fund,[55] supported by a bank and a foundation, and it recently sponsored a development in Brockton, Massachusetts, that included a health center and a supermarket in the same complex—a difficult feat given tax credit restrictions.[56] New York's well-known Primary Care Development Corporation[57] is a community development entity operating nationally with a mission to improve primary care in neighborhoods where residents lack access;[58] it also administers a state-created Community Health Care Revolving Capital Fund for New York.[59]

Spotlight: Regulating (and Encouraging) Investments

Since regulators must guard the solvency of insurers, so there is money on hand to pay claims and reimburse providers, insurance companies' investments are somewhat prescribed. Income earned from investments can also be used to reduce the level of premium increases required. Even so, insurers—acutely aware of how nonclinical factors affect their enrollees' health and medical expenses[60]—have been devoting funds to address social determinants of health. And the assets they can bring to bear are considerable: in 2020, major New York-licensed insurers offering comprehensive health coverage (not counting large insurers licensed in other states that sold coverage in New York, like CVS/Aetna and Cigna) reported over $15.8 billion in total assets invested in 2020, and over $45 billion in revenue.[61] California's insurance regulator guides insurers on making financially sound investments that yield environmental and social benefits.[62] Oregon's SHARE initiative requires coordinated care organizations participating in the state's Medicaid program and meeting minimum financial standards to invest a portion of their net income or reserves on services to address health equity and social determinants of health.[63] In New York, health plans participating in the Medicaid Managed Care program reported collective total losses of $146 million in 2019 and $170 million in 2020, though some individual plans such as Fidelis (Centene) reported strong net income both years ($96.7 and $78.7 million, respectively).[64] Many insurers, however, do maintain reserves that are many multiples higher than regulators require. It may be possible[65] to tap those funds to provide credit enhancements for affordable housing, primary care facilities, or other community capital investments, making it easier for projects to attract lenders or reduce loan costs.

One other important point to consider regarding investments by insurers is how these expenses are treated by state and federal regulators. Under federal rules for minimum loss ratios,[66] insurers must provide rebates to businesses and consumers if they do not pay 80% or 85% of their premiums out in medical care or quality improvement activities. Some community investments may fall into this medical care/quality category; the DFS rules for premium increase applications, however, do not make this distinction, and instead simply calculate the ratio as projected medical claims incurred divided by total premiums. This method allows DFS to keep a tight lid on rate increases for consumers but may act as a disincentive for insurers who wish to make these community investments, since they will be treated the same way as rent, supplies, salaries, and other administrative expenses.[67]

Insurers as Anchors

With purchasing power comes great responsibility

Alongside community investments, some insurers are addressing economic instability in their communities by paying more attention to where they spend their money, and how they recruit and compensate workers. Their activities resemble those of a coalition of major health systems seeking to anchor their communities nationwide through more thoughtful allocation of funds.[68] Certainly, insurers in New York are large employers and spend significant amounts of money on goods and services. In 2020, for example, major New York health plans offering comprehensive coverage reported over $6.5 billion in administrative expenses, a category that includes over $2.8 billion in salaries and benefits, and hundreds of millions of dollars in additional expenditures for auditing, actuarial and other consulting services, legal fees, marketing, advertising, and equipment.[69]

Key Takeaways

In 2020, major New York health plans reported over $6.4 billion in administrative expenses, over $2.8 billion in salaries and benefits, and hundreds of millions more in expenditures for a variety of professional services and supplies.

Some health plans use the procurement process to improve economic opportunity by seeking out a more diverse pool of service providers, and supporting training programs for workers they need.

Action Option

New York could consider efforts to encourage these proactive kinds of procurement activities.

Massachusetts BCBS, although it does not participate in the state's Medicaid program, is an example of a health plan that expresses its equity commitment through an aggressive and transparent approach to supplier diversity, using its purchasing power to support diverse businesses and "helping to build capacity in the business community and by advocating and acting to create a level playing field."[70] The company's most recent annual progress report for the 20-year-old program reports "direct diversity spending" totaling $43 million, a 23% increase over the previous year, and $37 million in support of salaries of workers for companies reached under the program, accounting for 200 jobs in Massachusetts. The

California Insurance Department's diversity program also tracks supplier diversity efforts and works to connect insurers and minority- and women-owned businesses.[71]

Other health plans have found different ways to provide economic support for communities in the short and long term. Excellus BCBS announced in late 2021 that it had raised its minimum wage for employees to $18 per hour, from $15, well above the general upstate New York minimum of $13.20.[72] The company estimated that more than 600 workers would see wage hikes, about 15% of the company's nearly 4,000 employees. Healthfirst, the Manhattan-based, nonprofit plan that is sponsored by hospitals and focuses on public programs, is trying a creative approach to filling its data processing needs: it partnered with a technology services company to create a professional development program to prepare residents of the Bronx—New York's poorest county[73]—for a career in information technology. The company hopes to hire 10 contractors trained in the program initially and about 30 more afterward.[74] As part of its focus on social drivers of health, Highmark BCBS of Western NY took a similar tack, announcing $500,000 in support for a "data analytics boot camp" designed to prepare underrepresented workers for tech careers through a tuition-free course.[75]

Many health plans maintain retail offices to assist in enrollment, but EmblemHealth's "Neighborhood Care"[76] program provides a variety of services at 14 offices in New York City and Long Island to members and non-members alike. Manhattan-based nonprofit EmblemHealth, through its subsidiaries GHI and HIP, participates in all public and commercial markets and also insures many New York City employees. The first office opened near EmblemHealth's lower-Manhattan headquarters in 2012 just after Hurricane Sandy hit, and subsequent office sites have been added based on where members live, proximity to mass transit, and in areas that are underserved. Multiple languages are spoken at the offices, and the company tries to staff them with local residents too. Since the facilities are often co-located with offices for AdvantageCare Physicians, a multi-specialty practice that serves many Emblem enrollees, members can get help with doctor's appointments and other issues. Some of the larger offices log 100 visits a day, and about 130,000 people visited the offices annually, for classes in tai chi, yoga, meditation, cellphone literacy, and chronic disease management. Healthy cooking and eating classes—culturally attuned to diverse neighborhoods like Chinatown and Bensonhurst—are among the most popular events, and farmers' markets are held at each site on weekends.[77] One Boston provider is pioneering a unique community service: it offers tax preparation help for patients, such as determining eligibility for the earned income tax credit.[78]

Provider Networks that Are "More Adequate"

Helping plans meet enrollees where they are

Health care systems and providers have taken up the challenge of addressing health care disparities through a variety of activities, but the concept of what a health care network means is evolving as well. Federal and state laws and regulations establish minimum network adequacy requirements for facilities and providers to meet the full spectrum of enrollees' health care needs in a timely manner.[79] The rules are administered by the state Department of Health, the state Department of Financial Services and the NY State of Health Marketplace (NYSOH),[80] and they govern networks for public insurance programs like Medicaid and Child Health Plus, commercial health coverage for individuals and employer groups, and individual coverage through New York's Affordable Care Act (ACA) marketplace. Some provider types reflect the particular needs of the enrollees in the program, such as Child Health Plus and Medicaid, but there is significant overlap—many provider types are required in multiple public and private programs. Earlier Medicaid initiatives and the exigencies of the COVID-19 pandemic, however, have shifted the focus to new kinds of providers that are disrupting the notion of what is an adequate network.

Key Takeaways

Growing evidence suggests that "racial concordance" between clinicians and patients improves health outcomes, yet the percentage of Black and Latine medical providers continues to lag way behind their representation in the population as a whole.

Action Option

New York could revisit its network adequacy standards and consider a focus on the diversity of provider panels, and the inclusion of new kinds of providers that are being used to deliver services meeting social care needs or who are trusted messengers in communities.

New York's Delivery System Reform Incentive Payment (DSRIP) program,[81] a federal Medicaid waiver program launched in 2014 and wrapped up in March 2020, sought to reduce hospital readmissions by encouraging collaborations between health care providers and community-based organizations (CBOs) to address both medical and social needs. Many promising partnerships[82] were developed under the program to educate enrollees and to increase access to behavioral health, substance use disorder treatment, and other needs such as housing and nutrition. Under the value-based payment component of the initiative, health plans pursuing more advanced payment arrangements were required to enter into at least one health equity contract with CBOs addressing social care needs. Among the more common interventions were food and nutrition, pediatric asthma, and economic stability of families.[83] In some cases, these benefits were delivered through new technology platforms developed to help health plans connect their members to services through databases of local community-based organizations, organized by type of service and neighborhood or zip code. In the teeth of the pandemic, Healthfirst turned to one such entity, NowPow (now owned by UniteUs), making the app available on members' phones

through their Healthfirst app. Customer service also used the app to connect members to needed social services.[84]

In the Albany area, Healthy Alliance[85] (formerly known as the Better Health Alliance) is another new high-tech social care network. It was originally formed by a DSRIP Performing Provider System covering six upstate counties and is now growing far larger. The organization (also partnering with UniteUs)[86] continues to manage a social care network, and it formed what it calls an independent practice association (IPA) in 2018 with a subset of its network members to help social care providers contract with insurers. The organization views itself as a "public utility" model with over 580 partners in 26 upstate counties, offering 1,350 separate programs and with over 3,500 users of various types serving 26,000 community members. Services supplied by Healthy Alliance IPA include collecting data on screening and service connections, providing and monitoring referrals and other activities, and helping users with technical and payment issues.

Building on these earlier efforts, New York's pending New York Health Equity Reform waiver amendment [87] presents a multi-faceted strategy to scale these earlier initiatives up. Under this plan, inclusive Health Equity Regional Organizations (HEROs) would develop data-informed regional needs and priorities to be carried out by plans and providers. New Social Determinants of Health Networks (SDHNs) would be charged with organizing CBOs to address the full spectrum of social needs in a region. Increased support for equity-focused, value-based payment arrangements is also an important part of the proposal. An open question is whether additional financial support proposed in the amendment will be enough to allow CBOs to adapt their own data systems to electronically transfer social needs data safely and securely among multiple plans and providers (particularly given plans' interest in "closed loop" referrals, in which they are notified of the results of an intervention in a timely fashion)—or to take on meaningful financial risk through value-based payment transactions.

Enlisting CBOs effectively improves the diversity of local provider networks—and lessens enrollees' mistrust of the health care system

One hidden benefit of enlisting CBOs in the delivery of social care benefits is that foregrounding local organizations and community health workers helps connect enrollees with trusted sources of information and assistance—in effect improving the diversity of local provider networks, and ameliorating enrollees' mistrust of the health care system, long a problem. State and federal minimum network standards typically focus on the number and types of providers but are largely silent on the race, ethnicity, gender or sexual orientation of providers, and the languages that they speak. As evidence mounts that "racial concordance"—patients and providers who share the same racial identity—is associated with improved outcomes, lower expenditures, better primary care, and other positive results[88]—underrepresentation

of minorities in the health care profession is still troubling. As one report summarized, "a preponderance of scientific evidence supports the view that a diverse health care workforce constitutes *a compelling national interest*... [emphasis added]," yet it found that while the gender gap has been effectively closed, less than 12% of U.S. physicians identify as either Black or Latine, although the percentages of these groups in the U.S. population are 18.3% and 13.4%, respectively.[89] The same study, reviewing medical school matriculation for the past 40 years, found that Black men accounted for 3.1% of the national medical student body in 1978 and 2.1% in 2019.

New York rates are very similar,[90] though there has been a 2022 uptick in Black medical school matriculants[91] and recent progress in licensing of Black nurse practitioners (NPs), which exceed their presence in the state population, though Latine NPs still fall far short.[92] Certainly additional resources are required.[93] It may be that existing programs involving loan forgiveness to address shortage areas or to increase the pipeline from underrepresented communities into the health professions should be revisited, refocused, and strengthened.[94] One recent study[95] (and an accompanying webinar discussion) stressed the importance of pathway or "pipeline" programs focused on underrepresented groups, which provide young people with academic and financial support at an early age and encourage them to follow an academic medicine career without fear of crushing debt (since assuming future support through a loan forgiveness program would be highly speculative). The report suggests several ways to fix "leaky pipes" in such programs.

Though fostering a diverse health care workforce is a compelling national interest, profound underrepresentation persists

Health plans, grappling with provider shortages and understandably leery of being held solely accountable for network diversity under current stresses,[96] may have a role to play, given their resources and relationships with providers and health systems. An Illinois Blue Cross plan, for example, recently created[97] an Institute for Physician Diversity in partnership with academic medical schools, teaching hospitals, and nonprofit associations to increase the supply of physicians from underrepresented groups. L.A. Care Health Plan, a large Los Angeles County public plan, recently made a $155 million commitment to a diversity initiative that includes recruitment bonuses, loan forgiveness, scholarships, and training.[98] The Washington, D.C. marketplace, the DC Health Benefit Authority, adopted a 2021 resolution to require plans to provide incentives for primary care and specialty physicians to practice in underserved areas, and to provide scholarships for STEM students and medical students of color in health professional schools in the area.[99]

Spotlight: Cultural Competency

In the shorter term, several other initiatives under consideration by the NAIC working group seek to breathe life into the application of the federal Cultural and Linguistically Appropriate Services (CLAS) standards introduced in 2010 by the Department of Health and Human Services and refreshed more recently as part of the agency's Think Cultural Health campaign.[100] A workgroup on the NAIC's special committee is examining a range of options on the "role of the insurance sector in increasing diversity and cultural competency in networks,"[101] with an eye on network adequacy standards and provider directories for consumers.

Contracts[102] for New York's Medicaid Managed Care program include extensive requirements for cultural and linguistic competency, including training of staff, certification that participating providers are trained, and the development of a comprehensive plan that includes a community needs assessment identifying important populations in each service area, a requirement that might be considered for other types of coverage. Although New York lawmakers recently adopted legislation requiring certain real estate professionals to undertake training in cultural competency,[103] a federal tracking map groups New York in a category of states where legislation to require cultural competence training for health providers has been introduced but not passed into law.[104] Relatively minor regulatory changes, such as allowing providers to file a single certification of completed training for all the insurers with whom they contract, in all lines of business, would relieve providers of an administrative burden.

"The provision of health services that are respectful of and responsive to the health beliefs, practices, and needs of diverse patients can help close the gap in health outcomes. The pursuit of health equity must remain at the forefront of our efforts; we must always remember that dignity and quality of care are rights of all and not the privileges of a few."

Think Cultural Health (HHS)

California requires cultural competency training for all health care providers,[105] and it recently added a requirement that continuing education courses also include training in implicit bias.[106] Under the DC exchange's new standards, health plans must ensure that their network providers complete detailed cultural competency training annually; review provider networks to determine the race, ethnicity, and primary language in order to establish a baseline; and then develop a 5-year goal to improve diversity.[107] New regulations[108] preparing for the "public option" plan in Colorado will require plans to collect data from their network providers and front office staff (on a voluntary basis) on their race, ethnicity, sexual orientation, gender identity, and disability for inclusion in the provider directory.

To compare or use plans, many health plan enrollees or prospective enrollees turn to state-maintained or health plan websites, another arena for diversifying

communication and outreach—or failing to. Generally, the plan websites are more extensive than the marketplace provider search, which links to a NYS DOH site that can be used to compare plans and identify the plans with which specific providers and facilities participate. Although only a Spanish translation is shown as a prominent link, translation services are available, and providers can be screened for spoken languages.[109]

Reviewing their materials shows a wide range of approaches at individual plan websites. MetroPlus's website, reflecting the diversity of its New York City service area, was instantly translatable into 12 languages. Some websites were only available in English, though many offered Spanish translation toggles, and some offered both Spanish and Chinese. Health plan websites typically include links to a "find a doctor" function, sometimes varying by product, and these applications also vary in usefulness to enrollees with limited English proficiency; most offer the same number of translations as the homepage. The websites usually include screening tools to find providers who speak different languages; some display this feature prominently, while others require a consumer to already be enrolled in the plan or to conduct an "advanced search" or similar process. Some websites also indicate whether a provider's office includes staff who speak additional languages, a helpful addition.

Empire BCBS HealthPlus, the New York subsidiary of Elevance Health (formerly known as Anthem BCBS) allows consumers to screen providers by race and ethnicity, rare among the websites surveyed; it also includes links to a downloadable directory with icons indicating whether a provider has completed cultural competency training.[110] The web-based provider directory[111] for UnitedHealthcare public program enrollees includes listings of spoken language and the ability to select providers with special cultural competence, in such categories as disability, LGBTQ identification, and status as refugee, immigrant or financially challenged. New York policymakers and regulators recently moved to protect the LGBTQ population from discrimination, inform them of their rights under state health insurance laws, and remind insurers of their obligations.[112] Helping these consumers find trusted providers could improve health outcomes.

The Biden administration recently took a different tack in approaching these network adequacy needs, requiring[113] that federal marketplace plans increase the proportion of "essential community providers" available to consumers, a category of providers that includes federally qualified health centers and hospitals serving a disproportionate share of uninsured patients; there are currently over 1,000 in New York.[114]

Consumer advocates also stress the importance of regular "secret shopper" exercises to test the accuracy and adequacy of provider networks, particularly when it comes to scheduling appointments.[115]

Driving Equity Improvement Through Benefit Design

Broadening benefits to address pressing social needs

Just as Medicaid and Medicare initiatives are spurring innovations in provider networks, benefit-related regulatory changes for the two public programs are also pushing the envelope on enrollee benefits. The Centers for Medicare & Medicaid Services sets rules for Medicaid benefits, and states may add more from a menu of optional benefits, such as prescription drugs. The agency recently authorized new benefits "in lieu of services" already provided, and states like New York have in turn encouraged Medicaid managed care plans to provide medically tailored meals to certain enrollees,[116] a benefit shown to produce better outcomes for diabetes patients and others.[117] Other plans have introduced social determinants of health interventions through authorities for community care coordination services and value-added services.[118] Some Medicaid plans have worked to help lower-income members obtain smart phones through existing assistance programs in order to access telehealth services.[119] Healthfirst is partnering with the Mt. Sinai Health System and the New York Legal Assistance Group to provide legal services to enrollees facing "health-harming" legal situations, such as eviction.[120] Other states have greatly expanded on these authorities through federal waivers or legislation.[121] California's Medicaid waiver (Cal-AIM) contains a number of community supports that plans are encouraged to provide, such as extensive housing transition navigation services and housing deposits, including rental security deposits and the first month's coverage of utilities.[122]

Key Takeaways

The Medicaid and Medicare programs are increasingly encouraging health plans to provide benefits to address social needs, such as food insecurity, unstable housing, asthma, and loneliness.

Action Option

New York could also revisit its benefit standards and cost-sharing provisions to determine if there are opportunities to reduce health disparities.

Similarly, CMS sets benefits for Medicare, but it also allows insurers offering Medicare Advantage plans to include certain additional benefits. Enhanced benefit authority for plans beginning in 2017 now includes supplemental benefits for chronically ill beneficiaries, including food, medically tailored meals, pest control, physical improvements to their homes, and general financial support.[123] Such supplemental benefit offers are increasing in New York and the nation.[124] In 2021, one plan in the Albany area provided a companionship benefit[125] to Medicare Advantage members in response to mounting evidence on the health effects of social isolation.[126]

Benefits addressing social determinants of health are not as common in the commercial market, which is subject to different rules and market forces. Except for preventive care and some other federal requirements, larger employers set benefit

levels in self-insured arrangements for the most part, and New York's insurance law[127] establishes minimum benefits for employer groups with over 100 employees in fully insured plans. Benefits for New York's marketplace plans (the Essential Plan and qualified health plans, or QHPs) and employer groups with 100 or fewer employees are based on ACA requirements for essential health benefits, updates to a federal list of recommended primary and preventive care services, and the small group plan option selected by New York early in the ACA implementation as its benchmark plan.[128]

Federal rules have provided states with a pathway to update their essential health benefits packages

Under those standards, health plans are required to provide dietitian services and test strips and other supplies for diabetic enrollees, for example—but not food or medically tailored meals for enrollees, whether food insecure or not.[129] Screening for bone mineral density, breast cancer, and prostate cancer is required under New York's state Insurance Law benefit requirements, but there are no provisions for screening for social determinants of health. New York's marketplace is requiring insurers to provide social determinants of health screening for at least 75% of their Essential Plan (EP) members (but not QHP enrollees) in 2023.[130] The new EP requirement tracks federal guidance for screening and the National Committee for Quality Assurance screening measures added to its Healthcare Effectiveness Data and Information Sets (HEDIS) reporting requirements.[131]

Federal rules, including recent updates, have provided states with a pathway to update their essential health benefits packages, and several states have refreshed their benefit lists to provide new benefits and remove barriers to drug treatment or gender-affirming care.[132] The new CMS final rule for exchange plans refines guidance on discriminatory benefit designs, and earlier guidance established a process under which states can exempt alterations to the essential benefit package from the federal requirement that states "defray" the cost of revised benefits.[133] The Massachusetts health exchange recently announced new health equity standards eliminating cost sharing for several conditions that disproportionately afflict Black and Latine enrollees, such as diabetes, asthma, coronary artery disease, and hypertension,[134] and the DC exchange is taking a similar approach.[135]

Risks of Bias from Artificial Intelligence and Clinical Guidelines

Because technology trained on racist systems will act in racist ways

Just as digital tools, telehealth, and apps are now part of consumers' health plan experience, the use of artificial intelligence, also known as machine learning, has become increasingly common in making decisions about allocation of health care resources.[136] But pioneering research in the uses of artificial intelligence in health care, often through complex algorithms used to determine "who gets what," has uncovered bias in formulas that prop up inequitable care. These include predictive analytics based on anticipated health spending that deprive Black patients of special care to prevent a hospital readmission and [137] algorithms guiding decisions in cardiology, nephrology, obstetrics, and urology. An exhaustive House Ways and Means Committee report recently catalogued the way race is misused in basic clinical decision support tools.[138]

Key Takeaways

There is growing evidence that increasingly prevalent machine learning programs, clinical guidelines, and artificial intelligence (AI) tools used to make care decisions are racially biased.

Action Option

Since they might develop such tools for sale to customers, use them for utilization review activities, or contract with providers who are using these AI tools, health plans are in a good position to serve as stewards that protect against racial bias affecting clinical decisions.

A "playbook" issued by AI researchers on identifying and fixing algorithmic bias highlights the importance of "stewards" who are accountable for algorithmic oversight in an organization. [139] This would seem to be a natural role for health plans, since they may own affiliated companies that are developing machine learning tools for sale or use by other entities, rely on them for their own utilization reviews, or contract with providers who use these tools. Following recently enacted legislation, Colorado is establishing guidelines for insurers to follow when large amounts of external data are used so that discriminatory effects can be removed.[140] As part of its health equity efforts, Pennsylvania is working with Medicaid managed care plans to mitigate bias in the algorithms plans use.[141] The DC benefit exchange adopted rules[142] that require carriers to review clinical algorithms and diagnostic tools for biases and inaccuracies and file corrective plans when needed; the agency will report aggregate outcomes to alert other plans and providers. Other researchers are using algorithms to detect and uproot bias in health care and to deliver better care,[143] efforts to which carriers could contribute.

Excellus BCBS reported a multi-faceted approach to combat racial bias from machine learning and artificial intelligence models. The company's data team is working to manage bias in the models it uses, and language to identify and address bias in algorithms will be added to its new contracts with vendors. Excellus also reported taking part in a community initiative to eliminate the use of race-based medicine, such as kidney function measurement. Finally, the company is working on acquiring key data points around health equity to test and mitigate bias in the future.[144]

Employer-Sponsored Insurance

Large employers have a vital role to play in improving health equity

While health equity efforts commonly focus on public program coverage, many of the same problems can be found in employer sponsored insurance (ESI), New York's largest source of coverage, with enrollment that approximates Medicaid Managed Care, Medicare Advantage, Child Health Plus, the Essential Plan, and qualified health plans combined.[145] A 2020 study[146] estimates that about 78% of workers at private-sector establishments are eligible for ESI in New York, eligibility that probably disqualifies them from accessing low-cost Essential Plan coverage or premium tax credits through the marketplace. Overall, about half of Black and Latine workers are enrolled in coverage through their employers.[147]

Key Takeaways

Employer-sponsored insurance (ESI) is the largest source of coverage in New York, and, although many of the same inequities are found in commercial coverage as in public programs, little attention is paid to this market segment.

Action Option

Encouraging large employers to support equity-focused programs—such as varying premium contributions from employees based on salary range—might help reduce economic barriers to access among lower-wage workers.

For lower-income workers with ESI, cost burdens can be high. Average annual deductibles for New York private sector workers with ESI were $1,775 for individuals and $3,657 for families in 2021.[148] According to recent census data, about 3.18 million New Yorkers earning less than 400% of the federal poverty level ($51,520 for an individual and $106,000 for a family of four) were enrolled in "private insurance," mostly job-based coverage through employers or unions.[149] ESI policyholders earning less than 200% FPL spend an average of 10% of their household income on premiums and out-of-pocket payments, and as much as 14% if a family member is in fair or poor health.[150] A national analysis rates a quarter of workers with ESI as "underinsured" based on their premium or out-of-pocket costs.[151] One recent study found that one-third of food-insecure people in the U.S. are privately insured,[152] while another found that lower-income workers with commercial coverage faced difficult social determinants of health: emergency department overutilization; higher prevalence of diabetes, obesity, and behavioral health issues; decreased use of preventive services; and greater likelihood of living in areas with poor access to food.[153]

Most employer plans provide some sort of wellness benefit to workers, such as smoking cessation or diet help, but some insurers and employers have moved more aggressively to address the disparities that might arise among those with ESI, given the affordability pressures that might cause workers to postpone or cancel needed care. For example, one UnitedHealthcare program[154] uses de-identified claims data to proactively identify who is most likely to need support with social determinants of health. Call center staff contact employees potentially in need of assistance and

can then help these enrollees access nutritious meals, obtain internet or smartphone access, connect with local support groups, or find financial assistance. According to UnitedHealthcare, eligible individuals have accepted over 50% of the offers of support made through this program.

One core feature of the ESI market to keep in mind is that about 59% of New York private-sector employees are enrolled in self-funded plans,[155] under which the employer bears the risk of coverage and hires an insurer or other entity to administer plans; with the exception of preventive care requirements under the Affordable Care Act, very few state or federal benefit mandates apply. This puts the onus to improve health equity on "plan sponsors" (the employers or unions that organize the benefit) instead of on health plans. A business group recently published a helpful guide on social determinants of health for employers that explains the potential value of social determinants programs—both as support for valued employees and as a way to reduce costs—and supplies a checklist to follow in developing a program.[156] Some approaches for employers interested in promoting health equity for their workers seem obvious but underused: only about one in five employers in a 2021 survey by a prominent health benefits firm[157] structured employee contributions based on pay levels or job grades, and a major annual survey of employer coverage[158] found that only 7% of firms maintained programs to lower cost sharing for lower-wage workers. Creative action by policymakers or strong leadership from employers and union leaders will be required to alter this equation, but work might begin with the state and city of New York first, which cover large numbers of workers, dependents, and retirees, mostly in fully or partially self-funded plans.[159]

A major annual survey of employer coverage found that only 7% of firms maintained programs to lower cost sharing for lower-wage workers

Insurers administering coverage for large groups typically lack detailed data on race and ethnicity because employers sign up employees and dependents during annual open enrollment periods and submit the roster to administrators or insurers. That's the case with a large fund managed by the Service Employees International Union Local 32BJ,[160] which represents about 200,000 workers and dependents, primarily building employees, in New York and the northeast. The union provides health benefits to members through funds that are jointly managed by the union and building owners, with an insurer administering the medical benefit. While the union counts among its membership a high percentage of Spanish speakers, Poles, and Albanians, it lacks comprehensive data on the race and ethnicity of its members. But through the collective bargaining process, the union is able to achieve access goals that help limit disparities for all members, starting with a strong living wage, no required contribution to the health plan by members, and lower cost sharing, with $0 copays at selected providers and a union health facility. Last year, concerned that its maternal outcomes were poorer than those of the general population, the

32BJ fund launched a maternal health program built around hospitals that agreed to meet rigorous quality standards, with support from a team of social workers and incentives for members to participate. A separate fund maintained by the union provides a legal services benefit, including a $1,000 payment toward the costs of attaining U.S. citizenship.[161]

The Need for Better Data (Still)

Without better data, inequities will remain hidden and unaddressed

One could write a book about how important data on race and ethnicity are for improving health equity, and in fact someone did—almost 20 years ago. *Eliminating Health Disparities: Measurement and Data Needs*, a 2004 book-length report,[162] highlighted the importance of race and ethnicity data, and offered thoughtful and practical suggestions for a way past barriers in obtaining and using data effectively. But despite the two-decade head start (and the wealth of related studies issued since),[163] most of the same problems exist today. Much of the rich data is devoid of race and ethnicity (as well as gender preference, disability, spoken language, and economic status), incomplete,[164] or unreliable.[165]

Key Takeaway

Collection of race and ethnicity data still lags way behind what is needed to measure disparities or develop new value-based payment programs targeting inequity.

Action Option

Potential options for New York include clarifying the ability of plans to offer incentives for enrollees to provide the data, and setting specific targets for plans to achieve.

One recent study[166] focused on the need for federal action to improve race and ethnicity data collection, starting with updating the federal Office of Management and Budget's (OMB) 1997 standards to "more accurately reflect the demographics of the U.S. population." Citing "increasing racial and ethnic diversity" and the "growing number of people that identify as more than one race and ethnicity," OMB recently issued a preliminary rule on potential updates.[167] Despite a 2004 insurance industry study that concluded that "there are no legal barriers to the collection of race and ethnicity by health insurance plans,"[168] a recent analysis and survey[169] found lingering concern among health plans, providers, and employers over potential legal liability, and included a detailed analysis to allay those concerns. New York is one of handful of states with regulations,[170] originally intended to protect consumers from racial discrimination, that prohibit insurers from collecting data on race and ethnicity *on insurance applications*. It may be time to revisit that rule or provide some clarification. Rhode Island health plan regulators recently proposed specific targets for health plan collection of race and ethnicity data.[171]

Efforts are underway on several fronts to improve race and ethnicity reporting. Utah, for example, has updated its guidelines for agencies collecting race and

ethnicity data.[172] Racial equality is a centerpiece of the Biden Administration's domestic policy agenda,[173] and federal health agencies have been prodding states to improve race and ethnicity data[174] and providing additional resources.[175] New York regulators have adopted[176] first-time quality measures stratified by race and ethnicity for a handful of conditions promulgated by the National Committee for Quality Assurance (NCQA) for the Healthcare Effectiveness Data and Information Set (HEDIS), national guidelines used by plans and regulators.[177] Some New York insurers participating in Medicaid, Child Health Plus, and the Essential Plan may be eligible for additional payments for improving the amount and accuracy of data reported under state incentive programs. Since health plans participating in the New York State of Health (NYSOH) marketplace rely on enrollment data provided by the marketplace, a successful demonstration project by the NYSOH marketplace with the help of its enrollment counselor partners[178] to increase the amount and quality of race and ethnicity data could make their jobs easier and supplement their own efforts. The program revised the basic questionnaire to better reflect the race and ethnicity of potential enrollees with more modern and inclusive standards, made it a little more difficult to "skip" the voluntary request for data, and, most importantly, carefully explained the reason for the request. Prefacing requests to consumers about race and ethnicity with a detailed rationale for doing so remains a key element of successful data collection, since it was first highlighted more than 20 years ago.[179] California is moving ahead with establishing performance standards on measures stratified by race and ethnicity: both commercial plans[180] and Exchange plans[181] may have to either meet the quality standards that are set or pay assessments into a special fund.

Without adequate data, inequities will remain unseen and unaddressed

As one analyst noted, "without adequate data, inequities will remain unseen and unaddressed,"[182] but better data will also be required to harness progress through equity-focused alternative payment methodologies that many believe are critical to advancing health equity.[183] Propagating value based-payments[184] was the core of New York's DSRIP Medicaid waiver, and it is central to the new waiver amendment under discussion.[185] Many templates have been developed to connect value-based payments to improved equity;[186] a pilot developed by Healthfirst and the Mt. Sinai Health System to improve maternal outcomes provides a good example.[187]

Plans are pursuing a variety of strategies to improve data. At MetroPlus, where race and ethnicity data collection is a priority, the company encourages staff and providers to use all low-stress "touchpoints"—times when enrollees won't feel uncomfortable or threatened by the request—to solicit the information, store it in its own data warehouse, and then use it to fill in missing or incorrect information it receives on state enrollment rosters. EmblemHealth is working on aggregating race and ethnicity data it has gathered from different programs—care management and quality improvement initiatives, for example—all in one place. Excellus BCBS reports focusing on standardizing existing data sets and building the infrastructure

to enhance direct data collection, storage, and analysis for the imputed data it began gathering in 2021.[188]

While voluntary, self-reported race and ethnicity data is the gold standard, a Massachusetts plan chose not to wait. It simply collected as much self-reported race and ethnicity data as it had on over 1.3 million commercial members, redoubled its outreach efforts to members to get more, used sophisticated data tools based on surnames and geocoding to make an educated guess on the data it lacked, and combined them with all the clinical measures it uses. It then published the results,[189] *asked* to be held accountable for improving in areas where the data indicated disparities, and began developing equity-focused payment measures for its providers. Federal Medicare regulators recently outlined a similar indirect method of improving race and ethnicity data.[190] A senior federal Labor Department official, acknowledging the complexity of the data issues, put his finger on the dilemma: "these issues are so important… but we shouldn't view the data as a precursor to taking action. I don't think these issues give us the privilege of waiting until we have pristine data."[191] One simple approach that might be worth a try would be for health plans or the NYSOH marketplace to offer a modest incentive to enrollees who provide the needed data, such as a gift card. Implementing such a program might require addressing some regulatory issues,[192] but it might also significantly improve the data.

Planning, Measuring, and Reporting Equity Efforts

Challenging health plans to do better

Though reliable data from plans stratified for race and ethnicity across markets are still probably years away, there are many other tools to encourage health plans to tackle equity issues and measure their progress in doing so. For example, the ACA requires health plans on the federal or state marketplaces to submit a detailed "quality improvement strategy" annually.[193] These strategies must include a payment component—either incentives to enrollees or a value-based payment adjustment for providers—in one of five categories: quality improvement, preventing hospital readmissions, wellness and health promotion, health information technology, and reducing disparities. The strategies and follow-up reporting are reviewed by state or federal officials, and if they do not meet set standards, corrective action may ensue.

Key Takeaway

Federal and state rules have begun to encourage carriers to submit plans on how they'll address disparities in the care their enrollees receive.

Action Option

Added transparency could help measure the effectiveness of individual health plan interventions, and minor changes in plan reporting to include equity-focused activities is one option that might make it easier for policymakers and regulators to assess individual plan efforts and encourage slower-moving members of the convoy.

Unfortunately, these filings typically fly under the radar—they are usually exempted from public review when insurers invoke proprietary information clauses. A proposed federal rule notes that 60% of plans subject to the federal marketplace rules submitted projects related to reducing health disparities but provides no other details. Greater transparency for these filings could help identify best practices, inform consumers, and hold health plans accountable for their equity efforts. The Biden administration has made one improvement, requiring marketplace carriers to submit a plan for reducing health disparities, along with a project from one of the four other categories. [194] The federal proposal on disparity strategies applies to both federal and state exchanges, so health plans selling qualified health plans on the NYSOH marketplace will be affected as well.

The NYSOH marketplace[195] has also proposed a voluntary program for health plans offering Essential Plan coverage through the marketplace as part of its own quality improvement program. Under the EP Quality Incentive, plans accumulate points for their performance on designated quality measures, and higher-ranking plans earn the higher premium bonuses based on their performance. Announced in February 2022,[196] the program earmarked five bonus points to health plans that voluntarily submitted a Health Disparities Implementation Plan (HDP) in addition to their quality reporting. Plans were also required to work toward meeting a minimum standard for reporting race and ethnicity data. The HDP is required to lay out steps taken by the plan to gather that data and how it will use the data to

improve care. For the program, insurers can earn 2.5 bonus points by submitting a new HDP, which must report back on progress toward meeting the race and ethnicity data and performance improvement goals.

Public reporting would provide a more unbiased snapshot of health plan efforts if some shortcomings were addressed. The main filing for health plans participating in New York public programs, Medicaid Managed Care Operating Reports,[197] includes a lump-sum payment category of "Other Medical" (Line 28), where health plans are instructed to report value-based payments that may be related to social determinants of health, and another category (Line 49) for incentive payments to providers for "in lieu of services" (ILOS) expenses, but without any details. Similarly, the corollary reports[198] for insurers operating in public and private markets—annual statements and supplements based on NAIC standards and filed with regulators—track medical claims payments in a handful of categories (but not primary care) and "incentive payments, withhold adjustments and bonus payments" to providers, but once again without any context on the type of program or goal to which the payments are tied. Legislation[199] approved in 2022 would have required improved reporting by health plans on their primary care spending—another essential element of advancing health equity[200]—and an appointed commission to explore ways to advance primary care, but it was vetoed.

Minor changes to existing reporting requirements would provide much more useful information about health plan equity efforts

ACA provisions instituting national minimum loss ratio standards[201] for insurers (the percentage of premiums that a health plan must pay out in claims or reimburse consumers or businesses) require a separate report, the supplemental health care exhibit (SHCE), with an "improve health quality expenses" section with several subcategories—but it does not require reporting on expenses specifically related to reducing disparities or addressing social determinants of health. In comments on a recent CMS draft regulation,[202] some insurers recommended that a category on social determinants of health be added to the report, but the agency deferred action on that change in the final rule. Another provision in the SHCE includes reporting of dollar amounts for "community benefit expenses," which are reported across different lines of business, but is accompanied by only a short narrative of the general programs the spending supports.[203]

Minor changes to required reporting would provide much more useful information to policymakers, regulators, consumers, and the unions and businesses that purchase coverage. Another option would be a separate annual report on health equity activities, similar to the community benefit report required of tax-exempt hospitals as part of IRS rules and the Affordable Care Act, to hold these institutions accountable for the public subsidies they receive through their nonprofit tax status.[204] While New York's market includes both for-profit and nonprofit insurers, most for-profit insurers participate in markets where public funding is provided,

such as Medicaid, Medicare, Qualified Health Plans, the Essential Plan, or city and state employee health benefit programs. With some adjustments to reporting requirements, New York and other states could also provide guides or rankings of health plans' commitments to health equity for consumers and businesses, much like existing guides focused on quality and customer satisfaction.[205] Massachusetts HMOs report annually on their community benefit activities, based on guidelines issued by their state Attorney General.[206]

In the absence of a state reporting requirement, some plan reports stand out. Humana's report includes data on its Medicare members' "healthy days" in selected markets, adapted from a CDC measure. Kaiser Permanente, the California integrated delivery system, releases one of the most comprehensive reports, detailing quality measures, clinical trials, research projects, support for medical education, economic development, its work achieving a neutral carbon footprint, economic development, and community investments. The company, whose organization includes a community investment committee of the full board and regional community health officers,[207] is unique among health plans in that it reports its community health investments *as a percentage of its operating revenue*.

Outsourcing Equity

Jump-starting equity efforts with accreditation standards

Another option for states is to effectively "outsource" health equity improvements by requiring health plans to achieve accreditation status through the NCQA's health equity certification programs.[208] The most recent program, Health Equity Accreditation Plus (HEA), is based on earlier programs going back to 2010, such as Multicultural Health Care (MHC) distinction, based on the federal CLAS standards. The HEA builds on earlier programs through a focus on collecting data on individuals' and communities' social risk and needs, soliciting input from communities, forming partnerships with community organizations, and setting measurable and specific goals.

Key Takeaway

Some states are requiring health plans to attain a special accreditation in health equity or multi-cultural health to bring focus to health plans' activities and jumpstart equity efforts.

Action Option

New York could consider a similar requirement for its plans as a way of centering health equity efforts.

A handful of states and localities have adopted the NCQA requirement for Medicaid plans, Exchange plans, or both. For example, Pennsylvania requires plans serving the Medicaid population to be accredited for the MHC.[209] After commissioning a study[210] that found positive returns from MHC accreditation in four plans, the Covered California exchange required all pans to achieve the NCQA accreditation by 2023.[211] The DC benefit exchange added

the requirement in 2021, and the Biden administration recently solicited comments on whether NCQA accreditation should be required to participate in the federal marketplace.[212] Some health plan trade associations pushed back on the proposed standard, citing timing issues, costs, and the risks and fairness of requiring compliance with a standard promulgated by a single entity when other approaches may achieve the same result. But adopting such a standard would be a practical way to bundle many first-generation equity tools (such as language and cultural competence) together with newer ones (such as community partnerships to tackle social care needs) into a single process. EmblemHealth (through its HIP licensee) is preparing to attain the NCQA's health equity accreditation in 2023 for all lines of business; Excellus BCBS is preparing to seek it in 2024, also for its multiple lines of business. Only two plans currently hold NCQA accreditation for health equity. UnitedHealthcare recently announced that it had achieved NCQA health equity accreditation for its New York UnitedHealthcare Community plan, which focuses on public programs,[213] and MetroPlus is accredited for health equity as well for its Medicaid line of business.[214]

Conclusion

Leveling up with a much-needed sense of urgency

New York's leaders in government, the provider community, businesses, health plans, and advocates are engaged in advancing health equity and reducing disparities in many ways. While New York compares favorably to many other states on equity,[215] the chasms it must cross to create a truly equitable health care system are enormous and saddening. That said, New York has plenty of advantages in the vital work of advancing health equity.

For starters, New York's earlier coverage expansion efforts and its successful implementation of the ACA have reduced the uninsured rate for New York to the 5% range, far below that of large states like Texas (18%) and Florida (12%). A strong advocacy community has long driven the adoption of consumer protections and coverage enhancements; it has recently been working for fairer treatment of immigrants in New York, including the coverage gap for uninsured immigrants. New York's insurance market includes a mix of for-profit plans, but also many provider-sponsored and nonprofit plans with deep roots in their communities; many of these plans, as outlined above, are undertaking a wide range of innovative programs and investment to counter systemic inequity. Preparation for the 1115 Medicaid waiver amendment has required thinking specifically and creatively about the population Medicaid serves and how to build on earlier initiatives to improve equity. If successful, the waiver amendment would generate new resources and momentum toward a more equitable health care system.

New York also has some other structures in place that could be leveraged toward equity efforts, including a comprehensive Provider Network Data System and Quality Assurance Reporting Requirements that apply across all markets and types of plans, including commercial coverage, which are key pillars for system-wide equity improvements. Although regulation for health insurers is split between the Department of Financial Services, the Department of Health, and the NY State of Health Marketplace housed at DOH, the agencies enjoy substantial regulatory discretion, can tap leverage through contracting and certification processes, and are accustomed to collaborating on important initiatives. The DFS is unusual in that it regulates all kinds of insurers, not just health insurers, as well as banks and other financial institutions. It also manages state and federal community investment initiatives, and it is a leader among regulators in requiring institutions to manage the financial risks of climate change.[216]

In a very important step, DFS recently released a detailed request for information (RFI)[217] to all insurers in the New York market offering fully insured commercial coverage (excluding Medicaid and Medicare) regarding their health equity programs. In an accompanying press release,[218] the agency cited the responsibility of the industry to contribute to greater health equity and said the information request will "establish a foundation from which to build thoughtful, data-driven policy moving forward and evaluate the full impact of existing programs across the entire industry to ensure better outcomes for all New Yorkers." The RFI includes detailed questions on how plans define and identify health disparities, the programs they've developed to address them, spending on the programs as a percentage of overall spending, equity-focused value-based payments or other incentives in use, network adequacy standards, data gathering and regulatory and legal barriers.

Importantly, the RFI signals New York's interest in tackling equity issues in the commercial market as a complement to the public program efforts underway. A truly synchronous approach across market segments could generate huge benefits, such as employer-sponsored plans and insurers tapping the new Social Determinants of Health Networks to provide services proposed under the pending 1115 waiver amendment, thus helping to sustain them, or commercial health plans collaborating to address regional needs identified by the HEROs. In many ways, the task at hand is best described as "leveling up:" encouraging plans to invest or procure in ways that level economic opportunity; migrating a successful intervention from one market segment to another; or requiring a program adopted successfully by one health plan to be implemented by all plans, a way to hurry the slower-moving members of the convoy along.

A commitment to prioritize alignment will be critical to avoid wasteful and confusing friction caused by differing regulatory standards and approaches, whether it's providing guidance on a screening tool[219] or ensuring that social care needs data

are transferred safely and efficiently through the health care system, the subject of an active public/private collaborative effort.[220] Close collaboration and focus will also be needed to implement short-term interventions, while keeping the pots simmering on the longer-term goals. Perhaps most importantly, state leaders and plans could provide a desperately needed sense of urgency. As one group of Black leaders recently wrote about reemerging from the COVID era: "Everyone keeps saying 'We can't wait for things to get back to normal,' and we say, 'We're not going back to normal. We died in normal.'"[221]

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