

EVOLVING NETWORK ADEQUACY REQUIREMENTS TO CLOSE HEALTH EQUITY GAPS

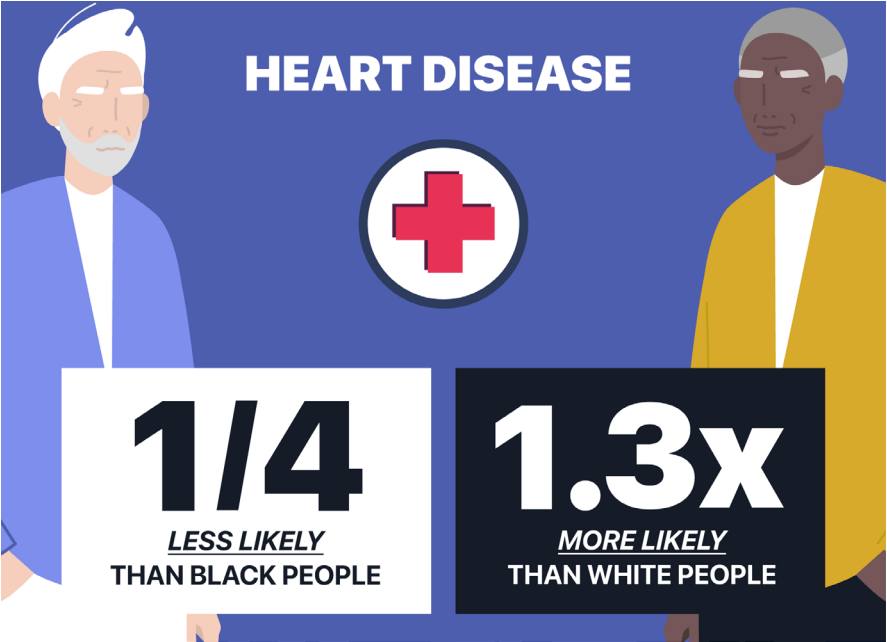
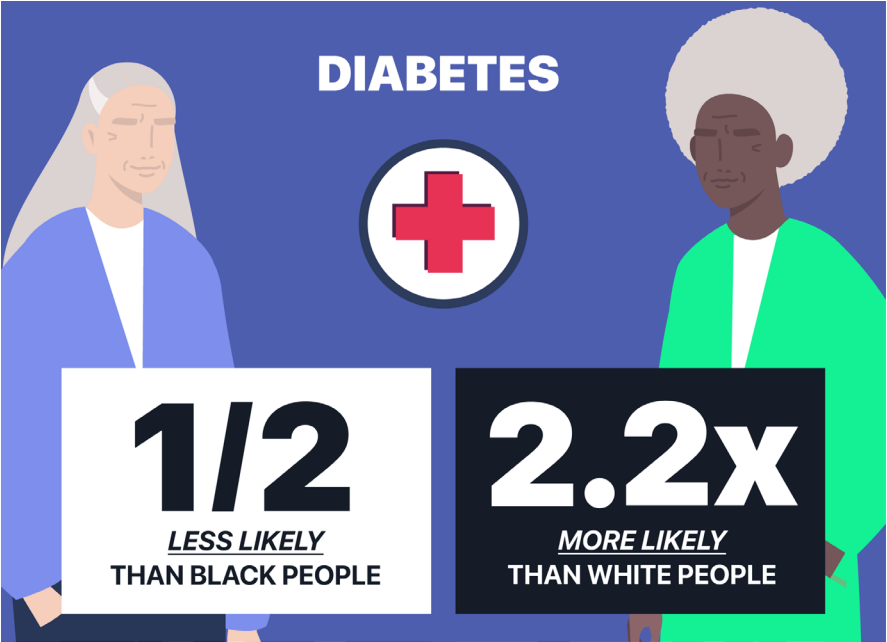
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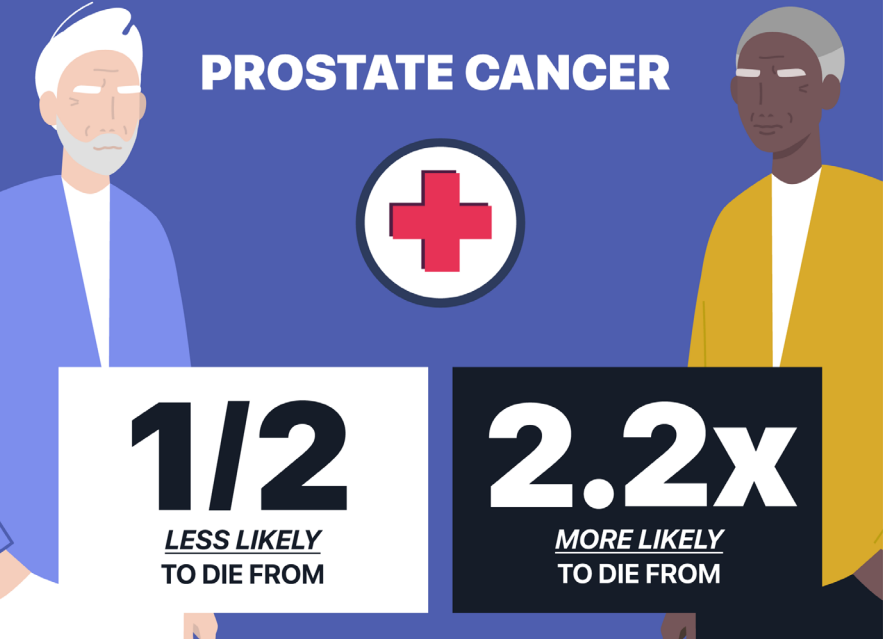
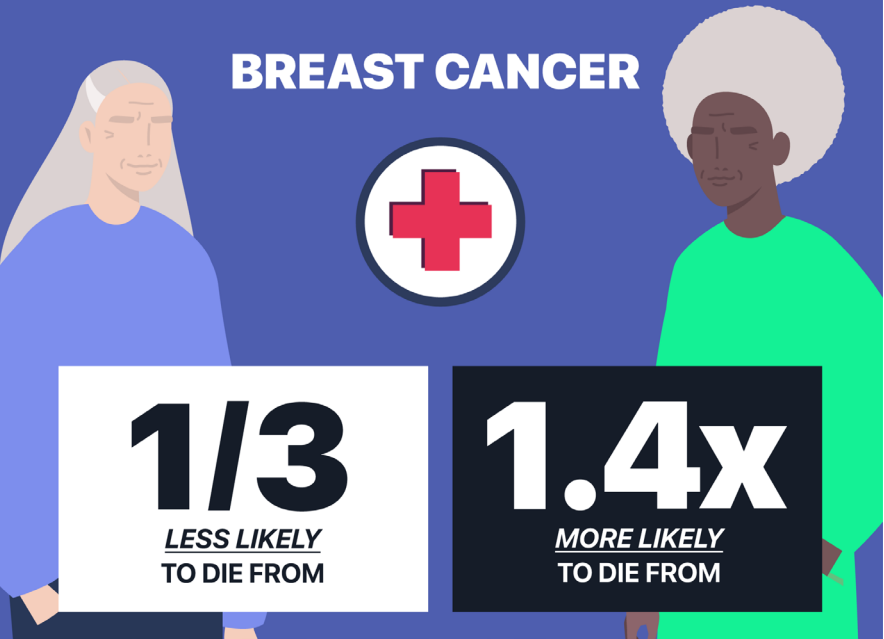
Prepared for NAIC, R&I Workstream #5



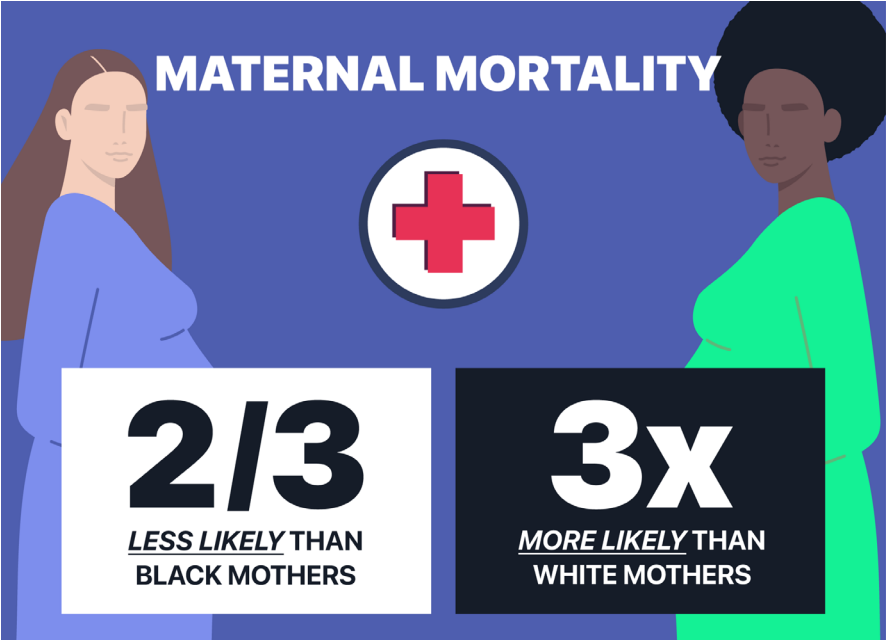
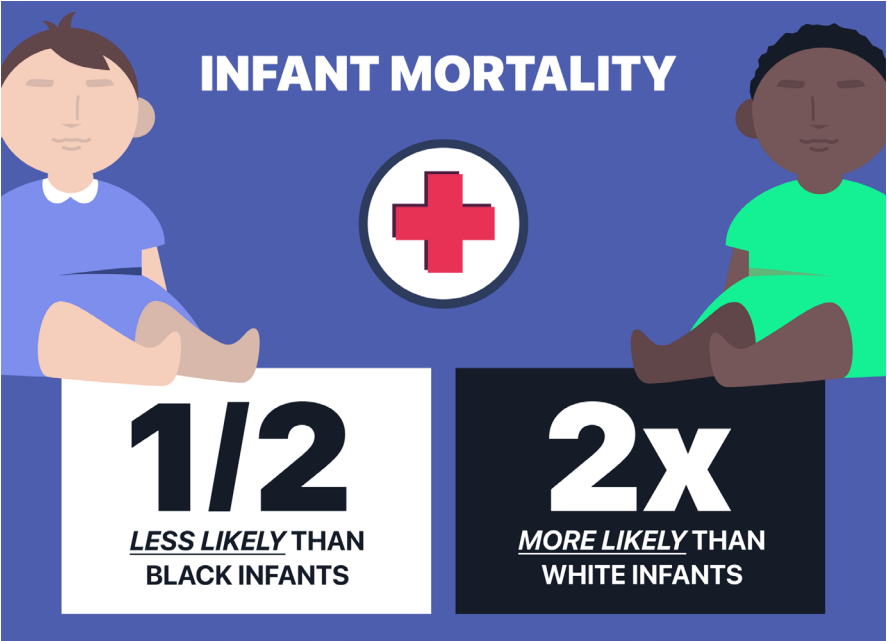
There are enormous differences in health outcomes between White and Black Americans.



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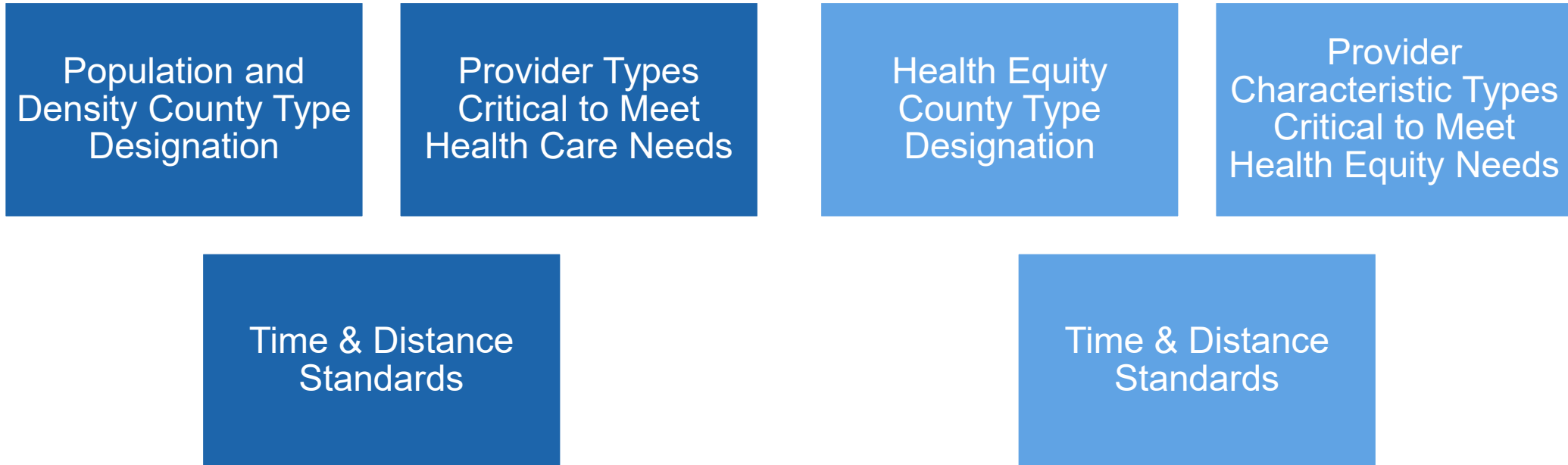


Health Equity Network Adequacy

- Quest Analytics is developing a framework to measure and monitor progress toward improving the health equity standing of health plan beneficiaries
- New standards will help to ensure issuers offer provider networks that meet the critical health equity needs of the population
- The framework has two pillars: (1) A **health equity** county type designation and (2) **provider characteristic types**, including race, that are critical to meeting the health equity needs of the community served
- The framework builds off existing concepts around network adequacy requirements utilized by CMS



Adding a Health Equity Lens to Network Adequacy



Today

- Many requirements to ensure consumers have access to provider and facility types within time and distance metrics
- Based on a population/density county type designation

Tomorrow

- Network standards ensure consumers have access to provider and facility health equity characteristic types within time and distance metrics
- Vary based on a health equity designation



County Type Designations

County	Population	Density
Large Metro	≥ 1,000,000	≥ 1,000/mi ²
Metro	≥ 1,000,000	10-999.9/mi ²
Micro	50k-199,999	10-99.9 /mi ²
Rural	10k-49,999	10-49.9/mi ²
CEAC	Any	<10/mi ²

Today

- Network adequacy is assessed at the county level, and counties are classified into five county type designations based on population and density parameters

County	Foreign Language % of Population*	% of Providers within 1 mile of public transportation*
HE 1	10%	50%+
HE 2	20%	40%
HE 3	30%	30%
HE 4	40%	20%
HE 5	50%+	10%

Tomorrow

- Health equity assessed at the county level with counties being classified into various county type designations
- Beneficiary files configured to direct health equity access measures based on need rather than population density



Establish Provider Types to Measure

Provider Types

- 001 – General Practice
- 002 – Family Practice
- 003 – Internal Medicine
- 004 – Geriatrics
- 005 – Primary Care – Physician Assistants

Today

- Typical standards measure provider specialty types and facility specialty types that critical to meeting the health care needs of the population

Provider and Facility Characteristics

- 001 – Provider Language
- 002 – Provider Proximity to Public Transit
- 003 – Facility Mortality Score
- 004 – In-home Services Provided by Provider
- 005 – Provider Ethnicity

Tomorrow

- Network standards measure provider and specialty characteristic types that are critical to meeting the health equity needs of the population



Time and Distance Measurements

Primary Care/Large Metro	
Time	Distance
10 minutes	5 miles

Provider Language/County Ranking 1	
Time	Distance
10 minutes	5 miles

Facility Attributes	
75% contracted	High performing facilities

Today

- Many standards demonstrate networks do not unduly burden consumers in terms of travel time and distance to the provider types

Tomorrow

- Standards designed to demonstrate networks do not unduly burden consumers in terms of travel time and distance to the provider characteristic types
- Requiring contracting percentages against supply builds of precedent (e.g.: ECP on Exchange)



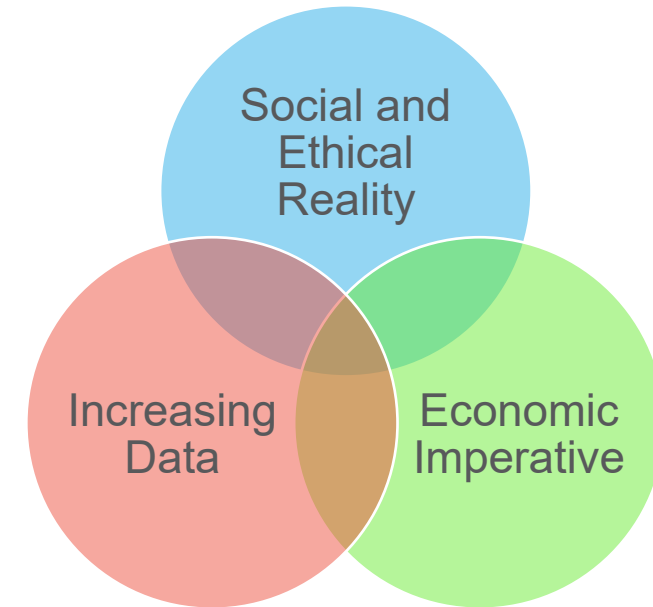
We can't do that!

- We don't have the data
- Clinicians aren't available
- Providers won't contract
- Special interests are too strong
- The data is too sensitive



But We Must

The screenshot shows the Deloitte Insights website. The main article is titled "US health care can't afford health inequities" and is dated June 22, 2022. The article's summary states that health inequities in the US cost \$320 billion annually and could reach \$1 trillion by 2040. The article is authored by Jay Bhatt, Andy Davis, Neal Batra, and Brian Rush. The article text begins with: "Inequities across the US health system limit underserved people's access to affordable, high-quality care, create avoidable costs and financial waste that span society, and impact every individual's potential to achieve health and well-being. To understand how far-reaching this issue is, Deloitte's actuarial team developed a model to quantify the link between health care spending and health care disparities related to race, socioeconomic status, and sex/gender. The team analyzed several high-cost diseases (e.g., diabetes, asthma, and cardiovascular disease), determined the proportion of spending that could be attributed to



What standards would address deficiencies in provider networks, and improve access to INN benefits, for plan enrollees of color?

