MHBE Health Equity Workgroup

Session 2 – September 10, 2021

MARYLAND HEALTH BENEFIT EXCHANGE

Agenda

1:00 - 1:10 | Welcome and Updates
Johanna Fabian-Marks, MHBE Director of Policy and Plan Management
Dania Palanker, co-chair
Sheila Woodhouse, co-chair

1:10 - 1:15 | Vote on Session 1 Meeting Minutes
All members

1:15 - 1:25 | MHBE's Current Race, Ethnicity and Language Data Collection Processes
Becca Lane, MHBE Health Policy Analyst

1:25 - 1:55 | Guest Presentation: Best Practices for Race, Ethnicity and Language Data
Michelle Jester, America's Health Insurance Plans

1:55 - 2:25 | Discussion
All members

2:25 - 2:30 | Public Comment

2:30 | Adjournment

Updates

- Charter approved
- Co-chairs approved
  - Dania Palanker
  - Sheila Woodhouse
- Survey results

MHBE 101 – Overview

- **MHBE is a state-based health insurance marketplace/exchange launched in 2014**
  - Operates the **Maryland Health Connection** enrollment platform (website, app, call center)
  - Serves most **Medicaid** enrollees (1.2M) and legally present people in the **individual market** (165,000 - no affordable employer coverage, ineligible for Medicaid/Medicare)
  - Only source of **financial assistance** for people in the individual market: federal subsidies to cap premiums at 0%-8.5% of income and reduce cost-sharing for low-income individuals, state premium assistance for young adulrts
- **MHBE authority/scope includes**:
  - Conducting **outreach and enrollment** activities, overseeing the Navigator program
  - **Enhancing MHC** to improve the enrollment experience
  - **Setting plan certification standards** for individual market plans sold through MHC. Plan certification standards can encompass features such as plan design (e.g. covering certain services pre-deductible) and information provided to consumers (e.g., giving MHBE provider network data so we can offer an integrated provider directory during plan shopping)
  - Administering the **reinsurance** program and **young adult subsidy** program

MHBE 101 - Purposes of the Exchange

(c) Purpose. -- The purposes of the Exchange are to:

(1) reduce the number of uninsured in the State;

(2) facilitate the purchase and sale **of qualified health plans in the individual market** in the State by providing a transparent marketplace;

(3) assist qualified employers in the State in facilitating the enrollment of their employees in qualified health plans in the small group market in the State and in accessing small business tax credits;

(4) assist individuals in accessing public programs, premium tax credits, and cost-sharing reductions; and

(5) supplement the individual and small group insurance markets outside of the Exchange.

Insurance Article 31-102 Annotated Code of Maryland, *Maryland Health Benefit Exchange*

MHBE 101 – General Powers of the Board/Guardrails

- The Board can take “any lawful action that the Board determines is necessary or convenient to carry out the functions authorized by the Affordable Care Act and consistent with the purposes of the Exchange.”
- The powers of the Board cannot supersede the “authority of the Commissioner to regulate business in the State” or the requirements of the ACA.

Insurance Article sections 31-102(d)(1); 31-106 (b) Annotated Code of Maryland

Survey Results

- Higher priority:
  - Health literacy
  - Outreach & enrollment
  - REL data collection and analysis
- Moderately high priority:
  - Coverage for populations currently ineligible through MHC
- Medium priority:
  - Aligning with statewide quality of care initiatives
- Moderate-to-low priority:
  - Insurance design (cost-sharing/benefits and provider diversity)
- Lower priority:
  - Quality improvement

Session 1 Minutes

Health Equity Concepts Refresher

Health Disparities vs. Health Equity

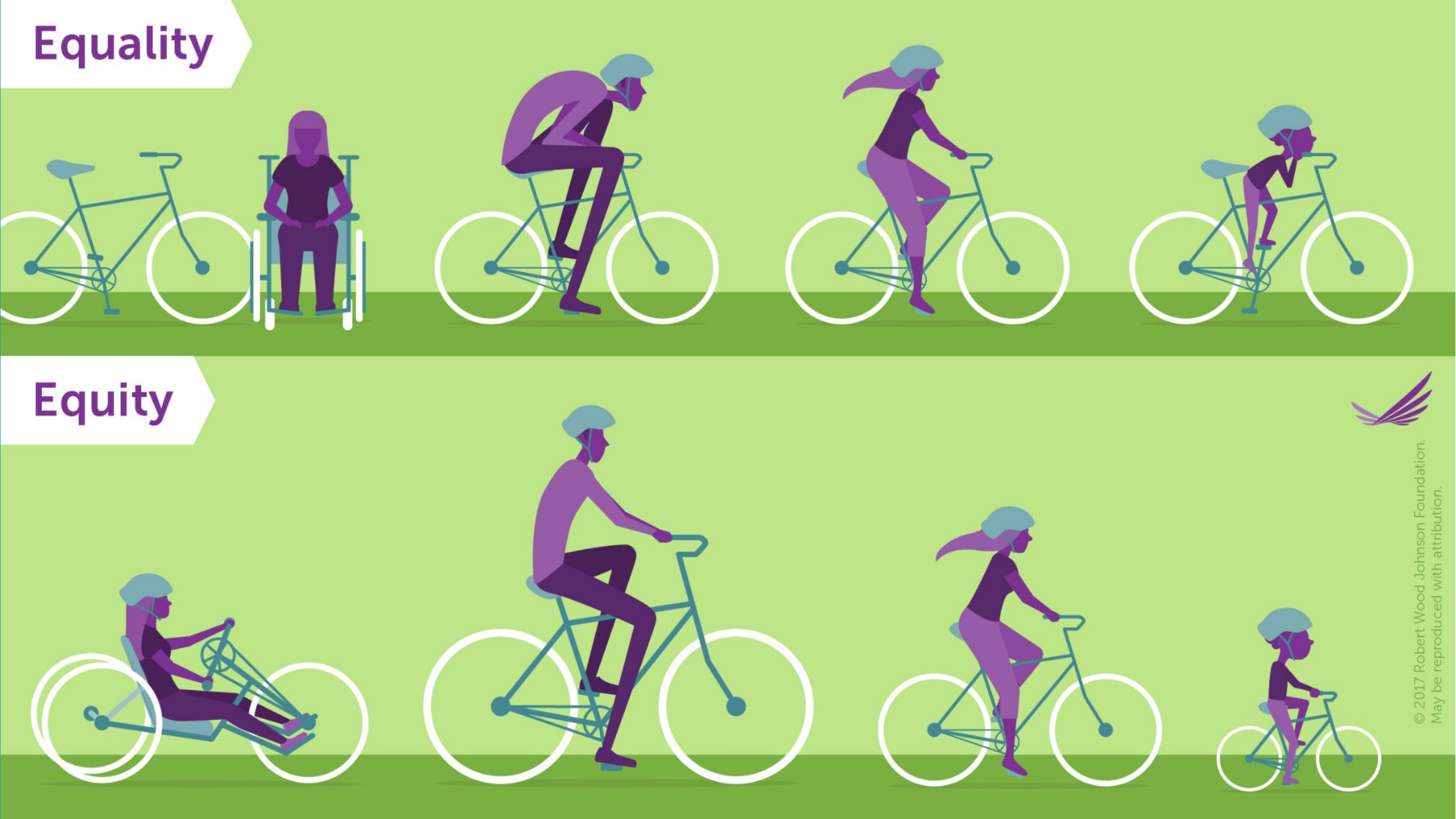
Health disparities:
"Avoidable differences in health outcomes experienced by people with one characteristic (race, gender, sexual orientation) as compared to the socially dominant group (e.g., white, male, cis-gender, heterosexual, etc.)."

Health equity:
"Everyone has a fair and just opportunity to attain their optimal health, regardless of race, ethnicity, disability, gender identify, sexual orientation, socioeconomic status, geography, or any other social barrier/factor."

The *process* of health equity is about removing barriers to everyone having an opportunity to attain optimal health.

MARYLAND HEALTH BENEFIT EXCHANGE

Source: Tekisha Dwan Everette, Dashni Sathasivam, and Karen Siegel, "Health Equity Language Guide for State Officials," Health Equity Solutions and **State Health & Value Strategies**, August 2021, https://www.shvs.org/resource/health-equity-language-guide-for-state-officials/.


Equality
Equity

Social Determinants of Health

“...the daily context in which people live, work, play, pray and age and that affect health. SDOH encompass multiple levels of experience from social risk factors (such as socioeconomic status, education, and employment) to structural and environmental factors (such as structural racism and poverty created by economic, political, and social policies).

These latter factors are also known as upstream factors, or root causes of inequities. Factors closer to the individual level are known as downstream factors.”

Source: Tekisha Dwan Everette, Dashni Sathasivam, and Karen Siegel, “Health Equity Language Guide for State Officials,” Health Equity Solutions and **State Health & Value Strategies**, August 2021, https://www.shvs.org/resource/health-equity-language-guide-for-state-officials/.

Figure 1

Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment Income Expenses Debt Medical bills Support	Housing Transportation Safety Parks Playgrounds Walkability Zip code / geography	Literacy Language Early childhood education Vocational training Higher education	Hunger Access to healthy options	Social integration Support systems Community engagement Discrimination Stress	Health coverage Provider availability Provider linguistic and cultural competency Quality of care

Health Outcomes

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

Health Insurance Literacy

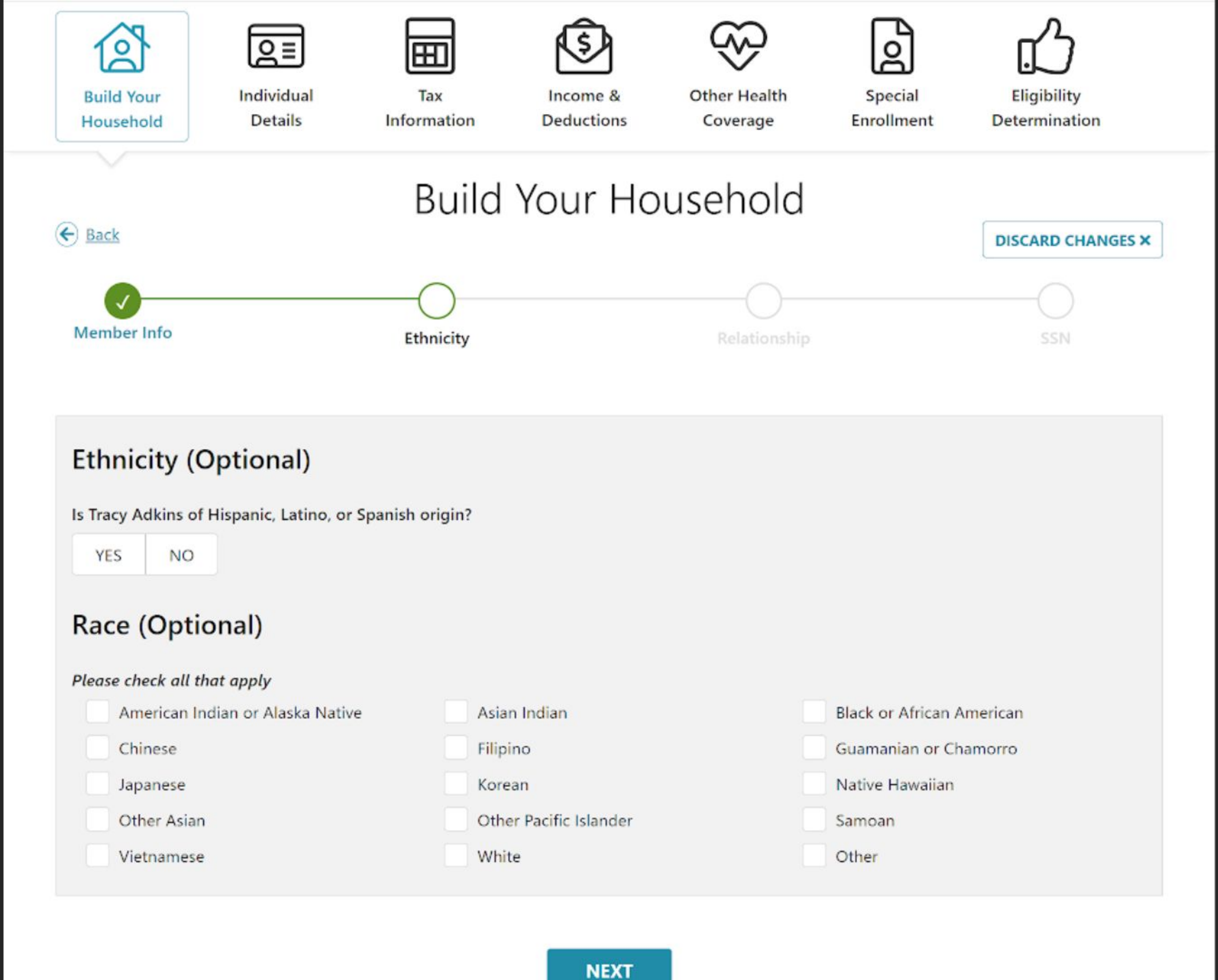
“...the degree to which individuals have the knowledge, ability, and confidence to find and evaluate information about health plans, select the best plan for their own (or their family’s) financial and health circumstances, and use the plan once enrolled.”

Source: State Health Access Data Assistance Center & Robert Wood Johnson Foundation

MHBE’s Current REL Data Practices

REL Data at MHBE

- R/E questions are optional
- OMB and HHS data collection standards
- MHBE R/E data transmitted to insurers at enrollment and used for:
    - Tracking enrollment trends
    - Setting targets
    - Informing outreach
- ~35% select “other”
- MHC application gives 42 options for “primary language.”
    - MHBE supports notices and full website features in Spanish; other language data is for customer support and website translation
- MHC application collects other demographic data: sex, age, location, household size



Build Your Household

Ethnicity (Optional)

Is Tracy Adkins of Hispanic, Latino, or Spanish origin?

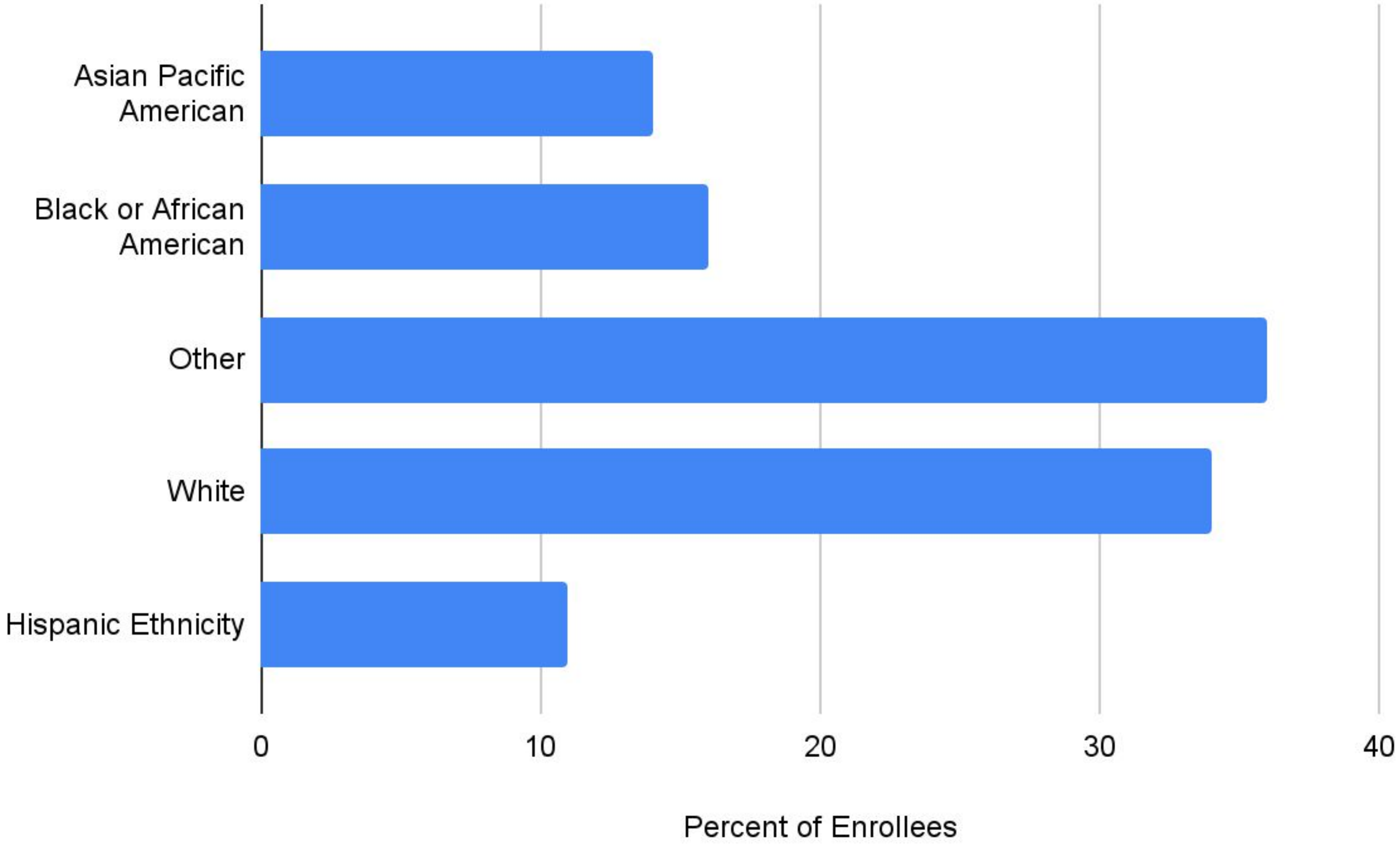
YES NO

Race (Optional)

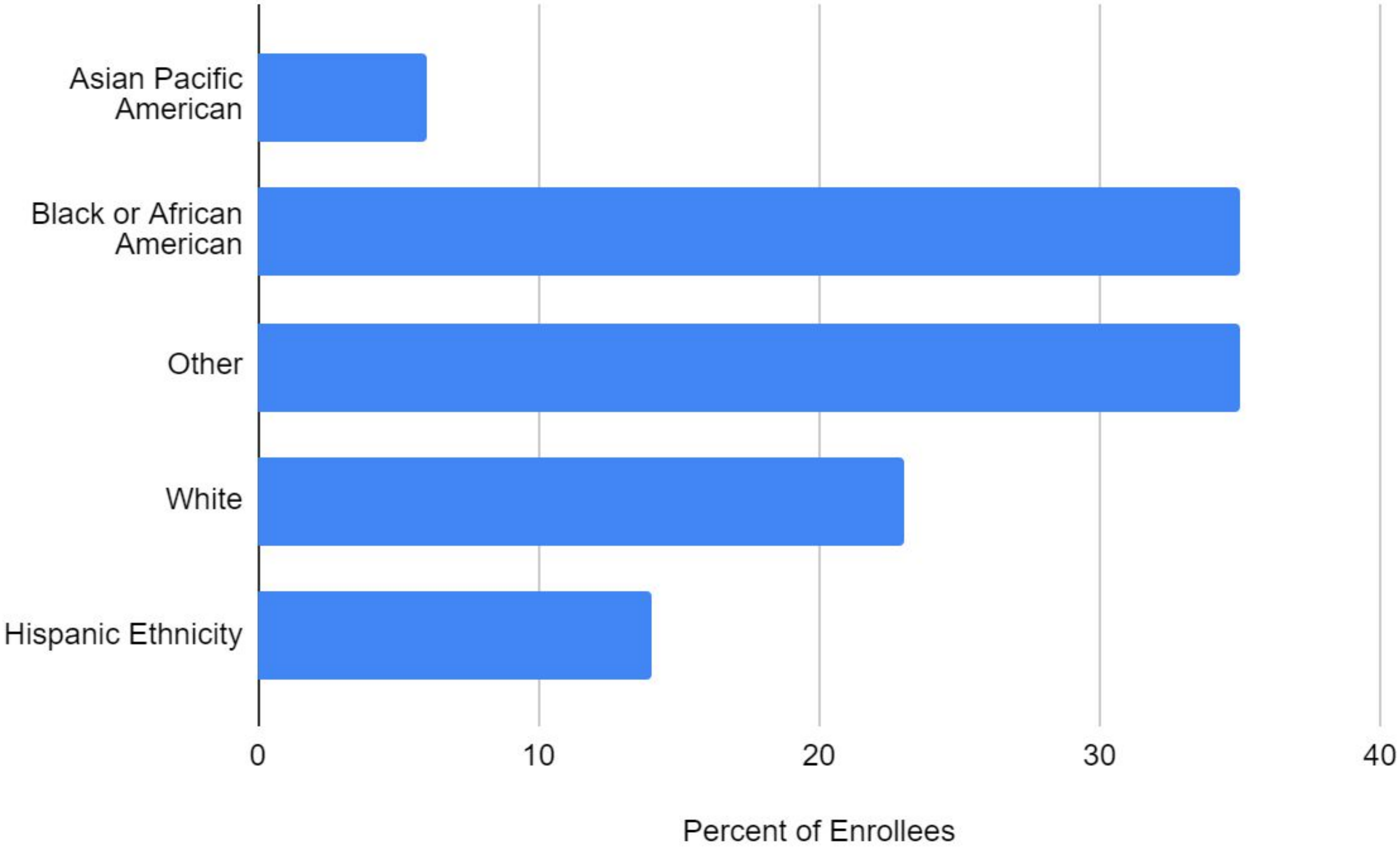
Please check all that apply

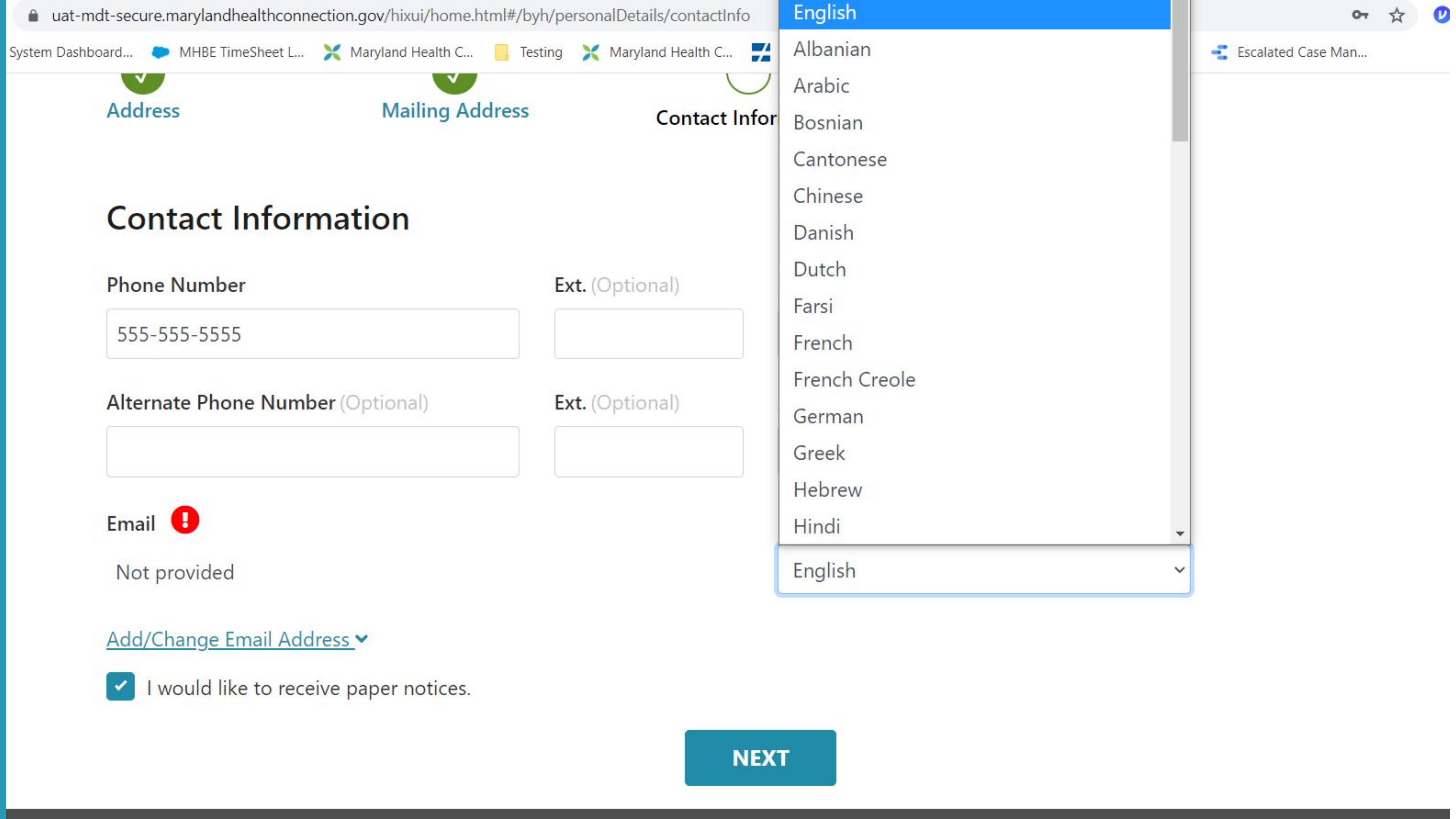
- ☐ American Indian or Alaska Native
- ☐ Chinese
- ☐ Japanese
- ☐ Other Asian
- ☐ Vietnamese
- ☐ Asian Indian
- ☐ Filipino
- ☐ Korean
- ☐ Other Pacific Islander
- ☐ White
- ☐ Black or African American
- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other

QHP Enrollment, July 2021



Medicaid Enrollment, July 2021





Contact Information

Phone Number

555-555-5555

Ext. (Optional)

Alternate Phone Number (Optional)

Ext. (Optional)

Email !

Not provided

English

Add/Change Email Address

☑ I would like to receive paper notices.

Presentation: Michelle Jester, AHIP

Best Practices for Collecting Demographic Data, Promoting Diverse Provider Networks to Advance Health Equity

Michelle Jester, Executive Director of Social Determinants of Health

September 2021

Best Practices for Demographic Data Collection

Best Practice: Gather Buy-In and Develop Data Strategy

- Gather buy-in from leadership, staff, member advisory committees, and other relevant stakeholders on the importance of collecting demographic data.
    - Highlight how this data aligns with mission and/or strategic priorities of the organization and how it will improve care to the people you serve.

- Build trust of communities you serve

- Data strategy: how do you intend to use the data? Intended use may impact the type of data you collect.
    - May not need granular data on race/ethnicity depending on what you plan to use it for

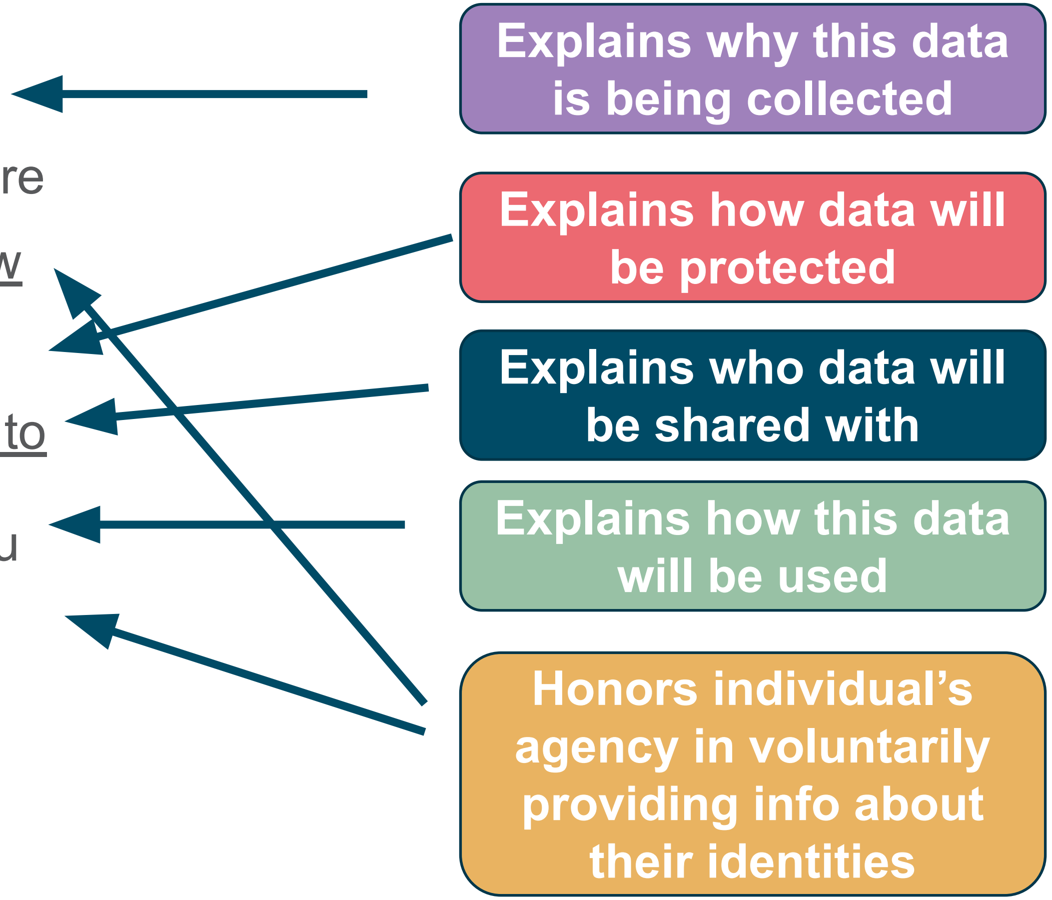
Best Practice: Have Scripts on Why Collecting Demographic Data and Honor Individual Agency

Example Script:

We understand that many things in life can affect your health. We are always looking to better understand our members' needs to improve the services we can offer. Would you be willing to help us learn more about you? It should only take 5 – 10 minutes. Some of the questions are personal and you don't have to answer them if you don't want to. We protect everything that you share just like how we protect your health information. Only members of the care team will have access to this information. This information will help us make sure you're getting the care you want and need. Your decision to answer or to refuse to answer will NOT impact your ability to receive care.

[If administered in-person or orally over the phone: Do you have any questions before we get started?]

[If administered on paper form: Please let us know if you have any questions or concerns by contacting XYZ]



Explains why this data is being collected

Explains how data will be protected

Explains who data will be shared with

Explains how this data will be used

Honors individual's agency in voluntarily providing info about their identities

Adapted from PRAPARE Implementation and Action Toolkit: https://www.nachc.org/wp-content/uploads/2019/04/NACHC_PRAPARE_Chpt2.pdf

Script for Race/Ethnicity Data Collection

Script: Why are we asking about your race and ethnicity?
All of our patients deserve high quality healthcare. By sharing your race and ethnicity with us, you are helping us make sure everyone receives the best and most culturally appropriate care possible. We ask every patient the same questions. Your responses are private. You do not have to answer these if you do not feel comfortable.

Definitions:
Race is one way our society groups people together. Categories of race have been made up over time. These categories are often based on things we can see, like a person's skin color, but don't truly indicate biological differences.

Ethnicity is based on how we identify with other people when we share certain experiences or backgrounds with them. This may include things like language, history, religion, or culture.

http://images.healthcare.pressganey.com/Web/PressGaneyAssociatesInc/%7B6df15bb8-92aa-44b7-ac82-fcea3a00d5f0%7D_Press_Ganey_Equity_Partnership_Webinar__Jan_20_2021_Mount_Sinai.pdf

Best Practice: Collect Standardized and Structured Data but Balance Validated vs Vetted Questions

- Ensure data is discrete and structured (rather than open-ended) to promote interoperability. This will help with reporting, aggregation, analysis, and data sharing/exchange.
  - Standardize the data—NOT necessarily the question to allow for relationship-building conversation

- Importance of evidence-based (validated) AND stakeholder-driven (vetted)
  - Just because questions have been in use for a while doesn't mean they are "vetted"

- Ensure you involve all relevant stakeholder groups to develop, vet, and test questions
- Consider question's:
  - Sensitivity
  - Data Burden
  - Actionability
    - Ensure have processes in place to respond to needs given legal requirements (e.g., tribal affiliation, veteran status, domestic violence)
- Importance of vetted translations

- Balance standardization vs local customization, especially across communities
  - Core and optional, roll-up to core

Data Standards: English Proficiency & Language Preference

ACA Sec. 4302 (used in ACS, CPS, NHIS)	**AHIP Health Equity Workgroup Recs: Paper Form or Paper HRA***	**AHIP Health Equity Workgroup Recs: Health Care Setting Questions** (adapted from AHRQ)
How well do you speak English? • Very well • Well • Not well • Not at all Do you speak a language other than English at home? • Yes (specify) • No **Limited actionability and utility with these questions.** **English proficiency could be viewed as “judgmental” while Language at Home doesn’t focus on health-related information**	**Speaking:** • What language do you feel most comfortable speaking? This can include a specific language and/or different types of sign language. • I choose not to respond **Reading and Writing:** • What language do you prefer to use when reading materials? This can include a specific language, Braille, large print, and/or digital documents that can be spoken out loud. • I choose not to respond **Outreach Preferences:** • How would you prefer to be contacted with information related to your health care? - Phone Call - Text Message - Secure Email - Mailed Letter	**Speaking:** • What language do you feel most comfortable speaking with your doctor or nurse? This can include different types of sign language. • If an interpreter in your preferred language was available right now, would you choose to use one for your health care visit? • Are you comfortable using an interpreter if they are only available through: - Telephone: Y/N - Video: Y/N - In-person: Y/N - I choose not to respond **Reading and Writing:** • In what language do you prefer to read information related to your health care? This can include a specific language, Braille, large print, and/or digital documents that can be spoken out loud. • I choose not to respond

Ethnicity and Race

1. Do you identify as LatinX or Hispanic? (select one)

- I am LatinX or Hispanic
- I am not LatinX or Hispanic
- I choose not to respond

Allow organizations to choose which nationalities to include when asking more granular race/ethnicity questions based on most common nationalities in their areas.

1A. If you are LatinX or Hispanic, what is your background? If you are not LatinX or Hispanic, please skip this question. ***(Select from the list below or write down your response if your background is not listed)***

- Argentinian
- Brazilian
- Chilean
- Columbian
- Cuban
- Dominican
- Ecuadorian
- French Guaianian
- Guatemalan
- Haitian
- Honduran
- Mexican or Chicano
- Indigenous Mexican American
- Nicaraguan
- Peruvian
- Puerto Rican
- Salvadorian
- Venezuelan
- Other Indigenous Central American
- Other Indigenous South American
- Other (please specify): ______________

2. Please tell us which race(s) you identify with: *(select all that apply)*

- Native American, Alaska Native, or Indigenous
- Black
- Asian
- Native Hawaiian or Pacific Islander
- White
- I only identify as LatinX or Hispanic
- I choose not to respond

2A. If you identify as Asian, Black, Native Hawaiian, Pacific Islander, White, or American Indian or Alaska Native, please tell us your background. *(If your background is not listed, please let us know by writing on the blank line).* (Organizations may choose which nationalities to include when asking more granular race/ethnicity questions based on most common nationalities in their areas)

Black
- African American
- Angolan
- Barbadian
- Eritrean
- Ethiopian
- Ghanaian
- Haitian
- Jamaican
- Kenyan
- Liberian
- Nigerian
- Senegalese
- Somalian
- South African
- Sudanese
- Other:

Asian
- Bangladeshi
- Burmese
- Cambodian
- Chinese
- Filipino
- Hmong
- Indian
- Indonesian
- Japanese
- Korean
- Laotian
- Mongolian
- Pakistani
- Thai
- Vietnamese
- Other:

Native Hawaiian or Pacific Islander
- Chuukese
- Chamarro
- Fijian
- French Polynesian
- Guamanian
- Marianaian
- Marshallese
- Native Hawaiian
- Palauan
- Papua New Guinean
- Samoan
- Tongan
- Yap
- Other: __________

White or European
- Balkan
- Dutch
- English
- French
- German
- Greek
- Irish
- Israeli
- Italian
- Polish
- Portuguese
- Russian
- Scandinavian
- Scottish
- Spanish

Arab, Middle Eastern, or North African
- Afghani
- Egyptian
- Iraqi
- Iranian
- Jordanian
- Kurdish
- Kuwaiti
- Lebanese
- Libyan
- Palestinian
- Saudi
- Syrian
- Turkish
- Other:

Native American, Indigenous, or Alaska Native
- Apache
- Athabascan
- Chinook
- Choctaw
- Chickasaw
- Cherokee
- Creek
- Hopi
- Iroquois
- Navajo
- Sioux
- Wichita
- Yakima
- Other: _______

2B. For those who identify as more than one race or ethnicity: Do you identify more strongly with one race or ethnicity over another?

2C. Cultural Identity: Are there things about your culture or cultural identity that you would like us to know?

Best Practice: Build Appropriate Privacy & Security to Protect Data

- Update privacy policies and protocols to ensure appropriate protection and security of sociodemographic data
  - **This should also apply to any partners or vendors you work with! Particularly those who do not currently fall under HIPAA**

- Develop data governance principles to ensure ownership of data stays with individual and to guide data sharing

- Educate and build trust with community

Best Practice: Strategize Data Collection Workflow Using Five Rights Framework

THE RIGHT INFORMATION

IN THE RIGHT FORMAT

WITH THE RIGHT PEOPLE

VIA THE RIGHT CHANNELS

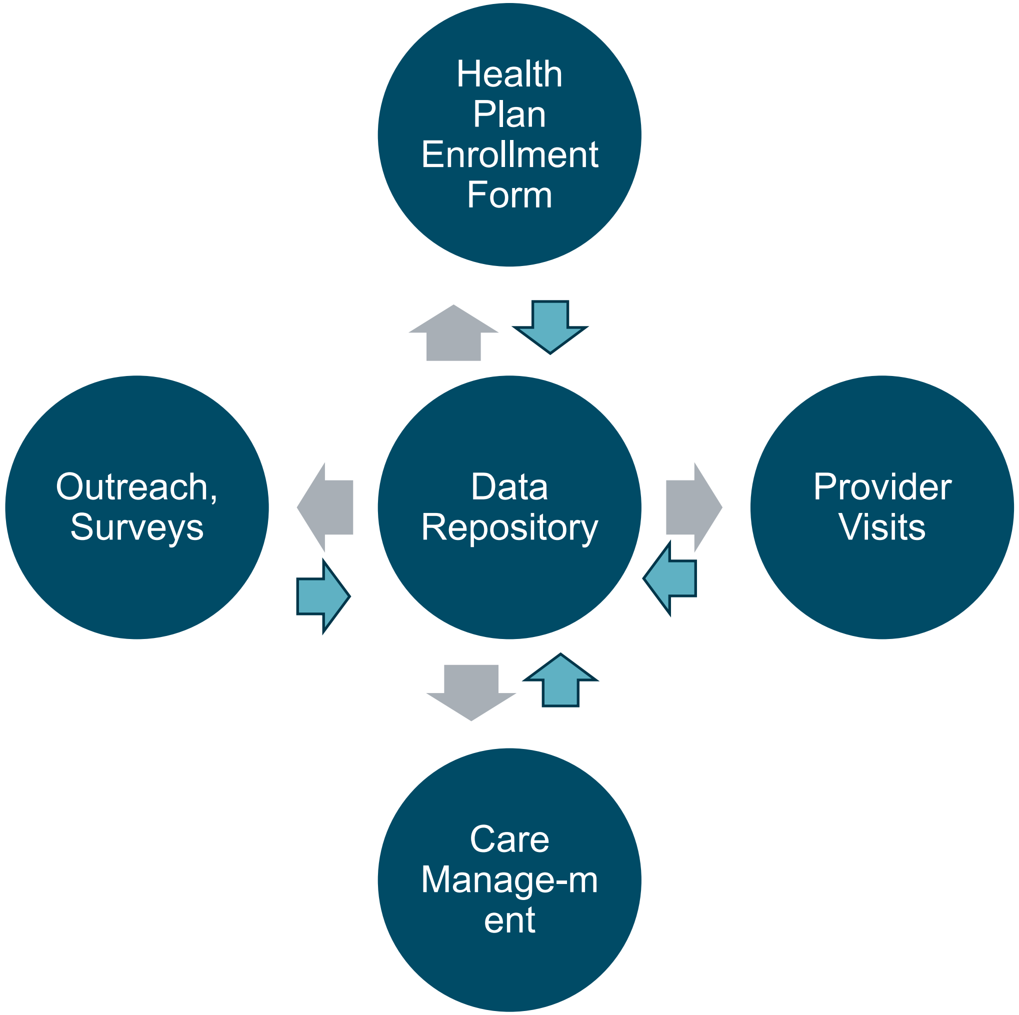
AT THE RIGHT TIMES

Best Practice: Determine Data Collection Approach & Workflow

CDS 5 Rights	Workflow Considerations—Work with Cross-Sector Team
Right Information--WHAT	What information do you want to collect? What resources do you have to respond to needs? • Crosswalk data: Do you already collect info as part of enrollment, other health assessments, member outreach, care management, customer service communications, or initiatives? • **Don't need to double-document! Collect once and use many times.**
Right Format--HOW	How do you want to collect this information and how will it be stored? • Self-Assessment vs conversations with staff (**tradeoffs of each: honesty, convenience, confusion**) • Stored for actionability at individual-level, population-level (e.g., visualization, stratification)
Right Person—WHO	Who will collect the data? Who will act on the info? Who needs to see the info to inform care? • Care managers, CHWs, etc. collect the data and help address needs • Those who administer other assessments (HRA) or other initiatives collect data • Share data with provider networks, population health management team, SDOH team, equity team, clinical leadership, policy team to inform programs, services, advocacy, • Cross-train staff
Right Time—WHEN	When is the right time to collect this information so as to best inform care and services? • Enrollment • At medical visit • Annual outreach surveys or HRAs (frequency of data collection) • Regular check-ins with care managers, etc.
Right Place--WHERE	Where are we collecting this information? Are there other initiatives this data could add value to? • Plant health plan staff in provider office or hospital or in community; CHW visits out in field • Virtually or telephonically

Best Practice: Build Interoperabe Data Exchange Systems

- To Improve Response Rate, Have to Work Together!
- Align with partners along the care continuum to identify opportunities and infrastructure needed for data collection & exchange
- **Collect once, use many times**
  - Reduces burden on consumers and care system
- Consumers don't have to provide sensitive information at every interaction with health care or with human/social services.
  - Helps ensure data isn't in a bunch of different databases as well from security standpoint
- Examine potential to leverage other data sources (e.g., government agencies, employers, etc.) to fill in gaps to avoid double data documentation and data collection burden
- Use APIs to make existing systems interoperable



Best Practice: Embrace Patient-Centered Approaches to Data Collection and Train Staff Who Would Be Involved in Data Collection

- One person’s data is another person’s life experiences, so it’s important to use patient-centered approach
  - Shift mindset from “collecting data” to “getting to know your population—one person at a time”

- **Empathic Inquiry or Motivational Interviewing Skills to Use:**
  1) **Supporting autonomy:** Explain why you are collecting this information and how it will be used.
     - “Is it ok to ask you these questions? At any point, you can let me know you’d like to stop.”

  2) **Reflective listening** and affirming individual’s experiences while **avoiding stigma** by being compassionate
     - “Sounds like you’re tired of bouncing around between housing situations.”

  3) **Noting strengths and resilience of individual**
     - “Sounds like you’ve been working hard to make ends meet. You are clearly very resourceful and creative”. “It takes a lot of strength to get through such a tough situation. You really have a lot of grit.”

  4) **Connecting to resources when appropriate, desired, and available**—focus on priorities
     - “Getting help navigating your care sounds like your highest priority”

- CHWs, patient navigators, care managers, care coordinators, O&E staff, eligibility assistance staff, nurses often have relevant training and/or lived experiences that lend themselves to collecting personal data.

Best Practice: Start Small and Iterate

- Conduct small pilots or Plan Do Study Act (PDSA) cycles to test data collection workflows and data assessment tools. Refine and iterate depending on results.
- Test questions with small group of members to learn how they respond to being asked, what new information you learn, observations about the process, and discuss how you could apply that new information to inform care

PLAN

List the tasks needed to set up the implementation

DO

Describe what actually happened when you ran the implementation

STUDY

Describe the measured results and how they compared to the predictions

ACT

Describe what modifications to the plan will be made for the next implementation cycle from what you learned.

Direct Data Collection Methods, Challenges, & Opportunities

Direct Data Collection Method	Challenges	Opportunities
Enrollment	Legal barriers/state laws preventing demographic data collection at enrollment	Check with governing bodies of State Insurance Exchanges to see if any laws prohibiting or limiting collection of race/ethnicity as part of enrollment.
	Challenges to revising enrollment forms (state agencies, employers)	
	HIPAA 834 transaction doesn't require demographic codes	
Survey Data	Negative member reaction to surveys—distrust, perception of potential discrimination for benefit eligibility, don't understand purpose	Design surveys, HRAs, or outreach materials that would have strong relevance for members to increase response rate. Explain why asking for this info & how will be used to inform care. Work with employers to survey members. Do more targeted outreach.
	Difficult to have successful outreach due to churn, address changes, hesitancy or lack of interest to respond	
	Employers prohibit health plans from surveying their staff	
EHR Data and Claims Data	Not routinely shared with plans unless attached to claim	Educate providers on importance of sharing demographic data with plans. Focus more on data standardization and interoperability to increase data sharing across care system continuum
	Lack of data standards and interoperability (USCDI v2 July 2021) and technological infrastructure needed	
	HIPAA 837 transaction doesn't require demographic codes	
Lack of Accuracy & Completeness & Standardization	MA plans get data from SSA—but still not accurate nor complete Medicaid agencies use different codification structures	Have federal data standards. Understand challenges with data collection

Considerations for Demographic Data Collection

- Be patient: Can take time to create data/coding systems, privacy protections, technological infrastructure and to build consumer trust
- If honor individual agency in providing this information, organizations should not be penalized for failing to collect data consumers are unwilling to share
- Consider best ways for data sharing so everyone can equitably participate in one system rather than having to participate in multiple systems that have participation costs. For example, using APIs can make existing systems (HIEs, HINs, etc.) interoperable and can help ensure data is collected and shared once and is accessible by anyone.
- Issues with Indirect Data:
  - Often inaccurate and lacks trust. Will become more inaccurate as populations become more diverse
  - Hard to compare apples to apples if different organizations use different methods
  - More limited utility: Should not be used to inform individual interventions or services and not be populated into member databases
- Race/Ethnicity categories and codes selected
  - Center for Disease Control and Prevention (CDC) and Office of Management and Budget (OMB) categories for race and ethnicity don't align so hinders standardization and aggregation efforts

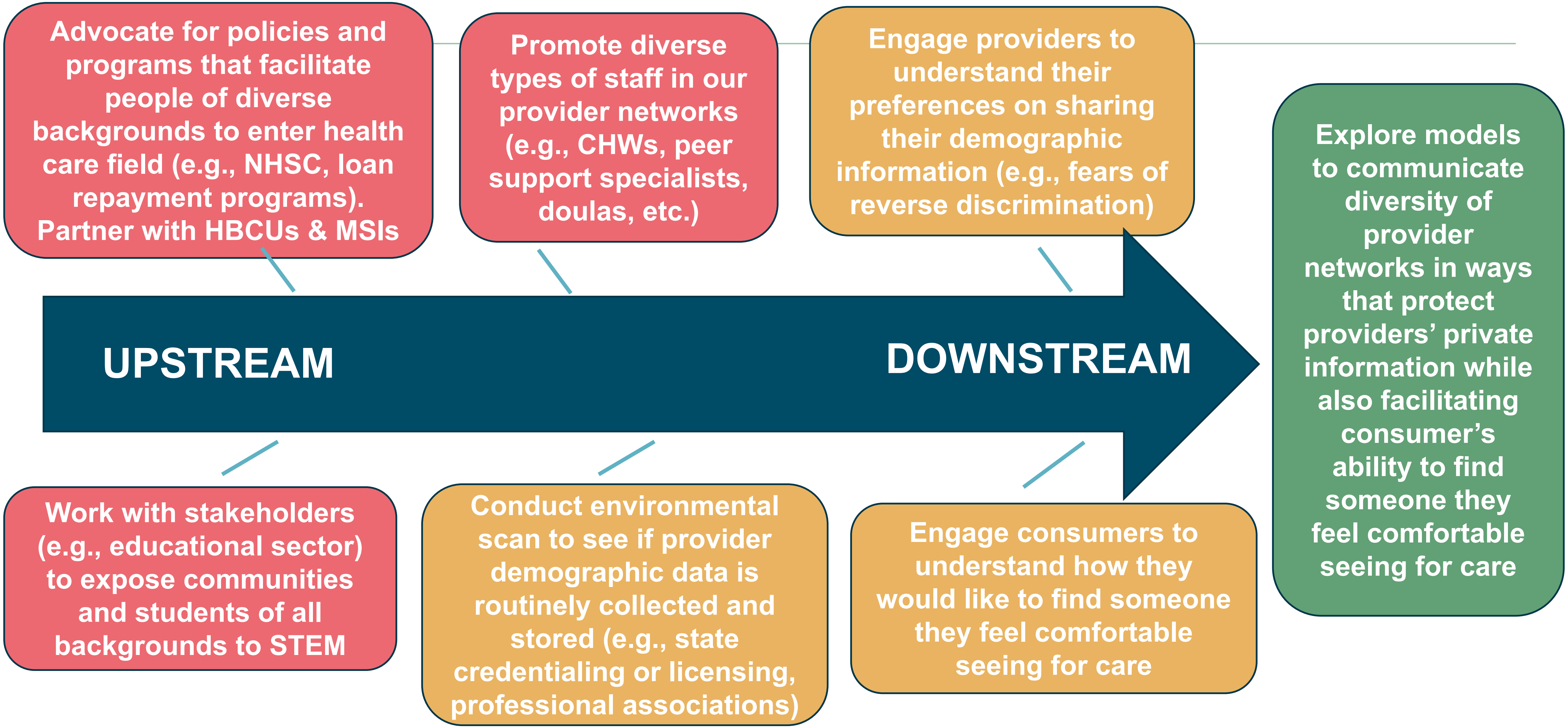
Promoting Diverse Provider Networks

Promoting Diverse Provider Networks

- **Strategic Goal:**
  - Promoting diverse provider networks that reflect the communities we serve and disclosing provider demographics will allow our beneficiaries to find providers that meet their preferences and needs to receive culturally competent and patient-centered care

- **Challenges:**
  - Cumbersome for consumers to find providers that meet their needs and preferences
  - Providers may be hesitant to provide demographic information over fears of reverse discrimination
  - Providers may have to provide this information to multiple entities (e.g., networks, credentialing, etc.)
  - Insurers worried about being able to accurately collect this information and display it in ways that is easy for consumers to find but in ways that protect providers’ personal information

Promoting Diverse Provider Networks



Advocate for policies and programs that facilitate people of diverse backgrounds to enter health care field (e.g., NHSC, loan repayment programs). Partner with HBCUs & MSIs

Promote diverse types of staff in our provider networks (e.g., CHWs, peer support specialists, doulas, etc.)

Engage providers to understand their preferences on sharing their demographic information (e.g., fears of reverse discrimination)

UPSTREAM

DOWNSTREAM

Explore models to communicate diversity of provider networks in ways that protect providers’ private information while also facilitating consumer’s ability to find someone they feel comfortable seeing for care

Work with stakeholders (e.g., educational sector) to expose communities and students of all backgrounds to STEM

Conduct environmental scan to see if provider demographic data is routinely collected and stored (e.g., state credentialing or licensing, professional associations)

Engage consumers to understand how they would like to find someone they feel comfortable seeing for care

Importance of Unconscious Bias, Anti-Racism, Cultural Humility Training

Goals

Want to promote respectful relationships between care team and members—regardless of racial or cultural harmony—to ensure equitable care is delivered to all. Develop best in class unconscious bias, anti-racism, and cultural humility training that leads to action rather than just raise awareness and that is designed as continuous learning rather than “check the box”

Activities

Complete!

Environmental scan of over 500 minority owned DEI firms. Used weighted evaluation criteria to narrow down to short-list

In process

Stakeholder engagement with consumers and providers to inform curriculum and delivery modality

Work with vendor to develop training. Pilot test and refine. Implement across industry and provider networks

Approach credentialing agencies to see if can get “gold star” accreditation to standardize our training across industry

AHIP
Guiding Greater Health

Questions?

Michelle Jester, Executive Director of Social Determinants of Health
mjester@ahip.org

ahip.org /AHIP @ahipcoverage @ahipcoverage AHIP

Discussion

- Do you have experience that offers insight into why people may be selecting “other” as a response to the R/E questions?
- What strategies would you like to see MHBE consider for improving the R/E response rate?
- Other impressions?

Public Comment

Next Steps

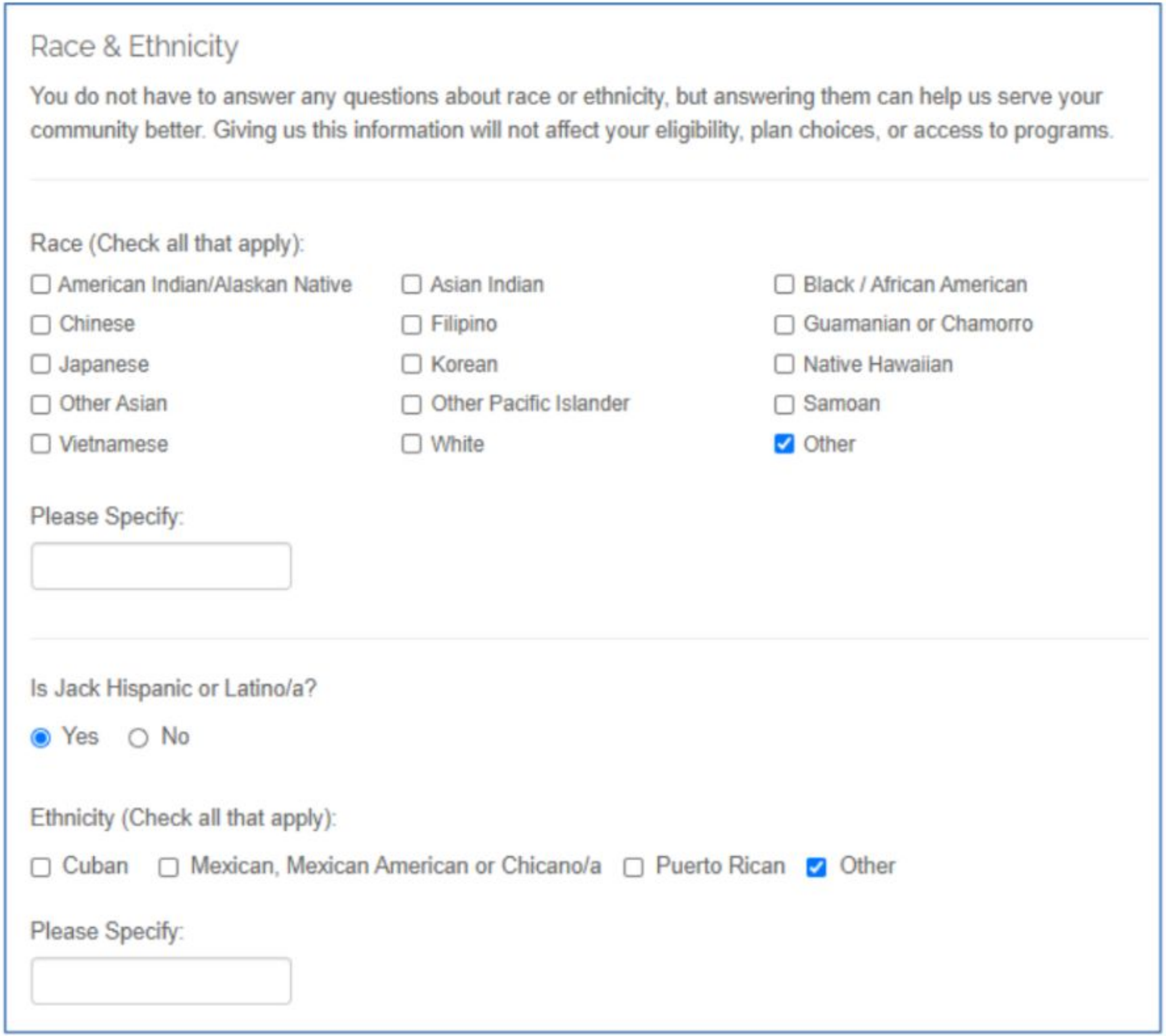
- TBD

Next meeting: Friday, September 24, 1 - 2:30 PM

Workgroup Webpage

Appendix

NY:



Race & Ethnicity

You do not have to answer any questions about race or ethnicity, but answering them can help us serve your community better. Giving us this information will not affect your eligibility, plan choices, or access to programs.

Race (Check all that apply):

☐ American Indian/Alaskan Native	☐ Asian Indian	☐ Black / African American
☐ Chinese	☐ Filipino	☐ Guamanian or Chamorro
☐ Japanese	☐ Korean	☐ Native Hawaiian
☐ Other Asian	☐ Other Pacific Islander	☐ Samoan
☐ Vietnamese	☐ White	☑ Other

Please Specify:

Is Jack Hispanic or Latino/a?

● Yes ○ No

Ethnicity (Check all that apply):

☐ Cuban ☐ Mexican, Mexican American or Chicano/a ☐ Puerto Rican ☑ Other

Please Specify:

MARYLAND HEALTHBENEFIT EXCHANGE

Plan Certification and Affordability Initiatives

Value Plan Standards

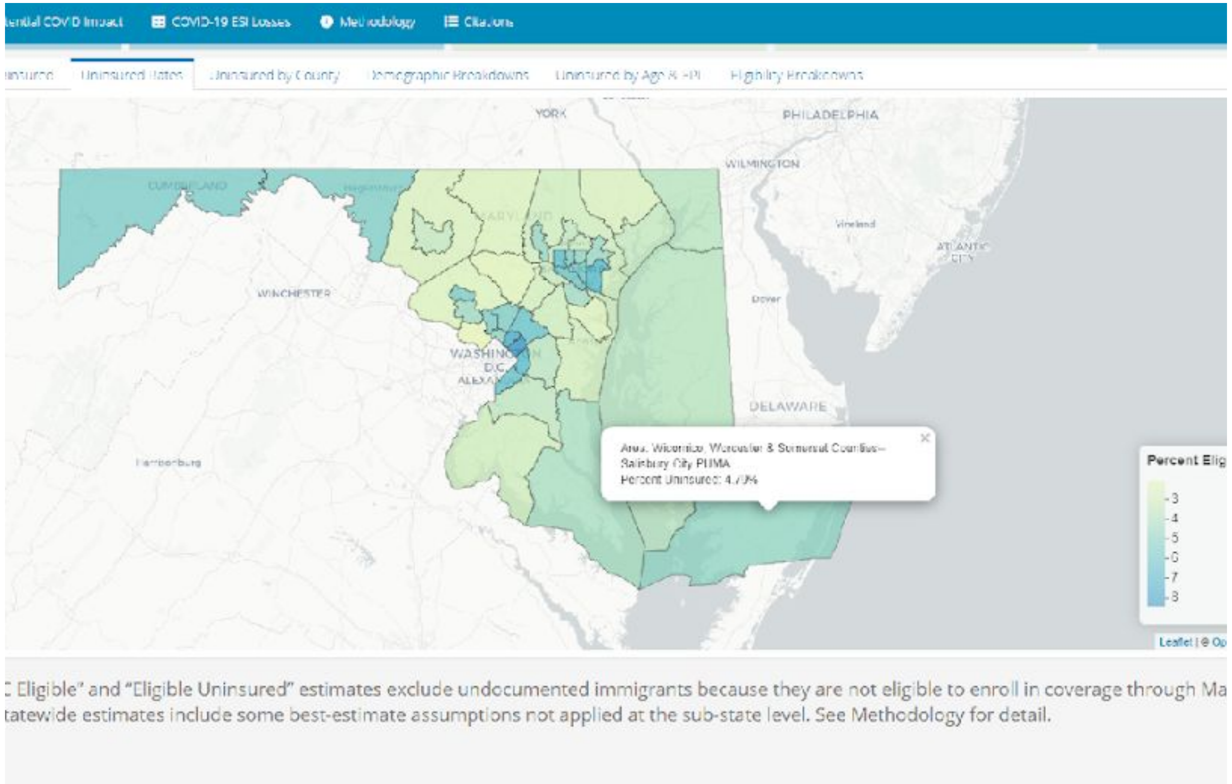
- Diabetes disproportionately affects people of color in Maryland. For PY 2022, MHBE worked to better support Maryland's diabetes initiatives by requiring silver and gold value plans to offer diabetes supplies without cost sharing

Young Adult Subsidy

- Black and Hispanic young adults in Maryland are 2x-3x more likely to be uninsured than White young adults

MHBE Uninsured Dashboard

Interactive MHBE Uninsured Dashboard available at: https://www.marylandhbe.com/wp-content/docs/COVID_Uninsured_Analysis_Dashboard_April2021.html



Eligible" and "Eligible Uninsured" estimates exclude undocumented immigrants because they are not eligible to enroll in coverage through Ma
tatewide estimates include some best-estimate assumptions not applied at the sub-state level. See Methodology for detail.

MARYLAND HEALTH BENEFIT EXCHANGE

Possible Content & Focus Areas

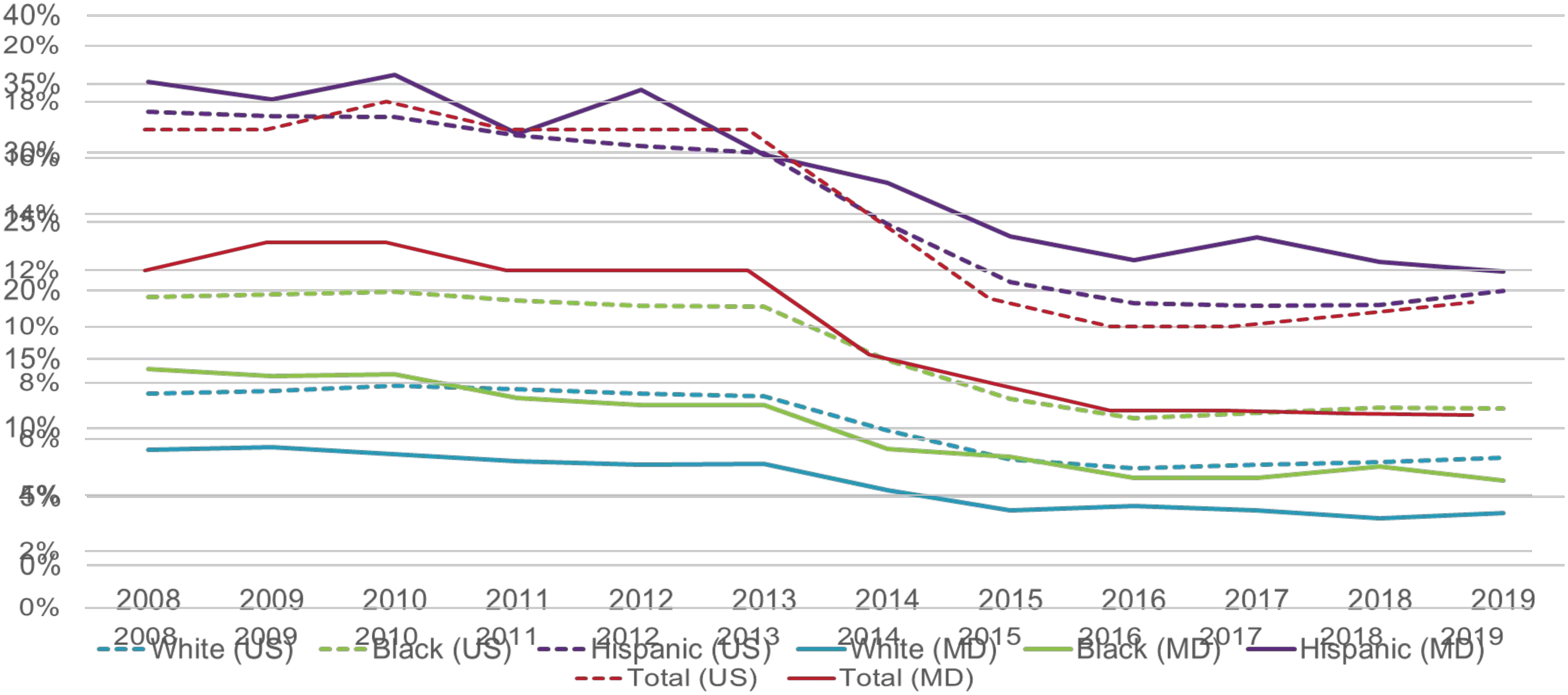
- Race, ethnicity & language (REL) data collection
- Access to coverage (e.g., outreach and enrollment efforts)
- Insurance design (e.g., cost sharing and coverage/benefits)
- Supporting the statewide vision for high-quality primary care
- Quality improvement
- Other?

Background information:

- Carrier presentations on health equity
- Current MHBE outreach strategies
- Other?

Enrollment by Race & Ethnicity

Percent Uninsured by Race and Ethnicity, MD and US



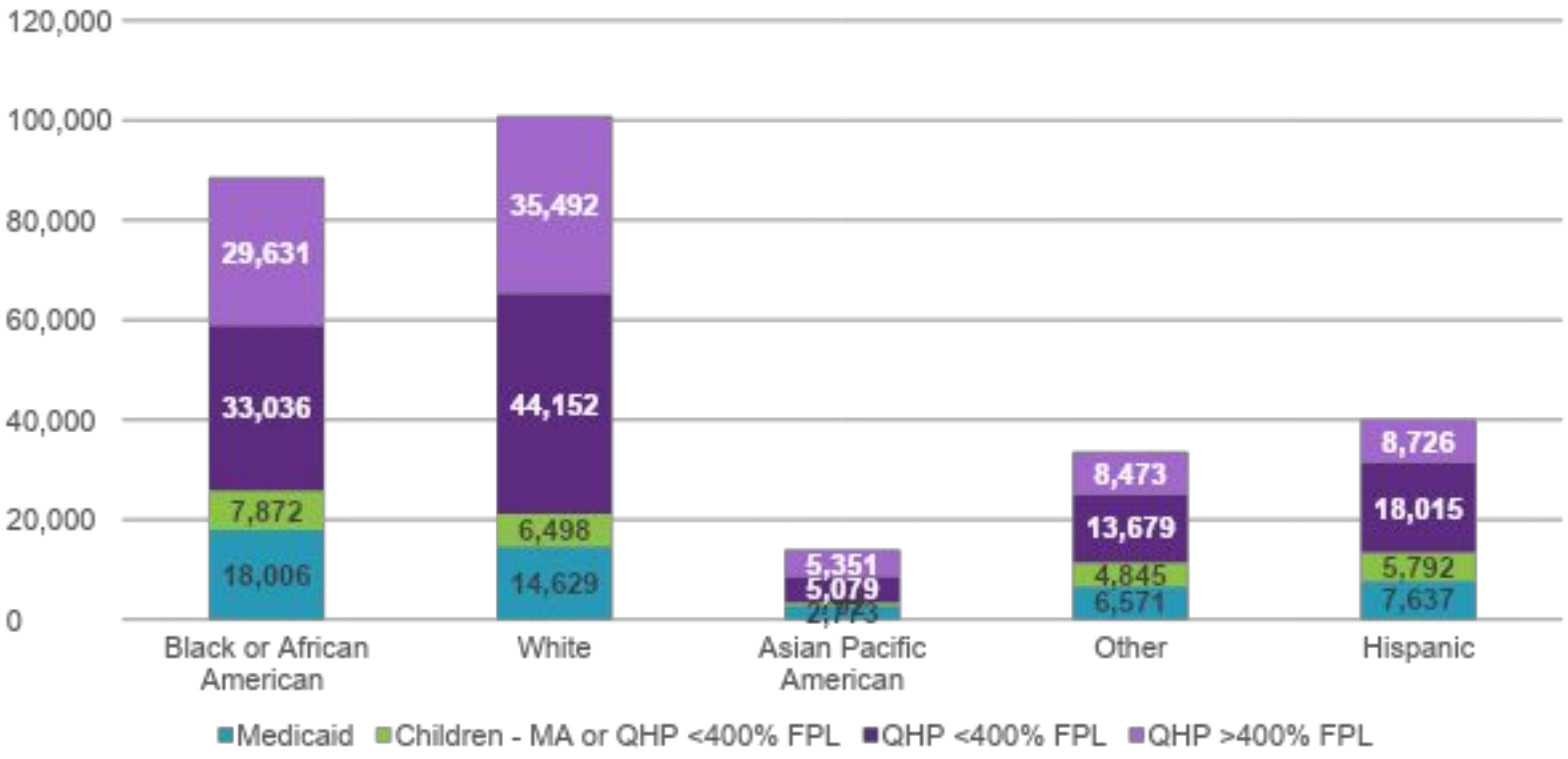
Data from Kaiser Family Foundation, Uninsured Rates for the Nonelderly by Race/Ethnicity, https://www.kff.org/uninsured/state-indicator/nonelderly-uninsured-rate-by-raceethnicity

MHBE Medicaid Enrollment, QHP Enrollment, and Uninsured by Race and Ethnicity

MHBE analysis of 2019 5-year American Community Survey Data File. Data excludes individuals ineligible to enroll in Medicaid or QHPs through MHBE.

MARYLAND HEALTH BENEFIT EXCHANGE

Uninsured by Eligibility for Financial Assistance, by Race and Ethnicity



MHBE analysis of 2019 5-year American Community Survey Data File. Data excludes individuals ineligible to enroll in Medicaid or QHPs through MHBE.