Health Equity Workgroup
Minutes

September 24, 2021
1PM-2:30PM

Members in Attendance:
Richard Amador
Bryan Gere
Diana Hsu
Kim Jones-Fearing
Stephanie Klapper
Allison Mangiaracino
Jomy Mathew
Megan Renfrew
Jimmy Williams
Marietherese Oyalowo
Dania Palanker
Ligia Peralta
Tricia Swanson
Barb Tighe
Nikki Vernick
Sheila Woodhouse

Members of the Public:
Jasmin Shaw
Philemon Kendzierski
Kris Hathaway
Ari Holland-Baldwin

MHBE Staff:
Tamara Cannida-Gunter
Kimberly Edwards
Johanna Fabian-Marks
Becca Lane
Betsy Plunkett

Welcome
Johanna opened the meeting and announced the official transition to the cochairs as facilitators for the workgroup going forward.

Dania began by going over some ground rules for discussion, including raising hands and staying on topic. She introduced the topic for the day and noted that this discussion may highlight why collecting better data in the future will be helpful for targeting outreach.

Vote on minutes
Dania asked for any edits on the minutes from 9/24/21 and no members had any changes. Dania requested a motion; Ligia moved to approve the minutes. Stephanie seconded the motion. No members opposed. The 9/24/21 minutes were approved.

MHBE's Current Marketing and Outreach Strategies
Betsy Plunkett presented on MHBE's marketing and outreach strategies.

Their objectives are to increase enrollment in QHPs, retain customers enrolled during the covid and Easy Enrollment special enrollment periods (SEPs), and recommit efforts to address racial disparities in health care.

Target audiences are QHP-eligible uninsured, including young adults (ages 19-34), Black and Hispanic/Latino Marylanders, and residents of rural regions with high uninsured rates.

MHBE completed this year's survey research in July 2021. MHBE contracts with a research agency for this research. MHBE also contracts with some marketing agencies that specialize in Black and Hispanic/Latino audiences.

This year's research showed that Hispanic Marylanders are more likely to be familiar with Maryland Health Connection (MHC) but that Black Marylanders have the highest favorability with MHC. The research also looked at knowledge about the American Rescue Plan, satisfaction with MHC (white Marylanders are more often satisfied with their MHC experience than Black and Hispanic Marylanders), difficulty affording health expenses, and more.

Betsy then shared the media organizations that MHC partners with to reach different communities around the state. Although covid has made it more difficult to attend community events to do outreach in person, MHC has partnerships that help with outreach: for example, MHC and AFRO are holding a Facebook Live event together in October.

Bryan – It's possible that the lower favorability among Black consumers reflects the historical distrust in the health care system. Strategies to reach out should build trust

Stephanie – Thanks to everyone at MHC for this work. MCHI will continue to share MHC events on social media. Comment about terminology: when talking about young adults, it is inaccurate to call them "young invincibles" because when offered affordable coverage they tend to apply at the same rate as older adults. The reason they are less likely to be covered is an affordability issue and because they are less likely to have jobs that provide employer-sponsored insurance, not an attitude that they don't need health coverage.

Nikki – how are you using enrollment data to target marketing data? Do you use race/ethnicity and geography data and then follow up to see if targeted marketing has been effective? Also, if outreach drives people to the site, how many people are "lost in the process," i.e. get to the website but don't apply and/or enroll? Do we have that data separated out by race/ethnicity?
Answer – we work closely with the policy and IT data teams, and the marketing agency has a data team. We always look at demographic breakdowns. We now have new census data and the policy team is working on distilling that. We use research and data to inform everything we do. For example, data on enrollment in rural areas,
Nikki – what additional data would you find helpful to further your marketing efforts?
Answer – the names, addresses, phone numbers and emails of all the uninsured in Maryland. The Easy Enrollment program and if we're able to partner with the Department of Labor, direct contact is always good because there's a lot of guesswork. Even if we targeted the areas with the most uninsured, like even a zip code in Prince George's County, with direct mail campaigns, it would be really expensive so we try to target in other ways like on cable in those areas, places that aren't as expensive

compared to DC. It's confusing for people in areas like PG County because there is also marketing for the DC Exchange in those general areas.

Joshua – when you're measuring the success of your outreach efforts for these demographics, how often are you tracking how successful they were? When do you decide to reassess your strategy or innovate? It is clear you try to use the most current and effective ways to reach people, but how do the metrics that you're collecting influence those decisions?
Answer –Marketing can't take credit for all increases in enrollment, so it is hard to use metrics to determine strategy directly, but there is a correlation between marketing efforts and enrollment numbers during the open enrollment period, especially compared to special enrollment periods which aren't marketed. We inform strategy with reports like the one being presented on today. It's hard to tell how exactly people hear about MHC because they could hear/see several different forms of outreach before they apply. This is just a challenge with marketing in general.

Immigration Eligibility Standards

Tamara Cannida-Gunter presented on immigration eligibility standards.

Immigrants under the 5-year bar who would otherwise qualify for Medicaid if not for immigration status ("qualified immigrants") are eligible for QHP and for financial assistance (APTC). Immigrants exempt from the 5-year bar, such as children, pregnant women, asylees and refugees are also QHP-eligible, as are lawfully residing non-qualified immigrants and non-immigrants, such as student/work visa holders, temporary residents, or those with a pending application for asylum.

Undocumented immigrants and DACA recipients are not eligible for QHP, despite DACA recipients being lawfully present.

Immigrants eligible for financial assistance include lawfully present immigrants with income between 138% and 400% of the federal poverty line (FPL), and qualified immigrants under the 5-year bar with income up to 400% of FPL.

Johanna Fabian-Marks provided additional context: Maryland is home to about 244,700 undocumented immigrants, about 116,000 of whom are uninsured. MHBE is in the beginning stages of writing a report to the legislature on coverage options for undocumented immigrants and other populations ineligible for existing programs based on other states' approaches. We will inform the group of any upcoming briefings, and anyone is welcome to reach out to Johanna or Becca to discuss the report more. Slide 17 in the presentation for this session, which can be found on the workgroup webpage, contains several fact sheets with more details about eligibility for immigrant populations.

Discussion and Questions
Kim Jones-Fearing – Can you say more about marketing in the high-density DC-area to the Black population? I didn't hear mention of DC-metro radio stations.
Answer – We do some metro radio. We have a challenge with Virginia and DC having their own marketplaces. Last year and this year we put ads on the metro and bus station screens from PG County to DC. DC metro radio is a lot more expensive and it's

hard to get all the right messaging in. But this year, healthcare.gov has increased their marketing spend and that will drive traffic to the MHC website.
Kim – What about specific radio stations?
Answer – I can send you the full list of stations.
Kim – Your survey results mentioned that Black Americans have more difficulty with their insurance and care expenses, can you talk more about why that is? There was an article about property values causing premiums to be more expensive for African Americans. There are fewer hospitals in PG County versus Montgomery County even though they have similar population sizes, would that have anything to do with premiums?
Answer – Our premiums are consistent across the state, they're based on your household size and income so it shouldn't vary based on your situation beyond that. [Staff note: Insurers are allowed to set premiums based on geography per the ACA and some states have more dramatic differences in premium depending on your region within a state. Maryland is not one of those states with noticeable regional differences in premium amount.] Your cost sharing expenses might end up being higher if you need to use your coverage more. Also, many people are not aware of the American Rescue Plan, which makes premiums a lot more affordable for a lot of people, so marketing about that is important.

Ligia – Thank you for presenting information on immigration. Do you foresee changes in methodology when giving more granular data to legislators? If so, will that be shared with the group? It's okay if there is no answer to this right now.
Answer – Can you clarify what you mean by "changes in methodology"?
Ligia – Will you be looking at more granular data about who is eligible and ineligible?
Answer – We don't anticipate changing our methodology, but we are able to break this data down to the sub-state level with our current methodology even though we haven't yet.

Marietherese - When working on marketing research and strategy, do you reach out to faith groups?
Answer - We often do reach out to faith leaders, individually and focus groups. We also have a list of faith partners to whom we send blurbs that can be read from the pulpit. We also share graphics and other materials about coverage with them.

Richard - Has the marketing team ever done a survey of Community Assistance Workers (CAWs) of what they have to say on a microscopic level about this data? For example, you mentioned public charge as possibly affecting people's experience with MHBE. In his experience, there are a lot of other things that can affect people's experience. Some of his long-time clients still don't understand how the process works: new mothers don't understand how to keep their baby covered. A lot of Hispanics deal with community organizations that have application counselors (ACs) who don't have access to application portal like a navigator does and don't explain things like a navigator would.
Answer - This is more of a question for the operations team—staff such as Heather Forsyth, Tamara Cannida-Gunter, Ginny Seyler, and Rita Dyer can support with situations like this. Tamara will pass along the idea to Heather that a survey of CAWs would help improve some of these issues. It might be helpful to talk more about enrollment operations more in the workgroup.

Populations that need more targeted outreach

Stephanie – Possibly target outreach to a demographic within the AAPI population that is lagging in health coverage, if there is one?
Answer – Staff will look at the data we have on this.

Kim – Sometimes you need to spend more money to make things more equitable, even if it's hard to make decisions that affect budgets.
Answer – This is important. Also, the marketing team could share more details about how much of the marketing budget goes to targeting each demographic group. In addition to budget size, partnerships are also an important way to increase enrollment because they improve trust.

Joshua – LGBTQ+ population – We should revisit ideas to update the language in the application to make it more inclusive and make sure that the options for sex and gender aren't only binary. The language used on the application should be reflective of the most modern way people are self-identifying

Enrollment targets

Kim – Agree that we should set enrollment targets.

Nikki - Does MHBE already have the data it needs to do the analytics to set and meet enrollment targets? We need to know what the trends have been in the past and see what reasonable targets would be over the next 5 or 10 years.
Answer – Good point; the recommendations might include both to set targets and also to change the data collection process in order to facilitate that.

Dania – Can someone on the call say more about the data we have and the data we would need?
Answer – We have uninsured and eligibility data for Black, white, AAPI, and Hispanic categories at the state level. We can break it down to the county level but would need more time to do that. We also can disaggregate by more specific identities that roll up to the Asian / Pacific Islander category as defined by the OMB, but don't have more specific options for the other broad race categories. As our presenter said during session 2, it might be helpful for us to include more subcategories (as long as they still roll up into the broad OMB categories).
Dania – do we know how many people don't answer the race and ethnicity questions?
Answer – we are currently working on figuring this out, but we do know that a lot of people skip it. Changing the way we ask the question would help.
Dania – California and DC will soon newly require insurers to collect race and ethnicity data, so there will be data collected on both ends (on the Exchange side and the insurer side). New York is also considering changing the way they ask the questions.

Richard – Did you know that at one point, the Exchange was reporting "Chinese" for every person who didn't answer the race and ethnicity questions?
Answer – No, we were not aware, but it is helpful to know that it happened. Fortunately our data doesn't indicate that this is happening currently.

Dania – Would anyone like to talk about anything that we haven't discussed yet?

Richard – Education is important. And to clarify previous points, maybe there could be more of a dialogue between marketing and operations to include more specific content in the marketing and have the navigators prepared with certain materials. Has seen the same problems happen year after year and is often a problem of people not explaining things to consumers- there should be a way to address that.
Diana – Let's make sure that we're not just giving people more paperwork and handouts—we should make sure new information is presented in an engaging way.

Joshua – it would be great if specific training could be tailored to reaching certain populations and be available for CAWs and non-CAWs.

Public comment

Jasmin Shaw – Others' comments covered what she was going to say. Interested in the 18-34-year-old population; people often don't understand what they're filling out on the application.

Chat comments

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00:54:44.246,00:54:47.246
Tamara Cannida-Gunter -MHBE-: If anyone needs assistance with cases or
consumers, please contact me directly Tamara Gunter tamara.cannida-
gunter@maryland.gov or 410 547 6784

00:55:00.818,00:55:03.818
Becca Lane -MHBE-: Thank you, Tamara!

00:59:57.737,01:00:00.737
Betsy Plunkett -MHBE-: If you have any ideas for outreach partnerships,
I'd love for you to share them with me at betsy.plunkett@maryland.gov

01:00:23.225,01:00:26.225
Becca Lane -MHBE-: Thanks Betsy!

01:11:08.115,01:11:11.115
Nikki Vernick: I like the idea of setting targets at the most granular
level possible by R/E and by geography.

01:14:27.737,01:14:30.737
Ligia Peralta: Agree with Richard. Education or retraining is important.

01:14:49.134,01:14:52.134
Betsy Plunkett -MHBE-: Perhaps this needs to be part of a more specific
training manual too.

01:15:41.526,01:15:44.526
Tamara Cannida-Gunter -MHBE-: What Richard is speaking of should be
deferred to MDH. They would and do offer training.

01:17:54.961,01:17:57.961
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Joshua Morris, HCAM: I agree with Richard. Also, I think demographic specific training could be added and some of that material could be made available to non-CAWs (and tailored to be more educational rather than procedural for non-CAWs).

01:18:10.843,01:18:13.843
Stephanie Klapper: We at Maryland Health Care for All are hosting a webinar for our coalition to kick off outreach and discuss new resources for health equity on October 12 at 7PM. Workgroup members and members of the public are invited to attend. You can find more information at https://healthcareforall.com/webinar/

01:19:48.861,01:19:51.861
Betsy Plunkett -MHBE-: Tamara/Becca, will you please pass that on to Heather? I'd be glad to offer support.

01:20:23.059,01:20:26.059
Richard Amador: I'll mention it to Heather when I see her, as well. (:

01:21:10.008,01:21:13.008
Nikki Vernick: Thanks for a great meeting!

01:21:36.576,01:21:39.576
Tamara Cannida-Gunter -MHBE-: Heather will be informed Betsy. Thanks Richard,

01:21:57.015,01:22:00.015
Stephanie Klapper: I echo the thanks to MHBE and to Dania!

01:22:00.142,01:22:03.142
Bryan Gere: Thank u

01:22:04.873,01:22:07.873
Bryan Gere: Have a nice weekend