MARYLAND HEALTH BENEFIT EXCHANGE

2021 Health Equity Workgroup Recommendation Report

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Executive Summary

At the request of the Standing Advisory Committee, MHBE convened a workgroup to explore how MHBE could use its authority to reduce inequities in healthcare coverage and health outcomes faced by people of color. Based on information from other states, presentations from experts, and the expertise of members, this Health Equity Workgroup identified the following recommendations and areas for further investigation for MHBE.

Capture Granular Race and Ethnicity Data

Redesigning the race and ethnicity questions on the Maryland Health Connection (MHC) application to reflect best practices will help MHBE identify and address racial and ethnic enrollment disparities. Only about 70 percent of consumers currently answer these questions. A higher response rate and more granular data will more clearly show which populations need targeted outreach; MHBE can set goals accordingly.

The workgroup also recommends establishing another workgroup dedicated to data collection. This future group would discuss how to use the data once it is collected, further changes to the race and ethnicity questions, and how to redesign the sex and gender questions on the MHC application to be inclusive of nonbinary consumers.

Require NCQA Distinction in Multicultural Health Care or Health Equity Accreditation

MHBE should include achievement of Distinction in Multicultural Health Care or Health Equity Accreditation from the National Committee for Quality Assurance (NCQA) as a plan certification standard for PY2024 in alignment with the efforts of the Washington DC Health Benefit Exchange.

MHBE Website and Resource Enhancements for Health Insurance Literacy

MHBE should provide additional consumer-focused resources on health insurance literacy on the MHC website through the website's chatbot, Flora; the use of tooltips on the plan shopping page to define key terms; enhancement of existing health insurance literacy resources; and the addition of resources on how to use benefits. Resources should be consumer-tested to ensure they are as clear and accessible as possible. MHBE should audit the consumer experience for Spanish-speaking consumers and make improvements accordingly. Lastly, MHBE should consider partnering with community organizations to provide a health insurance literacy curriculum.

Support Community Health Workers

MHBE and insurers should continue discussing alternative payment models (APMs) that support community health workers.

Reduce Cost-Sharing for High-Disparity Conditions

MHBE and insurers should explore the feasibility of applying the Plan Year 2022 Value Plan standard for diabetes supplies[i] to all private plans on MHC and explore other opportunities to reduce cost-sharing for high-disparity conditions, starting with small cost-sharing changes with minimal impact to actuarial value (AV) and consumer cost-sharing.

Lower health coverage barriers for immigrants

Documented and undocumented immigrants face barriers to obtaining health coverage. MHBE should continue exploration and discussion of coverage options for these individuals.

Mitigate implicit bias

Implicit bias effects every level of health care. MHBE should institute regular training to mitigate implicit bias for internal staff and contractors, and strengthen opportunities for vendors, call center staff, consumer assistance workers, connector entity staff, and other staff to take implicit bias training.

Collaboration and partnership

MHBE should collaborate with existing partners, and form new partnerships with relevant groups, especially community and local organizations, to move forward on these recommendations.

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Background

In 2020, the Maryland Health Benefit Exchange's (MHBE) Standing Advisory Committee (SAC), with board liaison approval, requested the convening of a health equity workgroup to identify ways in which MHBE could advance health equity, or in other words, contribute to ensuring that "everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, gender identity, sexual orientation, socioeconomic status, geography, or any other social barrier/factor."[1]

Beginning in August 2021, the health equity workgroup explored an agenda that covered health equity topics both relevant to MHBE's authority and reflective of similar efforts occurring in other states. These topics included race and ethnicity data collection, outreach and enrollment strategies, health insurance literacy, payment for community health workers, and cost-sharing for conditions that disproportionately impact people of color.

Health Disparities in Maryland

The events of the past two years have led MHBE to prioritize health equity work— specifically racial and ethnic health disparities. The COVID-19 pandemic has exacerbated existing racial health disparities: the Black population has a disproportionately high infection rate and severity of cases compared to other populations. Additionally, the renewed protesting against police brutality towards Black people and other people of color drew greater social awareness to the impact of racism on health outcomes.

Health inequities that impact the Black population are significant and consistent across virtually all conditions. To highlight the magnitude of the issue, the non-Hispanic Black population has a higher mortality rate than the population overall, the non-Hispanic white population, and the Hispanic population (829.9 per 100,000 in 2018, compared to 715.4, 721.9, and 352.2, respectively). Deaths from diseases of the heart, cancers, and cerebrovascular diseases (e.g., stroke) are all disproportionately high among the Black population. Deaths from diabetes are twice as high among the Black population than among the white population (32.4 per 100,000 compared to 16.4 per 100,000). Infant mortality is 2.5 times higher in the Black population than the white population (10.2 per 1,000 live births, compared to 4.1).[2] MHBE must do its part to work against these unjust, preventable deaths.

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[1] 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/.

[2] Maryland Statewide Racial and Ethnic Mortality Data 2018, Office of Minority Health and Health Disparities, Maryland Department of Health, https://health.maryland.gov/mhhd/Documents/Maryland%20Statewide%20Racial%20and%20Ethnic%20Mortality%20Data%202018%20.pdf.

The Maryland Office of Minority Health and Health Disparities (MHHD) attributes the higher caseloads of COVID-19 among "minority"[3] populations to higher employment in essential occupations, more limited ability to telework, and higher likelihood of living in higher-density, multigenerational households. The combination of these factors leads to increased within-household and between-household spread, which leads to a higher probability of infection. These populations also have more severe cases once infected due to higher prevalence and severity of comorbidities such as diabetes and asthma, less access to healthcare resources due to poverty and racism, and higher general stress due to violence, poverty, and racism.[4]

It is crucial to acknowledge that health disparities are not fully attributable to differences in income and education. Poverty certainly contributes to poor health and, due to policies that have blocked them from accessing wealth in the ways available to the white population, the Black population has a higher prevalence of low-income. However, racial health disparities remain significant after controlling for the effect of income and education.[5] For example, Figures 1 and 2 separate income and education from diabetes rates when comparing the Black and white populations and still show a disparity.[6] As MHHD specifies and these figures suggest, racism itself contributes to stress and therefore vulnerability to disease.

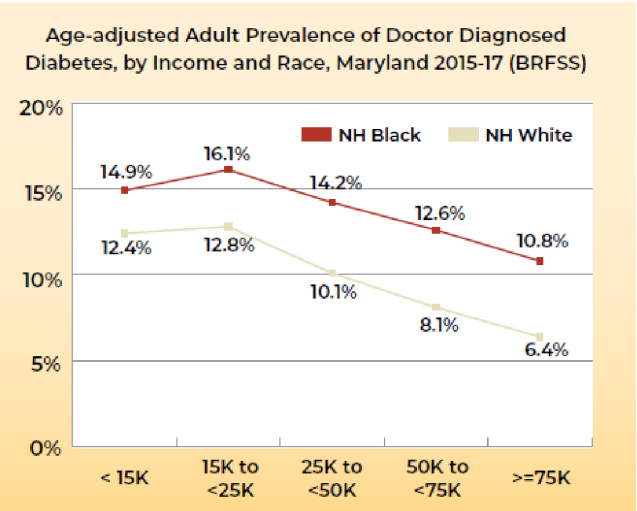


Figure 1

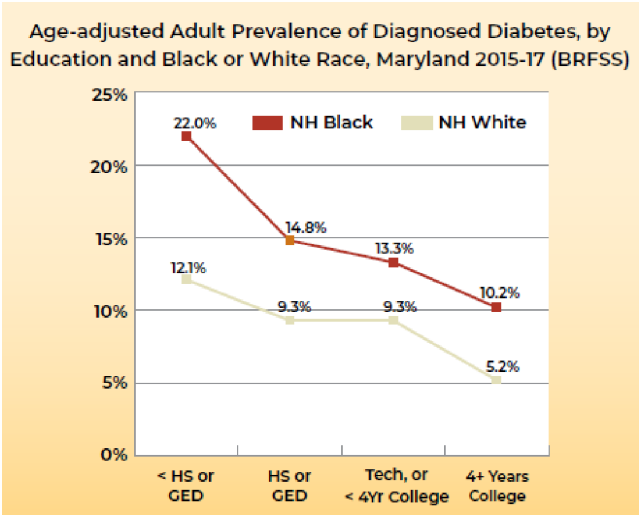


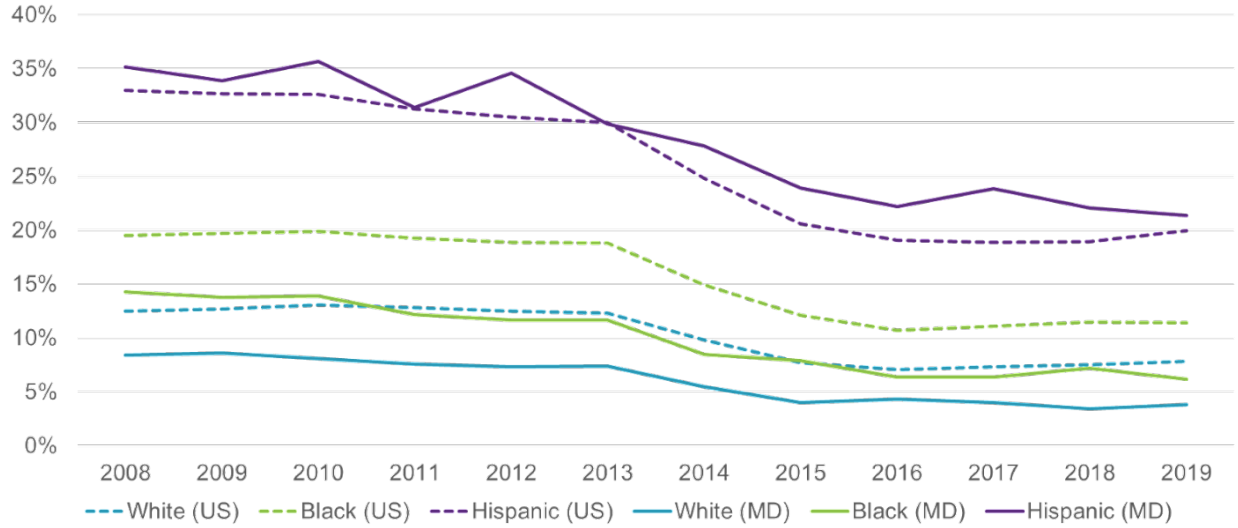
Figure 2

[3] The workgroup recognizes that the word "minority" is not best-practice terminology for referring to racialized groups. This is simply an account of the information provided by MHHD.
[4] MHBE Health Equity Workgroup, Session 1, Office of Minority Health and Health Disparities Presentation, Slide 16, https://www.marylandhbe.com/wp-content/uploads/2021/09/HEW_Final-Presentation_Session-1.pptx.pdf.
[5] MHBE Health Equity Workgroup, Session 1, Office of Minority Health and Health Disparities Presentation, Slide 19, https://www.marylandhbe.com/wp-content/uploads/2021/09/HEW_Final-Presentation_Session-1.pptx.pdf.
[6] Behavioral Risk Factor Surveillance Survey, 2015-2017, MHBE Health Equity Workgroup, Session 1, Office of Minority Health and Health Disparities Presentation, Slide 19, https://www.marylandhbe.com/wp-content/uploads/2021/09/HEW_Final-Presentation_Session-1.pptx.pdf.

Enrollment

As shown in Figure 3, Black/African American and Hispanic/Latino Marylanders are uninsured at disproportionately high rates compared to white Marylanders. MHBE dedicates marketing resources specifically to outreach to these populations. Workgroup members agreed that MHBE should not limit its scope to enrollment; MHBE should also concern itself with consumers' ability to use their benefits and coverage.

Figure 3: Uninsured Rates for the Nonelderly by Race/Ethnicity (Kaiser Family Foundation)[7]



MHBE's Role and Scope

The Maryland Health Benefit Exchange (MHBE) is a state-based health insurance marketplace launched in 2014. MHBE operates the Maryland Health Connection (MHC) enrollment platform, which includes a website, mobile app, and call center. MHC also partners with navigators who provide consumers with personal enrollment assistance. One in 5 Marylanders come through MHC to get coverage, whether through the individual market or Medicaid; although MHC is the "front door" for Medicaid enrollment, MHBE does not set Medicaid policy.

Purpose

Per §31-102(c) of the Maryland Insurance Article, the purpose of MHBE is as follows:

> *(c) Purpose. -- The purposes of the Exchange are to:*
>
> *(1) reduce the number of uninsured in the State;*

[7] "Uninsured Rates for the Nonelderly by Race/Ethnicity," *Kaiser Family Foundation,* 2019, https://www.kff.org/uninsured/state-indicator/nonelderly-uninsured-rate-by-raceethnicity.

(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.[8]

Plan certification

MHBE sets policy for qualified health plans (QHPs) offered on the individual market by defining plan benefits and working with insurers on the QHPs they offer on MHC. Because MHBE certifies these QHPs, it has some authority to guide plan design (e.g., which services are covered pre-deductible), and to dictate the information provided to consumers (e.g., insurers giving MHBE provider network data so MHBE can offer an integrated provider directory during plan shopping).

Marketing, outreach, and enrollment

MHBE has a budget of several million dollars for marketing and communications that is focused on underserved populations, specifically Black, Hispanic/Latino, and young adult Marylanders. MHBE has a strong outreach and enrollment presence through relationships with navigators, who work directly with consumers in communities.

Data capabilities

MHBE primarily collects and analyzes its own enrollment data. When necessary, MHBE works with the Maryland Health Care Commission (MHCC) to access claims data.

Affordability initiatives

The state reinsurance program (SRP) subsidizes high-cost claims to bring down the cost of premiums for everyone in the individual market. Premiums have dropped by about 30 percent since 2018 (from $235 to $162 per month, on average).[9] Beginning in January 2022, MHBE will launch a two-year state-funded pilot program that provides premium assistance to young adults aged 18-34.

[8] Md. Ins. Code Ann. §31-102(c).
[9] "State Reinsurance Program Annual Public Forum," *Maryland Health Benefit Exchange,* July 16, 2021, https://www.marylandhbe.com/wp-content/uploads/2021/07/Reinsurance-Annual-Public-Forum-2021_Presentation.pdf.

Limitations on authority

MHBE's Board of Trustees can take "any lawful action that the Board determines is necessary or convenient to carry out the functions authorized by the Affordable Care Act [ACA] and consistent with the purposes of the Exchange." However, the powers of the Board cannot supersede the "authority of the [Maryland Insurance] Commissioner to regulate business in the State" or the requirements of the ACA.[10]

Many factors beyond healthcare access, such as the social determinants of health (SDOH), contribute to health outcomes. MHBE has a specific role to play in addressing health disparities; although SDOH efforts are largely beyond MHBE's reach and are not addressed in these recommendations, the workgroup emphasizes the importance of improving SDOH for achieving health equity.

Current Health Equity Work in Maryland

The 2021 legislative session produced four bills addressing health equity. MHBE is not directly involved with these activities but should stay informed and act in alignment with them.

Maryland Heath Equity Resource Community Act

According to the Maryland Department of Health, this piece of legislation "provides significant new grant funding and state resources for local communities to address health disparities, improve health outcomes, expand access to primary care and prevention services, and help reduce health care costs. The Maryland Community Health Resources Commission (CHRC) will implement this Act with the assistance of the Health Equity Resource Community (HERC) Advisory Committee, the Maryland Department of Health's Office of Minority Health and Health Disparities, and Chesapeake Regional Information System for our Patients (CRISP)."[11]

Shirley Nathan-Pulliam Health Equity Act

This Act established the Maryland Commission on Health Equity, an organization which must use a health equity framework to evaluate the health of state residents and work collaboratively across government to improve health. The new Commission will examine the impact of a variety of social determinants of health (SDOH) on health outcomes in Maryland.[12] The Commission will explore and make recommendations about provider requirements for implicit bias training, training on race,

[10] Md. Ins. Code Ann. §31-102(d)(1); §31-106 (b).
[11] "Community Health Resources Commission," *Maryland Department of Health,* https://health.maryland.gov/mchrc/Pages/home.aspx.
[12] The list of SDOH in this Act includes safe and affordable housing; education; employment opportunities; economic stability; workplace diversity, equity, and inclusion; transportation; social justice; environment; public safety and incarceration; and food insecurity.

ethnicity, and language data collection, and National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care.[13]

Race and Ethnicity Information Act

This Act updated requirements for the Office of Minority Health and Health Disparities (MHHD) to work with the Maryland Health Care Commission to publish report cards on diversity in the health professions as well as on the prevalence of a range of diseases by race and ethnicity.[14]

Implicit Bias Training and the Office of Minority Health and Health Disparities Act

This Act also adds more components to MHHD's data reporting requirements. It also requires that, beginning in April 2022, anyone applying to renew a health occupations license or certification take an approved implicit bias training program. MHHD is charged with approving a list of implicit bias training programs that can be taken to fulfill these licensing requirements.[15]

Members

Workgroup members include representation from consumer advocates, navigators, physicians, insurers, state agencies, hospitals, and universities. They also represent the geographic diversity of Maryland.

Name	Affiliation
Dania Palanker (Chair)	Center on Health Insurance Reforms, Georgetown University
Sheila Woodhouse (Co-chair)	University of Maryland Medical Capital Region Health Medical Group
Richard Amador	HealthCare Access Maryland

[13] "Public Health - Maryland Commission on Health Equity (The Shirley Nathan-Pulliam Health Equity Act of 2021)," *Maryland General Assembly,* June 15, 2021, https://mgaleg.maryland.gov/mgawebsite/Legislation/Details/SB0052?ys=2021RS&eType=EmailBlastContent&eId=e81ebf07-7158-4d9c-90b1-953a356cb008.
[14] "Public Health – Data – Race and Ethnicity Information," *Maryland General Assembly,* June 15, 2021, https://mgaleg.maryland.gov/mgawebsite/Legislation/Details/SB0565?ys=2021RS&eType=EmailBlastContent&eId=e81ebf07-7158-4d9c-90b1-953a356cb008.
[15] "Public Health - Implicit Bias Training and the Office of Minority Health and Health Disparities," *Maryland General Assembly,* June 15, 2021, https://mgaleg.maryland.gov/mgawebsite/Legislation/Details/SB0005?ys=2021RS&eType=EmailBlastContent&eId=e81ebf07-7158-4d9c-90b1-953a356cb008.

Noel Brathwaite	MDH Office of Minority Health & Health Disparities
Alyssa Brown	MDH Office of Health Care Financing
Shari Curtis	Prince George's Healthcare Action Coalition
Bryan Gere	University of Maryland Eastern Shore
Diana Hsu	Maryland Hospital Association
Kim Jones-Fearing	Kim Jones-Fearing MD LLC
Stephanie Klapper	Maryland Citizens' Health Initiative
Nicole Mallette and Jimmy Williams*	Maryland Insurance Administration *Nicole Mallette – Sessions 1 & 2; Jimmy Williams – Sessions 3-8
Allison Mangiaracino	Kaiser Permanente
Jomy Mathew	United Healthcare
Joshua Morris	HealthCare Access Maryland
Marie-Therese Oyalowo	University of Maryland Eastern Shore
Ligia Peralta	Casa Ruben, Inc.
Megan Renfrew	Health Services Cost Review Commission
Patricia Swanson	CareFirst BlueCross BlueShield
Barbara Tighe	HealthCare Access Maryland
Nikki Highsmith Vernick	Horizon Foundation

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Content & Discussion Summary

The topics explored by the workgroup were those that members collectively ranked as the highest priority. MHBE staff presented the group with a list of possible topics, invited discussion and new ideas, and collected priorities with an online form. Each workgroup session focused on a different topic area, and most had a presentation from a subject matter expert. Some sessions included presentations from MHBE staff on the agency's current policies and practices, and a representative from each of the insurers that have plans on Maryland Health Connection (MHC) presented on their company's health equity efforts. For more details on any of the workgroup sessions, please see the meeting materials on the MHBE website.

Race and ethnicity data collection

MHBE collects data on race and ethnicity on the MHC application. One question asks about Hispanic ethnicity, and the race question provides a list of answers that includes many specific subgroups. These questions are required to be optional by CMS. Currently, fewer than 70 percent of applicants report race and ethnicity on their MHC application.

Workgroup members discussed additional barriers to answering race and ethnicity questions, such as low literacy, and how navigators and other consumer assistance workers (CAWs) can help address these barriers with consumers. There was some conversation about whether to cross-train navigators and community health workers: they provide resources to the same population but may not have the time or budget to perform both functions at the same time.

In this session, workgroup members also discussed and asked for more information on coverage for undocumented immigrants and other immigrants who are ineligible for coverage through Medicaid or through MHC.

Outreach and enrollment

The MHC marketing team conducts robust outreach and contracts with market research agencies to inform their strategy. Their target population is the QHP-eligible uninsured, including young adults ages 18-34, Black and Latinx/Hispanic communities, and residents of rural regions with high uninsured rates. MHC partners with organizations to reach different communities around the state through events, radio and television, billboards and signage, social media, faith-based groups, and more.

This session also featured a MHBE staff presentation on eligibility standards for immigrants based on the interest expressed in the previous session. 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 nonqualified immigrants and non-immigrants, such as student/work visa holders, temporary residents, or those with a pending application for asylum. 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. Undocumented immigrants and DACA recipients are not eligible for QHP, despite DACA recipients being lawfully present. Maryland is home to about 244,700 undocumented immigrants, about 116,000 of whom are uninsured.

The workgroup group discussed how granular, county-level analysis of race and ethnicity by eligibility status could help MHBE further target outreach to populations with disproportionately high uninsured rates. Data can't indicate directly which piece of marketing led a consumer to enroll, though there is a correlation between marketing efforts and open enrollment numbers. However, comparing the demographic makeup of the QHP-eligible population to the demographic makeup of the enrolled population in each county would indicate where efforts should be concentrated.

Health insurance literacy (HIL)

The group agreed that MHBE has a responsibility to ensure that patients are knowledgeable about and able to take advantage of their benefits once they are enrolled in a plan. Uncertainty over benefits, cost-sharing and pre-deductible coverage can lead patients to avoid necessary and preventive care.[16] For example, they may not trust that there is no cost-sharing for certain preventive services if they've experienced billing errors or difficulty affording bills before. More than half of adults in the U.S. report having low confidence in using their insurance to access health care and most adults have inadequate knowledge of their annual out-of-pocket costs and plan deductible amounts.[17] There are HIL disparities by race/ethnicity, socioeconomic status, and insurance status:[18] in one study, Black and Hispanic enrollees answered 53 percent and 50 percent of questions correctly on a test of HIL knowledge, respectively; white enrollees answered 74 percent correctly.[19]

MHBE's existing efforts to encourage benefit utilization includes preventive service email reminders to enrollees at ages 40 and 50 for mammograms and colonoscopies. Also, the Maryland Health Connection website offers decision support tools, including a total cost calculator on the plan shopping page, provider and drug search tools, and a live chat function. The MHC website has links to one-pagers for specific populations, such as Spanish-speaking consumers and the LGBTQ+ community.

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[16] Yagi, Brian, et al., Association of Health Insurance Literacy with Health Care Utilization: A Systematic Review, Journal of General Internal Medicine, May 2021 https://link.springer.com/article/10.1007/s11606-021-06819-0.

[17] Edward, Jean, et al., Significant Disparities Exist in Consumer Health Insurance Literacy: Implications for Health Care Reform, Health Literacy Research and Practice Volume 3, Issue 4, November 2019, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6831506/.

[18] Villagra, Victor, et al., Health Insurance Literacy: Disparities by Race, Ethnicity, and Language Preference, American Journal of Managed Care Volume 25, Issue 3, March 2019, https://www.ajmc.com/view/health-insurance-literacy-disparities-by-race-ethnicity-and-language-preference. ;
Edward, Jean, et al., Significant Disparities Exist in Consumer Health Insurance Literacy: Implications for Health Care Reform, Health Literacy Research and Practice Volume 3, Issue 4, November 2019, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6831506/.

[19] Villagra et al, 2019.

The workgroup agreed that understanding plan benefits is difficult for many people, for many different reasons, and that this can even be a barrier to enrollment and trust in the system for some. They discussed making coverage information materials simpler to understand and tailored to consumer needs. The group also reviewed open enrollment and special enrollment period rules for QHP and Medicaid as part of this conversation.

Community Health Workers (CHWs)

MHBE's Standing Advisory Committee has discussed the value of community health workers and addressing social determinants of health. The challenge to incorporating CHWs into a care strategy is the fee-for-service payment system in which they are not reimbursable. The health equity workgroup heard from the Maryland Primary Care Program (MDPCP) about their team-based, patient-centered care payment models that allow for the use of and payment for nontraditional services like CHWs to address the SDOH so that MHBE and insurers might consider how to support approaches to care that include CHWs and SDOH. Work in this area would not be unprecedented, as CareFirst is already an aligned payer with MDPCP.

In this session, workgroup members felt that it was challenging to identify a role for MHBE in addressing SDOH and exploring alternative payment models (APMs), but some acknowledged the value of considering the insurers' role in investing upstream in housing improvements, food security, and other structural social determinants of health.

Cost-sharing design

Conditions like asthma, diabetes, maternal mortality, and congestive heart failure disproportionately affect patients of color. Some states are attempting to reduce patients' cost burden for treating these conditions. From the MHBE perspective, most of these conditions are also among the highest-cost conditions reimbursed by the state reinsurance program. Reduced cost-sharing for these conditions could possibly reduce costs in addition to improving health outcomes. MHBE's value plans currently require insulin coverage without cost-sharing.

Many workgroup members agreed that reducing cost-sharing for these conditions is a good idea, but also discussed the challenge of keeping other services affordable. Insurers shared a concern that their plan offerings are already at the top of the allowable actuarial value range.

Presenters

The workgroup heard presentations from guest speakers as well as from each of the insurers that issue plans on the Exchange. For more details on any of these presentations, please see the meeting materials on the MHBE website.

Guest speakers

Dr. Noel Brathwaite, Director of the Maryland Office of Minority Health and Health Disparities (MHHD), presented in the first workgroup session on how MHHD is working towards its mission of

changing the trajectory of health disparities. MHHD provides Minority Outreach and Technical Assistance (MOTA) grants, provides COVID-19-related funding, and funds some community health workers. He also provided an overview of the several health equity bills that were passed during the 2021 legislative session.

Michelle Jester, Executive Director of Social Determinants of Health at America's Health Insurance Plans (AHIP), presented on best practices for collecting demographic data to advance health equity, and to a lesser extent, on promoting diverse provider networks.

An appropriate presenter on health insurance literacy could not be identified. Staff reached out to MHBE's health literacy contacts, including Dr. Cynthia Baur, Director of the Horowitz Center for Health Literacy at the University of Maryland School of Public Health, who informed us that the topic of health *insurance* literacy, as opposed to health literacy generally, has not recently been the subject of research and interventions as much as it was during the early years of the Affordable Care Act (ACA).

Emily Gruber, Health Equity Manager with the Maryland Primary Care Program, presented on MDPCP's advanced primary care model, which includes:

- Improvements in care delivery
- Integration of behavioral health in primary care
- Screening for social needs and referrals to resources
- Council of patients and caregivers to give feedback
- Performance-based incentive program
- Clinical quality measures aligned with state goals
- Patient engagement, shift care utilization to preventive care

The multidisciplinary care team approach used by MDPCP participating providers can include Community Health Workers (CHWs). In organizations that use this approach, CHWs help with addressing SDOH needs. CHWs are not used at every practice but are employed/deployed differently in the organizations where they are employed. Some are employees of the practice they work in, and some practices contract with community-based organizations that provide CHWs. There is no standard payment structure for CHWs within the program.

Jennifer Libster, Health Equity Advisor with the Washington DC Health Benefit Exchange Authority presented on how DC's Exchange is adjusting cost-sharing in their standard plans for conditions that disproportionately impact people of color in DC.

Insurer presentations

Kaiser Permanente's presenter was Stacey Shapiro, Senior Director of Population Care Management at Mid-Atlantic Permanente Medical Group. Ms. Shapiro shared an overview of how Kaiser Permanente is addressing health equity. Kaiser Permanente has national and local level diversity, equity, and inclusion (DEI) strategies for their workforce. They have achieved the Distinction in Multicultural Health Care from the National Committee on Quality Assurance (NCQA)

and have a race, ethnicity, and language data reporting rate of 80 percent. They use this data to identify areas for quality improvement and to decrease variation on performance metrics by race and ethnicity, as well as by age and gender. Kaiser Permanente also funds a mobile health vehicle and programs like Good Hair, Good Health to provide vaccinations and other preventive care.

CareFirst's presenter was Brian Wheeler, Vice President of Provider Collaboration and Network Transformation. Mr. Wheeler presented on CareFirst's health equity strategy and how their status as an aligned payer with Maryland's Primary Care Program (MDPCP) fits into this strategy. CareFirst collects local-level data and analytics to measure disparities and set targets for ongoing evaluation. They incentivize provider performance with respect to health equity and are trying to move from a volume-based system to a value-based system with patient-centered medical home (PCMH) and accountable care organization (ACO) models. They also invest in certain social and economic initiatives related to COVID relief, vaccines, food insecurity, and partner with community organizations. As an aligned payer with MDPCP, CareFirst follows MDPCP's principles for alignment, including financial incentives, care management, quality measures, data sharing, and "practice learning" (joint educational opportunities). They do not yet have the data showing the effectiveness of aligning with MDPCP but are using a social risk score algorithm to help them measure the impact of patient-centered care. Finally, CareFirst requires cultural competence and implicit bias training for providers.

UnitedHealthcare's presenter was Jomy Mathew, Chief Medical Officer, Community & State. Dr. Mathew expanded on previous workgroup discussion by sharing UHC's SDOH investment strategy. Because 80 percent of health outcomes are determined by social and environmental factors and only 20 percent by medical care, UHC believes that payers have a responsibility to act as community connectors and bring together organizations to solve community issues together. UHC is also working on performance measures to incentivize providers to "close the loop" on social needs referrals and make sure patients receive the services to which they were referred. UHC uses CHWs to help develop patient-centered care plans, often for frequent utilizers of emergency services who need more preventive care, and to conduct outreach to members who are especially vulnerable.

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Recommendations

The workgroup met a total of eight times to discuss the above topics and provides the following recommendations to the MHBE Standing Advisory Committee. The workgroup intends this as a starting place for MHBE to incorporate a focus on equity into its work; therefore, some recommendations encourage a deeper dive into certain topics.

MHBE should redesign demographic data question(s) on the MHC application, set response rate goals, and support data collection strategies that increase response rates.

Race and ethnicity

Redesigning the race and ethnicity questions on the MHC application could improve the response rate for this data, which would give MHBE a more accurate picture of enrollment disparities. Currently, less than 70% of MHC applicants report their race and ethnicity. Other states, like New York, and organizations like AHIP are increasing their data response rates with changes to their application questions.

The redesigned questions should be formatted to include an option for people who identify only as Latinx/Hispanic, not with any race, which may result in a single question for race/ethnicity instead of two. The terminology describing the Latinx/Hispanic category should be informed by community input. The question(s) should also include introductory text explaining how the race/ethnicity data will be used.

The response options should be inclusive without being overwhelming: the AHIP presentation showed examples with dropdown lists or accordion-style formats that expand when a larger category is clicked. Having specific response options can make applicants more likely to answer the question and would enable MHBE to further disaggregate data by subgroup. The MHC application could also require applicants to check a box that says “choose not to respond” instead of skipping the question.

MHBE should encourage insurers that carry plans on MHC to collect their own race/ethnicity data, but flexibility should be allowed on how this data is collected. Some carriers already have a data collection system in place; for example, Kaiser Permanente collects race/ethnicity data at the point of care and would not want to change this practice.

Other states, including California[20] and New York,[21] set targets for insurers' collection of race/ethnicity data and/or have insurers report the data back to them. Before emulating these states, MHBE should coordinate between its operations team and insurers. If deemed appropriate based on these discussions, MHBE could consider setting data collection goals in the plan certification standards for future plan years. MHBE should ensure that any data collection goals are attainable based on typical rates for similar organizations; such goals would not be enforced with penalties.

Sex and gender

Similarly, redesigning the sex and gender questions to be nonbinary-inclusive would improve MHBE's data on sex- and gender-based disparities. This redesign might include separating the sex/gender question into one question for sex assigned at birth and another for gender identity. The Washington State Health Benefit Exchange has begun redesigning its sex and gender questions to align with best practices.

Implementing redesigned sex and gender questions would require more preparation than the race/ethnicity question(s). MHBE would need to seek partnership with the trans community[22] for support, including insight on appropriate question wording and response options. Also, MHBE and MDH would need to work together to discuss the technical and operational updates that would be necessary for Medicaid to receive sex and gender data from MHC applications that is not in a binary format. Though Medicaid currently only has the technical capability to receive binary data for gender, MDH supports this change from a policy perspective.

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[20] https://hbex.coveredca.com/stakeholders/plan-management/PDFs/Plan-Management-Advisory-Slides_1_14_2016_FINAL.pdf slide 24 OR https://board.coveredca.com/meetings/2016/1-21/2017%20QHP%20Issuer%20Contract_Attachment%207_Final%20Draft_1-21-2016.pdf page 9 and for reference https://hbex.coveredca.com/stakeholders/plan-management/PDFs/Public-RE-Percentage-for-03-22-16-Meeting.pdf

[21] "Invitation and Requirements for Insurer Certification and Recertification for Participation in 2022," *NY State of Health,* page 52, https://info.nystateofhealth.ny.gov/sites/default/files/2022%20NY%20State%20of%20Health%20Plan%20Invitation.pdf.

"To reduce disparities across patient groups, health plans must first understand where disparities exist, the magnitude of the disparities, and why these disparities are occurring within their member population. As a first step towards stratification of quality data by patient race, ethnicity, language spoken, and other demographic variables health plans will need to increase reporting of data by race and ethnicity. The enrollment transactions that NY State of Health provides to health plans include self-reported race and ethnicity information that consumers provide as part of the NY State of Health application. Most, but not all, plans provide this data as part of the patient record with their QARR submissions. All plans must report this data with their QARR submissions."

[22] We are using "trans" as the umbrella term that includes non-binary, genderqueer, gender non-conforming, agender, bigender and other identities. The intersex community should also be consulted.

Implementation

MHBE should support enhanced training, including scripts and talking points, for call center staff and consumer assistance workers (CAWs) on how to ask new demographic questions about race, ethnicity, sex, and gender in an effective but nonconfrontational way. The goal for these questions is to collect better data, but not at the expense of the comfort of consumers. Part of New York's pilot for their new race and ethnicity data collection process included extensive training for call center and assistance workers.[23]

Future work

In general, the health equity workgroup recommends convening another workgroup dedicated to continuing the conversation about how to improve demographic data collection and how the data will be used when it is obtained.

Quality improvement was lower on the list of priorities for the workgroup to study, but they recommend that in the future, MHBE explore how to use the more robust stratified race and ethnicity data to inform quality improvement strategy. For example, MHBE could disaggregate the rate of certain services, such as preventive care screenings, by race and ethnicity to observe whether there are disparities and then work to correct any disparities.

MHBE should include achievement of Distinction in Multicultural Health Care from the National Committee for Quality Assurance (NCQA) as a plan certification standard for PY2024.

According to the final report of the social justice and health disparities working group at the Washington DC HBX, "NCQA awards Distinction in Multicultural Health Care to organizations that meet or exceed standards in providing culturally and linguistically appropriate services (CLAS). NCQA evaluates how well an organization complies with standards for:

- Collecting race/ethnicity and language data.
- Providing language assistance.
- Cultural responsiveness.
- Quality improvement of CLAS.
- Reduction of health care disparities."[24]

Washington DC's workgroup recommended that all their carriers achieve this NCQA distinction. As of this writing, MHC carriers are also in DC's market, so achieving the distinction in Maryland as

[23] Colin Planalp, "New York State of Health Pilot Yields Increased Race and Ethnicity Question Response Rates," *State Health and Value Strategies,* September 9, 2021, https://www.shvs.org/new-york-state-of-health-pilot-yields-increased-race-and-ethnicity-question-response-rates/.
[24] Recommendations of the Social Justice & Health Disparities Working Group to the District of Columbia Health Benefit Exchange Authority, *DC Health Benefit Exchange Authority,* July 12, 2021, https://hbx.dc.gov/sites/default/files/dc/sites/hbx/event_content/attachments/HBX Social Justice and Health Disparities Working Group Final Report_0.pdf.

well may be a relatively simpler endeavor. MHBE should align the timing of this requirement with DC's timeline as much as possible; the next opportunity to include the distinction would be Plan Year 2024 because plan certification standards for PY 2023 have already been approved.

Note: NCQA is transitioning the Distinction in Multicultural Health Care to "Health Equity Accreditation."[25] Carriers should consult with NCQA to determine what steps are appropriate for them based on where they are in the Distinction or Accreditation process.

MHBE should use improved data to set granular enrollment targets by race/ethnicity and geography and bolster population-specific targeted outreach strategies.

MHBE conducts outreach to populations with disproportionately high uninsured rates, including the Black and Latinx/Hispanic communities, and already reports race/ethnicity enrollment data at the state and county levels. By setting enrollment targets that are aligned with the demographics of the eligible population in each county, MHBE could further support existing outreach efforts. Currently, MHBE has one enrollment target: 30% of total on-exchange enrollment should be made up of young adults. Setting more goals like this would bring additional focus to the importance of community-specific outreach strategies and help MHBE's outreach team track their progress.

MHBE should support health insurance literacy with enhancements to the website and materials and potentially a curriculum for community organizations.

Health insurance literacy curriculum

MHBE should provide a health insurance literacy curriculum for community organizations. Such a curriculum should not be mandatory and should undergo frequent, regular updates to ensure the relevance of the information. Research shows that low health insurance literacy leads to avoidance of necessary care. Curricula are an interactive way to support community education about insurance terminology and the importance of insurance. Any curriculum adopted should be high-quality, culturally appropriate, and flexible enough to address the specific needs of each community within which it is used. Implementing this recommendation would require careful consideration of how the curriculum would be distributed and how the communicators would be trained and supported. For example, MHBE could consider partnering with universities to have students do health insurance literacy community outreach. Any organization MHBE partners with to create, customize, adopt and/or implement must be procured through MHBE's formal procurement process.

[25] "Health Equity Accreditation: Current Multicultural Healthcare Customers," *National Center for Quality Assurance,* https://www.ncqa.org/current-multicultural-healthcare-customers/, accessed March 10, 2022.

MHBE website and resource enhancements

MHBE should also provide additional consumer-focused resources on health insurance literacy on the MHC website. First, the website's chatbot, Flora, could be programmed to answer questions about key health insurance terms (e.g., deductible, coinsurance, etc.).

MHBE should enhance existing resources such as information on how to choose a plan and consumer assistance factsheets, and ensure that all materials explaining benefits and cost-sharing are as clear as possible and available in all the ways that consumers will engage with it. MHBE can do this by conducting focus groups and other consumer testing to inform the format and delivery of materials and could encourage insurers to increase outreach and clarify the presentation of coverage details as well. MHBE might also consider creating webpages with information on how to use insurance rather than focused on enrollment.

MHBE can use the tooltips on the plan shopping page that define key terms to further assist consumers to make educated choices about the best plan for them. For example, including more information on the benefits of a Silver CSR plan versus a Bronze plan could help consumers understand which plan would be higher-value for their situation. These tooltips should not be used to nudge or steer consumers towards specific plans or metal levels because a person's individual circumstances ultimately dictate which plan will be their best choice.

Enrollment experience for consumers with primary languages other than English

The workgroup frequently discussed how the enrollment experience could be improved for consumers with primary languages other than English and made several recommendations to this effect. In general, MHBE should audit the consumer experience for consumers with primary languages other than English, particularly Spanish speakers. Based on feedback from consumer assistance workers, the Spanish translation of the MHC and MHBE websites should be audited for accuracy and translations improved as necessary. Search engine optimization (SEO) should also be audited to ensure that Spanish-language web searches yield links to the MHC website—one workgroup member mentioned that their clients cannot always find the MHC website when searching for health insurance in Spanish. MHBE can also audit the application-to-mailing process to ensure that consumers receive mailings in Spanish if they reported their primary language as Spanish on the application. Lastly, MHBE could provide training on technical terminology for all assisters in English, Spanish, and other languages as necessary with a focus on interpreting this terminology for consumers. This recommendation responds to feedback about the inconsistency of the quality of interpretation.

MHBE and insurers should continue discussing alternative payment models (APMs) that support community health workers (CHWs).

MHBE can aid these discussions with continued research on CHW payment models. MHBE can also encourage insurers to continue supporting upstream social determinants of health. Lastly, the workgroup believes there is value in supporting navigators and CHWs to share resources and refer

clients to each other but does not necessarily support a recommendation to cross-train navigators and CHWs because of the additional burden this would place on individuals in these roles.

MHBE and insurers should continue exploring the feasibility of reducing cost-sharing for high-disparity conditions.

Specifically, MHBE and insurers should explore the feasibility of applying the Plan Year 2022 Value Plan standard for diabetes supplies to all private plans on MHC, not just value plans. This would eliminate insulin and glucometer cost-sharing for all private plans on MHC. MHBE should also continue exploring the feasibility of eliminating and/or reducing cost sharing in value plans for services that prevent and manage other conditions besides diabetes that disproportionately impact patients of color in Maryland. In determining which conditions to prioritize, MHBE should consider:

- Which conditions have evidence of the highest disproportionate impact and cost-related barriers to care,
- How MHBE can align priorities with the Statewide Integrated Health Improvement Strategy and other state population health goals, and
- The cost impact to the state reinsurance program, since many high-disparity conditions are also among the most common or high-cost.

MHBE and insurers would need to start with small cost-sharing changes with minimal impact to actuarial value (AV). The workgroup discussed the "balloon effect" challenge of adjusting cost-sharing while staying within the statutory requirements for AV: reducing cost-sharing in one area often requires an increase in other patient cost-sharing features such as deductibles, out of pocket maximums, copays, and coinsurance. Additionally, changes to predeductible coverage and cost-sharing would affect the compatibility of high deductible health plans (HDHPs, as defined by §223(B)(2) of the Internal Revenue Code) with Health Savings Accounts (HSAs). Any cost-sharing changes should account for the effect on HDHPs offered on MHC.

MHBE should continue exploration and discussion of coverage options for individuals who are currently ineligible for existing programs—specifically undocumented immigrants.

The workgroup discussed the barriers to healthcare faced by documented and undocumented immigrants and how equitable outcomes cannot be achieved without facilitating access to care for certain populations.

MHBE should take internal action to address implicit bias.

Advancing equity requires an equity approach in all areas, even for those who do not have direct interactions with consumers or patients. MHBE should institute regular implicit bias training for internal staff and contractors, and strengthen opportunities for vendors, call center staff, consumer assistance workers, connector entity staff, and other staff to take implicit bias training. Whatever training is implemented should be procured through MHBE's formal process.

MHBE should act within its scope to address implicit bias at the point of care.

MHBE's role in promoting equity at the point of care will likely be a supportive one, as equity and implicit bias are the subject of new state legislation and action by other state agencies. MIA is integrating cultural competency into network adequacy regulations; MHBE should support and follow the progress of these regulatory updates in case action is necessary. Additionally, care providers are newly required to take one implicit bias training to renew their licensure or certification through the state occupations boards. The Office of Minority Health and Health Disparities is newly required to cultivate a list of implicit bias trainings that they certify for use in compliance with new provider licensing and certification requirements.[26] MHBE should stay engaged with these activities to ensure that the pathway to care after health insurance enrollment is equitable and continue to explore what MHC carriers are doing to combat implicit bias and advance equity.

Partnership and collaboration

As much as possible, MHBE should collaborate with existing partners, and form new partnerships with relevant groups, especially community- and local-level organizations, to move forward on these recommendations.

MHBE should establish regular, face-to-face opportunities for feedback with representatives of existing partners that work directly with consumers, such as connector entities, and should solicit direct consumer insights by facilitating listening sessions. These sessions should be less structured than focus groups and more like the semi-structured interviews used in qualitative research. A less formal structure would allow participants to guide the conversation and feel heard. One workgroup member suggested emulating the regional meetings conducted to design the Health Equity Resource Communities grants. Alternatively, MHBE could work with partners to request time on the agendas of existing community meetings that might have more reach and participation.

MHBE should make sure that the meetings are as accessible to consumers as possible. If held in person, any listening session should also be available for participation online. MHBE should also identify a way to compensate consumers for participating in listening sessions. The time commitment to participate can be a barrier for many who do not have expendable time or income. Providing compensation will increase engagement and improve the diversity of experiences that participants represent.

Lastly, it was specifically noted by workgroup members that MHBE should coordinate with MIA on any off-exchange implications of new, equity-focused policies.

[i] By eliminating insulin and glucometer cost-sharing.

[26] Implicit Bias Training and the Office of Minority Health and Health Disparities Act of 2021.