MHBE Health Equity Workgroup

Session 1 – August 31, 2021

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Agenda

3:00 - 3:20 | Welcome and Introductions
Johanna Fabian-Marks, MHBE Director of Policy and Plan Management, and Becca Lane, MHBE Health Policy Analyst

3:20 - 3:30 | Workgroup Charter: Discussion and Vote
All members

3:30 - 3:50 | Presentation from the Maryland Office of Minority Health and Health Disparities
Dr. Noel Brathwaite, MHHD Director

3:50 - 3:55 | Insurance Enrollment by Race & Ethnicity
Johanna Fabian-Marks, MHBE Director of Policy and Plan Management, and Becca Lane, MHBE Health Policy Analyst

3:55 - 4:25 | Discussion of Possible Focus Areas & Priority Setting
All members

4:25 - 4:30 | Public Comment

4:30 | Adjournment

Members

Member	Affiliation
Richard Amador	HealthCare Access MD
William Ashley	LifeBridge Health System
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	Maryland Insurance Administration
Theressa Lee	Maryland Health Care Commission
Allison Mangiaracino	Kaiser Permanente

Member	Affiliation
Jomy Mathew	United Healthcare
Joshua Morris	HealthCare Access MD
Marie-Therese Oyalowo	University of Maryland Eastern Shore
Dania Palanker*	Center on Health Insurance Reforms, Georgetown University
Ligia Peralta	Casa Ruben, Inc.
Megan Renfrew	Health Services Cost Review Commission
Patricia Swanson	CareFirst BlueCross BlueShield
Barbara Tighe	HealthCare Access MD
Nikki Highsmith Vernick	The Horizon Foundation
Sheila Woodhouse*	University of Maryland Medical Capital Region Health Medical Group

*Interested in co-chairing

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Introduction to MHBE

Introduction to MHBE

What is MHBE?

- Independent state agency

- Operates Maryland Health Connection

- Serves 1 in 5 Marylanders
  o 165,000 enrollees in individual market
  o 1.2 million in Medicaid

MHBE Strengths and Opportunities

- Marketing and communication

- Outreach and enrollment

- Data analytics

- Plan certification

- Affordability initiatives (reinsurance, young adult premium assistance)

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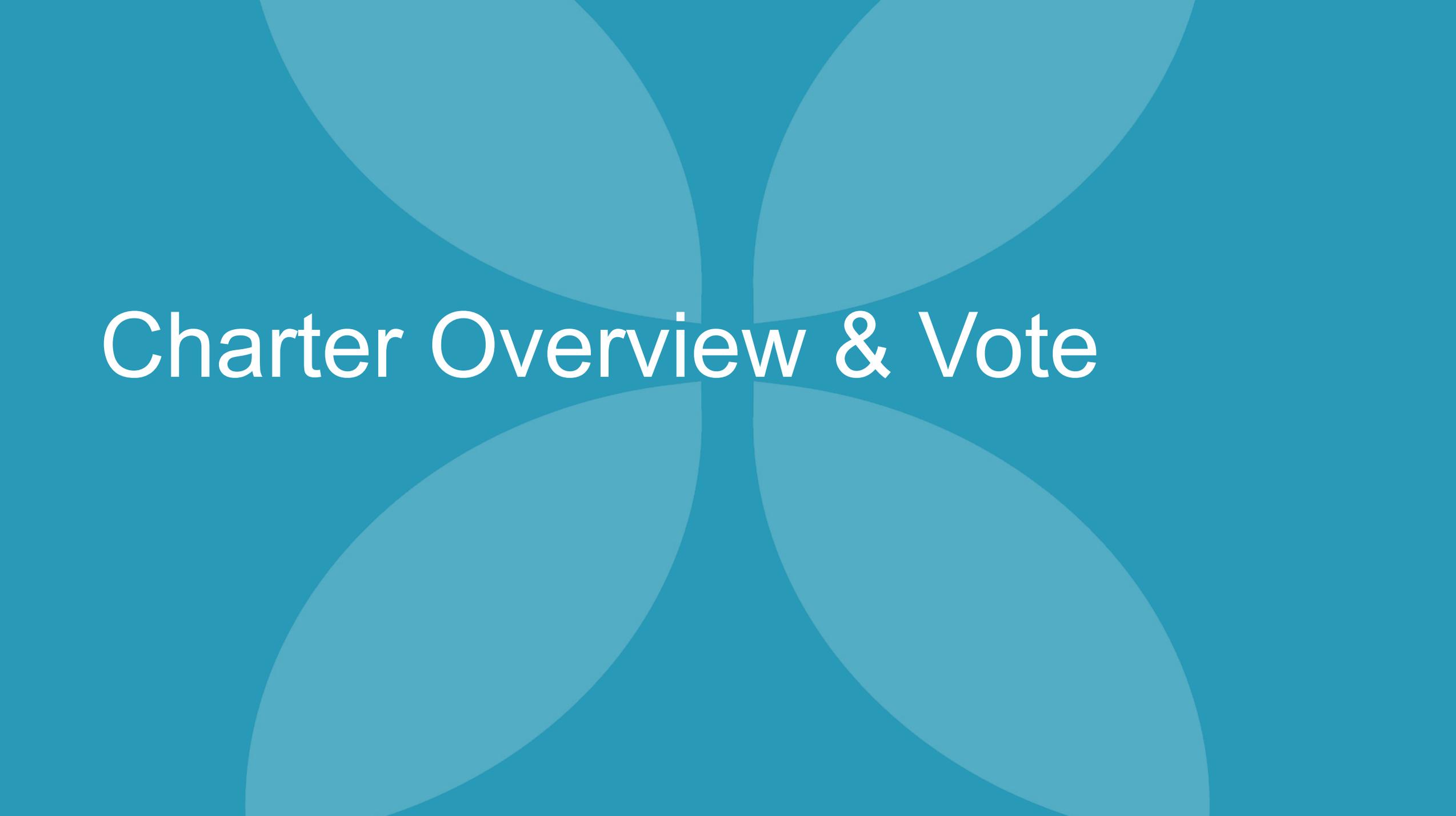
Charter Overview & Vote

Health Equity Definitions

- Health equity

- Health inequities

- Race & ethnicity

- Social determinants of health

STATE Health & Value **STRATEGIES** | Driving Innovation Across States

A program supported by the Robert Wood Johnson Foundation

Home   About   Resources for States   Expert Perspectives   Contact   COVID-19   Health Equity

Templates & Toolkits | Aug 9, 2021

Health Equity Language Guide for State Officials

Tekisha Dwan Everette, Dashni Sathasivam, and Karen Siegel, Health Equity Solutions

HEALTH EQUITY:[4,5,6,7,8] 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.

Further Context: When focusing on racial equity in health, advancing health equity means dismantling the systemic racism that underlies differences in the opportunity to be healthy, including addressing social and economic barriers to positive health outcomes. Since we have never had a truly equitable health care system, progress toward the goal of health equity is often benchmarked by measuring reductions in health disparities.

Terminology in Action: *Health Equity* in All Policies is an approach that incorporates an equity lens in the policy-making process within the executive branch with the goal of addressing structural racism and the related social and economic factors contributing to inequities in health and opportunity.

Use this term when: The people facing disparities are part of a minoritized or historically oppressed group.

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/.

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Presentation from the Maryland Office of Minority Health and Health Disparities

Health Equity Workgroup Meeting

Maryland Health Benefit Exchange

Noel Brathwaite, PhD

Director, Office of Minority Health and Health Disparities

Maryland Department of Health

August 31, 2021

Health Disparities
In the Age of COVID-19

Definition

A health disparity is when a group of people (as per Census designation) experience a higher or disproportionate rate of illness, injury, disability, or death than another or comparison group.

Impact/Effect

HDs can have a profound, negative effect on entire population or individual communities.
Examples: Difference in accessing quality care and support services; ability to get a diagnosis, manage the disease; uneven representation in health care professions, research and clinical trials.
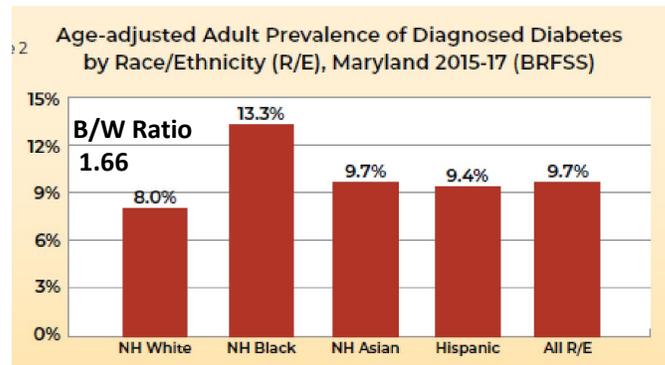
COVID-19 Exacerbated Racial Health Gaps/Differences

Reasons for Minority Disparities
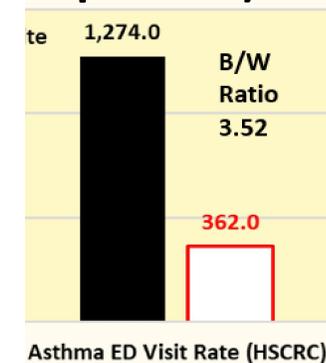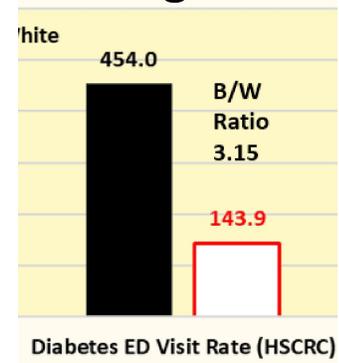# (COVID Influence)

- **Higher minority <u>frequency</u> of infections (more cases):**
  - More employment in essential occupations
  - Less ability to telework (*causing between household spread*)
  - More likely to be in larger, high density, multigenerational households (*causing within household spread*)
  - Combining "between household spread" and "within household spread": *2x by 2x => 4x more infection probability*

- **Higher minority <u>severity</u> once infected:**
  - Less access to healthcare resources due to poverty and racism
  - Higher prevalence/severity of comorbidities (HTN, Diabetes, Asthma, etc.)
  - Higher general stress due to violence, poverty and racism

Maryland Disparities in COVID-19 Relevant Comorbidities

- **Minorities have higher disease prevalence for several relevant high-risk COVID comorbidities**

- **And much higher severity (seen in the huge ED visits disparities)**

Age-adjusted Adult Prevalence of Diagnosed Diabetes by Race/Ethnicity (R/E), Maryland 2015-17 (BRFSS)

B/W Ratio 1.66

NH White 8.0%, NH Black 13.3%, NH Asian 9.7%, Hispanic 9.4%, All R/E 9.7%

Diabetes ED Visit Rate (HSCRC) — White 454.0, B/W Ratio 3.15, 143.9

Asthma ED Visit Rate (HSCRC) — 1,274.0, B/W Ratio 3.52, 362.0

High Blood Pressure ED Visit Rate — 662.1, B/W Ratio 3.27, 202.6

■ Black □ White

Age-adjusted rate per 100,000 population, 2017 data, HSCRC
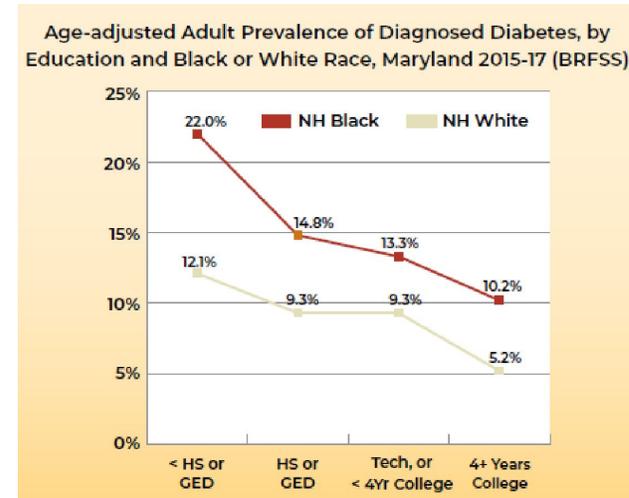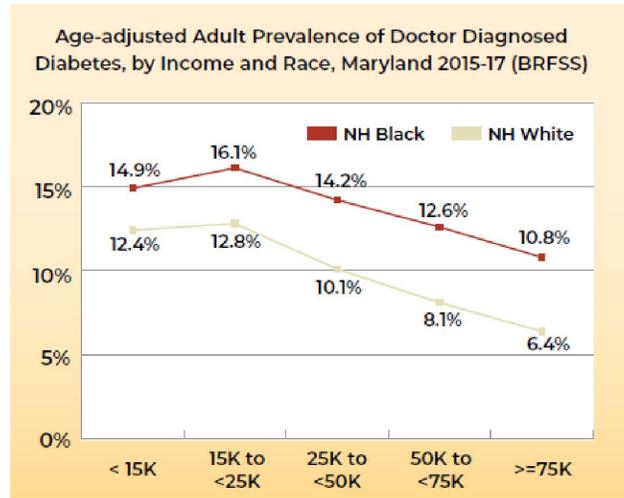
How Social Determinants Drive Health Factors

Role of Social Determinants

- **Income/Education matters in health regardless of race.**
- **Race matters in health regardless of income/education.**
- **Minorities have lower income/education and suffer worse health outcomes.**
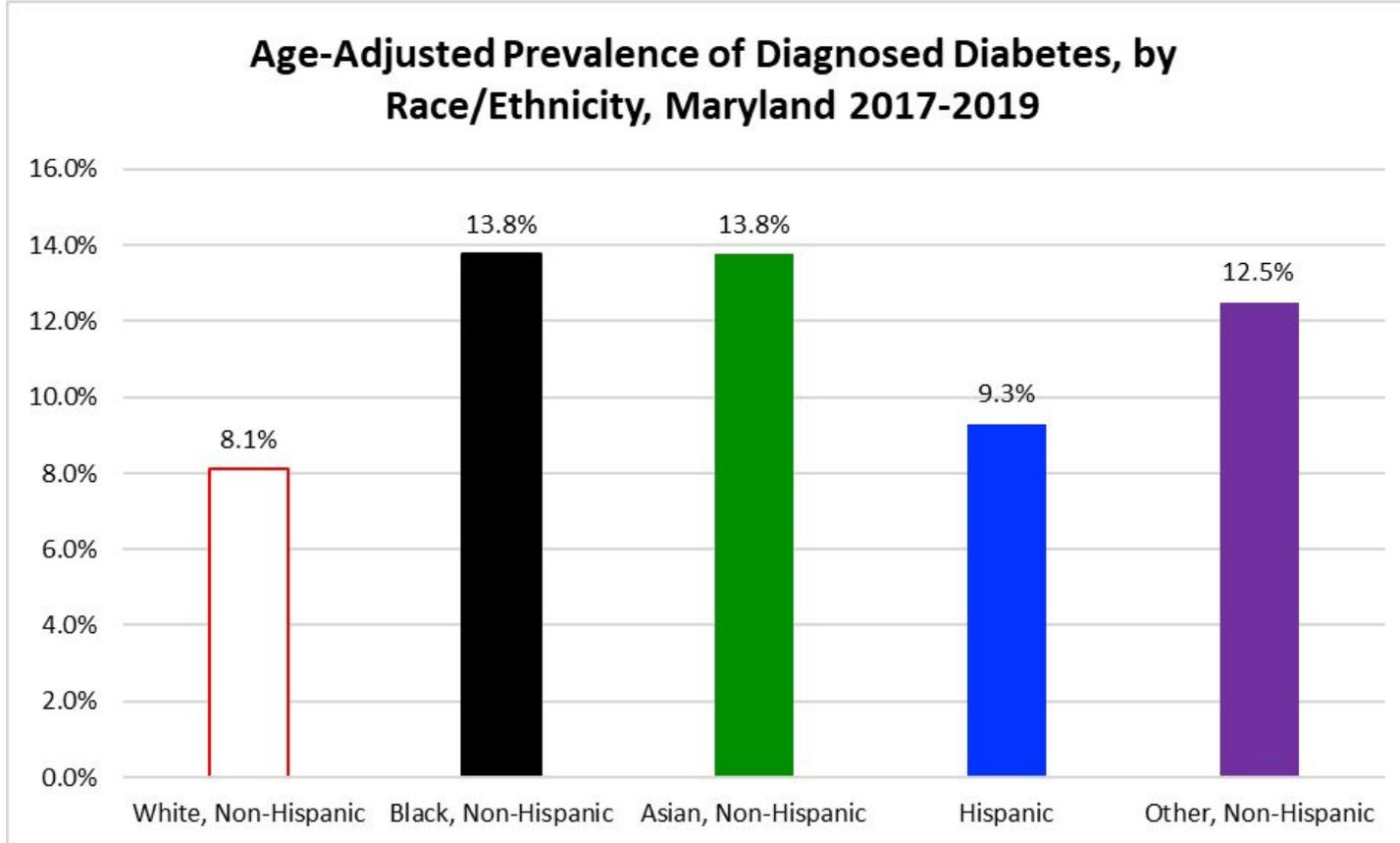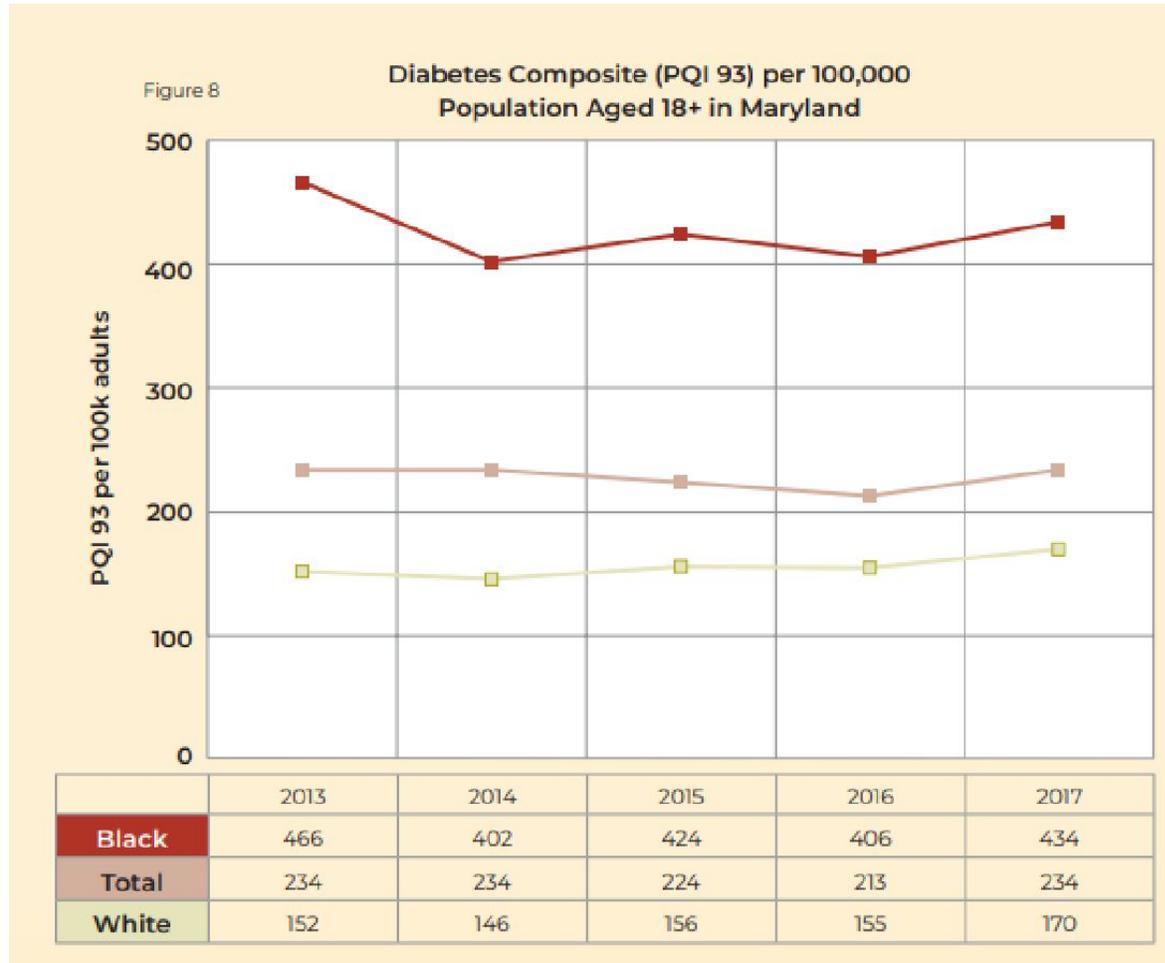
<u>Diabetes Example</u>

Maryland Diabetes Action Plan
https://phpa.health.maryland.gov/ccdpc/Documents/Diabetes%20Action%20Plan%20
documents/Diabetes%20Action%20Plan%20June%201%202020.pdf

Case Study:
Diabetes Disparities

Diabetes Prevalence Disparities

Age-Adjusted Prevalence of Diagnosed Diabetes, by Race/Ethnicity, Maryland 2017-2019

Diabetes Hospital Admission Disparities

Figure 8

Diabetes Composite (PQI 93) per 100,000 Population Aged 18+ in Maryland

PQI 93 per 100k adults

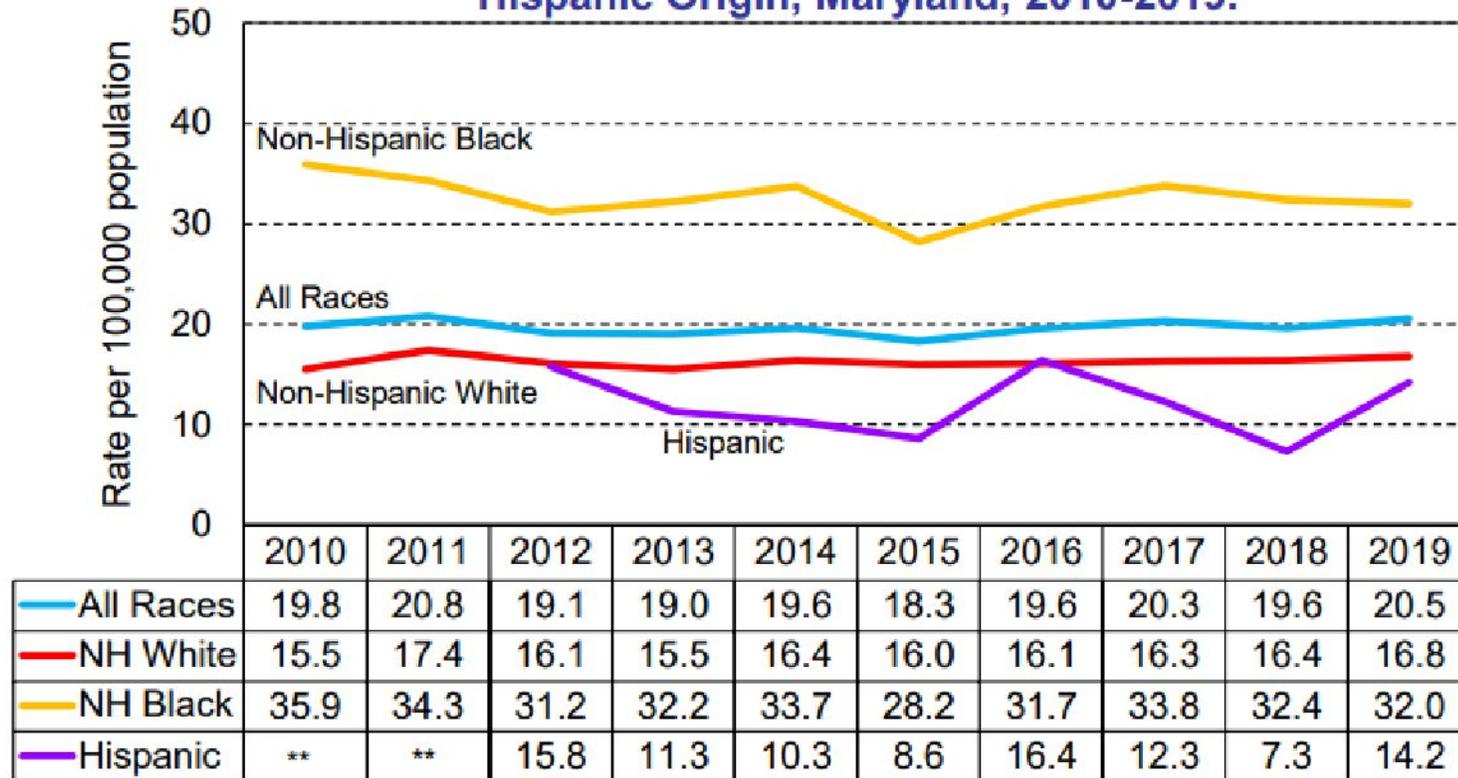|	2013	2014	2015	2016	2017
Black	466	402	424	406	434
Total	234	234	224	213	234
White	152	146	156	155	170

PQI 93 is a composite of all of the Diabetes Admissions that are preventable by good Primary Care.

Diabetes Mortality Disparities

DIABETES MELLITUS
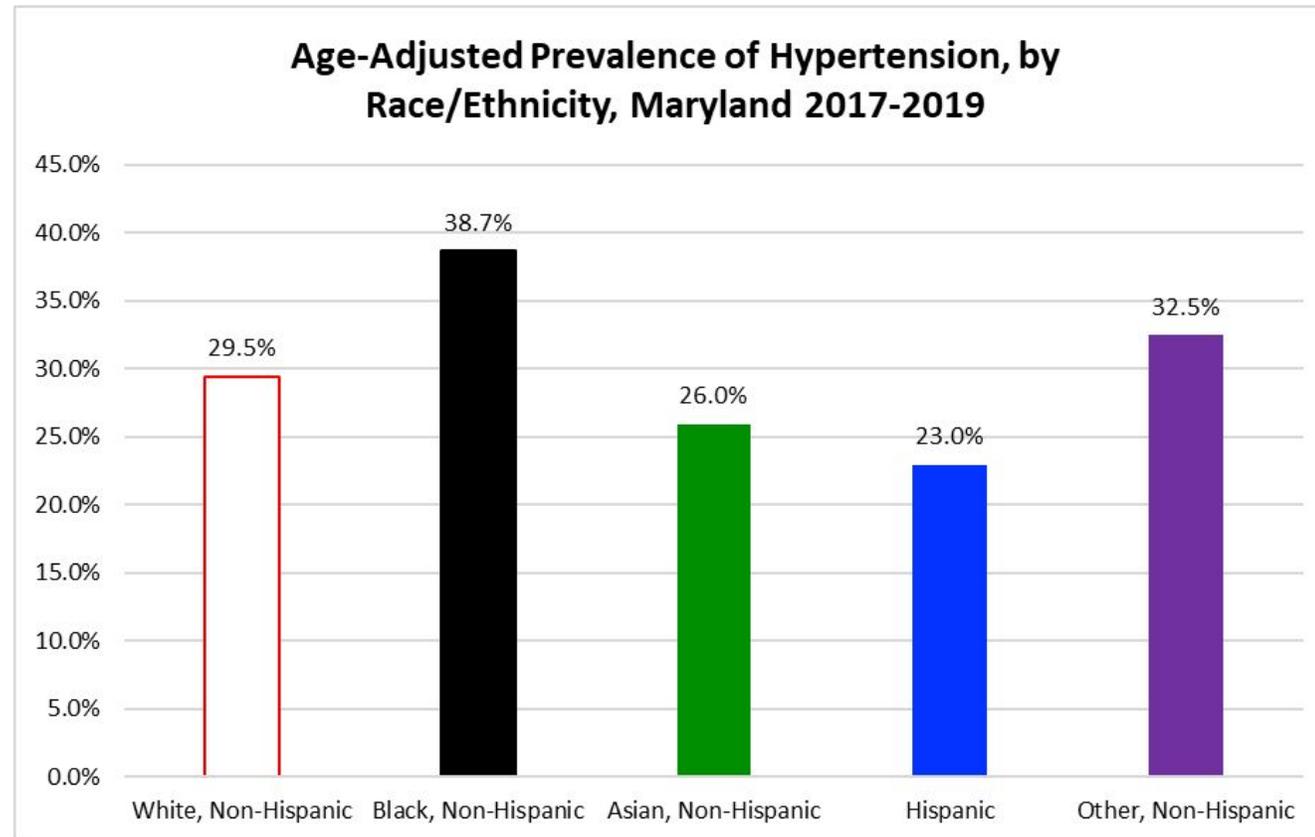
Age-Adjusted Death Rate* for Diabetes by Race and Hispanic Origin, Maryland, 2010-2019.

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
All Races	19.8	20.8	19.1	19.0	19.6	18.3	19.6	20.3	19.6	20.5
NH White	15.5	17.4	16.1	15.5	16.4	16.0	16.1	16.3	16.4	16.8
NH Black	35.9	34.3	31.2	32.2	33.7	28.2	31.7	33.8	32.4	32.0
Hispanic	**	**	15.8	11.3	10.3	8.6	16.4	12.3	7.3	14.2

Case Study:
Cardiovascular Disease Disparity

Hypertension Prevalence Disparities

Age-Adjusted Prevalence of Hypertension, by Race/Ethnicity, Maryland 2017-2019

Heart Disease Death Disparities

DISEASES OF THE HEART

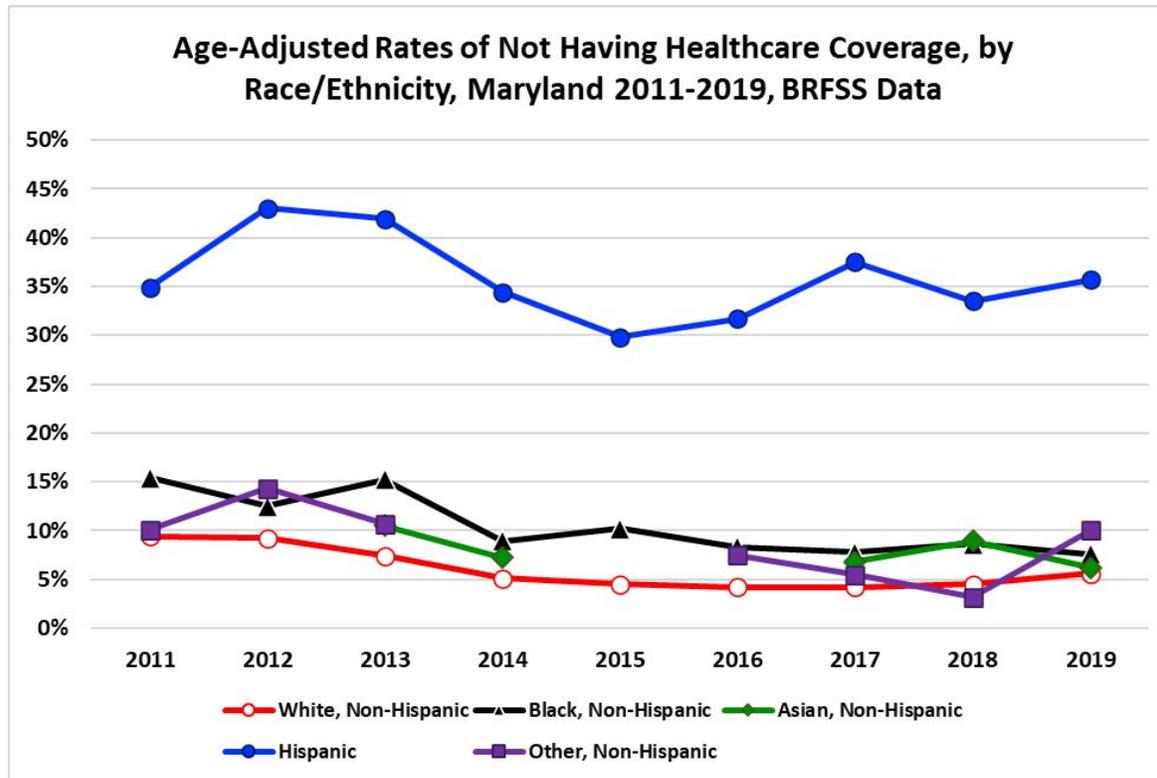**Age-Adjusted Death Rate* for Diseases of the Heart by Race and Hispanic Origin, Maryland, 2010-2019.**

Non-Hispanic Black

All Races

Non-Hispanic White

Hispanic

Rate per 100,000 population
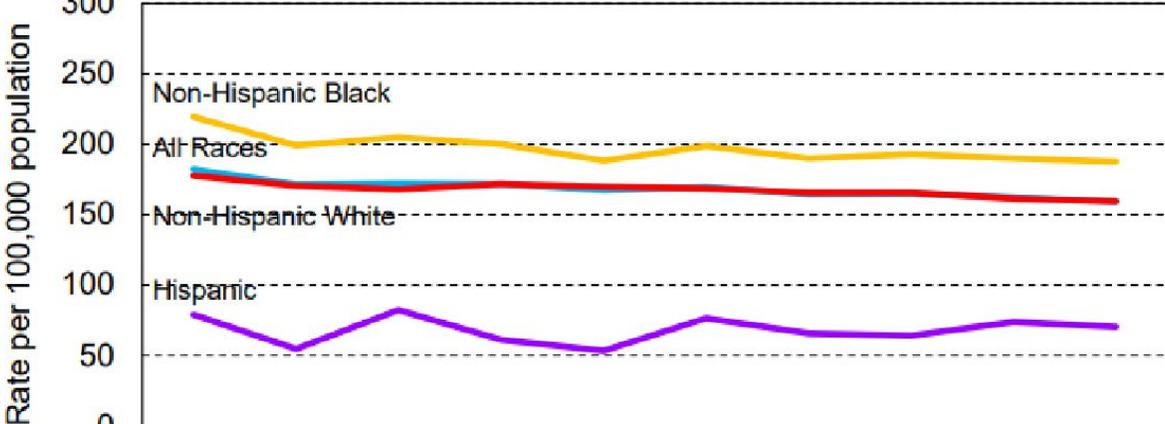
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
All Races	182.0	171.4	171.9	171.7	167.1	169.3	164.6	164.8	162.1	159.5
NH White	177.5	170.4	167.8	171.6	169.8	168.6	165.4	165.5	161.3	159.5
NH Black	219.3	198.9	204.7	199.8	188.4	198.6	190.0	192.7	190.0	187.7
Hispanic	78.8	54.5	82.1	60.9	53.2	76.3	65.5	64.1	73.7	70.2

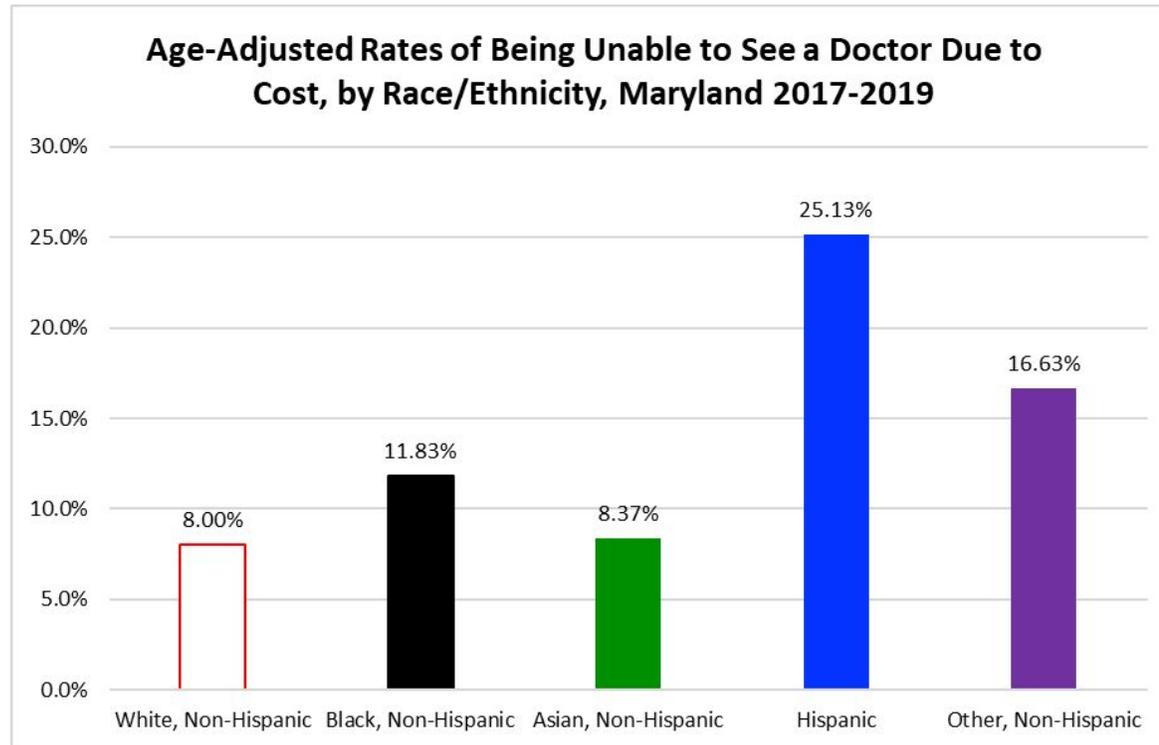# Case Study:
Health Insurance Disparity

Health Insurance Disparities

- **The ACA improved health insurance coverage for most groups.**
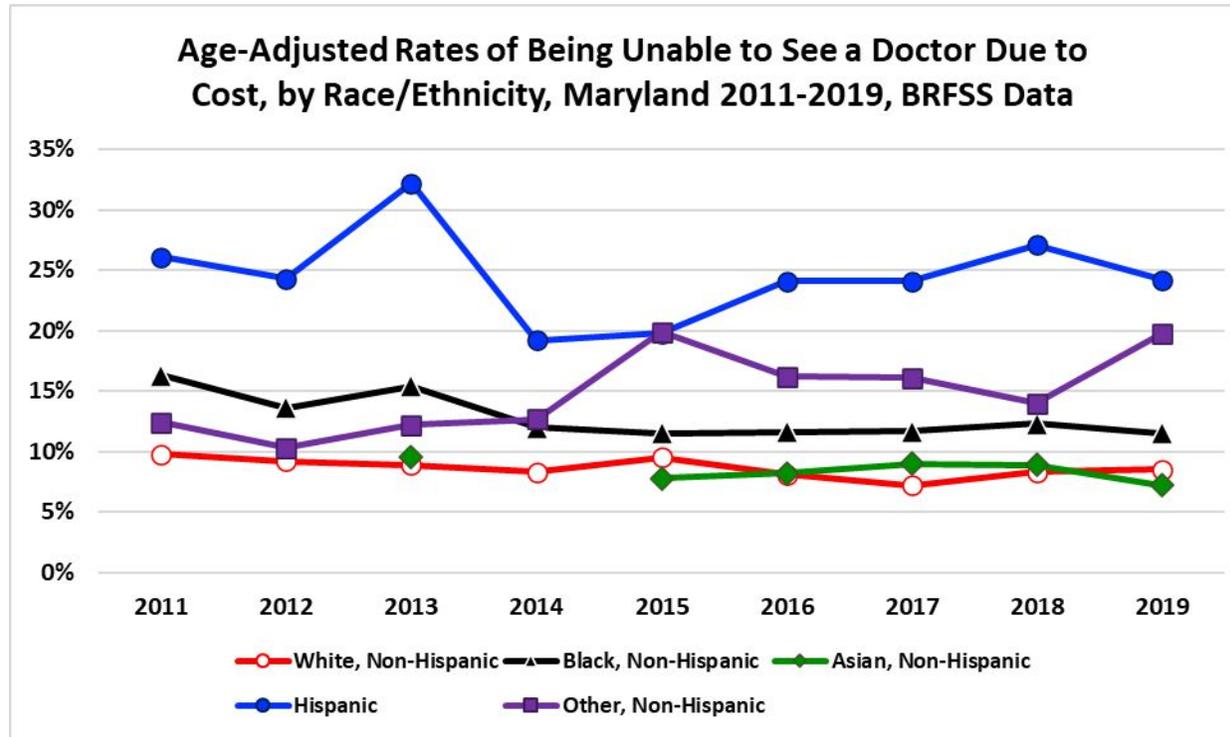- **Although under the Trump administration, improvements flattened. And for Hispanics, reversed.**

Age-Adjusted Rates of Not Having Healthcare Coverage, by Race/Ethnicity, Maryland 2011-2019, BRFSS Data

Legend: —○— White, Non-Hispanic ▲▲▲ Black, Non-Hispanic ◆ Asian, Non-Hispanic
●— Hispanic ■ Other, Non-Hispanic

Affordability of Care Disparities by Race/Ethnicity

Minorities, especially Hispanics, are much less able to afford doctor visits.

Age-Adjusted Rates of Being Unable to See a Doctor Due to Cost, by Race/Ethnicity, Maryland 2017-2019

- White, Non-Hispanic: 8.00%
- Black, Non-Hispanic: 11.83%
- Asian, Non-Hispanic: 8.37%
- Hispanic: 25.13%
- Other, Non-Hispanic: 16.63%

Affordability of Care Disparities by Years (2011 to 2019)

Age-Adjusted Rates of Being Unable to See a Doctor Due to Cost, by Race/Ethnicity, Maryland 2011-2019, BRFSS Data

SECTION II

Role and Work of MHHD In Addressing Disparities

MHHD MISSION

EMBRACE

 Accessing Health Insurance In Low Income, Language Challenged, Immigrant Community. Langley Park, PGC

MOTA

NON-COVID

- ⬜ 21 GRANTEES IN 15 JURISDICTIONS

COVID

- ⬜ EASTERN SHORE POULTRY WORKERS

- ⬜ NEW CDC DETECTION: DEPLOYING 8 CHWs

Local Health Departments

 COVID-19

      CARES FUNDING

      ELC DETECTION : 12 CHWs

      ELC EXPANSION

Legislative Mandates 2021

Bill	Bill Title
HB0028/SB5	Public Health – Implicit Bias Training
HB0309/SB565	Public Health - Data - Race and Ethnicity Information
HB0463/SB172	Maryland Health Equity Resource Act
SB0052/HB78	Public Health – Maryland Commission on Health Equity (The Shirley Nathan–Pulliam Health Equity Act of 2021)

New Funding Expansion

- Addressing Social Determinants of Health and Cultural Competency

- SDOH prevent from getting MC in the first place

Q & A
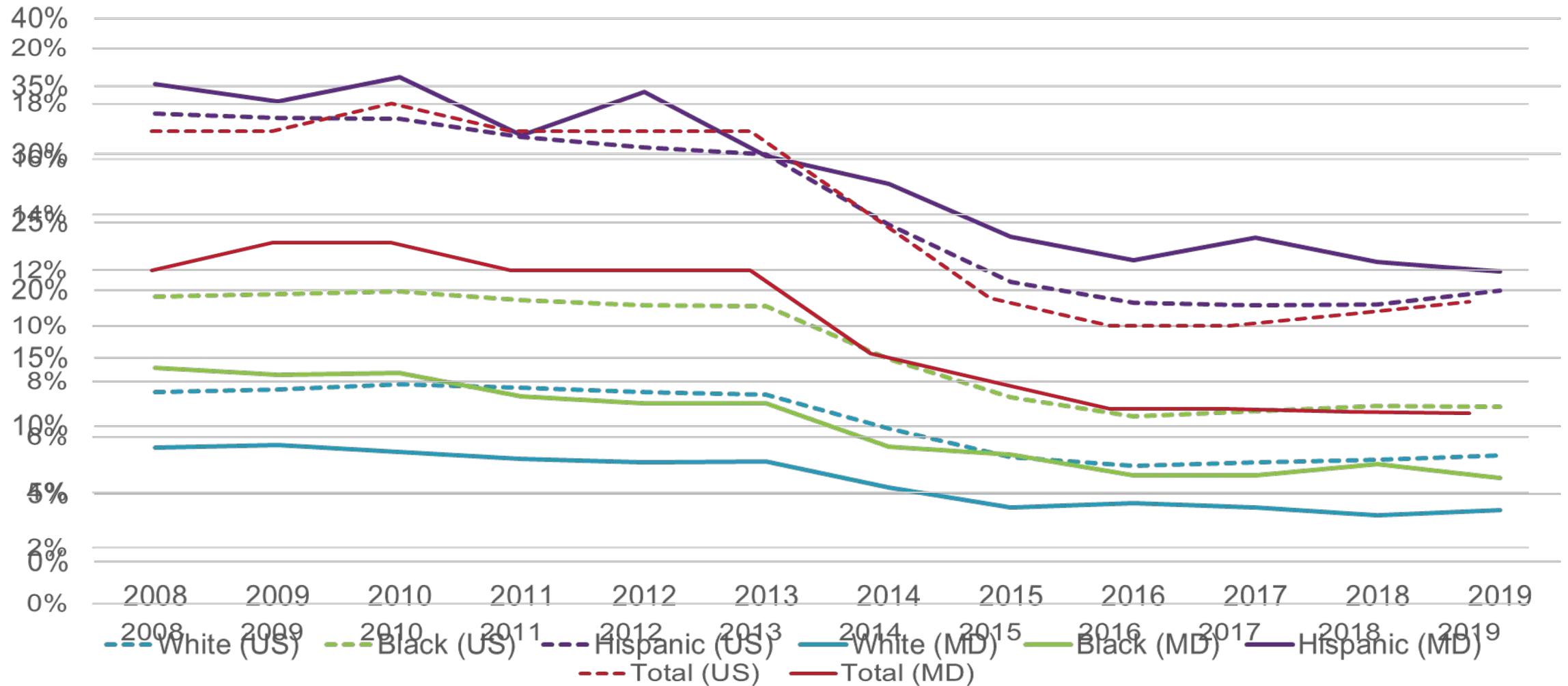
Thanks for attending!

Do you have any Questions?

We can be contacted through our website. MHHD -

https://health.maryland.gov/MHHD

Or by email:

MDH.HealthDisparities@Maryland.gov

Enrollment by Race & Ethnicity

Percent Uninsured by Race and Ethnicity, MD and US

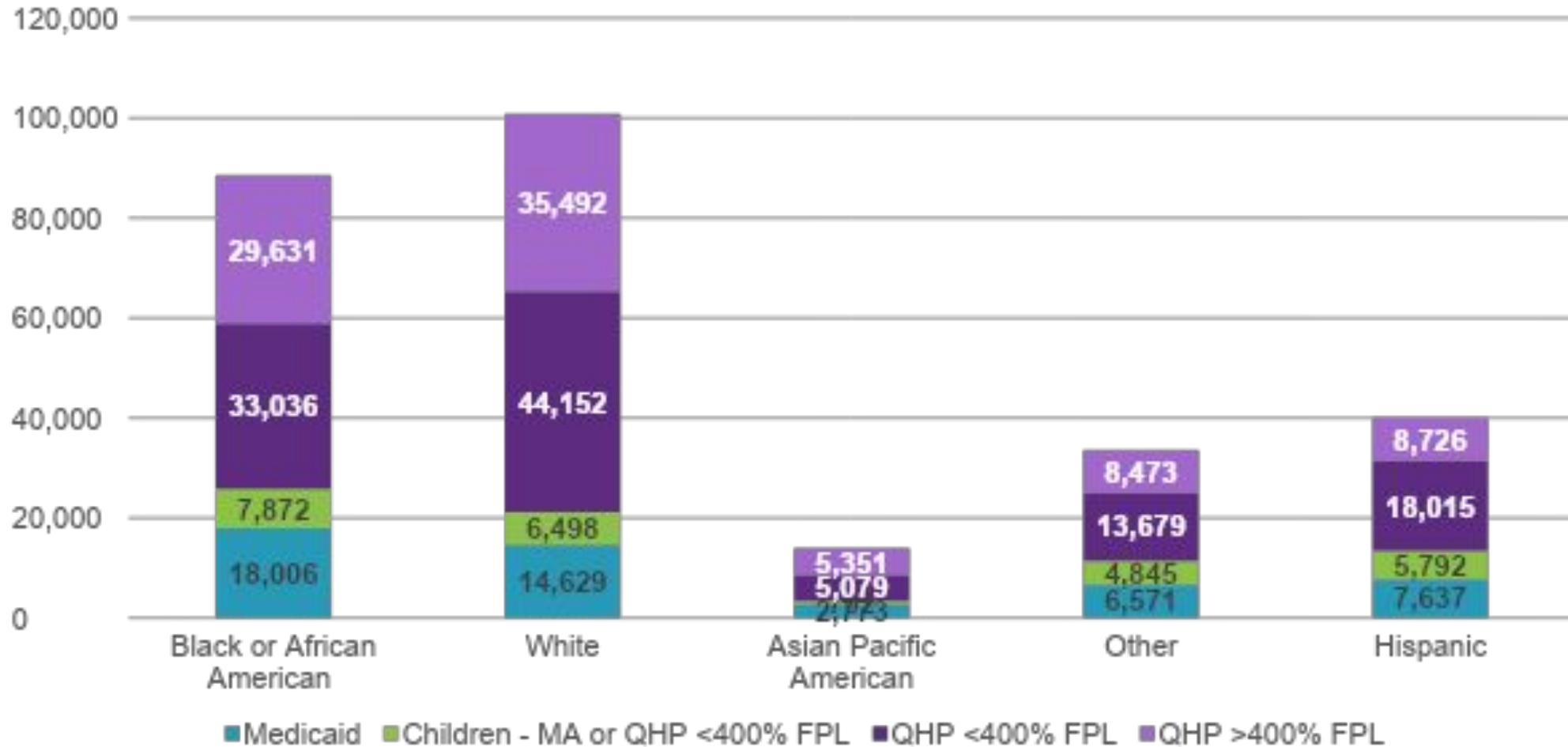Legend: White (US), Black (US), Hispanic (US), White (MD), Black (MD), Hispanic (MD), Total (US), Total (MD)

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.
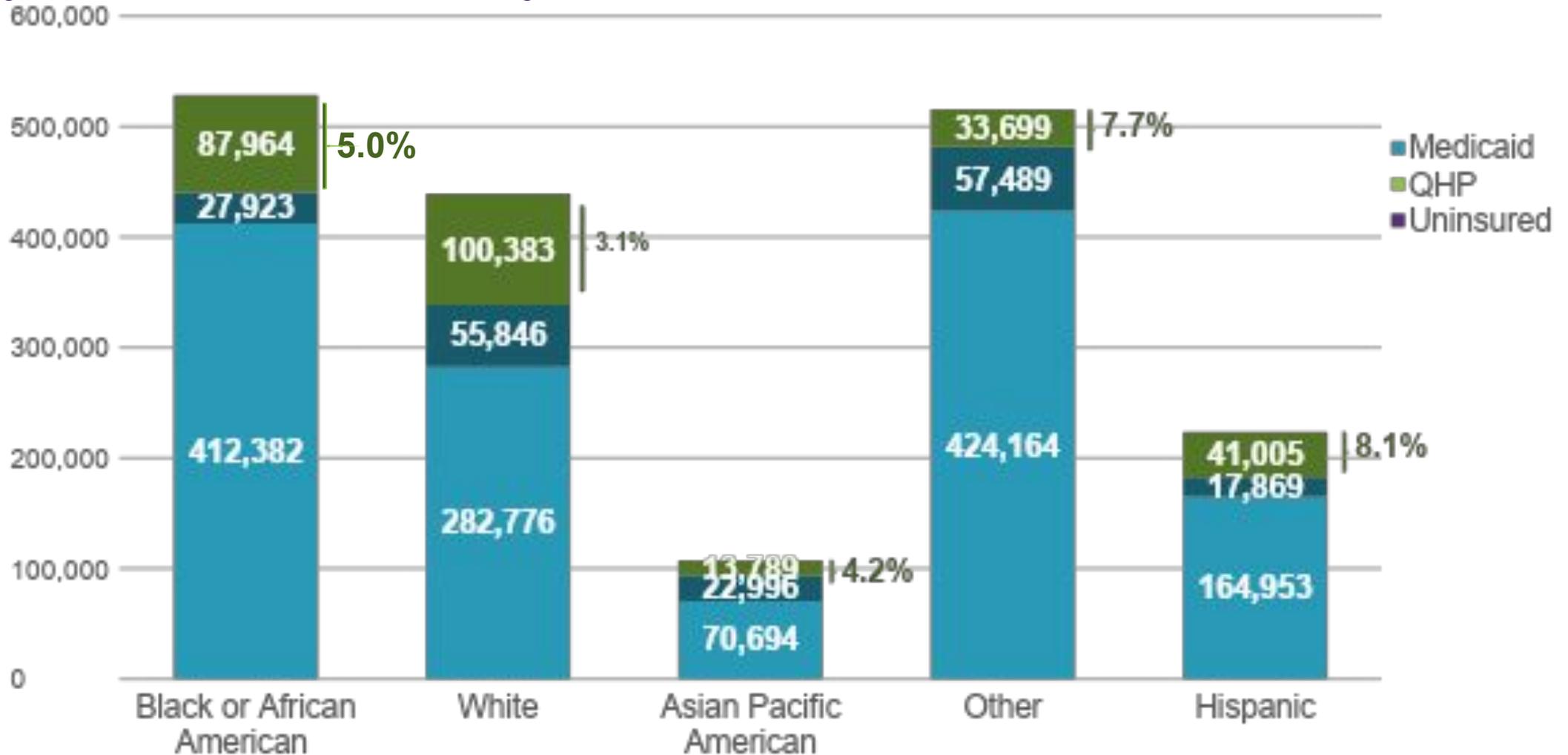
Uninsured by Eligibility for Financial Assistance, by Race and Ethnicity

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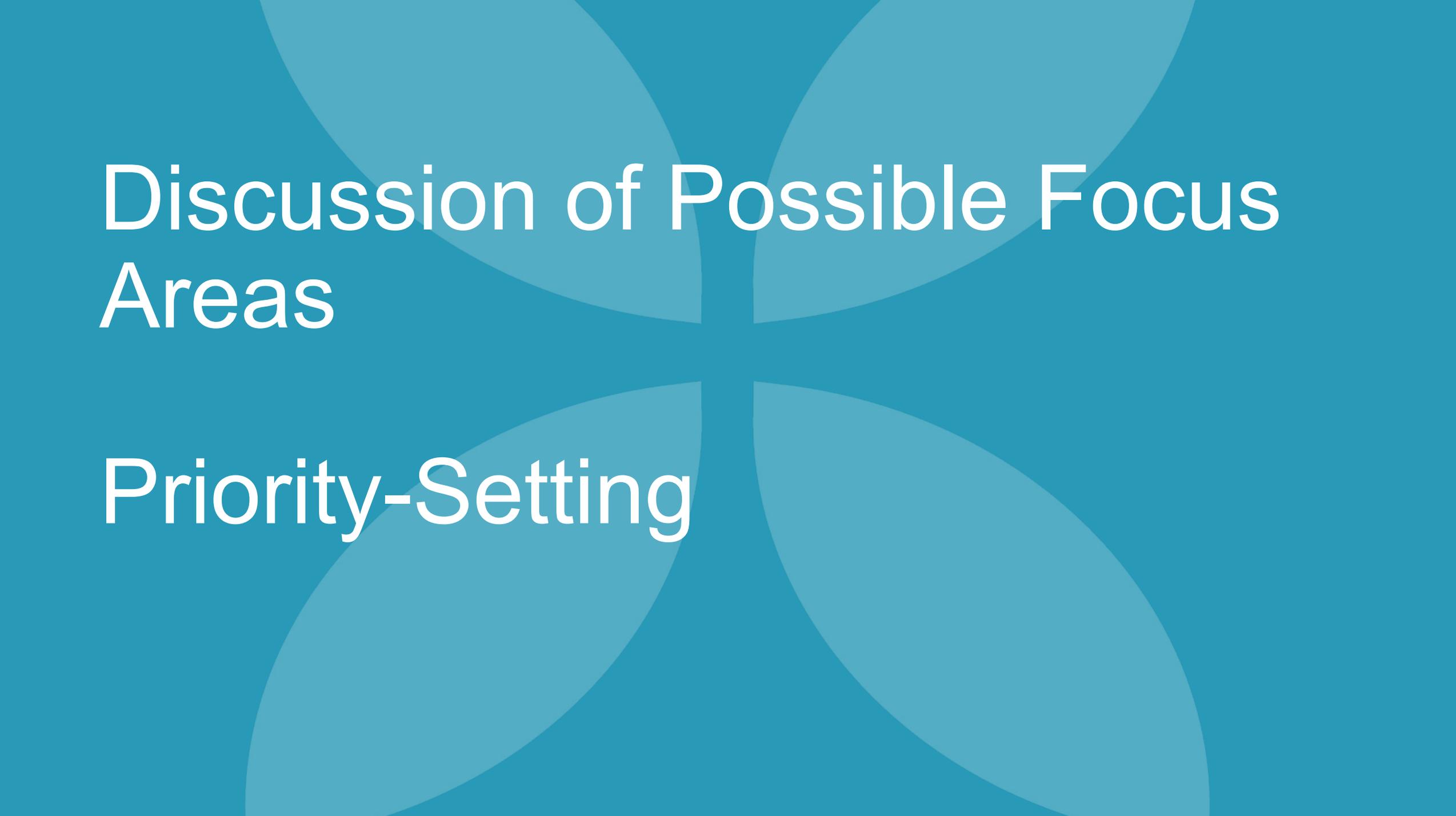
Discussion of Possible Focus Areas

Priority-Setting

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?

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Public Comment

Next Steps

- Vote on co-chairs
- Vote on focus areas
- Other?

Next meeting: Friday, September 10, 1 - 2:30 PM

Workgroup Webpage

Appendix

# 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

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MHBE Uninsured Dashboard

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

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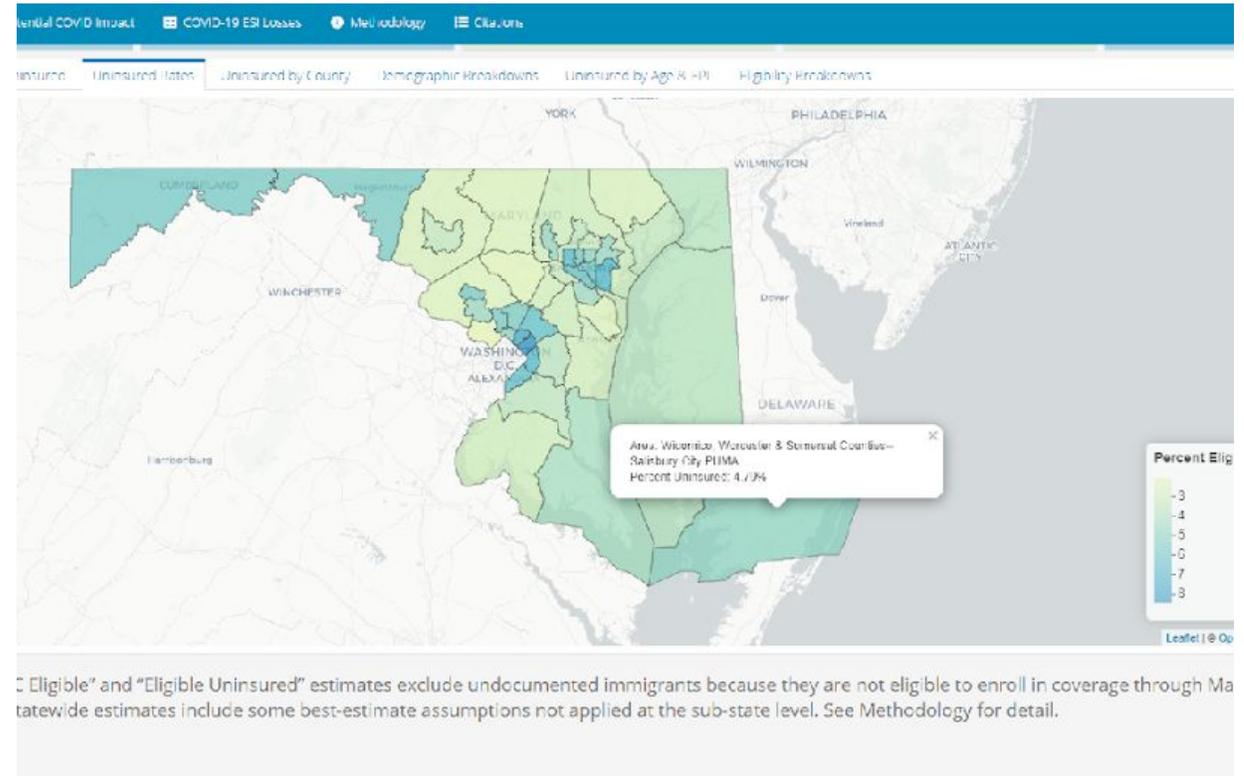
HEALTH INEQUITIES:[7,8,9] Differences that are unfair and unjust without comparison to another group.

Further Context: An equity frame[9] connects the dots between disparate outcomes and the disparities in power and privilege in which they are rooted. Focusing on disparities can lead to the assumption that one group's behavior, intelligence, or genetics are the cause of any differences. Focusing on inequities draws attention to the root causes of these differences. For example: Disparate access to health care means that one group has less access than another. Inequitable access to health care means that one group experiences unjust limitations on their access to health care.

Terminology in Action: Racial and ethnic impact assessments are a tool for evaluating the likelihood that a policy will amplify or reduce *inequities* for certain communities.

Use this term when: A population experiences outcomes that are different than expected based on population size or the average outcome.

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/.

RACE[7,8] is a social construct that separates people into groups based on physical characteristics—often skin color—and other factors like cultural affiliation or ancestral history.

ETHNICITY[9,10] specifies shared social characteristics (e.g. language, geographic background, religion, food, etc.) and manifests through traditions and language.

Further Context: Race and ethnicity are often conflated. The key difference is that racial distinctions were created by groups with privilege who imposed these categories on others. Ethnicities are often self-identified and formed by those belonging to the group.

Terminology in Action: The department implemented expanded/granular *race* and *ethnicity* categories to increase the likelihood that respondents will "see" themselves in the question and choose to answer.

Use these terms when: Focusing on factors related to race or ethnicity. If considering both race and ethnicity or the distinction is not clear, use "race and ethnicity."

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/.

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SOCIAL DETERMINANTS OF HEALTH (SDoH)[12] are 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**[13] (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**[14,15] or **root causes** of inequities. Factors closer to the individual level are known as **downstream factors**.

Further Context: SDoH is sometimes used to mean or signal racism or disparities by race. Similarly, "urban" and "low income" are often substituted for Black or Latino(a). Conflating race with income or geography disregards: 1) not all people of color live in urban or low-income households, and 2) disparities by race persist at all levels of income and across locations and are the consequences of systemic racism. In other words, negative SDoH are often caused by systemic racism, but are not synonymous with racism.

Terminology in Action: The agency demonstrated its commitment to addressing *social determinants of health* by collaborating with other agencies to increase access to healthy housing, food, and environments and by ensuring all health initiatives considered the root causes driving health disparities experienced by people of color.

Use this term when: Focusing on factors affecting health beyond the traditional health system and which disproportionately impact certain groups of people as a result of historic and systemic oppression. This term should not be used as a substitute for discussing or addressing racism.

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