

MHBE Health Equity Workgroup - Session 1 Meeting Minutes

Tuesday, August 31, 2021

3:00 – 4:30 PM

Meeting held via video conference

In Attendance:

Richard Amador, HealthCare Access Maryland (HCAM)
William Ashley, LifeBridge Health System
Noel Brathwaite, Maryland Office of Minority Health and Health Disparities
Alyssa Brown, Maryland Department of Health (Medicaid)
Shari Curtis, Prince George's Healthcare Action Coalition
Bryan Gere, University of Maryland Eastern Shore (UMES)
Diana Hsu, Maryland Hospital Association
Kim Jones-Fearing, MD LLC
Stephanie Klapper, Maryland Citizen's Health Initiative
Theresa Lee, Maryland Health Care Commission
Nicole Mallette, Maryland Insurance Administration
Allison Mangiaracino, Kaiser Permanente
Jomy Mathew, United Health Care
Joshua Morris, HealthCare Access Maryland
Marie-Therese Oyalowo, UMES
Dania Palanker, Georgetown University
Ligia Peralta, Casa Ruben Inc.
Megan Renfrew, Health Services Cost Review Commission
Patricia Swanson, CareFirst
Barbara Tighe, HCAM
Nikki Highsmith Vernick, The Horizon Foundation
Sheila Woodhouse, University of Maryland Medical Center

MHBE Staff:

Michele Eberle
Johanna Fabian-Marks
Becca Lane

Welcome and Introductions

Johanna Fabian-Marks, MHBE Director of Policy and Plan Management, welcomed everyone to the meeting and explained that the conversations of the MHBE Standing Advisory Committee, which advises the MHBE Board of Trustees on policy issues, led to the creation of this workgroup.

Next Becca Lane, MHBE Health Policy Analyst, shared the [agenda](#) for the meeting and invited all members to introduce themselves and for those who were interested in co-chairing the group to put themselves forward.

After members introduced themselves, Johanna gave a brief overview of MHBE and its strengths and opportunities. MHBE is an independent state agency, which means that the MHBE Executive Director reports to a board of directors. MHBE operates Maryland Health Connection, which includes a website, mobile app, and call center, and partners with navigators for in-person enrollment assistance. MHBE serves 1 in 5 Marylanders who come through MHC to get coverage, whether through the individual market or Medicaid.

Although MHBE is the “front door” for Medicaid enrollment, it does not set Medicaid policy. It does have more of a role in setting policy related to plans that are offered through the individual market by defining plan benefits and working with insurers on their offerings.

MHBE has a budget of several million dollars for marketing and communications, with a focus on open enrollment each year that it tries to focus that on underserved populations, including Black, Hispanic, and young adult Marylanders. MHBE has a strong outreach and enrollment presence through relationships with navigators, who are the “boots on the ground” in communities. MHBE collects and analyzes enrollment data. If necessary, MHBE can work with MHCC to access claims data but mostly works with its own enrollment data. MHBE certifies the plans that are offered through MHC and so has some authority to guide plan design. Lastly, MHBE oversees some affordability initiatives: the reinsurance program subsidizes individual claim costs to bring down rates for everyone in the individual market, and MHBE is about to launch a two-year pilot of premium assistance for young adults.

[Workgroup Charter: Discussion and Vote](#)

Due to time constraints, the vote on the charter was conducted after the meeting through a Google form. Results on the adoption of the charter will be available in the minutes for Session 2.

[Presentation from the Maryland Office of Minority Health and Health Disparities](#)

Dr. Noel Brathwaite, MHHD Director, began by commenting on the introductions given by the other group members, saying that they are evidently already familiar with the information from the first part of his presentation and so began presenting at slide 28.

Dr. Brathwaite said that the mission of MHHD is to change the trajectory of these disparities because if the trajectory does not change, disparities in diabetes, heart disease, cancers, and now covid, will remain.

There are not only disparities in illness and severity of illness, but also in insurance coverage, and ability to afford doctor visits and other out-of-pocket expenses for Black and Hispanic Marylanders.

MHHD's mission is to change the trajectory of these disparities; Dr. Brathwaite shared some of the ways they are working towards this goal. One of MHHD's programs is Minority Outreach and Technical Assistance (MOTA). MOTA funds 21 grantees in 15 jurisdictions. They also provide covid-related funding to local health departments from CARES funding and ELC Detection/Expansion, which includes 12 community health workers.

Dr. Brathwaite then described four 2021 legislative mandates; these bills attempt to reduce disparities and move towards equity. HB0028/SB5 requires that providers have implicit bias training. HB0309/SB565 requires standardization and stratification of race and ethnicity data across all branches of government so that policies and programs can be relevant and data driven. HB0462/SB172, the Maryland Health Equity Resources Act, intends to provide local community-based organizations the opportunity to develop changes in health care, wellness centers and health equity related programs over the next couple of years. SB0052/HB78 establishes the Maryland Commission on Health Equity.

Dr. Brathwaite explained that between 2011 and 2019, disparities by race and ethnicity were highlighted; going forward, in 2021, health equity is the focus. He shared a hope that this workgroup will develop recommendations beyond health insurance to ensure that everyone has an opportunity for optimal health, regardless of income, age, race and geography.

Insurance Enrollment by Race & Ethnicity

Becca Lane then shared some enrollment data from MHBE's analysis of 2019 5-year ACS data. (Slide 40 was skipped because Dr. Brathwaite's presentation covered this material).

The race/ethnicity categories with the highest uninsured rate are Black/African American and Hispanic, meaning that Black and Hispanic Marylanders are uninsured at disproportionately high rates compared to other race and ethnicity categories.

Second, Becca shared the breakdown of uninsured Marylanders by eligibility for financial assistance. Of those who are uninsured, those who are eligible for QHP make up the largest share. The number of Medicaid-eligible is lower even than the number of QHP-eligible who are under 400% of the federal poverty level.

Discussion of Possible Focus Areas & Priority Setting

Becca Lane first presented the group with a list of possible focus areas, including race and ethnicity data collection; outreach and enrollment; insurance design, including cost-sharing and benefits; supporting statewide primary care coordination strategies; and quality improvement.

Alyssa Brown with Maryland Department of Health asked about MHBE's methodology for obtaining the data on the Medicaid-eligible uninsured population. Johanna explained that these numbers were from MHBE's analysis of the Census' 5-year ACS estimates, rather than exact (this is noted in the slide deck and in these minutes, above, for the sake of clarity).

Diana Hsu with the Maryland Hospital Association made the point that exploring coverage and benefits in this workgroup is important because health insurance access depends on more than enrollment.

Dr. Jones-Fearing asked for more information on the reasons why the Black and Hispanic populations are enrolled at lower rates than the white population. Johanna answered that MHBE does annual surveys for outreach that indicate awareness and cost as the main barriers.

Dr. Jones-Fearing then asked if there is any requirement for employers who do not offer health insurance to tell employees that they may be eligible for QHP. Dr. Bryan Gere said he also wondered about the scope of current outreach to certain populations. Shari Curtis said that there is a lot of effort around getting people to enroll but that coverage utilization is also important.

Dr. Ligia Peralta said that the concept of public charge is an issue, especially for new US residents, because people are concerned about consequences if they obtain services like health coverage. This is a concern for the Hispanic/Latino population that needs to be better understood and addressed, possibly with data. Shari Curtis suggested that navigators and CHWs be equipped with information on public charge and other issues of concern to share with consumers because there are other places besides employers where people will be getting information.

Richard Amador made the point that navigators are not immigration experts and often have to "color inside certain lines" of the norms established by MHBE with respect to insurance coverage. He mentioned that MHBE was quick to give guidance on how to answer people's questions about public charge.

Dania Palanker says another issue worth looking into is provider networks. Not only do people have access to providers, but do they have access to the right providers? Dania says it has come up in her research that many people would like to have providers that

have had similar experiences to them. Other exchanges have not developed ways to address this issue. She also suggests that the group try to understand the other barriers to accessing care when people already have insurance. Even if these things, such as transportation, fall outside the scope of what the exchange can address, she suggests looking at any MD-specific data to understand these other barriers to access.

Dr. Marietherese Oyalowo shared a takeaway from the “Well Connected Communities” program on the Eastern Shore that access to transportation is one of the big issues when the researchers look into the drivers of health disparities. She would like to see rural disparities and transportation addressed.

Theresa Lee highlighted the importance of prioritizing the expertise of the community through the work of the workgroup and beyond to ensure that the approaches taken reflect communities’ lived experience.

Joshua Morris says that trust in the health care system is lacking in the Black community and other communities of color, which is a barrier to seeking care. He thinks that some outreach and education has been very successful, such as Kaiser Permanente’s Good Hair, Good Health program, in which ambassadors go to barbershops and salons to meet people who are uninsured or underinsured to enroll them on the spot or do health literacy education. He suggests using these social spaces more often, and also having ambassadors who are not necessarily from the state government or any specific organization who can share this information to build trust.

Theresa added that there are already so many programs out there that the remaining work is to make sure people are connected to them; Joshua agreed.

Ligia Peralta asks if the group can explore providing coverage for undocumented individuals and expand our focus to explore eligibility to cover those who are in that category. Shari responded that although the exchange isn’t positioned to act on all of the recommendations the workgroup might want to make, MHBE does have influence within the state and could work with other agencies to follow through.

Public Comment

No public comments were made.

Adjournment

The group’s follow-up actions include voting on the adoption of the charter, the co-chairs, and focus area priorities, and were encouraged to share any additional thoughts with Becca and Johanna.



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