PRESS RELEASE

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DC Health Benefit Exchange Authority Takes Action to Achieve Social Justice and Equity in Health Insurance Coverage

Washington, DC –The DC Health Benefit Exchange Authority (DCHBX) Executive Board voted to adopt recommendations from its Social Justice and Health Disparities Working Group, in an effort to stop racism in health care. These recommendations are focused on three crucial areas in order to establish practices, structures, and policies that can be implemented by DCHBX and DC Health Link health plans to (1) expand access to providers and health systems for communities of color, (2) eliminate health outcome disparities for communities of color, and (3) ensure equitable treatment for patients of color in health care settings and in the delivery of health care services. There are 100,000 people and more than 5,200 employers with private health insurance coverage through DC Health Link. DCHBX is responsible for DC Health Link – the Affordable Care Act on-line health insurance marketplace in DC. The recommendations are for coverage through DC Health Link. However, several recommendations will also benefit residents not covered through DC Health Link.

"We believe these recommendations provide critical guidance for how to move forward in addressing health equity in the District of Columbia," said **Diane C. Lewis, M.P.A., Chair of the DCHBX Executive Board** and **Chair of the DCHBX Social Justice and Health Disparities Working Group**. "Stopping systemic racism in health care is complex and requires comprehensive approaches. This effort has raised difficult and challenging issues, and the working group's willingness to be open to new ideas and approaches made these recommendations possible."

"People of color who live in the District of Columbia deserve to be as healthy as possible," said **Dr. Cara James, President and CEO of Grantmakers In Health** and **Vice Chair of the DCHBX Social Justice and Health Disparities Working Group.** "We have to do all that we can to eliminate health disparities and improve health outcomes for minority residents. The recommendations made by the Social Justice and Health Disparities Working Group will help advance health equity in the District."

"We must be committed to advancing equity, diversity and inclusiveness in all industries and in all arenas, including the financial services industry," said **Karima M. Woods, Commissioner of the DC Department of Insurance, Securities and Banking** and **member of the DCHBX Social Justice and Health Disparities Working Group.** "This holds true for the insurance industry as we work with insurers to achieve the most equitable coverage possible for District residents."

The District of Columbia is the first state-based marketplace to take such a broad approach to stopping systemic racism in health care.

The DCHBX Executive Board established the Social Justice and Health Disparities Working Group in the fall of 2020. In addition to Board Chair Lewis, DCHBX Board Members Tamara Watkins and DISB Commissioner Karima Woods served on the working group. Dr. Cara James, Former Director of Office of Minority Health at CMS, was Vice-Chair. The Working Group members included representatives from health insurance companies on DC Health Link, DC hospitals, DC community health centers, consumer and patient advocates, and health insurance brokers. Other working group members included experts from DC Health and DHCF, who provided subject area expertise. The Working Group met 12 times (Feb – June) for 1.5 to 2-hour meetings. The Working Group received presentations from many experts including AHIP, BCBS, all DC Health Link health plans and health plans in other states, NCQA, and other experts on bias, equity, and many other areas looking at systemic racism in health care. In addition to support from DCHBX staff, the Working Group was staffed by Dr. Dora Hughes, nationally recognized for her two decades of work in the field of minority health and health equity and an Associate Research Professor at the Milken Institute School of Public Health at George Washington University (GW). Expert staffing from GW was funded by the Robert Wood Johnson Foundation's State Health and Value Strategies program.

The Working Group unanimously adopted recommendations on June 24, 2021 and the DCHBX Executive Board unanimously adopted the Working Group's recommendations on July 14, 2021. These recommendations supplement important work being done by City agencies, community leaders, providers, and payers. The full report from the DCHBX Social Justice and Health Disparities Working Group is available at: https://hbx.dc.gov/sites/default/files/dc/sites/hbx/event_content/attachments/HBX%20Social%20Justice%20and%20Health%20Disparities%20Working%20Group%20Final%20Report.pdf

Social Justice and Health Disparities Working Group Recommendations

Although the problems are complex and require comprehensive approaches to stop racism in health care, DC Health Link health plans and DCHBX can be part of the solution.

Focus Area 1: Expand access to providers and health systems for communities of color in the District

The vast majority—over 96 percent—of District residents have health coverage, which ranks Washington, DC among the best in the country for coverage. However, there is a shortage of hospitals, urgent care facilities and other providers in areas of DC, leading to difficulties with obtaining medical care for many residents of color. Access to diverse providers is limited as well.

Recommendations:

Carriers:

- Provide incentives for both primary care and specialist physicians to practice in underserved areas in DC
- Support access to diverse medical professionals
    - Provide scholarships for STEM students and medical school students of color in health professional schools in the District.
        - DCHBX will provide the infrastructure as necessary.
    - Review provider networks to determine the race, ethnicity and primary language of their providers to establish a baseline, and develop 5-year goals to improve the diversity of the networks.

Focus Area 2: Eliminate health outcome disparities for communities of color in the District

Blacks and Latinos are hospitalized at over three times the rate of their white counterparts. About 40 percent of non-Hispanic blacks compared to 28 percent of non-Hispanic whites have high blood pressure, and the rate of diagnosed diabetes is 77 percent higher among non-Hispanic blacks than non-Hispanic whites. African American men have the highest cancer death rate of any racial and ethnic group in the U.S.

Recommendations:

Carriers:

- Collect and use comprehensive, member-level racial, ethnic and primary language data to support and collaborate with network providers to reduce racial and ethnic inequities
    - No later than Plan Year 2023, obtain race, ethnicity, and language data directly from members via mail, email, telephone and electronic portals, and other mechanisms. Share with DCHBX baseline metrics for data collection, annual goals and, beginning in Plan Year 2024, progress in meeting such goals.
    - Provide aggregate data by race, ethnicity, and primary language to DCHBX for select diseases and health conditions, in consultation with DCHBX.

DCHBX:

- HBX should include race and ethnicity data (if provided by enrollee) in its 834 files to carriers for individual marketplace enrollees. Carriers may have to modify their 834 consumption to absorb the data. HBX should also explore the feasibility of changing the application for small group employees to collect this information and provide to carriers via 834 files.

DCHBX:

- Modify insurance design for DC Health Link standard plans to eliminate cost-sharing, including deductibles, co-insurance, and co-payment, for medical care, prescription drugs, supplies and related services that prevent and manage diseases and health conditions that disproportionately affect patients of color in the District.
    - HBX Standard Plan Working Group to review and develop for consideration a Value-Based Insurance Design to support adherence for patients with chronic conditions. The Social Justice and Health Disparities Working Group recommends the following prioritization of conditions to be assessed for AV and premium impact by the HBX Standard Plans Working Group: (1) for the adult population-- diabetes, cardiovascular disease, cerebrovascular disease, mental health, and HIV, as well as cancer of the breast, prostate, colorectal and lung/bronchus; and (2) for pediatric population-- mental and behavioral health services.
        - Waiver of cost-sharing is only for the underlying condition and does not include co-morbidities. For example, for an enrollee with diabetes, heart disease treatment would continue to have cost-sharing. Additionally, cost-sharing may be waived for HSA compatible, high deductible health plans only to the extent permitted by federal law. Insurance plan design changes are limited to AV standards approved under federal law.
    - Health plans are encouraged to evaluate impact of design changes on enrolled population and provide periodic updates on trends to DCHBX. Furthermore, health plans are encouraged to expand their current health equity support and pilot programs to include patients for whom there will be no cost-sharing for treatment of certain specific conditions. Because product design changes will require provider education, DCHBX shall include in their budget funding for provider education in consultation with the health plans.
    - New insurance design should apply to standard plans in the individual marketplace.
    - DCHBX must also develop new standard plan design, which must include this new insurance design, for the small group marketplace to be offered for plan year 2023.

Carriers:

- Identify disparities in care by stratifying quality measures by race, ethnicity and primary language

- Conduct "Equity Audits" based on race, ethnicity, and primary language data with focus on HEDIS measure performance, patient experience and provider payment. Such audits should align with NCQA requirements as feasible.
- Update existing contracts with medical management vendors to require assessment of vendor performance with caring for diverse populations, and development of goals and timeline for improvement.

Focus Area 3: Ensure equitable treatment for patients of color in health care settings and in the delivery of health care services in the District

Myriad studies have found that persons of color are less likely to receive equitable treatment across a range of health conditions, leading to significant disparities in health and health outcomes. Implicit bias from providers and biased clinical algorithms contribute to inequitable treatment. Implicit bias, along with false beliefs about biological differences, can lead to disparities in recommended treatment and poor provider communication during medical visits, which in turn contributes to experiences of perceived discrimination and poor quality of care. Blacks in particular are more likely to report being treated unfairly and with disrespect by providers because of their race.

<u>Recommendations:</u>
Carriers:

- Require network providers to complete cultural competency training, which should reflect widely available, recommended resources and tools to mitigate implicit bias
  - Provide and require cultural competency training to support the delivery of culturally and linguistically competent services, in adherence to the Department of Health and Human Services Office of Minority Health's A Physician's Practical Guide to Culturally Competent Care and other resources listed by CDC's National Prevention Information Network.
  - Require cultural competency training annually for all providers in network. Incentives should be offered to encourage non-network providers to complete training as well.
  - Require cultural competency training in provider contracts, which should be tailored to both primary care physicians and medical specialists.
  - DCHBX will reach out to DC Health to learn how it has encouraged cultural competency training for providers, including whether provider licensure requirements could be leveraged for this purpose.
- Obtain the National Committee for Quality Assurance's (NCQA's) Multicultural Health Care distinction
  - Seek this distinction, awarded for organizations that meet or exceed standards in providing culturally and linguistically appropriate services.

- Review clinical algorithms and diagnostic tools for biases and inaccuracies and update appropriately
    - Each carrier will conduct and report to DCHBX on efforts to assess clinical management algorithms that may introduce bias into clinical decision making and/or influence access to care, quality of care, or health outcomes for racial and ethnic minorities. Within one year, carriers will report the outcomes of such assessments to DCHBX, as well as plans and timeline for correction, as necessary.
        - Such reports will be used for informational purposes regarding the types and prevalence of algorithms that are found to potentially bias care for diverse populations. These reports will be considered proprietary and confidential.
        - DCHBX may report aggregate outcomes from these reports.
    - Within one year, prohibit use of race in estimating glomerular filtration rate (GFR) by hospitals, laboratories, and other providers in network, in alignment with guidelines promulgated by the National Kidney Foundation.

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