



**BlueCross
BlueShield**
Association



CREATING A MORE EQUITABLE SYSTEM FOR THE HEALTH OF AMERICA

April 2024

EXECUTIVE SUMMARY

Everyone should have access to affordable, high-quality health care regardless of race, ethnicity, national origin, sex, gender identity, sexual orientation, disability, or age. Through our National Health Equity Strategy, launched in April 2021, Blue Cross Blue Shield Association (BCBSA) is committed to changing the trajectory of health disparities and building a more equitable health care system – for everyone.

Every Blue Cross and Blue Shield (BCBS) company has launched local initiatives to address health disparities, with more than 400 programs already in place.

There is no simple answer to achieving health equity, and no single entity can achieve it alone. That's why we will continue to work with public and private partners to improve how care is delivered – to reduce and eliminate the existing health inequities and disparities – so that every person can experience an equitable, effective health care system that delivers better health.

Good public policy can help achieve this goal. The policy platform that follows outlines commonsense, consensus-based solutions that can meaningfully improve how care is delivered and experienced by people who have traditionally been underserved.

Our platform includes four foundational priorities:

1 IMPROVING ACCESS AND AFFORDABILITY

2 ADDRESSING AND MITIGATING THE IMPACTS OF SOCIAL DRIVERS OF HEALTH

3 BUILDING AN EQUITABLE HEALTH CARE WORKFORCE

4 HARNESSING AND STANDARDIZING HEALTH EQUITY DATA

These priorities reflect our capacity to use state and federal policy levers; address many health conditions and social needs; and are specific enough to be impactful and actionable, but broad enough to evolve. They matter to all our members and stakeholders because disparities and inequities exist in all populations.

1 IMPROVING ACCESS AND AFFORDABILITY:

We must make health coverage – particularly preventive care – more affordable, more accessible and more available for as many Americans as possible. We advocate for expanding supplemental benefits in Medicare Advantage (MA), eliminating barriers to enrollment in Medicaid, permanently extending enhanced Affordable Care Act (ACA) tax credits, and increasing telehealth flexibilities.

2 ADDRESSING AND MITIGATING THE IMPACTS OF SOCIAL DRIVERS OF HEALTH (SDOH):

We believe health equity cannot be achieved without addressing social drivers of health – those factors such as where people live, access to healthy food and reliable transportation that influence a significant part of a person’s health. We believe SDOH cannot be addressed in silos, so we must bolster efforts by community-based organizations to provide services that address SDOH, foster public-private partnerships, incentivize industry and accreditation standards and ensure that health plans have the tools they need to address SDOH in local communities.

3 BUILDING AN EQUITABLE HEALTH CARE WORKFORCE:

Investing in initiatives to expand and diversify the health care workforce, expanding the availability of non-physician practitioners, and addressing provider burnout and promoting workforce wellness will improve access to care, specifically racially and ethnically concordant care, which can lead to better health outcomes.

4 HARNESSING AND STANDARDIZING HEALTH EQUITY DATA:

To advance health equity, we must be able to measure the effectiveness of care delivery with more complete, high-quality data. We recommend standardizing race, ethnicity, and language (REL) and sexual orientation and gender identity (SOGI) data collection categories; mitigating the unintended consequences of bias in cases where imputing REL and SOGI data is necessary; and building trust in data collection by protecting consumer privacy and security.

We thank the many partners, advocates and scholars who have worked with us to build these solutions. They can help achieve the goal we all seek to accomplish: an equitable, affordable, and accessible high-quality system that cares for everyone. No exceptions. We look forward to driving these solutions with strong partners to support the people and communities we are committed to serving.

BACKGROUND

Long-standing social structures of racism and discrimination have hurt the health and well-being of generations of Americans simply because of their race. Compounded by systemic and personal bias, social factors have created an environment where people of color are more likely to have negative experiences with the health care system when compared to white people. Issues such as a lack of access to equitable and quality health services have resulted in high rates of chronic illnesses and a greater risk of early death.

As the health care partner to 1 in 3 Americans, BCBSA and its member companies engage in efforts across the country to combat these systematic injustices. We are committed to advancing health equity by increasing access to high-quality health care regardless of race, ethnicity, sex, gender identity, sexual orientation, or age.

“Health equity means increasing opportunities for everyone to live the healthiest life possible, no matter who we are, where we live, or how much money we make.”

– Robert Wood
Johnson Foundation

WHY HEALTH EQUITY MATTERS

The health disparities and inequities that have plagued the U.S. health system are well documented. We know these inequities rob people and communities of years of life and prevent historically marginalized people from receiving the care they need. Numbers paint a grim picture.



Black infants are more than

2X AS
LIKELY

to die than white infants in the U.S.

Black mothers are nearly

3X AS
LIKELY

to die from pregnancy-related causes than white women

Black and Hispanic children are more than

3X AS
LIKELY

to experience food insecurity as white children – a condition that impacts health

Tackling the systemic injustices that lead to these inequities in health and social conditions is our moral obligation.

HEALTH DISPARITIES IN THE U.S.

- Black and American Indian/Alaska Native (AI/AN) Americans are more likely to die from treatable conditions and are at higher risk for many chronic health conditions, from diabetes to hypertension.^{1,2}
- Black and AI/AN Americans live fewer years, on average, than white Americans.³
- Rural African American and American Indian/Alaska Native adults are more likely to have multiple chronic health conditions than non-Hispanic white rural American adults.⁴
- Among adults with any mental illness, Black (39%), Hispanic (36%), and Asian (25%) American adults were less likely than white (52%) American adults to receive mental health services as of 2021.⁵
- Black, Hispanic, and AIAN Americans are less likely to have health insurance, more likely to face cost-related barriers to getting care, and more likely to incur medical debt.^{6,7}
- LGBTQIA+ Americans report being more likely to delay care, less likely to have a usual source of care, and more likely to be concerned about medical bills than their non-LGBTQIA+ counterparts.⁸
- 4 in 10 adults with disabilities reported experiencing unfair treatment in healthcare settings, at work, or when applying to public benefits. Among American adults with disabilities, Black and Hispanic Americans were more likely than white Americans to report unfair treatment or judgment in each of the three settings.⁹

While the effects of health disparities related to race, socioeconomic status, and sexual and gender identity on the quality of care and health outcomes are widely studied, less is known about the larger economic implications of such disparities. In 2022, Deloitte [published an analysis](#) of avoidable health spending due to health inequities, with projections stretching out to 2040. Deloitte's estimates are based on the proportion of spending attached to five high-cost diseases: breast cancer, diabetes, colorectal cancer, asthma, and cardiovascular disease. The firm found that health inequities account **for more than \$320 billion today**—a number that could grow—in annual avoidable health care spending.

Historically marginalized people are more likely to be affected by these rising costs. Put simply, addressing health inequities will reduce health care costs for all.



Today, inequities in the U.S. generate excess health care costs totaling about **\$320 BILLION ANNUALLY.**

1. [Mortality Amenable to Health Care, Deaths per 100,000 Population | Commonwealth Fund](#)

2. [Disparities | Fact Sheets \(hhs.gov\)](#)

3. [National Vital Statistics Reports Volume 70, Number 12 November 09, 2021 \(cdc.gov\)](#)

4. [Rural Health: Addressing Barriers to Care \(nihcm.org\)](#)

5. [Key Data on Health and Health Care by Race and Ethnicity | KFF](#)

6. [Trends in Differences in Health Status and Health Care Access and Affordability by Race and Ethnicity in the United States, 1999-2018- PubMed \(nih.gov\)](#)

7. [aspe-aian-health-insurance-coverage-ib.pdf \(hhs.gov\)](#)

8. [Microsoft Word- LGBT Health IB_Final.docx \(hhs.gov\)](#)

9. [Four in Ten Adults with Disabilities Experienced Unfair Treatment in Health Care Settings, at Work, or When Applying for Public Benefits in 2022 \(urban.org\)](#)

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IMPROVING ACCESS AND AFFORDABILITY

Everyone deserves access to high-quality, affordable health care, but marginalized communities continue to experience gaps in access and barriers to affordability. [Evidence](#) shows that both the quality and affordability of care can close gaps in health outcomes based on race, ethnicity, sex, gender identity, sexual orientation, and age. With health care costs growing every year and a shortage of health care providers in critical geographic and specialty areas, it is more urgent than ever that we commit to accelerating efforts to improve access and bring down costs.



PRIORITY AREA RECOMMENDATIONS

1. **Congress and CMS should expand access to Medicare Advantage (MA) supplemental benefits.**
2. **CMS should improve enrollment and retention efforts for Medicaid-eligible individuals.**
3. **Congress should permanently extend premium enhanced tax credits on marketplace premiums.**
4. **Congress should promote and invest in access to care through telehealth.**

PRIORITY AREA: Medicare Advantage Supplemental Benefits

Recommendation: Congress should maximize MA supplemental benefits for the chronically ill.

Rationale: Medicare Advantage can offer benefits that address SDOH, such as meals and in-home support. These services can help keep people healthy in ways they may not be able to afford or have access to without such coverage. Without them, marginalized people may experience more chronic illnesses or poorer quality of life and require more expensive levels of care.

Background: The introduction of Special Supplemental Benefits for the Chronically Ill (SSBCI) was a major shift in MA policy to bring more holistic care to MA beneficiaries. Three years into implementation of the CHRONIC Care Act, we have an opportunity to improve the reach of these benefits. We must also collect the data needed to measure the impact on MA beneficiaries who need them most.

However, beneficiaries also need to know what is available to them to make more informed choices about their benefit options. The Medicare Plan Finder (MPF) is one path toward achieving that goal. Plans offering additional, health-related supplemental benefits increased substantially between 2018 and 2020, including meal provision (20% of plans to 46% of plans), transportation (19% to 35%), in-home support services (8% to 16%) and acupuncture (11% to 20%). We should lean into this trend and ensure that minoritized populations are receiving the benefits they need.

TAKING ACTION:

1. **Modify SSBCI eligibility criteria:** Congress should modify the eligibility criteria for SSBCI to maximize the potential value of the services for those who can benefit the most.
2. **CMS should:**
 - a) **Clarify “chronic condition”:** Clarify that functional need/ frailty and cognitive need meet the definition of “chronic condition”
 - b) **Allow flexibility in SSBCI eligibility:** Broaden eligibility criteria for SSBCI to allow for additional flexibility (e.g., health-related social needs (HRSN), indicators of high health care utilization, etc.)
 - c) **Develop stronger evidence on SSBCI benefits:**
Convene a multi-stakeholder workgroup to develop recommendations around building, managing, and disseminating a stronger evidence base on non-medical supplemental benefits
 - d) **Expand SSBCI categories:** Expand the categories of supplemental benefits listed in the MPF and indicate more clearly when limits apply
 - e) **Improve clarity of MPF:** Modify the MPF to show comprehensive summaries of available supplemental benefits. We recommend working with health plans to improve and test the online MPF so that stakeholders can provide suggestions on how to file for some of the more complex benefits.
 - f) **Consult stakeholders on clarity of benefits:** CMS should also conduct ongoing working sessions with health plans to assist with creating and testing web based MPFs so that stakeholders can provide suggestions on how to file for some of the more complex benefits.



Common Special Supplemental Benefits for the Chronically Ill (SSBCI):

- Extended Meals
- Food and Produce
- Transportation for Nonmedical Needs
- Pest Control
- Indoor Air Quality Equipment and Services
- Social Needs Benefits
- Complementary Therapies
- Services Supporting Self-Direction
- Structural Home Modifications
- General Supports for Living
- “Other” SSBCI

PRIORITY AREA: **Medicaid Coverage and Services**

Recommendation: CMS should remove barriers to enrollment and retention for Medicaid-eligible individuals by supporting state outreach, community collaboration and improved enrollment technology.

Rationale: As a major source of health coverage for people of color, Medicaid programs can help address racial health disparities. However, those who might benefit most encounter significant barriers, such as a lack of knowledge about the enrollment process.

Background: Individuals reporting physical health problems were more likely to be misinformed about the Medicaid enrollment process, as were non-Hispanic Black individuals compared with non-Hispanic white individuals. Studies have shown that in states with straightforward Medicaid enrollment procedures, these populations are more likely to be better informed. There are several underutilized tools to reduce misinformation about the enrollment process, including Community-Based Organizations (CBOs) and Integrated Eligibility Systems (IES). Engaging with CBOs can help states better understand the needs and preferences of marginalized communities. IES can help reduce the chance of duplicating efforts when people apply for multiple state and federal benefits at the same time. However, the evidence shows these tools alone are not enough to address the problem.

TAKING ACTION:

1. **Ensure enrollment education:** CMS should work with states to ensure they have robust strategies to promote awareness of the Medicaid program and Medicaid application process and that they provide other key information, such as alerts about redeterminations.
2. **Include multiple languages:** CMS outreach campaigns should be available in multiple languages and disseminated in collaboration with trusted CBOs. CMS should promote opportunities for states to work with CBOs to connect with the Medicaid-eligible population.
3. **Ease concerns about immigration status:** CMS campaigns aimed towards immigrant communities should make clear that enrollment in Medicaid will not impact immigration status or public charge determinations.
4. **Maximize the use of IES:** CMS should continue to work with states to stand up IES and modernize aging systems, in line with the Medicaid Information Technology Architecture framework.
5. **Promote mobile enrollment:** For in-person enrollment, CMS should work with states to deploy mobile enrollment offices to areas with no brick-and-mortar enrollment office. Communities with limited internet access in rural areas and those with mobility limitations would benefit from this outreach. States should post schedules for mobile enrollment events on Medicaid websites and share with CBOs.

PRIORITY AREA:
Marketplace Access and Affordability

Recommendation: Congress should increase access to marketplace plans and providers by maintaining affordability through tax credits and by promoting and investing in access to care through telehealth.

Rationale: Marketplace plans include preventive care and critical screenings that can help close gaps in health outcomes for those who may not have access to or be able to afford such services. They are also vital coverage options for those with limited access or ability to afford other types of commercial coverage. Leveraging quality, affordable coverage options moves us toward greater health equity.

Background: The American Rescue Plan Act (ARPA) and the subsequent Inflation Reduction Act (IRA) temporarily made coverage on the marketplaces more affordable by increasing and expanding premium tax credits (PTC). That lowered the amount consumers must contribute to their premiums. However, the enhanced premium tax credits expire at the end of 2025. We must protect these important credits because their loss could disproportionately impact minoritized populations. For example, the non-Hispanic Black population, young adults and people with incomes between 138% and 400% of the federal poverty level would have experienced [the largest coverage losses](#) if the enhanced PTCs had expired in December 2022.

EFFECTS OF PREMIUM TAX CREDITS (PTCS) EXPIRING ON MINORITY GROUPS

Characteristics	Enhanced PTCs Extended		Enhanced PTCs Expire		Change	
	Number of People*	Uninsurance Rate	Number of People*	Uninsurance Rate	Number of People*	Percent
Income Group						
Below 138% of FPL	12,071	14.0	13,159	15.3	1,089	9.0
138 - 200% of FPL	3,815	13.0	4,450	15.2	634	16.6
200 - 400% of FPL	6,501	9.1	7,650	10.7	1,149	17.7
Race/Ethnicity						
American Indian/ Alaska Native	526	10.9	585	12.1	59	11.3
Asian/Pacific Islander	1,490	9.5	1,611	10.2	120	8.1
Black, non-Hispanic	2,950	8.6	3,472	10.1	522	17.7
Hispanic	9,689	19.1	10,380	20.5	690	7.1
Age Group						
19-34	10,592	14.8	12,087	16.9	1,495	14.1

Source: Urban Institute Health Insurance Policy Simulation Model, 2022. PTCs – Premium Tax Credits; FPL – Federal Poverty Level
 *Measured in Thousands

Additionally, marketplace plans all include preventive care and health screenings with limited cost-sharing. Providers must have the flexibility to provide such care where and how patients seek it, whether in person or via telehealth. This will enhance consumer trust, address privacy concerns, and increase the use of preventive care, improving health and reducing costs for all.

TAKING ACTION:

1. **Extend premium tax credits:** Congress should permanently extend the enhanced ARPA premium tax credits.
2. **Provide telehealth flexibility:** Congress should increase ability of providers to use telehealth as a mode of delivering needed care to help address gaps in access.
3. **Invest in broadband access:** Congress should invest in broadband access to facilitate the delivery of care in underserved and rural areas. This includes access to information and delivery of care, such as patient portals, telehealth, member apps and interfaces, mobile medical solutions, digitally enhanced screening, monitoring and treatment technologies and connectivity for health care centers and hospitals.

ADDRESSING AND MITIGATING IMPACTS OF SOCIAL DRIVERS OF HEALTH

Recommendation: Address the social drivers of health to improve health equity by bolstering efforts of community-based organizations, fostering public-private partnerships, ensuring adequate data collection; and providing flexibility for payers to include SDOH-related benefits.

Rationale: Addressing SDOH may not only improve health outcomes but also lower health care costs and utilization. Marginalized populations are more likely to experience SDOH that make it difficult to live their healthiest lives. This is why addressing SDOH is vital for improving health equity.⁴

Background: SDOH can hurt health outcomes. For example, those who experience unreliable access to transportation are more likely to miss health appointments, reducing their ability to receive needed medical care.⁵ The lack of stable transportation can also limit access to healthy, nutritious foods, which can raise the risk of nutrition-related health conditions like heart disease and diabetes.⁶ Families who experience housing instability because of low income may also experience food insecurity.⁷ The interconnectedness of SDOH and health outcomes reiterates how necessary it is to address them holistically. It is not enough to promote healthy choices if there are too many barriers to making those choices.

We believe we need the same robust data on SDOH as we do on REL and SOGI data. Without SDOH data standards, it is difficult to understand the SDOH needs of a community, to define the baseline for SDOH needs that contribute to the design of interventions specific to that community and to measure the impact of interventions and policies on improving the environment that creates these SDOH. An interconnected data infrastructure is key to breaking down barriers and sharing information between partners and stakeholders to address SDOH across MA, Medicaid managed care organizations (MCOs), employer-sponsored coverage and the marketplace exchanges. Closing the gaps in current SDOH data collection that limit the ability to aggregate data across settings or use data to inform policy and operations, guide quality improvement or evaluate interventions is also critical.^{8,9,10}

Finally, harmful SDOH disproportionately impact historically marginalized communities because of institutionalized racism. While we cannot advance health equity through addressing SDOH without addressing racism and ableism, we can work together to acknowledge these facts and take up the work of addressing harm.



The World Health Organization defines SDOH as the non-medical factors that influence health outcomes. They are the conditions in which people work, grow and live, along with the wider set of forces and systems that create the conditions of everyday life.²

SDOH impact as much as **50% of health outcomes.**³

PRIORITY AREA RECOMMENDATIONS

1. **Bolster Community-Based Organizations' efforts to provide SDOH services**
2. **Foster public-private partnerships**
3. **Develop and adopt industry national industry standards**
4. **Establish meaningful accreditation standards**
5. **Ensure health plans have the tools to address SDOH**

PRIORITY AREA: Community-Based Organizations

Recommendation: Congress should allow CBOs to be reimbursed for SDOH services.

Rationale: Because of the complex interaction between SDOH and health disparities and inequities, we must not work in silos. Health plans, providers, CBOs, beneficiaries, businesses, data and metrics experts, and federal and state government policymakers must collaborate.

Background: CBOs are essential to connecting members to social services and supports that seek to address SDOH. However, CBOs often do not have the infrastructure, capacity, or resources to serve all individuals referred to their organization. For CBOs to continue to operate and partner with health plans they must have the support and infrastructure in place to provide services to the communities who need them.

TAKING ACTION:

1. **Support CBOs to address health equity:** Congress should introduce and pass legislation that allows CBOs to be reimbursed for the services they provide and support payment models that incorporate CBO services. This will allow CBOs to bolster their infrastructure, be paid adequately for the services they provide and connect members to services that address SDOH to improve overall health and well-being.

PRIORITY AREA: Public-Private Partnerships

Recommendation: Congress should support public-private partnerships to address SDOH by incentivizing the adoption of technology-driven solutions that can improve outcomes for individuals at risk of poor health outcomes, experiencing barriers to care and services or with health-related social needs.

Rationale: Public-private partnerships are necessary to address SDOH and allow the health care sector to accomplish more through collaboration. A commitment to strong partnerships between public and private entities to advance health equity is essential to mitigating the negative impacts of SDOH on health outcomes. Federal, state, and local governments should work with the private sector to achieve the goal of eliminating health disparities.

Background: SDOH are the structural and systematic factors such as food, housing, education, and transportation that impact health outcomes. These factors can impact as much as 50% of health outcomes, compared to clinical care, which only impacts 20% of health outcomes. Addressing SDOH is critical to

achieving health equity and may also decrease health care utilization and cost. These recommendations reflect policy solutions we believe will most effectively address SDOH and help create a more equitable health care system.

TAKING ACTION:

1. **Foster private-public partnerships:** Federal, state, and local governments should work with the private sector to eliminate health disparities perpetuated by SDOH.¹¹ A commitment to strong partnerships between public and private entities to advance health equity is essential to mitigating the negative impacts of SDOH on health outcomes.
2. **Incentivize technology-driven solutions:** Congress should support public-private partnerships to address SDOH by incentivizing the adoption of technology-driven solutions that can improve outcomes for individuals at risk of poor health outcomes, experiencing barriers to care and services or with health-related social needs.
3. **Build CBO capacity:** Congress should support capacity-building and sustainability of CBOs to ensure they have adequate resources and infrastructure necessary for these partnerships to succeed.
4. **Monitor regulatory changes:** Federal and state government agencies should ensure regulatory changes are truly impacting SDOH without creating unintended negative consequences for beneficiaries.

PRIORITY AREA: Industry Data Standards

Recommendation: The Administration should develop and adopt national SDOH standards to enable health care organizations to collect SDOH data, address needs and measure the impact of interventions.

Rationale: The lack of SDOH data standards available to health care organizations creates challenges for consistent collection of data to accurately address SDOH needs.

Background: Industry data standards are integral to collecting, analyzing, and acting upon SDOH data. Data standards must be consistent across health plans, providers, and CBOs for collaboration, needs identification, solution development and outcomes measurement. The current lack of aligned data standards and interoperability impacts health plans' ability to identify community needs and develop programs to address SDOH needs.



BCBS IN ACTION

BCBSA and BCBS companies are proud to be founding and active members of the HL7 Gravity Project, a multi-industry effort to reduce current barriers to integration of social risk data into clinical decision making to improve health outcomes.

This initiative is shaping how SDOH data can be collected in a standardized manner and incorporated into electronic health records.

TAKING ACTION:

1. **Work with standard-setting organizations:** Governments should work with industry standard-setting bodies, such as the HL7 Gravity Project, to standardize data elements that will help differentiate social risks, social needs, social vulnerability and SDOH.
2. **Incentivize collection of standardized SDOH data:** CMS should incentivize the collection of standardized SDOH data supporting national industry standards developed through the HL7 Gravity Project, with input from health plans, providers, accreditation bodies, and CBOs. This effort should include defining social risks, SDOH and HRSNs and identifying appropriate use cases for each. This will allow for greater consistency in the data collected and enable all stakeholders—plans, providers, and CBOs—to derive the most meaning from it.
3. **Collect SDOH data during enrollment:** CMS should begin collecting demographic and SDOH data at enrollment, using the standards created with input from key stakeholders.

PRIORITY AREA: Accreditation Standards

Recommendation: Accreditation bodies should consider the roles of various entities in identifying and addressing SDOH needs when developing accreditation standards for health plans.

Rationale: If accreditation bodies emphasize the systemic nature of SDOH, activities addressing them should not focus exclusively on individual-level assessments and interventions without considering the systems and environments that create disparate SDOH needs.

Background: Identifying and addressing SDOH needs is essential for improving health outcomes and reducing long-standing health inequities. Effective SDOH initiatives will require the efforts of a range of stakeholders and policymakers to develop and implement SDOH interventions that address the root causes of inequities, including poverty, employment, and equal access to quality education.

BCBSA supports efforts that promote collaboration between accreditation bodies, CMS, health care organizations, public health entities and community partners to develop consistent data-driven strategies to measure the impact of SDOH interventions, data analysis and methodologies to track and evaluate outcomes pre- and post-intervention. To understand and address SDOH needs, we need robust and standardized methodologies and systems to analyze SDOH data. While there are several national tools including the social deprivation index and the social vulnerability index, data are not consistently available at a sufficiently granular level such as ZIP code or census tract to properly capture nuance and variation by, for example, neighborhood or subpopulation. Access to standardized and granular community-level chronic disease measures and SDOH data will enable a broader understanding of multiple dimensions of health at the individual, community, and population levels. Ongoing analysis of this data can support and facilitate resource allocation, prevention, access to care and targeted interventions to address disparities and improve the nation's health and well-being.



BCBSA supports the National Committee for Quality Assurance (NCQA)'s efforts which promote SDOH data collection and interventions to advance health equity, particularly adding Healthcare Effectiveness Data and Information Set (HEDIS) Social Need Screening and Intervention measures and requiring use of standardized data that can be exchanged between health plans and providers.

Furthermore, we support NCQA's efforts to expand SOGI data collection and the stratification of and racially and ethnically stratified HEDIS measures reporting.

TAKING ACTION:

1. **Clearly define SDOH:** Accreditation bodies should define and differentiate between social risks, social needs, social vulnerability, and social drivers of health. They should better define and identify how to collect SDOH data and provide examples of how organizations can address SDOH needs. This will allow health plans to accurately measure and assess SDOH initiatives. The lack of SDOH data available to health care organizations creates challenges for moving forward with new accreditation standards on SDOH.
2. **Collaborate on establishing standards:** To address the systemic nature of SDOH, community-level interventions need to be structured to foster collaboration between multiple health plans, CBOs, community partners and providers. Accreditation bodies should encourage health plans to assess long-term and sustainable SDOH activities at the community level.
3. **Consider roles in developing accreditation standards:** Accreditation bodies should consider the roles of various entities in identifying and addressing SDOH needs when developing accreditation standards for health plans.
4. **Support accreditation bodies:** CMS should support the work of accreditation bodies, in collaboration with industry, to develop ways to measure impact of SDOH initiatives.

PRIORITY AREA:

Health Plan Tools to Address SDOH

MEDICARE ADVANTAGE

Recommendation: Congress and the Administration should enact legislation and regulation that allows Medicare Advantage plans to address SDOH needs.

Rationale: Medicare Advantage has been at the forefront of advances in care delivery that address SDOH, illustrated by the growth in non-emergency transportation benefits, nutrition and grocery benefits and innovative programs such as social isolation through in-home support.

Background: Medicare Advantage is a vital partner in efforts to eliminate health disparities and improve care as the program increasingly serves a more diverse and lower-income population with greater clinical complexity as compared to traditional Fee-for-Service Medicare.

TAKING ACTION:

1. **Pass legislation to enhance supplemental benefit offering:** Congress should pass H.R. 4074, the Addressing Social Drivers in Medicare Advantage Act, which would allow plans to not only offer supplemental benefits based on chronic conditions but also based on additional factors such as income and socioeconomic status.
 2. **Allow SDOH-related reimbursement:** CMS should offer Medical Loss Ratio (MLR) flexibilities by including additional SDOH-related expenses and rural provider support payments in the MLR numerator for MA to support efforts that advance health equity.
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MEDICAID

Recommendation: CMS should address SDOH in Medicaid by ensuring capitation rates account for SDOH and including Medicaid in Center for Medicare and Medicaid Innovation SDOH demonstrations.

Rationale: Medicaid managed care plans are well positioned to help advance health equity by addressing SDOH. Using existing touchpoints with beneficiaries such as care management and care coordination, health plans ensure individuals are screened for any unmet HRSNs, refer them to community providers and CBOs to address those needs and connect beneficiaries to wraparound services to help promote health and well-being.

Background: Individuals on Medicaid experience SDOH needs across food, housing, and transportation. Medicaid managed care organizations are working to address these needs through innovative programs and connecting members to the services they need. Ensuring capitation rates account for SDOH would give managed care organizations greater flexibility to connect members to benefits and services related to food, housing, transportation, and other social needs that may be impacting their health. Including Medicaid in the Center for Medicare and Medicaid Innovation (CMMI) demonstrations will provide CMS and health plans with better understanding of how to address the SDOH needs of the Medicaid population.

TAKING ACTION:

1. **Ensure capitation rates account for SDOH:** CMS' standardized risk-scoring and risk adjustment methodologies should better incorporate social risk factors to ensure that capitation rates enable issuers to meet the needs of members with health-related social risks. Additionally, CMS should provide guidance identifying a non-exhaustive list of specific health-related social services and supports to address common SDOH needs (transportation, housing, etc.) that states can include in capitation rates.
 2. **Include Medicaid SDOH demonstrations:** CMMI should consider ways to include Medicaid in demonstrations that can provide high-value care and address the SDOH needs for diverse members, including historically marginalized communities.
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COMMERCIAL

Recommendation: Federal regulators should address SDOH in the commercial market by including spending for SDOH in the MLR numerator and allowing plans to provide SDOH interventions outside of wellness programs.

Rationale: Many individuals enrolled in commercial plans have SDOH needs that, if properly addressed, could improve access to health care services and health outcomes. To facilitate the adoption of SDOH interventions for commercial plan members, we encourage policymakers to consider allowing flexibility in meeting existing requirements pertaining to MLR and wellness programs.

Background: Commercial plans continue to create innovative programs and benefits to address the SDOH needs of their members. However, there are barriers that limit the extent of these interventions by commercial plans. By modifying the MLR formula to include spending on SDOH benefits in the numerator and issuing clarifying guidance on which programs qualify for treatment as Quality Improvement Activity expenses, CMS could provide a vital incentive for issuers to make additional investments in SDOH. Additionally, allowing commercial plans to deliver SDOH interventions beyond wellness programs will allow them to better target members with critical SDOH needs. Implementing SDOH interventions through wellness programs as currently structured may create inefficiencies and additional disparities as they would not be targeted to SDOH needs identified through the screening process.

TAKING ACTION:

1. **Include spending for SDOH benefits and programs in MLR numerator:** Federal regulators should modify the MLR formula to support efforts that address SDOH by including spending for benefits related to SDOH in the numerator of the MLR formula along with spending on clinical services. Regulators should also clarify guidance on the types of SDOH programs that qualify for treatment as Quality Improvement Activity (QIA) expenses for MLR reporting purposes. Many SDOH programs may meet the requirements to qualify as QIA, but existing guidance was not written with these newer, more innovative programs in mind.
2. **Allow delivery of SDOH intervention beyond wellness programs:** CMS should consider allowing SDOH interventions to be delivered outside the confines of wellness programs. One of the only mechanisms to address SDOH in the individual market is through wellness and health rewards programs. These programs are limited in focusing on disparately impacted communities by existing regulatory restrictions. CMS should modify the requirement that participatory wellness programs must be available to all similarly situated individuals to allow for health plans to screen, identify and provide interventions for members with SDOH needs within wellness programs or develop an alternate method for health plans to identify and address SDOH for high-need members.

BUILDING AN EQUITABLE HEALTH CARE WORKFORCE

The American health care industry is facing an unprecedented staffing shortage across most specialties and regions. Compounding that shortage, our workforce lacks the racial and ethnic diversity needed to achieve true equity for patients and providers.¹² While some specialties are more racially diverse, others, such as ophthalmology, radiation oncology and orthopedic surgery, continue to lack diversity.



The picture is similar for medical schools. The most recent statistics for enrollment in the U.S. show that ethnic and racial minorities continue to be grossly underrepresented.¹²

The reasons for this lack of diversity and representation are complex. Historical and current structural barriers embedded in workforce recruitment and retention practices have limited access to education and employment in health professions among minoritized populations in the U.S. Dismantling these barriers by addressing the makeup of our health care workforce at every stage of the education and employment pathway is urgent to improve health outcomes for minoritized populations.

PRIORITY AREA RECOMMENDATIONS

1. **Invest in initiatives to expand and diversify the workforce**
2. **Expand availability of non-physician practitioners**
3. **Address provider burnout and promote wellness**

PRIORITY AREA: **Expanded and More Diverse Workforce**

Recommendation: Congress, HHS, and academic institutions should invest in and diversify educational paths for health care professions.

Rationale: Studies show a significant association between patient-provider racial/ethnic concordance and improved health outcomes, increased likelihood of patients visiting providers and higher patient satisfaction scores.¹³ However, because of a lack of diversity in the medical professions, few patients from minoritized communities have access to providers who resemble them or understand their lived experiences.

Background: Training and education are key to expanding and diversifying our health professional workforce. But the training landscape — its standards, curricula, and infrastructure — must be better developed, standardized, and resourced to ensure equitable training and schooling. We must consider how to help a more diverse group of students find access to high-quality training so they can fill the full scope of our workforce needs.

For instance, a one-size-fits-all approach, such as a traditional four-year medical school, cannot solve our workforce crisis, nor do it equitably. There are other paths to entering health care professions in most demand. Community colleges have the potential to offer more access to a wider range of health care training programs. Compared to other post-secondary education programs, they are generally more accessible and affordable, serve all states and regions of the country, and have the infrastructure and programming needed to train students in locations where health care workers are needed most.

TAKING ACTION:

1. **Fund K-12 pipeline programs:** Congress should fund, and support K-12 STEM education pipeline programs. These could include: the federally funded Health Career Opportunities Program (HCOP); academic readiness programs to support students going on to college or postgraduate programs; and ensuring multiple educational pathways exist to help individuals from minoritized and underrepresented populations enter health care professions.
 2. **Incentivize post-secondary school partnerships:** Congress should support incentives for community colleges, universities, and graduate medical schools to partner with under-resourced urban and rural school systems to establish K-12 health sciences academies.
 3. **Establish national working group on diversity:** The Department of Health and Human Services (HHS) should establish a national working group on health care workforce diversity. This working group could focus on reviewing and assessing workforce diversity initiatives across the country, the challenges and roadblocks impeding efforts to increase diversity as well as identifying successful programs, initiatives, and best practices.
 4. **Research best practices in concordant care:** The National Institute of Health (NIH) should conduct a study on best practices in providing culturally and linguistically appropriate care throughout the health care continuum. The study should assess a broad range of health care entities (including hospitals, health systems, long-term care and nursing home facilities, community health centers, provider groups and managed care entities) and provide a public compendium of examples and lessons learned.
 5. **Integrate post-secondary Diversity, Equity, and Inclusion (DEI) strategies:** Undergraduate programs, community colleges, medical schools and academic medical centers should integrate DEI and health equity strategies and efforts in curriculum, staffing and business operations.
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PRIORITY AREA:

Availability of Non-Physician Practitioners

Recommendation: Congress and the Center for Medicare and Medicaid Innovation (CMMI) should enable non-physician practitioners to play a greater role in the health care workforce to alleviate physician shortages and improve access to concordant care.

Rationale: Expanding the availability of non-physician providers can improve access to care and specifically benefit rural populations and regions with fewer primary care providers.

Background: Evidence suggests that expanded use of non-physician providers across the medical and behavioral health spectrum has the potential to improve access, reduce costs, and enhance availability of racially and ethnically concordant care.¹⁴ The non-physician workforce is diverse across gender, race and ethnicity, immigrant status, parental status, and educational attainment. Research has also shown that care from non-physician practitioners does not impact patient outcomes and can play a valuable role in optimizing health care services.

TAKING ACTION:

1. **Provide non-physician scholarships:** Congress should establish grants and scholarships for accredited education programs aimed at increasing diversity among the non-physician workforce, including community health workers, physical/occupational/respiratory/speech therapists, patient navigators, home health aides, physician assistants and advanced practice registered nurses.
 2. **Establish national standards for non-physician competencies:** Federal agencies should collaboratively establish national standards for direct care competencies that draw on existing core competency sets and are applicable to all direct care workers regardless of payment source. Federal leaders should provide guidance to states on how to integrate these competencies into their training standards and credentialing programs.
 3. **Ensure non-physician inclusion in value-based care models:** CMMI should continue to build non-physician health care providers into the design and requirements for broad value-based models, Medicaid waivers or other Medicaid value-based waivers and into existing demonstrations.
 4. **Promote non-physician leadership:** The Health Resources Service and Administration should develop programs that advance racially and ethnically diverse health care leadership and strengthen existing pipeline programs to develop a cadre of professionals who may assume influential positions in academia, government, and private industry.
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PRIORITY AREA:

Provider Burnout and Wellness

Recommendation: Federal agencies and academic institutions should promote the inclusion of mental health services, peer support and mentorship in health care workplaces and educational institutions to support historically marginalized professionals and students.

Rationale: Provider burnout is affecting the entire health care workforce and is one of the major factors fueling a worsening workforce shortage. Addressing this attrition is urgent to recruit and retain more historically marginalized practitioners, for whom systemic inequalities contribute to even higher levels of burnout.

Background: A National Academy of Medicine report defines symptoms of burnout as high emotional exhaustion, depersonalization (i.e., cynicism), and a low sense of personal accomplishment from work.

Research suggests around 1 in 3 physicians are experiencing burnout at any given time, which not only puts their well-being on the line, but also compromises patient care. Practitioners of color, however, face greater risk of burnout from explicit and implicit racial biases and existing disparities in health care. Furthermore, the culture of burnout starts before practitioners are in the field. Research finds that non-white nursing students have reported negative experiences in school, including discrimination, microaggressions, feeling unwelcome and excluded, unsupported by faculty and a lack of mentors.

TAKING ACTION:

1. **Develop resources for providers of color:** The Substance Abuse and Mental Health Services Administration should develop and invest in mental health support services tailored to the needs and lived experiences of health care providers of color.
 2. **Offer peer support programs:** Federal agencies should support the development, implementation, and expansion of peer support programs during work hours, such as the Healer Education Assessment and Referral (HEAR) Program.¹⁵
 3. **Reduce isolation:** The Agency for Healthcare Research and Quality (AHRQ) should scale, expand and make available the National Nursing Home COVID-19 Action Network to other health care providers, particularly providers of color.
 4. **Integrate wellness into educational settings:** Health care training programs, medical schools and graduate medical education programs should integrate comprehensive wellness and mental health supports into the learning environment, such as a Weill Cornell plan to assign all medical students to advisory groups that include physician wellness mentors.¹⁶
 5. **Enable recruitment of diverse mentors:** Congress and state governments should support and invest in university programs that increase the diversity of faculty, mentors and preceptors through recruitment and retention-focused initiatives. Evidence indicates that mentoring programs for students from underrepresented groups are more effective when they include faculty from those groups who have firsthand understanding of the unique challenges these students regularly confront.¹⁷ For example, the University of North Dakota College of Nursing in Grand Forks provides mentoring to American Indian students through its Recruitment/Retention of American Indians in Nursing program.¹⁸
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HARNESSING AND STANDARDIZING HEALTH EQUITY DATA

Data is foundational to understanding disparities and to measuring our progress in eliminating them.¹⁹ A lack of standards, complete data, and protocols around gathering data stand in the way of achieving health equity. Improving the quality and completeness of REL and SOGI data will enable us to better identify and understand health disparities and drive health equity.²⁰ However, we must mitigate the potential risk of bias and discrimination by engaging and partnering with health care stakeholders.



Today, no national standards exist to enable the collection of consistent, standardized REL and SOGI data, making it difficult to identify and measure the impact of interventions in underserved communities. More robust high-quality, reliable data are key to measuring, monitoring, and reporting the outcomes of any interventions and the disparities associated with those outcomes.

In addition to data standards, we must have thoughtful protocols around how to engage with individuals and their families to collect this data. Accessible, easy-to-use collection tools and appropriately framed questions about identity will be critical to building trust and collecting the data needed to measure and improve health equity.

PRIORITY AREA RECOMMENDATIONS

1. **Standardize data categories**
2. **Engage stakeholders to mitigate unintended consequences of bias**
3. **Ensure use of HIPAA Privacy and Security Measures**

PRIORITY AREA: Standardized Data Categories

Recommendation: The federal government should incentivize development and adoption of standardized REL and SOGI data.

Rationale: Achieving improvement in the quality and completeness of REL and SOGI data is foundational to identifying and understanding health disparities and driving health equity.¹⁹

Background: Standardized, disaggregated data could create opportunities for insurers, health care providers, employers, and patient advocates to design and implement targeted solutions to better meet the needs of various communities. In addition to the data standards, trust in the collection process will always be a factor that affects the ability to collect reliable data. Uniformity in the data collection tools, lexicon and framing of questions is therefore essential.

TAKING ACTION:

1. **Adopt Statistical Policy Directive No. 15:** HHS should adopt the revised Office of Management and Budget's Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity (OMB SPD 15) standards as efficiently and effectively as possible and require private-sector program participants to use this new standard. HHS also should build on SPD 15 by creating minimum standards for collecting language and SOGI data with input from diverse stakeholders within and outside the federal government.
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PRIORITY AREA:

Bias Identification and Mitigation

Recommendation: Health care organizations should collect R/E data directly from consumers when possible; when data can only be imputed, the federal government should develop bias identification and mitigation strategies.

Rationale: Collection of R/E data directly from consumers is the gold standard. When this is not possible, analytical tools and algorithms may be used to impute (assign probable R/E status from known data such as ZIP codes) this data. However, imputed data may miss or misrepresent the presence of health inequities, potentially leading to ineffective interventions or unintended consequences.

Background: Inclusion of race and ethnicity and other health equity data in health care data collection is important to health equity programs. However, the potential risk of bias and discrimination must be mitigated. Algorithms, when used effectively, can be beneficial to patients and improve health outcomes, but unmitigated bias can have unintended consequences.

TAKING ACTION:

1. **Develop mitigation strategies for algorithms:** The federal government should develop and adopt bias identification and mitigation strategies by engaging and partnering with health care stakeholders who utilize analytical and algorithmic tools, such as health plans and providers.
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PRIORITY AREA:

HIPAA Privacy and Security Measures

Recommendation: Organizations should ensure they comply with applicable federal and state laws and regulations regarding access, use and disclosure of such information, including but not limited to the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and its implementing regulations.

Rationale: Individually identifiable health equity data is considered protected health information (PHI) under HIPAA. When using health equity data sets, extra care is needed to ensure that this type of data is maintained with adequate privacy and security safeguards.

Background: Transparency engenders trust, and trust can make people more comfortable in sharing REL, SOGI and other data. This transparency–trust cycle can create a bond between a patient and the health care community. Where this bond exists, people may become more comfortable sharing their data. When this bond is broken, or not yet formed, people will be wary of sharing their data. The interplay of trust and transparency in health care is increasingly recognized as a critical driver of health outcomes.²¹

Health care organizations must also be transparent about the intended use of health equity data. For example, if a health plan asks its members about their gender identity, an explanation about why such information is needed and how it will be used to help guide the member's care is essential.

TAKING ACTION:

1. **Establish standards for trust in data collection practices:** Stakeholders must establish standards that determine how best to engage with individuals and their families in a transparent manner that fosters and maintains trust as data is collected.
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