DC Health Benefit Exchange Authority

Public Hearing on
Bill 24-0558, the "Stop Discrimination by Algorithms Act of 2021"

Testimony of Diane C. Lewis, Chair
D.C. Health Benefit Exchange Authority Executive Board
Before the
Committee on Government Operations and Facilities,
Council of the District of Columbia
Robert C. White, Jr., Chairperson

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Virtual Meeting Platform
John A. Wilson Building
1350 Pennsylvania Avenue, NW
Washington, D.C. 20004

Good afternoon, Chairman White, members of the Committee on Government Operations and Facilities, and staff, my name is Diane Lewis and I am the Chair of the Executive Board of the DC Health Benefit Exchange Authority (HBX). Thank you for the opportunity to appear before you today to testify on Bill 24-558, the "Stop Discrimination by Algorithms Act of 2021".

HBX, and its Executive Board, is an independent agency established by DC policymakers to implement the Affordable Care Act and to build and operate DC's state-based on-line health insurance marketplace, otherwise known as "DC Health Link". More than 100,000 people get their health insurance through DC Health Link, including more than 5,300 District small businesses and nonprofits covering 85,000 people (including Congress) and 15,000 residents with individual marketplace health insurance.

My testimony today is limited to Bill 24-558's application to health insurers offering coverage through DC Health Link and the medical care our enrollees receive. In that respect, we are supportive of the goals of the legislation to root out unjust discrimination. That being said, there are a few clarifications to the bill we would like to see made—clarifications we have also shared with the Office of the Attorney General.

Events over the last several years continue to expose the systems of inequity and racism in which we all live and work, including in healthcare, and have forced our country to take a more honest look at ourselves, our values, and our commitment to justice. These events, including COVID-19, highlighted the long history of racism and mistreatment of people of color in the health care system and the subsequent travesties that result when left unaddressed.

As Dr. Martin Luther King Jr. said "Of all the forms of inequality, injustice in health care is the most shocking and inhumane."

The HBX Executive Board believes it is critical to be part of the solution to help end systemic racism and injustice in healthcare. In 2020, the HBX Executive Board created a working group on Social Justice and Health Disparities, which I chaired and Dr. Cara James, President and CEO, Grantmakers in Health, (former director of the Office of Minority Health at HHS/CMS) vice-chaired. We asked the working group to identify ways HBX can help while recognizing it was important not to displace or replace the work District agencies, community leaders, providers, and payors are already doing. Our goal was to identify specific solutions within HBX's authority that HBX can implement with health insurers that offer coverage on DC Health Link.[1] All our health plans served on the working group and voluntarily agreed to take significant actions to help address health disparities and racism. The Working Group issued many recommendations[2] including, for

[1] *See e.g.*, "Washington, D.C.'s State-Based Marketplace is Addressing Health Disparities and Systemic Racism in Health Care', Lewis, D., Health Affairs, March 17, 2022, available at https://www.healthaffairs.org/do/10.1377/forefront.20220315.92335; "Using Health insurance Reform to Reduce Disparities in Diabetes," Monahan. C. and Clark J., Commonwealth Fund, August 18, 2022, available at https://www.commonwealthfund.org/blog/2022/using-health-insurance-reform-reduce-disparities-diabetes-care; "What Four States are doing to Advance Health Equity in Marketplace Insurance Plans," Commonwealth Fund, April 13, 2022, available at https://www.commonwealthfund.org/publications/issue-briefs/2022/apr/what-four-states-are-doing-advance-health-equity-marketplace.

[2] Recommendations of the Social Justice & Health Disparities Working Group to the District of Columbia Health Benefit Exchange Authority, July 12, 2021, 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_0.pdf

example, modifying health insurance benefit design for DC Health Link standard plans to eliminate cost-sharing for conditions that disproportionately affect patients of color in the District. In July 2021, the HBX Executive Board adopted[3] unanimous recommendations of the Working Group and, in July 2022, received a report[4] on health plan implementation of the new requirements.

In our initial research and implementation work with our health plans, we identified how health care clinical decision-making tools and algorithms perpetuate health disparities among communities of color. For example, one clinical decision-making tool called GFR estimates how well kidneys function. The tool's "race adjustment" automatically added points to the score for Black patients, making it look like their kidneys functioned better. The artificially inflated score delayed kidney treatment and prevented some patients from receiving life-saving transplants. Importantly, DC Health Link insurers all agreed to prohibit the use of race in estimating GFR by their network providers. It should be noted that the National Kidney Foundation revised its guidelines to prohibit the use of race in estimating GFR.

Moreover, people of color are less likely to be eligible for intensive care management or receive timely diagnoses or appropriate care for heart failure, kidney disease, certain cancers, osteoporosis, and many other conditions. To that end, our carrier partners agreed to conduct reviews, report to HBX, and take steps to address clinical management algorithms which may introduce bias into clinical decision making and/or influence access to care, quality of care, or health outcomes for patients of color. Several of our carriers are putting systems in place to conduct on-going reviews of clinical diagnostic tools that use race adjustment.

As a result of these efforts, we support clarifying B24-0558 to recognize the work that our health plans are doing with us to avoid duplication while also allowing the provisions in B24-0558 to serve their goal of rooting out discrimination perpetuated through bias in algorithms.

In addition, we support clarifying the bill to include clinical guidelines. Many clinical standards developed by national clinical organizations use race in treatment guidelines. In a New England Journal of Medicine Article in 2020, researchers identified 13 clinical tools that use race-

[3] DC Health Benefit Exchange Authority Executive Board Resolution, "To adopt the consensus recommendations of the Social Justice and Health Disparities Working Group to advance equity and reduce health disparities in health insurance coverage for communities of color," (July 2021), available at: https://hbx.dc.gov/sites/default/files/dc/sites/hbx/publication/attachments/Resolution%20on%20Social%20Justice%20%20Health%20Disparities%20Working%20Group%20Recommendations.pdf%20FINAL.pdf.

[4] Available at: https://hbx.dc.gov/sites/default/files/dc/sites/hbx/event_content/attachments/SJWG%20Slides%20July%2013%202022%20Year%20One%20DRAFT.pdf

adjustment, exacerbating health disparities and inequities.[5] For example, Vaginal Birth after Cesarean Risk Calculator deemed Black women high risk and classified them as candidates for C-section delivery if they had a prior C-section, while White women would be given a choice of C-section or vaginal birth. C-sections are not only more expensive but have a much higher medical risk of severe complications and death. The good news is that this standard was revised recently to eliminate this race adjustment.[6] Unfortunately, many other clinical tools continue to use race adjustment to the detriment of Black people and other communities of color.

In our work, we learned that some health care algorithms can introduce and exacerbate bias in health care and therefore health outcomes. Basic instruments like pulse oximeters, to determine blood oxygen saturation level (a device we all learned more about during COVID), are calibrated based on white skin resulting in less accurate results for those with darker pigments. (Note that the FDA recently established a committee to look at this problem) Bringing transparency to guidelines and algorithms is an important step to understanding and correcting embedded biases that discriminate against people of color.

In conclusion, while we believe that algorithms have the potential to be unbiased, neutral tools, we cannot turn a blind eye to the history of inequitable care and must purposefully act in ways that do not perpetuate these disparities. We must be intentional in our efforts to address injustice and ensure health equity.[7] Racism and bias are institutionalized and manifest in many ways. The need for B24-0558 is clear. Thank you and I am happy to answer any questions.

[5] "Hidden in Plain Sight – Reconsidering the Use of Race Correction in Clinical Algorithms," Vyas, D., Eisenstein, L., and Jones, D., New England Journal of Medicine, August 2020, available at https://www.nejm.org/doi/full/10.1056/NEJMms2004740.
[6] "Changing the Equation: Researchers Remove Race from a Calculator for Childbirth," Palmer K.,STAT, June 3, 2021, available at https://www.statnews.com/2021/06/03/vbac-calculator-birth-cesarean/
[7] Locke T, Parker V, Thoumi A, Goldstein B, Silcox C (2022). Preventing Bias and Inequities in AI-enabled Health Tools. Washington, DC: Duke-Margolies Center for Health Policy.