



## FIVE THINGS TO KNOW ABOUT RACE, ETHNICITY, LANGUAGE (REL) DATA & COLLECTION

... from Premera Blue Cross

**True health equity** cannot be achieved without data to uncover disparities and drive meaningful change. That's why Premera is focused on collecting data from our members so we can better understand their experience.

Here are the five things to know about the collection of Race, Ethnicity, and Language (REL) data, including the requirements and how the data is collected, which can help you understand the issues and how Premera is working to create a better, more equitable, experience for members.

### What is it?

Premera receives accreditation from the National Committee for Quality Assurance (NCQA), an accreditation committee that accredits and certifies a wide range of health care organizations. Due to our accreditation, we adhere to the NCQA mandate that we collect and report REL data for at least 80% of our member population. The data is used for record keeping and is part of our required Healthcare Effectiveness Data and Information set (HEDIS) scoring.

Race refers to the social construction and categorization of people based on perceived shared physical traits that result in the maintenance of a sociopolitical hierarchy. Ethnicity is a characterization of people based on having a shared culture (e.g., language, food, music, dress, values, and beliefs) related to common ancestry and shared history. Language is the specific communicative system used by a particular group of speakers, with its distinctive vocabulary, grammar, and phonological system.

**Why is it important?** Many Americans experience barriers to health that are beyond their control. [America's Health Rankings® 2023 Annual Report](#), presented by the United Health Foundation and the American Public Health Association, underscores this reality. The report reveals widening disparities across key health measures, especially in chronic condition care.

In many cases, the conditions in which people live and work are contributing to those disparities. Also known as [social determinants of health](#) (SDOH), these conditions include access to nutritious food, affordable housing, transportation and financial stability, among others, and they can influence up to 80% of health outcomes.<sup>1</sup>

SDOH are more prevalent than one might think. For example, it's estimated that within an average employee population:<sup>2</sup>

- Up to 5% are at risk of homelessness
- Up to 25% live with high levels of both financial and food insecurity
- Up to 30% are socially isolated

The cost implications of those disparities are significant. Inequities in health can lead employees to miss work more often or be less productive at work, and that sort of absenteeism can cost U.S. employers \$3,600 per hourly employee and \$2,650 per salaried employee, annually.<sup>3</sup> Altogether, health inequities cost approximately \$320B and could exceed \$1T by 2040 if they go unaddressed.<sup>4</sup>

**What's the current industry landscape?** Not only are we mandated to collect 80% direct reported and collected member REL data as part of our required HEDIS scoring, the Centers for Medicare and Medicaid Services (CMS) requires that we collect this data for our Individual plans in Alaska. We anticipate that Washington State will also make collecting this data a requirement in 2025. For members, providing their REL data is 100% optional.

Without the right data, it's hard to quantify the extent of health disparities impacting the health and well-being of communities across race and ethnicity, sexual orientation, gender identity and socioeconomic status. To do this in a relevant, personalized, and timely manner, we first need to understand our members through the voluntary collection of REL data.

Nationally, several Blues plans as well as other national insurers, including Aetna through CVS Health, and Cigna, are collecting REL data.

**What should employers consider?** Employers can play a role in advancing health equity at the workplace. Keeping health equity in mind as they consider health plan and network design, employee engagement opportunities and clinical strategies may help move the needle in the right direction — and over the long term, these strategies may also reduce costs.

**Premera's strategy.** At Premera, we've been on our journey to make healthcare more accessible and inclusive for our members. We believe that it is not only about making sure everyone has equitable access to quality, affordable healthcare but also ensuring the resources and opportunities are tailored to fit the specific needs of a person or community.

We have been very intentional as we've built out our health equity program for our members. Data is key to our program. Without data from our members, we cannot identify and address health inequities in a meaningful way. REL data will not affect a member's health plan benefits, premiums, or coverage eligibility. REL data will be securely stored in our Enterprise Database Warehouse and is only accessible by Premera authorized data analysts. Storage will adhere to the same access restrictions and legal/ethical guidelines as other personal protected information (PPI) as mandated by federal laws.

Beginning in January 2025, Premera will have a questionnaire on the member secure website and the Premera mobile app. We'll be sending emails and mailers to members to let them know of the program and to explain the questionnaire. We'll also have information available in B'Link for employers to use to encourage their employees to voluntarily participate in the REL data gathering.

1. Employers Can Do More to Advance Health Equity. Harvard Business Review, January-February 2023. Available: <https://hbr.org/2023/01/employers-can-do-more-to-advance-health-equity>[Opens in new window.](#)
2. Optum Advisory Service internal analyses, 2020. WITH General insights from Optum Advisory Services Commercial customers, 2021. Accessed: Dec. 14, 2023.
3. Health Equity in the Workforce: An Employer Resource Guide. Available: <https://www.heart.org/en/healthy-living/company-collaboration/well-being-works-better/health-equity-in-the-workforce/employer-resourceguide>[Opens in new window.](#)
4. Batra, N. Bhatt, J. Davis, A. Dhar, A. Gerhardt, W. U.S. health care can't afford health inequities. Deloitte, June 22, 2022. Available: <https://www2.deloitte.com/us/en/insights/industry/health-care/economic-cost-of-health-disparities.html>[Opens in new window.](#)