

Health Equity Coverage Recommendation Form

Title: Health Equity in Diabetes

Date of Last Review: 1/1/2026

Research Section

Background

Health equity in diabetes among racial minority groups addresses the significant disparities in diabetes prevalence, management, and outcomes. Racial minorities, particularly African Americans, Hispanic/Latino communities, Native Americans, and some Asian American subgroups, experience higher rates of diabetes and its complications compared to their white counterparts. These disparities are driven by a complex interplay of socioeconomic factors, limited access to quality healthcare, cultural barriers, and systemic inequities within the healthcare system. Addressing health equity involves comprehensive strategies such as increasing access to preventive care, culturally tailored health education, improving diet and lifestyle resources, and enhancing community-based support systems. Reducing these disparities requires concerted efforts from healthcare providers, policymakers, and community organizations to create equitable and inclusive health environments.

Inequities discussed on the [Office of Minority Health Website](#)¹

[Diabetes and Black/African Americans:](#)²

- In 2024, non-Hispanic Black or African American adults were diagnosed with diabetes 24% more frequently than adult of the total population.¹
- In 2021, non-Hispanic Black or African Americans were diagnosed with end stage renal disease due to diabetes 2.19 times more often than the total population.²
- In 2022, non-Hispanic Black or African Americans died from diabetes at a rate that was 40% higher than the total population.

[Diabetes and American Indians/Alaska Natives:](#)³

- In 2024, American Indian/Alaska Native adults were diagnosed with diabetes 36% more often than the total population.¹
- In 2021, non-Hispanic American Indians/Alaska Natives died from diabetes 66% more often than the total population.

[Diabetes and Asian Americans:](#)⁴

- In 2024, Asian American adults were diagnosed with diabetes 6% more often than adults of the total population.¹
- From 2019-2021, among Asian subgroups,²
- Asian Indian and Filipino adults were diagnosed with diabetes more often than adults of the total population, 21% and 37% respectively.
- Korean adults were diagnosed with diabetes 31% less often than adults of the total population.
- Chinese, Japanese, and Vietnamese adults also had lower rates of being diagnosed with diabetes than adults of the total population.
- In 2022, non-Hispanic Asian American men and women died from diabetes less often than the total population, 40% and 37% respectively.³

[Diabetes and Hispanic/Latino Americans:](#)⁵

- In 2022, Hispanic/Latino American died from diabetes at a rate that was 36% below the total population.¹
- In 2022, Hispanic/Latino adults experienced 28% more instances of visual impairments than the total population.¹
- In 2024, Hispanic/Latino adults were diagnosed with diabetes at a rate that was 13% higher than the total adult population.²

[Diabetes and Native Hawaiians/Pacific Islanders](#)

- National data for this population is limited.
- From 2022-2024, Native Hawaiian/Pacific Islander adults were diagnosed with diabetes at the same rate as adults from the total population.¹
- In 2022, non-Hispanic Native Hawaiians/Pacific Islanders died from diabetes at a rate 57% higher than the total population.²
- In 2014, American Samoans had the highest rate of diagnosed diabetes among surveyed Native Hawaiian and Pacific Islander sub-populations. They were diagnosed with diabetes at a rate that was 31% higher than all Native Hawaiian/Pacific Islander adults.³

Review of current, peer-reviewed evidence from established sources

- In 2018, [Marquez and colleagues](#) published a report on a Framework for Addressing Diabetes-related Disparities in US Latino Populations.⁶ The article aimed to offer a better understanding of underlying causes and influencing factors to guide future efforts to eliminate racial/ethnic disparities in diabetes control. Key findings include evidence that diabetes care services can be designed to accommodate heterogeneity within the Latino American community by addressing key modifiable predictors of poor glycemic control, including insurance status, diabetes care utilization, patient self-management, language access, culturally appropriate care, and social support services. Future research efforts should evaluate the effect of structurally tailored

interventions that address these key modifiable predictors by targeting patients, providers, and health care delivery systems.

- In 2013, [Ricci-Cabello and colleagues](#) published a meta-analysis and systematic review on health care interventions to improve the quality of diabetes care in African Americans.⁷ This systematic review identified 31 health care–promoted interventions specifically aimed at improving the quality of diabetes care in African Americans, most of which targeted patients (71% targeted patients, 16% targeted the health care system, and 13% were multifaceted). The evidence gathered showed that interventions targeting African American diabetic patients, which mainly included culturally adapted DSM education, reduced the percentage of HbA1c by 0.8%. A lower level of evidence was observed in relation to interventions targeting the health care system and multiple-target interventions, although available evidence suggests that they can be effective and have the potential to improve diabetes care and health outcomes. The authors concluded that “this systematic review provides evidence about the key role that health care can play in reducing ethnic disparities in African American patients with type 2 diabetes by designing and conducting interventions aimed at this specific purpose.”
- In 2022, [Hill-Briggs and colleagues](#) published a report on social determinants of health, race, and diabetes population health improvement among Black/African Americans.⁸ Authors wrote the following:
 - “Key findings from the American Diabetes Association’s scientific review of five social determinants of health (SDOH) domains (socioeconomic status, neighborhood and physical environment, food environment, health care, social context) are highlighted. Population-based data on Black/African American adults illustrate persisting diabetes disparities and inequities in the SDOH conditions in which this population is born, grows, lives, and ages, with historical contributors. SDOH recommendations from US national committees largely address a health sector response, including health professional education, SDOH measurement, and patient referral to services for social needs. Fewer recommendations address solutions for systemic racism and socioeconomic discrimination as root causes. SDOH are systemic, population-based, cyclical, and intergenerational, requiring extension beyond health care solutions to multi-sector and multi-policy approaches to achieve future population health improvement.”

Review of clinical practices guidelines from professional associations and societies in regard to these findings

American Association of Clinical Endocrinology:

In 2022, the AACE put out the following guideline; [American Association of Clinical Endocrinology Clinical Practice Guideline: Developing a Diabetes Mellitus Comprehensive Care Plan](#).⁹ Authors recommended preventive screening and management of comorbidities including obesity. They state, “There is evidence that community programs involving cross-age peers can be effective at delivering nutritional interventions and in reducing BMI particularly in low-income or minority populations.”

American Diabetes Association:

In 2025, the American Diabetes Association (ADA'S) updated their [Standards of Medical Care in Diabetes](#).¹⁰ As part of their review, authors noted that most youth with type 2 diabetes come from racial/ethnic minority groups, have low socioeconomic status, and often experience multiple psychosocial stressors. Consideration of the sociocultural context and efforts to personalize diabetes management are of critical importance to minimize barriers to care, enhance adherence, and maximize response to treatment.

Do any of these findings relate to any of our current policies?

None of the above findings are applicable to any of our current medical policies at this time.

Summary

Medical Policy:

Diabetes disproportionately affects minority populations in the US, including African Americans, American Indians/Alaska Natives, Asian Americans, and Hispanic Americans. Causes of the higher prevalence of Diabetes in these populations are likely multifactorial and complex, as diabetes has a number of comorbidities affected by biological, socio-economic, and environmental factors. Currently, evidence and guidelines suggest that health care models, society-wide models, and patient care must change to address these disparities.

Pharmacy Policy:

According to the 2025 Standards of Care in Diabetes, some pharmacy related barriers to adequate diabetes care include affordability and accessibility (due to transportation, geographic distance, and long work hours). With the exception of the GIP/GLP-1 agonists, most medications recommended in the guidelines for the treatment of diabetes, as well as traditional glucose monitoring kit and supplies, are available on the formulary without restriction. While prior authorization can be a barrier to access for patients, they are sometimes necessary for higher cost drugs to ensure appropriate utilization and to avoid covering for conditions that lack high quality evidence regarding safety and/or efficacy or are considered a benefit exclusion, like weight loss is for many of our groups.^{11, 12, 13}

Over the previous year, several improvements have been made by pharmacy policy to improve access to care for our members. Our GIP/GLP-1 agonists policy has been simplified with step therapy removal and now only requires a diagnosis of type 2 diabetes for our preferred products. For members who meet authorization criteria for a preferred GIP/GLP-1 agonist therapy, we now load authorizations for all preferred products in the class so members can switch preferred products without requesting a new prior authorization. We have fixed some existing issues and now have auto-approval for continuous glucose monitors up and running for members with claims for insulin. We also implemented auto-approval for insulin pumps for members with claims for rapid or short acting insulin.

Access to a pharmacy can be another barrier to medication adherence. The pharmacy department has a pharmacy network team that ensures we have a broad network of pharmacies for patients to go to receive medications and immunizations. Additionally, we contract through a mail order pharmacy, Postal Prescription Services, that eliminates the need for members to spend time going to the pharmacy. For some plans, members get reduced copays when utilizing this service.

Pharmacy has reviewed this topic and notes there are no actionable changes to pharmacy policies at this time.

Recommendation:

No recommended health equity updates to policies at this time. We will continue to review data and professional organization recommendations for future health equity updates.

References

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CORE Revision History Section

DATE	SUMMARY OF CHANGES
12/21/2023	Initial review.
12/26/2024	Annual update. No changes.
12/26/2025	Annual update. No medical policy changes.

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