ESTIMATING POTENTIAL IMPACTS OF HEALTH INSURANCE BENEFIT MANDATES ON RACIAL/ETHNIC DISPARITIES ATTRIBUTABLE TO DISPROPORTIONATE BENEFIT COVERAGE

This document presents an approach to assessing a state-level health insurance benefit mandate bill's potential impact on racial/ethnic disparities for Medi-Cal beneficiaries enrolled in Department of Managed Health Care (DMHC)-regulated plans. The racial/ethnic composition between Medi-Cal beneficiaries and persons enrolled in privately funded[1] insurance differs. Therefore, state legislation exempting one type of insurance (either Medi-Cal or privately funded insurance) from mandates may create, exacerbate, or reduce racial/ethnic disparities in access to care or health outcomes.

The California Health Benefits Review Program (CHBRP) analyzed the California Health Interview Survey (CHIS) data and estimated the racial/ethnic composition of Medi-Cal beneficiaries and persons who are enrolled in privately funded insurance. CHBRP used the resulting distribution to estimate the racial/ethnic composition of the California population whose insurance can be subject to mandate legislation – the population included in all CHBRP analyses.

This document explains:

- The methods and limitations for estimating the racial/ethnic composition of Medi-Cal beneficiaries and persons who are enrolled in privately funded insurance, and
- The criteria CHBRP will use to determine when to estimate the impact of a mandate on racial/ethnic disparities.

[1] Privately funded insurance includes most employment-based group insurance and individually purchased insurance. Although technically publicly funded, for the purpose of this paper, enrollees in DMHC-regulated plans associated with California Public Employees' Retirement System (CalPERS) have been included in privately funded insurance. For more information, see CHBRP's resource *Estimates of Sources of Health Insurance in California*, available at http://chbrp.org/other_publications/index.php.

Method

CHBRP's analyses focus on enrollees in plans and policies regulated by the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI) because these are the health insurance products subject to state-level benefit mandates. Most of these enrollees are aged 0 to 64, in part because Californians aged 65 and over primarily have Medicare (which is not subject to regulation by DMHC or CDI) as their primary health insurance. Some Californians aged 0 to 64 are also enrolled in one or another type of health insurance not regulated by DMHC or CDI. For example, employers may self-insure, which means the health insurance they offer employees and retirees (as well as dependents) is subject only to federal law.[2, 3]

CHIS, the largest state health survey in the nation, is conducted on a continuous basis with annual data updates. It is a random-dial telephone survey that asks questions on a wide range of health topics; hence, responses on race/ethnicity and type of insurance are self-reported.

The 2014 results from CHIS were used under the following parameters:

- Californians aged 0 to 64
- The demographic category[4] titled "Race-UCLA CHPR (2007 and beyond)," which utilizes self-reported information to identify respondents as: Latino, Asian. African American, White, or Other
- The health insurance category titled "Type of current health insurance coverage-all ages"

CHBRP estimated the racial/ethnic composition of two groups of insured Californians: Medi-Cal beneficiaries and enrollees with privately funded insurance. As the majority of the Medi-Cal beneficiaries (including those dually eligible for Medi-Cal and Medicare) aged 0 to 64 are enrolled in DMHC-regulated plans,[5] and the majority of Californians enrolled in employment-based or privately purchased health insurance are enrolled in DMHC-regulated plans or CDI-regulated policies,[6] CHBRP assumes that the racial/ethnic compositions presented in the following figures represent that of the Medi-Cal beneficiaries in DMHC-regulated plans and enrollees in privately funded health insurance plans and policies regulated by DMHC or CDI. CHBRP applied those proportions to enrollees with insurance that can be subject to state-level mandates.

---

[2] Employee Retirement Income Security Act of 1974 (ERISA).
[3] For more information on enrollment in plans/policies subject to state-level benefit mandates, see the CHBRP report *Estimates of Sources of Health Insurance in California for 2016* available at http://www.chbrp.org/other_publications/index.php
[4] For more on how CHIS approaches the issue of race and ethnicity, see *Race and Ethnicity using the California Health Interview Survey (CHIS)*, available at http://healthpolicy.ucla.edu/Documents/pdf/race_doc_dec2008.pdf:
[5] Report by the California Department of Health Care Services available at http://www.dhcs.ca.gov/services/Documents/MMCD/December152015Release.pdf
[6] See the CHBRP report *Estimates of Sources of Health Insurance in California for 2016* available at http://chbrp.org/other_publications/index.php

There are several limitations to this method. First, as previously noted, CHBRP is unable to parse the CHIS data to the CHBRP population specifications (only enrollees in DMHC-regulated plans and CDI-regulated policies), thus an assumption is made regarding racial/ethnic compositions being equivalent between the CHIS and CHBRP populations aged 0 to 64. Second, because the CHIS survey method relies on self-report, there may be some inaccuracies in enrollees' description of their insurance, which may lead to an underestimation of the number of Medi-Cal beneficiaries in the CHIS data. Third, official data on the number of Medi-Cal beneficiaries includes those who were beneficiaries for a limited time (e.g., for only a few months while between jobs) or who have specific conditions not always captured in survey data (e.g., conditions that require admission to a nursing home or otherwise make response to a telephone survey less likely).

Despite these limitations, CHIS is a widely used source of data on populations that include both Medi-Cal beneficiaries and enrollees with privately funded insurance. Therefore, CHBRP finds the CHIS estimates of racial/ethnic compositions sufficiently representative to use in CHBRP's analyses.

Results

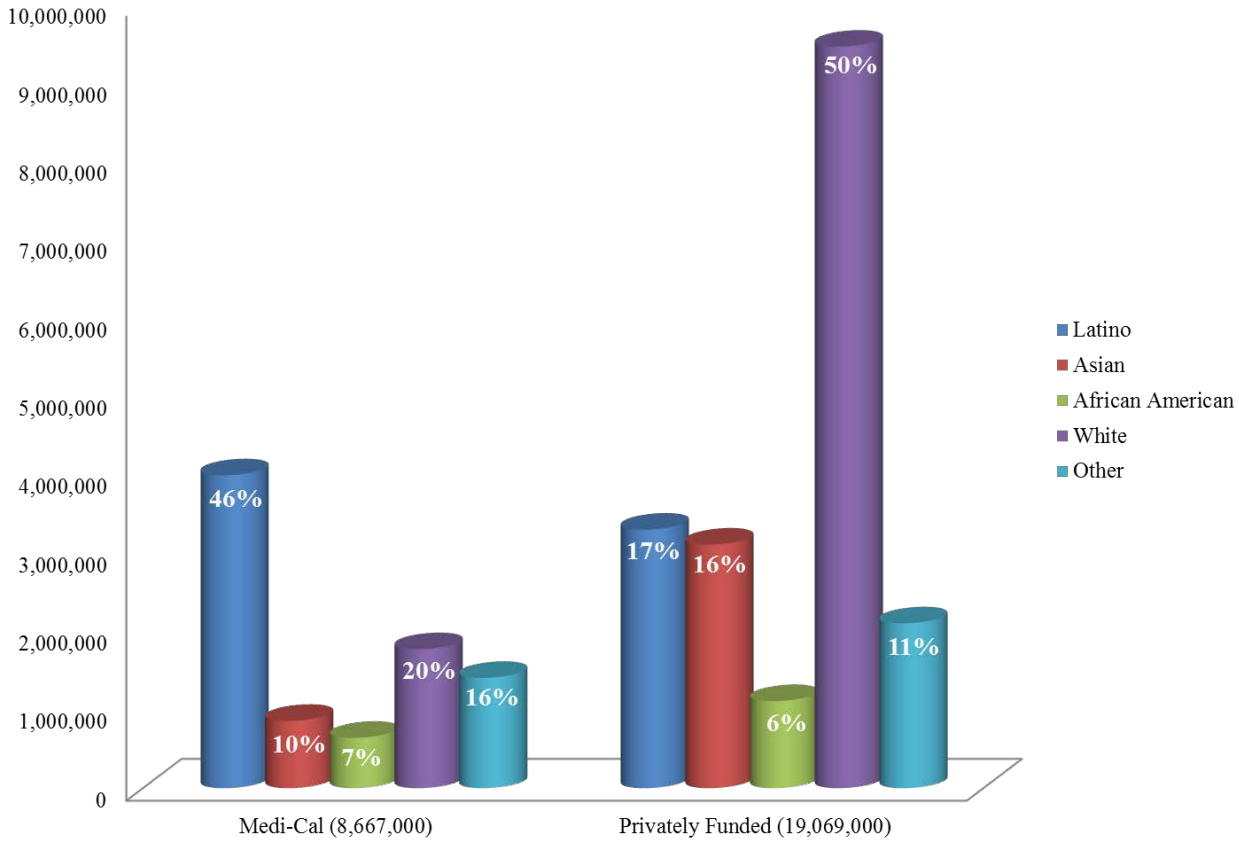
As noted in Figure 1, below, the 2014 CHIS data show that about 19 million Californians aged 0 to 64 report having privately funded insurance (employment-based or purchased from the individual market) and about 9 million Californians aged 0 to 64 report that they are Medi-Cal beneficiaries. The racial/ethnic compositions vary between the two groups.

- As noted in Figure 1, for Californians aged 0 to 64:
    - The proportions of Latinos, African Americans, and Others who are Medi-Cal beneficiaries are similar[7] to the proportions enrolled in privately funded health insurance.
    - The proportions of Asians and Whites who are Medi-Cal beneficiaries are less than the proportions enrolled in privately funded health insurance.

As Figure 1 illustrates, nearly half of Latinos and African-Americans aged 0 to 64 years are enrolled in Medi-Cal. In contrast, Asian and White Californians aged 0 to 64 years are much more likely to have privately funded insurance than to be enrolled in Medi-Cal. Thus, among persons in this age group, Latinos, African Americans, and Others have a disproportionately high representation in Medi-Cal as compared to Whites and Asians.

[7] The term "similar" is used when there are less than twice as many persons in one health insurance category than in the other.

Figure 1. 2014 Race/Ethnicity of Californians, **aged 0 to 64**, with Medi-Cal or Privately Funded Insurance (Percentages Indicate Representation Among Medi-Cal Beneficiaries or Among Enrollees with Privately Funded Insurance)



Source: California Health Benefits Review Program based on the 2014 California Health Interview Survey (CHIS). *Notes:* (1) The "Other" category includes individuals who self-identify their race as other single race, two or more races, or American Indian/Alaska Native. (2) Privately Funded includes most employment-based group insurance including some "public" employers, such as those offering health insurance through the California Public Employees' Retirement System (CalPERS), and individually purchased insurance.

Criteria

CHBRP will use the following set of criteria to determine whether a proposed mandate could produce disproportionate impacts on benefit coverage and utilization. If the following criteria are met, a mandate may lead to the creation, exacerbation, or reduction in racial/ethnic disparities in health outcomes (Table 1). Each of the criteria must be met for CHBRP to estimate an impact on racial/ethnic disparities:

Table 1. Criteria Required to Project Potential Impacts on Disproportionate Benefit Coverage, Utilization and Health Outcomes

Disproportionate benefit coverage andutilization
1. The mandate would exempt either (a) DMHC-regulated plans enrolling Medi-Cal beneficiaries or (b) DMHC/CDI-regulated plans and policies enrolling others (persons who are not Medi-Cal beneficiaries) from providing the required benefit coverage
2. The exempt insurance does not comply with the mandate (e.g., does not cover the mandate-relevant test, treatment, or service or does not do so as the mandate would require)
3. Among enrollees with insurance subject to the mandate, there is a projected postmandate change in benefit coverage
4. Among enrollees with insurance subject to the mandate, there is a projected postmandate change in utilization of a mandate-relevant test, treatment, or service
Disparities in public health outcomes
1. Disproportionate benefit coverage and utilization criteria (above, 1-4) affirmed, and
2. The mandate-relevant test, treatment, or service is known to be medically effective

A hypothetical example of how CHBRP could use the criteria described above is included in Appendix A.

Conclusion

Potential Impacts of Benefit Mandate Exemptions

The racial/ethnic composition of Medi-Cal beneficiaries is significantly different from that of enrollees with privately funded insurance. If a proposed mandate exempts one type of insurance (either Medi-Cal or privately funded insurance), the coverage, utilization, and health outcomes of these beneficiaries would remain the same, while those enrollees with insurance subject to the bill would receive the newly mandated coverage. This could lead to greater utilization of services that may improve health outcomes.

If the mandate-relevant tests, treatments, or services are known to be medically effective, exempting the health insurance of one group of enrollees from the impacts of a mandate could create, exacerbate, or reduce racial/ethnic disparities in access to care or health outcomes. Such an outcome is attributable to the differences in racial/ethnic composition between Medi-Cal beneficiaries and enrollees with privately funded insurance.

Appendix A: Hypothetical Example

The hypothetical example below demonstrates how CHBRP might identify and report potential impacts of a benefit mandate on racial/ethnic disparities attributable to disproportionate benefit coverage.

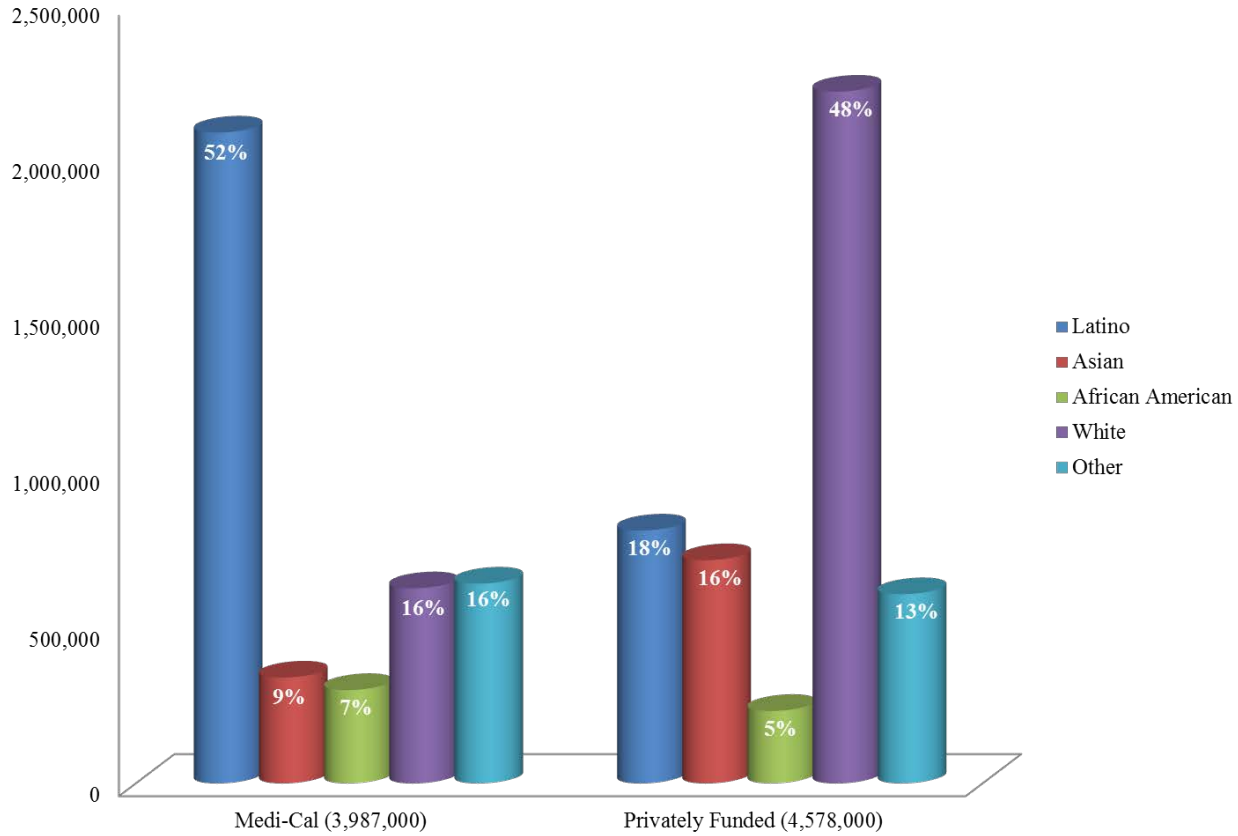
Previously, if a benefit mandate bill proposed exempting from compliance the health insurance of DMHC-regulated plans enrolling Medi-Cal beneficiaries, CHBRP may have reported what appears in Table B-1 as "original text." However, should all the criteria listed in Table 1 (in the main body of this document) be met, and should the relevant treatments and services be primarily used by children (aged 0 to 17), language similar to what appears as "proposed text" in Table A-1, would be used

Table A-1. Original and Proposed Conclusions

Original Report Text	Proposed Text Using Criteria and Baseline Data
"CHBRP investigated the effect that the bill would have on health disparities by gender, race, and ethnicity...CHBRP does not have access to the racial/ethnic distribution of enrollees among plans and policies that would be subject to the mandate nor did CHBRP find literature about differential use or outcomes of mandate-relevant treatments by race; **therefore, the public health impact of the bill on reducing potential racial and ethnic health outcome disparities is unknown**."	Medi-Cal beneficiaries enrolled in DMHC-regulated plans do not have coverage for the benefit the bill would mandate. As the bill exempts plans from providing benefit coverage to Medi-Cal beneficiaries, the coverage/utilization impacts projected in this report would occur only among enrollees in privately funded DMHC-regulated plans and CDI-regulated policies. **Because (when compared with their presence among enrollees whose health insurance would be subject to the bill) Latinos and African Americans are proportionally more present among Medi-Cal beneficiaries aged 0 to 17 (the age group most likely to use mandate-relevant treatments) than are other races/ethnicities (see Figure A-1), CHBRP anticipates that the mandate would create or acerbate disparities in coverage/utilization and health outcomes for Latinos and African Americans.**

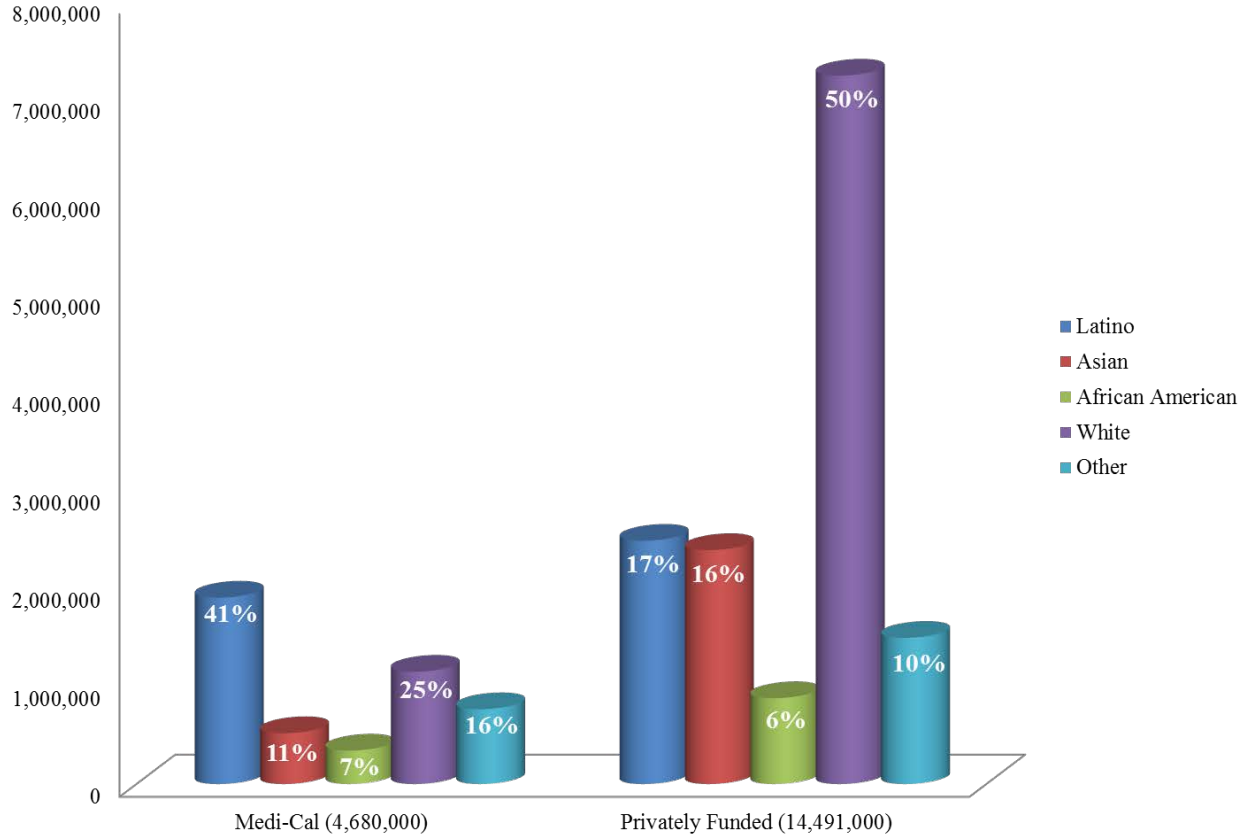
In addition, for the hypothetical example the two figures that follow, Figures A-1 and A-2, would be included to illustrate that the presence of persons from different racial/ethnic groups varies between adults aged 18 to 64 and children aged 0 to 17.

Figure A-1. 2014 Race/Ethnicity of Californians, **aged 0 to 17**, with Medi-Cal or Privately Funded Insurance (Percentages Indicate Representation Among Medi-Cal Beneficiaries or Among Enrollees with Privately Funded Insurance)



S*ource:* California Health Benefits Review Program based on the 2014 California Health Interview Survey (CHIS).
Notes: (1) The "Other" category includes individuals who self-identify their race as other single race, two or more races, or American Indian/Alaska Native. (2) Privately Funded includes most employment-based group insurance including some "public" employers, such as those offering health insurance through the California Public Employees' Retirement System (CalPERS), and individually purchased insurance.

Figure A-2. 2014 Race/Ethnicity of Californians, **aged 18 to 64**, with Medi-Cal or Privately Funded Insurance (Percentages Indicate Representation Among Medi-Cal Beneficiaries or Among Enrollees with Privately Funded Insurance)



S*ource:* California Health Benefits Review Program based on the 2014 California Health Interview Survey (CHIS).
Notes: (1) The "Other" category includes individuals who self-identify their race as other single race, two or more races, or American Indian/Alaska Native. (2) Privately Funded includes most employment-based group insurance including some "public" employers, such as those offering health insurance through the California Public Employees' Retirement System (CalPERS), and individually purchased insurance.