



Guideline for Estimating Impacts of Benefit Mandates on Gender and Racial Disparities

SB 1704, passed in 2006, (*California Health and Safety Code* Section 127660 *et seq.*) charges the California Health Benefits Review Program (CHBRP) to analyze legislation proposing mandated health insurance benefits. The law specifically requests that CHBRP assess the extent to which a mandated benefit will have an “impact on the health of the community, including diseases and conditions where gender and racial disparities in outcomes are established in peer-reviewed and scientific literature.”

Health disparities include racial and gender differences in health status, mortality rates, disease prevalence, and receipt of health services. Policymakers in the United States have sought to address health inequalities and improve the health of the overall population.

This document reviews the process used by CHBRP to examine gender and racial disparities in reports to the legislature on proposed mandated health insurance benefits. A summary of CHBRP conclusions from reports through 2006, can be found in Table 1 below.

Definitions and Approach to Investigating Disparities

Several competing definitions of “health disparities” exist. CHBRP relies on the definition proposed by Braveman (2006):

“A health disparity/inequality is a particular type of difference in health or in the most important influences of health that could potentially be shaped by policies; it is a difference in which disadvantaged social groups (such as the poor, racial/ethnic minorities, women, or other groups that have persistently experienced social disadvantage or discrimination) systematically experience worse health or greater health risks than more advantaged groups.”

Because health insurance mandates primarily affect the insured population, it is important to examine whether there are health disparities within the insured population. Insurance status has been found to be an important factor in health disparities, particularly in explaining racial health disparities (Kirby et al. 2006, Lillie-Blanton and Hoffman 2005).

Among the age 18-64 insured population of California in 2003, blacks, Hispanics, and other minorities report worse overall health status compared to non-Hispanic whites (CHIS 2003). This finding is consistent with much of the academic literature and policy reports that document racial and ethnic disparities in overall health status and disparities within specific health conditions (e.g. Ren and Amick 1996, CDC 2007).

In contrast to racial and ethnic disparities, no major gender differences in self-reported health status were found among the California insured adult population (CHIS 2003). Of course, some diseases



and conditions primarily affect only one gender (e.g. breast cancer, prostate cancer) and others that have a greater prevalence for one gender (e.g. lupus is more common among females).

When possible, the CHBRP reports detail differences in disease prevalence, health services utilization, and health outcomes by gender and race/ethnicity. This baseline information can help legislators assess the potential for differential impact of a mandate bill across different groups.

Four steps are used to assess whether disparities exist and whether the proposed mandate will have an impact on gender and/or racial disparities.

Step 1: Conduct Literature Review

In establishing baseline information, the first step is reviewing the peer-reviewed literature for evidence of gender and racial disparities related to the mandate. The specific keywords used for the literature search will vary according to the characteristics of the particular mandate. Using the keywords, the academic literature is searched for gender and racial/ethnic differences by: (1) prevalence of relevant health conditions or diseases, (2) utilization of relevant health services, and (3) relevant health outcomes.

Using AB 8 (2004) (a bill that would have required a minimum length of stay after a mastectomy or lymph node dissection for the treatment of breast cancer) as an example, the sample keywords used for the literature review were:

- Breast cancer + prevalence + race
- Breast cancer + prevalence + gender
- Breast cancer + prevalence + ethnicity
- Breast cancer + race + outcomes
- Breast cancer + race + mortality
- Mammography + race
- Mastectomy + disparities + race
- Mastectomy + race
- Mastectomy + ethnicity
- Mastectomy + length of stay
- Mastectomy + length of stay + race
- Mastectomy + race + inpatient
- Mastectomy + race + outpatient
- Mastectomy + coverage + race
- Lymph node dissection + race

In addition to conducting this review of the literature, the medical effectiveness literature review is also reviewed for any articles that have information on gender or racial disparities.

Step 2: Review Data Sources

The next step in establishing baseline disparities is to identify data sources that will allow for the examination of relevant prevalence, health utilization, and outcomes measures by gender and

race/ethnicity. California-specific data are preferred; however, when California data are not available, national data sources are used. The following data sources are reviewed for this information:

- California state maintained registries
- California Health Interview Survey
- California Behavioral Risk Factor Survey
- National Health Interview Survey
- National Health and Nutrition Examination Survey
- National Vital Statistics System
- WONDER database maintained by CDC

In addition to these data sources, CHBRP attempts to identify any other relevant data sources. The content expert is also consulted for this purpose.

Step 3: Determine Whether a Qualitative Assessment Regarding Disparities Can Be Stated

Frequently, steps 1 and 2 identify disparities with regards to the health conditions and outcomes related to the proposed mandate; however, there is not always information on disparities with respect to the specific elements of the proposed mandate. For example, in analyzing the mandate on the pediatric asthma education bill AB 264, the literature and data sources revealed that minority children have more severe asthma symptoms and receive fewer preventive medications compared with white children. No racial disparities were identified, however, with regards to asthma education services that would be required under AB 264. As a result, the AB 264 CHBRP report concluded that the mandate would not impact racial disparities.

There are three main conclusions regarding the potential for mandates to impact gender or racial disparities: (1) no evidence to suggest that the mandate will result in a decrease in disparities; (2) the mandate may result in a decrease in disparities; and (3) we cannot conclude whether the mandate will result in a decrease in disparities.

The following scenarios are ones where we state that there is *no evidence to suggest* that the mandate will result in a decrease in disparities:

- No gender and/or racial disparities are reported in the literature or found in relevant data sources.
- The mandate is not expected to result in any changes in utilization.
- The medical effectiveness review does not suggest that an increase in utilization of the benefit will result in improved health outcomes.

The following scenarios are ones where the mandate *may* result in a decrease in disparities:

- There is a documented disparity in prevalence and/or utilization, the benefit is considered effective in improving health outcomes, and the benefit is expected to result in increased utilization

- The benefit is more effective for traditionally disadvantaged gender and/or racial groups or is deemed effective and more acceptable by disadvantaged groups.

The following scenario is one where we *cannot conclude* whether the mandate will result in a decrease in disparities:

- There state of the medical effectiveness literature is not of the necessary caliber to make conclusions with regards to the effectiveness of the mandated benefit. An example of this scenario is the analysis of AB 1185 – Chiropractic care.
- The proposed legislation does not lend itself to a typical CHBRP analysis and therefore the medical effectiveness or utilization sections cannot be used to determine the possible impact of the mandate on health disparities. Previous examples include the CHBRP reports on mental health parity and high deductible health plans.

Step 4: Determine Whether a Change in Disparities Can Be Quantified

Ideally, when a reduction in disparities is deemed possible, CHBRP reports would be able to quantify the effect of the proposed mandate on gender and racial disparities. In order to accomplish this, the following information is needed:

- Baseline incidence or prevalence of a condition by gender and/or race within the insured population
- Coverage impacts by gender and/or race – the gender and/or racial breakdown of the population affected by the specific mandate
- Utilization impacts by gender and/or race – the gender and/or racial breakdown of increased use of the benefit due to the mandate
- Medical impacts by gender and/or race – gender- and/or race-specific calculations of the effectiveness of the benefit in improving health outcomes

In most cases, it is not possible to obtain the necessary information to quantify the impact of a proposed mandate on gender or racial disparities. For example, the CHBRP review of SB 749, which required coverage for autism screening, found that blacks were more likely to have a diagnosis of autism and were treated for autism later compared to whites. Therefore, the review concluded that to the extent that the mandate results in earlier diagnosis and treatment for autism, this bill could reduce the disparities between whites and blacks associated with later diagnoses and treatment. The potential benefits, however, could not be quantified because it was not possible to examine the diagnosis and outcomes of autism by race within the insured population.

Table 1. Summary of CHBRP Conclusions Regarding Gender and Racial Disparities

CHBRP report	Conclusion	Justification
AB 8 – Minimum mastectomy stay	No effect	Lack of evidence on effectiveness of longer stays on health outcomes
AB 213 – Lymphedema	No effect	No baseline data or literature on gender and race
AB 228 – HIV+ transplants	No effect	Mandate not expected to increase number of transplants to HIV+ persons
SB 573 – Intoxication	No effect	No problem identified
SB 415 – Alzheimer’s drugs	No effect	No anticipated increase in utilization of AD drugs due to mandate
SB 572 – Mental health	Cannot conclude	Analysis restricted to summary due to nature of the bill
SB 749 – Autism screening	Possible reduction in racial disparities	Disparities identified; cannot quantify due to lack of estimates within insured population
SB 913 – Rheumatoid arthritis	No effect	No expected increases in utilization of drugs
AB 1185 – Chiropractic care	Cannot conclude	The quality of the examined studies was not sufficient to make a medical effectiveness determination
AB 264 – Asthma education	No effect	No evidence of differences regarding receipt of education services
SB 1223 – Hearing aids	No effect	No evidence of differences regarding receipt of hearing aids
SB 1508 – Propofol	No effect	No expected changes in utilization in colonoscopies or screening
SB 1245 – Cervical cancer/HPV	No effect	Mandate not expected to change utilization of screening
SB 2012 – Orthotics & Prosthetics	No effect	No impact on health outcomes

References

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