

**POLICY BRIEF**

**Reducing Racial and Ethnic  
Disparities in Health Care:  
Partnerships Between  
Employers and Health Plans**

*July 2009*

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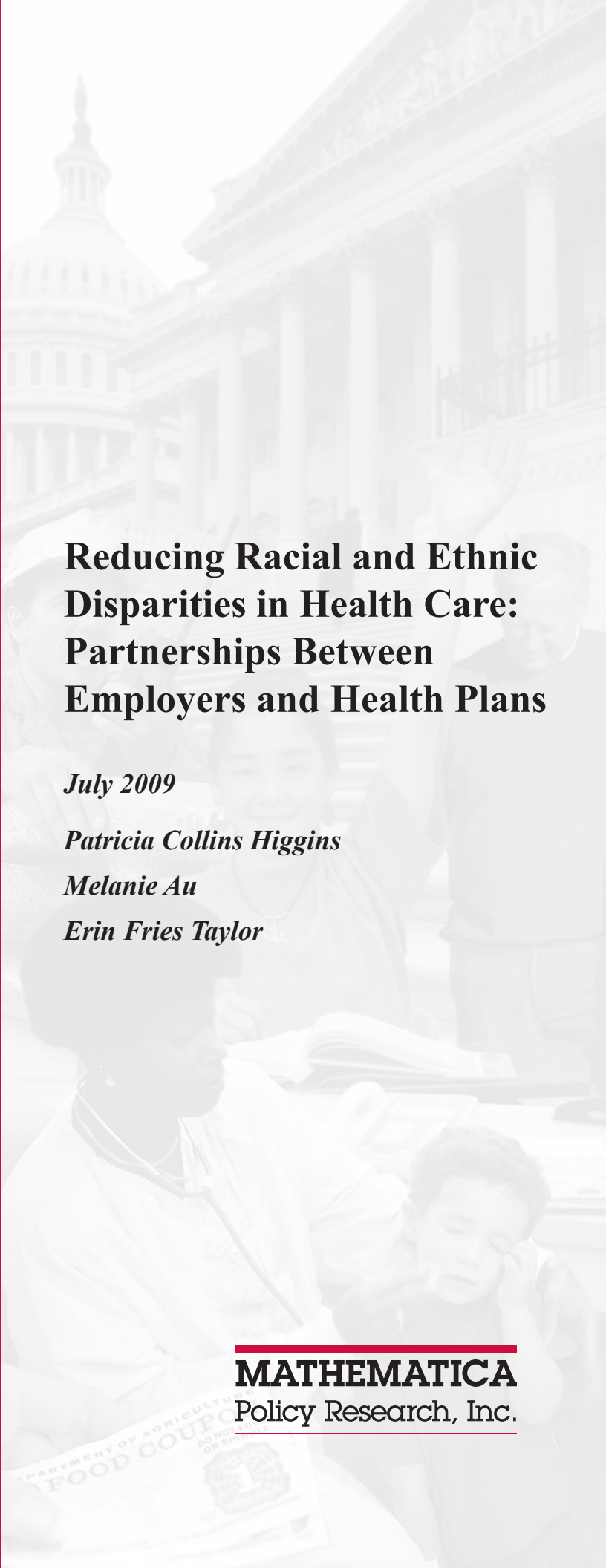
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## **Reducing Racial and Ethnic Disparities in Health Care: Partnerships Between Employers and Health Plans**

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## ***Reducing Racial and Ethnic Disparities in Health Care: Partnerships Between Employers and Health Plans***

Health plans and employers rarely work together to address racial and ethnic (r/e) health care disparities in the workforce. However, such collaborations have the potential to strengthen the quality of data used for disparities measurement and the development of targeted programs to reduce disparities. Drawing on interviews with large employers, health plan representatives, government officials, and national experts, this policy brief assesses current health plan/ employer partnerships addressing disparities, provides an overview of barriers that prevent partnerships from forming, and discusses strategies to encourage increased involvement of employers in the future.

### **Issues at a Glance**

In both the public and private sectors, there is growing interest in what health plans can do to identify and reduce racial and ethnic health care disparities (NHPC 2009b). Currently, most of the racial and ethnic data supporting such initiatives differ by enrollee payment source.

- Health plans serving Medicare and Medicaid enrollees commonly obtain information on the race and ethnicity of beneficiary members from federal and state governments. However, the information contains only limited distinctions and the quality and completeness of Medicaid data vary by state.
- Racial and ethnic data on commercially insured enrollees typically are not available from purchasers such as employers.

To fill these gaps, health plans need to collect their own data. Yet a recent national survey indicates that only half of commercial plans even attempt to do so (Rosenthal et al. 2009). This lack of data limits health plans' capacity to assess disparities and design targeted interventions to reduce them.

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### **The Role of Employers**

Health plans have found it challenging to develop effective data collection strategies that produce sufficiently complete data. Because different strategies yield data from different subgroups of patients, leading plans use multiple strategies to collect r/e data, as described in a toolkit recently created by the National Health Plan Collaborative (NHPC).<sup>1</sup> These strategies include direct methods, such as members' self-reporting of race and ethnicity during enrollment or clinical encounters (primary data collection) or linking to Medicare/Medicaid data (secondary data collection). Plans also have used indirect or proxy methods of r/e data collection, such as geocoding and surname analysis. While indirect methods have become more sophisticated in recent years, self-reported information on race and ethnicity remains the gold standard (Lurie and Fremont 2006). However, even those health plans with the most success in using direct methods over several years have managed to collect r/e data from only about 30 percent of their members (NHPC 2009b).

As health plans consider how to improve disparities in data collection and analysis, employers have emerged as a potentially valuable source of self-reported r/e data. There are two major

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reasons why employer involvement in health plan disparities assessment has been a focus of interest:

- Employers covered by Title VII of the Civil Rights Act of 1964 are required to collect and maintain records on the race and ethnicity of their employees (Burke et al. 2008).<sup>2</sup> These data are periodically reported to the U.S. Equal Employment Opportunity Commission (EEOC). If employers would share these data with health plans, the plans could use the data to identify and address disparities among their membership.
- Employers are the major purchasers of commercial health insurance in the United States. Racial and ethnic health care disparities in commercial populations likely represent significant costs to employers through lost productivity and increased health care costs (NBGH 2009). Thus, employers have an interest in enhancing the value of their health expenditures by improving health care quality and reducing disparities. Employers with substantial diversity in their workforce have even more incentive to address disparities.

Despite this rationale for greater employer involvement in r/e health care disparities reduction, a recent survey of employers and health plans showed that employers are only moderately aware of disparities. A little over half of employers surveyed recognized that disparities exist (Rosenthal et al. 2009). Moreover, only a tiny fraction of employers (3 percent) had examined disparities in the quality of health care received by their workforce.

### **Employers' Involvement in Disparities Reduction**

Employers' involvement in measuring and addressing r/e health care disparities is in a very early stage of development. In recent years, many employers have been increasingly focused on value-based purchasing in health care. Through its emphasis on enhancing quality of care, value-based purchasing has indirect ties to disparities reduction. However, it remains quite rare for employers to be working directly on disparities, either internally or in partnership with health plans or others (Rosenthal et al. 2009). Despite limited employer involvement to date, a few notable partnerships have recently emerged.

**Partnership Between the Office of Minority Health and the National Business Group on Health.** This initiative is a partnership between the U.S. Department of Health and Human Services' Office of Minority Health (OMH) and the National Business Group on Health (NBGH), a nonprofit purchaser coalition whose members provide health coverage to more than 50 million people. The public-private initiative was launched in February 2008. It aims to improve employers' awareness of disparities and influence health care purchasing strategies over a two-year period (National Partnership for Action press release, February 11, 2008).

The core of this partnership is a 25-member Racial/Ethnic Health Disparities Board, composed of NBGH and OMH staff, NBGH member organizations' health promotion program staff, and disparities experts. The board's four subcommittees have specialized in different projects, including reviewing the literature on health care disparities, conducting a survey of NBGH members to assess employers' activities related to disparities, and updating a 2003 NBGH issue brief outlining the business case for employers to get involved in reducing disparities. The Disparities Board survey of NBGH employer members finds most employers are unaware of disparities as a business issue and are uncertain how to begin addressing health care disparities in their employee population (NBGH 2009). Moreover, in their role as purchasers, employers are not actively pursuing measurement and reduction of health care disparities among their

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employees. The partnership's updated business case for employers provides specific strategies for employer-driven r/e data collection, solicitation of employee feedback on issues of access and quality of care, collaborative efforts with health plans, and development of workplace interventions to reduce disparities (NBGH 2009). Now in its second year, the board's goals include continuing to spread awareness of disparities among large employers, investigating models of disparities reduction that will benefit different types of employers, and potentially expanding the initiative's focus to include issues of workers' compensation and disability among racial and ethnic minorities.

**Partnerships Between Health Plans and Employers.** Partnerships between health plans and employers to assess r/e health care disparities remain rare, partly because of employers' lack of awareness of disparities or their placing a low priority on disparities reductions. However, there are a few examples of collaborations on disparities issues between large (Fortune 500) employers and health plans, as described below.

- *Improved Breast Cancer Screening.* One collaboration arose when a large employer noticed rising costs for breast cancer treatment among its employees and approached CIGNA—a health plan with which it contracts—to conduct an in-depth analysis of the factors influencing breast cancer screening rates (NHPC 2009a). The employer agreed to share employee race and ethnicity data because these characteristics (along with job type, job function, and home zip code) were potential explanatory factors for low breast cancer screening rates. However, analyses revealed race and ethnicity were not significantly associated with the likelihood of being screened. Rather, job type and job function were the primary predictors of screening. These results enabled CIGNA and the employer to design appropriate interventions to increase breast cancer screening among employees. Participants say that involving all key decision makers from the beginning, as well as clearly specifying the goals and products of the partnership, were critical factors in completing the project to the satisfaction of both organizations.
- *Sharing of EEOC Data.* Another Fortune 500 company's interest in reducing disparities in health care for its diverse workforce resulted in its sharing employee r/e data collected for the EEOC with all of its health plans, including 4 national health plans and 20 smaller HMOs across the country. To share r/e data, the company's third party administrator (TPA)<sup>3</sup> added fields for race and ethnicity to eligibility data sent to health plans. Health plans have not yet used these data for disparities assessment. This is perhaps because other employers are not sharing EEOC data, so health plans are unable to assess disparities across their memberships. In addition, the employer has not required or provided an incentive for plans to do so. The company also has collaborated with one of the large health plans with which it contracts to assess Health Plan Employer Data and Information Set (HEDIS) data to identify disparities using proxy data for race and ethnicity. Results indicated that disparities existed in many areas across r/e groups. The company implemented several programs based on study results, including one that made preventive care free to all employees and another that made prescription drugs available free or at a reduced rate to employees with chronic conditions.
- *Web-Based Self-Reporting.* A third example of employer and health plan collaboration involves another Fortune 500 company frequently cited as a leader in disparities activities. This company is not yet comfortable with sharing EEOC data but it is considering other means of helping health plans obtain r/e data. For example, the employer is collaborat-

ing with one large health plan to create a WebMD-run portal on which employees who access the site can self-report r/e data. So far, 50 percent of those using the portal have self-identified their race and ethnicity.

**Health Plan Evaluation and Contracting Decisions.** Some employers are beginning to use evaluation tools such as eValue8 to assess health plans' disparities work. eValue8 is a survey tool used by employers and purchaser coalitions to assess health plans' performance in health information technology adoption, communications, disease management, provider performance, patient safety, pharmacy management, behavioral health, finance, and administration (eValue8 2009). For the past several years, eValue8 also has included questions on health plans' disparities-related activities, such as racial and ethnic data collection and analysis. While the disparities component of the eValue8 tool indicates a general recognition of the importance of disparities by purchasers, several purchasers and purchasing coalitions we spoke with emphasized that disparities are not a priority area compared to other components of the eValue8 tool, such as disease management. Some employers—particularly those in the public sector—place importance on health plans' responses to the disparities questions, but plans' disparities activities rarely, if ever, drive employers' contracting decisions.

Representatives from health plans also report that more employers are asking about disparities work in Requests for Proposals (RFPs) eliciting bids for group coverage. Although this has garnered the attention of health plans, plan representatives suggest that employers still vary considerably in their interest in disparities and most are unlikely to make contracting decisions based on a plan's work in reducing disparities. Several purchaser coalition representatives and national experts suggested that employers' relative lack of interest in disparities has a dampening effect on health plans' decisions to collect r/e data and to develop initiatives to reduce disparities.

### Barriers to Employers' Involvement in Disparities Reduction

Although the partnerships described here suggest that employers are slowly becoming more attuned to the issue of disparities, the interviews conducted for this study revealed several barriers to employer involvement.

**Lack of Employer Awareness of the Importance and Cost of Disparities.** The primary barrier to employer involvement in disparities reduction is lack of awareness of health care disparities. According to purchaser coalition groups and other experts from the field, employers do not understand that health care disparities likely exist in their workforce and that these disparities affect employee health and productivity as well as company finances. Corporate leaders often do not understand that disparities in quality of health care can lead to worsening health outcomes, and ultimately increases in direct and indirect costs, through higher health services utilization and lost productivity (NBGH 2009). Until a clear link is made between health care disparities and the corporate bottom line, experts believe that movement to assess and reduce health care disparities in the workforce will be slow.

**Legality of Sharing Race and Ethnicity Data.** Employers say they remain concerned about the legality of sharing r/e data, although scholars have argued that employer sharing of these data is legal and should be encouraged (Burke et al. 2008). Title VII of the Civil Rights Act of 1964, which prohibits discrimination on the basis of race, national origin, and sex, requires every covered employer (that is, private employers, state and local governments, and educational institutions with 15 or more employees) to collect and maintain records on the race

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and ethnicity of employees. Depending on the size of the employer, these data are regularly reported to the EEOC. Burke and colleagues argue that using employer-collected data to evaluate r/e health care disparities also falls within the scope of Title VII, because health benefits may be a condition of employment and Title VII's discrimination protections include all aspects of employment. In fact, employers covered under Title VII may face liability if health benefits offered to employees can be connected to racial or ethnic health care disparities (Burke et al. 2008).

Despite these assertions of the legality of employers' involvement in r/e health disparities assessment, employers nonetheless express serious concerns regarding the privacy of employee information. Because r/e data are collected for Title VII purposes, employers are wary of using the data for other purposes without informing employees. Employers also are concerned that employees might view the sharing of these data with health plans as a discriminatory act if a plan denies coverage. In the absence of a clear precedent establishing the legality of r/e data sharing, most employers perceive the potential risks outweigh the potential benefits, according to several national experts and purchaser coalition representatives.

**Administrative Burden and Cost.** Employers that recognize the importance of disparities reduction and the legality of sharing data must still contend with the administrative burden and the cost of sharing data to assess disparities. Large companies often use TPAs to administer health plan benefits. In order for employers to transfer r/e data to health plans, the TPA must have the information technology capabilities, software, and staff to receive and send data. According to national experts, some TPAs do not have these capabilities. Moreover, to prepare for data sharing, an employer needs dedicated internal staff to compile and stratify employee r/e data for each health plan with which it contracts. A lack of common categories for r/e data collection introduces difficulties in standardizing and analyzing data from different organizations, an issue that an Institute of Medicine committee currently is working to correct (Higgins and Taylor 2009). There may also be challenges related to interoperability of data systems between organizations.

**Other Considerations.** Our discussions with purchasers and purchaser groups suggest that some employers are not convinced health plans have the level of technical sophistication necessary to correctly assess and address disparities. One employer recalled a serious health plan error, in which third-generation Hispanic Americans were sent letters in Spanish, based on surname analysis. Some employers harbor concerns that health plans will repeat such errors if entrusted with employee r/e data. Another employer, which had shared EEOC data with health plans, indicated that doing so was not yet useful because other employers were not sharing data. This limits the extent to which a health plan can assess disparities across its membership.

### **Lessons Learned**

In the current economic environment, disparities assessment and reduction is a secondary priority for employers and health plans alike, according to several purchasers and plans. However, some employers, particularly those with a diverse workforce, realize that addressing disparities ultimately has the potential to reduce health care costs and create a more productive and healthy workforce. Leading health plans continue to work towards more fruitful collaborations with employers and development of better methods of disparities assessment.

### Lessons at a Glance

- Although some activity is taking place, many barriers to employer involvement in assessing and reducing r/e health care disparities remain.
- Lack of awareness of disparities, legal and privacy concerns, perceived administrative burdens, and costs of data sharing have limited collaborations between employers and health plans.
- Several strategies may increase employer involvement, including educating employers and employees on the causes and consequences of disparities, promoting the business case for disparities reduction, emphasizing the legality of r/e data sharing, and creating more visible and cohesive national leadership around these issues.

*... demographic shifts in the U.S. workforce may eventually spur more employers and health plans to work together to reduce health care disparities ...*

As disparities continue to be discussed by health plans, purchaser coalitions, and political figures, more employers may recognize disparities as a salient issue that is closely tied to value-based purchasing. Moreover, demographic shifts in the U.S. workforce may eventually spur more employers and health plans to work together to reduce health care disparities, according to several experts. As the U.S. population continues to diversify and employers become more attuned to the direct and indirect costs of health care disparities, collaboration between purchasers and health plans on reducing disparities may increase.

### Endnotes

1. The National Health Plan Collaborative is a group of 11 health insurance plans which have worked together since 2004 to share strategies to address racial and ethnic disparities. For more information, see <http://www.nationalhealthplancollaborative.org/> and Taylor and Gold (2009).
2. Covered employers include private employers, state and local governments, and educational institutions with 15 or more employees.
3. A third party administrator is an independent organization that performs administrative services for other entities, such as employers or insurance companies.

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The authors thank the Agency for Healthcare Research and Quality (AHRQ), the funders of this work. This policy brief was part of a larger project for AHRQ evaluating the National Health Plan Collaborative. We also thank Marsha Gold for her comments and suggestions.

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