FOREWORD

SPECIAL ISSUE ON HEALTH EQUITY

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Health equity is created when people have a fair opportunity to reach their health potential. This concept gained attention as an essential approach to addressing the upstream influences of detrimental socioeconomic conditions and the long-standing historical, legal, and social barriers and discrimination targeted at minority groups, especially Blacks and Latinos, the LGBTQ+ community, people with disabilities, and other underserved populations. Although the concept of health equity was already at the center stage among researchers in the public health literature before the pandemic, the health crisis exposed the sources of disparities among different US populations that affect access to health care, quality of care, and final health outcomes.

This special issue of the *American Journal of Health Economics* on health equity results from the effort of almost two years of work, from the initial call in August 2022 to the final acceptance and publication of the manuscripts you will read in this edition. It also follows the inaugural meeting in October 2021 of the Economics of Health Equity Interest Group, which discussed the current state of health economics literature on health disparities and motivated further research on health equity–related topics. The agenda covered discussions of race/ethnicity, sexual orientation, gender identity, and disability topics in health economics. This edition is the first special edition on health equity in this journal. We intended not to cover all issues entailing health equity but to offer novel economic research to address health equity issues across different populations.

The five papers that are part of this special issue incorporate different perspectives of the discussion based on advanced and innovative methodologies, measurement, populations, and data that are being used to estimate disparities and inequities in the health economics literature, especially on access to health care and quality of care. They all reflect on health-care equity access to quantity and quality of care, highlighting the need for equitable access to and use of preventive, diagnostic, and therapeutic services to maximize an individual's health potential.

Three of the papers in this special edition intend to fill the large gap in the literature on transgender health care, gender identity, and same-sex couples. They further study the topic of access to care and gender identity in various groundbreaking ways, considering the significant uninsurance rates among this population. Mann, Campbell, and Hien Nguyen examine how coverage of gender-affirming care under Medicaid impacts transgender people's mental health. They are the first to document a causal link using a stacked synthetic difference-in-differences model that exploits policy variation and Medicaid eligibility at the state-by-year level. They show that when gender-affirming care is covered under Medicaid, there is a significant improvement in the mental health of low-income

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transgender people. Once health coverage is available, other barriers to access to quality care can profoundly affect a population consistently harassed by society.

Fumarco, Harrell, Button, Schwegman, and Dils evaluate mental health-care providers' discrimination based on their discretion in accepting patients. They are pioneers in an audit study that uses causal inference methodology to study the intersectionality of race/ethnicity and gender identity discrimination in the mental health-care industry. Using an audit field experiment of mental health access by requesting appointments for common mental health concerns (anxiety, depression, and stress) from "simulated" patients with randomly racial/ethnic-signaled names and gender identity disclosures, the authors can isolate biases separately arising from patients' race/ethnicity and gender identity on providers' decisions to accept prospective patients. The study underscores the differences in facing discrimination between African American and Hispanic transgender and non-binary individuals compared with their White counterparts. Transgender people with Black- or Latino-sounding names face the most significant discrimination, while no evidence of discrimination is found for White transgender people.

Before 2015, access to health care among the LGBTQ+ community was mostly limited to individual-based benefits and some exceptions among corporations offering same-sex domestic partners health-care-coverage benefits. Carpenter, Harrell, and Hegland offer a larger picture of access to health care through the lens of the expansion of legal access to same-sex marriage versus the offering of same-sex domestic partner benefits by private employers. Their detailed information on private employers, workers, and health-care benefits allows them to unveil the unintended adverse effect of the nationwide expansion of same-sex marriage on private employers that were previously offering same-sex domestic partner benefits, showing a considerable reduction in same-sex domestic partner benefits but no effect on different-sex domestic partner benefits.

Regarding health and care, individuals are in the most vulnerable positions at the earliest and latest stages of life. This edition also has a focal point on the broader role of health-care policies and administrative burdens to improve health-care coverage and access and to reduce health disparities faced by children of Hispanics and immigrants and by Hispanic and Black older adults. Arbogast, Chorniy, and Currie examine how the increase in administrative burden (i.e., stricter and frequent income or eligibility checks or automatic disenrollment) more severely reduces the public health insurance coverage among children with Hispanic, immigrant, or noncitizen parents. Their novel research explores the broader concepts of hasty, cumbersome, and lengthy changes in policy implementations that could act as indirect barriers to access among eligible populations, especially children whose parents are directly excluded from public health access.

Meanwhile, Antwi, Meille, and Moriya's work emphasizes the role of health-care coverage among older adults in reducing disparities in health-care usage, specifically emergency department (ED) visits and the payer mix of Black and Hispanic patients compared with White patients. Their clever extension of the regression discontinuity differences-in-differences (RD-DD) framework to an regression discontinuity differences-in-differences-in-differences (RD-DDD) framework using the discontinuity of outcome at age 65 allows them to estimate the effect of the Affordable Care Act Medicaid expansion on ED visits in both expansion and non-expansion states and the rate of uninsured ED visits. They estimate an increase in ED visits among Hispanics in non-expansion states. More importantly, they get suggestive

evidence that ED visits were less likely from uninsured patients or patients with complications due to preventable diseases.

Policies and practices around health-care coverage and access to quantity and quality of care would depict the general framework of health equity and the well-being of underserved populations. Health economists have the skills to evaluate policies, estimate causal impacts, and design environments that can improve the conditions for everyone to reach their optimal health potential.

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