



Enrollee Characteristics, Use of Services, and Health Plan Performance: Evidence from the California Health Interview Survey (CHIS)

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Making informed decisions with respect to selecting a health plan can be a daunting task for most consumers. Measures of quality are often difficult to come by, and the measures themselves can be quite subjective.

Currently, the Office of the Patient Advocate (OPA) provides considerable information about the quality of care rendered by the different health maintenance organizations (HMOs) in the state. Using data generated from the Health Plan Employer Data and Information Set (HEDIS) and the Consumer Assessment Health Plan Survey (CAHPS), OPA integrates information into a health plan “report card.” However, some limitations exist. First, OPA’s responsibilities for grading the quality of care are limited to HMOs, which covered 61% of California working-age adults in private health insurance plans in 2003. Second, OPA’s measures are based largely on data provided by the plans, limiting demographic and health status data on their enrollees. Thus, even though measures of individual health plan performance may be affected by enrollee characteristics, it remains difficult to determine how much of a given plan’s performance is due to the mix of enrollees and how much is due to plan-specific factors. The two sets of factors need to be separated.

Methods

Using information from the 2003 California Health Interview Survey (CHIS), this study examined quality-of-care data for both HMO and non-HMO plans. CHIS data, generated directly from interviews with a cross-section of Californians who are representative of the state’s non-institutionalized population living in households, provided a unique opportunity to compare enrollee characteristics across plans and to assess the impact that differences in enrollee characteristics might have on measures of plan quality.

Through cross-tabular and multivariate analysis of CHIS data, this study (1) developed demographic, economic, and health-status profiles for each of

California’s largest plans, including Kaiser, Blue Cross, Blue Shield, PacifiCare, and Health Net, and (2) examined how both enrollee and plan characteristics affect consumer utilization of services and satisfaction with health care plans. Because utilization rates of screening services for various diseases are one way to compare and rate health plan performance, the study looked closely at screening factors for cervical, breast, prostate, and colorectal cancers.

In 2003, over 14.3 million California adults were enrolled in health care plans either through an employer or through private purchase. Of these 14.3 million, 8.7 million were enrolled in HMO plans and another 5.6 million were enrolled in non-HMO plans. The following findings are based on an assessment of all privately insured adults age 18–64 in the CHIS.

Findings

Characteristics of California’s Privately Insured Adult Population

A comparison of the distribution of enrollee characteristics within each of the major health plans in California reveals the following:

- HMO enrollees were more likely than non-HMO enrollees to be Latino, non-white, and non-citizens, and to have limited English language proficiency.
- HMO enrollees were less well educated and came from families with lower household incomes than non-HMO enrollees.
- HMO enrollees were more likely than non-HMO enrollees to be obese and to rate their health as fair/poor.

Screening Rates for Cervical, Breast, Prostate, and Colon/Rectal Cancer

Plan-by-plan comparisons for various screening tests reveal the following:

- Asians, non-citizens, and those with little or no English language proficiency were less likely to have been screened for most cancers than other demographic groups.
- Non-high-school graduates and individuals living in households with incomes of less than \$20,000 were less likely to have received screening tests than those with more education and/or living in higher-income households.

- There appear to be wider variations in screening rates by education and income among non-HMO enrollees than among HMO enrollees. This suggests that HMOs may treat their enrollees with greater consistency. However, it is not clear whether such consistency confers any health benefit.
- Enrollees who reported that they “didn’t need” services in the past year were less likely to have been screened than individuals who reported either having problems getting access to care or having no problems getting access to care. However, the meaning behind reports of not needing services is unclear and merits further investigation.

Impact of Enrollee Characteristics on Screening

Our primary finding is that the demographic, economic, and health status characteristics of enrollees, whether in HMO or non-HMO plans, can significantly affect the use of various screening services. Although age is one important predictor of the use of screening services, it is overshadowed by the following factors in determining whether or not an enrollee is screened:

- Non-citizens and non-native English speakers are less likely to receive timely screenings than U.S.-born citizens and those whose native language is English.
- Enrollees with low incomes and low levels of education are generally less likely to have been screened for cervical cancer, breast cancer, prostate cancer, and colorectal cancer than enrollees from higher-income and higher-education households.
- Asian women are significantly less likely to be screened for cervical and breast cancer than other women.
- Duration of enrollment in a plan appears to have little impact on the probability of having been screened. However, the meaning of this finding is in question for several reasons. Retention rates vary widely and in some plans are extremely low. And with most screening protocols well developed, enrollees may have sufficient consumer information to request screening at appropriate intervals, and plans may be following similar practices in getting enrollees into screening services.

Consumer Satisfaction with Health Care Plans

In general, plans ranked quite high in terms of consumer satisfaction. The prevalence of problems getting access

to services was quite low. However, in considering the following findings, bear in mind that we do not know whether enrollees had a choice of plans, or which plans they might have chosen. Nor did we do comprehensive analyses of the impact of demographic characteristics on satisfaction levels.

- HMO enrollees gave slightly lower satisfaction ratings to their plans than did non-HMO enrollees.
- More HMO enrollees reported having a problem finding a doctor/nurse they were happy with in the past 12 months than was true of non-HMO enrollees.
- HMO enrollees were somewhat more likely than non-HMO enrollees to report problems with care delays while waiting for plan approval. They were also a bit more likely to have problems getting access to specialists.

Policy Implications and Recommendations

The economic, demographic, and health status mix of California’s privately insured health plan enrollees varies from plan to plan and between HMO and non-HMO plans. It is important to develop an approach to consider these differences when assessing quality of care within and between plans and developing the health plan “report cards.” It is especially important when comparing plans by examining screening rates for different diseases. Researchers and policymakers may want to separately report screening rates for different population groups or adjust screening rates to reflect a comparable mix of enrollees.

To fairly assess the quality of care of health plans, it will be necessary to look closely at plans with high proportions of enrollees who are non-white, with low incomes, low levels of education, and limited English proficiency, and assess what plans are already doing to address potential disparities in screening based on enrollee characteristics; examine disadvantaged groups—those who are getting care and those who are not—along with plan practices that may be associated with enrollees getting appropriate care; and investigate whether HMOs have instituted consistent practices that might lead to less variation in screening utilization.

Because demographic factors are related to lower screening utilization, we also recommend further investigation into the following:

- the relationship between the demographics of HMO enrollees, their utilization of screening services, and their satisfaction ratings;

- the barriers to health care facing non-citizens and the practices health plans can institute to help non-citizens gain access to preventive services;
- the reasons for Asian women’s underutilization of screening services for cervical and breast cancers and ways to increase screening rates; and
- the health status of people who state they “didn’t need” services in order to discern which factors might be associated with their self-assessment.

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