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FINDINGS BRIEF

HMO Enrollees Experience Fewer Disparities than Other Insured Populations

For Educational Factors, HMOs Help “Close the Gap”

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— Kevin Fiscella,
University of
Rochester

People enrolled in health maintenance organizations (HMOs) experience fewer disparities than patients insured through traditional indemnity plans, at least for education factors, according to new findings at the University of Rochester. Kevin Fiscella, M.D., and colleagues found that health care utilization rates were roughly similar among HMO enrollees, regardless of their level of education. HMO membership had no appreciable effects on income or racial/ethnic-related disparities in health utilization; disparities for these groups were comparable to non-HMO insurance.

By contrast, utilization patterns differed significantly on the basis of patients' education level among those who had indemnity insurance. For example, in the group with indemnity insurance, those who had less than a high school education had half the odds of seeing a specialist for their last doctors' visit than did college graduates. Those with indemnity insurance were also less likely to access care from a mental health professional than were HMO enrollees.

HMO enrollees generally fared better than non-enrollees on a variety of other measures of health care utilization as well, including the number of physician visits in the past year, rates of surgery, and visits to specialists. The findings were adjusted for a range of factors including income, race/ethnicity, and language.

“Overall, being in an HMO has a beneficial effect,” says Fiscella. This runs counter to previous research as well as conventional wisdom — which holds that HMOs restrict access to care by applying cost-containment techniques to patient populations. Fiscella explains that, in fact, the opposite may be true. “HMOs' population focus, their emphasis on quality, and their accountability

to accreditation organizations makes them better positioned than indemnity plans to drive appropriate utilization behavior,” he says.

Health care disparities can take many forms; a person's income level, educational attainment, or their race/ethnicity can make a difference in whether or how they access the health care system. Unlike many studies where income and insurance status were the primary factors driving disparities, Fiscella found that income mattered relatively little in his analyses. Indeed, the only significant interaction between HMO membership and income was for usual source of care: HMO enrollees with the highest incomes were significantly more likely to have a usual source of care than were people in the highest income group who were insured through indemnity plans. Among those in the lowest income group, there was no difference in likelihood of having a usual source of care between HMO and non-HMO members.

“Our findings dispelled the popular myth that disparities are simply a result of not having health insurance,” says Fiscella.

Background

Disparities have captured the public's attention over the past several years, in part as a result of federal initiatives such as the Clinton administration's Healthy People 2010, which set a national goal of eliminating differences in health status between white individuals and racial and ethnic minorities by the year 2010. Recent private-sector efforts to measure and improve health care quality have also increased public awareness of health care disparities.

HMOs responded to health care purchasers' increased interest in quality by implementing pro-



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University of
Rochester

ACADEMY
FOR HEALTH SERVICES
RESEARCH AND
HEALTH POLICY
1801 K Street, NW
Suite 701-L
Washington, DC 20006
Tel: 202-292-6700
Fax: 202-292-6800
Web: www.hcfo.net
E-mail: HCFO@ahsrhp.org

Program Director
Anne K. Gauthier

Deputy Director
Deborah L. Rogal

Senior Research Manager
Jason S. Lee, Ph.D.

Editor
Christina E. Folz

Writer
LeAnne B. DeFrancesco

grams to collect quality indicators, such as mammography and immunization rates, and reporting their findings to members. It was in this context that the researchers started to question whether managed care may actually do a better job of eliminating disparities than traditional insurance plans, and, more specifically, whether quality measurements could play a role in making that happen.

According to Fiscella, HMOs are well-positioned to address health care disparities by using Health Plan Employer and Data Information Set (HEDIS) measures to monitor quality of care among minority members and those who are socioeconomically disadvantaged.

“When you start measuring something, people begin paying attention to it,” says Fiscella. “If the importance of racial and ethnic disparities among the insured is established, HMOs will do what they can to eliminate them.”

Social Class and Health Care

The researchers used 1996-1997 data from the Community Tracking Study Household Survey¹ to study the relative significance of race/ethnicity versus social class in accounting for health care disparities, and the potential for managed care to reduce these disparities. Social class, as measured by education, income, and occupation, is a powerful determinant of access to health care, says Fiscella, with people of a higher socioeconomic status generally accessing more appropriate and cost-effective care.

There are many factors related to social class that may drive access to health care. Income level, language, level of literacy, and beliefs about health can each affect whether patients seek treatment. Physician factors, such as doctors' perceptions of their patients with a low socioeconomic status, may also influence treatment decisions. For example, patients with a low socioeconomic status are more likely to have chronic health problems (such as diabetes or heart disease), treatment for which typically takes precedence over provision of preventive care. Physicians may also treat certain patients differently if they have preconceived notions about whether those individuals will adhere to prescribed regimens.

“There is a powerful relationship between illness and socioeconomic status,” says Fiscella. Poorer people tend to have shorter lives that involve chronic diseases, which are usually more severe and begin earlier in life than those that afflict people with higher incomes. The poor are

also at greater risk for mental illnesses, such as depression. “We found that HMOs actually help close the gaps among income groups by providing a source of usual care to all their enrolled patients,” he adds.

Health care system factors also play a role in determining how or whether people seek care. For example, HMOs encourage the use of preventive care by eliminating or reducing the co-pay for appointments and sending out reminders that patients are due for check-ups. These activities promote appropriate utilization, presumably resulting in fewer health care disparities among HMO enrollees.

Lessons for Research and Policy

Fiscella suggests that HMOs should begin to collect patient-level data, including measures of education, income, race, and ethnicity, in addition to gathering information on health care quality. Hospitals already collect patient-based data, Fiscella says, and HMOs could benefit from doing so as well, by using the information to identify and address health care disparities.

“HMOs are doing better than non-HMOs in eliminating disparities, at least as far as they relate to educational factors, but we believe HMOs have untapped potential to address racial and ethnic disparities as well,” says Fiscella. Fortunately, he adds, as HMOs enroll more people through Medicaid and Medicare, reducing these disparities has become more achievable than ever. These implications presume that indemnity-type plans do not have the interest or capacity to do the kinds of data collection required.

Because Fiscella's study grouped all types of HMOs together, it could not determine whether various kinds of managed care organizations have differing effects on disparities. Previous research indicates that not-for-profit HMOs deliver higher quality care than investor-owned HMOs, suggesting that patients in the former type of organization may more appropriately utilize care.

“These differences warrant further examination,” says Fiscella. “Strengthening the kinds of HMOs that have a more beneficial effect on disparities represents one possible policy option that could be gleaned from this research.” ■

¹ The survey, administered by the Center for Studying Health System Change, tracks health care system changes within communities nationally. It is a nationally representative survey of 60,446 individuals from 32,000 households.

For more information, contact Kevin Fiscella, M.D., at 716-442-7470.