

Health Profiles of Racial/Ethnic Minorities Enrolled in Medicare Managed Care Plans

Final Report: Results from the Medicare Managed Care CAHPS[®] Surveys

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EXECUTIVE SUMMARY

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Medicare is a federal program that provides health care coverage for elderly and many disabled Americans. At its inception in the mid-1960s, Medicare was a “one-size-fits-all” fee-for-service-based system that mimicked private sector health insurance plans. In the 1970s, health maintenance organizations and other forms of managed care programs were given the option to participate in Medicare, but enrolled only a small segment of the Medicare population. Beginning in 1985, managed care plans began to participate in Medicare in greater numbers and enrollment increased substantially. In the late 1990s, Medicare managed care was expanded into a menu of new private sector options by the Medicare+Choice program. In 2001, about 15% of Medicare beneficiaries are currently enrolled in managed care plans.

The Centers for Medicare and Medicaid Services—formerly the Health Care Financing Administration—are giving increased attention to the measurement of Medicare managed care health plan performance. The Medicare Managed Care (MMC) Consumer Assessment of Health Plans Study (CAHPS®) Surveys were created to obtain information from enrollees in Medicare managed care plans. Respondents are asked questions concerning their assessment of their plans and providers, their overall health status, health conditions, and health system utilization in the last six months. The surveys have been conducted annually since 1997.

This study combines three years (1997, 1998, and 1999) of MMC CAHPS Survey data in order to study several racial/ethnic subgroups. Some of these subgroups are of such small relative size that many random sample surveys fail to capture enough respondents to allow detailed quantitative analysis. Because the MMC CAHPS questions are essentially the same from year to year, combining several years of data is feasible as well as desirable in order to increase sample size for the subgroups.

The racial/ethnic subgroups examined in this study include non-Hispanic/Latino Whites, non-Hispanic/Latino Blacks or African Americans, non-Hispanic/Latino Asians, non-Hispanic/Latino American Indians or Alaska Natives, and non-Hispanic/Latino Native Hawaiians or other Pacific Islanders. In addition, the Hispanic/Latino-origin group is examined. (The Hispanic/Latino-origin group consists of persons of any race; however, only Hispanics/Latinos of a single, self-identified race are examined in this study.) For purposes of comparison, each racial/ethnic minority group is contrasted with non-Hispanic/Latino Whites and a separate chapter is devoted to each. For simplification, “non-Hispanic/Latino” is dropped when referring to a non-Hispanic/Latino racial group, unless otherwise indicated (e.g., “White” refers to non-Hispanic/Latino Whites, “Black” to non-Hispanic/Latino Blacks, and so on).

Overview of Findings Across Racial/Ethnic Groups and Across Genders

Sociodemographics

Females outnumber males for most racial/ethnic groups in the MMC population—the lone exception is for American Indians/Alaska Natives. The “youngest” group of MMC enrollees as

measured by age distribution is American Indians/Alaska Natives, whereas the “oldest” group is Native Hawaiians/other Pacific Islanders. The White group has the greatest percentage of high school graduates and the Asian group has the highest proportion of college graduates. Blacks, American Indians/Alaska Natives, and Hispanics/Latinos have the lowest high school graduation rates.

Health Status, Health Conditions and Health Care Utilization

Racial/Ethnic Group Comparisons

Black, Hispanic/Latino, and American Indian/Alaska Native MMC enrollees report worse health currently than other racial/ethnic groups. Native Hawaiians/Pacific Islanders report the greatest improvement in health in the last year and American Indians/Alaska Natives report the most adverse change in health. For all subgroups, heart disease is the most common disease, and chronic obstructive pulmonary disease (COPD) is the least common disease among five health conditions (i.e., heart disease, cancer, stroke, COPD, and diabetes) asked about on the CAHPS Survey. American Indians/Alaska Natives report the highest and Asians the lowest incidence of the five conditions.

Asian and Native Hawaiian/Pacific Islander MMC enrollees make the fewest visits to a doctor’s office. Blacks and American Indians/Alaska Natives have the highest frequencies of five or more doctor visits. Whites are most likely to see a specialist. American Indians/Alaska Natives have high—and Asians low—rates of use of hospitals and emergency rooms. It is worth mentioning that high rates of inpatient hospitalization and emergency room use for a particular group could be a negative consequence of inadequate care, particularly when accompanied by infrequent doctor and specialist visits, as exemplified, for example, by American Indians/Alaska Natives.

Whites rely most heavily on the use of prescription medicines. American Indians/Alaska Natives have the highest rates of use of medical devices and services.

Gender Comparisons

Female MMC enrollees report worse current health than males of the same racial/ethnic group. Men are more likely than women to report that their health was unchanged compared with one year ago. Among those that did report a change, both men and women are more likely to report improved health rather than worse health, with men being slightly more likely than women to report improved health.

Despite reporting worse overall health, most females report lower rates of the five serious health conditions than their male counterparts—the one exception being a slightly higher reported incidence of diabetes among Black women than among Black men. The diabetes rate is also high for American Indian/Alaska Native females. Diabetes tends to be most prevalent for females, except for Whites and Hawaiians for whom heart disease is most common. Among males, heart disease is most common for all subgroups, with the exception of Blacks for whom diabetes is number one. COPD is the least common of the five serious diseases for both males and females. The incidence of serious disease for males exceeds that for females by 10% to 50%, depending on the specific condition.

Female MMC enrollees in a given racial/ethnic group are more likely to visit a doctor than males in the same group. Further, among persons who do see a doctor, females tend to make more frequent visits than males. Females also use special medical equipment, special therapy, and home health care more than males. However, females make less use of specialists, hospitals, emergency rooms, and prescription drugs than males do.

Highlights of Findings by Racial/Ethnic Group

This section follows the format of the various chapters in comparing racial/ethnic minority groups with the White group.

Black

Forty percent of Black MMC enrollees are male, compared with 44% of White MMC enrollees. Thirteen percent of Black MMC enrollees are under the age of 65, compared with 6% of Whites. Nearly one-half of Blacks do not complete high school, compared with only one-fourth of Whites. Black MMC enrollees rate their overall health worse than Whites rate theirs. Blacks are less likely than Whites to report ever having been told by a doctor that they had heart disease, cancer, or COPD. On the other hand, Blacks are nearly twice as likely to report having diabetes. Diabetes is the number one reported disease for Blacks among the five contained in the CAHPS surveys, whereas it is third among Whites. For Whites, heart disease is the top reported condition. Blacks make fewer doctor's office visits, but otherwise utilize the health care system more than Whites do. Black MMC enrollees are less likely than Whites to ever become a regular user of cigarettes. Among MMC enrollees who do become smokers, Blacks are less likely to quit than Whites. Black and White MMC enrollees who smoke are about equally likely to be advised by a doctor to quit.

Asian

The Asian MMC population has proportionately fewer males than the White MMC population does, but the gender difference is slight. Asians have greater proportion of college graduates, but also a higher proportion of individuals with eight or fewer years of schooling, compared with Whites. More of the Asian MMC population is concentrated in the 65- to 74-year old age group than it is for Whites. Asian MMC enrollees rate their overall health similar to how Whites rate theirs. Asians are more likely than Whites to report diabetes, but less likely to report other serious health conditions. Asians are also less likely than Whites to report conditions that interfere with work or independence or to need help with certain tasks. Compared with Whites, Asians are less likely to go to a doctor, be hospitalized, and use prescription medicine, but more likely to use home health care and special medical equipment. A much smaller percentage of Asian MMC enrollees have ever smoked than is the case for Whites. Further, those Asians who have smoked are more successful than Whites in quitting.

American Indian or Alaska Native

The American Indian/Alaska Native MMC population has proportionately more males than the White MMC population does. The median age of an American Indian/Alaska Native MMC

enrollee is several years younger than that for Whites. Nearly one-half of American Indian/Alaska Native MMC enrollees do not complete high school, compared with one-fourth of White MMC enrollees. Approximately half as many American Indians/Alaska Natives graduated from college as is the case for Whites. American Indians/Alaska Natives rate their health worse than Whites rate theirs. American Indians/Alaska Natives are more likely than Whites to report ever having been told by a doctor that they had heart disease, stroke, diabetes, or COPD; Whites, however, are more likely to report cancer. American Indians/Alaska Natives are more likely than Whites to report having a condition that interferes with their work or independence and to report needing help with personal care needs or routine needs. On the other hand, American Indians/Alaska Natives are a little less likely than Whites to report having a health condition that has lasted for at least three months. American Indian/Alaska Native MMC enrollees were less likely than Whites to have gone to a doctor’s office, but those who did see a doctor made more frequent visits than Whites. American Indians or Alaska Natives are more likely than Whites to go to a hospital or an emergency room. American Indian/Alaska Native MMC enrollees are more likely than Whites to start smoking, and those who do are less likely to quit. American Indians/Alaska Natives who are smokers are less likely than White smokers to be advised to quit.

Native Hawaiian or other Pacific Islander

The Native Hawaiian or other Pacific Islander MMC population has proportionately far fewer males (36%) than the White MMC population does (45%). A greater proportion of Native Hawaiians/Pacific Islanders fails to complete high school—and a smaller proportion graduates from college—compared with Whites. The proportion of MMC enrollees that rates their health as “Much better now” or “Somewhat better now” compared with one year ago is twice as great for Native Hawaiians/Pacific Islanders as it is for Whites. Differences in the incidence of several serious health conditions between Native Hawaiians/Pacific Islanders and Whites are small. Native Hawaiians/Pacific Islanders are more likely to have a condition that interferes with their work or independence than Whites. Further, Native Hawaiians/Pacific Islanders are more likely than Whites to report needing help with personal care needs or routine needs. Native Hawaiian/Pacific Islander MMC enrollees are less likely than Whites to visit a doctor’s office or specialist, but more likely to go to an emergency room. Native Hawaiian/Pacific Islander MMC enrollees are less likely than Whites to smoke; however, quit rates among smokers are comparable for the two groups.

Hispanic/Latino

The population of Hispanic/Latino MMC enrollees consists of proportionately more males than the (non-Hispanic/Latino) White MMC population does. The Hispanic/Latino MMC population is younger than that for Whites. More than one-half of Hispanic/Latino MMC enrollees do not complete high school, compared with one-fourth of White MMC enrollees. The college graduation rate for Hispanics/Latinos is only one-half of that for Whites. Hispanic/Latino MMC enrollees rate their health as generally worse than Whites rate their health. However, a much higher percentage of Hispanics/Latinos than Whites rate their health as “Much better now” or “Somewhat better now” compared with one year ago. Hispanics/Latinos are considerably more likely to have been told by a doctor that they had diabetes, whereas Whites are much more likely

to report cancer. Hispanics/Latinos are more likely than Whites to report having a condition that interferes with their work, but Hispanic/Latino-White differences in other implications of health conditions are small. Hispanic/Latino MMC enrollees are less likely to go to a doctor’s office, but more likely to go to a specialist, compared with Whites. Emergency room visit rates are nearly identical. Hispanics/Latinos are less likely than Whites to have a personal physician. Hispanic/Latino MMC enrollees are less likely than Whites to start smoking, but the likelihood of quitting is roughly the same for both groups.

Discussion and Further Research Suggestions

This CHARTBOOK highlights a number of differences and similarities between the MMC racial/ethnic subgroups studied in the MMC CAHPS Surveys. Asians have the best self-reported overall health and lowest health care utilization levels. Whites self-report good health but nevertheless are above-average utilizers. The group with the poorest self-reported health is American Indians/Alaska Natives, followed by Blacks. Hispanics/Latinos tend to be average in terms of self-reported health status and utilization of health care services.

Female MMC enrollees report worse health, compared with males of the same racial/ethnic group. However, most females also report lower rates of several serious health conditions than their male counterparts.

Current smoking is most prevalent among American Indians/Alaska Natives and least prevalent among Asians—particularly female Asians. Among those who have ever smoked, Asians have the highest quit rates, along with Native Hawaiians/other Pacific Islanders; Blacks and American Indians/Alaska Natives are least successful in quitting. Differences among the groups in a smoker being advised to quit are small.

While the information in this CHARTBOOK reveals many differences between racial/ethnic groups, it does little by way of attempting to explain these differences, identifying a number of issues that warrant further research. Some of the more interesting and timely subject areas include: further segmentation of the MMC CAHPS data for research on differences in health status and health care use by gender; analyses of factors that explain smoking and quitting and the relationship of smoking to health conditions, by race, ethnicity, and gender; the relationship between prescription medicine coverage, use, health conditions, and health plan characteristics; differences across racial/ethnic groups in the use of emergency rooms and how they are related to cultural factors, educational outreach, and individual medical decisions; and comparisons of the health status, health conditions, and health utilization patterns of self-reported biracial MMC enrollees with those of the separate single-race individuals.

I. INTRODUCTION

INTRODUCTION

Racial and ethnic disparities in health status, health insurance coverage, health care utilization, and treatment patterns have become of increasing concern to policymakers. A substantial body of literature has documented racial and ethnic differences in health care access and utilization, as well as disparities in specific treatments.¹ Most of this literature has focused on African Americans and Hispanics/Latinos in comparison with the White majority, in part because other racial/ethnic minority groups represent a very small proportion of the population and, thus, sufficient data are not available to permit examination of their health care patterns.

The Medicare Managed Care CAHPS surveys, conducted annually for the Centers for Medicare and Medicaid Services, collect data from a large sample of Medicare beneficiaries who are enrolled in Medicare managed care plans. The large sample size of these surveys (79,137 in 1997, 107,024 in 1998, and 143,085 in 1999), when combined and after excluding individuals who responded in more than one year, offer a rich data base for examining sociodemographic, health status, and health care utilization patterns of Medicare beneficiaries, by racial and ethnic characteristics. The sample observations for each of the racial/ethnic groups of interest—non-Hispanic/Latino White, non-Hispanic/Latino Black/African American, non-Hispanic/Latino Asian, non-Hispanic/Latino American Indian/Alaska Native, non-Hispanic/Latino Hawaiian/Pacific Islander, and Hispanic/Latino—are shown in Exhibit I-1. (Note: Figures in Exhibit I-1 indicate the number of single-race persons only.)

EXHIBIT I-1. NUMBER OF UNDUPLICATED, SELF-INDICATED SINGLE-RACE AND HISPANIC/LATINO MMC CAHPS RESPONDENTS, 1997-1999

White*	Black*	Asian*	Native Hawaiian/Pacific Islander*	American Indian/Alaska Native*	Hispanic/Latino†
244,030	16,097	5,139	3,951	865	12,098

*Non-Hispanic/Latino. †Hispanics/Latinos may be of any race; number shown is for single-race persons only.

Source: MMC CAHPS Surveys for 1997, 1998, and 1999.

Note: Numbers exclude persons of unknown Hispanic/Latino ethnicity.

This CHARTBOOK presents sociodemographic and health-related data for each of these population subgroups, overall and for the aged, and then presents detailed information on sociodemographic characteristics, health status, and health care utilization reported by respondents to the Medicare Managed Care CAHPS Surveys. The information presented provides comparisons between each subgroup and the White, non-Hispanic/Latino majority in order to assess differences in health status and health care utilization patterns for Medicare beneficiaries enrolled in Health Maintenance Organizations (HMOs), by race/ethnicity and gender.

The initial section of the CHARTBOOK presents summary tables characterizing health status, health care utilization, and differences in health care utilization patterns, by race and gender, for Medicare HMO enrollees who self-report specific medical conditions, including, heart disease, cancer, stroke, chronic obstructive pulmonary disease (COPD), and diabetes.

Limitations of the descriptive profiles presented here include that these respondents are all enrolled in Medicare HMOs and that health status, health conditions, and utilization of services are all self-reported by the respondents. However, Medicare HMOs provide a defined network of providers, comprehensive benefit coverage at low financial cost to enrollees, and most provide care coordination and management for enrollees with chronic health conditions and have developed practice guidelines for care. Consequently, differences in health care utilization by race, ethnicity, and gender, particularly for those with specific conditions, if found, suggest problems in delivery of health care that may need to be addressed if all Medicare beneficiaries enrolled in HMOs are to be accorded similar, consistent care.

Endnotes

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- ¹ Lowe RA, Chhaya S, Nasci K, Gavin LJ, et al. Effect of ethnicity on denial of authorization for emergency department care by managed care gatekeepers. *Acad Emerg Med.* 2001;8:259-266. Monheit AC, Vistnes, JP. Race/ethnicity and health insurance status: 1987 and 1996. *Med Care Res Rev.* 2000;57(suppl 1):11-35. Weinick RM, Zuvekas SH, Cohen JW. Racial and ethnic differences in access to and use of health care services. *Med Care Res Rev.* 2000;57(suppl 1):36-54. Waidmann TA, Rajan S. Race and ethnic disparities in health care access and utilization: An examination of state variation. *Med Care Res Rev.* 2000;57(suppl. W1):55-84. Gaskin DJ, Hoffman C. Racial and ethnic differences in preventable hospitalizations across 10 states. *Med Care Res Rev.* 2000;57(suppl 1):85-107. Eggers, PW, Greenberg, LF. Racial and ethnic differences in hospitalization rates among aged Medicare beneficiaries, 1998. *Health Care Financing Review* 21 (Summer 2000): 91-105.