



Women and Managed Care in California: An Examination of Selected Services

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This policy brief highlights findings from a study that examined the availability of selected health care services for women in managed care settings in California. These services are health promotion, disease prevention, mental health, and substance abuse services—all areas of need that emerged from focus groups conducted with low-income women in 1997.¹

The study is based on findings from a written questionnaire survey conducted in 1997 with 27 licensed commercial managed care plans in California and 12 Medi-Cal managed care systems (local initiatives and county organized health systems, referred to as LIs/COHS in this brief). In addition, structured interviews were conducted with 25 health care providers in the sampled commercial managed care plans. Information from the provider interviews is not representative of all providers, but rather illustrative of the interviewed providers' experiences, which can help to identify themes in practice settings.

Commercial Managed Care Plans

Coverage for Preventive Screenings, Health Promotion, and Health Education

All commercial plans surveyed reported that they offered the following as part of their best-selling health plan: Pap smear, screening mammography, and routine physical examination. Almost all plans (more than 90%) reported that they covered some form of health promotion and health education services.

Interviews with providers indicated that the majority were, for the most part, satisfied

with the preventive and health promotion services that their female patients were offered, though several also recognized barriers of cost, transportation, childcare, and language in women's ability to receive services.

Coverage of Mental Health and Substance Abuse Services

Nearly one-half of the plans reported that their mental health and substance abuse services were fully "carved out"; that is, all services were provided through a separate entity for a capitated rate.

Eighteen of the 22 plans that reported covering outpatient mental health coverage required co-payments and one reported no co-payments (three did not respond). Of 18 plans that reported outpatient coverage for substance abuse, 14 reported they required co-payments, one reported no co-payments, and three did not respond.

Co-payments were slightly less common for inpatient mental health and inpatient substance abuse services. Of the 19 plans that reported coverage for inpatient mental health services, 11 reported the use of co-payments and five reported no co-payments. For inpatient substance abuse (n=17), 12 reported co-payments and two reported no co-payments.

Several providers interviewed were dissatisfied with the lack of adequate options for referral to mental health providers.

Coverage of Specific Health Promotion Programs

The most commonly offered health promotion programs were smoking cessation (22

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Only 7 plans had protocols for eating disorders and 4 had them for domestic violence, which are particularly important areas for women.

plans) and nutrition counseling (21 plans). Less likely to be offered were weight-loss programs, mental health promotion, stress reduction classes, and substance abuse prevention.

Education Approaches Used to Provide Health Information and Promotion

Health information was most frequently provided through print materials (brochures and newsletters), health education classes, educational videos, and self-care materials. Close to 60% of plans also reported using health risk appraisals, Internet Web sites, 24-hour telephone health advisors, and health promotion counseling.

Well-Woman Benefit

Seventeen plans (nearly two-thirds) reported that they offered a well-woman benefit. For most plans this benefit was defined as an annual obstetric/gynecologic visit for breast and cervical cancer screening. Many plans mentioned that women could self-refer for this visit.

Language Access and Cultural Competency

The majority of the commercial plans surveyed reported that they offer health promotion and education materials in languages other than English. The most frequently mentioned language was Spanish, with 78% of plans reporting materials in this language. Of 24 plans responding, 18 reported that they have professional interpreters available to clients, and 6 reported that they do not.

Health Risk Assessment

Forty-four percent of plans (12 plans) reported that they had their own protocols for assessing the risk factors of individual members. Approximately 30%-40% of plans reported that they had protocols for assessing smoking, dietary habits, obesity, alcohol use, and drug use.

Mental Health/Substance Abuse Assessment

Depression is the most common area for which mental health assessment guidelines exist. Approximately 60% of plans reported that they have such guidelines. Ten plans had protocols to assess for substance abuse or anxiety disorders. Only 7 plans had

protocols for eating disorders and 4 had them for domestic violence, which are particularly important areas for women.

Public Medi-Cal Managed Care Programs: Local Initiatives and County Organized Health Systems (LIs/COHSs)

Coverage for Preventive Screenings, Health Promotion, and Health Education

All responding LIs/COHSs reported that they provide Pap smears, screening mammography, and routine physical examinations. They also have health promotion and health education programs.

Over three-fourths of plans offered smoking cessation programs and nutritional counseling, while slightly more than half of the plans offered weight loss programs.

Education Approaches Used to Provide Health Information and Promotion

LIs/COHSs relied primarily on written materials such as newsletters, brochures, and health education classes. Other common approaches (reported by two-thirds of plans) were health promotion counseling, 24-hour telephone personal health advisors, and self-care materials and books. Less frequently used were health risk appraisals, educational videos, and health plan Web site information.

Contracts with Community Providers

Many of the LIs/COHSs report that they have contracts with community providers, such as community health centers and family planning centers.

Language Access and Cultural Competency

In addition to English, all of the LIs/COHSs report that they offer health promotion and education materials in Spanish. One-fourth report they offer these services in Chinese, and one-third offer them in Vietnamese. Thai, Cambodian, and Farsi are cited by at least one plan each as "other" languages of health promotion materials.

Health Risk Assessment

Overall, one-fourth of these plans had developed protocols for assessing smoking, dietary habits, obesity, alcohol use, drug use, and domestic violence. Several plans mentioned the guidelines developed by the California Department of Health Services as

a future assessment tool.

Mental Health/Substance Abuse Assessment
Most commonly reported by the LIs/COHSs were guidelines for assessment of depression (42%). Much less common were guidelines for assessment of domestic violence, eating disorders or substance abuse, with three-quarters or more of plans having no assessment in place.

Key Findings and Conclusions

The findings from this study provide a starting point for understanding how managed care has tried to address and organize women's health care services. Models are needed that will help to shape a future health delivery system that will be more responsive to women's needs and will more fully engage women in the management and maintenance of their own health care.

The Perspective on Women's Health is Limited
Managed care has not yet fostered a cohesive and comprehensive approach to delivering women's health care. Fragmentation of services continues to exist throughout the system. For example, the well-woman benefit, while sounding like a comprehensive approach to women's health care, primarily focuses on reproductive health care. Women's health care needs encompass much more.

Preventive Health Services Offered by Most Plans

Women's preventive health services are offered by most managed care plans in California. In addition to clinical preventive screenings, health promotion activities—particularly smoking cessation and nutrition counseling—were offered by many plans. Weight reduction, stress reduction, mental health promotion, and substance abuse prevention were not widely offered. Managed care plans need to give greater support to these important health promotion activities.

Carve-Outs Can Increase Fragmentation

Mental health and substance abuse services were often carved out making them external to the managed care plan and the enrollee's usual source of care. Primary care providers reported concerns with referring patients to

providers they were not familiar with, as well as a lack of mental health and substance abuse providers to whom to refer patients. In addition, primary care providers often do not have access to information about treatment their patients may be receiving except from the patient herself. Furthermore, high co-payments for these services may deter those seeking care. Managed care plans need to explore more effective ways to increase access and preserve continuity of mental health and substance abuse care while protecting patient confidentiality. Recently passed legislation by the State Legislature and signed by the Governor will address some of the issues related to parity by requiring diagnosis and treatment of mental illness under the same rates, terms, and conditions as other medical conditions.

Preventive and Health Promotion Services

Mental health-related services such as domestic violence prevention, eating disorders, stress reduction, and alcohol and substance abuse, are priorities to many women, but are not systematically assessed in the managed care setting. Domestic violence has only recently gained attention from a few plans. The organizational responsibility and structure of women's health in managed care needs to be expanded to address the current gaps in coverage.

All Plans Need Stronger Links with Public Health Agencies

Partnerships between managed care plans and public health agencies could help strengthen efforts to improve the population's health. Commercial managed care plans could benefit, as many Medi-Cal plans already do, from closer linkages with public health agencies. Many health agencies have public education and outreach programs that would be beneficial to all women. The experience of the public health agencies and their understanding of population-based health make collaborative efforts important.

Conclusion

In closing, findings show some accomplishments and significant deficits. Overall, it appears that women's voices have been

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heard in selected areas. Managed care plans cover and largely promote clinical preventive health services, particularly breast and cervical cancer screening, and smoking and nutrition counseling. But managed care plans need to consider stronger mandates for more comprehensive programs in women's health that will cover a broader range of services throughout the life cycle. Furthermore, coverage for mental health services needs to be extended, co-payments reduced, and a more integrated system of assessment and referral with medical care providers developed.

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¹Wyn R, Leslie J, Glik D, Solis B., 1997, *Low-Income Women and Managed Care in California*, UCLA Center for Health Policy Research and the Pacific Institute for Women's Health.

Data Source

The findings in this Policy Brief are based on the report entitled, "Women and Managed Care in California: An Examination of Selected Services." The data are based on a questionnaire survey conducted in 1997 with licensed commercial managed care plans in California and with Medi-Cal local initiatives and county organized health services. Written questionnaires were sent to the medical directors of each plan. In a few plans, the medical director referred us to another staff person to complete the questionnaire. The overall response rate was 84%.

Structured interviews were also conducted with health care providers in the sampled commercial plans. Primary care providers were selected in stages using provider directories. Seventeen primary care providers were interviewed. In addition, eight interviews were conducted, based on

referrals from the primary care providers, with non-physician health care providers.

The full report, entitled "Women and Managed Care in California: An Examination of Selected Services," will be available at the Center's website address at www.healthpolicy.ucla.edu. or from the Pacific Institute at 2999 Overland Ave. Suite 111, Los Angeles, CA 90064 or www.piw.h.org

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