Disparities in Access to Well-Child Visits among Commercial Health Plans in 2022: Insights from National Reporting

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Background

Well-child visits provide children with timely immunizations, proper developmental and preventative services, and allows parents to discuss any concerns about their children that are health-related.[1] While these visits are important for all children, large gaps remain in the adherence of well-care child visits by race and ethnicity.[1] Three out of every five children in the US are privately insured, making identifying and acting on disparities among commercial plans critical.[2] The *Child and Adolescent Well-Care Visits* measure is a Healthcare Effectiveness Data and Information Set (HEDIS®)* quality measure that can help health plans identify where disparities in care exist. The measure is used in national quality programs such as the Marketplace Quality Rating System to set accountability, transparency and payment expectations for healthcare quality.[3]

Research Objectives

To describe the quality of care delivered by health plans to commercially-insured children, as observed in the first year of the nationally reported race- and ethnicity-stratified *Child and Adolescent Well Care Visits* measure.

Study Design

Measure Description and Population Studied: *Child and Adolescent Well-Care Visits:* The percentage of members 3 – 21 years of age who had at least one comprehensive well-care visit with a primary care physician or an obstetrician/gynecologist during the measurement year.

Product Line: Members must have been enrolled in commercial health plans that reported HEDIS performance.

Measurement Period: January 1, 2022 – December 31, 2022

Unit of Analysis: Health plan

Plans reported separately on the following race and ethnicity categories:

Race	Ethnicity
American Indian or Alaskan Native	Hispanic or Latino
Asian	Not Hispanic or Latino
Black or African American	
Native Hawaiian or Other Pacific Islander	
White	
Some Other Race	
Two or More Races	

Outcomes

NCQA evaluated the following three criteria:

Reporting feasibility: Defined as plans' ability to report at least 30 members in each race and ethnicity category for the measure.

Data completeness: Evaluated based on the proportion of unknown data (members without a race and ethnicity identification).

Measure performance: Examined disparities in outcomes between, and variation in health plan performance by, racial and ethnic groups, nationally and by census region.

All analyses were completed in R.[4]

* HEDIS is a registered trademark of the National Committee for Quality Assurance.

Findings

Reporting Feasibility

Many plans could report minimum required sample sizes for at least two of the race categories, but very few plans were able to report minimum required sample sizes across all race groups.

- 400 (95.9%) of the 417 commercial plans reporting to HEDIS were able to report a valid total rate.
- Among those 400 plans, 71.5% could achieve the minimum denominator sample size for reportable rates in at least two of the race categories
- Only 10.3% could achieve the minimum denominator sample size for reportable rates among all race categories.
- 47.0% of plans were able to achieve minimum reportable denominators across two or more ethnicity categories which was equal to the percent of plans able to report all ethnicity categories.

Data Completeness

Ethnicity had a greater percentage of unknown data (63.2%) than race (37.6%).

- The distribution of missingness was generally bimodal - plans either had a substantial amount of missing or substantial amount of non-missing race and ethnicity data.

Measure Performance

On average, commercial plans provided well-care visits to 57% of eligible children and adolescents, however rates varied by race and ethnicity, with wide ranges of plan performance within each group.

- The highest quality care was observed in the Asian (64.3%) and Non-Hispanic or Latino (59.1%) groups.
- The lowest quality care was observed in the Native Hawaiian or Other Pacific Islander (52.7%) and Hispanic or Latino (54.6%) groups
- Within each group, differences between the highest (90th percentile) and lowest (10th percentile) performing plans ranged from 27.6 percentage points (Black or African American) to 35.2 points (Native Hawaiian or Other Pacific Islander).
- Across Census regions, a 10-11 percentage point disparity between the racial groups experiencing the highest and lowest quality persisted.
  - Slightly larger differences were observed in the Pacific (13 points) and South Central regions (15 points)

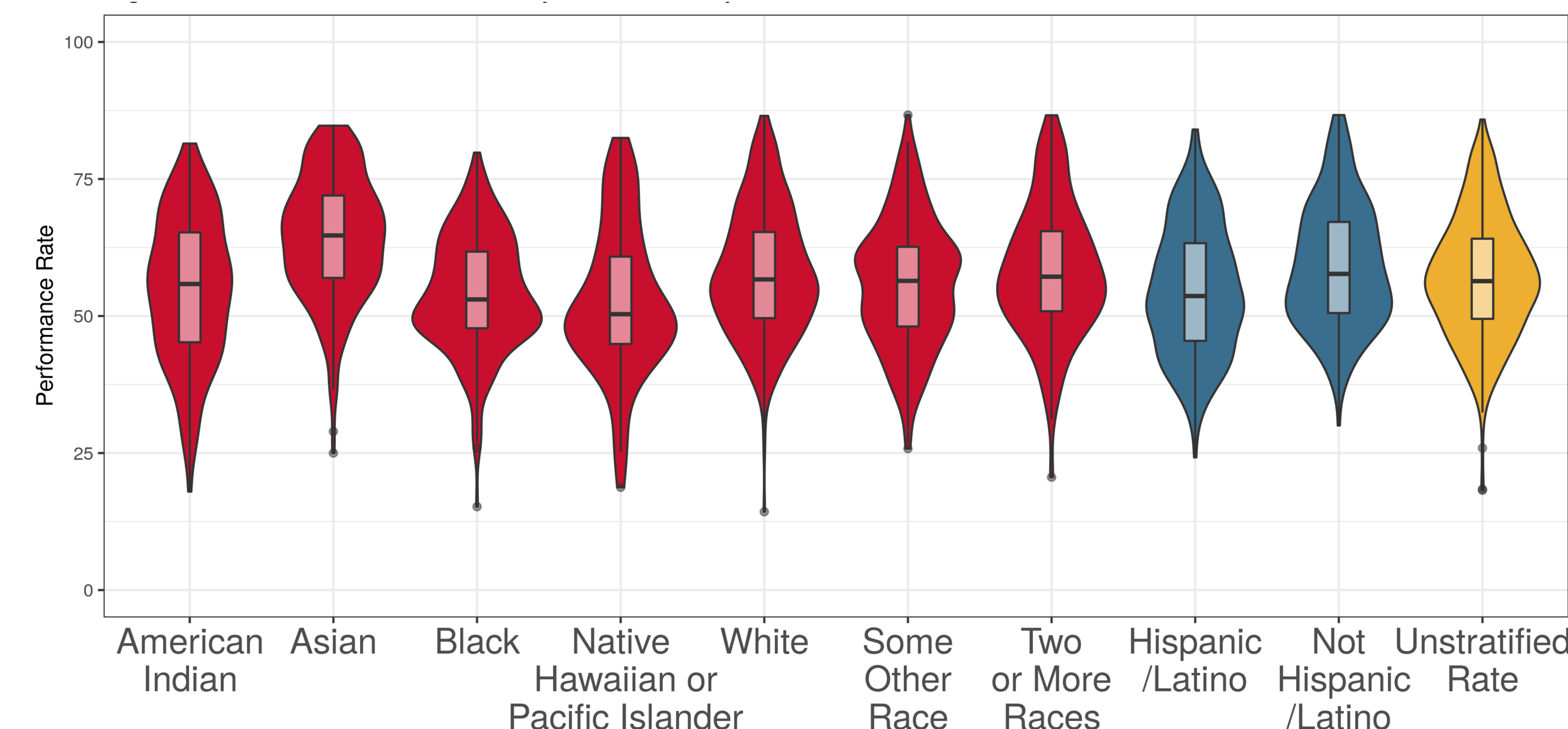
Table 1: *Child and Adolescent Well Care Visits* National Commercial Health Plan Performance by Race and Ethnicity

Group	Category+	Plans (n)	Mean	Median	StdDev	Within-Group Variation in Plan Performance (90th vs. 10th percentile)*
Race	American Indian or Alaska Native	135	54.8	55.8	13.2	34.1
	Asian	256	64.3	64.7	11.2	29.4
	Black or African American	249	54.1	53.0	10.5	27.6
	Native Hawaiian or Other Pacific Islander	68	52.7	50.3	13.6	35.2
	White	305	58.0	56.7	11.7	29.4
	Some Other Race	224	55.9	56.4	11.6	29.8
	Two or more Races	122	58.2	57.2	12.1	31.0
Ethnicity	Hispanic or Latino	290	54.6	53.7	11.7	30.8
	Not Hispanic or Latino	231	59.1	57.7	11.3	28.4
Total		400	57.0	56.4	11.2	28.8

+ Individuals with unknown race or ethnicity omitted from table

** Difference between group-specific 90th and 10th percentiles, expressed in absolute percentage points*

Figure 1: *Child and Adolescent Well Care Visits* National Commercial Health Plan Performance Distribution by Race and Ethnicity



Conclusions and Policy Implications

- Most commercial health plans have sufficient data on member race to analyze performance disparities on this widely used pediatric quality measure.
- Ethnicity data were found to be less complete than race data for the measure, potentially limiting some disparities analyses.
- Clear disparities in access to routine child and adolescent well-care visits by race and ethnicity were identified, particularly for Native Hawaiian or Other Pacific Islander, Black or African American, American Indian or Alaska Native and Hispanic children.
- The wide variation in plan performance within groups suggests room for achievable quality improvement.
- Disparities persisted between Census regions, suggesting national quality improvement policy focus is needed to improve care.
- Recent changes to the Office of Management and Budget's federal standards for the collection of race and ethnicity may facilitate greater data completeness.[5] Organizations should consider alignment with these updated standards to facilitate national comparisons, improved data collection and targeted action.

References

1. Abdus, Salam, and Thomas M. Selden. "Well-Child Visit Adherence." *JAMA Pediatrics* 176, no. 11 (November 1, 2022): 1143–45. https://doi.org/10.1001/jamapediatrics.2022.2954.
2. Mykyta L, Keisler-Starkey K, Bunch L. More Children Were Covered by Medicaid and CHIP in 2021. Census.gov. Published September 13, 2022. https://www.census.gov/library/stories/2022/09/uninsured-rate-of-children-declines.htmlhttps://www.census.gov/library/stories/2022/09/uninsured-rate-of-children-declines.html.
3. Centers for Medicare & Medicaid Services. 2025 Quality Rating System Measure Technical Specifications. April 2024. Accessed June 11, 2024. https://www.cms.gov/files/document/2025-quality-rating-system-measure-technical-specifications.pdf
4. R Core Team (2021). R: A language and environment for statistical computing. R Foundation for Statistical Computing, Vienna, Austria. URL https://www.R-project.org/.
5. Federal Register Notice 2024-06469. Revisions to OMB's Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity. 2024. https://www.federalregister.gov/documents/2024/03/29/2024-06469/revisions-to-ombs-statistical-policy-directive-no-15-standards-for-maintaining-collecting-and

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