

# **1999 Consumer Assessment of Health Plans in Delaware**

*prepared for*  
**The Delaware Health Care Commission**

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## TABLE OF CONTENTS

|   | <b>Page</b> |
|---|-------------|
| List of Figures .....   | iv          |
| Summary of Findings.....                                      | 1           |
| Introduction .....  | 3           |
| Context .....   | 4           |
| Project Scope and Methodology.....                            | 6           |
| CAHPS and Comparative Performance Measurement Systems .....   | 8           |
| Delaware Insurance Enrollment by Plan Type.....               | 9           |
| Overall Ratings by People Who Were Surveyed.....              | 13          |
| What Non-Elderly Respondents Said About Specific Topics ..... | 20          |
| Conclusion .....  | 26          |
| Endnotes.....   | 28          |

## LIST OF FIGURES

| <b>Figure</b>  | <b>Page</b> |
|--|-------------|
| 1 “Strict” vs. “Loose” Managed Care Coverage by County .....                                 | 11          |
| 2 Health Plan Enrollment by Health Status, Age 18-64 .....                                   | 11          |
| 3A Overall Rating of Health Insurance by Year and Plan Type, Age 18-64 .....                 | 12          |
| 3B Overall Quality of Health Insurance by County and Plan Type, Age 18-64 .....              | 12          |
| 3C Overall Quality of Health Insurance by Health Status and Plan Type, Age 18-64 .....       | 15          |
| 3D Overall Quality of Health Insurance by Choice and Degree of Managed Care, Age 18-64 ..... | 15          |
| 4A Overall Rating of Health Care by Year and Plan Type, Age 18-64 .....                      | 16          |
| 4B Overall Quality of Health Care by County and Plan Type, Age 18-64 .....                   | 16          |
| 4C Overall Quality of Health Care by Health Status and Plan Type, Age 18-64 .....            | 17          |
| 4D Overall Quality of Health Care by Choice and Degree of Managed Care, Age 18-64 .....      | 17          |
| 5 Overall Rating of Personal Doctor by County and Plan Type, Age 18-64 .....                 | 18          |
| 6 Overall Rating of Specialists by County and Plan Type, Age 18-64 .....                     | 18          |
| 7A People’s Experiences in Getting the Care They Need .....                                  | 22          |
| 7B People’s Experiences in Getting the Care They Need .....                                  | 22          |
| 8 People’s Experiences in Getting Care Quickly .....   | 23          |
| 9 People’s Experiences with How Well Their Doctor Communicates .....                         | 23          |
| 10 People’s Experiences with the Doctor’s Office Staff .....                                 | 25          |
| 11 People’s Experiences with their Health Plan Customer Service .....                        | 25          |

## SUMMARY OF FINDINGS

### Health Insurance and Health Care Ratings

- The overall rating of health insurance plans and health care increased from 1997 to 1998 and decreased from 1998 to 1999. The differences are statistically significant.

### Enrollment

- In 1999, 44 percent of Delawareans reported being enrolled in “strict” managed care plans, 44 percent in “loose” managed care plans, 12 percent in traditional fee for service plans. Enrollment in strict managed care plans increased by 7 percent, while enrollment in fee for service plans dropped by 3 percent.

### Health Insurance Ratings by Choice of Health Plans

- Those people who have **choice** of more than one health plan tend to rate their health plans higher than those people who do not have choice, but the difference by choice is not statistically significant.
- Overall ratings of health care tend to be higher when people are in fee-for- service or loose managed care plans and lower when people are in strict managed care plans (not statistically significant).

### Health Insurance Ratings by Plan Type

- Fee for service plans were rated higher than managed care in the case of overall quality ratings of health plans and quality of care, and the differences by plan type are statistically significant.
- In terms of overall ratings of personal doctors and specialists, there were no statistically significant differences by plan type (managed care vs. fee for service).
- Of 16 specific measures, 4 statistically differences by plan type were discovered. In each case, fee for service was rated higher than managed care.

### Health Insurance Ratings by County

- The overall ratings of quality of plans, quality of care or personal doctor indicated no statistically significant differences by county.
- There was statistically significant difference indicated for overall rating of specialists. Sussex County residents rated specialists highest, followed by New Castle County residents and then by Kent County residents.
- Of 16 specific measures, 2 statistically significant differences by county were discovered. For the two measures, Sussex County residents reported the highest level of satisfaction, followed by New Castle County residents and then by Kent County residents.

### Health Insurance Ratings by Health Status

- Quality of plan and quality of care ratings were lower among those people who report the lowest **health status**. The differences were statistically significant.
- There were no statistically significant differences by health status for overall ratings of personal doctors and specialists.
- Of 16 specific measures, 11 statistically significant differences by health status were determined. People who rated themselves as having excellent health were the most satisfied with each.

**Quality of Health Insurance Comparison**

The following table summarizes our 1999 findings for overall ratings of health plans, quality of care, personal doctors and specialists. **Bold (blue)** type indicates a change (yes to no, or no to yes) from 1998 to 1999.

**Summary of Global Ratings\*  
1999 Data for Respondents Age 18-64**

| Overall Rating of:     | Statistically Significant by:                      |   |  |
|------------------------|--|---|--|
|                        | Plan Type<br>(Fee for Service and<br>managed care) | County<br>(Kent, New Castle,<br>Sussex) | Health Status<br>(Excellent, Good,<br>Poor/Fair) |
| Quality of Health Plan | Yes<br>(FFS>MC)                                    | No                                      | <b>Yes(E&gt;G&gt;F/P)</b>                        |
| Quality of Health Care | <b>Yes (FFS&gt;MC)</b>                             | No                                      | Yes<br>(E>G>F/P)                                 |
| Personal Doctor        | <b>No</b>  | No                                      | No   |
| Specialists Seen       | No   | <b>Yes (S&gt;N&gt;K)</b>                | <b>No</b>  |

Note: Changes in 1999 data are in **bold (blue)**.

## 1. INTRODUCTION

For the last three years, the Delaware Health Care Commission has funded the Consumer Assessment of Health Plans Study (CAHPS) in Delaware. A consumer survey was selected as the means of collecting data because the Commission believes that patients' perspectives need to play a key role as state policymakers look to solve existing problems and build consensus around workable solutions. The CAHPS survey approach provides a practical and flexible yet standardized set of instruments to collect information on access to and satisfaction with health care services and delivery systems. CAHPS stresses measurement using a state-of-the-art tool that has a record of helping improve patient care and that meets the highest research standards.

One of the goals of the Delaware Health Care Commission is to continue to develop policy solutions acceptable to all stakeholders in the health care market. Commission research projects are organized around and designed to balance measures to improve access, control costs and enhance quality. The 1999 CAHPS report addresses two of the central questions often asked about quality and the changing health care systems. First, what role do consumer satisfaction surveys play in the assessment of possible quality differences? Second, are there verifiable quality differences between fee for service (FFS) and managed care in Delaware?

Managed care continues to dominate Delaware's health care market. When asked which health plan they were enrolled in, 88 percent of respondents claimed to be enrolled in some form of managed care plan. Recent studies estimated 85 percent for the entire country.

A distinct finding of the 1999 statewide consumer satisfaction survey indicates that Delawareans are less satisfied with their health plans than they were last year. In 1999, FFS plan participants reported greater satisfaction with their plans than do those respondents enrolled in managed care plans by a small, but statistically significant margin. The changes in Delawareans' attitudes are reflective, albeit to a lesser degree, of what is happening around the United States. This newly discovered gap between FFS and managed care ratings can be explained by three factors. First, the reported difference could indicate real difference between the quality of health plans-particularly in the areas of customer service and easy finding a specialist. Second, people who remain in traditional FFS plans are likely the enrollees who are most satisfied with their health plans. As less satisfied enrollees move to managed care, one would expect the average FFS rating to increase. Third, the ongoing managed care "bashing" heard throughout the country – and not the actual quality of health service – could influence managed care enrollees' ratings of their health plans. These negative stories, furthermore, might lower the comparative ruler that FFS enrollees use to rate their health plans and indirectly improve their ratings.

State policymakers need accurate information in order to effectively respond to consumers' demands and needs through sound legislation, as is emphasized by the Prospective Payment Assessment Commission:

Continued pressure to control...expenditures, combined with rapid changes in the financing and delivery of services, has focused renewed attention on the quality of care provided to beneficiaries. Assessing and improving quality continues to be hampered by inadequate information.<sup>1</sup>

Two other reports published in 1998, one by Mark Chassin of the National Roundtable of Health Care and the other by the President's Advisory Commission of Consumer Protection and Quality of Health Care, point out ways in which we can take advantage of new opportunities to raise the quality of care for all consumers. According to the Presidential Commission, "A key element of improving health care quality is the nation's ability to measure the quality of health care and provide easily understood, comparable information on the performance of the industry."<sup>2</sup>

The health care market continues to change rapidly, as do the opinions and attitudes on how to best adjust. Managed care companies have continued to grow in size, but their profitability has diminished. Many health leaders suggest that improving the cost effectiveness and quality of offered health plans and the care delivered will become more crucial to the survival of HMOs. In any case, these changes indicate that it is

very important for policymakers to support research that monitors quality, costs and access, on an ongoing basis.

Market advocates, moreover, believe that providing more information about quality to the public will induce health plans, hospitals, and physicians to compete by improving the quality of their care in the expectation of increased market share.<sup>3</sup> Consumers and employers need access to unbiased, easy to understand information to assist them in making necessary health care choices. These groups often are forced to select health care for themselves, their families, and their employees based on insufficient information on quality. They need information that is easily understandable and informative, but narrow in scope. According to the People-to-People Health Foundation, "Many consumers of medical services, newly empowered by an emergent, market-driven insurance world that offers them more choices, are being thrust into this maelstrom often ill equipped to understand its complexities, much less know what course may be right for them."<sup>4</sup>

In an attempt to provide timely, unbiased data, the Health Care Commission contracted with the College of Human Resources, Education, and Public Policy (CHEP) at the University of Delaware to conduct an independent survey on consumer satisfaction with the Delaware Health Care system. This is the third year of the CAHPS survey. Prior results can be found in the 1997 and 1998 *Consumer Assessment of Health Plans* reports available from the Delaware Health Care Commission. A major goal of the research is to help Delaware policymakers identify what legislative and/or regulatory changes might be needed to improve the quality of Delaware's health care delivery system. The collection of unbiased information, as is done for the Delaware Consumer Assessment of Health Plans Study, is important for forming recommendations on regulating managed care and assessing the experiences of Delaware's consumers. Moreover, the Commission's Committee for Managing Managed Care has identified independent surveys as one of the best means to assist it in making policy decisions. Many decisions are based on the premise that the public's opinion must be considered a key factor in order to create sound policy.

The following report begins with a discussion of the concept of measuring the quality of health care and related policy issues. We present a brief overview of the various forces that shape the public's perceptions of Delaware's health care system and the need for greater access to quality information. We then examine the increasing usage of CAHPS by state governments. To fully understand the background and methodology of the CAHPS project, we strongly encourage readers to take the time to review **Sections 2 - 4**. Starting in **Section 5**, we present the numerical results from the 1999 CAHPS survey. We begin with a detailed analysis of enrollment patterns by county and plan type (FFS vs. managed care). Then, in **Sections 6 and 7**, we describe the results of the major body of the CAHPS survey. Our discussion focuses on differences between FFS and managed care.

## 2. CONTEXT

### Experience Versus Perception

In the past, legislative bodies have been left to make health care policy based on often incomplete and anecdotal information. If managed care legislation is to be enacted in Delaware, legislators must be provided with realistic and accurate portrayals of what consumers expect from health care. The Kaiser Family Foundation keeps track of the public opinion on managed care and regularly releases the information. Following will be a brief discussion of several key findings from the most updated Kaiser report on the public's attitudes toward managed care. It is very important to keep in mind that the Kaiser findings are based on a national survey of individuals' opinions. The Delaware CAHPS methodology applies a stricter standard: survey results are based on consumers' actual, first-hand experiences with the health care system.

The Kaiser study indicates that Americans with traditional fee-for-service plans are more likely to give their plans a grade of A (37 percent compared to 26 percent of people in managed care). Americans continue to express generally negative views about managed care. These negative views on managed care have not changed significantly since 1997. While many say that managed care has increased access to preventive health services, majorities believe managed care has decreased access to specialists, decreased the time doctors spend with patients and decreased quality of care for the sick. And one in two Americans feel that

managed care has not produced significant health care savings. Only 37 percent of Americans who hold negative views towards managed care based their opinions on their own experiences; most (53 percent) based their views on media coverage and reports from family and friends.<sup>5</sup>

As the later sections of this report will describe, the 1999 CAHPS data indicates several aspects of care for which managed care ratings fall below those for FFS plans. In the 1999 CAHPS survey, we discovered two statistically significant differences for four global ratings, and four statistically significant differences for ratings of 16 specific measures. Where we did find these differences, the gaps are not nearly as large as suggested by national opinion surveys. Once again, it is important to keep in mind that the CAHPS data predominantly are based upon the respondents' own experiences and are less subject to influence from second-hand information obtained from sources such as the popular media.

## **Media Coverage**

Quality of health care continues to make headlines and is the focus of several health care survey research studies. To a large extent, the public's opinions and attitudes on health care have been shaped by information collected through biased or poorly constructed surveys as well as from negative health care reports in the media. Although the media has been frequently criticized for this, a recent article in *Health Affairs* analyzed managed care media coverage overall and found that the large majority of all media coverage of managed care was neutral in tone. However, in television and newspaper coverage, which is where most Americans receive their news, the tone was negative in more than half of the reports. Managed care has received an inordinate amount of media scrutiny that has permeated the public's perceptions and quite possibly tainted their impressions of the industry as a whole. The public's concerns about managed care are often based on hearsay from media coverage, friends, and family and not on personal experience. The concern is that the media tends to neglect the big picture.<sup>6</sup>

## **Role of Consumer Satisfaction Surveys**

Consumer satisfaction surveys are meaningful tools for gauging the quality of health care. Information from these surveys will help facilitate a better understanding of consumers' health care information needs, help develop an educated consumer, and put policymakers in a better position to develop laws to protect consumer interests. They are helping the health care industry determine what consumers expect and want from their health care plans. A telephone survey taken in December 1996, on behalf of the National Coalition on Health Care, reported that slightly more than 80 percent of those surveyed felt they needed to be better informed in order to evaluate the quality of medical care from doctors and hospitals.<sup>7</sup> Despite the abundance of recently published information on health care, little of it has been targeted at helping consumers determine which health plan is best to meet their needs. Many health care decisions are frequently made with more of a concern for price than quality. "Consumer information is the linchpin of consumer choice."<sup>8</sup> Therefore, more information on performance and quality needs to be developed and provided to consumers so that they can make educated decisions.

Employers, purchasing coalitions, the Health Care Financing Administration, and state governments are using consumer surveys in increasing numbers. Stephen Isaacs explains the importance of consumer satisfaction surveys in a *Health Affairs* article. He writes that they are

of great importance to businesses striving to maintain employee satisfaction, to consumer watchdogs trying to make sure that people have the wherewithal to make sound health plan choices, and to government entities funding large programs that are aimed at potentially vulnerable populations.<sup>9</sup>

Large purchasers such as Xerox, the Health Insurance Plan of California, and the State of Wisconsin Employee Trust fund, have used improved quality data as a means of achieving their purchasing objectives: reducing the cost of health coverage, improving access to health care, and improving quality.<sup>10</sup>

Until recently, only a limited amount of information on the quality of managed care has been readily available in most states, including Delaware. At the time Delaware started conducting CAHPS surveys in October of

1996, it was the first state to use it on a statewide basis for Medicaid, Medicare, and commercial populations. Since then, CAHPS has expanded into a major source of consumer information in the United States and is being implemented in various forms in at least 37 states. The sponsors for CAHPS projects vary from state to state; many projects are undertaken with a joint public/private sector agreement.

### **State Role in Quality Assurance**

In light of the nation's rejection of federal health care reform, the state's role has been elevated. States have a complex role in creating legislation for managed care because they must protect health care consumers without simultaneously detracting from health plans' ingenuity and cost management. While it may be desirable to allow market forces to determine the outcomes of health care, the market is not flawless and the right policies can help the industry function more efficiently. A recent report by Families USA, "HMO Consumers at Risk: States to the Rescue", indicates that states, legislatures, and governors are responding with alacrity and with reason to address issues such as quality of care.<sup>11</sup>

The Families USA report discusses a number of state initiatives and laws that regulate HMOs and frequently include provisions designed to maintain or improve the quality of care. In 1996, 40 states passed legislation and laws regulating HMOs. The report cites the following five major areas of quality where states have enacted HMO laws:

- *Collection, analysis, and reporting of managed care access and quality-of-care data* [emphasis added]
- Requirements for an HMO internal quality assurance plan
- Standards by which decisions to approve and deny care are made
- Prohibitions against gag rules
- State monitoring and oversight

Minnesota has some of the most aggressive laws for mandating data collection, ensuring that this data is provided to the public, and requiring a state-sponsored consumer satisfaction survey. The states of Maryland and New Jersey published consumer satisfaction reports intended to provide a detailed analysis of how HMOs are meeting the needs of their members. Additionally, Minnesota, Georgia, and Maine are among the states that legislated "leading" quality assurance plan requirements. During 1995 and 1996 there were 18 states that required managed care plans to furnish new and more extensive information to current and potential customers. During this same time period, both New York and New Jersey became two of the strongest regulators of managed care by enacting consumer protection laws in this area.<sup>12</sup>

### **3. PROJECT SCOPE AND METHODOLOGY**

Two of CHEP's public service and research centers, the Institute for Public Administration (IPA) and the Center for Applied Demography and Survey Research (CADSR), conducted the research for the Delaware CAHPS through a telephone survey for the Delaware Health Care Commission. The 1999 data was collected over the course of twelve months (January 1999 through December 1999) with 150 surveys being completed each month. (The 1998 survey was conducted over 12 months at 150 surveys per month.) The 1999 sample size is sufficient for producing statewide and county level estimates. At the 95 percent confidence level, the sampling error is approximately +/- 2.4 percentage points statewide, +/- 2.9 percentage points for New Castle County, and +/- 5.8 for Kent and Sussex Counties. Respondents without health insurance were included in the survey panel so that data will be available to examine and compare the health care systems available to all adults in the state.

The Commission in conjunction with the University of Delaware developed a list of survey topics and concepts thought to be important including:

- Overall evaluations of health plans and care
- Overall evaluations added for personal doctors and specialists seen)

- Evaluations of specific aspects of the consumers' health care experience (e.g., people's experience in getting the care they needed)
- Utilization
- Health insurance plan
- Health status
- Demographic information

These topics, among others, resulted in more than 50 questions. The selection of specific survey topics was guided by research showing that health consumers want to know about other consumers' assessments of the health care process, knowledge about their interaction with health care professionals, access, continuity and coordination.

### **CAHPS Framework**

Survey questions for this study originated from two sources: 1) prior work conducted by CHEP and 2) the national CAHPS 2.0 Survey. CAHPS provides a set of standardized survey questions developed to assess consumer experiences of different populations in a variety of health care delivery systems. The standardized CAHPS questions were developed by RAND, Harvard Medical School, and the Research Triangle Institute (RTI) under a cooperative agreement from the federal government's Agency for Health Care Policy and Research (AHCPR), which is currently known as Agency for Healthcare Research and Quality (AHQR).

In consultation with the Delaware Health Care Commission, the project team constructed the survey questionnaire used for the Delaware study. Five design principles guided the development of this survey instrument:

1. Developing a survey instrument that is suitable for and allows for valid comparisons across a wide range of insured populations (both privately insured and those in publicly funded programs such as Medicare and Medicaid) and between the two major types of health care delivery systems (FFS and managed care).
2. Focusing on information that policymakers want and need to know when they are analyzing changes in Delaware's health care system.
3. Focusing on assessments of health care experiences for which consumers are the best or only sources of information.
4. Developing a survey instrument that is easy for consumers (survey respondents) to understand.
5. Making sure that the data is as accurate and reliable as possible.

This study moves health care quality assessment to a higher analytical level. With its emphasis on consumers' experiences with health care and their health care plans, the study progresses from the subjective, attitudinal measurement favored in recent health policy surveys. The study has been guided by health services research indicating that consumers want to know other consumers' assessments of the care process, including the interaction with health care professionals, access, continuity, and coordination. The emphasis on measuring these concepts is greater in the CAHPS study than in earlier or concurrent surveys.

Many problems that previously accompanied health surveys were addressed in designing the survey instrument for this study. As was discussed earlier, critics of public opinion surveys often point out that question responses are based on hearsay and stories seen on television and in the media rather than first hand experience. An example of this attitudinal question format from a widely publicized national survey states, "Do you think managed care will improve the quality of care people receive?" The CAHPS format, on the other hand, deviates positively from this subjective style of questioning as it focuses on consumers' actual experiences with their health care coverage. For example, the CAHPS questionnaire asks, "In the last six months, how often did doctors or other health professionals spend enough time with you?"

Other commonly encountered problems of health surveys include diverse interpretation of survey items, memory decay, survey comparability and timeliness, inconsistent or atypical experiences, and respondent burden. The CAHPS methodology addresses all of these problems. Several technical survey design issues are described in the next paragraph. Even though this might seem like technical information overkill, reading through the detail helps the user to more fully understand the major advantages of using CAHPS.

The CAHPS survey employs many questionnaire devices in order to provide an easily understood question for the respondent as well as providing standardized questions that can be easily compared across populations. CAHPS also changes time frames from six months to twelve months. This helps to improve accuracy in the results. Questions that measured the consumer's overall or global evaluations of health care and their health plan were rated using the 0-10 scale. Using scales such as this allows for comparisons across health care delivery systems, among public and private insurance programs, and across different geographic regions. Questions asking respondents about specific problems with care or health plans ask for "Yes/No" responses; they deal with experiences that are important to consumers, even if they occurred only once. The choice among these methods was based on the approach that seemed best to enable respondents to describe important aspects of their experience. For some aspects of care, such as communication, listening, or time spent with providers, respondents were asked how often their interactions with providers met their standards, "always, usually, sometimes, or never." The decision to use the variety of response formats was made as a direct result of extensive testing conducted by the CAHPS national development team.

#### **National CAHPS Benchmarking Database**

The primary purpose of the National CAHPS Benchmarking Database (NCBD) is to facilitate comparisons of CAHPS survey results among various types of CAHPS sponsors and across geographic regions. Currently, the National CAHPS Benchmarking Database has commercial data for 20 participating organizations (sponsors), Medicaid data for 16 sponsors, and Medicare data for 310 managed plans. We hope to expand future Delaware CAHPS studies by including more comparative analysis. The NCBD will be a useful resource for future comparisons and understanding of the Delaware survey results.

## **4. CAHPS AND COMPARATIVE PERFORMANCE MEASUREMENT SYSTEMS**

Accrediting organizations such as the National Committee on Quality Assurance (NCQA), state associations of HMOs and other plans, state regulators, the Foundation for Accountability (FAACT), and the Quality Measurement Advisory Service (QMAS) are all currently using, endorsing, or seriously studying the efficacy of using CAHPS for their constituencies. This trend will generate enormous spin-off benefits for purchasers, health plans, providers, regulators, and other government agencies. A coordinated network of quality measurement alliances will encourage the creation of benchmarking databases. This will facilitate cross-market comparisons of health plan performance as measured by CAHPS.

One of the top accreditors and reviewers of managed care plans is the National Committee on Quality Assurance (NCQA), a non-profit group comprised of consumers, government, and purchasers. On a largely volunteer basis, managed care plans seeking accreditation approach NCQA for performance assessment. NCQA uses a tool termed the Health Plan Employer Data and Information Set (HEDIS), which is used to measure performance. NCQA has been a vehicle behind much of the push for measurement of quality in health care. Obtaining accreditation is intended to signify a higher performance level. The NCQA has assessed approximately three-quarters of the HMOs in the United States with approximately the same number currently involved in the NCQA accreditation process.

Thirty large corporations, including Xerox, General Motors, and IBM, will not contract with a health plan that is not accredited by NCQA. Furthermore, health plans view NCQA as significant because as an independent body it can provide an unbiased assessment of quality. NCQA has entered into a plan to merge performance measurement development effort with the American Medical Accreditation Program and the Joint Commission on Accreditation of Healthcare Organizations. This will make performance measurement more efficient and coherent across all levels of the health care system.<sup>13 14</sup>

Though it is not flawless, HEDIS is one of the best known and more comprehensive of the performance measurement systems in existence. HEDIS measures are used by over 90% of HMOs in the United States.<sup>15</sup> It incorporates indicators that cover quality of care, access and satisfaction, and finances and management. HEDIS 3.0, the latest version of the Health Plan Employer Data and Information Set, is used to provide information to purchasers and consumers about the quality and performance of managed health care plans in a standardized format, thereby creating more uniformity in reporting measurements of health care. HEDIS 3.0 replaces the Member Satisfaction Survey with the standardized CAHPS 2.0H Survey. (The letter “H” designates the HEDIS version.) This movement to CAHPS will provide comparable member satisfaction information from health plans across the country. This benchmark data will allow for more comprehensive analysis of Delaware CAHPS data in future years.

## **5. DELAWARE INSURANCE ENROLLMENT BY PLAN TYPE**

The 1999 Delaware CAHPS survey results are detailed in the next major section of the report. The survey asks adults (age 18 and above) about their experiences with their current health plan and medical care during the previous twelve months. It examines the types of health insurance coverage (FFS vs. managed care) as well as a classification approach based on the degree of managed care (“strict” vs. “loose”). We examined differences by key demographic variables including age, health status and county of residence. Moreover, we introduced choice of health plans as a new variable in the 1999 CAHPS survey. The 1999 Delaware CAHPS report discusses the consumer’s 0-10 scale global ratings of their health plan, quality of care, personal physicians, and specialist. The survey also focuses on the consumer’s specific experience in getting the health care they need, getting the care quickly, communicating with their physician and being treated well by the office staff. The survey also asks about people’s experiences with their health plan’s customer service and information provided by the health plan. Delaware has committed to conducting CAHPS surveys on an ongoing basis. The resulting time series data allows for year-to-year comparisons of the Delaware data.

A distinct finding of the 1999 statewide consumer satisfaction survey indicates that Delawareans are less satisfied with their health plans than they were last year. In terms of differences by plan type, our data reveals that Delawareans enrolled in FFS plans report greater satisfaction with their health plans over those who are enrolled in managed care plans. We did find statistically significant differences by health status, year and degree of managed care. In terms of overall ratings of health care, as mentioned earlier, our data reveals a statistically significant difference between managed care and FFS enrollees. The overall ratings of quality of care vary by age, plan type and health status by a statistically significant margin.

## Health Plan Enrollment

Before discussing consumer assessment in further detail, it will be informative to present basic information about plan enrollments in Delaware. Since beginning this project, we have received a large number of inquiries that asked what percentage of Delawareans is currently enrolled in managed care plans. To make the percentage results more accurate, we applied a new methodology of categorizing respondents by health plan in 1999. In the previous two years, respondents' plan type was determined by their recognition of plan titles. Respondents were given three plan titles - FFS, HMO and PPO/POS - to identify their own plan types. This methodology ignored the possibility that some respondents may fail to understand the nuances between FFS and loose managed care. In the 1999 CAHPS survey, we determined respondents' plan type by characteristics of a plan. Managed care is classified into two categories-strict managed care and loose managed care (how the degree of managed care is classified will be discussed later). We decided that the percentage of respondents enrolled in managed care should include those who claimed to be in both strict managed care plans and loose managed care plans.

Based on the new methodology, the 1999 CAHPS data indicates that 88 percent of respondents received their coverage through a managed care plan including HMOs, preferred provider organizations (PPOs), or point-of-service (POS) plans. This is very close to the 85 percent figure that recent studies have estimated for the entire United States. By county, managed care enrollment of the non-elderly has reached 89 percent in New Castle County, 85 percent in Kent County, and 90 percent in Sussex County, as seen in **Figure 1**. These county differences are not large enough, however, to be statistically significant.

## Choice vs. No Choice

As managed care and increased competition among health plans transform the health care system, policy makers are concerned about what role consumers are playing in this transformation. For consumers to be active forces in the changing health care market, they must be able to choose a health plan that suits their needs. However, previous studies have shown that there are variations in plan offerings to families and employees across the country. People living in rural and small metropolitan areas or working in small firms are less likely to have a choice of two or more health plans than those living in large metropolitan areas or working in larger firms. It is widely believed that choice of health plans figures heavily in consumers' satisfaction with their current plan. Studies have shown that consumers are more satisfied with their health plan, regardless of the type of plan and its restrictions, provided they have a choice of plans.<sup>16</sup>

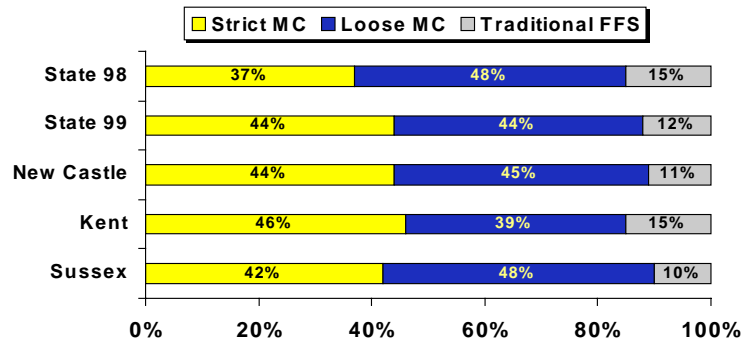
Given its important policy implications, we introduced choice of health plans as a new variable to examine the differences in rating the health care system. According to the 1999 CAHPS survey, 52 percent of the respondents indicated that there was more than one choice available to them and 33 percent said they had no choice in selecting health plans. In **Section 5-7**, we will discuss what influence choice of health plans has on Delawareans' rating of the health care system.

## Degree of Managed Care

"Strict" versus "loose" managed care is determined through a set of questions on the CAHPS survey, which asks respondents a few questions about their health plan requirements. Our methodology is based on the approach used by the Kaiser Family Foundation / Harvard surveys such as the 1997 National Survey of Americans on Managed Care. Respondents are asked if they must select doctors from a list, if they must select a primary care physician, and if they must obtain referrals. Answering "yes" to all these items puts them in the strict category. Loose managed care is defined by "yes" responses to some but not all questions and no "yes" responses puts the plan in the traditional category. According to the 1999 CAHPS data in **Figure 1**, 44 percent of respondents were enrolled in strict managed care programs and 44 percent in loose managed care. Only 12 percent of respondents reported to be enrolled in traditional fee-for-service programs. At the county level, New Castle County residents report 44 percent enrollment in strict managed care programs and only 11 percent in traditional programs. Kent County has the lowest percentage enrolled in strict managed care at 46 percent but the most enrolled in traditional programs with 15 percent. Sussex County residents report 42 percent in strict managed care and 10 percent in traditional plans.

To help understand the state’s health insurance market, we also analyzed coverage by self-reported health status. Respondents were asked to rate their overall health using five categories ranging from “poor” to “excellent.” For reporting purposes, health status is collapsed into three groups: “excellent/very good” (63.7 percent), “good” (27.6 percent), and “fair/poor” (8.7 percent). The trailing numbers in parentheses give the percentage of respondents in each health status category.

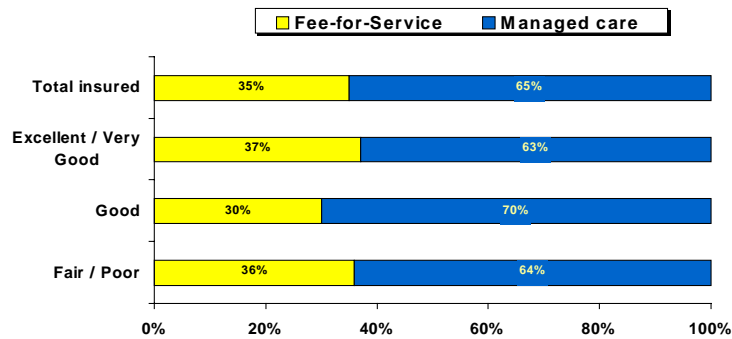
**Figure 1: “Strict” vs. “Loose” Managed Care Coverage by County (1999)**



Note: Differences by county are not statistically significant.

Source: 1999 CAHPS Survey

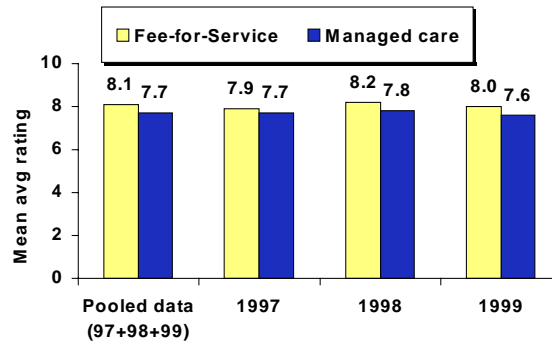
**Figure 2: Health Plan Enrollment by Health Status, Age 18-64**



Enrollment differences by health status are statistically significant.  
 Health status distribution: 64% Ex/VG, 27% Good, 9% Fair/Poor.

Source: 1999 CAHPS Survey

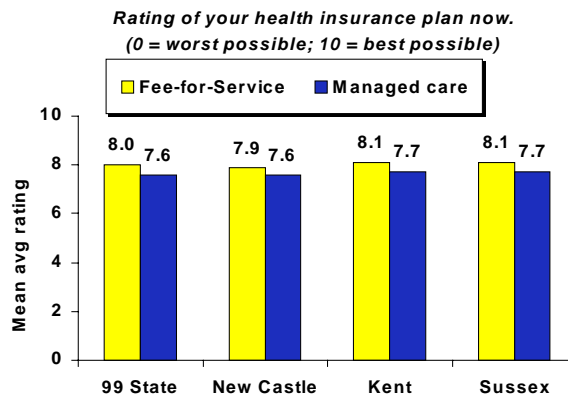
### Figure 3 A: Overall Rating of Health Insurance by Year and Plan Type, Age 18-64



Note: There are statistically significant differences by year and by plan type.

Source: 1999 CAHPS Survey

### Figure 3 B: Overall Quality of Health Insurance by County and Plan Type, Age 18-64



Note: Differences by plan type are statistically significant; differences by county are not.

Source: 1999 CAHPS Survey

According to the 1999 CAHPS data displayed in **Figure 2**, among the non-elderly, 63 percent of the healthiest respondents (in “excellent” or “very good” health status) are enrolled in managed care plans while 64 percent of the non-elderly respondents in worst health (in “fair” or “poor” health status). In the previous two years, there was a substantial movement of enrollees in “fair/poor” health to managed care plans-70 percent of respondents in “fair” or “poor” health were covered by managed care plans in 1998, up from 59 percent in 1997. However, the 1999 CAHPS data reveals that managed care plans no longer have a greater tendency to enroll “healthier clientele” than do traditional FFS plans.

## **6. OVERALL RATINGS BY PEOPLE WHO WERE SURVEYED**

Respondents were asked four survey questions, which we used to evaluate overall satisfaction. We asked respondents to give us overall ratings of their insurance plan and the health care they had received in the past twelve months. For each of these four questions (or, global measures), a rating scale of 0 - 10 is used with 0 equating to the “worst possible” and 10 equal to the “best possible.”

### **Elderly vs. Non-Elderly**

Similar to what last year’s data showed, Delaware’s elderly population (65 and above) report greater overall satisfaction levels than do the non-elderly population (18 - 64 years of age). For each of the four global measures, elderly ratings are greater by a statistically significant margin – than non-elderly ratings. As evidence of this, consider the ratings for quality of health plans and quality of care. Delaware’s elderly rate their health plans 8.7 compared to a 7.7 overall rating among those respondents 18 – 64 years of age. When asked to rate their doctors and specialists, elderly respondents reported higher satisfaction levels for both. This higher level of satisfaction appears between health care ratings as well with elderly Delawareans reporting an average of 9.0 and non-elderly reporting satisfaction levels of 8.2.

This very positive level of satisfaction among seniors, and thus with the Medicare program, can be explained by three factors. First, the Medicare program provides seniors with a generous health insurance program. The traditional program has few restrictions on the choice of providers; it does not impose strong utilization review, and beneficiaries face relatively low direct out-of-pocket expenses. Second, national studies show that younger patients as well as the chronically ill have lower satisfaction levels with their health care. Health care satisfaction levels increase as one grows older – until the age of 70 – when they start to decline along with the patient’s health status.<sup>17</sup> Third, national surveys consistently show that seniors tend to report higher levels of satisfaction with most government services, not just health programs.

Effective January 1, 1999, Delaware seniors lost their Medicare managed care plan options. Our survey results reflected this difference. Delaware seniors rated their plans 8.7 in 1999 compared to a rating score of 8.6 in 1998. Seniors also rated health care higher in 1999 (9.0) than in 1998 (8.9). However, for each overall rating, the difference by year is not statistically significant. This finding is compatible with what the following discussion will indicate. As we will see, for both the elderly and non-elderly in Delaware, choice of health plans does not make a statistically significant difference in rating health plans and health care.

In most of the analysis that follows, the elderly were separated from non-elderly adults due to the influence Medicare has on the satisfaction ratings of older Delawareans. From a state-policy perspective, this reporting decision recognizes that Medicare is a federal program that has its own rigorous quality measurement and quality-reporting program. Furthermore, changes in state policies will not directly impact the Medicare program in Delaware. This reporting decision follows the format used throughout the United States for the commercially insured and Medicaid populations. Without controlling for age, much of the statistical analysis would generate biased results.

## Quality of Health Plans

In the 1999 CAHPS survey, we did a year-by-year comparison of rating of health plans. **Figure 3 A** indicates that in the past three years, respondents in FFS have been continuing to give higher rating of their health insurance than those who are in managed care. Differences by year and plan type are statistically significant. **Figure 3 A** also shows that the overall rating of health insurance plans increased from 1997 to 1998 and decreased from 1998 to 1999.

The decreased rating of health plans from 1998 to 1999 can also be seen in **Figure 3 B - 3 C**, in which differences are examined by county, health status and plan type. FFS ratings decreased from 8.2 to 8.0, and managed care ratings decreased from 7.8 to 7.6. Keeping in mind the fact that more than three-quarters of Delawareans are now enrolled in managed care plans, it is not surprising that for all respondents overall satisfaction ratings of health plans decreased from 7.9 in 1998 to 7.8 in 1999.

The 1998 data showed that, FFS plan participants report greater satisfaction with their plans than do those respondents enrolled in managed care plans by a small, but statistically significant margin. Looking at county-level results, we found statistically significant differences by plan type, but not by county. This year, Kent County and Sussex County respondents report the higher ratings for their care at 8.1 for FFS and 7.7 for managed care respectively (see **Figure 3 B**). Even though it is not clear, which county is most satisfied, the 1999 data as well as the pooled 98-99 data both show that New Castle County respondents are the least satisfied with their health plans. As will be discussed in more detail later, it is important for readers to keep in mind that New Castle County residents tend to give more negative ratings about many services – not just their health plans.

Although people in the poorest health tend to give the lowest ratings, the 1998 CAHPS survey didn't show a direct correlation between health status and plan ratings. However, the 1999 data showed that the positive correlation between health status and plan ratings (E>G>F/P) became statistically significant (see **Figure 3 C**).

As we mentioned earlier, choice of health plans and degree of managed care have been used as new variables to examine the differences in rating of health plans and health care. According to the data in **Figure 3 D**, respondents with choice of health plans tend to give higher ratings of their health insurance (7.9) than do those without choice (7.8). Also, respondents in loose managed care programs are more satisfied with their health insurance than those in strict managed care programs. Differences by degree of managed care are statistically significant while differences by choice are not.

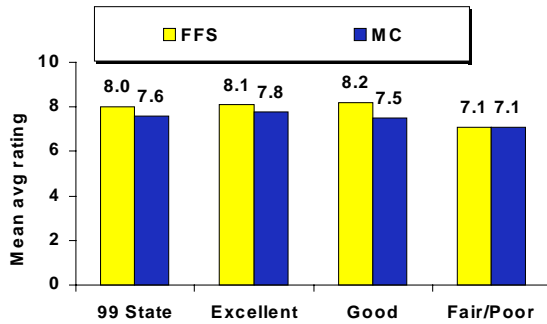
## Quality of Health Care

The year-by-year comparison of the ratings of health care comes up with a result similar to that of health plans (see **Figure 4 A**). Generally, respondents in FFS have been more satisfied in the past three years with the health care they received than those who are in managed care. Difference by plan type is statistically significant. Moreover, the overall rating of health care increased from 1997 to 1998 and decreased from 1998 to 1999.

As presented in **Figure 4 B**, Delawareans report that they are less satisfied with their health care in 1999 than in 1998. FFS plan members give an 8.4 rating, down from 8.6 in 1998; managed care members grade their care an 8.2, down from 8.4 in 1998. Differences are statistically significant by plan type (FFS>MC), but not by county. As can be seen in **Figure 4 C**, respondents in poorer health reported less satisfaction (7.1 for FFS and 7.1 for managed care) with their health care than those in excellent/good health (8.1 for FFS and 7.8 for managed care). The national CAHPS development team discovered similar findings when they tested their standardized questionnaire. Health status may be related to ratings of health care for at least three reasons: 1) sicker people tend to give more negative ratings in general; 2) some people – not necessarily just those in worse health – are likely to give negative ratings about anything, including their health, their health plans, and the care they receive; or 3) respondents in “fair/poor” health could in fact get worse care and receive lower quality service from their health plans.

Again, choice of health plans makes no statistically significant difference in the rating of health care (see **Figure 4 D**). Differences by the degree of managed care are statistically significant, with respondents in loose managed care giving higher rating of health care than those in strict managed care.

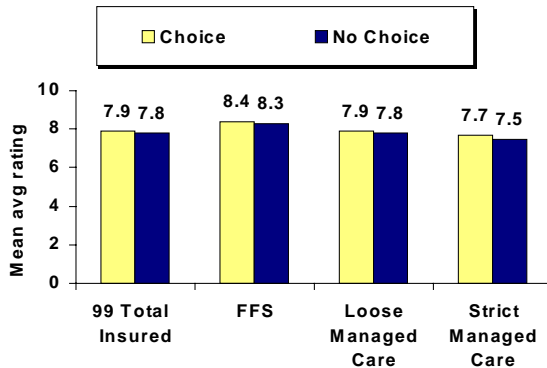
**Figure 3 C : Overall Quality of Health Insurance by Health Status and Plan Type, Age 18-64**



Note: Differences by plan type and health status are statistically significant.

Source: 1999 CAHPS Survey

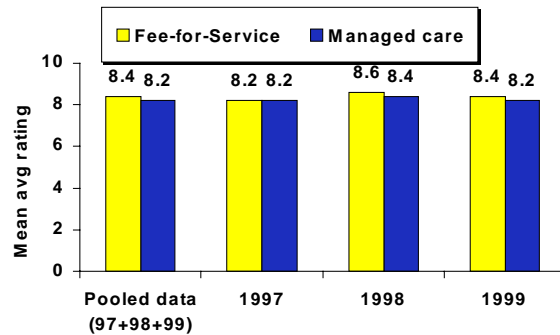
**Figure 3 D: Overall Quality of Health Insurance by Choice and Degree of Managed Care, Age 18-64**



Note: Differences by degree of managed care are statistically significant; differences by choice are not.

Source: 1999 CAHPS Survey

**Figure 4 A: Overall Rating of Health Care by Year and Plan Type, Age 18-64**

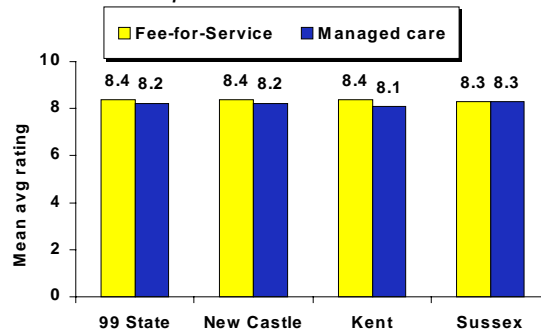


Note: There are statistically significant differences by year and by plan type.

Source: 1999 CAHPS Survey

**Figure 4 B: Overall Quality of Health Care by County and Plan Type, Age 18-64**

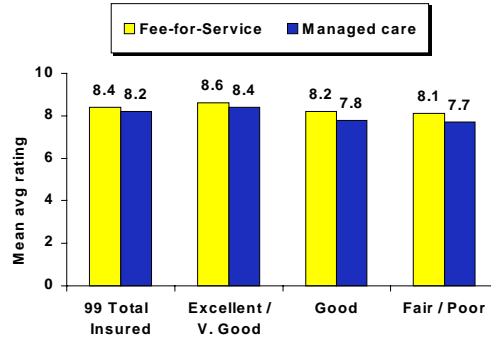
*Rating of the care you've received from all doctors and other health care professionals in the last twelve months.*



Note: Differences by plan type are statistically significant; differences by county are not.

Source: 1999 CAHPS Survey

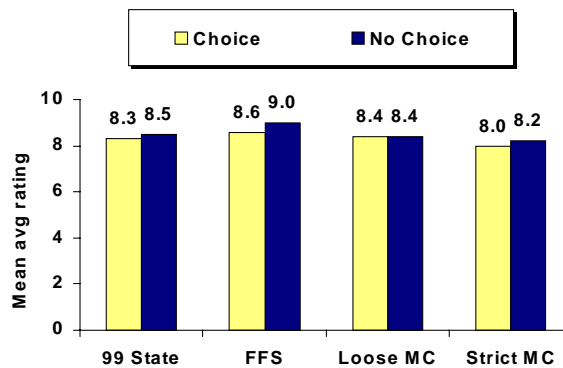
### Figure 4 C: Overall Quality of Health Care by Health Status and Plan Type, Age 18-64



Note: There are statistically significant differences by health status and by plan type.

Source: 1999 CAHPS Survey

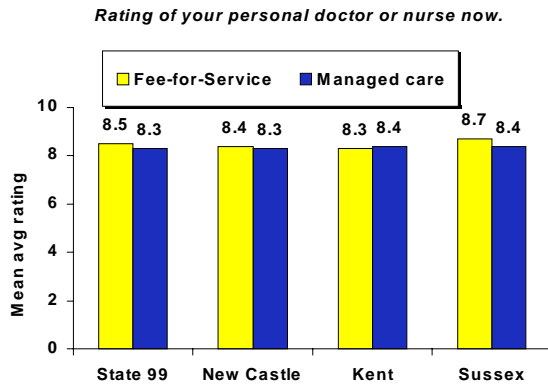
### Figure 4 D: Overall Quality of Health Care by Choice and Degree of Managed Care, Age 18-64



Note: Differences by degree of managed care are statistically significant; differences by choice are not.

Source: 1999 CAHPS Survey

**Figure 5: Overall Rating of Personal Doctor by County and Plan Type, Age 18-64**

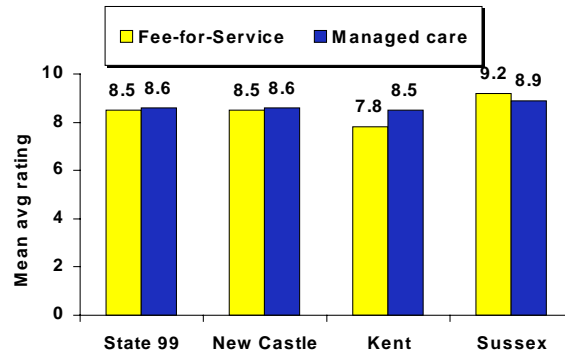


Note: There are no statistically differences by plan type or by county.

Source: 1999 CAHPS Survey

**Figure 6: Overall Rating of Specialists by County and Plan Type, Age 18-64**

*Rating of the specialist you saw most often in the last 12 months.*



Note: Differences by county are statistically significant; differences by plan type are not.

Source: 1999 CAHPS Survey

## Quality of Physicians and Specialists

The 1999 CAHPS survey also asked respondents to give overall ratings of their personal physician and their specialists. As seen in **Figures 5**, the results indicate that no statistically significant difference exists by plan type in the ratings of the respondents' personal physician. Managed care participants rate their personal doctor lower than those in FFS plans (8.3 vs. 8.4). This difference could be due to actual performance differences in physicians or it could be due to other factors such as managed care enrollees expressing their dissatisfaction with having to pick a primary care physician from an HMO provider list. Our data shows no statistically significant differences by either county or health status.

To learn more about physician quality, we asked respondents to give 0-to-10 ratings of the specialists they saw most often over the past twelve months. Keep in mind that respondents base their ratings on care received from all specialists and physicians – not just doctors practicing in Delaware. This is particularly relevant for specialist ratings given that consumers and insurance companies are more willing to look outside the state for complicated and expensive procedures.

**Figure 6** shows that overall ratings are higher for specialists than for personal physicians. Our data did show statistically significant differences by county (S>N>K), but there are no statistically significant differences by plan type and by health status. Our limited data visually suggest plan type differences: specialists seen by FFS enrollees received an average rating of 8.5 versus 8.6 for those seen by managed care enrollees. This is a possible area of significance that we will want to analyze next year. When asked to rate their specialists, respondents who report themselves in "fair/poor" health gave a rating score of 8.3 for FFS and 8.7 for managed care. Those in either "good" health or "very good/ excellent" gave rating scores of 8.5 for FFS and 8.5 for managed care and 8.5 for FFS and 8.7 for managed care, respectively. However, differences by health status are not statistically significant. Respondents who report themselves in worse health most likely will have more experience with a specialist, which would provide the opportunity to give a more negative rating. Also, many in worse health could suffer from chronic conditions in which little positive progress is made. This would lead to greater respondent dissatisfaction with their physicians and specialists. Overall though, Delawareans responded favorably in regard to their personal doctors and specialists.

Results of our analysis for overall quality are summarized in the following table. The first column shows the survey item (question). For example, there is a statistically significant difference (at the 95 percent confidence level) for quality of health care by health status, but not by county or plan type. "E>G>P" means respondents in "excellent/very good" health gave the highest ratings, followed in order by those in "good" and then by those in "poor or fair" health. For more detailed results, look for the corresponding bar charts shown in **Figures 4 - 11**.

**Delaware CAHPS  
Summary of Global Ratings\*  
1999 Data for Respondents Age 18-64**

| Overall Rating of:     | Statistically Significant by:                      |   |  |
|------------------------|--|---|--|
|                        | Plan Type<br>(Fee-For-Service and<br>Managed Care) | County<br>(Kent, New Castle,<br>Sussex) | Health Status<br>(Excellent, Good,<br>Poor/Fair) |
| Quality of Health Plan | Yes<br>(FFS>MC)                                    | No                                      | <b>Yes (E&gt;G&gt;F/P)</b>                       |
| Quality of Health Care | <b>Yes (FFS&gt;MC)</b>                             | No                                      | Yes<br>(E>G>F/P)                                 |
| Personal Doctor        | <b>No</b>  | No                                      | No   |
| Specialists Seen       | No   | <b>Yes (S&gt;N&gt;K)</b>                | <b>No</b>  |

Note: Changes in 1999 data are in **bold (blue)**.

## 7. WHAT NON-ELDERLY RESPONDENTS SAID ABOUT SPECIFIC TOPICS

The 1999 Delaware CAHPS survey includes a series of 16 questions in regard to specific aspects of people's health care experiences. Respondents were asked about their experiences in getting the care they need, in getting care quickly, with how well their doctors communicate, with the physician's office staff, and with their health plan's customer service. These groups of questions are used to present a clearer picture of the different aspects of health care that affect residents in the state of Delaware. The reporting groups for the CAHPS survey are designed to summarize specific categories of health plan members' experiences with providers and plans.

For a majority of the items, Delawareans seem basically satisfied with these specific aspects of their medical care. Without having standards or more benchmark data from other states, it is not obvious what criteria should be used to label an item as "problematic." (The Picker Institute in cooperation with the Quality Management Advisory Service has made substantial progress in building a database of comparative CAPHS information.) We label an item "problematic" if it is flagged by more than 20 percent of the respondents. Based on this criterion, two items seem most problematic –; waited less than 15 minutes past their appointment time and consumers not receiving all the help they needed when they called their health plan customer service.

For each of the 16 specific measures, we tested for statistically significant differences by four respondent characteristics: health plan type (FFS vs. managed care), county, choice and health status. By factors of four and five, respectively, we found much greater variation by county and health status than by plan type. This pattern for health status is not surprising given a substantial number of studies showing that people in worse health tend to report more problems with care than do people in better health.

The large number of differences by county also is not surprising given recent public opinion surveys conducted by the University of Delaware's Center for Applied Demography and Survey Research (CADSR). These studies suggest that, in general, residents of New Castle County hold more negative views than residents of Kent county and Sussex county. As part of the November 1998 *Choices for Delaware* conference, CADSR conducted a statewide survey to capture information showing public attitudes on diverse issues such as economic growth, education, and health care. The instrument included questions asking about specific measures of quality of life. Respondents from New Castle County repeatedly reported the

lowest marks. It should not be surprising; therefore, that we discovered significant county-level differences for nearly half of 16 CAHPS questions addressing specific aspects of care.

Respondents from Kent County report the most problems with specific aspects of their health care followed in order by respondents from New Castle County and then Sussex County. As we discovered with the global (0 - 10 scale) ratings, people in Sussex and New Castle Counties are more satisfied with the specific components of their health care and health plans. The next section of the report presents a detailed examination of these 16 specific measures of health care and health plans. Please note that the accompanying charts show where we found statistically significant differences by plan type, county, choice and health status.

### **People's Experience in Getting the Care They Need**

**Figures 7A and 7B** show the results for the four items in the "getting needed care" category. One "flagged" or problematic item falls within this category, 5 percent of the respondents reported problems with obtaining approvals from their health plans.

For three of the four items, our data also showed statistically significant differences by health plan type, county, and choice and/or health status. (In the following discussion and throughout Section 7 of this report, only statistically significant differences are mentioned in the text.) Kent County residents reported a less difficult time finding a physician (14.3 percent) than the residents of New Castle and Sussex counties (16.7 and 37.5 percent) did.

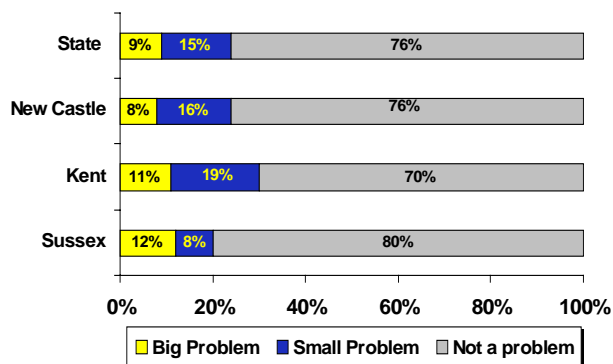
Sussex County residents reported less difficulty getting approvals easily (11.3 percent) than in New Castle and Kent Counties (14.2 and 13.6 percent). Kent County residents reported more difficulty getting needed tests and treatments (17.2 percent in comparison to 12.8 percent in Sussex and 15.6 percent in New Castle). FFS participants reported that they received needed treatment more often (87 percent of the time), than managed care plan participants, (84 percent). Respondents in worse health reported more difficulty receiving needed treatments and tests (13.9 percent) than those in better health (4.2 percent).

### **People's Experience in Getting Care Quickly**

For the four specific items presented in **Figure 8**, between 83.0 and 87.0 percent of respondents reported that they usually or always receive care quickly. Our data did not show any statistically significant differences between FFS and managed care plan enrollees. Those in poorest health report greater difficulties for three measures of getting care quickly. For example, 20.0 percent of those in the lowest health category had to wait more than 15 minutes, compared to 21.0 percent of those in the healthiest category. The most dramatic change from last year is the increase from 15.0 to 27.0 in the percentage of Delawareans reporting long waits past their appointment times. However, this increase does not indicate poor office management, because the national CAHPS development team decided that 15 minutes, decreased from 30 minutes in 1998, is the right criterion. Future Delaware CAHPS surveys will follow this recommendation.

## Figure 7 A: People's Experiences in Getting the Care They Need

*When asked how much of a problem it was to get a physician or nurse they are happy with, % of respondents say...*

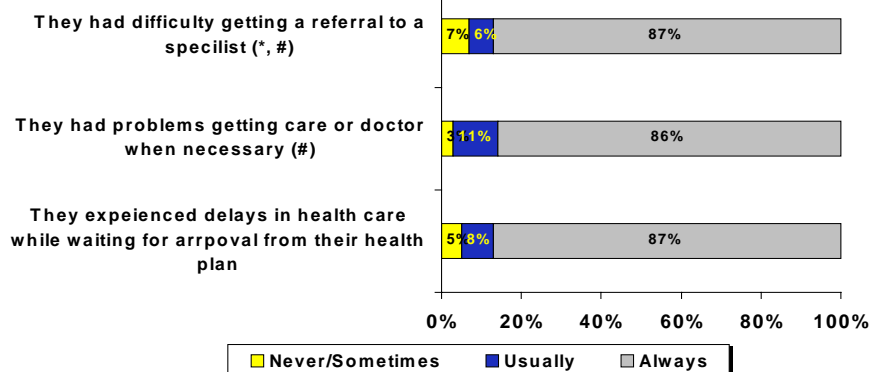


Significant differences by: (\*) = Health Plan, (^) = County, (#) = Health Status and (+) = Choice.

Source: 1999 CAHPS Survey

## Figure 7 B: People's Experiences in Getting the Care They Need

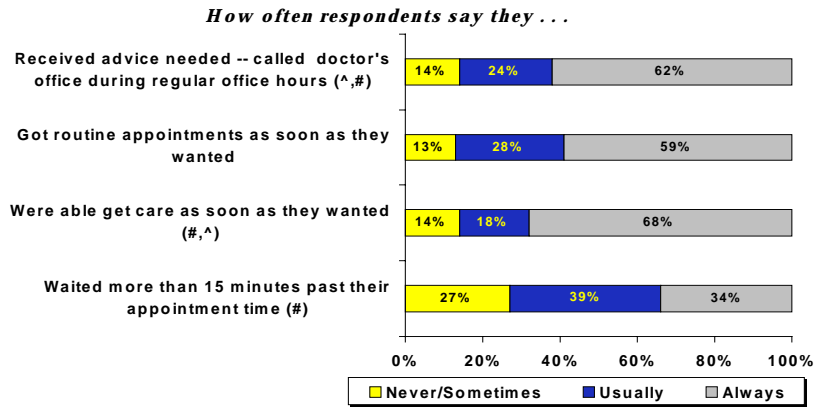
*How often respondents say ...*



Significant differences by: (\*) = Health Plan, (^) = County, (#) = Health Status, and (+) = Choice

Source: 1999 CAHPS Survey

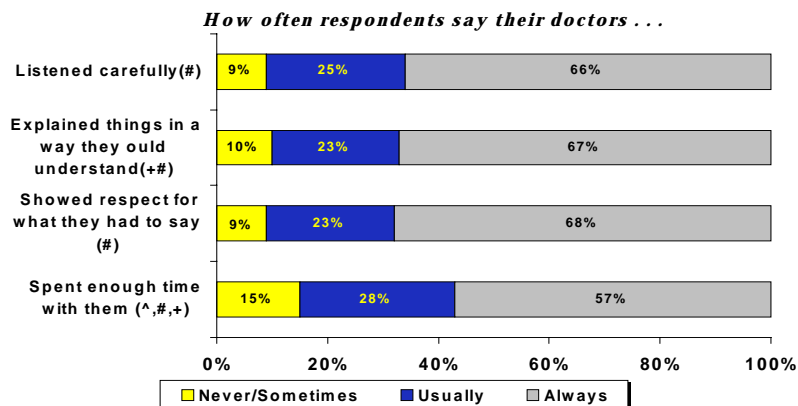
## Figure 8: People's Experiences in Getting Care Quickly



Significant differences by: (\*) = Health Plan, (^) = County, (#) = Health Status, and (+) = Choice

Source: 1999 CAHPS Survey

## Figure 9: People's Experiences with How Well Their Doctor Communicates



Significant differences by: (\*) = Health Plan, (^) = County, (#) = Health Status, and (+) = Choice

Source: 1999 CAHPS Survey

## **People's Experiences with How Well Their Doctors Communicate And Their Experiences with the Staff at the Doctor's Office**

The results for the specific items in **Figure 9** show that Delawareans generally report few problems relating to how well their doctors communicate, and there are no statistically significant differences by plan type. Less than 10.0 percent of the respondents describe problems with their physician not listening carefully, not explaining things in a way that can be understood, or not showing respect. More people – but only 15.0 percent – report problems with their doctors spending enough time with them. For all four specific measures, the data shows no statistically significant differences between FFS and managed care enrollees.

Health status, choice and county of residence have statistically significant effects on the perception of how well doctors communicate. Kent County residents report a higher level of problems with their doctors with 2.0 percent reporting that their doctors never listen to them carefully, 2.0 percent reporting that their doctors showed no respect for what they had to say, and 3.4 percent reporting that their doctors did not spend enough time with them. Sussex County residents reported highest satisfaction with their doctors communication with 2.0 percent stating that their doctors did not listen to them carefully, 1.0 percent reporting that their doctors showed no respect for what they had to say and 2.0 percent reporting that their doctors did not spend enough time with them. Sussex County residents reported slightly greater satisfaction with their physicians in the overall ratings. Communication marks for Sussex County physicians correlates with the high global satisfaction rates reported in the 1999 CAHPS survey.

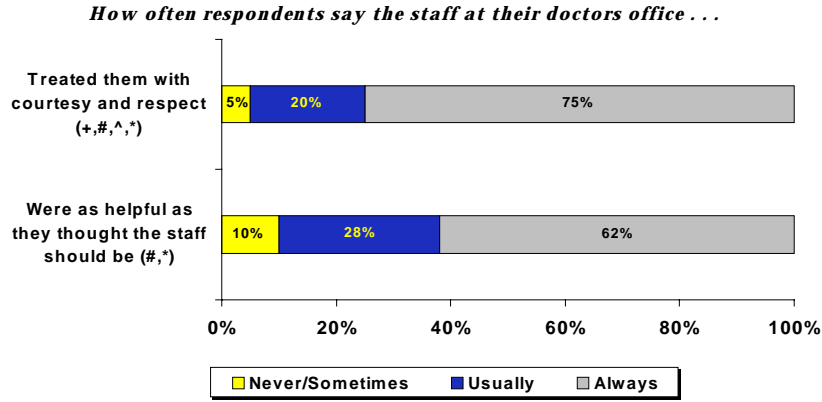
Respondents in worse health reported greater problems in communicating with their physicians. Among Delawareans in “poor” health, 2.8 percent reported that their doctors never listen to them carefully, 1.8 percent said that their doctors showed no respect for what they had to say, and 8.2 percent reported that their doctors did not spend enough time with them. Of those Delawareans reporting to be in “good” health, 1.5 said that their doctors never listen to them carefully, 1.8 percent reported that their doctors never or only sometimes showed respect for what they had to say, and 2.1 percent claimed that their doctors did not spend enough time with them.

**Figure 10** shows similar patterns for the doctors' office staff. More than 90 percent of the state's respondents report overall positive experiences with the staff. Respondents in poorest health report the most frequent problems: when asked if they were treated with courtesy and respect, approximately 10.1percent report problems compared to approximately 4.8 percent for the healthier respondents; when asked if the staff were as helpful as they thought they should be, 11.8 percent of the respondents in poor health report problems compared to 9.8 percent for the healthier respondents. Sussex County respondents give the highest marks for the question asking how often the staff treats them with courtesy and respect, with only 1.0 percent reporting problems.

## **People's Experience with Their Health Plan's Customer Service**

The final group of specific measures relates to people's experiences with their health plan's customer service and paperwork. **Figure 11** shows that Delawareans give relatively lower ratings for customer service. Of those respondents who called in the previous twelvemonths, only 49.0 percent reported “always” getting the help needed. Much less concern was expressed about paperwork; only 16.0 percent of all respondents reported a problem here. For these two specific measures, the data showed statistically significant differences by plan type and choice, but not by county or health status.

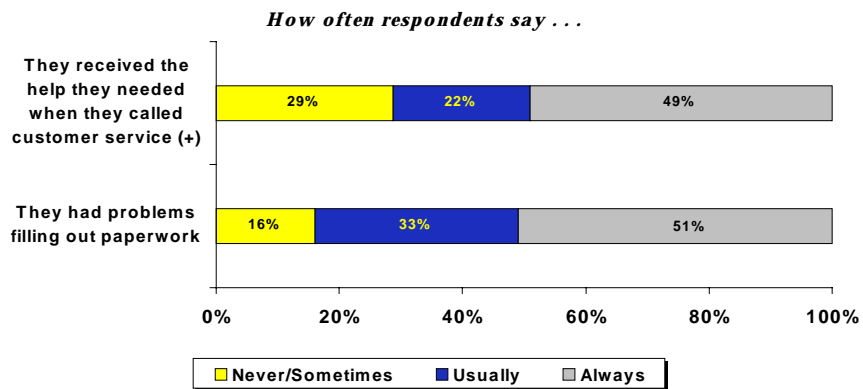
## Figure 10: People's Experiences with the Doctor's Office Staff



Significant differences by: (\*) = Health Plan, (^) = County, (#) = Health Status, and (+) = Choice

Source: 1999 CAHPS Survey

## Figure 11: People's Experiences with Their Health Plan Customer Service



Significant differences by: (\*) = Health Plan, (^) = County, (#) = Health Status and (+) Choice

Source: 1999 CAHPS Survey

## 8. CONCLUSION

The 1999 Delaware CAHPS report addresses two of the central questions often asked about quality and the changing health care systems. First, what role do consumer satisfaction surveys play in the assessment of possible quality differences? Second, are there verifiable quality differences between fee for service (FFS) and managed care in Delaware?

An important movement to more accurately measure and monitor the quality of health care has sprung up in the United States and has been incorporated into the strategic plans of the Delaware Health Care Commission. Changes in the health care industry have been largely market driven since the failure of national health care reform. Having decided that the 1993 Clinton plan was unacceptable and that we could not live with the cost of unrestricted fee-for-service care, the nation made a collective decision in favor of managed care. As a consequence, only about one-quarter of our health care remains fee-for-service. Consumers, as well as other stakeholders, are raising questions regarding quality of care and how it is being impacted by decreasing costs. The significance of health care quality has risen, while the concern for cost alone has decreased. "As the nation shifts from fee-for-service toward managed care, few issues attract more attention than the tension between quality and cost,"<sup>18</sup> states David Eddy, a physician and internationally recognized authority in the field of quality of health care.

This focus on quality has brought the role of the consumer to the center of the debate, with special attention given to the impact managed care has on the health care system and what the public thinks about managed care. Governments, managed care organizations, and other groups are scrutinizing the consumers' reactions to cost control measures and the general movement away from fee-for-service plans in order to meet the new market demands of a managed care based delivery system.

In line with the goal of improving quality measurement, there has been a dramatic increase in the utilization of evidence-based CAHPS satisfaction surveys. With information from the CAHPS survey that focuses on respondents' own personal experiences, rather than simply on opinions, policymakers will be better equipped to develop and respond to health care legislation. The CAHPS framework as applied in Delaware has captured new insights about consumer satisfaction levels in both managed care and FFS settings.

Public leaders often are asked to make health policy decisions based on anecdotal information and reports from the popular media. Front-page reports often suggest that managed care deserves blame for just about everything people do not like about medicine. Evidence from public opinion polls indicates that the American public has bought into this negative coverage of managed care. The data from our Delaware CAHPS study, however, does not support such a negative perspective.

Below, we will explain why the evidence from our study does not support the contention that HMOs clearly lead to worse quality of care. Before doing so, it is important to understand that Delawareans did report several negative aspects of managed care. In terms of the four overall (0 - 10) ratings, managed care respondents give lower ratings for their health plans and health care. In terms of the 16 specific measures of quality included in our CAHPS survey, managed care respondents give lower ratings for four: 1) had difficulty in getting a referral to a specialist; and 2) being treated with courtesy and respect; and 3) doctor's office staff were as helpful as they thought the staff should be; 4) had problems filling out paperwork.

The case in favor of managed care is built on three general findings. First, in terms of overall (0-to-10) ratings of personal doctors and ratings of specialists, our data shows no significant differences between managed care and FFS plans. Second, for the 16 specific measures, plan type has no significant effect on ratings for 12 of the 16 specific measures. To add some context to this total, our data reveals 5 statistically significant differences by county and 11 by health status. Finally, where we did find statistically significant higher ratings for FFS plans, all margins of difference are relatively small.

Managed care has become the leading form of health insurance for the non-elderly in Delaware. In 1999, about 88 percent of the non-elderly population in Delaware claim to be enrolled in managed care, compared to the national estimation of 85 percent. The Delaware CAHPS through its attention to facts versus opinions reveals that despite what has been previously presented through flawed surveys and anecdotal-based

evidence, there is not enough evidence to support the notion of a strong managed care backlash in Delaware.

## ENDNOTES

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<sup>1</sup> Prospective Payment Assessment Commission, March 1997.

<sup>2</sup> The President's Advisory Commission on Consumer Protection and Quality of Health Care, Executive Summary [WWW document], URL <http://www.hcqualitycommission.gov>.

<sup>3</sup> Chassin, Mark, Robert Galvin and the National Roundtable on Health Care Quality, "The Urgent Need to Improve Health Care Quality", *JAMA* (September 16, 1998): 1004.

<sup>4</sup> House Resolution 94 (138<sup>th</sup> General Assembly).

<sup>5</sup> "The Public, Managed Care, and Consumer Protection", Kaiser Public Opinion Update, July 1999.

<sup>6</sup> Mollyann Brodie, Lee Ann Brady, and Drew E. Altman, "Media Coverage of Managed Care: Is There a Negative Bias?" *Health Affairs* (January/February 1998): 7-25.

<sup>7</sup> The National Coalition on Health Care (NCHC) (1997). *How Americans Perceive the Health Care System: A Report on a National Survey* (Conducted for the NCHC by International Communication Research) [WWW document]. URL <http://www.nhc.org/perceive.html>.

<sup>8</sup> Elizabeth W. Hoy, Elliot K. Wicks, and Rolfe A. Forland, "A Guide to Facilitating Consumer Choice," *Health Affairs* (Winter 1996): 9-30.

<sup>9</sup> Stephen L. Isaacs, "Consumer's Information Needs: Results of a National Survey," *Health Affairs* (Winter 1996): 31-41.

<sup>10</sup> Hoy.

<sup>11</sup> Families USA (1997). *HMO Consumers at Risk: States to the Rescue* [WWW document]. URL <http://www.familiesusa.org/mancare.htm>.

<sup>12</sup> Families USA.

<sup>13</sup> Thomas Bodenheimer, "The American Health Care System: The Movement for Improved Quality of Care, The New England Journal of Medicine (February 11, 1999), 488-492.

<sup>14</sup> The National Committee on Quality Assurance. *AMAP, JCAHO, NCQA Announce Plans to Merge Performance Measure Development Efforts*. [WWW document]. URL <http://www.ncqa.org>.

<sup>15</sup> The National Committee on Quality Assurance. [WWW document]. URL <http://www.ncqa.org>.

<sup>16</sup> Notes from: Gawande, Atul., et al., "Does Dissatisfaction with Health Plans Stem from Having No Choices?" *Health Affairs*, Vol. 17, No. 3 (September/October 1998); Davis, Karen, et al., "Choice Matters: Enrollees Views of their Health Plans," *Health Affairs*, Vol. 14, No.2 (Summer 1995)

<sup>17</sup> *The Economic Report of the President* (Washington, D.C.: GPO, 1997), 126.

<sup>18</sup> David M. Eddy, "Balancing Cost and Quality in Fee-For-Service versus Managed Care," *Health Affairs* (May/June 1997): 162-173