

2000 Consumer Assessment of Health Plans in Delaware

Prepared for
The Delaware Health Care Commission

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SUMMARY OF 2000 DATA HIGHLIGHTS

Health Insurance Enrollment

- In 2000, 47 percent of Delaware's non-elderly (aged 18-64) population reported enrollment in strict managed care plans, 44 percent in loose managed care plans. Nine percent reported to be enrolled in traditional fee-for-service (FFS) plans. Since 1999, enrollment in strict managed care plans increased by 3 percent, while enrollment in FFS plans dropped by 3 percent.

Health Insurance and Health Care Ratings by Plan Type

- Overall ratings of health insurance and health care for FFS plans did not change between 1999 and 2000. However, overall ratings of health insurance and health care for managed care plans decreased from 1999 to 2000. There is only one chance in 20 that the observed differences could be the result of sampling error. This criterion is used throughout the report.

Health Insurance and Health Care Ratings by Degree of Managed Care

- The overall ratings of **health insurance** were higher for "loose" managed care plans versus "strict" managed care plans. The differences are statistically significant.
- Differences in the overall ratings of **quality of health care** by degree of managed care were substantively minor, but statistically significant. Fee-for-service plans were rated highest followed by loose managed care and strict managed care plans.

Health Insurance Ratings by County

- The overall ratings of quality of plans, quality of care, personal doctor, or specialists indicated no statistically significant differences by county.

Health Insurance Ratings by Health Status

- Quality of **plan** ratings were lower among those people who report the lowest health status. The differences were not statistically significant.
- 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.

Specific Aspects of Health Care Services

- 86 percent of Delawareans report that getting the care they needed was “not a problem”.
- Four potential problems cited by respondents were:
 1. Receiving the help needed when they called customer service (19 percent);
 2. Waiting more than 15 minutes past appointment time (17 percent);
 3. Having problems filling out paper work (16 percent); and
 4. Doctors not spending enough time with them (16 percent).

Uninsured

- The overall ratings for health care, doctors, and specialists by those who do not have insurance were lower than for those with health insurance by a statistically significant difference.

Quality of Health Insurance Comparison

The following table summarizes our 2000 findings for overall ratings of health plans, quality of care, personal doctors and specialists. **Blue** type indicates a change (yes to no, or no to yes) from 1999 to 2000.

The first column shows the survey item (question). For example, there is a statistically significant difference for quality of health plan by degree of managed care and plan type, but not by county and health status. “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.

Summary of Global Ratings*

2000 Data for Respondents Age 18-64

Note: Changes in 2000 data are in **Blue**.

Overall Rating of:	Statistically Significant by:			
	Degree of managed care (strict, loose, traditional fee for service)	Plan Type (Fee-for-service and managed care)	County (New Castle, Kent, Sussex)	Health Status (Excellent, Good, Fair/Poor)
Quality of Health Plan	Yes (T>L>S)	Yes (FFS>MC)	No	No
Quality of Health Care	No	Yes (FFS>MC)	No	Yes (E>G>F/P)
Personal Doctor	Yes (T>L>S)	Yes (FFS>MC)	No	No
Specialists Seen	Yes (T>L>S)	Yes (FFS>MC)	No	Yes (E>G>F/P)

1. INTRODUCTION

Since 1997, the Delaware Health Care Commission has contracted with the College of Human Services, Education and Public Policy (CHEP) at the University of Delaware to conduct the Consumer Assessment of Health Plans Study (CAHPS), an independent survey on consumer satisfaction with the Delaware health care system. The collection of unbiased information, as is obtained for the Delaware CAHPS, provides the necessary information for forming policy recommendations on regulating managed care, and assessing the health care experiences of Delaware's consumers. Moreover, the Delaware Health Care Commission has identified independent surveys as one of the best means to assist it in making policy decisions. Therefore, utilization of the CAHPS survey in policymaking provides a practical and flexible, yet standardized set of instruments to collect information on issues related to health care services and delivery systems in Delaware.

This year's CAHPS report provides useful information for a variety of other stakeholders involved in Delaware's health care system. Consumers and employers need access to unbiased, easily understandable information to assist them in making necessary health care choices. These groups are often forced to select health care for themselves, their families, and their employees based on insufficient information on quality. That is why it is imperative for these groups of individuals to have access to health care information such as the type provided by the Delaware CAHPS study.

Briefly, a distinct finding of the 2000 statewide CAHPS survey indicates that more Delawareans are enrolled in managed care plans than traditional fee-for-service (FFS) plans. However, in 2000, FFS plan participants reported greater satisfaction with their health plans than do those respondents enrolled in managed care plans by a small, but statistically significant margin. These changes in Delawareans' health plan enrollment and attitudes are reflective, albeit to a lesser degree, of what is happening around the United States. The Harvard School of Public Health published a study in a recent issue of *Health Affairs* reporting that, although most Americans are enrolled in managed care plans, the proportion of those who rate the managed care industry as doing "a good job" in serving their customers is only 29 percent¹. This placed managed care companies just above tobacco companies, with 28 percent of consumers believing that the tobacco companies are doing a "good job" serving their customers². While managed care and tobacco companies had the fewest positive responses, computer software companies, banks, and hospitals had the most people indicate that these industries were best serving constituent interests

(72-78 percent). These conflicting views over health plans and other aspects of health care experiences make health care system improvement efforts a difficult challenge for policymakers.

Additional results of the Delaware CAHPS report include ratings of specific aspects of health care services. For example, a majority of respondents (86 percent) thought getting needed care in Delaware was “not a problem”. This is an important result to note in light of the conflict between increased enrollments in managed care plans and decreased satisfaction with managed care plans. Other results related to specific aspects of health care will be discussed in more detail in the pages that follow.

The 2000 CAHPS report begins with a discussion that addresses two of the central questions often asked about quality and the changing health care systems. First, are there verifiable quality differences between FFS and managed care in Delaware? Second, what role do consumer satisfaction surveys play in the assessment of possible quality differences? To fully understand the background and methodology of the CAHPS project, we strongly encourage readers to take the time to review **Sections 2 - 4**. **Section 5** discusses the numerical results from the 2000 CAHPS survey focusing on plan type, degree of managed care and health status. **Sections 6 and 7** describe the results of the major body of the CAHPS survey.

Mentioned in the final pages of this CAHPS report is a short discussion of the uninsured population and the problems they experience. An analysis was conducted which found that individuals without health insurance rated experiences with overall health care, doctors, and specialists lower than those with insurance. The CAHPS 2001 report will expand on these findings and provide a more in-depth examination of the uninsured problem in Delaware.

Future CAHPS reports will also provide comparisons of Delaware results with other CAHPS surveys through the National CAHPS Benchmarking Database (NCBD). The NCBD will release its first *NCBD Annual Report* in the summer 2001 that focuses on key differences and similarities in CAHPS survey results. This report will be a useful resource for the Delaware CAHPS 2001 report.

2. CONTEXT

Managed Care and Quality

Managed care has evolved into the predominant form of health insurance coverage. Nationally, by 1999, only 8 percent of persons with employer-sponsored health insurance coverage had traditional FFS insurance.³ As later sections of this CAHPS report will describe, in Delaware, 91 percent reported to be enrolled in a managed care plan (either strict or loose) with only 9 percent enrolled in traditional FFS insurance plans.

Growth in the managed care industry has resulted from a multitude of factors including managed care's ability to provide services at lower costs than FFS care⁴. Under the earlier managed care model, costs were controlled through prepayment and restricted formularies for medications, both of which reduced utilization and cost. The lower insurance costs resulted in more employers providing only managed care coverage options for their employees. This led to employee complaints about restricted choice of providers and subsequently, the move toward the development of more looser networks of managed care such as point-of-service (POS) and preferred provider organizations (PPOs)⁵. The cost control measures inherent in the managed care model influenced support from policymakers and the business community alike. However, the degree of quality of health care services provided by managed care plans has been and continues to be a major point of contention among virtually all involved within the health care industry.

In the past, supporters of HMOs argued that prepayment for health care services would allow physicians to optimally allocate resources, would increase use of preventative services, and would increase the quality of care for acute and chronic conditions. Adherents to this philosophy believed continued use of FFS payment led to uncoordinated care⁶. More recently, with the onset of the managed care backlash, opponents of HMOs argue that the decreased costs of managed care services have adversely affected the quality of health care. While both rationales supporting or opposing either FFS or managed care's ability to improve quality are plausible, most studies, in balance, show little differences in quality between managed care and FFS health insurance plans.

For example, the Institute of Medicine (IOM) National Roundtable on Health Care Quality published a report in 1998 in the *Journal of the American Medical Association (JAMA)* citing that:

“Serious and widespread quality problems exist throughout American medicine. These problems....occur in small and large communities alike, in all parts of the country, and with approximately equal frequency in managed care and fee-for-service systems of care...Quality of care is the problem, not managed care.”⁷

The National Roundtable Report further emphasizes that even if strategies encouraging quality improvement are developed, “there are no clear models of exemplary delivery systems to emulate.”⁸ Hospitals, health plans, physicians, or other health care institutions do not have a standard blueprint for solving the multitude of quality improvement problems.

IOM has released a series of other reports focusing on improving quality of health care services. In IOM’s 2000 report the U.S. health care system was described as a “tangled and highly fragmented web”.⁹ The report stated that key to untangling and unifying the health care system is a nationwide effort to build a technology infrastructure that would eliminate most handwritten clinical data and would implement an automated medication order system, among other recommendations. The purpose of greater use of information technology is to avoid (or reduce) medical error that, as IOM identifies, could enhance overall quality of care. The 2001 IOM report again focused on quality issues, this time explaining why care for chronic conditions should be improved¹⁰. IOM points out that chronic conditions are the leading cause of illness in the United States and consume a substantial portion of health care resources because of the longevity of chronic conditions. IOM recommends a more multidisciplinary team approach to treating chronic conditions. This could improve quality and decrease costs for patients.

The common theme found throughout much of the IOM reports is the emphasis on quality improvement of the nation’s health care system. What should not be overlooked is that millions of Americans do receive high-quality health care from competent physicians, nurses, and other health care practitioners who are committed to patient care. However, for the health policymaker, recognition of problem areas in the delivery of quality health care services is both timely and valuable to the ongoing health care reform debate.

The debate over managed care and quality is further compounded by the resurgence in health care spending. In the 1990s, managed care contained costs largely through price discounts from physicians and other health care providers. With the onset of the 21st century, pressures outside the health care industry have, once again, begun to drive up health care spending. These

pressures include the availability of new technology, pharmaceutical expenditures, trends in the aging of the U.S. population, and increases in national prosperity¹¹. New and existing technology will account for two-thirds of the annual increases in health care spending while pharmaceutical expenditures will increase at a rate of 14 to 17 percent each year. The proportion of the U.S. population aged 65 and older will increase 33 percent between 2000 and 2020, and increased national prosperity may lead more people to increase spending on health care because they can afford to do so¹². Should the policy debate return to focusing on health care financing, efforts to improve quality of care may be postponed.

Growth of Consumerization

A significant trend that has developed from the debates over managed care and costs is the consumerization of the health care market. Consumers have started to pay for more out of pocket health care expenses, causing them to become more active in shaping their health care experiences¹³. Two trends measure these experiences. One is Americans' satisfaction with their own medical care; the other is the degree of confidence in their ability to pay for a major illness. In 2001, the Harvard School of Public Health released a study stating that from 1978-2000, 80 percent of Americans have reported that they are satisfied with their last visit to a physician¹⁴. The same study also indicates that the proportion reporting confidence in their ability to pay for a major illness has risen from 50 percent in 1978 to 67 percent in 2000¹⁵.

With respect to managed care experiences, the proportion of Americans who believe that growth of managed care is unfavorable increased from 28 percent in 1995 to 52 percent in 2000. This statistic is interesting with respect to how Americans view their health care experiences. Although most Americans are enrolled in managed care plans, the proportion of those who rate the managed care industry as doing "a good job" in serving their customers is only 29 percent. Of job various industries such as banks, hospitals, drug companies and others, managed care was rated just above tobacco companies¹⁶. These conflicting views the public holds on health policy issues make improvement efforts of the health care system more complex for policymakers.

Other key factors that have shaped the role of consumerization include media coverage and the growth of the Internet. Both of these informational sources have the potential to influence health care decisions especially as they relate to quality. The problem is the growing concern over the reliability of information found on the Internet as well as the media's role in scrutinizing the managed care industry.

Role of Consumer Satisfaction Surveys

The increased role of the consumer in the health care market highlights the importance of obtaining valid and reliable information about their experiences. Herein lies the importance of consumer satisfaction surveys such as CAHPS. Consumer satisfaction surveys are meaningful tools for gauging the quality of health care. Information from the CAHPS surveys helps facilitate a better understanding of consumers' health care information needs, helps develop an educated consumer, and places policymakers in a better position to develop laws to protect consumer interests.

Many state and federal legislators have responded to consumer surveys about the quality of managed care by passing legislation concerning benefits packages, use of emergency room services, and the physician-patient relationship¹⁷. In July 2000, Delaware enacted legislation establishing procedures for external reviews of health plan decisions (Senate Bill 299). Delaware also enacted legislation requiring a health plan's medical doctor to be a Delaware licensed physician, and enacted a series of mandated benefit bills. At the federal level, Congress has considered legislation proposed as the Patient Protection Act¹⁸, but various parts of this legislation involving the liability of health plans are currently undergoing substantial review.

Outside the policymaking process, consumer surveys provide information to consumers on the quality of health plans, rather than focusing solely on the price of health care services. This helps to better educate the consumer when making health care choices for either themselves or their families. Likewise, employers and purchasing coalitions have used quality data to achieve their objectives of reducing costs, improving access to health care and improving quality.

The multiple uses of quality data by policymakers, consumers, and employers emphasize the urgency of continuing to expand efforts at obtaining and assessing information from consumers on their health care related experiences. As will be seen in the next section, the CAHPS methodology offers one method that continues to provide relevant and reliable health care information.

3. PROJECT SCOPE AND METHODOLOGY

The CAHPS user group has expanded into a major source of consumer information in the United States. Utilization of CAHPS has rapidly grown from four early users and three demonstration sites in 1997 to an active network of CAHPS users in 48 states. The user group includes the largest federal health care purchasers (Centers for Medicare and Medicaid Services (CMS), formerly known as the Health Care Finance Administration (HCFA); Office of Personnel Management (OPM); and the Department of Defense (DOD)). The user group also includes Medicaid agencies, state employee benefits offices, purchasing coalitions, and private employers among others¹⁹. In Delaware, CAHPS was first introduced in 1996 and has since been used on a statewide basis for Medicaid, Medicare, and commercial populations.

Research for the Delaware CAHPS is conducted for the Delaware Health Care Commission through two research centers at the University of Delaware's College of Human Services, Education and Public Policy (CHEP). These two centers are the Institute for Public Administration (IPA) and the Center for Applied Demography and Survey Research (CADSR). The Commission, in conjunction with the IPA and CADSR, developed the following list of topics to be included in the CAHPS survey design:

- 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 experiences
- Utilization
- Health insurance plan
- Health insurance status (variable added for the 2001 CAHPS report)
- Health status
- Demographic Information

The survey topics and questions were guided by research showing what health consumers want to know, prior work conducted by CHEP, and a set of standard questions provided by the national CAHPS Survey.

Important to note about the CAHPS survey design is its ability to measure consumers' *first hand* experiences with health care and their health care plans. In doing so, the CAHPS study progresses from subjective, attitudinal measurements often used in health policy surveys.

Consumer responses to these public opinion surveys are often based on information heard from media sources, rather than actual experiences. An example of an attitudinal question format might state, “Do you think managed care will improve the quality of care people receive?” The CAHPS format deviates positively from the subjective style by asking, “In the last twelve months, how often did doctors or other health professionals spend enough time with you?” Emphasis on consumer experiences moves the CAHPS survey of health care quality assessment to a higher analytical level.

Other commonly encountered problems of health care surveys that the CAHPS methodology addresses are diverse interpretation of survey items, memory decay, survey comparability and timeliness, inconsistent or atypical experiences, and respondent burden. These technical survey design issues are described in the next paragraph. 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.

4. CAHPS AND ACCREDITATION

The CAHPS survey measures quality assessment. As such, CAHPS is increasingly utilized by accrediting organizations such as the National Committee on Quality Assurance (NCQA). NCQA is one of the top accreditors and reviewers of managed care plans. NCQA began accrediting managed care organizations (MCOs) in 1991, in response to the need for standardized, objective information about the quality of these organizations. On a largely volunteer basis, managed care plans seeking accreditation approach NCQA for performance assessment. Through a rigorous and comprehensive evaluation process NCQA assesses the quality of the key systems and processes that make up a health plan. Accreditation also includes an assessment of care and service plans delivered in important areas such as immunization rates, mammography rates and member satisfaction. In Delaware, Blue Cross/Blue Shield completed affiliation with CareFirst, Inc. in 1999 and is one such organization accredited by NCQA.

In 2000, NCQA scored accreditation by using two tools: the Health Plan Employer Data and Information Set (HEDIS) and CAHPS 2.0H. HEDIS is the performance measurement tool of choice for more than 90 percent of the nation's managed care organizations. HEDIS helps health plans and other providers collect health care data using a set of standardized performance measures so purchasers and others can reliably compare plan performance²⁰. It incorporates indicators that cover quality of care, access and satisfaction, and finances and management. The most recent version of HEDIS replaces its Member Satisfaction Survey with the standardized CAHPS 2.0 survey (renamed CAHPS 2.0H. The "H" designates the HEDIS version). This movement toward including CAHPS with HEDIS provides comparable member satisfaction information from health plans across the country. Accreditation scoring with CAHPS 2.0H is based on survey results and national benchmark and threshold data. This benchmark data will allow for more comprehensive analysis of Delaware CAHPS data in future years.

CAHPS continues to move in the direction of providing comparisons of CAHPS survey results through the National CAHPS Benchmarking Database (NCBD). The NCBD facilitates sponsor comparisons of CAHPS survey results to support quality measurement and improvement. It also provides access to CAHPS data to support health policy research. The NCBD released the first *NCBD Annual Report*²¹ in the fall of 2001. The report will focus on key differences and similarities in CAHPS survey results. In addition, the NCBD resources will be used by the Agency for Healthcare Research and Quality in developing the National Health Care Quality Report, which will

be sent to Congress in Summer 2003. These and other efforts on the part of the NCBD will be useful resources for future comparisons and understandings of the Delaware CAHPS survey results.

5. DELAWARE INSURANCE ENROLLMENT BY PLAN TYPE, DEGREE OF MANAGED CARE AND HEALTH STATUS:

The 2000 Delaware CAHPS survey results are detailed in this section of the report. Survey data was collected over the course of twelve months (January 2000 through December 2000) with 150 surveys completed each month. The 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 (see section 5A). This data will allow for future analysis and comparisons between insured and uninsured individuals in Delaware.

The survey asked adults (age 18 and above) about their experiences with their health plan and medical care during the previous twelve months. While the 1999 CAHPS study was largely based on a comparison between plan types (FFS vs. managed care), the 2000 CAHPS study focuses more on a classification approach based on the degree of managed care ("strict" vs. "loose"). Differences by key demographic variables including age, health status and county of residence are also analyzed.

Other factors discussed in the report include global ratings of health plans, quality of care, personal physician, and specialist (responses to these factors were based on a 0 - 10 scale, with 0 considered lowest and 10 considered highest). 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. In addition, the survey asked about people's experiences with their health plan's customer service and information provided by the health plan.

Plan Type

The 2000 CAHPS data indicates that 67 percent of respondents received their coverage through a managed care plan (HMOs, PPOs, or POS) and 33 percent were enrolled in FFS. However, this result was based on a simple dichotomy of plan types: managed care and FFS. The dichotomy of plan types is very useful for the purpose of analysis and has been a major basis of previous CAHPS projects. However, this approach ignores the possibility that some respondents may not be able to capture the nuances between FFS and other more flexible managed care plans. (Based on a series of questions asking about characteristics of respondents' health plans, as we describe in the next section, our estimate of managed care enrollment increases to 91 percent.)

The journal *Health Affairs* published a report indicating that consumers may not understand key concepts of managed care and that this lack of understanding applies to their own health plan. The study found that consumers often over report plan restrictions on access and choice. This finding is valuable because people's perceptions of plan restrictions may be more important than plan characteristics in influencing their assessments of care²². The Center for Studying Health System Change (HSC) produced a similar report suggesting that caution should be exercised when making comparisons between people in different plan types, if self-reporting of plan types is used²³. HSC's research recommends that policymakers should recognize the low ratings of managed care given by consumers might not present the most accurate picture to make comparisons between managed care and other plan types.

To avoid some of the issues related to self-reporting of plan type, the 1999 Delaware CAHPS study began to incorporate another classification that includes traditional FFS, strict managed care, and loose managed care. The 2000 CAHPS project continues to apply this methodology by examining all respondents' assessment by plan type and degree of managed care.

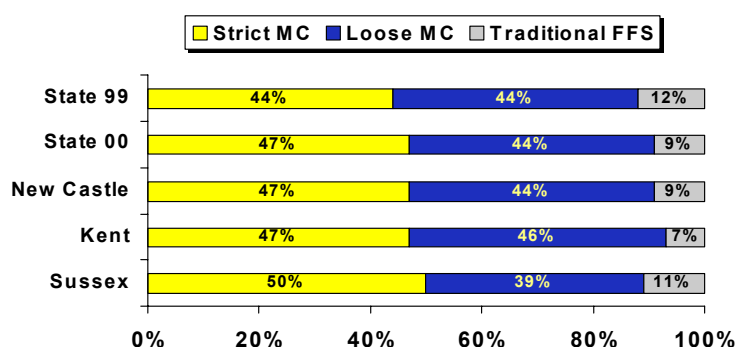
Degree of Managed Care

Managed care can be classified as either strict or loose. The classification is determined through a set of questions on the CAHPS survey asking respondents about their health plan requirements. For example, 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 places them in the strict category. Loose managed care is defined by "yes" responses to some but not all

questions and no “yes” responses places the plan in the traditional FFS category. This 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.

Based on this approach, the 2000 CAHPS data indicates that 91 percent of respondents were enrolled in plans featuring some degree of managed care, while 9 percent were enrolled in traditional FFS plans (see **Figure 1**). Compared to 1999, total managed care enrollment increased by 3 percent. By classification, strict managed care enrollees currently account for 47 percent of the total managed care enrollment. Not only is this a jump from 44 percent in 1999, but also strict managed care enrollees currently constitute the larger proportion of total managed care enrollees since 1998. Loose managed care enrollees remained unchanged at 44 percent. The share of traditional FFS enrollees shrank from 12 percent in 1999 to 9 percent in 2000.

Figure 1: “Strict” vs. “Loose” Managed Care Coverage by County (2000)



Note: Differences by county are not statistically significant.

Source: 2000 CAHPS Survey

At the county level, New Castle County residents reported 47 percent enrollment in strict managed care programs and only 9 percent in traditional FFS programs. Kent County has the percentage of strict managed care enrollees at 46 percent but the least enrolled in traditional programs with 7 percent. Sussex County has the highest percentage of strict managed care enrollees at 50 percent and 11 percent in traditional FFS plans.

Overall, the Delaware CAHPS results are similar to national trends. In the United States, by 1999, only 8 percent of persons with employee-sponsored health insurance had traditional FFS with total

managed care enrollment in at 92 percent. Nationally HMOs account for 29 percent of the total managed care population, PPOs 41 percent of the total managed care population, and POS with 22 percent of the total managed care population.²⁴

Concomitant to the shrinking of traditional FFS enrollment is the fact that Delawareans are generally less satisfied with their health plans than they were last year (see detailed discussion in Section 6). In terms of differences by the degree of managed care, our data reveals that traditional FFS enrollees report highest satisfaction with their health plans, while strict managed care enrollees give the lowest rating of their health plans. The rating difference is statistically significant. In terms of overall ratings of health care, our data do not reveal a statistically significant difference among the ratings of different degrees of managed care.

Health Status

Coverage by self-reported health status was analyzed to help understand the state's health insurance market. 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" (65 percent), "good" (27 percent), and "fair/poor" (8 percent). The numbers in parentheses give the percentage of respondents in each health status category.

Uninsured Analysis

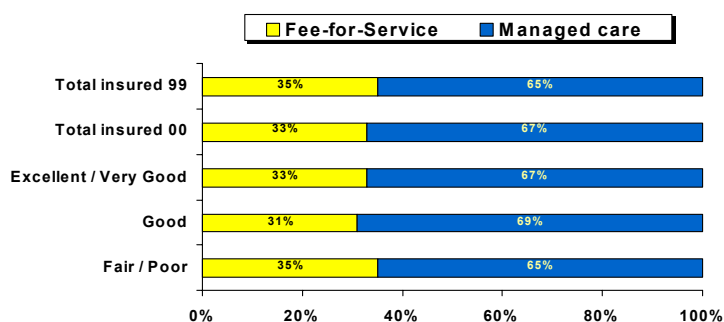
The 2000 CAHPS data was used in a general linear model (regression with dummy independent variables) to begin analyzing the uninsured population. For this analysis, dependent variables included global ratings of health care, doctors and specialists. Independent variables included county, gender, age, education, health status, and insurance status.

The results indicated that those without health insurance rate their overall health care, doctors, and specialists lower than those with health insurance (ratings of health care were .81 lower; ratings of doctors were .29 lower; and ratings of specialists were 1.1 lower). Overall health care ratings for the uninsured were almost a full point lower than the insured responses, probably because the uninsured face more adverse experiences with the health care system such as declined accessibility to needed services covering the full continuum of care. The uninsured often have a more difficult time finding a physician willing to provide medical services or referrals,

although recent implementation of Delaware's Community Access Program, which matches uninsured people with more than 100 doctors and health care providers, may increase the ratings of doctors by the uninsured population²⁵. Ratings of specialists by those without health insurance were just over a full point lower than responses by the insured population to the same aspect of their health care experience. Considering many uninsured have problems finding a physician, it is not surprising that they have even more difficulty finding a specialist who will provide physician recommended medical care.

Understanding the uninsured in Delaware is no easy task since the population is as complex as it is diverse. However, how to better help the uninsured and lessen the financial burden on hospitals or other health care institutions providing uncompensated care to the uninsured is an important policy question. Future CAHPS reports will further address these concerns by building off the CAHPS 2000 model and its results.

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



Enrollment differences by health status are not statistically significant.
Health status distribution: 65% Ex/VG, 27% Good, 8% Fair/Poor.

Source: 2000CAHPS Survey

According to the 2000 CAHPS data displayed in **Figure 2**, among the non-elderly, 67 percent of the healthiest respondents (in “excellent” or “very good” health status) are enrolled in managed care plans. Managed care plans also report 69 percent of the respondents in “good” health status and 65 percent of the respondents in worst health (in “fair” or “poor” health status). The differences by health status are small and not statistically significant. This information may indicate that risk

selection, by which some managed care plans are accused of picking the healthier enrollees and dumping the sicker ones, is not the case in Delaware.

6. OVERALL RATINGS BY PEOPLE WHO WERE SURVEYED

The Delaware CAHPS report discusses the consumer's ratings of their health plan, quality of care, personal doctors, and specialist. Ratings are based on a 0 – 10 scale, with 0 being the lowest and 10 being the highest. 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 administration. We examined differences in global ratings by plan type and degree of managed care. We also measured the differences by key demographic variables including age, health status, and county of residence.

Elderly vs. Non-Elderly

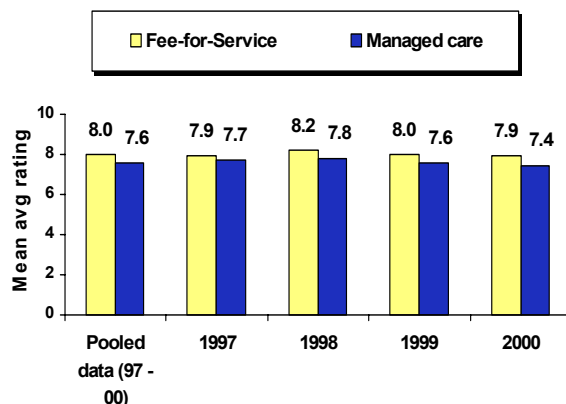
Delaware's elderly population (age 65 and above) report greater overall satisfaction levels than do the non-elderly population (age 18 - 64). For each of the four global measures (health plan, quality of care, personal doctors, and specialists), elderly ratings are greater than non-elderly ratings by a statistically significant margin. In the following analysis, however, 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. The reporting decision follows the format used throughout the United States for the commercially insured and Medicaid populations.

Quality of Health Plans

A year-by-year comparison of health plans was conducted for the 2000 CAHPS survey. The Analysis of Variance (ANOVA) by year and plan type indicates that in the past four years, respondents in FFS plans have continually given higher ratings of their health insurance than those who are in managed care plans. The rating differences range from 0 to 0.3 on a 0–10 scale. Differences by year and plan type are statistically significant. **Figure 3 A** also shows that the

overall rating of health plans has been decreasing since 1998, corresponding to the overall trend of the growing market share of managed care.

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



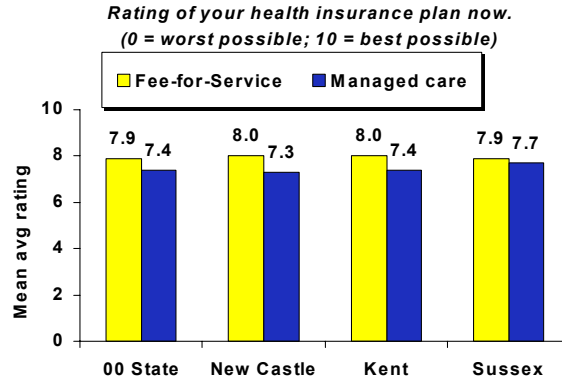
Note: There are statistically significant differences by year and by plan type (at .05 level).

Source: 2000 CAHPS Survey

The decreased rating of health plans from 1999 to 2000 is further emphasized in **Figure 3 B-3 C**. These figures examine differences by county, health status and plan type. FFS ratings decreased from 8.0 to 7.9, and managed care ratings decreased from 7.6 to 7.4. Considering that about 91 percent of Delawareans are now enrolled in some form of a managed care plan, it is not surprising that for all respondents, overall satisfaction ratings of health plans decreased from 7.8 in 1999 to 7.6 in 2000.

The 2000 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. Last year New Castle County respondents gave lower ratings in both plan types than respondents in the other two counties. This year, New Castle County respondents gave the lowest rating (7.3) for managed care while Sussex County respondents gave the lowest rating (7.9) for FFS. Overall, we found that rating differences are statistically significant by plan type, but not by county (see **Figure 3 B**).

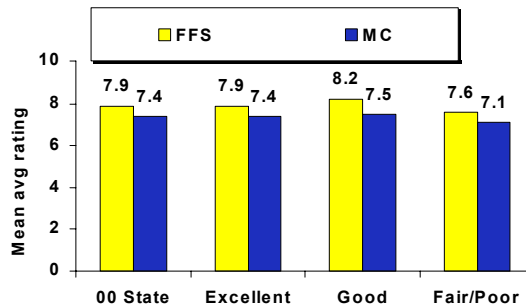
Figure 3 B: Overall Quality of Health Insurance by County and Plan Type, Age 18-64



Note: Differences by plan type are statistically significant (at .05 level); differences by county are not.

Source: 2000 CAHPS Survey

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



Note: Differences by plan type are statistically significant (at .05 level), differences by health status are not.

Source: 2000 CAHPS Survey

Although people in the poorest health tend to give the lowest ratings, the 2000 CAHPS survey did not show a direct correlation between health status and plan ratings (see **Figure 3 C**). Future Delaware CAHPS studies may report otherwise. The Harvard Medical School analyzed responses from the Washington State demonstration of CAHPS, which asked employees to rate 20 different health plans.

The findings suggest that effects of differences between health plan ratings between sicker and healthier patients may be large enough to consider presenting plan ratings separately by subgroups of patients. While these findings are important, further analysis applied in larger implementations of CAHPS is needed to study the effects more precisely. Researchers will be particularly interested in those sub-group differences in light of the recent Kaiser Permanente settlement (*Metzler v. Kaiser Foundation Health Plan Inc.*)²⁶. Under the settlement Kaiser, one of the oldest and largest health maintenance organizations, will make its hospitals, clinics, and procedures more accessible to patients with mobility disabilities. The settlement could significantly influence other HMOs and likewise impact patient ratings of their health plan.

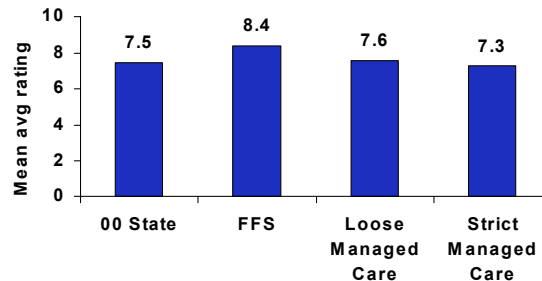
As we mentioned earlier, degree of managed care has been used as an important variable to examine the differences in rating of health plans and health care. According to the data in **Figure 3 D**, respondents in loose managed care programs are more satisfied with their health plans than those in strict managed care programs. Not surprisingly, respondents enrolled in FFS programs appeared to be most satisfied with their health plans. This is also compatible with the analysis results based on plan types (managed care vs. FFS).

Quality of Health Care

Results of the year-by-year comparison of health care ratings are similar to that of health plans. Generally, respondents in FFS programs have been more satisfied in the past three years with the health care they received than those who are in managed care programs. Difference by plan type is statistically significant. The overall rating of health care increased from 1997 to 1998 but has been decreasing in years thereafter (see **Figure 4 A**).

As presented in **Figure 4 B**, Delawareans report that they are slightly less satisfied with their health care in 2000 than in 1999. FFS plan members indicated the same rating of 8.4 as in 1999. Managed care members rated their care 8.1, down from 8.2 in 1999. Differences are statistically significant by plan type (FFS>MC), but not by county. As can be seen in **Figure 4 C**, respondents

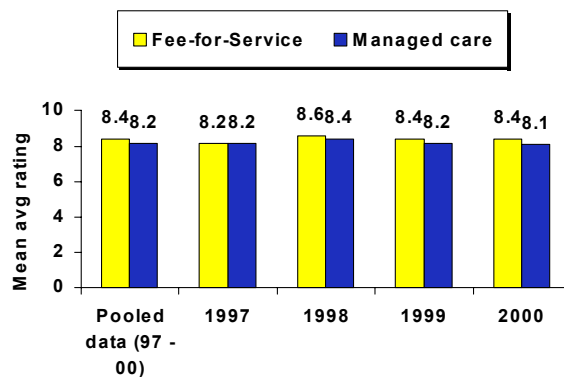
**Figure 3 D: Overall Quality of Health Insurance
by Degree of Managed Care, Age 18-64**



Note: Differences by degree of managed care are statistically significant (at .05 level).

Source: 2000 CAHPS Survey

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

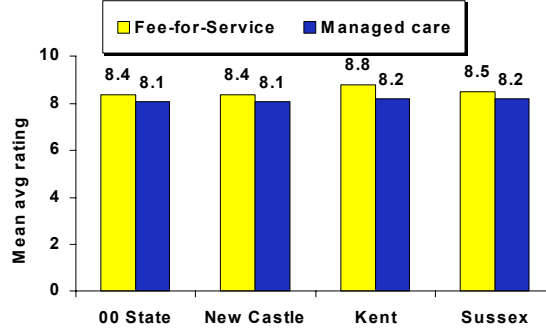


Note: There are statistically significant differences by year and by plan type (at .05 level).

Source: 2000 CAHPS Survey

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

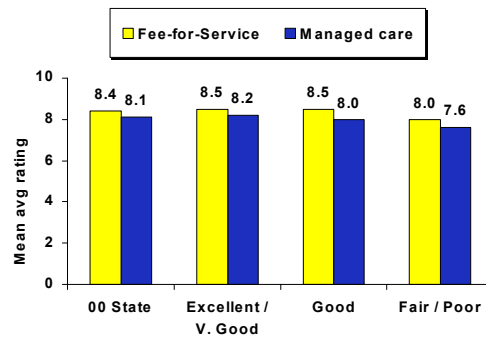
Rating of the care you've received from all doctors and other health care professionals in the last twelve months.



Note: Differences by plan type are statistically significant (at .05 level); differences by county are not.

Source: 2000 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 (at .05 level).

Source: 2000 CAHPS Survey

in poorer health reported less satisfaction (8.0 for FFS and 7.6 for managed care) with their health care than those in excellent/good health (8.5 for FFS and 8.2 for managed care). As we have seen - and will see - rating differences by health status may not be statistically significant for all global measures or for all specific aspects of health care services. However, according to the CAHPS results, healthier respondents tend to give higher ratings than those in poorer health. The national CAHPS development team discovered similar findings when they tested its 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.

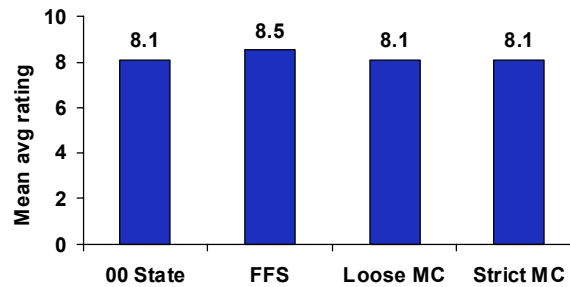
Rating differences by the degree of managed care are statistically significant, with respondents in loose managed care giving higher ratings of health care than those in strict managed care (see **Figure 4 D**).

Quality of Doctors and Specialists

The 2000 CAHPS survey asked respondents to give overall ratings of their personal physician and their specialists. As seen in **Figure 5**, the results indicate that statistically significant differences exist by plan type in the ratings of doctors and specialists. Managed care participants rate their personal doctor lower than those in FFS plans (8.2 vs. 8.7). This difference could be due to actual quality differences in doctors 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 show no statistically significant differences by either county or health status.

To learn more about physician quality, we asked respondents to give 0 - 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 doctors – 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 such as joint replacement procedures and cardiac surgery.

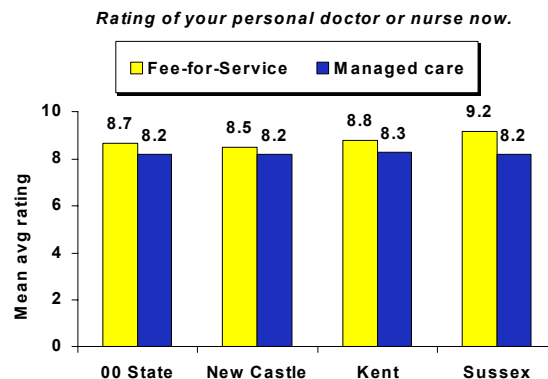
Figure 4 D: Overall Quality of Health Care by Degree of Managed Care, Age 18-64



Note: Differences by degree of managed care are statistically significant (at .05 level).

Source: 2000 CAHPS Survey

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

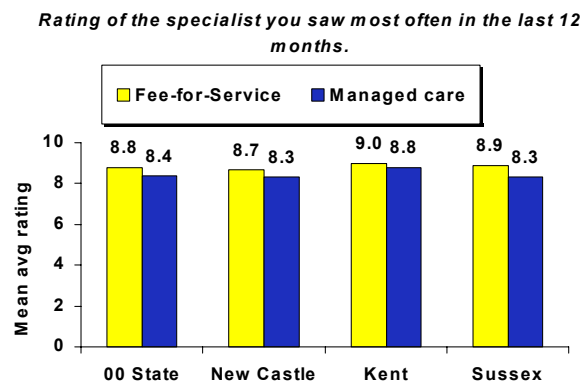


Note: Differences by plan type are statistically significant (at .05 level); differences by county are not.

Source: 2000 CAHPS Survey

Figure 6 shows that overall ratings are higher for specialists than for personal doctors. The CAHPS data showed that statistically significant differences exist by plan type and not by county. This data also indicates that specialists seen by FFS enrollees received an average rating of 8.8 versus 8.4 for those seen by managed care enrollees. When asked to rate their specialists, respondents who report themselves in “fair/poor” health gave a rating score of 8.4 for FFS and 7.8 for managed care. Those in either “good” health or “very good/ excellent” gave rating scores of 8.6 for FFS and 8.5 for managed care and 9.0 for FFS and 8.5 for managed care, respectively. Differences by health status are 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 individuals in worse health could suffer from chronic conditions. This may lead to greater respondent dissatisfaction with their doctors and specialists. Overall though, Delawareans responded favorably to their personal doctors and specialists.

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



Note: Differences by plan type are statistically significant (at .05 level) ; differences by county are not.

Source: 2000 CAHPS Survey

Results of our analysis for overall quality are summarized in the following table (see **Table 1**). The first column shows the survey item (question). For example, there is a statistically significant difference for quality of health plan by degree of managed care and plan type, but not by county and health status. “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. The corresponding bar charts shown in **Figures 3-6** provide more detailed results.

**Table 1: Delaware CAHPS
Summary of Global Ratings*
2000 Data for Respondents Age 18-64**

Overall Rating of:	Statistically Significant by:			
	Degree of managed care (strict, loose, traditional fee for service)	Plan Type (Fee-for-service and managed care)	County (New Castle, Kent, Sussex)	Health Status (Excellent, Good, Fair/Poor)
Quality of Health Plan	Yes (T>L>S)	Yes (FFS>MC)	No	No
Quality of Health Care	No	Yes (FFS>MC)	No	Yes (E>G>F/P)
Personal Doctor	Yes (T>L>S)	Yes FFS>MC	No	No
Specialists Seen	Yes (T>L>S)	Yes (FFS>MC)	No	Yes (E>G>F/P)

Note: Changes in data results between 1999 and 2000 are in **bold (blue)**.

7. WHAT NON-ELDERLY RESPONDENTS SAID ABOUT SPECIFIC TOPICS

The 2000 Delaware CAHPS survey includes a series of 16 questions targeting specific aspects of people's health care experiences. Respondents were asked about their experiences in:

- Getting the care they need;
- Getting care quickly;

and experiences with:

- How well their doctors communicate;
- The physician's office staff;
- Their health plan administration

Sixteen questions are grouped into these five categories to present a clearer picture of the different aspects of health care that affect residents in the State of Delaware.

For a majority of the items, Delawareans seem largely satisfied with 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 Quality Management Advisory Service has made substantial progress in building a database of comparative CAHPS information.) Last year we labeled an item "problematic" if it is flagged by more than 20 percent of the respondents. Based on this criterion, we found two "problematic" areas in 1999 but no item appears "problematic" in 2000. If we use a more rigorous standard of 15 percent as a threshold, the following four items appear to be relatively "problematic":

- They received the help they needed when they called customer service (19 percent);
- They waited more than 15 minutes past their appointment time (17 percent);
- They had problems filling out paper work (16 percent);
- Doctors spent enough time with them (16 percent)

Keep in mind that the first two items are also the only two "problematic" areas identified last year. These relatively "problematic" areas could be the focus of the collective efforts by policymakers, health plans, and health care providers.

Each of the 16 specific measures was tested for statistically significant differences by four respondent characteristics: degree of managed care, health plan type (FFS vs. managed care), county, and health status. Both degree of managed care and plan type make statistically significant differences for 14 out of the 16 items. County makes statistically significant differences for only two of the 16 items. These results are also compatible with our previous analyses where plan type and degree of managed care make statistically significant differences for all global ratings while county does not for any of them. Health status is a statistically significant factor for most of the categories except health plan administration.

The next section of the report presents a detailed category-by-category examination of the 16 specific measures of health care and health plans. **Table 2** summarizes our findings and shows where statistically significant differences are found by plan type, degree of managed care, county, and health status.

People's Experience in Getting the Care They Need

Table 2 shows the results for the three items in the “getting the care they need” category. Generally, respondents are very satisfied with their experiences in getting needed care. For all three items, there are less than 5 percent of the overall respondents reporting a big problem and more than 80 percent reporting no problem. Getting access to health care services is one of the key indicators measuring the whole health care system. Our analysis results show that Delaware is doing quite well in this respect. Plan type makes statistically significant differences for only one out of the three items (“had problems getting care or doctor when necessary”). When using degree of managed care as a variable, however, the results indicated that the stricter a health plan is, the more likely its enrollees are to report problems in getting access to health care. There is also a direct association between assessment and health status, with healthier respondents being more satisfied with those specific items. Differences by degree of managed care and health status are both statistically significant. County does not play a statistically significant role in assessment variations.

People’s Experience in Getting Care Quickly

Compared to the last year, more respondents (67 percent) reported that they never and sometimes had waited for more than 15 minutes past their appointment time, a huge jump from 27 percent in 1999. Among all five categories, however, the “getting care quickly” category has seen a relatively high percentage of respondents (14 to 17 percent) reporting negative assessment in each item (“never/sometimes” indicates negative assessment except in the case of “waited for more than 15 minutes past their appointment”). Though neither of these items will be identified as “problematic” areas according to last year’s criteria, the relatively higher percentage still indicates that more attention should be paid to this category as a whole. The data also show that plan type and degree of managed care make statistically significant differences for three out of the four items, respectively. The more flexible a managed care plan is, the more respondents tend to give a positive assessment.

People’s Experiences with How Well Their Doctors Communicate and Their Experiences with the Staff at the Doctor’s Office

Table 2 shows that Delawareans generally report few problems relating to how well their doctors communicate, with 84 percent to 91 percent of respondents reporting that they always or usually got treated well by doctors. Less than 10 percent of the respondents described problems with their physician not explaining things in a way that can be understood or not showing respect. 13 percent of respondents reported problems with their doctors not listening carefully. 16 percent of respondents reported problems with doctors not spending enough time with them. For all four specific measures, the data show statistically significant differences by health status and degree of managed care, with healthier enrollees and enrollees in looser managed care tending to report less or no problem. Plan type makes statistically significant differences for all items except “spent enough time with them”. Once again, county makes no statistically significant differences for any of the four items.

Table 2: People's Experience with Specific Aspects of Health Care Services
(Percentage of Respondents)

	Big problem	Small problem	Not a problem
Getting the care they need			
Had difficulty getting a referral to a specialist (#+)	5%	9%	86%
Had problems getting care or doctor when necessary (*#+)	3%	10%	87%
Experienced delays in health care while waiting for approval from their health plan (#+)	4%	10%	86%
Health plan administration			
Found or understood information in the written materials (*+)	12%	28%	60%
Received the help they needed when they called customer service	19%	27%	54%
Had problems filling out paper work (*+)	16%	31%	53%
	Never/Sometimes	Usually	Always
Getting care quickly			
Received advice needed when calling during regular office hours (*#+)	14%	26%	60%
Got routine appointments as soon as they wanted (*+)	14%	33%	53%
Were able to get care as soon as they wanted (*+)	14%	16%	70%
Waited more than 15 minutes past their appointment time (*#)	67%	16%	17%
Doctor's communication			
Listened carefully (*#+)	13%	25%	62%
Explained things in a way they could understand (*#+)	8%	25%	67%
Showed respect for what they had to say (*#+)	9%	26%	65%
Spent enough time with them (#+)	16%	31%	53%
Courtesy of office staff			
Treated them with courtesy and respect (*^#+)	8%	21%	71%
Were as helpful as they thought the staff should be (*^#+)	12%	29%	59%

Significant differences by: (*)=Health Plan, (^)=county,
(#)=Health Status, and (+)="Degree of Managed Care"

When asked about their experiences with the doctors' office staff, respondents also gave a very positive assessment. For both items, more than 88 percent of the state's respondents reported overall positive experiences in being treated by doctors' office staff. A distinct finding here is that assessment differences are statistically significant by all four variables (plan type, degree of managed care, health status, and county). In addition to the similar patterns of rating differences by plan type, degree of managed care, and health status seen in other categories, we found that this is the only category where county plays a statistically significant role. Sussex County residents seemed to be more satisfied with the doctors' office staff. When asked if they had been treated with courtesy and respect, 60 percent reported "always" and only 12 percent reported "never/sometimes", the corresponding percentages in New Castle County and Kent County are 55 percent, 21 percent and 46 percent, 20 percent. When asked if the staff were as helpful as they should be, 61 percent of Sussex County respondents reported "always" and only 14 percent reported "never/sometimes". 52 percent of New Castle County respondents and 47 percent of Kent County respondents reported "always". In both New Castle County and Kent County, 17 percent of respondents reported "never/sometimes".

People's Experience with Their Health Plan's Administration

This category contains two items measuring people's experiences with their health plan administration, including customer service and paperwork. More than 81 percent of respondents reported either no problem or a small problem in these two items, but we also found that more than 10 percent of respondents reported a big problem for each item in this category. Sixteen percent of respondents reported a big problem in filling out paperwork, while 19 percent of respondents--the highest percentage in all 16 items--reported a big problem when asked if they had received the help they needed when they called customer service. Compared to other categories, this category also has seen a relatively high percentage of respondents reporting a big problem and thus, deserves more attention and efforts for quality improvement. As has been seen, another category that has similarly high percentages of negative assessments is "getting care quickly". These CAHPS results suggest that more efforts could be directed to these two categories to improve the quality of health care services.

8. CONCLUSION

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. The increased attention over quality measurement is mostly due to conflict between 1) the changing enrollment trends toward managed care plans and away from traditional FFS plans; and 2) changing consumer attitudes toward managed care and FFS plans. While more individuals have enrolled in managed care plans, overall quality of care ratings for this plan type is decreasing. Quality is equally important to monitor since health care costs are increasing. The increased costs pose a vital policy question of how various cost containment strategies will affect the quality of care received by health care consumers. Hence the monitoring and the measuring of quality are at the heart of much debate over ways to reform the health care system. The President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry summarizes the importance of quality assessment by stating that, “

“A key element of improving health care quality is the Nation's ability to measure quality of care and provide easily understood, comparable information on the performance of the industry. Advances in quality measurement and reporting have enabled us to determine the flaws in the current system.”²⁷

The Advisory Commission goes on to emphasize the importance of ensuring that comparative information on health care quality is valid, reliable, comprehensive, and available to the public. CAHPS offers one approach to achieving that type of comparative information, especially considering the continued efforts on the part of the NCBDB to provide benchmark information.

Utilization of the CAHPS approach has increased dramatically since its inception in 1996. CAHPS is now used in various forms throughout 48 states, creating a network of evidence-based consumer satisfaction information. This is a huge change from 1997 in which there were only four users and three demonstration sites. 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.

Several key findings of the 2000 CAHPS study are:

- Ninety-one percent of Delaware's non-elderly--aged 18-64--population reported enrollment in a managed care plan (either "strict" or "loose"). Nine percent of Delawareans reported enrollment in traditional FFS plans. Since 1999, enrollment in strict managed care plans increased by 3 percent, while enrollment in FFS plans dropped by 3 percent.
- The overall ratings of health insurance were highest for "loose" managed care plans versus "strict" managed care plans.
- Differences in the overall quality of health care by degree of managed care were minor, but statistically significant. Fee-for-service health plans were rated the highest followed by loose managed care plans and strict managed care plans.
- Quality of plan ratings and quality of care ratings were lower among those people who report the lowest health status. The differences were not statistically significant.
- Eighty-six percent of Delawareans report that getting the care they needed was "not a problem".

The 2000 Delaware CAHPS report focuses on the experiences of individuals who have health insurance. This report would not be complete without mentioning the role of the uninsured in developing health care policy. Quality improvement, cost containment, and consumer protection are probably meaningless to the 42.6 million uninsured individuals living in the U.S. In 1999, Delaware's uninsured population was 109,000 (14 percent of the total population). Important to note is that a majority of Delaware's uninsured adults have remained uninsured for a significant amount of time (13 months or longer)²⁸. Nationally, these individuals are usually characterized as full-time employees--or are spouses or children of such workers, are over age 17 and are often of Hispanic origin.¹

The problem the uninsured face is that their chances of gaining access to needed medical care is greatly reduced. There is strong evidence of a relationship between insurance status and health outcomes. For example, uninsured individuals often experience more avoidable hospitalizations

¹ For Delaware, the 2000 Census data indicated that 37, 277 Hispanics currently reside throughout Delaware. This is approximately 4.8 percent of Delaware's total population. Of the total Hispanic population, slightly less than 24 percent are without health insurance coverage. While a significant number of Hispanics living in Delaware are uninsured, they do not comprise a large proportion of the overall number of uninsured.

and higher mortality rates than their insured counterparts because they are sicker upon admission or receive less trauma related care when hospitalized from the emergency room²⁹. Furthermore, when the uninsured are able to gain access to health care services, such as a primary care physician or specialist, they pay extensively more than insured individuals. A recent *New York Times* article reported that, if uninsured people seek care that is not emergency related, doctors and hospitals often insist on payment by requiring an advanced deposit³⁰. As a result, some uninsured people struggle for years to pay medical bills, or put off seeking medical care until minor problems become major. For policymakers, understanding the disparities in health care experiences of the uninsured population versus the insured could mean that addressing quality issues necessarily involves addressing access issues.

Future CAHPS reports will provide an analysis of the health care experiences faced by the uninsured population. This will assist state policymakers with identifying and better understanding the uninsured population in Delaware.

Endnotes

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²⁹ "No Health Insurance? It's Enough to Make You Sick," The American College of Physicians-American Society of Internal Medicine, Spring 2000, <http://www.acponline.org/uninsured/lack-fore.htm>

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