1998 Consumer Assessment of Health Plans in Delaware

prepared for
The Delaware Health Care Commission

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TABLE OF CONTENTS

LIST OF FIGURES

1. INTRODUCTION

For the last two 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 1998 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?

A key finding of the 1998 statewide consumer satisfaction survey indicates that Delawareans are more satisfied with their health plans than they were last year. Managed care continues to dominate Delaware's health care market with 74 percent of Delaware's non-elderly adults enrolled in some form of managed care plan, which represents a 5 percent increase from the 1997 survey results. The 1997 data showed no statistically significant difference in satisfaction between managed care and FFS enrollees. This year, however, 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. A study released by the Kaiser Family Foundation in September of 1998 showed that Americans are increasingly concerned about managed care. The Kaiser results indicated that 42 percent of those surveyed throughout the United States felt that HMOs are doing a "bad job" which demonstrates a sharp rise from 26 percent in September of 1997.[1]

This newly discovered gap between FFS and managed care ratings can be explained by four factors. First, people who remain in traditional FFS plans likely are 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. Second, our survey sample size (the "n") increased by more than 40 percent this year, thereby providing more statistical power to detect small statistically significant differences in our data. Third, the opinions expressed in the Kaiser survey might in fact accurately reflect deteriorating managed care quality. However, it is highly unlikely that in just one year managed care quality dropped as much as the Kaiser numbers suggest (a 16 point – or 62% increase – in the percent of Americans saying HMOs are doing a "bad job.") Finally, 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 two national health leaders in a 1998 *Journal of the American Medical Association* (JAMA) article:

> The demand for information on the quality of health care in the United States has been growing steadily over the past two decades…Increasing pressures for cost control and the spread of managed care throughout the country create an urgent, shared need for information on health care quality among all health care stakeholders: consumers, public and private purchasers, policymakers, health plans, and provider organizations (e.g., hospitals, physician groups and clinics).[2]

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."[3]

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. In 1997, HMO's throughout the United States collectively lost $768 million as compared to a $700 million profit in 1996. In the first 6 months of 1998, 57 percent of HMO's reported losses.[4] 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.[5] 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."[6]

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 second year of the CAHPS survey. Prior results can be found in the 1997 report *Consumer Assessment of Health Plans* 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.

Very importantly, the 1998 CAHPS report serves as a foundation for other Delaware Health Care Commission projects such as the Delaware Managed Care Consumer Protection Subcommittee which was created with House Resolution 87 (1998). The subcommittee mission is to combine efforts at the state and national level to determine what is known about quality of care measurement and the best way to use the information.[7] 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 will then examine the increasing usage of CAHPS by state governments. To fully understand the background and methodology of the CAHPS project, we strongly encourage the reader to take the time to read **Sections 2- 4**. Starting in **Section 5**, we present the numerical results from the 1998 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.

Due to the fact that Delaware has the distinction of being the first state in the country to use the CAHPS framework for a statewide survey of all residents, we have only very little comparative benchmark data. In

later sections of the report, we mention that national organizations, such as the Quality Measurement Advisory Service (QMAS) working in partnership with the Picker Institute, will be building benchmarking databases. We hope to expand future Delaware CAHPS studies by including more comparative analysis.

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 recently published the results of a national public opinion survey titled *Attitudes Toward Managed Care and Regulation*. Following will be a brief discussion of several key findings from this Kaiser survey. 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.

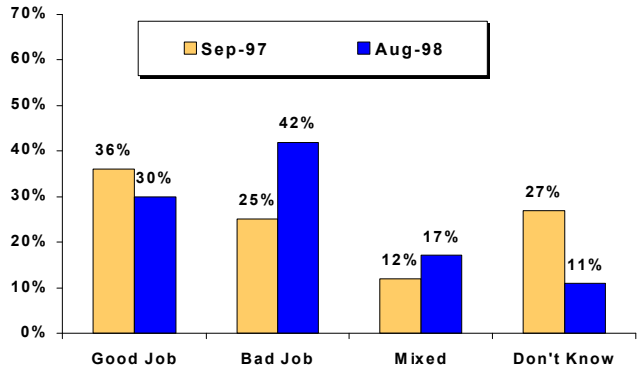
The Kaiser 1988 data indicate that 36 percent of Americans, up from 21 percent in September of 1997, feel that managed care companies are doing a bad job, as shown in **Figure 1**. The results also indicate that Americans have negative opinions on specific areas of managed care. For example, 56 percent believe that the system has "decreased the quality of health care for patients," up from 45 percent in 1997; 33 percent are "very worried" that their managed care plan is more interested in saving money than in providing them with the best treatment if they are sick, up from 18 percent just a year ago; and 64 percent feel their HMOs decrease the amount of time doctors spend with patients, up from 61 percent in 1987. Only 37 percent of Americans who reported managed care is doing a bad job based their views on their own experiences; most (53 percent) based their views on media coverage and reports from family and friends.[8]

As the later sections of this report will describe, the 1998 CAHPS data indicates several aspects of care for which managed care ratings fall below those for FFS plans. However, we discovered only a few statistically significant differences, and where we did find these differences, the gaps are not nearly as large as suggested by the Kaiser 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

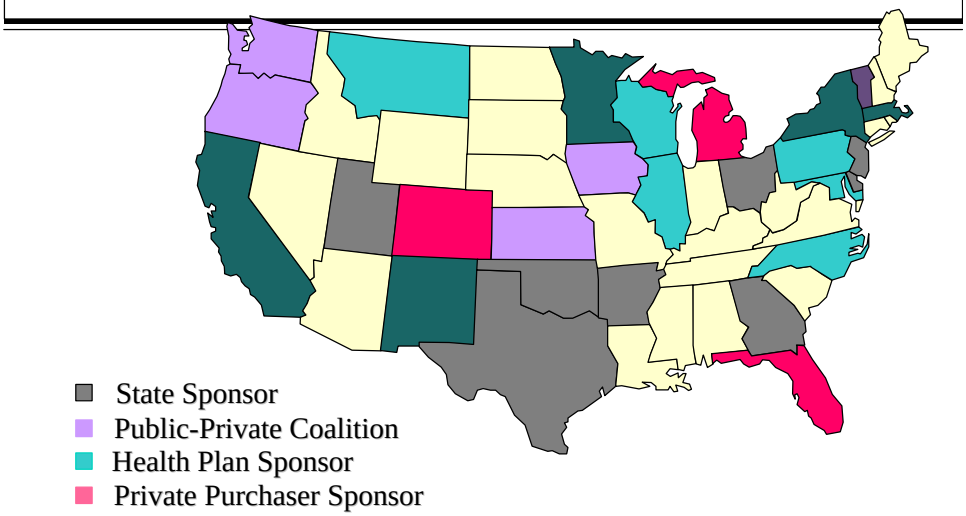
Quality of health care issues continues to make headlines and is the focus of several health care survey research studies. To a large extent, the public's opinions and attitudes on health care have been shaped by information collected through biased or poorly constructed surveys as well as from negative 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 that 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.[9]

Figure 1: More Americans Now Say HMOs are Doing a Bad Job



Source: Kaiser Family Foundation/Harvard Survey of Americans on the Consumer Protection Debate (September 1998)

Figure 2: CAHPS Sponsors



Source: National CAHPS Consortium (Fall 1998)

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.[10] 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."[11] 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.[12]

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.[13]

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 27 states. The sponsors for CAHPS projects vary from state to state; many projects are undertaken with a joint public/private sector agreement, as is shown in **Figure 2**.

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.[14]

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.[15]

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 1998 data was collected over the course of thirteen months (October 1997 through October 1998) with 150 surveys being completed each month. (The 1997 survey was conducted over 9 months at 150 surveys per month.) The 1998 sample size is sufficient for producing statewide and county level estimates. At the 95 percent confidence level, the sampling error is approximately +/- 2.2 percentage points statewide, +/- 2.7 percentage points for New Castle County, and +/- 5.4 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 (new for 1998)
- Evaluations of specific aspects of the consumers' health care experience (e.g., people's experience in getting the care they needed – several additions and modifications in 1998)
- Utilization
- Health insurance plan
- Health status
- Demographic information

These topics, among others, resulted in more than 60 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). For last year's survey, Delaware had the distinction of being the first state to use the CAHPS questions (CAHPS draft questionnaire) for a statewide survey intended to provide information about both public and private health plans. Because the "draft" version of the national questionnaire was used last year, there have been numerous and substantial changes in the Delaware questionnaire and consequently in the items reported in the 1998 report.

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 are 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 attempts to prevent "memory decay" problems by using relatively short time frames such as "six months" or "currently." This keeps survey results current and 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 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.[16] [17]

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.[18] 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 1998 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 six 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 ("light" vs. "heavy"). We also examined differences by key demographic variables including age, health status, and county of residence. The 1998 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 key finding of the 1998 statewide consumer satisfaction survey indicates that Delawareans are more 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 and county. In terms of overall ratings of health care, as mentioned earlier, our data reveals no statistically significant difference between managed care and FFS enrollees. The overall ratings of quality of care vary by age and health status by a statistically significant margin but not by plan type.

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 currently are enrolled in managed care plans. Based on our 1998 data, 74 percent of non-elderly adults receive their coverage through a managed care plan including HMOs, preferred provider organizations (PPOs), or point-of-service (POS) plans. This represents a 5 percent increase from the 1997 survey. This number is very close to the 75 percent national level reported in a 1997 study published in *Health Affairs*.[19] It is interesting to also note that based on this *Health Affairs* study, managed care enrollments among U.S. workers have risen to 73 percent in 1995, up from 51 percent in 1993. By county, managed care enrollment of the non-elderly has reached 76 percent in New Castle County, 75 percent in Kent County, and 65 percent in Sussex County, as seen in **Figure 3.** These differences are not large enough, however, to be statistically significant.

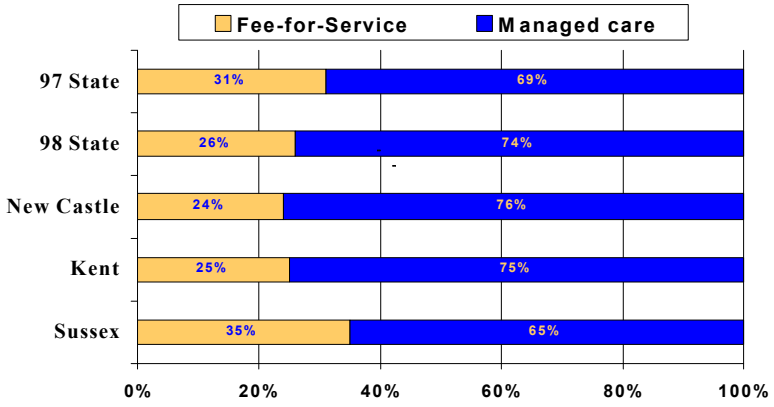
Degree of Managed Care

"Heavy" versus "light" 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 heavy category. Light managed care is defined by "yes" responses to some but not all questions and no "yes" responses puts the plan in the traditional category. As shown in **Figure 4**, Delaware's results are very similar to national averages with 37 percent of respondents enrolled in heavy managed care programs as compared to 35 percent nationally. National results also show that 14 percent of respondents are in traditional programs compared with 15 percent in Delaware. New Castle County residents report 48 percent enrollment in heavy managed care programs and only 14 percent in traditional programs. Kent County has the lowest percentage enrolled in heavy managed care at 29 percent but the most enrolled in traditional programs with 20 percent. Sussex County residents report 34 percent in heavy managed care and 15 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" (27.3 percent), and "fair/poor" (8.8 percent). The trailing numbers in parentheses give the percentage of respondents in each health status category.

The 1998 CAHPS data displayed in **Figure 5** reveals that managed care plans have a greater tendency to enroll "healthier clientele" than do traditional plans. Among the non-elderly, 75.6 percent of the healthiest

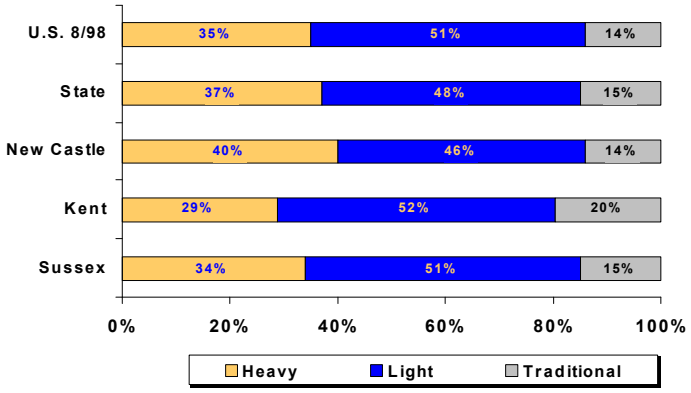
Figure 3: Health Plan Enrollment by County, Age 18-64



Note: Differences by county are statistically significant.

Source: 1998 CAHPS Survey

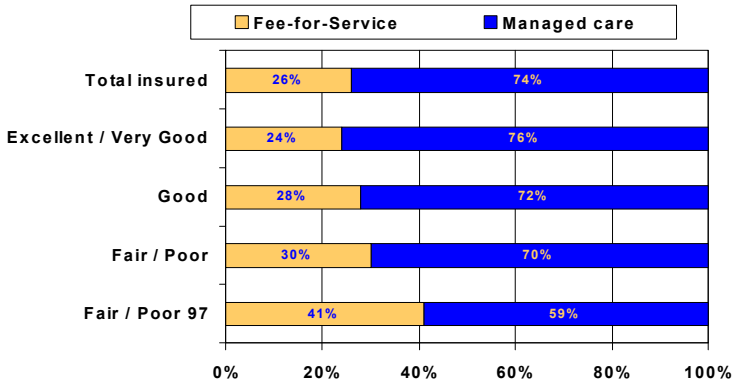
Figure 4: Heavy vs. Light Managed Care Coverage by County



Note: Differences by county are not statistically significant.

Source: 1998 CAHPS Survey

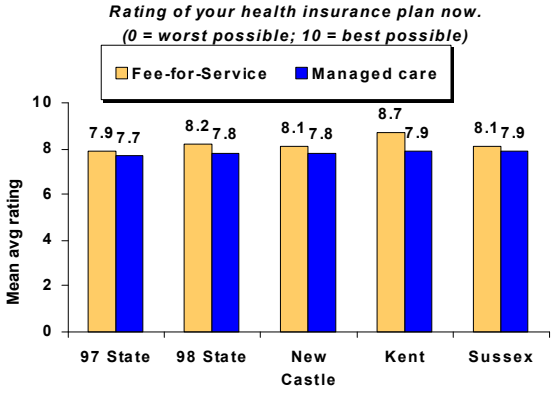
Figure 5: Health Plan Enrollment by Health Status, Age 18-64



Enrollment differences by health status *are not* statistically significant.
Health status distribution: 66% Ex/VG, 26% Good, 8% Fair/Poor.

Source: 1998 CAHPS Survey

Figure 6: 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*. Pooled data for 97+98 indicates significant differences by county and plan type.

Source: 1998 CAHPS Survey

respondents (those reporting “excellent” or “very good” health status) are enrolled in managed care plans compared to 69.9 percent of the non-elderly respondents in worst health (those reporting “fair” or “poor” health status). Our data, however, shows a substantial movement of enrollees in “fair/poor” health to managed care plans. Up from 59 percent last year, 70 percent of respondents in “fair” or “poor” health are now covered by managed care plans. Health policy analysts see this trend, which is similar to what has been found throughout the U.S., as one of several reasons why employers, consumers, and policymakers should anticipate larger rates of increase in managed care premiums. This trend also has given managed care companies increased incentives to seek more cost effective processes for treating chronic diseases such as diabetes.

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 six months. The 1998 questionnaire added two new overall rating questions for personal physicians and specialists seen. 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 8.6 compared to a 7.9 overall rating among those respondents 18 – 64 years of age. This higher level of satisfaction appears between health care ratings as well with elderly Delawareans reporting an average of 8.9 and non-elderly reporting satisfaction levels of 8.4.

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."[20] Third, national surveys consistently show that seniors tend to report higher levels of satisfaction with most government services, not just health programs.

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. (Effective January 1, 1999, many Delaware seniors lost their Medicare managed care plan options; in next year’s CAHPS study, we will look for resulting changes in satisfaction ratings.)

Quality of Health Plans

As seen in **Figure 6**, Delaware respondents reported an increase in overall satisfaction with their health plans in the 1998. FFS ratings increased from 7.9 to 8.2, and managed care ratings increased from 7.7 to 7.8. Keeping in mind the fact that close to 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 increased from 7.8 in 1997 to 7.9 in 1998. This one-tenth of a point increase proves to be only “marginally” statistically

significant at a 90 percent confidence level. (Our general criterion for "statistical difference" requires a 95 percent confidence level.)

The 1997 data showed no statistically significant difference in satisfaction between managed care and FFS enrollees. This year, however, 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. What stands out about the results in **Figure 6** is the increase in statewide FFS ratings from 7.9 in 1997 to 8.2 in 1998. Managed care ratings also increase on the ten-point scale from 7.7 in 1997 to 7.8 in 1998. In the first major section of this report ("Introduction"), we present four possible explanations for the growing gap between plan ratings.

Looking at county-level results, we found statistically significant differences by plan type but not by county. By combining 1998 and 1987 data (pooling the data), we found statistically significant differences by county. This year, Kent County respondents report the most favorable ratings for their care at 8.7 for FFS and 7.9 for managed care. Last year, Sussex County respondents gave the highest ratings. This change in relative position might reflect changes in health plan performance, or it might simply be due to the relatively small sample sizes for Kent and Sussex counties. (Our CAHPS sample mirrors the distribution of the state's population.) Even though it is not clear which county is most satisfied, the 1998 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.

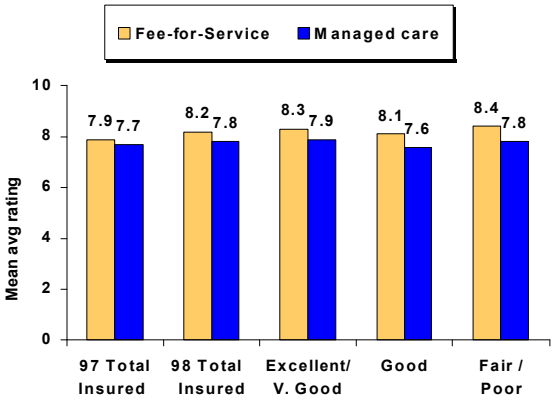
The 1997 CAHPS survey showed a direct correlation between health status and plan ratings, with people in the poorest health giving the lowest ratings. The falling heights of the bars in last year's bar chart clearly showed this relationship (making it visually significant). However, the relatively small number of people in the "good" and "fair/poor" health status categories probably prevented this relationship from passing the test of statistical significance. As is illustrated in **Figure 7**, the 1998 data does not show a clear correlation between health status and plan ratings. Not only does the relationship fail to achieve statistical significance, it also does not meet the more intuitively appealing test of visual significance. The situation is not so positive for quality of health care, though. The next section of this report will discuss the visually and statistically drop-off in ratings given by respondents in poor health.

Quality of Health Care

As presented in **Figure 8**, Delawareans report that they are more satisfied with their health care in 1998 than in 1997. FFS plan members give an 8.6 rating, up from 8.2 in 1997; managed care members grade their care an 8.4, up from 8.0 in 1997. Like last year, we did not find statistically significant differences by plan type or county. As was mentioned above and can be seen in **Figure 9**, respondents in poorer health reported less satisfaction (8.3 for FFS and 8.3 for managed care) with their health care than those in excellent/good health (8.7 for FFS and 8.6 for managed care). We determined health status from the results of the answer to the following survey question: "In general, how would you rate your overall health now…excellent, very good, good, fair, or poor?"

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.

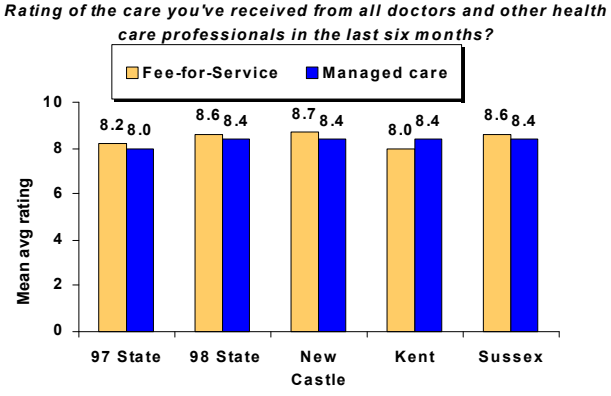
Figure 7: Overall Quality of Health Insurance by Health Status and Plan Type, Age 18-64



Note: Differences by plan type *are statistically significant*; differences by health status are not. **Pooled data for 97+98** *indicates significant differences* by health status.

Source: 1998 CAHPS Survey

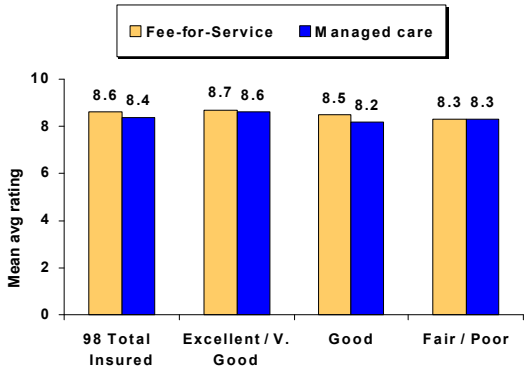
Figure 8: Overall Quality of Health Care by County and Plan Type, Age 18-64



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

Source: 1998 CAHPS Survey

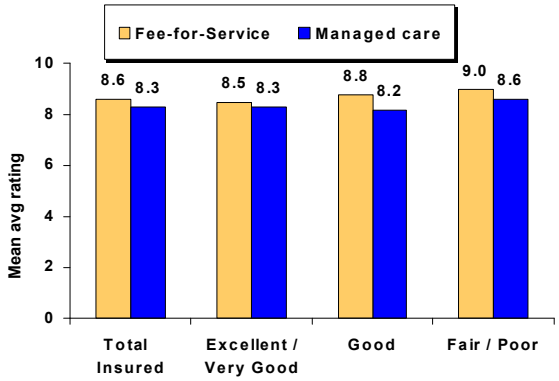
Figure 9: Overall Quality of Health Care by Health Status and Plan Type, Age 18-64



Note: There are statistically significant differences by health status but not by plan type.

Source: 1998 CAHPS Survey

Figure 10: Overall Rating of Personal Doctor by Health Status and Plan Type, Age 18-64

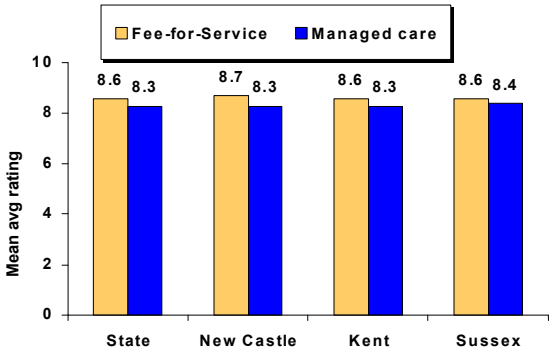


Note: Differences by plan type *are statistically significant*; differences by health status are not.

Source: 1998 CAHPS Survey

Figure 11: Overall Rating of Personal Doctor by County and Plan Type, Age 18-64

Rating of your personal doctor or nurse now?

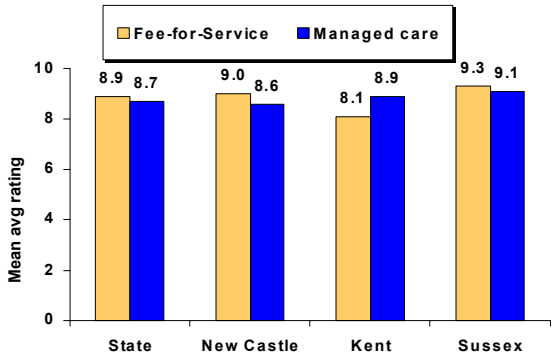


Note: Differences by plan type are statistically significant; differences by county are not.

Source: 1998 CAHPS Survey

Figure 12: Overall Rating of Specialists by County and Plan Type, Age 18-64

Rating of the specialist you saw most often in the last 6 months.



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

Source: 1998 CAHPS Survey

Quality of Physicians and Specialists

The 1998 CAHPS survey also contained two additional overall ratings questions that did not appear in the 1997 CAHPS survey. These questions asked respondents to give overall ratings of their personal physician and also for their specialists. As seen in **Figures 10 and 11**, the results indicate that a 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. 8.6). This difference could be due to actual quality 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 six 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 such as joint replacement procedures and cardiac surgery.

Figure 12 shows that overall ratings are higher for specialists than for personal physicians. Our data did not show statistically significant differences by county or plan type. Our limited data visually suggest plan type differences: specialists seen by FFS enrollees received an average rating of 8.9 versus 8.7 for those seen by managed care enrollees. This is a possible area of significance that we will want to analyze next year. (The 1999 CAHPS questionnaire increases the reference period from six months to twelve months. This should provide us with more data from plan members who had seen a specialist and consequently can give ratings.)

Specialists' ratings proved to be statistically significant by health status. Respondents who report themselves in "fair/poor" health report less satisfaction with their specialists (7.9 - FFS and 8.4 - managed care) than those in either "good" health (9.0 - FFS and 8.6 - managed care) or "very good/excellent" health (9.1 - FFS and 8.9 - managed care). 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 6 - 17**.

Delaware CAHPS
Summary of Global Ratings*
1998 Data for Respondents Age 18-64
(Statistically significant differences shown in parentheses)

	Statistically Significant by:		
Overall Rating of:	**Plan Type** (**F**ee-**F**or-**S**ervice and **M**anaged **C**are)	**County** (**K**ent, **N**ew **C**astle, **S**ussex)	**Health Status** (**E**xcellent, **G**ood, **P**oor/Fair)
Quality of Health Plan	**Yes (FFS>MC)**	**No**	**No**
Quality of Health Care	**No**	**No**	**Yes (E>G>P)**
Personal Doctor**	**Yes (FFS>MC)**	**No**	**No**
Specialists Seen**	**No**	**No**	**Yes (E>G>P)**

***This chart shows differences for the four global questions only. In the next section of the report, we report results for 17 items relating to specific aspects of quality of health plans and quality of care. In terms of these specific items, our data shows 10 statistically significant differences by health status, 8 by county, and 2 by plan type.

****Items new in 1998 Survey

7. WHAT NON-ELDERLY RESPONDENTS SAID ABOUT SPECIFIC TOPICS

The 1998 Delaware CAHPS survey includes a series of 17 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, three items seem most problematic – not being encouraged to exercise or eat a healthy diet; plans not dealing with approvals without a lot of time and energy; and consumers not receiving all the help they needed when they called their health plan customer service.

For each of the 17 specific measures, we tested for statistically significant differences by three respondent characteristics: health plan type (FFS vs. managed care), county, 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 and Sussex counties. 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 17 CAHPS questions addressing specific aspects of care.

Even though the CAHPS data showed noticeable differences for the specific measures, the pattern is fundamentally different than what was found in the *Choices for Delaware* survey. 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 17 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, and health status.

People s Experience in Getting the Care They Need

Figures 13a and 13b show the results for the five items in the "getting needed care" category. Two of the three problematic – or "flagged" – items fall within this category. Less than half of the respondents (43%) reported being encouraged by their physicians to exercise or eat a healthy diet. And, 21.0 percent of the respondents reported problems with obtaining approvals from their health plans.

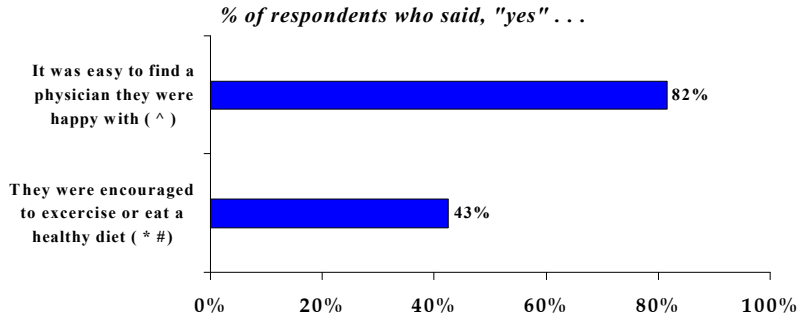
For four of the five items, our data also showed statistically significant differences by health plan type, county, and/or health status. (In the following discussion and throughout Section 7 of this report, only statistically significant differences are mentioned in the text.) Kent County residents reported a more difficult time finding a physician (35.6 percent) than the residents of New Castle and Sussex counties (15.5 and 24.5 percent) did. The county's lowest number of physicians per capita can explain the reported difficulties of finding a physician in Kent County. The University of Delaware study *Primary Care Physicians in Delaware* reports the following 1998 population to physician ratios by county: Kent, 1,708 persons to 1 physician; New Castle, 1,114:1 and Sussex 1,267:1.[21]

Sussex County residents reported greater difficulty getting approvals easily (26.0 percent) than in New Castle and Kent Counties (21.6 and 14.0 percent). Kent County residents reported more difficulty getting needed tests and treatments (18.2 percent in comparison to 12.0 percent in Sussex and 6.9 percent in New Castle). Delawareans in managed care reported that their physicians encouraged them to exercise and eat healthy diets more than FFS plans (50.9 percent vs. 44.2 percent). Conversely, FFS participants reported that they received needed treatment more often (87.3 percent of the time), than managed care plan participants, (83.6 percent). Respondents in worse health reported more difficulty receiving needed treatments and tests (15.8 percent) than those in better health (6.3 percent).

People s Experience in Getting Care Quickly

For the four specific items presented in **Figure 14**, between 84.0 and 89.0 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

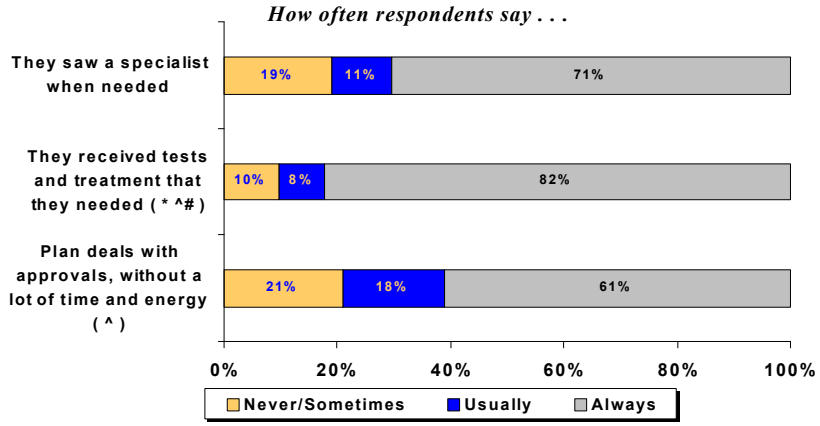
Figure 13A: People s Experiences in Getting the Care They Need



Significant differences by: (*) = Health Plan, (^) = County, (#) = Health Status

Source: 1998 CAHPS Survey

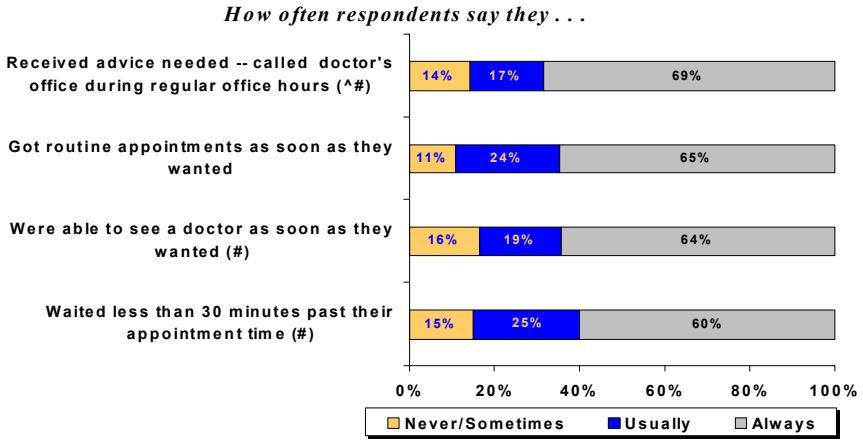
Figure 13B: People s Experiences in Getting the Care They Need



Significant differences by: (*) = Health Plan, (^) = County, (#) = Health Status

Source: 1998 CAHPS Survey

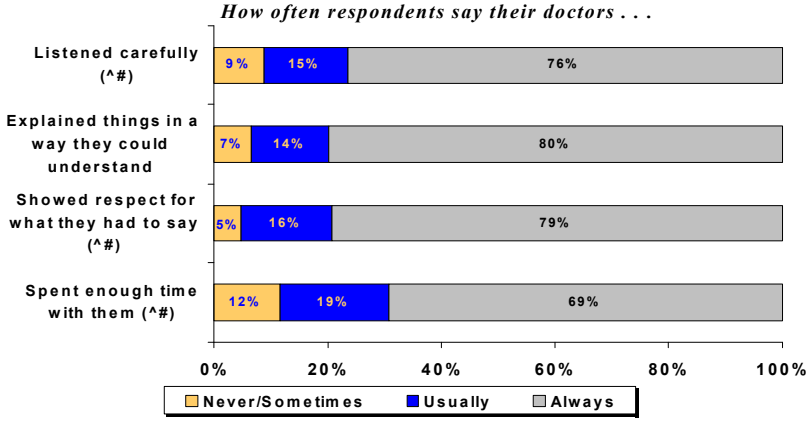
Figure 14: People s Experiences in Getting Care Quickly



Significant differences by: (*) = Health Plan, (^) = County, (#) = Health Status

Source: 1998 CAHPS Survey

Figure 15: People s Experiences with How Well Their Doctor Communicates



Significant differences by: (*) = Health Plan, (^) = County, (#) = Health Status

Source: 1998 CAHPS Survey

measures of getting care quickly. For example, 13.0 percent of those in the lowest health category had to wait more than 30 minutes, compared to only 7.0 percent of those in the healthiest category. The most dramatic change from last year is the drop from 57.0 to 15.0 in the percentage of Delawareans reporting long waits past their appointment times. This improvement unfortunately does not indicate improved office management; it largely can be attributed to the change in the CAHPS criterion for a "long wait" from 15 minutes to 30 minutes. The national CAHPS development team recently reversed this decision and decided that 15 minutes is the right criterion. Future Delaware CAHPS surveys will follow this recommendation.

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 15** 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 12.0 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 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 17 percent reporting that their doctors never listen to them carefully, 6.9 percent reporting that their doctors showed no respect for what they had to say, and 15.7 percent reporting that their doctors did not spend enough time with them. Conversely, Sussex County residents reported highest satisfaction with their doctors communication with 4.1 percent stating that their doctors did not listen to them carefully, two percent reporting that their doctors showed no respect for what they had to say and four percent reporting that their doctors did not spend enough time with them. Sussex County residents reported 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 1998 CAHPS survey.

Respondents in worse health reported significantly greater problems in communicating with their physicians. Among Delawareans in "poor" health, 21.1 percent reported that their doctors never listen to them carefully, 15.8 percent said that their doctors showed no respect for what they had to say, and 23.2 percent reported that their doctors did not spend enough time with them. Of those Delawareans reporting to be in "good" health, 6.9 said that their doctors never listen to them carefully, 2.9 percent reported that their doctors never or only sometimes showed respect for what they had to say, and 9.0 percent claimed that their doctors did not spend enough time with them.

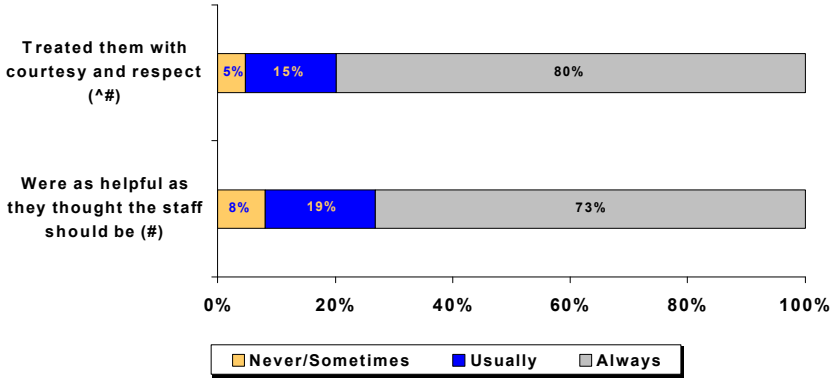
Figure 16 shows similar patterns for the doctors' office staff. More than 90 percent of the state's respondents report overall positive experiences with the staff. Respondents in poorest health report the most frequent problems; approximately 15.0 percent report problems compared to approximately 5 percent 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 1.4 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 17** shows that Delawareans give relatively lower ratings for customer service. Of those respondents who called in the previous six months, only 49.1 percent reported "always" getting the help needed. Much less concern was expressed about paperwork; only 5.4 percent of all respondents reported a problem here. For these two specific measures, the data showed no statistically significant differences by plan type, county, or health status.

Figure 16: People s Experiences with the Doctor s Office Staff

How often respondents say the staff at their doctors office . . .

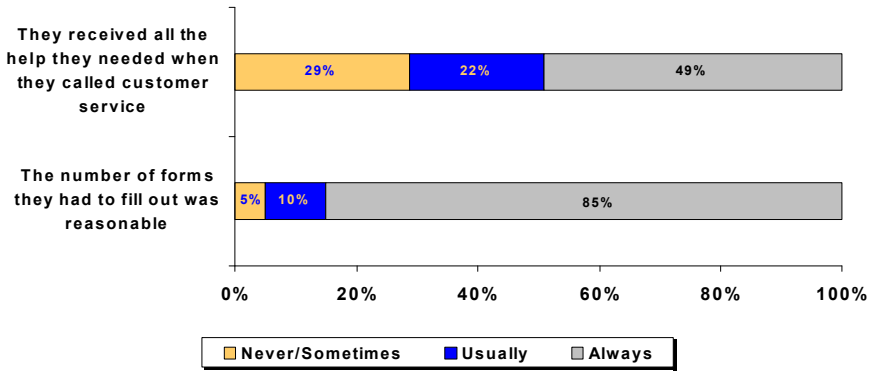


Significant differences by: (*) = Health Plan, (^) = County, (#) = Health Status

Source: 1998 CAHPS Survey

Figure 17: People s Experiences with Their Health Plan Customer Service

How often respondents say . . .



No significant differences by plan type, county, or health status.

Source: 1998 CAHPS Survey

8. CONCLUSION

The 1998 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,"[22] 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 personal doctors. Both of these lower ratings might be explained to some extent by one common factor: consumers expressing concerns about having to pick a primary care physician from those on their HMO's provider panel. In terms of the 17 specific measures of quality included in our CAHPS survey, managed care respondents give lower ratings for two: 1) being encouraged by their doctor to exercise and eat a healthy diet; and 2) receiving needed tests and treatments. The "exercise and diet" result runs counter to HMO's commitment to emphasize preventive services. Advocates of managed care would suggest that reports of not receiving "needed tests" more accurately can be viewed as managed care's attempts to cut back on unnecessary tests and treatments.

The case in favor of managed care is built on three general findings. First, in terms of overall (0-to-10) ratings of health care and ratings of specialists, our data shows no significant differences between managed care and FFS plans. Second, for the 17 specific measures, plan type has no significant effect on ratings for 15 of the 17 specific measures. To add some context to this total, our data reveals eight statistically significant differences by county and 10 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 clearly become the dominant form of health insurance for the non-elderly in Delaware, reaching 74 percent in 1998 – up five points in just one year. 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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