



Patient Experiences with Managed Care: A Survey

SURVEY HIGHLIGHTS

DISSATISFACTION

Managed care organization members report less satisfaction and lower quality of care than fee-for-service (FFS) users.

- Overall, managed care members are more likely to rate their plan as fair or poor (21%) than are fee-for-service users (14%).
- Fifteen percent of managed care members rate the quality of health care services they have received as fair or poor, compared with 6 percent of fee-for-service members.
- Managed care users are far more likely than fee-for-service users to rate their plans as fair or poor for access to services, including specialty care (23% v. 8%), emergency care (12% v. 5%), waiting time for a routine appointment (28% v. 11%), and convenience of their provider's location (17% v. 4%).
- Managed care members are also much less satisfied than fee-for-service enrollees with their plans' ease of changing doctors (25% v. 6%), choice of doctors (25% v. 5%), and quality of doctors (17% v. 4%).
- Managed care members are more likely than fee-for-service enrollees to rate their regular doctor or nurse as fair or poor in terms of really caring about them and their health (12% v. 4%), spending enough time with them (17% v. 8%), making sure they understand what they've been told (9% v. 3%), being accessible by phone or in person (18% v. 9%), treating them with dignity and respect (4% v. 1%), and listening to them carefully (9% v. 4%).

CHOICE

Satisfaction with one's plan is related to choice of coverage.

- Twenty-nine percent of managed care enrollees report that they had no choice regarding their type of plan.

- Managed care enrollees who did not have the option of joining a fee-for-service plan are twice as likely to rate their plan negatively as those who had a choice (32% v. 16%).
- Of all managed care members, those without a choice of fee-for-service are much more likely than those who did have a choice to rate their plans as fair or poor for the quality of health care services used (22% v. 12%), the range of services covered by the plan (30% v. 15%), their coverage of preventive care (28% v. 14%), the availability of emergency care (17% v. 10%), access to specialty care (35% v. 18%), and reasonableness of fees (34% v. 21%).

INSTABILITY OF COVERAGE

Working Americans change health plans frequently, most involuntarily.

- Almost half (45%) of all insured adults report being enrolled in their current plan for less than three years.
- Nearly three-quarters (73%) of those adults who changed plans in the past three years did so involuntarily, usually because their employer changed plans (32%) or because they changed or lost their job (29%).
- Instability of coverage is greatest among managed care enrollees; 53 percent of managed care enrollees have been in their current plan less than three years, compared to 37 percent of fee-for-service members.
- Involuntary changes of plans disrupt continuity of care and patient-physician relationships. For managed care members, changing plans often requires changing physicians. Forty-one percent of managed care members had to change their doctors when they joined their current plans, compared with 12 percent of fee-for-service enrollees.
- Among managed care members, adults enrolled in HMOs (48%) were much more likely to have had to change doctors when they joined their current plan than were PPO members (29%).
- Members of both managed care and fee-for-service plans who have belonged to their plans for ten or more years are much less likely to rate their plans negatively (11% and 12%) than those who have belonged to their plans for less than three years (24% and 17%).

COSTS AND PAPERWORK

Costs of care and paperwork requirements are a source of dissatisfaction for both managed care and fee-for-service enrollees.

- Three in ten members of both fee-for-service (31%) and managed care plans (30%) are dissatisfied with the premium they must pay for their plan.
- Thirty percent of fee-for-service members, and 25 percent of all managed care members, are dissatisfied with their plan's out-of-pocket costs.
- Roughly equal numbers of adults and their families in both fee-for-service (50%) and managed care (55%) spent between \$1 and \$500 out-of-pocket last year on medical bills which were not covered by insurance. However, many more fee-for-

service members (35%) than managed care members (21%) spent more than \$500.

- Among managed care enrollees, HMO members were twice as likely (23%) as PPO members (11%) to have spent no money out-of-pocket for medical care.
- HMO members, however, are far more likely (39%) than PPO members (15%) to be required to pay the entire cost of using doctors or hospitals not associated with their plan.
- Twenty percent of fee-for-service enrollees, and 16 percent of managed care members, are dissatisfied with their plans' paperwork requirements.

CHILDREN'S SERVICES

Parents in managed care plans are less satisfied with their childrens' access to care and quality of care received than those in fee-for-service plans.

- Managed care members (45%) are more likely than fee-for-service enrollees (39%) to have children under the age of 18.
- Members of managed care plans are less likely than fee-for-service members to be very satisfied with their childrens' access to diagnostic tests (66% v. 79%), and to emergency care (71% v. 81%).
- Parents of children in managed care are also less likely than parents of children covered by fee-for-service insurance to be very satisfied with their childrens' quality of care (76% v. 86%), and their doctor's overall attitude and behavior toward their children (77% v. 86%).
- Among parents of children in managed care, those in HMOs and PPOs are about equally likely to be very satisfied with their childrens' quality of care (76% v. 75%), access to routine check-ups and immunizations (78% v. 74%), access to emergency care (73% v. 67%), and access to diagnostic tests (66% v. 65%).

Managed care and fee-for-service enrollees have similar access to primary and preventive care.

- Forty-five percent of managed care and 46 percent of fee-for-service users visited their doctor or clinic one to six times during the past year. Forty-nine percent of managed care and 47 percent of fee-for-service users, respectively, made seven or more trips to their doctor's office or clinic last year.
- Nineteen percent of fee-for-service users and 17 percent of managed care members report having no regular source of care.
- Equal numbers of managed care and fee-for-service enrollees did not receive these preventive services in the last year:
 - pap smear (25% v. 24%);
 - pelvic exam (25% v. 24%);
 - mammogram (31% v. 31%);
 - blood pressure reading (14% v. 12%);
 - screening for prostate cancer (46% v. 48%); and
 - complete physical exam (36% v. 37%).

- However, managed care plans are much more likely than fee-for-service plans to cover the full cost of preventive services, including:
 - complete physical exam (58% v. 42%);
 - blood cholesterol test (59% v. 37%);
 - pap smear (69% v. 45%);
 - mammogram (70% v. 48%); and
 - screening for prostate cancer (59% v. 33%).
- Eleven percent of managed care enrollees and 9 percent of fee-for-service enrollees report that they postponed care they believed they needed in the past year, most often because of cost and/or lack of insurance coverage for that service.
- Among managed care enrollees, PPO members (16%) were twice as likely as HMO members (8%) to have postponed health care in the past year because they could not afford it.

USE OF SERVICES OUTSIDE PLAN

One in six managed care members sought non-emergency care outside their plan in the past year, usually because they wanted to see a better doctor.

- Managed care members enrolled in PPOs (27%) were more likely than those in HMOs (14%) to seek non-emergency care outside their plan.
- Among adults who received care outside of their plan, almost half of those in PPOs (45%) and one-third of those in HMOs (32%) reported that they did so to see a better doctor.
- More managed care members in Miami (22%) than in Los Angeles (16%) or Boston (14%) sought non-emergency care outside their plan in the past year.

LOW INCOME POPULATIONS

Lower income managed care members are less satisfied than lower income fee-for-service enrollees with almost every aspect of their coverage.

- Low-income adults enrolled in managed care are more likely (32%) than low income adults in fee-for-service (14%) to rate their plan overall as either fair or poor.
- Among adults with annual household incomes of \$15,000 or less, members of managed care plans are more likely than their fee-for-service counterparts to be dissatisfied with their plans' access to services, including the availability of advice by phone (37% v. 13%), availability of emergency care (21% v. 4%), waiting time for emergency care (28% v. 11%), waiting time for a routine appointment (38% v. 20%), waiting time in office for a routine visit (41% v. 16%), and the range of services covered (32% v. 16%).
- Managed care members with annual incomes of less than \$15,000 are also much more likely than fee-for-service enrollees in the same income bracket to consider as fair or poor their plans' quality of doctors (22% v. 3%) and choice of doctors (30% v. 5%).

Lower income managed care members are much less satisfied than higher income managed care members.

- Managed care members in the lowest annual income category (<\$15,000) are much more likely than managed care members in the highest income category (>\$75,000) to rate their plans negatively overall (32% v. 13%).
- Additionally, low income managed care members are much more likely than high income managed care members to rate as fair or poor their plans' quality of doctors (22% v. 11%), availability of emergency care (21% v. 7%), waiting time for a routine appointment (38% v. 22%), and the range of covered services (32% v. 13%).

VARIATION BY CITY

Satisfaction with managed care plans varies across the three cities: Boston ranks highest. Satisfaction with fee-for-service plans is constant across the three cities.

- In Miami, 24 percent of managed care enrollees rate their plans overall as fair or poor, compared with 20 percent in Los Angeles, and 18 percent in Boston.
- Fourteen percent of fee-for-service enrollees in each of the three cities rate their plan overall as fair or poor.
- Managed care members in Miami and Los Angeles are also much more likely than those in Boston to rate their plans as fair or poor on a variety of measures:
 - choice of doctors (27% in Miami, 29% in Los Angeles, 19% in Boston);
 - quality of doctors (22% in Miami, 19% in Los Angeles, 10% in Boston);
 - availability of emergency care (14% in Miami, 15% in Los Angeles, 8% in Boston);
 - coverage of preventive care (22% in Miami, 19% in Los Angeles, 14% in Boston);
 - reasonableness of fees (28% in Miami, 25% in Los Angeles, 21% in Boston); and
 - availability of advice by phone (29% in Miami, 30% in Los Angeles, 20% in Boston).

VARIATION AMONG TYPES OF MANAGED CARE

Satisfaction with aspects of managed care depends upon the type of plan.

- Thirty-nine percent of preferred provider organizations (PPO) members have had either major or minor problems with their plan not paying for services, compared with 25 percent of health maintenance organization (HMO) members.
- PPO members are more likely (34%) than HMO members (21%) to rate their plan's reasonableness of out-of-pocket costs as fair or poor.
- PPO members (26%) are more likely than HMO members (16%) to rate their plan's coverage of preventive services as fair or poor.
- More PPO members (21%) than HMO members (13%) consider the amount of paperwork associated with their plan as fair or poor.

- HMO members, however, are more likely (31%) than PPO members (21%) to rate their plan's waiting time for a routine appointment as fair or poor.
- HMO members are also more likely (27%) than PPO members (21%) to rate their plan's ease of changing doctors as fair or poor.

HEALTH PROFILE

Reported health status does not differ for managed care and fee-for-service users.

- Eighty-nine percent of managed care members and 91 percent of fee-for-service enrollees describe their own health as either excellent or good.
- Eleven percent of managed care members and 9 percent of fee-for-service enrollees describe their own health as either fair or poor.
- Similar proportions of managed care (22%) and fee-for-service (24%) members report that they or a family member had a serious illness requiring extensive medical care within the last year.
- Equal numbers of those in managed care (5%) and fee-for-service (6%) plans have a disability, handicap, or other chronic disease that keeps them from participating fully in school, work, housework, or other activities.

DEMOGRAPHICS

Managed care members tend to be younger, less educated, less affluent, and Black, Hispanic or female and to work in smaller firms than adults in fee-for-service plans.

- Half of managed care members (53%) are under the age of 40, compared to 43 percent of fee-for-service enrollees.
- Twenty-seven percent of managed care members have a high school education or less, compared to 21 percent of fee-for-service enrollees.
- Over one-third of managed care members (38%) have household incomes of \$35,000 or less, compared to one-quarter of fee-for-service enrollees (25%).
- Adults in racial/ethnic minority groups are more likely to be enrolled in managed care: 17 percent of managed care members are Hispanic, compared to 12 percent in fee-for-service; 11 percent of those in managed care are Black, compared to 8 percent in fee-for-service.
- Women account for 55 percent of managed care members and 51 percent of fee-for-service enrollees.
- Forty-four percent of managed care members work in firms with fewer than 500 employees, compared to 37 percent of fee-for-service enrollees.

Methodology

The Commonwealth Fund survey was carried out by Louis Harris and Associates, Inc., with 25-minute telephone interviews of a random sample of 3,348 adults, between the ages of 18 and 64, who had employment-based insurance. Respondents were screened to yield a final sample that was equally divided between fee-for-service members and managed care enrollees, with fee-for-service respondents included only if they had the option of joining a managed care plan. All respondents were asked to rate aspects of their

health insurance plan as excellent, good, fair, or poor and to indicate why, if applicable, they chose to be in a managed care plan. Boston, Los Angeles, and Miami, the three cities used in the random, population-based survey, were chosen because each has a relatively high penetration of managed care organizations, and different histories and patterns of industry growth. The survey was conducted between January 12 and March 27, 1994, and has a sampling error of plus-or-minus 3 percent.