Satisfaction And Choice: A View From The Plans

In a survey of HMO enrollees, what mattered was having choice at enrollment, not at the point of service.

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ABSTRACT: Communitywide surveys have demonstrated that managed care enrollees tend to express higher satisfaction with their health plan if they have been given the opportunity to make a choice between managed care and fee-for-service plans. This DataWatch shows similar results with plan-specific data, even for enrollees whose plan benefits include coverage for out-of-network services. That is, what matters seems to be choice at the time of enrollment, not at the point of service. Further, in the practical application of ranking plans on overall enrollee satisfaction, choice appears to be a more important influence than other factors that may receive attention, including enrollees' health status. We discuss this phenomenon with respect to competition and strategy in the managed care marketplace.

A RECENT STUDY BY Karen Davis and colleagues showed that satisfaction with a health plan may depend upon whether an enrollee had been offered a choice of plans.[1] Respondents who had a choice between managed care and fee-for-service plans had similar overall levels of satisfaction, regardless of the option chosen. In contrast, respondents who were offered only a managed care plan reported consistently lower satisfaction, a relationship that has been supported by other survey work.[2] Our objectives in this DataWatch are (1) to investigate this phenomenon with respect to plan-specific satisfaction; and (2) to explore its implications for strategy and competition in the managed care marketplace.

Background. The relationship between satisfaction and choice is hardly unknown to managed care strategists.[3] Recognizing that a managed care plan imposed on employees who are accustomed to fee-for-service insurance can bring about substantial dissatisfaction, employers often offer a choice of plans. But employers also recognize that by offering just one plan they increase their bargaining power with prospective vendors. Further, by offering just one

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plan they are better able to assess the plan's performance and to hold the plan accountable. With a choice of plans, it is difficult for employers to judge whether a plan is truly efficient or rather is just realizing (and, perhaps, even encouraging) a favorable selection of risks (a healthier population) through the enrollment process.[4]

In response to employers' desire for a cost-effective but less threatening form of managed care, health care companies have developed the point-of-service (POS) product. This typically combines health maintenance organization (HMO) coverage with coverage at a lower benefit level for services received from nonnetwork providers. The out-of-network benefit can be marketed as a safety net for employees who are wary of managed care and as a buttress against employee dissatisfaction.

Potential employee acceptance of the POS approach has encouraged many employers to gain greater plan accountability as well as lower costs by negotiating a "total-case-replacement" contract under which a single POS plan is provided to all employees. But are enrollees satisfied with this? Does choice at the point of service in fact lead to levels of satisfaction that are equivalent to those when choice is at the point of enrollment?

Data Source And Survey Methods

Among the holdings of our diversified health benefits company—NYLCare Health Plans—are four large HMOs (designated here as HMOs W, X, Y, and Z) that range from 150,000 to 325,000 members each and serve the metropolitan areas of Dallas, Houston, New York City, and Washington, D.C. These programs contract for medical services with a wide variety of providers, from solo physicians to integrated physician/hospital organizations, in proportions that differ substantially from one site to another. To its employer market, each HMO offers both a network-only and a POS product, the latter with a range of out-of-network benefit levels available.

During the past two years, our corporate office has arranged for an experienced market research firm to conduct centralized telephone surveys on enrollee satisfaction with the four HMOs. The purpose has been to help site managers understand the dynamics of satisfaction and identify problem areas suitable for intervention. Our application of these data to the present issue is, we believe, more than illustrative, given the sizable population involved, but generalization to other HMOs may not be warranted.

Each wave of our survey—1994 and 1995—was targeted to gain a respondent sample of 250 adult members from each site. The completed surveys reflect reasonably well the known characteristics of the sites' members. In particular, a cumulative distribution of re-

spondents by employer shows how the marketplace circumstances of our plans greatly affect the extent to which just a few employers may dominate their memberships. For example, the percentage of respondents covered by the top ten employers (1995 data) ranges from 21 percent (HMO X) to 63 percent (HMO Z).

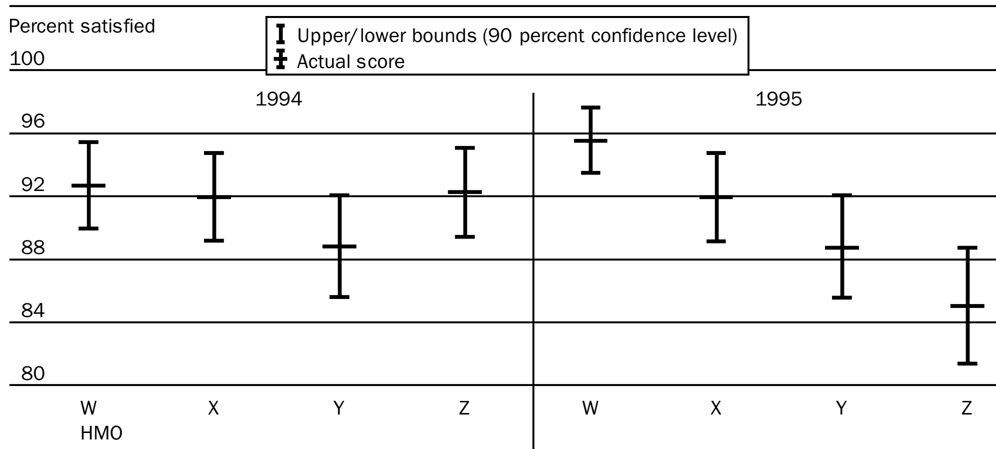
In the 1994 survey wave, a respondent's overall satisfaction with an HMO was measured on a ten-point scale, ranging from 10, "extremely satisfied," to 1, "not at all satisfied." In 1995 the response set was changed to a choice of five characterizations: "extremely satisfied," "very satisfied," "somewhat satisfied," "not very satisfied," or "not at all satisfied." To report the two sets of results using consistent methodology, we have combined the first three of these categories to reflect a "satisfied" response; for the scale used in 1994, we combined ratings of points 5–10 on the ten-point scale to reflect a "satisfied" response.

Findings

HMO rankings. Although the differing satisfaction metrics hinder longitudinal comparison, the relative rankings of the four HMOs are instructive (Exhibit 1). Most notably, HMO Z had been rated at a satisfaction level similar to that of the others in 1994 but fell noticeably in 1995. Although little difference in product mix is evident between the years, the proportion of HMO Z respondents who indicated that they had a choice of plans decreased (Exhibit 2). Perhaps this latter factor played a role in the lower satisfaction ranking.

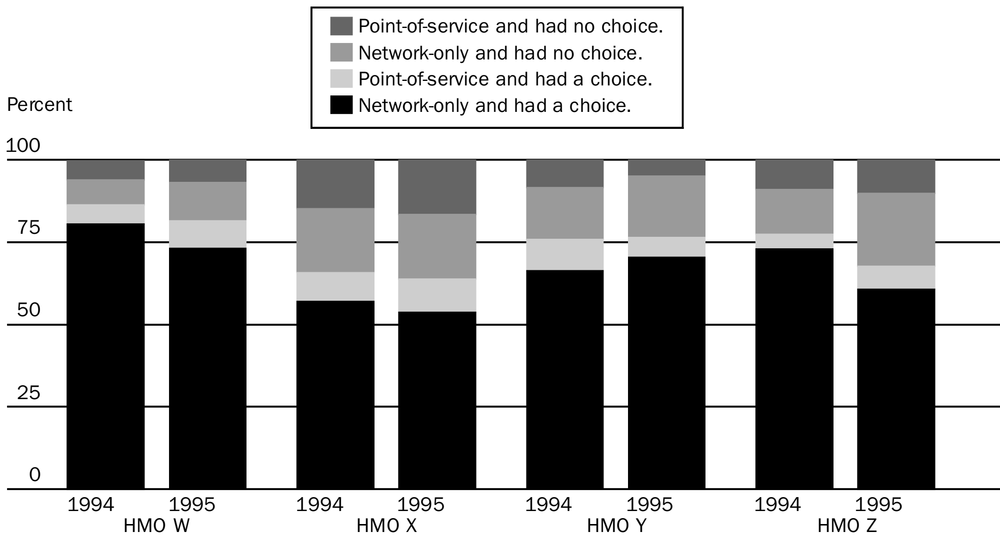
Choice, product, and satisfaction. To learn more about the inter-

EXHIBIT 1
Enrollee Satisfaction Scores, By Year And HMO



SOURCE: Based on authors' survey data.
NOTES: HMO is health maintenance organization. "Satisfied" defined in 1994 as the top six responses on a 1-to-10 scale and in 1995 as the top three of five verbal categories.

EXHIBIT 2
Product And Choice Membership Mix, By HMO, 1994–1995



SOURCE: Based on authors' survey data.
NOTE: HMO is health maintenance organization.

play among choice, product, and satisfaction and to control for the confounding effects of other potentially influential enrollee characteristics available from our survey (demographics, self-reported health status, and duration of enrollment), we ran logistic regressions on data from both the 1994 and 1995 survey waves, with the dependent variable of individual enrollee satisfaction defined as above, "satisfied" or not. Dummy variables were used to measure the independent effects of three product/choice combinations—network-only with choice, point-of-service with choice, and point-of-service without choice—against the base alternative of network-only without choice. Dummy variables were used also to measure any site-specific effect not attributable to other observed characteristics.

The results of each regression on enrollee satisfaction show similar and significant positive effects of the availability of choice, regardless of whether the enrollee chose the network-only or the point-of-service plan. Further, the satisfaction of point-of-service respondents who had no choice of plans was not significantly better (or worse) than that of the network-only respondents who had no choice.[5] Thus, what mattered was having choice at enrollment, not at the point of service.

Choice and other measures of satisfaction. Further analysis of our data reveals that choice correlated significantly with most of the more specific experiential measures that themselves contributed to general enrollee satisfaction, such as satisfaction with the quality of

care, with the accuracy of responses to enrollees' queries, and with the primary care physician. Satisfaction with specialists and hospitals, factors that had relatively less influence on general satisfaction, had little correlation with choice. We presume that our enrollees are accustomed to acting with less independence and more reliance on medical referrals in these latter areas.

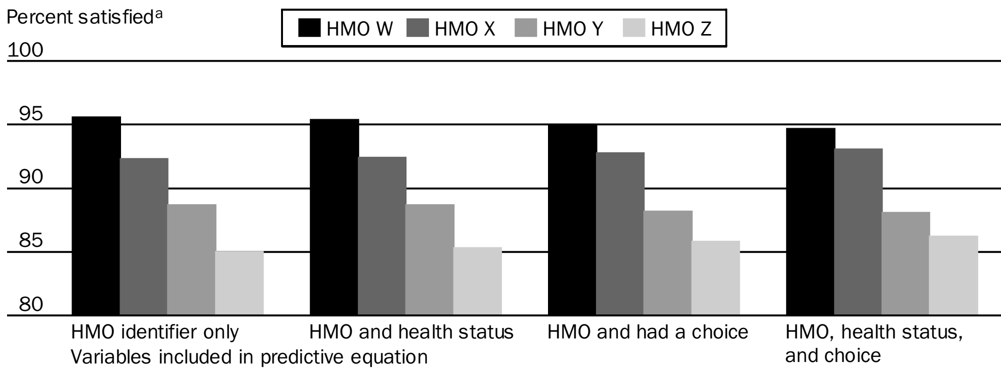
Effect of demographic variables. The importance of enrollment choice on satisfaction for our enrollees can be contrasted with the general lack of effect from the variety of demographic variables included in the regressions. Of the eleven dummy variables representing sex, age, income, and education, only two appear as significant predictors, each in only one of the two years. Only in the second survey wave does the number of years enrolled reach its anticipated level as a significant, positive correlate of satisfaction.

Importance of health status versus choice. The only variable other than plan choice (and the HMO Y dummy variable) to have a significant impact on member satisfaction in both waves of our survey is health status. The better an enrollee's self-reported health, the higher is his or her satisfaction with the HMO. This relationship looks to be quite strong, as noted by other surveys, and the finding is important to our HMOs in designing their quality-improvement initiatives.[6] Yet, with respect to the practical application of ranking plans on overall enrollee satisfaction, is health status more important than the availability of choice?

To compare the importance of choice and health status on plan rankings, we ran regressions separately for each of these variables (collapsing the choice/product composites into one dummy variable reflecting choice versus no choice), using only the site-specific dummy variables to capture any remaining systematic variation. From the resulting parameter estimates, we calculated the predicted probability of satisfaction for each observation, then averaged these to find the predicted overall satisfaction score for each site. After comparing this with the unadjusted scores predicted by the site-identifying variables only, we conclude that variations in choice explain more of the intersite differences in satisfaction than do variations in health status (Exhibit 3). Simply because the employed populations that are attracted to our four HMOs are much alike in their distributions of self-reported health status (the 1995 site-specific means range between 3.9 and 4.1 on a five-point scale), the individual effects cancel each other out to a greater extent than occurs with the choice variable.

Variations across plans. Beyond our own data, we have no hard information on enrollee variations in the choice factor across plans, particularly within a given market area, where comparative rank-

EXHIBIT 3
Satisfaction Scores Adjusted For Membership Differences, 1995



SOURCE: Based on authors' survey data.
NOTES: HMO is health maintenance organization. These results are similar to those for 1994.
[a] Average probablitity of satisfaction as predicted by logistic equation incorporating the independent variables specified (1995 survey).

ings on satisfaction are the most crucial. We surmise, however, that variations could be quite large among newer, smaller plans, in which enrollment may be mostly the result of successful marketing to relatively few employers. Using our parameter estimates to model the effect of the full range of possible variation in enrollment composition by choice yields a range of responses that appears great enough to alter a given plan's standing in its market: If 88 percent of all enrollees are satisfied when half had an opportunity to choose their plan, then 94 percent would be satisfied when all had a choice, but only 83 percent would be satisfied when none had a choice.

Problems In Satisfaction Measurement

The employer-specific factor. The acquisition of coverage through one's employer is, for better or worse, a preeminent characteristic of today's health care system. Fundamentally, then, health care is not available to consumers through a free market of goods and services. Rather, the health care market that is applicable to one worker may differ drastically from that of his neighbor.

Looking at whether or not managed care enrollees have had a choice of plans constitutes just a first step in examining how the variety of employer-specific health care markets affect satisfaction. Is this the first year a choice was provided (or taken away)? If a fee-for-service choice was available, how did the covered services, copayments, and deductibles (often employer-specific) differ from the managed care option? And what were the respective premium shares required from employees? Note that asking about enrollee satisfaction with, say, current out-of-pocket payment requirements is not sufficient, since the context of the alternatives forgone is

absent.

Since employer-specific factors such as those listed above are known to affect enrollments attained by competing plans, it would not be surprising if they also affect member satisfaction.[7] Some useful evidence is provided by a survey of health needs and plan performance fielded in six localities to the employees of three large corporations.[8] Of the fourteen HMOs in which employee respondents were targeted by more than one of the sponsors, three required statistical adjustment for employer-specific influences on the aggregate rankings. We theorize that a more numerous and diversified set of employers, as typically characterizes the total membership of an HMO, necessitates still more attention to employer-related issues.

Traditional surveys. Little recognition seems to be paid now to the potential biases inherent in comparing managed care plans on the satisfaction of enrollees who represent a diverse set of employer-specific enrollment scenarios. A traditional readership survey begun in 1992 by *Consumer Reports* was perhaps the first of what are now many publicized comparative satisfaction surveys, undertaken by public entities as well as by private entrepreneurs, in which individual "consumer" responses are simply aggregated.[9] Although the predictable promotion of favorable results by the subject managed care plans is generating increased public skepticism, even there the emphasis is on traditional validity issues such as biased question formats and inadequate response rates.[10]

Standardization efforts. Although a promising attempt to standardize satisfaction measurement and survey administration is being made by the National Committee for Quality Assurance (NCQA) in its development of the widely used Health Plan Employer Data and Information Set (HEDIS), guidelines for the collection of data on total plan memberships make no mention of employer-specific variables. The NCQA's concern about potential biases in plan-by-plan comparisons is evident, but its focus is placed on health status, which in our view is a secondary aspect, at least for programs marketed through employers (the determinants of satisfaction rankings may be different for Medicare, Medicaid, and other special populations).[11]

Data collection. To be sure, gathering data on choice of plans and other possibly influential characteristics of each respondent's enrollment situation would present a major burden for any broad-based member satisfaction survey. Given employees' notoriously poor recall of such information, supplementary sources of data are required. Yet we see no alternative if the survey is to be used for making interplan comparisons. Certainly, as with standard demographics, descriptive tables summarizing respondents' distributions

on these factors should accompany each release of satisfaction results. Although statistical adjustments might be used rigorously to standardize the comparative scores, we are concerned that the task would become overly complex, given the myriad of factors involved.

A proposal. The difficulties inherent in controlling for employer-specific variables suggest to us that resources now being devoted increasingly to publication of satisfaction data on the total membership of a health plan might be usefully redirected. Instead, large employers, as well as coalitions of employers who have worked together to standardize their plan offerings, should continue to generate their own satisfaction surveys, although using, as per the NCQA, a common core of questions and a standard methodology. Other major payers, notably Medicare and Medicaid (which are typically offered specially designed products with unique provider networks and administrative processes), should do their own surveys as well, and all of these payers should make their data available to smaller purchasers and consumers, as several large public employers are doing already.[12] Local governments, chambers of commerce, and community health agencies could contribute by generating "report cards" that list key indicators, such as overall satisfaction, explicitly by payer survey for each plan offered. Presumably the marketplace will reward those plans that score well across multiple enrollment scenarios.

Is choice the best option? Member satisfaction measurement is likely to continue to gain visibility. It is relatively easy to do, and the resulting measures unquestionably can be informative for the target audiences of employers and consumers when evaluating the quality of available plans.[13] Further, appropriately targeted interplan satisfaction data can be helpful to the plans themselves in improving quality. But attention by plans and employers to the marketing implications of comparative enrollee satisfaction surveys, to the exclusion of other objectives, may contradict the best long-term interests of the public, even if somehow these comparisons could be made unbiased. Yes, choice leads to satisfied employees, but at what price? As the cost advantage of managed care over fee-for-service plans continues to widen, is traditional indemnity coverage to be maintained with ever-increasing subsidies? And, even if choice comes to rest largely upon an array of managed care options, must a payer give up its legitimate interests in purchasing power, evaluation, and plan accountability?

Point-of-service improvements. A strict reading of our results would indicate that in a market where enrollee satisfaction scores are influential, HMOs should shy away from implementing even a POS program as a total replacement package. However, we are un-

convinced that the preservation of choice that is built into the POS product ultimately will fail to gain a level of consumer acceptance that is commensurate with multioption designs. Part of current enrollees' dissatisfaction with POS plans seems to be attributable to problems in managing access and coordinating care, which our organization, like others, is working to alleviate.[14] If unimpeded by short-term, misleading comparisons, such improvements may achieve a desirable solution that balances the interests of all parties in arranging for the health care of working Americans.

NOTES

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7. R. Ullman, "Marketing the Prepaid Group Practice: An Empirical Assessment," *The Group Health Journal* (Summer 1981): 14–23.
8. Allen et al., "The Employee Health Care Value Survey."
9. "Are HMOs the Answer?" *Consumer Reports* (August 1992): 519–531; "How Good Is Your Health Plan?" *Consumer Reports* (August 1996): 28–42; Minnesota Health Data Institute, *You and Your Health Plan: 1995 Statewide Survey of Minnesota Consumers* (St. Paul: MHDI, October 1995); H.B. Noble, "Study Rates Health Plans in 5 Areas around U.S.," *The New York Times*, 30 October 1995; "Scorecards for Managed Care Plans," *Health Pages, Pittsburgh* (Fall/Winter 1995): 15–23; "Managed Care Report Cards," *Health Pages, Front Range* (Fall/Winter 1996): 18–36; and L. Kertesz, "Patient Is King: Studies Define Customers' Satisfaction and the Means to Improve It," *Modern Healthcare* (29 April 1996): 107–120.
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12. California Public Employees' Retirement System, *Health Plan Quality/Performance Report* (Sacramento, Calif.: CalPERS, September 1996); and Federal Employees Health Benefits Program, *1997 FEHB Guide* (Washington: U.S. Office of Personnel Management, November 1996).
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14. Allen et al., "The Employee Health Care Value Survey."