Does Dissatisfaction With Health Plans Stem From Having No Choices?

Even a small amount of choice might restore public confidence in health insurance, a 1997 survey suggests.

by Atul A. Gawande, Robert J. Blendon, Mollyann Brodie, John M. Benson, Larry Levitt, and Larry Hugick

ABSTRACT: Data from a 1997 nationwide telephone survey are used to assess the relationship between choice and public opinion about managed care. We found that only a minority of the working-age population effectively control what health plan they get. Persons without choice were markedly more dissatisfied with their health plan, especially when enrolled in managed care. In multivariate analysis, how respondents rated their health plan depended as much on whether they lacked choice as on whether they were enrolled in managed care. Persons without choice also had more negative opinions about managed care in general. The results suggest that the managed care "backlash" may persist so long as consumers have little control over health insurance decisions.

Discontent with managed care is running high, and the public favors remedial government action.[1] The source of the "backlash" against managed care, however, is unclear. Is the problem that its restrictions are too onerous, or is it something else?

A growing body of literature suggests that a lack of insurance choices could be a core problem driving the public's dissatisfaction with health care. Prior surveys have found that persons who were forced to enroll in managed care were significantly less satisfied with their plan and their care than were managed care enrollees who could choose a traditional fee-for-service plan.[2] Interestingly, for those given a choice, there was no difference in satisfaction between

Atul Gawande is a postdoctoral fellow at Harvard School of Public Health and a surgical resident at Brigham and Women's Hospital in Boston. Bob Blendon is professor of health policy and political analysis at Harvard University in Cambridge, Massachusetts. Mollyann Brodie is a senior researcher and director of special projects at the Henry J. Kaiser Family Foundation in Menlo Park, California, where Larry Levitt is director of California grants and of the Changing Health Care Marketplace project. John Benson is deputy director of the Harvard Opinion Research Program at the university's public health school. Larry Hugick is director of political and media polling and senior project director at Princeton Survey Research Associates in Princeton, New Jersey.

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traditional insurance and managed care.[3] Ralph Ullman and colleagues showed that having a choice even among managed care plans improved satisfaction.[4] Enrollees who were offered a choice between NYLCare's network-only and less restricted point-of-service (POS) plans were more satisfied than were those who were given no choice. Type of plan made no difference in satisfaction once the effect of choice was taken into account.

These studies raise important questions. Does choice affect satisfaction with health plans on the national level as profoundly as it does in these regional studies? Do the number and variety of choices matter? Does choice affect public opinion about managed care?

The overall importance of choice in the managed care backlash also depends on the extent to which Americans lack choices. Surveys have estimated that 44–58 percent of workers who have insurance are given no choice of plans.[5] However, even persons who have options may be denied effective choice. For example, an employer may drop an employee's plan from the available list, forcing him or her to change. Also, the variety may be so limited as to represent no choice at all—for example, when no plan offered allows a family to keep its chosen providers. The proportion of Americans with genuine control over their choice of health plans remains unknown.

We sought to gather evidence about choice and its significance using national data taken from a more comprehensive survey of public attitudes toward managed care and regulation.[6] Specifically, we aimed (1) to estimate the extent of choice people actually have; (2) to assess the degree to which choice, managed care, and other factors affect dissatisfaction with one's particular health plan and managed care overall; and (3) if choice matters, to determine whether the number or perceived variety of options affects satisfaction.

Data And Methods

Data collection. Princeton Survey Research Associates conducted this telephone survey, which was designed by researchers at the Henry J. Kaiser Family Foundation and Harvard University, between 22 August and 23 September 1997, with a randomly selected national sample of 1,204 adults (sampling error of ±3 percent, response rate 49 percent).[7] For this analysis of insurance for the working-age population, we restricted the sample to insured adults under age sixty-five, for a total of 778 subjects (Exhibit 1).

Choice questions. We asked respondents, "When you enrolled in your current health plan, did you have a choice of more than one plan, or was only one plan available?" This is worded to capture not only those with choices through a single employer but also those with choices through different family employers, the individual

EXHIBIT 1
Demographics Of The Study Sample, Selected Characteristics

Characteristic	Percent of sample[a]
Male	50%
Nonwhite	19
College degree or more	32
Income	
Less than $10,000	5
$10,000–$19,999	10
$20,000–$29,999	18
$30,000–$49,999	28
$50,000–$74,999	22
$75,000–$99,999	10
$100,000 or more	7
Not employed	19
Part-time workers	11
Full-time workers	70
Source of coverage	
Respondent's employer	68
Spouse/family member's employer	17
Other source (public program or self-purchase)	15
Insurance type	
Heavy managed care	34
Light managed care	45
Traditional insurance	21
Employer forced a change in plan in past five years	31

SOURCE: Kaiser/Harvard/Princeton Survey Research Associates Managed Care Survey, 1997.
NOTE: N = 778.
[a] Does not include "do not know" or "refuse" answers.

market, or public insurers. We also asked if persons were forced to change health plans because of an employer's decision during the past five years. For those with a choice, we asked how many plans were available and if they thought "there was enough variety—or not enough variety—among the plans you had to choose from."

How insurance type was determined. Respondents could not reliably classify their plans (54 percent either had never heard of "managed care" or were unsure what the term meant), so we asked specific questions about insurance to establish its type. We asked whether their plan required them to do any of the following: choose doctors from a list and pay more for care from doctors not on the list; select a primary care doctor or medical group; or obtain a referral before seeing a specialist or doctor outside the plan. We classified respondents as being in "heavy" managed care if they reported that their plan, as typical health maintenance organizations (HMOs) do, had all of these characteristics. If respondents said that their plan had some but not all, as typical preferred provider organizations (PPOs) and POS plans do, we categorized their plan as "light" managed care. If respondents said that their plan had none, we scored

them as being in traditional insurance (Exhibit 1).[8]

Statistical analysis. We analyzed the data using the chi-square test or Kruskal-Wallis test where appropriate ($p < 0.05$). For the continuous variable of age, however, we compared differences in mean age. We performed all multivariate analyses using logistic regression for fifteen dummy variables representing choice, insurance type, income, being forced to change plans, education, having dependents, health status, and employment status.[9]

Research Results

Persons enrolled without choice. Of insured respondents, 42 percent said that they were given no choice of health plans when they enrolled in their current plan (Exhibit 2). Even among those given choices, one in five complained of not having enough variety (Exhibit 3). Also, 31 percent of adults said that their employer forced

EXHIBIT 2
Percentage Of Americans Reporting That They Had No Choice Of Health Plans, By Selected Variables, 1997

Variable	Had no choice[a]
Total sample (N = 761)[b]	42%
Dependent status	
Has a dependent child	43
Does not have a dependent child	41
Insurance type	
Heavy managed care	37*
Light managed care	41
Traditional insurance	53
Whether employer forced a change in plan in past 5 years	
Forced to change plans	50*
Not forced to change plans	38
Employment status	
Self-employed	34
Employed (except self-employed)	43
Not employed	47
Employed full time	40
Employed part time	47
Income	
Less than $10,000	65*
$10,000–$19,999	53
$20,000–$29,999	49
$30,000–$49,999	39
$50,000–$74,999	35
$75,000–$99,999	34
$100,000 or more	42

SOURCE: Kaiser/Harvard/Princeton Survey Research Associates Managed Care Survey, 1997.
[a] Had no choice of plans at the time respondents chose their current health plan.
[b] Excludes "do not know"/"refuse" responses (17 subjects).
* $p < 0.05$.

them to change their health plan during the past five years (Exhibit 1). Overall, 63 percent of respondents had no choice of plans, had plans of inadequate variety, or were forced to change plans.

Sex, race, education, employment status, marital status, and health status did not affect the likelihood that respondents would have no choice or be dissatisfied with their variety of choices. However, respondents with low incomes disproportionately lacked choices. Among those with choices, income did not affect whether respondents reported having enough variety. Although persons with children were just as likely as those without children were to be offered a choice of plans, they were significantly more likely to say that their choices were inadequate. Also, those in a heavy managed care plan were most likely to have a choice but less likely to be satisfied with those choices.

Among respondents with choices, 29 percent had two options, and 34 percent had three. The more choices people were offered, the more likely they were to report that they had enough variety. Of persons with three or more plans from which to choose, 86 percent said that they had enough variety, compared with 63 percent of persons with two options ($p < 0.001$).

Persons with no insurance choice reported having their current

EXHIBIT 3
Percentage Of Americans Having A Choice Of Plans But Not Enough Variety, By Selected Variables, 1997

Variable	Not enough variety[a]
Total sample (N = 431)	20%
Dependent status	
Has a dependent child	27*
Does not have a dependent child	14
Insurance type	
Heavy managed care	27*
Light managed care	15
Traditional insurance	12
Whether employer forced a change in plan in past 5 years	
Forced to change plans	30*
Not forced to change plans	15
Employment status	
Self-employed	20
Employed (except self-employed)	20
Not employed	17
Employed full time	19
Employed part time	26

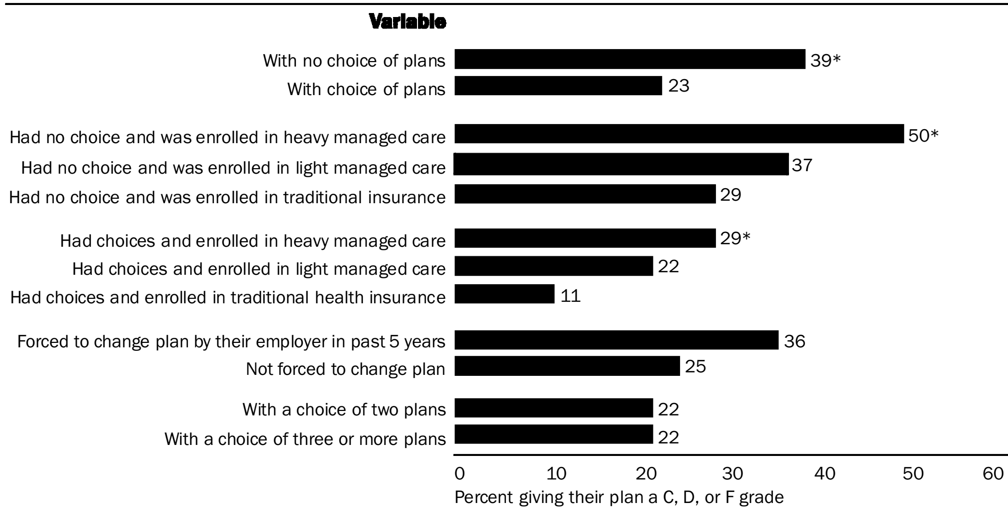
SOURCE: Kaiser/Harvard/Princeton Survey Research Associates Managed Care Survey, 1997.
[a] Among respondents with a choice of health plans, those reporting that there was “not enough variety” when they chose their current plan.
* $p < 0.05$.

plan for a median duration of three to four years. This was no different from those with choices.

Persons forced to change plans. Sex, race, education, income, marital status, presence of dependent children, employment status, and health status did not affect the likelihood that an employer had forced a respondent to change plans during the past five years. Respondents who were forced to change, however, were less likely to have a choice of plans now (Exhibit 2). When given choices, they were more likely to have an inadequate variety of options (Exhibit 3). Those forced to change plans also were less likely to have traditional insurance now (12 percent versus 21 percent, $p < 0.05$), and their median duration of enrollment, one to two years, was shorter ($p < 0.05$).

Satisfaction levels. Respondents were markedly unhappier with the performance of their health plan when they did not choose that plan (Exhibit 4). Almost 40 percent of those not given a choice gave their plan a C (average), D (poor), or F (failing) grade—nearly double the proportion of those who chose their plan. This effect became more acute when we took plan type into account. Half of those in heavy managed care without choice gave their plan low grades, compared with 29 percent of those in traditional insurance without choice. In multivariate analysis only three independent factors were significant: choice, insurance type, and having children. Persons without choice were 2.6 times as likely as those with choices were

EXHIBIT 4
Percentage Of Americans Giving Their Plan A Low Rating, By Extent Of Choice, 1997



SOURCE: Kaiser/Harvard/Princeton Survey Research Associates Managed Care Survey, 1997.
* $p < 0.05$.

to give their plan a low grade; those in heavy managed care were 2.8 times as likely as those in traditional insurance; and those with a dependent child were 1.5 times as likely as those without one.[10]

Having even two options seemed to help (Exhibit 4). However, having more than two choices did not make a significant further improvement in the grade given to a person's health plan, although it did improve respondents' satisfaction with their variety of choices.

Choice and opinion about health care. Persons without choice had more negative opinions about insurers and managed care in general (Exhibit 5). They were significantly more likely to say that managed care makes it more difficult to see specialists, decreases the time doctors spend with patients, and generally provides lower-quality care. Persons with no choice of plans gave managed care less credit for lowering costs and were less likely to believe that any such savings go to them. They also were much less likely to trust their insurers to do the right thing.

In multivariate analysis, only lacking choice was a consistent factor, which increased the likelihood of a negative response 1.5 to 2.5 times, depending on the question. However, enrollment in managed care did significantly and independently increase the likelihood of not trusting one's insurer (odds ratio 3.9 for heavy managed care, 3.1 for light managed care).

Negative convictions persisted no matter what terminology was used. Whether plans were termed *HMOs*, *managed care*, or *health insurance*, persons who lacked choice were significantly less likely to say that health plans do a good job of serving consumers.

Lack of choice did not affect support for increasing regulation of managed care. Asked whether they believed that government should act "to protect consumers" or that such regulation "would raise the

EXHIBIT 5
Americans' Opinions About Managed Care, By Extent Of Insurance Choice, 1997

	Had no choice at all	Had choice
Respondents who say that managed care plans		
Make it harder to see specialists	75%*	55%
Decrease the time doctors spend with their patients	72*	62
Decrease the quality of health care	56*	48
Make it easier to get preventive services	48	53
Have helped to keep health care costs down	27*	36
Make health care more affordable for people like them	54*	65
Respondents who trust their health plan to do the right thing for their care, at least most of the time	70*	84
Respondents who trust their primary care doctor to do the right thing for their care, at least most of the time	84	88

SOURCE: Kaiser/Harvard/Princeton Survey Research Associates Managed Care Survey, 1997.
* $p < 0.05$, compared with respondents who had a choice when they enrolled in their current plan.

cost too much," almost half in all groups favored government action.

Variety of choices matters. Persons who said that they had an inadequate variety of choices gave their health plan poorer grades than others did and were less likely to trust their insurer (Exhibit 6). They also were more negative about managed care in general.

In some cases, results comparing those with and without choices may mask the negative opinions of this group that has options but inadequate variety. For example, 67 percent of respondents with an inadequate variety of choices, and 53 percent of those with no choices, were worried that when they become sick, their health plan would be more concerned about saving money than about what their best treatment would be. By comparison, significantly fewer respondents who had enough choices expressed this fear (45 percent, $p < 0.05$). Persons who were forced to change plans also were more likely to worry about their sickness coverage than others were (59 percent versus 46 percent, $p < 0.05$).

Policy Implications

Our findings indicate that an important factor driving opinion on managed care is not just the type of health plan people are enrolled in, but the extent to which they have a choice in the matter. According to our national survey, persons without choice at enrollment are substantially less satisfied with their plan and with managed care in general than are persons with choices.

Consistent with previous surveys, we found that 42 percent of insured adults under age sixty-five were given no choice of health

EXHIBIT 6
Opinions About Managed Care Among Americans With A Choice Of Plans, By Variety Of Choices, 1997

Respondents with a choice of plans who	Not enough variety	Enough variety
Give their plan a C, D, or F grade	50%*	17%
Say managed care plans		
Make it harder to see specialists	68*	52
Decrease the time doctors spend with their patients	68	62
Decrease the quality of health care	58*	46
Make it easier to get preventive services	44	55
Have helped to keep health care costs down	32	37
Make health care more affordable for people like them	52*	68
Trust their health plan to do the right thing for their care, at least most of the time	62*	89
Trust their primary care doctor to do the right thing for their care, at least most of the time	77	90

SOURCE: Kaiser/Harvard/Princeton Survey Research Associates Managed Care Survey, 1997.
* $p < 0.05$, compared with respondents who report that they had enough variety when they chose their current plan.

plans at the time of their last enrollment, a proportion that increases as income declines.[11] Interestingly, the self-employed and the not employed reported having choices no less often than others did. Presumably they had choices through the individual market, a spouse, or public programs. If we take into account the respondents who had choices but reported either that the variety was inadequate (disproportionately, persons with children) or that they were forced by an employer to change plans during the past five years, then only a minority seems to have had an adequate choice of plans.

Respondents without choices were more unsatisfied, ranking their plans lower and believing that managed care makes it more difficult to see specialists, decreases time spent with patients, provides lower-quality care, and does not save them money. Persons with choices but an inadequate variety of them also were more unsatisfied with their plan's performance and with managed care.

Why choice matters remains unclear. Our survey captured those who did not have "enough variety," but we did not ascertain differences in the content of people's choices. Thus, we do not know whether what counts is the number of choices in and of itself or having a choice of plans with different levels of restriction, even if offered by a single carrier.

We also did not ask detailed questions about care, such as whether persons who lack choice change providers or submit to less-than-optimal treatment more often. As a result, we could not determine the extent to which our findings reflected the psychology of choice rather than an actual difference in care. Persons may be satisfied with what they choose simply because they choose it. However, discontent among the "choiceless" may be at least partly a reaction against employers' choices. Persons without choice have disproportionately low incomes and, according to other studies, work for small employers.[12] They may have inferior plans in terms of quality of care, cost sharing, benefits, or provider networks.

The policy response. Since employers predominantly decide what plan is offered, competition requires insurers to please them first and foremost. Employers do have reasons to select the plan that employees would want. However, employees do not all want the same thing; it is not always easy to figure out what they want; and employers also must satisfy their own and their stockholders' financial interests. In a 1993 Foster-Higgins survey, most managed care organizations reported that price was more important than patient satisfaction or quality in succeeding with employers in the marketplace.[13] The dissatisfaction we found among persons without choice may reflect a divergence in what consumers and employers seek when picking plans.

"Regulations that loosen managed care restrictions may not improve satisfaction without measures to increase choice."

Why do negative opinions of managed care persist even among those who choose it? Perhaps some choose managed care for cost reasons but then are unhappy about the restrictions that make the lower costs possible. However, it also may be that managed care is not responding to this minority's signals. With employers driving the marketplace, managed care plans may be structured primarily to meet employers' preferences in balancing cost and quality.

Whether lack of choice leads to discontentment with managed care because people simply prefer choice, because enrollees without choice are reacting against restrictions they did not agree to, or because their plans are actually inferior (or because of all three), choice clearly matters. Our findings also suggest that regulations that loosen managed care restrictions may not improve satisfaction without measures to increase choice.

As President Clinton's Advisory Commission on Consumer Protection and Quality in the Health Care Industry struggled in the fall of 1997 to reach consensus on proposals to address public discontent with managed care, one of the thorniest and most divisive issues was whether consumers should be assured the right to choose their health plan.[14] The *Washington Post* announced in a page-one headline in October 1997 that the "Commission Would Guarantee Patient Choices," but its scoop proved wrong.[15] The divided commission's final recommendations included no such guarantee.[16]

The original HMO Act of 1973 had provisions, since repealed, that sought to ensure that employees had a choice between an HMO and a traditional plan. It is noteworthy that we found that respondents with two choices gave their health plan much better grades than did those with only one option—grades that were similar to those of persons having far more variety. Policies, whether of employers or of government, to ensure even a small amount of choice may help to restore public confidence in health insurance and health care.

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NOTES

1. R.J. Blendon et al., "Understanding the Managed Care Backlash," *Health Affairs* (July/August 1998): 80–94.
2. A.R. Davies et al., "Consumer Acceptance of Prepaid and Fee-for-Service Medical Care: Results from a Randomized Controlled Trial," *Health Services*

Research 21, no. 3 (1986): 429–452; and K. Davis et al., "Choice Matters: Enrollees' Views of Their Health Plans," *Health Affairs* (Summer 1995): 99–112.
3. Further analysis of the Commonwealth Fund survey, however, did find evidence suggesting lower satisfaction in network-model HMOs and PPOs than in group/staff-model HMOs and fee-for-service plans—even after controlling for extent of choice. C. Schoen et al., "Image and Reality: Managed-Care Experiences by Type of Plan," *Bulletin of the New York Academy of Medicine* (Winter Supplement 1996): 506–531.
4. R. Ullman et al., "Satisfaction and Choice: A View from the Plans," *Health Affairs* (May/June 1997): 209–217.
5. C. McLaughlin, "Health Care Consumers: Choices and Constraints" (Paper presented at the Robert Wood Johnson Foundation's meeting, "The Power of Choice in the Health Care Marketplace and Its Consequences," Washington, D.C., 19 November 1997); and K. Davis, testimony before the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, hearing on consumer choice of health insurance plans and providers, Washington, D.C., 25 June 1997.
6. Blendon et al., "Understanding the Managed Care Backlash."
7. Ibid. Standard techniques were used in the survey to ensure the representativeness of the sample. To compensate for known biases from different levels of participation by different subgroups of the population, the sample data were weighted in analysis using parameters from the most recently available census data. Also, we employed random-digit dialing, replicate subsamples, callbacks staggered over times of day and days of the week, refusal conversions, and systematic respondent selection within households. For more detailed discussion of our methods and the representativeness of the data, see Blendon et al., "Understanding the Managed Care Backlash."
8. Direct estimates of enrollment by plan type find a similar distribution to that shown in Exhibit 1. KPMG Peat Marwick, *Health Benefits in 1997* (Arlington, Va.: KPMG Peat Marwick, 1997).
9. We do not include dissatisfaction with one's variety of choices as an independent variable because it could be an effect rather than a cause of discontent.
10. In a separate multivariate analysis of variety, those with an inadequate variety had significantly poorer plan ratings and negative opinions of managed care as well, and having dependent children became an insignificant contributor. Multivariate analysis results are available from the authors at Department of Health Policy and Management, Harvard School of Public Health, Fourth Floor, 677 Huntington Avenue, Boston, Massachusetts 02115.
11. McLaughlin, "Health Care Consumers."
12. J.R. Gabel, P.B. Ginsburg, and K.A. Hunt, "Small Employers and Their Health Benefits, 1988–1996: An Awkward Adolescence," *Health Affairs* (September/October 1997): 103–110.
13. Foster-Higgins, *Annual Survey of Employers* (1993), as reported in R. Bergman, "Study: Employers Consider Cost over Quality in Health Purchases," *Hospitals and Health Networks* (5 March 1994): 54.
14. "Quality Commission: Debates Choices, Appeals Process," Associated Press, 14 August 1997.
15. A. Goldstein, "Panel Outlines Protections for Health Care Consumers; Commission Would Guarantee Patient Choices," *Washington Post*, 23 October 1997, A1.
16. Advisory Commission on Consumer Protection and Quality in the Health Care Industry, "Consumer Bill of Rights and Responsibilities: Report to the President of the United States" (www.hcqualitycommission.gov/cborr/consbill.htm, November 1997).