Discussion of Papers by Paul Cleary and Arlene Bierman

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The conclusions of Paul Cleary’s work are not surprising. Consumer Reports evaluated its readers’ experiences with managed care plans in 1992, 1996, and again in 1999, and each time we found that satisfaction with doctors correlates highly with readers’ perceptions of their medical care and satisfaction with their HMOs. In all three surveys, measures of service quality—long waits on the phone, long waits in doctors’ offices, access to specialists, and so forth—also correlated highly with overall plan satisfaction. This year we observed that the ratings element most closely correlated with overall satisfaction was a plan’s response to questions and complaints.

Plans that did the best job of attending to their members’ problems ranked at the top of our Ratings. One quarter of our readers said that resolving complaints was a struggle. Only five percent of our respondents had used their plan’s formal grievance procedure, but half indicated they were not happy with the outcome. Forty percent said it took more than two months to resolve complaints. Clearly some people, albeit a small number, are having a hard time getting care and service from their HMO. Consumer Reports data parallels the findings reported in this paper.

What are we to make of these observations which do a very good job of separating the sheep from the goats in delineating differences in service among plans? No matter how much researchers and consumer advocates would like to have HMO members behave otherwise and choose plans based on the actual quality of medical care delivered, that does not seem to be happening and perhaps it never will even if such measures become available and gain widespread usage. How well a person relates to his or her doctor is likely to remain a strong determinant of health plan satisfaction. After all, the doctors are the entry point to the health care system and sick people have to trust those who care for them. How do we change that, or should we? Can we expect patients to bear the burden of monitoring the quality of care delivered in our health care system? Or is that a function for providers? We have mixed up dimensions of medical quality with service quality and call everything “quality.” A quality health plan may reflect only good service, but the implication is that somehow that medical care is good too. We know that may not be the case. How do we begin to teach consumers of health care, whether men or women, that the physician they implicitly trust may be over treating or under treating them, putting their health in jeopardy? This, I think, is the real
challenge facing us as we move to the next phase of consumer information and quality improvement.

Another way to look at these findings suggests that if the way a plan handles consumer complaints and grievances is a good predictor of member happiness, we should devise a good complaint measure and display it on report cards. As Paul Cleary points out, this is not an easy task. He correctly notes that use of complaint variables should be considered cautiously, and that if complaints were used to measure quality, an HMO would simply make it difficult to file them. Thus a plan having few or none would look better than its competitors. I have looked at consumer complaints for years for long term care insurance, Medicare supplement insurance, as well as managed care. There are always confounding variables that muddy the waters and make complaints a problematic ratings element. Does a plan or insurance company do a better job at inviting complaints? How does the agency that collects the complaints actually categorize them? Does one category truly measure what we think it does? Indeed the predictability of complaints and the difficulty of using them is one of the many paradoxes I find when writing about managed care.

Cleary also addresses the issue of how many ratings elements to show. We at Consumer Reports face this quandry all the time. While sometimes we get carried away and want to show everything, we are constrained by the physical pages of the magazine. But we must be mindful of the number of variables a person can absorb, process, and act upon. Limiting and combining variables is probably a good thing, but my experience reviewing many report cards suggests that sponsors sometimes combine too many categories which dilute their meaning and predictive power. Furthermore, simply listing variables on a printed page or web site without telling people how to use them or make trade offs in some linear fashion defeats the purpose. Too many sponsors believe that simply giving consumers information and letting them fend for themselves is enough. I would argue that it is not.

Arlene Bierman’s paper illustrates what I see as another paradox of managed care: the desperate need of older women for chronic care, the suitability of managed care organizations to provide it, and their unwillingness or inability to do so. Bierman succinctly sums up the plight of older women. More than 80 percent have one chronic disease, one quarter have three or more chronic conditions, women have fewer financial and social resources to cope with their diseases, and they are likely to be poor and live alone which makes it hard to handle their disabilities.

Given these grim realities about older women, a structure for assessing functionality and helping them improve the quality of their lives seems to be in order. Yet, the fragmented payment systems, profit motives of managed care organizations, and the lack of recognition and attention to the problem by the general public all conspire to increase the difficulty women face in their later years.

Managed care organizations should be ideal places for women to receive assessments of their functional abilities and necessary interventions. But as Bierman points out, the reimbursement system may produce insufficient funds to develop and finance the kinds of care needed to improve the functional outcomes of older women. She adds that health plans are not likely to set up programs to help older women because of the cost. Last year, outraged that the homebound elderly and especially women, lack enough food, I asked an executive of a New England HMO why the plan could not institute a program to help elderly members get enough to eat. After all, proper nutrition would head off some potentially serious illnesses. He replied that it would cost too much.

In 1998, Consumer Reports sent questionnaires to plans that had Medicare
risk contracts. We asked about their quality improvement activities in five areas: underuse, overuse, misuse, how well seniors are functioning in daily life, and the single quality improvement of which the plan was most proud. Only 23 percent of the plans reported that they had assessed the functional status of their Medicare members and had programs to intervene when beneficiaries were at risk. None that described an intervention indicated that they had measured the effectiveness of that intervention. Clearly, this isn’t good enough given the premise and the promise of managed care.

The challenges to improving the health of older women are significant. Are we as a country ready to face the challenges and more important, are we willing to redirect resources to make the quality of their lives better.