Problems, Complaint Action, and Resolution of Problems in a Managed Care Health Benefits Plan: Implications for Consumer Education

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The trend towards managed care health is unmistakable. In 1992, 48% of all health care plans were classified as managed care. The figure rose to 70% in 1995 (Glazer, 1996), a growth of 46% in only three years. Studies show that consumers are satisfied with these plans (Glazer, 1996; Schmidt, 1996), but there is no clear picture of satisfaction beyond general measures.

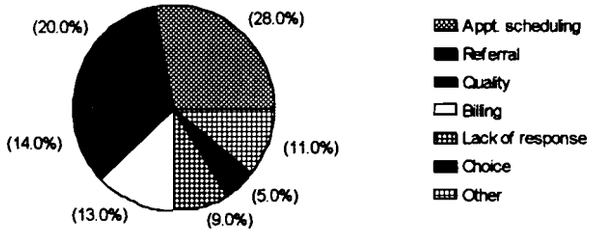
This study examines the types of action taken by consumers dissatisfied with their primary care physician in a managed care health plan. It investigates the relationship among the types of problems experienced, the types of actions taken, and how or whether the problem was resolved. The analysis can provide insight into why consumers take particular actions when dissatisfied, and whether the type of action and type of problem are related to problem resolution. By painting a more revealing picture of the actions of dissatisfied consumers and how problems are resolved, steps can be outlined to improved consumer satisfaction with primary care physicians.

Medical services have been described as a "loose monopoly." Consumers have limited choice, limited information, and often lack the ability to detect poor quality of services (Andreasen, 1985; Hirschman, 1970; Kolodinsky, 1995; Singh, 1991). Consumers tend to complain less to the direct provider of these services and more to friends and relatives (Andreasen, 1985; Best & Andreasen, 1977; Council of Better Business Bureaus, 1994; Kolodinsky, 1995; Singh, 1991). When they do complain, resolution rates are relatively low (Best & Andreasen, 1977; Kolodinsky, 1993; Singh, 1991). An important form of voicing complaints of dissatisfaction with medical care has been the ***exit*** option in which consumers ***switch*** physicians (Andreasen, 1985; Singh, 1991). Managed care health plans potentially limit this option because they require consumers to choose one primary care physician from a limited number in a network. If the opportunity for exit is decreased, consumer well-being may be decreased. If consumers are captive in these plans, what do they do when dissatisfied? If they take any action, are their voices heard?

Methods

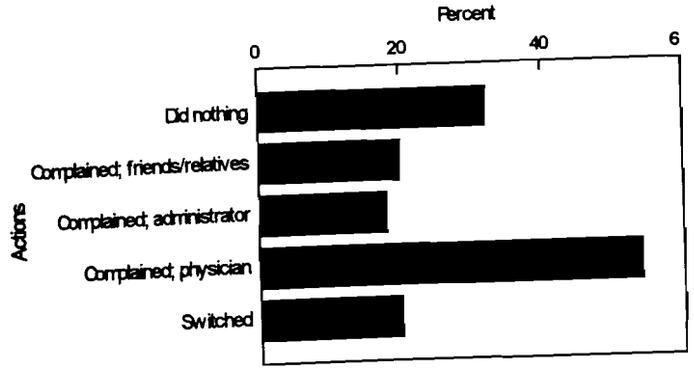
The population included all (2,955) employees enrolled in a managed care plan at a 7,500-student university in the northeast. Response rate was 42% with 1,238 completed questionnaires received. Average age of respondents was 43, and 78% were female. Six percent earned under $15,000 per year, while 14% earned over $60,000 per year. Thirty-one percent were dissatisfied with their primary care physician, and 84% had been enrolled in the health plan offered before the switch to managed care 15 months prior to this study. Appointment scheduling (28%) and referrals (20%) caused the largest percentage of problems for dissatisfied consumers (Figure 1).

Figure 1. Percentage distribution of problem types faced by dissatisfied consumers



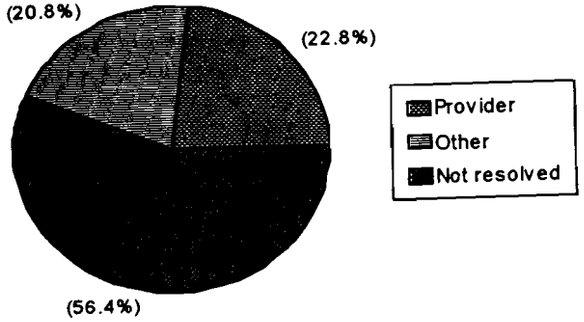
Most respondents complained to their physician (Figure 2). The percentage who complained to a physician is much higher than the percentage found by Andreasen (1985) and Singh (1991) (16.2% and 48%, respectively), but lower than the 61% Kolodinsky (1995) found. The percentage who did nothing is higher than Kolodinsky's (1995) and Andreasen's (1985) results (22% and 25%, respectively). The incidence of switching physicians (exit) is higher than Kolodinsky's (1995) results (17%), but lower than those of Andreasen (1985), Kasteler et al. (1976), and Singh (1991) which were 64%, 43%, and 49%, respectively. The majority of problems were not resolved (Figure 3).

Figure 2. Percentage distribution of complaint actions[a]



[a]Multiple responses allowed.

Figure 3. Percentage distribution of resolutions



Analysis of variance was used to identify whether relationships existed among problem types, complaint action, and resolution. The following null hypotheses were tested:

H_1: The type of complaint action taken is not related to the type of problem experienced.

H_2: Who resolves the problem is not related to the type of problem experienced.

H_3: Who resolves the problem is not related to the type of complaint action taken.

For H_1, individuals were placed into five groups determined by the type of action they took. The percentages of individuals experiencing each type of problem were compared. For H_2, respondents were placed into three groups, determined by who resolved their problem. The percentages of individuals experiencing each type of problem were compared. For H_3, respondents were placed into five groups, determined by the type of action they took. The percentages of complaints resolved by each of the methods were compared. Note, that because of multiple responses, Tables 1 through 3 cannot be interpreted as crosstabulation tables. To compare differences, one column at a time must be examined.

Results and Discussion

Results are presented in Tables 1, 2, and 3. Table 1 is interpreted as follows: for individuals who did nothing, what percentage had problems with referrals, billing, etc.? The test statistic indicates whether there were significant differences between the percentages of persons who did nothing by the type of problem. Further analysis using Tukey's B test (SPSS, 1996) indicated which problems were reported by significantly different percentages of consumers. The next four columns of Table 1 are interpreted similarly. The table shows that H_1, there is no relationship between type of action taken and type of problem experienced, must be rejected. Tukey's B test indicated that consumers were more likely to do nothing about their problem if it had to do with appointment scheduling or emergency care access, compared to other types of problems. Switching physicians within the network is more likely to occur when the problem is with quality of care and emergency care access, as seen in the last column of Table 1. These problems are ones that enrollees in a managed care plan may perceive they have little control over. There are a limited number of physicians from whom to choose, and once a primary care physician is chosen, there are administrative steps that must be taken to make a change. Appointment scheduling is in the hands of the physician's office, not the consumer. In addition, emergency care access is limited by the details of the health care plan.

Table 2 indicates that H_2, there is no relationship between type of problem and who resolved the problem, must be rejected. However, only the not resolved category was significant. Further testing

Table 1. Results for Differences in Complaint Actions by Type of Problem.

	Type of Action				
Problem with:	Did Nothing	Private Complaints	Complained to Physician	Complained to Administrator	Switched Physician
Referral	14%	14%	38%	19%	9%
Billing	11	22	55	33	0
Choice of Physician	20	20	20	60	20
Appointment Scheduling	47	25	25	9	0
Emergency Care Access	33	0	33	0	33
Quality of Care	17	5	23	17	35
Lack of Response to Inquiries	14	32	36	28	7
Other	16	25	17	25	0
F-statistic	2.65*	.47	1.50	1.14	3.87**

*$p \leq .05$; **$p \leq .001$

indicated that the problems least likely to be resolved were choice of physician, emergency care access, appointment scheduling, and lack of response to inquiries. As discussed previously, a consumer has little control because he/she is constrained by the conditions of the benefits plan. There is one exception. Lack of response to inquiries is theoretically in control of the primary care physician. However, even this area may be in control of the administrator of the benefits plan. If the networks created for care are too small and primary care physicians are over-loaded with patients, the physician may have little control over his/her ability to respond to complaints.

Table 3 shows that H_3, there is no relationship between type of resolution and type of action, must be rejected, for all actions except "did nothing." For physicians and administrators, it is reassuring that the highest percentage of resolutions were resolved by the party to whom they complained. But, for some consumers, the problem was resolved by someone other than the person to whom they complained. Further, while 58% of those who complained to the physician had their problem resolved by the physician, 41% of those who complained to the physician did not have their complaint resolved at all.

Table 2. Percentage Differences in Complaint Resolution by Problem

	Type of Resolution		
Problem with:	Resolved by Physician	Resolved by Administrator	Not Resolved
Referral	19%	14%	19%
Billing	16	22	33
Choice of Physician	0	20	80
Appointment Scheduling	6	6	62
Emergency Care Access	0	33	66
Quality of Care	5	35	29
Lack of Response to Inquiries	14	21	50
Other	16	8	16
F-statistic	.63	.30	3.01**

**p ≤ .001

Table 3. Percentage Differences in Complaint Resolution by Type of Action

	Type of Action				
Problem with:	Did Nothing	Private Complaints	Complained to Physician	Complained to Administrator	Switched Physician
Resolved by Physician	13%	7%	58%	13%	6%
Resolved by Administrator	21	9	18	51	21
Not resolved	30	30	41	22	30
F-statistic	1.58	5.31**	5.77**	6.96**	3.30**

**p ≤ .001

Conclusions and Recommendations

This study indicated that the majority (56%) of problems were unresolved for individuals who reported dissatisfaction with a primary care physician. Type of problem was related to the actions of doing nothing about a problem or switching physicians. Relationships also existed between lack of problem resolution and type of problem experienced. Type of action taken was related to problem resolution for actions taken, with the exception of "doing nothing." And, while the results show that resolution is frequently reached by the party to whom the patient complained problems often go unresolved.

A limitation of this study must be noted. This is a study of one managed care plan offered as an employee benefit, so, results may not be generalizable to all managed care plans. Future research is

needed to identify whether relationships such as the ones found in this study are similar in other populations.

It is important that consumers ask the right questions ***before*** they enroll in a managed care plan to assure they will receive a level of quality care that is acceptable to them. Based on the results of this study, questions consumers should ask to increase satisfaction include:

1. How many physicians are in the network and how many patients does each handle?
2. What is the average waiting time between calling for an appointment and actually seeing a physician? Is the average wait different for a "well" visit versus a "sick" visit?
3. What are the provisions for emergency care?
4. If there is a problem, is there a central location to handle complaints? Who is the first contact when a problem with the plan is encountered?
5. How easy is it to switch to another physician within the network?

One way of enabling consumers to obtain answers easily to the above questions and, thus, to choose a managed care plan is to establish agencies or companies that rate the quality of managed care plans in a geographic area. Rating would be in terms of number of physicians per patient, average waiting time per appointment, and ease of changing physicians within a plan. Such rating agencies could be in the public or private sector. Public sector agencies could research the issue, disseminate reports, (similar to consumer safety reports on toys), and represent the consumer before the legislature. Such a plan for Vermont was proposed by State Representative Elaine Alfano (Remsen, 1997). Private sector companies could charge patients for the information or could charge the care givers (the plan could then advertise that they received the "stamp of approval" from the evaluator). The mere existence of these groups will define for consumers the issues that are relevant in choosing a managed care plan.

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