A turbulent backlash against managed care in the mid-1990s pitted consumers and health care providers against health plans in a struggle for control over medical decision making. New findings from the Center for Studying Health System Change (HSC) Community Tracking Study Household Survey indicate consumer confidence in the system and trust in physicians increased slightly between 1997 and 2001, perhaps as a result of changes in laws and loosening of health plan restrictions. Nevertheless, there is strong evidence of continued public concern about the influence of health plans on medical decision making. For example, the level of trust in their physicians among people in fair or poor health has not increased, and more than 40 percent of privately insured Americans continue to believe their doctor is strongly influenced by health plan rules when deciding about their care.

In reaction to concerns underlying the managed care backlash, states introduced and passed a variety of patient protection laws, including rules mandating direct access to some specialists, provisions for obtaining the services of out-of-network physicians, financial incentive disclosure requirements and external reviews allowing consumers to appeal health plan decisions. Health plans also responded by offering broader physician networks and dropping or curtailing prior authorization requirements. Plans relaxed other preauthorization and concurrent utilization management controls and came to rely less on capitation, which was perceived by many as encouraging providers to stint on care.
While concerns that prompted the managed care backlash among consumers have eased, perceptions about health plans’ influence on medical decision making have not changed substantially since 1997 (see Table 1). Throughout 1997-2001, nearly 45 percent of privately insured Americans agreed that their doctor is strongly influenced by health insurance company rules when making decisions about their medical care (see Data Source). During this time, people in health maintenance organizations (HMOs) were considerably more likely than those in other types of plans to believe their health plan strongly influenced their doctor. In 2001, nearly half of HMO enrollees believed their doctor was strongly influenced by health plan rules, compared with less than 40 percent of those in other types of plans. Over time, however, HMO members grew marginally less likely to report health plan influence in medical decision making.

MORE TRUST IN DOCTORS

Although perceptions of health plan influence on medical decision making did not change, privately insured Americans in 2001 were more likely to agree their doctor would put their medical needs above all other considerations than they had been in 1997. This improvement in patients’ trust in their doctors may be a result of managed care plans’ loosened restrictions and other changes. Between 1997 and 2001, the proportion of people enrolled in HMOs who trusted their doctors to put their needs first rose from 90 percent to 92 percent. In contrast, the trust level of those in non-HMOs increased by less than one percentage point to 94 percent. In other words, the trust gap between HMO and non-HMO enrollees narrowed slightly.

MORE FREEDOM TO CHOOSE DOCTORS

A key aspect of consumer satisfaction with health care is patients’ ability to select their provider. With the rise of managed care, consumers faced the choice of seeing their regular doctor and paying more—sometimes considerably more—or going to a different doctor under contract with their health plan. Many patients also found they could not go to a specialist without first getting a referral from a primary care physician.

More recently, regulatory and marketplace changes have loosened restrictions on provider choice, and consumers appear to have noticed. In 1997, for example, 67 percent of the privately insured were very satisfied with the choice of primary care physicians available to them through their health plans (see Table 2). By 2001, the figure had risen to 70 percent, with most of the increase occurring among HMO enrollees. In contrast, the percentage of privately insured people who were satisfied with the choice of specialists available in their plan remained constant—about 72 percent—throughout the 1997-2001 period.

In response to the managed care backlash, some plans dropped gatekeeping arrangements or permitted direct access to certain types of specialists. Some states also

Data Source

This Tracking Report presents findings from the HSC Community Tracking Study Household Survey, a nationally representative telephone survey of the civilian, noninstitutionalized population conducted in 1996-97, 1998-99 and 2000-01. For discussion and presentation, we refer to a single calendar year of the survey (1997, 1999 and 2001). Data were supplemented by in-person interviews of households without telephones to ensure proper representation. Each round of the survey contains information on about 60,000 people, and the response rates ranged from 60 percent to 65 percent. Table 1 reflects responses to the following specific statements: “I think my doctor is strongly influenced by health insurance company rules when making decisions about my medical care.” “I trust my doctor to put my medical needs above all other considerations when treating my medical problems.” “I think my doctor may not refer me to a specialist when needed.”
passed legislation mandating standing referrals so people with chronic conditions did not need to get a referral each time they wanted to see a specialist for ongoing care. Some states required direct access to all or certain types of specialists, such as obstetrician-gynecologists. Patients in HMOs were less likely in 2001 to believe their doctor might not refer them to a specialist when needed, while no such decline was noted among non-HMO enrollees, evidence of weakened managed care.

These changes occurred when premium increases were relatively small and many employers, facing a tight labor market, chose to absorb much of the cost increases. Premium increases are now much higher—in part to cover the costs of loosened restrictions—and employers are looking for ways to hold down costs.

**NO PROGRESS FOR THOSE IN POOR HEALTH**

In general, people in fair to poor health—those most likely to need and use medical care—are somewhat less likely to trust the health care system. Americans in poorer health are considerably more likely to see strong health plan influence on their doctors’ decisions: more than 50 percent in 2001, compared with 43 percent for those in good health.

**People in fair to poor health—those most likely to need and use medical care—are somewhat less likely than others to trust the health care system.**

In addition, evaluations of trust in their doctors did not improve between 1997 and 2001 for those in poorer health, in contrast to reports of healthier people. While the percentage of people in good health who trusted their doctor to put their needs first rose slightly to 93 percent in 1997, the rate remained at 88 percent through the 1997-2001 period among those in fair or poor health.

Referral concerns also have not improved for those in poorer health, in contrast with the experience of those in better health. And the rate of concern differs substantially by health status: 13 percent of the healthy reported referral concerns in 2001, compared with 20 percent of those in fair to poor health.

It is not known to what extent these differences are caused by actual experience with the health care system and to what extent the mistrust of those with little need for health care declined as a result of consumers hearing fewer managed care horror stories. But it is clear that those in poorer health are less trusting of the health care system, and that recent changes have not lessened their concerns.

**FEWER PEOPLE CHANGE DOCTORS**

Another consumer concern expressed during the managed care backlash was the potential for a loss of continuity of care when a doctor was no longer under contract to a health plan. People also change doctors to obtain care that best meets their needs. Between 1997 and 2001, the percentage of privately insured people who changed their health care provider decreased from 12 percent to 11 percent (see Figure 1). Even among consumers who switched health plans—voluntarily or involuntarily—fewer changed doctors in 2001 than in 1997 (20% in 1997, compared with 17.5% in 2001).

Moreover, people were much less likely in 2001 than in 1997 to attribute their change of doctors to their health plan (29% in 1997, compared with 24% in 2001) (see Table 3). The decline was particularly noteworthy for HMO members (37% in 1997, 28% in 2001), probably reflecting broadened health plan networks that included more providers.
HEALTH PLAN CHANGES STABILIZE

Consumers also can be disrupted when their employers change health plan offerings due to cost, quality, worker dissatisfaction or health plan bankruptcy or consolidation. More Americans reported changing private health plans in 1999 than in 1997 (up from 16.7% to 18.4%), but the rate of switching plans remained steady after that. In 2001, 18 percent of privately insured consumers reported changing health insurance plans in the previous 12 months.

People were more likely to change plans because they or their spouse changed jobs in 2001 than they were in 1997. At the same time, consumers were less apt to switch to obtain a cheaper plan. With broader physician networks, fewer people had to switch plans to keep their doctor. As a result, people were less likely to attribute their switching of plans to a desire to obtain better services. Finally, while changes in employers’ health plan offerings remained the most important reason why people changed plans—more than 35 percent—this proportion did not change between 1997 and 2001.

PROSPECTS FOR THE FUTURE

In response to consumer concerns, health plans broadened their networks and lessened restrictions. These changes came at a cost. Employers now face double-digit premium increases and must make tough choices to rein in health care costs.

If employers choose to pass cost increases on to their workers, more people may choose to change plans to keep their premiums down. Alternatively, employers may give workers the choice to pay more for broader choice by offering plans with tiered provider networks. With consumers instead of health plans making the cost-choice trade-off, another backlash may be averted, at least among those in good health. Because they have many more health care visits, those in fair to poor health may find it less palatable than others to make such trade-offs.

Notes