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ARTICLE: Consumer Choice and the Managed Care Backlash

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SUMMARY:  
... To identify the type of health plan in which respondents were enrolled, each respondent was asked to recall the name of their health plan at the beginning of the survey, and to read the name of their health plan directly from their membership card at the end of the survey. ... For individuals for whom we could not classify plan type based on health plan name alone, we used additional information, as well as a listing of the types of products offered by each health plan in California. ... Models 1 to 3 estimated the relationships between each one of the three choice variables and overall satisfaction with health plan, while Model 4 includes all three choice variables. ... We observed statistically significant differences in the unadjusted rates at which consumers who reported being satisfied with their health plan were offered the choice of a wide-access plan. ... Table 4 presents the adjusted odds ratios and 95% confidence intervals ("CI") that consumers reported overall satisfaction with their health plan, derived from the logistic regression models. Each of the three choice variables is significantly associated with overall satisfaction with health plan in Models 1 to 3. ... Table 2: The Relationship between Selected Demographic Characteristics and Health Plan Choice among Enrollees in Employer-Sponsored Health Plans, California, 1997 (n=827) ... Table 3: Bivariate Relationship Between Overall Satisfaction with Health Plan and Health Plan Choice for Enrollees in Employer-Sponsored Health Plans, California, 1997 (n=827)...

TEXT:  
[*1]

I. INTRODUCTION

The backlash against managed care, in general, and Health Maintenance Organizations ("HMOs"), in particular, is a major health policy issue. n1 It has led to the formation of major commissions at the national and state levels, and to a great [*2] outpouring of legislative activity. n2 The U.S. Congress has been deadlocked over various versions of a Patients' Bill of Rights for the past two years. n3 As a nation, we are far from resolving the many problems consumers report experiencing with their HMOs. However, to prescribe an effective solution to the problem, it is important to understand the root causes of the consumer backlash. It is, after all, possible that a Patients' Bill of Rights will do little if it is not targeted to correct what is really bothering people about HMOs.

The introduction of HMOs was an attempt to correct some of the major shortcomings that consumers and purchasers experienced under the traditional fee-for-service indemnity ("FFS-I") system. n4 These problems included expenditures that were growing at an unacceptable rate, wide variations in medical practice not associated with differences in patient outcomes or medical need, and large amounts of inappropriate surgery and hospital admissions. n5 Under these circumstances, any serious policy that attempted to limit expenditures would need to create standards of appropriateness, to examine and curtail inappropriate use of services, and therefore limit the autonomy and authority of health professionals by subjecting their decisions to review and approval. Thus, any policy that tried to reduce and control health care expenditures to a significant degree would likely have caused a backlash among those physicians who would be asked to change the way they practice medicine and to be conscious of the costs of caring for their patients. One important cause of the backlash is doubtless the anger and frustration of many physicians who have seen their autonomy and authority for making patient care decisions threatened, if not substantially diminished. n6 Returning decision-making authority for patient care back to physicians may be an important part of the solution to the backlash. n7

However, until the late 1980s, HMOs served millions of Americans without a consumer backlash. By January 1990, there were 33 million Americans in HMOs and still no apparent backlash. For example, the California Public Employees Retirement System ("CalPERS")...
manages a consumer choice system for over one million people, offering multiple, responsible choice plans, including a dozen health plans (both HMOs and Preferred Provider Organizations ("PPOs")), with a limited employer contribution. n8 The CalPERS Board of Administration, made up of elected employee representatives and elected officials, listens carefully to their members and surveys them extensively regarding their satisfaction with their health plans. n9 For years, satisfaction with the CalPERS program has been very high and there was no [*3] discernable outpouring of anger and protest. Similarly, the Federal Employees Health Benefits Program ("FEHBP") serves about nine million employees, retirees, and dependents, also with a multiple, responsible choice of health plans, including many HMOs and a choice of "wide-access" plans (FFS-I and PPOs), again for years without a backlash. n10 To be sure, there were individual disappointments and problems to be resolved, as there are under any health insurance scheme. The same was the case for employees of other large firms that offered a wide range of health insurance choices to their employees.

What Happened?

In the early and mid-1990's, employers of tens of millions of people moved their employees and their families from FFS-I, fully or mostly employer paid, to lower cost HMOs with restricted panels of providers. n11 These employees were often offered little or no choice, were given inadequate explanation of the limitations of HMOs, and did not visibly share the financial savings realized by their employers. n12 Many employers panicked at the double-digit premium increases of the late 1980's and adopted a "single plan replacement" strategy, thinking that this would be the cheapest and easiest way to manage health care costs. n13 Many employees, who were moved into HMOs with little or no choice, suddenly discovered that they could no longer receive covered services from the doctors with whom they had established ongoing patient-physician relationships. n14 HMOs became the instrument of a pure "takeaway." n15 Perhaps what is at the root of much of the backlash is this lack of consumer choice of health plans. n16

We hypothesize that consumers are much more likely to be satisfied with their health plans, including HMOs, if they are given a choice of plans, especially a choice menu that includes a wide-access plan.

II.

"MCTF" SURVEY

A. Methods

1. Data Collection

In 1996, the Legislature and Governor of California enacted the creation of the [*4] California Managed Health Care Improvement Task Force ("MCTF"). n17 In 1997, the Governor appointed Alain Enthoven as Chairman of the 30 member Task Force, and Helen Schauffler was commissioned as Principal Investigator to direct a Survey of Public Perceptions and Experience with Managed Care. Between September 2 and September 24, 1997, a sample of adult Californians was selected to be surveyed using random digit dialing. Eligibility for the sample was limited to those who were 18 years or older, who had health insurance coverage at the time of the interview, and who had lived in California for 12 months or longer. The full sample consisted of 1,201 adults. The final sample used for analysis was restricted to persons insured through employer-sponsored coverage who were enrolled in either an HMO, PPO, or FFS-I plan, and included 827 respondents. The data were weighted by age, gender, race and region to reflect the distribution of the population in California.

The data were collected by the Field Research Corporation in San Francisco under the direction of the Center for Health and Public Policy Studies at the University of California, Berkeley. The survey interviews were conducted using a Computer Assisted Telephone Interview ("CATI") system and averaged 25 minutes in length. Interviews were primarily conducted in English, with 6% conducted in Spanish. Up to six attempts were made to contact and complete
interviews with an eligible adult in each randomly selected household.

2. Survey Instrument

Respondents were classified as being enrolled in either staff/group HMO, IPA/network HMO, PPO, or FFS-I health plans. To identify the type of health plan in which respondents were enrolled, each respondent was asked to recall the name of their health plan at the beginning of the survey, and to read the name of their health plan directly from their membership card at the end of the survey. To aid in the classification of health plan type, respondents were also asked three questions regarding: (1) their health plan’s use of physician networks; (2) requirements to select a primary care provider; and (3) requirements to obtain referrals prior to seeing specialists. For individuals for whom we could not classify plan type based on health plan name alone, we used additional information, as well as a listing of the types of products offered by each health plan in California. Using this methodology, we were able to classify 95% of survey respondents by type of managed care plan.

Consumer choice was assessed through three questions: (1) "How important is it to you to have the choice of more than one health plan?" (coded on a five-point Likert scale from very important to very unimportant); (2) "How many different health plans did you have to choose from?" (recorded in whole numbers); and (3) "Were you offered the choice of at least one health plan that allows you to go to ANY doctor or hospital you choose?" (coded as a dichotomous variable). Additionally, the question "Was the out-of-pocket premium cost to you for the health insurance plan that allows you to go to any doctor or hospital higher or lower than the cost of the other plans you could choose from, or was it about the same?" was used to differentiate respondents in wide access plans that had higher costs than the other plans they were offered.

Overall consumer satisfaction with health plan was assessed through the question: "Overall, how satisfied are you with your current health plan?" Additional [*5] satisfaction variables measured respondent satisfaction with their choice of hospitals, physicians, and specialists as well as their satisfaction with the health care system overall. Response categories for all of the satisfaction questions were, "Would you say that you are very satisfied, satisfied, neither satisfied nor dissatisfied, dissatisfied, or very dissatisfied?" Responses for all satisfaction variables were recorded as dichotomous dependent variables, where very satisfied and satisfied equal one, and neither satisfied nor dissatisfied, dissatisfied, and very dissatisfied served as the referent group.

3. Analysis Plan

The bivariate relationships between consumer choice of and satisfaction with health plan were estimated and statistical significance assessed using the Chi-square test. We also assessed the bivariate relationships between the three choice variables and respondent characteristics to identify potentially confounding variables to control for in the multivariate models. Four separate logistic regression models were estimated using different combinations of the three choice variables. Models 1 to 3 estimated the relationships between each one of the three choice variables and overall satisfaction with health plan, while Model 4 includes all three choice variables. The models control for the length of time respondents had been enrolled in their health plan, the type of health plan, self-reported health status, and demographics (age, race/ethnicity, gender, and annual family income). We also estimated four additional logistic models using satisfaction with choice of hospitals, physicians, specialists, and overall satisfaction with the health care system as dependent variables. Adjusted odds ratios and 95% confidence intervals were estimated based on the results of the logistic models.

B. Results

Overall, 77% of the adult Californians in our sample who were enrolled in employer-sponsored health plans in late 1997 reported that they were satisfied or very satisfied with their health plan. n18 Between 83% and 86% were satisfied with their choice of hospitals, physicians, and specialists; however only 61% were satisfied with the health care system overall.
We found that 80% of respondents were offered the choice of a wide-access plan that would allow them to visit any doctor or any hospital (PPO, FFS-I); 20% were not. Thirty-seven percent of respondents were offered a wide-access plan at the same or lower premium as HMO(s), and 43% were offered a wide-access plan at a higher premium than the HMO(s). In addition, 79% were offered the choice of two or more plans; 21% were not. In terms of actual plan chosen, 52% were enrolled in an IPA/Network model HMO, 24% in a group/staff model HMO, 18% in a PPO, and 6% in a FFS-I. Thus, of the 77% of respondents offered the choice of a wide-access plan, less than one third chose this option. Finally, approximately 86% of the respondents in employer-sponsored health plans reported that it is very or somewhat important to be given a choice of health plans.

Table 2 presents the bivariate relationships between demographic variables (race, gender, age, income) and health status with the three choice variables. We found that age is negatively and significantly associated with the importance of having a choice of two or more health plans, with the elderly (65 and older) being less likely to report that having choice is important to them. Annual household income is positively and significantly associated with having been offered a choice of two or more health plans. Additionally, age and race are significantly associated with having a choice of a wide-access plan. Thus, it was important to control for these respondent characteristics in the multivariate analysis.

Respondents who reported that having a choice of health plans was somewhat or very important were less likely to report being satisfied or very satisfied with their health plan compared to those who reported that having a choice was not important (75% vs. 86%). The unadjusted rates at which consumers reported satisfaction with their health plan did not differ significantly (p<.08) by whether or not they were offered a choice of two or more plans.

We observed statistically significant differences in the unadjusted rates at which consumers who reported being satisfied with their health plan were offered the choice of a wide-access plan. We found that 88% of respondents who were given a choice of a wide-access plan with an out-of-pocket premium about the same or lower than the other plans they were offered (same or lower premium) were very satisfied or satisfied with their health plan. Of the respondents who were offered a wide-access plan with an out-of-pocket premium higher than the other plans they were offered (higher premium), 75% were very satisfied or satisfied with their health plan. In contrast, only 64% of those without the choice of a wide-access plan reported being satisfied or very satisfied with their health plan.

Table 4 presents the adjusted odds ratios and 95% confidence intervals ("CI") that consumers reported overall satisfaction with their health plan, derived from the logistic regression models. Each of the three choice variables is significantly associated with overall satisfaction with health plan in Models 1 to 3. Model 1 shows that consumers who report that choice is important (somewhat or very important) are less than half as likely to be satisfied (satisfied or very satisfied) with their health plan compared to those who report that choice is not important. In Model 2, we found that consumers who were given a choice of two or more health plans were about 1.7 times as likely to be satisfied with their plan compared to those not given a choice. Similarly, Model 3 shows that consumers who were given a choice of a comparable or lower premium wide-access health plan are nearly four times as likely to report overall satisfaction with their health plan, and those who were given the choice of a higher premium wide-access plan were about 1.7 times as likely to be satisfied with their health plan compared to those not given this choice.

In Model 4, all three choice variables are included in the logistic regression model. The importance respondents place on having a choice of health plans and being offered a choice of a wide-access plan (both same and lower premium, as well as higher premium plans) remain statistically significant predictors of overall health plan satisfaction. Merely having a choice of two or more health plans is not statistically significant after adjusting for the other two choice
variables.

In all four logistic models, adults in staff/group and IPA/network HMOs were no more or less likely to report being satisfied with their health plan than those in PPO and FFS-I plans. Additionally, there were no significant differences in overall health plan satisfaction by race, gender, age, or income. However, those in fair or poor health were less likely, across all four models, to report that they were satisfied with their health plans. In addition, those who had been enrolled in their plan for more than five years were more likely to report being satisfied with their health plan across all four models compared to those who had been enrolled for five years or [*7] less.

Table 5 reports the adjusted odds ratios and 95% confidence intervals for four additional satisfaction measures as a function of the three choice variables. We found that having been offered the choice of a higher-premium wide-access plan increases the adjusted odds that adults with employer-sponsored coverage are satisfied or very satisfied with their choice of physicians (adj. OR = 1.85; 95% CI: 1.01, 3.38). We found that having been offered the choice of a same/lower-premium wide-access plan increases the adjusted odds that adults with employer-sponsored coverage are satisfied with their choice of hospitals (adj. OR = 3.72; 95% CI: 1.72, 8.08), choice of physicians (adj. OR = 8.59; 95% CI: 3.88-19.02), specialists (adj. OR = 4.8; 1.54, 15.16), and with the health care system overall (adj. OR = 3.58; 95% CI: 2.03, 6.31).

For the other choice variables, the importance of having a choice of health plans and being offered the choice of two or more plans are not significantly associated with any of these additional satisfaction measures.

III. COMMENTS

In 1999, among U.S. workers who were covered under employer-sponsored health plans, 35% were offered only one health plan, and another 15% were offered a choice of two plans. n22 The availability of choice of health plans is lowest for employees of small firms (3-50 employees) that offer health insurance coverage; approximately 91% of small firms that provide health benefits offer no choice or only one plan to their employees, compared to 61% of firms with 51-999 employees, and 22% of large firms with 1,000 or more employees. n23 Nationally, in firms offering an HMO, 36% of covered workers had no choice. n24

Our results suggest that having a choice of two or more health plans raises the adjusted odds of being satisfied or very satisfied to 1.66 without controlling for the other two choice variables, but is not statistically significant in all other model specifications. On the other hand, being offered a choice of health plans that includes a wide-access plan raises the adjusted odds of being satisfied or very satisfied with the health plan to 1.7 to 4.47, depending on model specification. Those who were offered a choice of a same/lower-premium wide-access plan were between 3.94 to 4.47 times as likely to be satisfied with their health plan. Those who were offered a choice of a higher-premium wide-access plan were between 1.70 to 1.89 times as likely to be satisfied with their health plan. That is, people who were offered the choice of a wide-access plan were roughly two to four times as likely to be satisfied with their health plan as people who were not, even though most of them did not choose the wide-access plan when offered.

That is, just having a choice of two or more plans (e.g., among two or more HMOs) is not in itself associated with much increase in satisfaction with a health plan. However, the mere fact of having been offered the choice of a wide-access plan somehow leaves even those people who do not select it more satisfied than those who were never offered the option. In fact, those who were offered a wide-access plan whose out-of-pocket premium was comparable or less expensive compared to the other plans offered had the greatest adjusted odds of being satisfied with their health plan. Having the choice of a wide-access plan, regardless of whether or not it is more [*8] expensive than the other plans offered, is independently explaining a significant amount of the variation in overall satisfaction with health plans, controlling for actual plan chosen. In addition, being offered the choice of a same or lower-premium wide-
access plan is significantly and positively associated with being satisfied or very satisfied with the choice of hospitals, physicians, specialists, and with overall satisfaction with the health care system. Thus, our findings are quite robust.

In a 1997 Henry J. Kaiser/Commonwealth Fund Survey, Davis and Schoen also looked at the relationship between health plan choice and satisfaction. They found that, of those in managed care plans with a choice of two or more plans, 14% were dissatisfied, while 22% of those with no choice were dissatisfied. On the other hand, 12% of respondents in FFS-I plans were dissatisfied, 8% of those with choice, 14% of those with no choice. An earlier Commonwealth Fund Survey of Patient Experiences with Managed Care found that 14% of respondents with FFS-I were dissatisfied with their health plan overall, while 16% of respondents in managed care (HMOs and PPOs) who had a choice of FFS-I were dissatisfied. In addition, they found that 31% of respondents in managed care without a choice of FFS-I were dissatisfied.

While our study reaches broadly similar conclusions, it adds to the previous work in three important ways. First, we compared HMOs or restricted plans (group/staff and IPA/network HMOs) with wide-access plans (PPOs and FFS-I), because PPOs do allow patients to receive insured services from any provider, like FFS-I, and unlike HMOs, which have closed provider networks. We view PPOs as FFS-I with "an upgrade," i.e. a list of providers who will accept the negotiated fee as payment in full. Second, ours is a multivariate analysis that controls for age, race, gender, income, health status, length of time enrolled in plan, whether the respondent thinks a choice of plan is important, was offered a choice of plans, and was offered a choice of a wide-access plan. In addition, we distinguish between the choice of a wide-access plan that is offered at the same or lower out-of-pocket premium cost as the other plans offered, or at a higher out-of-pocket premium cost. Third, our survey focuses on California, the state with the most developed HMOs.

IV. POLICY IMPLICATIONS

Patients' Bills of Rights, as they are presently defined, are not likely to solve the problem of the consumer backlash completely because they deal primarily with the symptoms of dissatisfaction, and not the fundamental causes. Our findings suggest that it is important for employers and other purchasers to offer a choice of health plans that includes a wide-access plan (FFS-I or PPO) if a lower cost HMO is offered, even though most employees will not choose it. In addition, our findings suggest that the highest health plan satisfaction rates (88%) are associated with being offered a PPO or FFS-I at a cost equal to or less than the out-of-pocket premium costs of the other plans offered.

Our findings suggest that one approach to reducing the backlash against HMOs ought to include policies that encourage employers to offer a choice of plans, including a wide-access plan, to their employees. Our findings also suggest that consumers are more satisfied, not only with their health plans, but also with their choice of hospitals, doctors, and specialists, and with the whole health care system, if they simply are given the choice of a wide-access plan at a similar or lower out-of-pocket premium cost compared to the other plans on the choice menu.

Second, by itself, our findings do not argue for multiple, responsible choice of plans, as offered by FEHBP, CalPERS, or large employers. We did not find that persons who were offered two or more health plans were any more satisfied than those who were not when controlling for importance of choice and choice of a wide-access plan. Providing a choice of a wide-access plan could be satisfied by simply offering a choice between one wide-access plan and one HMO. The main reason for offering multiple, responsible choice of plans is the need to create effective competition to provide value for money in a market in which health plans face price-elastic demand. But our findings are an additional reason to favor large scale, wide, responsible multiple arrangements such as FEHBP and CalPERS.

Third, our findings support the importance of risk adjustment of premiums because, in competition with closed-end HMOs (i.e., without a POS option), wide-access plans tend to
draw worse health risks and to suffer adverse selection that endanger their survival. For wide-access plans to survive, risk adjustment of premiums is likely to be necessary. Experience from FEHBP and CalPERS suggests that, without some form of risk adjustment, FFS-I and PPO plans go into a "death spiral." This problem can be managed in part by plan design.

Fourth, many employers have sought to use IPA/network model HMOs as single plan replacements, so they put pressure on the HMOs to include the great majority, if not all, of the doctors and hospitals in a market. This was basically a reinvention of "any willing provider." It weakened the bargaining power of the HMOs and their ability to select efficient high quality providers, and thus their ability to contain costs and reduce the backlash. Our findings suggest that perhaps a better strategy would be to offer a responsible choice of multiple plans that includes one or more wide-access plans, with at least one at an equal or lower cost than the other plans offered, and also one or more closed-end HMOs that can compete to provide the lowest cost option.

Table 1: Selected Demographic Characteristics of Enrollees in Employer-Sponsored Health Plans, California, 1997 (n=827)

Table 2: The Relationship between Selected Demographic Characteristics and Health Plan Choice among Enrollees in Employer-Sponsored Health Plans, California, 1997 (n=827)

Table 3: Bivariate Relationship Between Overall Satisfaction with Health Plan and Health Plan Choice for Enrollees in Employer-Sponsored Health Plans, California, 1997 (n=827)

Table 5: Adjusted Odds Ratios and 95% Confidence Intervals of Satisfaction with Hospitals, Physicians, Specialists, and the Health Care System for Enrollees in Employer-Sponsored Health Plans, California, 1997*.

FOOTNOTES:

n1. See generally Robert J. Blendon et al., Understanding the Managed Care Backlash, Health Aff., July-Aug. 1998, at 80 (discussing the fears of people enrolled in managed care plans as compared to their traditionally insured peers); Thomas Bodenheimer, The HMO Backlash—Righteous or Reactionary, 335 New Eng. J. Med. 1601 (1996) (discussing the substantive issues raised by the backlash against HMOs); Alain C. Enthoven & Sara J. Singer, The Managed Care Backlash and The Task Force in California, Health Aff. July-Aug. 1998, at 95 (reporting the findings of the California Managed Health Care Improvement Task Force); David Mechanic, Managed Care as a Target of Distrust, 277 JAMA 1810 (1997) (noting the increased public opposition to managed care).

n2. See Blendon, supra note 1, at 81; Bodenheimer, supra note 1, at 1601; Enthoven &


n5. See id.


n7. See Physician Survey, supra note 6.


n9. See id.


n12. See The Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits 1999 Annual Survey 42-54 [hereinafter Employer Health Benefits]; Enthoven Speech, supra note 11; Enthoven & Singer, supra note 1, at 97.
n13. See Enthoven Speech, supra note 11.


n15. See Enthoven Speech, supra note 11.


n17. The establishment of the California Managed Health Care Improvement Task Force was added by 1996 Cal. Stat. 815 1 (introduced as A.B. 2343). See Cal. Health & Safety Code 1342.1 (West 2000). See also Survey Brief, supra note 15, at 1. Section II of this article discusses the survey conducted by the MCTF. For clarity's sake, individual citations to the MCTF's report to the governor have been omitted. For more information on the MCTF survey and findings, see generally Findings and Recommendations, supra note 15 (discussing the MCTF survey and findings).

n18. See infra Table 1.

n19. See infra Table 2.

n20. See infra Table 3.

n21. See infra Table 4.

n23. See id. at 39, Exhibit 4.8.

n24. See Employer Health Benefits, supra note 12, at 47, Exhibit 5.5.

n25. See Patient Satisfaction, supra note 14.

n26. See id., Table 4.

n27. See id., Table 4.


n29. See id.