

Table 5. Summary of Studies Comparing Medicare Beneficiary–Reported Metrics

Study	Study Population	Data Time Period	Data Source	Metrics and Analysis	Main Findings	Methodological Notes
Farley et al. 2011	California Medicare CAHPS MA and TM respondents vs. the nation.	2008	Medicare CAHPS	Composites of 14 case mix–adjusted CAHPS measures on overall ratings, 4 composites of reported care, and receipt of preventive services. Comparisons with the nation were adjusted by urbanicity and socio–demographics.	CA’s higher MA performance relative to the nation is highly dependent on one large plan (after case mix adjustment).	Adjusted national estimates to accommodate California’s population diversity. Highlights variation in plan performance and how that can influence the conclusions drawn.
Elliott et al. 2011	Medicare CAHPS MA and TM respondents, including analysis of disparities in 7 vulnerable subgroups (low income, low education, less healthy, older, black, Hispanic, and female).	2007	Medicare CAHPS	Eleven case mix–adjusted CAHPS metrics, including 5 global care ratings, 5 composites of patient experience, and one other. Comparisons between HMO and TM included adjustments for socio–demographics, perceived health status using a difference in difference approach. They also adjusted for geography at the hospital referral region (HRR).	Overall MA–TM performance is higher on 5 metrics (including 3 prescription drug metrics and paperwork) and lower on 3. Difference–in–difference for vulnerable subgroups shows larger MA disparities relative to TM.	Highlights variation in performance depending on the metrics used. It also illustrates the effects of variation in plan performance on disparities. Part D metrics are heavily represented in the metrics on which MA scores better. The data were collected soon after the Part D program was started and could reflect transition issues, particularly in free–standing drug plans. (Many MA plans already had some prescription drug benefits and were probably less–affected by start up concerns).
Keenan et al. 2009	Medicare CAHPS respondents 65+ in MA and TM, grouped by healthy and sick.	2003–2004	Medicare CAHPS	Case mix–adjusted composite of items related to needing care, receiving care quickly, and physician interactions. Adjusters include age, education, and multiple self–reported health measures. Data supported county–level comparisons.	Beneficiaries rate MA lower than TM for all care experience measures except for office wait time. Those in MA report they are more likely to receive preventive services. TM–MA differences generally are greater for sick vs. healthy.	Used risk adjustment to account for subgroup differences. One of the few broad–based studies that compare sick to healthy individuals.
Mittler et al. 2010	Medicare CAHPS respondents in TM and MA 65+ and not dual eligible in 199 of 306 hospital referral regions (HRRs) with sufficient MA members.	2003	Medicare CAHPS merged with Medicare TM data for HRRs to create end–of–life expenditure index in TM.	Case mix–adjusted HRR means for 10 metrics regarding getting needed care, getting care quickly, being seen in 15 minutes, doctor’s communication, office staff, receipt of flu shot, receipt of pneumonia shot, and 3 overall ratings. Comparisons were within HRRs divided into quintiles on TM intensity.	CAHPS scores generally lower (7 measures) or no better (2 measures) than TM in high–intensity markets. High–intensity effect particularly strong in MA.	This study highlights variation in consumer reported quality across geographical areas, particularly among HMO enrollees. The reason for lower MA ratings in high TM intensity areas is not clear but Mittler suggests the findings may mean that consumer expectations in HMOs are shaped by the prevailing TM practices in high intensity markets.

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Kennan et al. 2010	Medicare CAHPS respondents in MA and TM in 196 of 306 HRRs with sufficient responses.	2001–2004	Medicare CAHPS	Pooled data by HRR on 14 metrics with similar interpretations for TM and MA (mainly care experiences and preventive care rather than insurance design). Metrics were adjusted for age, education, and various health status measures. Estimates account for sampling error and clustering; analysis by HRR, state, and plan.	MA and TM scores are highly correlated at the HRR level but MA scores within an HRR vary by plan and there is more geographical variation within the MA sector than in TM. While TM scores generally were higher than MA, the reverse was true on some metrics in some markets.	Study highlights variation in plan performance that its authors believe could reflect the influence of local market forces and organizational characteristics on plan performance. Analysis includes risk adjustment for differences in case mix.
Landon et al. 2004	Medicare CAHPS respondents 65+ in MA and TM, with adjustments to reflect areas of the country where both options are available.	2000 and 2001	Medicare CAHPS	Four overall ratings, 5 composite measures on beneficiary care experiences, and 3 reports of preventive services. Analysis used “matching weights” at the county level to case mix adjust comparisons by age, self– reported health status, education, and proxy use.	TM better on each global measure, personal physician, and problems getting needed care. MA better at prevention and paperwork. State and regional variability exists. Results stable across years.	Study’s main limitation is the study period (2000–2001). Also the findings provide insight mainly into HMO performance, not newer health plan types.
Balsa et al. 2007	Medicare beneficiaries 65+, surveyed in the respective years, enrolled in Medicare A and B (excluding dual eligibles, ESRD eligibles), living in a county with a Medicare+Choice option, and alive for the entire year.	1997–2001	National Health Interview Survey 1997–2001; Medicare Current Beneficiary Survey 1996–2000 (Cost and Use Files and 2001Access to Care Files).	Both surveys: whether person had delayed care due to cost reasons. NHIS: 4 items on access: usual source of care, 12–month responses on getting medical care, seen/talked to doctor, seen/talked to medical specialist; and 2–week items on saw or used services. Probit analysis is used to control for selection on terms of socio–demographics and health status associated with plan selection, with geographic and year fixed effects.	In general, this study found relatively little relationship between M+C enrollment and access measures or disparities in care. Hispanics in M+C were more likely to have a usual source of care than those in TM.	Paper emphasizes beneficiary’s choice of plan with an emphasis on whether there is evidence that managed care negatively affects care for minorities, taking into account choice, use, financial impact (self–reported out–of–pocket spending), and access.

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Safran et al. 2002	Medicare beneficiaries 65+, continuously enrolled for at least one year in HMOs and TM in mature plans in 13 states. Analysis based on those with a primary care physician.	1998	Data from Study of Choice and Quality in Senior Health Care; 9,625 respondents (8,118 long form) with 64% response rate.	Primary Care Assessment Survey (PCAS) with 11 summary scales to measure 7 defining characteristics: accessibility, continuity, integration, comprehensiveness, whole person orientation, clinical management, and sustained clinician–patient partnership. TM sample was matched to HMOs by age, sex, and zip code at baseline. Multivariate analysis controlled for socio–demographic variables, state, and selected chronic conditions.	Nine of 11 indicators favored TM, with financial access favoring HMOs and preventive counseling not varying by system. Network model HMOs generally performed better than staff/group models, with few differences by profit status.	This study includes some unique metrics on the characteristics of primary care relative to patient needs. The fact that HMOs performed more poorly than TM despite the explicit focus on mature markets and plans adds to the literature. However, the data are from 1998.
Pourat et al. 2006	Medicare community-dwelling beneficiaries 65+, distinguishing HMO vs. TM (by type of supplement), with an emphasis on those with chronic illness.	1996	MCBS	Ten questions on satisfaction with overall care and 12 on patient experiences with regular physician. Overall satisfaction metrics grouped into summary metrics on overall quality and access. Analysis focused on highly dissatisfied vs. others.	HMO enrollees generally were less satisfied than those in TM, except that HMOs scored better on access. Same pattern generally held for subgroups by health status. Fewer differences for those with no conditions.	This is now a relatively old study (1996). While it includes some controls for selection, it does not control for location.
Beatty and Dhont 2001	Medicare community-dwelling beneficiaries who are working-age disabled (18–64) or 65+, with 1+ instrumental activities of daily living limitation.	1994	MCBS (Access to Care File)	Measures of access to care (usual source of care, health problem, not seen doctor); affordability (delayed seeking care because of cost, trouble getting care); and perceived quality (satisfaction with doctor’s concern and overall health care quality). Logistical regression used to assess performance, controlling for age, gender, health status, disability, severity, and Medicare qualification status.	MA scored better than TM on access and affordability measures but no difference in satisfaction. Regardless of coverage, the least healthy and most disabled scored worst.	The study sample only included 358 Medicare HMO beneficiaries vs. 5,758 in TM. No adjustment for geography.

NOTE: See also the Ayanian et al. (2013a) in Table 4 for findings on a few CAHPS indicators.

SOURCE: Authors’ summary of findings reported in articles.