The Medicaid Program and Consumer Needs: a Survey Among Residents of a Poor Chicago Neighborhood

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Synopsis

A convenience sample of 200 inner-city residents were interviewed about their knowledge of benefits available under the Illinois Medicaid fee-for-service and prepaid programs; a second sample of 200 residents from the same community were interviewed about their health care information needs. All respondents were recruited from a Chicago neighborhood with one of the nation's highest rates of poverty, infant mortality, and births of low birth weight infants. The neighborhood also has been targeted as a demonstration site for an Illinois Department of Public Aid's prepaid Medicaid program.

Responses to the first interview indicated that neighborhood residents did not understand the operational features of Medicaid prepaid plans or the programmatic mission of these plans, and they did not want to enroll in existing prepaid plans. As determined in the second interview, residents desired information on the scope of Medicaid services, ways to assess quality of health care received, and options for maintaining their freedom to choose hospitals and physicians or clinics. The survey findings are compared with what is known about the reasons middle class employed families enroll in and disenroll from prepaid plans and the position of poor families in a cost-conscious health care system.

UNABATING PRESSURES to control health care costs have led State Medicaid programs to continue their 20-year tradition of experimenting with prepaid plans—Health Maintenance Organizations (HMOs)—for Medicaid recipients. Recent changes in Federal legislation (Omnibus Reconciliation Act, Public Law 97-35, 1981) granting more flexibility to Medicaid programs to restructure reimbursement and to limit Medicaid recipients' freedom to choose providers have facilitated efforts to establish demonstration sites for prepaid health care (*1*).

Illinois is one of the States that are beginning to test the prepaid concept (*2*). In 1984, the Illinois Department of Public Aid (IDPA) began a demonstration project in inner-city Chicago neighborhoods known to have high use of health care subsidized by Medicaid, particularly for hospital services. Enrollment into the Medicaid prepaid program is voluntary and disenrollment is unimpeded.

The 1985-86 goals for enrollment in the prepaid program were set at 120,000 Aid to Families of Dependent Children (AFDC) recipients, twice the actual enrollment of 60,000 recipients in the first year. The publicly stated goal of the program is to contain health care costs while maintaining the quality of services. Eventually, the goal of the prepaid plan is to enroll, permanently, 10 percent of the Medicaid population, or approximately 100,000 persons. Presently, IDPA is hoping to save 5 percent in Medicaid costs ($74 million saved, based on the 1985 Medicaid budget) by setting the capitation rate at 95 percent of projected fee-for-service costs (*3*).

Studies of resource allocation within HMOs support the contention that prepaid plans yield savings for Medicaid programs. Data from the Office of Economic Opportunity's demonstration projects of prepaid care document a 50 percent reduction in hospital use for low-income participants as compared with national norms for poor families (*4*). The 3-year cumulative experience in the District of Columbia's Medicaid prepaid plan netted a per capita annual savings of 35 percent.

Underlying these cost reductions were decreases in physician visits, use of pharmacies, number of hospital admissions, and length of hospital stay (*5*).

Success of an HMO in containing health care costs is contingent in part on the recruitment and retention of patients who will honor the HMO's contractual terms and who are not more disabled or ill than the broader population (*6*). When enrollment in an HMO (either publicly subsidized or private) is voluntary, the decision to join is a personal one subject to many factors and carries with it important ramifications for the HMO (*7*). Berki and Ashcraft's review of the cumulative evidence for determinants of voluntary enrollment concludes that younger families that anticipate having more children are more likely to enroll in a prepaid plan than are single people or families with few or older members (*8*). Given the sociodemographic differences between HMO and alternative plan enrollees, the discriminating factor appears to be projected need for pediatric, preventive, and maternal care.

Investigations have also been done of Medicaid recipients' reasons for joining a prepaid plan. Compared with the volume of research on the decision-making process of middle-class employed persons and families, however, there have been few efforts to obtain Medicaid recipients' perceptions and opinions of prepaid plans. Among earlier published reports is one of a survey of low-income families in East Baltimore who were Medicaid recipients unconcerned with financing their health care because they received public subsidies. These Medicaid families focused more on the characteristics of the delivery system that on copayments (*9*).

The most detailed analysis that has been published of Medicaid recipients' reactions to the option of prepaid health care is based on the California experience. Interest in how Medicaid families in California arrived at the decision to enroll in a HMO arose retrospectively as complaints were filed about marketing and recruitment practices (*10,11*). More recently, evidence has been published showing that Medicaid families without a regular health care provider were more likely to choose a Medicaid HMO (*12*). In another part of the country, Medicaid families preferred private practice arrangements and were similar to middle class families in being sensitive to travel time to sources of care (*13*).

The complexities and import of the process for choosing between traditional fee-for-service and prepaid health care require further investigation of why people enroll in and disenroll from health care plans (*14, 15*). Also, the special circumstances of Medicaid recipients in the health care system add some urgency to the need for this additional knowledge (*16, 17*).

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This report presents the results of two surveys of inner-city residents' knowledge of and attitudes toward IDPA fee-for-service and prepaid Medicaid programs. The surveys were conducted as a first step in the formulation of a consumer education program about prepaid plans, specifically, and the health care system, generally.

Features of the IDPA program that are idiosyncratic to circumstances in Chicago illustrate why it is important to understand Medicaid recipients' knowledge of and attitudes toward the health care system. An example—and a matter of particular concern—is the status of the Chicago Department of Health (CDOH). Before Medicaid HMOs, CDOH's clinics were the source of health care services for 25 percent of all Chicagoans. However, because CDOH is not a designated IDPA prepaid provider, Medicaid recipients enrolled in the prepaid program can no longer officially receive services from a CDOH clinic. If CDOH provides services to those Medicaid patients, the cost cannot be billed to IDPA but must be absorbed by CDOH. Such changes that were introduced with the prepaid plan have resulted in confusion among Medicaid recipients concerning where, from whom, and when they can receive health care.

Methods

Sample. Two hundred respondents answered questions about use of health care services and another 200 respondents answered questions about health

Table 1. Knowledge of HMO procedures and coverage among 156 respondents who had heard of HMOs

Procedures and coverage included in inquiry	Correct responses		Incorrect responses		"Don't know" responses	
	Number	Percent	Number	Percent	Number	Percent
HMO has same coverage as fee-for-service provider	58	39.7	23	15.8	65	44.5
HMO enrollment is voluntary	91	59.9	10	6.6	51	33.6
You may disenroll from an HMO	60	40.0	23	15.3	67	44.7
Everyone on AFDC grant is enrolled in an HMO	56	36.8	27	17.8	69	45.4
Choice of clinic or physician is limited	96	63.6	10	6.6	45	32.5
Choice of hospital is limited	96	63.6	6	4.0	49	32.5
You have your choice of hospital in an emergency	37	24.7	60	40.0	53	35.3

information needs. All participants were interviewed at a CDOH clinic near one of the largest Chicago Housing Authority projects. The clinic serves approximately 30 patients a day (30 percent family planning, 20 percent prenatal care, and 50 percent pediatric care). All new patients are required to appear at the clinic at 8 a.m.; repeat visitors make scheduled appointments.

Patients potentially eligible for an interview were identified by the clinic's social worker, who directed the interviewer to those patients. Based on the social worker's knowledge of the patient population, an effort was made to balance the sample for new and repeat visit patients. On the average, eight interviews were conducted per day, spanning the clinic's 8-hour work day. Ninety-one percent of the respondents were women, with an average age of 24 years (standard deviation = 7.4); all were black, and about half (47 percent) indicated that they usually obtained their health care from CDOH. The majority of the sample were either currently on Medicaid (71 percent) or had been enrolled in the Medicaid program at some time (80 percent) and thus were candidates for participation in the Medicaid prepaid plans. The respondents were not asked, however, if they had ever been approached about prepaid plan membership; they were asked if they had ever been enrolled in a prepaid plan.

The clinic serves residents of a neighborhood selected by IDPA for implementation of the Medicaid prepaid program. The neighborhood has been identified as one of the poorest in the nation (*18*), with a median household income of $7,600 in 1980 ($3,700 in constant 1967 dollars). Concomitant with widespread poverty are major health problems as reflected in the infant mortality rate and number of low birth weight babies born to neighborhood residents. In 1983, the most recent year for which data are available, the neighborhood's infant mortality rate was 18 deaths per 1,000 live births (versus 14 deaths per 1,000 live births for the city of Chicago and 11.2 deaths per 1,000 live births nationally) (*19*). The low birth weight rate in the same year was 13 percent of all neighborhood births (versus 6 percent of all births for the city of Chicago and 6.8 percent of births nationwide) (*19*). The magnitude of the socioeconomic and health problems in this Chicago neighborhood continues to draw national attention as evidenced by a recent Time magazine article on inner-city neighborhoods (*20*).

Survey instruments. The survey instrument used to obtain information on knowledge and use of health care services was developed in collaboration with CDOH's clinic personnel. The 40-item interview builds upon previous survey research on use of health care services (*21*). In the survey there are questions on previous experience with Medicaid, understanding of recipients' rights and options under the fee-for-service Medicaid program and Medicaid HMOs, and expectations for the future of health care services in their community. Specific questions were developed based on the observations of clinic staff as to the important dimensions of alternative programs as they related to Medicaid recipients' use of health care services. Care was taken to word each question so that the respondent could understand it.

A second survey instrument, a set of 23 questions concerning health information needs, was used in interviews with 200 additional patients at the same clinic. What health services and issues the respondents wanted to know more about, from whom and by what methods the respondents would like to procure that information, and how the respondents judge the quality of health care they receive were among the questions in this interview.

All 400 participants were interviewed one on one 2 days a week during May, June, October, and

November 1985. Individual interviews assured completeness of responses and helped to overcome the difficulties respondents might have had because of poor reading skills. Each interview was conducted by a university research associate who also serves as a junior reverend in the church directly across the street from the health department's facility where the interviews were held. Each questionnaire was pilot tested, and the results were reviewed in detail by the university research team and clinic staff before beginning the larger surveys. Use of one interviewer may have introduced a bias. However, the clinic's concern with the comfort of the patients in answering potentially sensitive questions dictated that one interviewer who is recognized in the community was preferable to a team of interviewers. There were few refusals to participate in either survey. In fact, many respondents talked at great length about their health care concerns once they had been asked for their opinions on the health care system.

Analysis of findings. Responses to questions concerning knowledge about available benefits, eligibility criteria, and so forth were coded as correct only when a response was given that agrees with IDPA–AFDC coverages under the fee-for-service and prepaid Medicaid plans (non-AFDC Medicaid coverage was not included in this analysis).

Three subgroups were identified in the survey to determine use and knowledge of health care services: (*a*) 156 respondents who had ever heard of HMOs, (*b*) 180 respondents answering questions about fee-for-service, and (*c*) 36 respondents who were or had been enrolled in a HMO.

The regulatory status of key characteristics of IDPA Medicaid programs follows.

Program characteristic	*Regulatory status* [1] *(April 1985)*	
	Fee-for-service	*Prepaid plan*
Choice of physician	Open	Limited
Choice of hospital	Open	Limited
Copayments for prescription	None	None
Copayments for dental care	None	None
Copayments for vision care	None	None

[1] As stated by the Illionois Department of Public Aid, Medical Assistance Program 1982, 1983, 1984, and 1985.

Under the fee-for-service Medicaid program, choice of physician and hospital is unrestricted and all services are free. The prepaid contracts awarded by Illinois limit the Medicaid recipient's choice of physician and hospital. Visits to the contracting physician or clinic are monitored by the contractor for monthly levels of utilization. All visits to a hospital must receive prior approval from the contracting physician or clinic, except emergency visits; those visits must be approved by the contracting physician or clinic within 24 hours of the incident. Transportation to services and pharmaceutical services are covered by the contracting physician or clinic. Dental and optometric services are covered by the HMO contractor or provided without cost to the recipient under the fee-for-service plan.

Table 2. Summary of respondents' knowledge of the financing and mission of Medicaid HMOs

Variables	*Responses*	
	Number	*Percent*
Source of revenue for Medicaid HMOs is:		
Individual billing to Public Aid for each visit	18	12
Monthly per capita payment	21	14
Copayment	3	2
Don't know	107	72
Mission of Medicaid HMOs is:[1]		
To improve health care	29	19
To save money	61	41
To decrease emergency room use	33	22
To limit utilization to 1 physician or clinic	59	39
Don't know	57	38

[1] Total percent exceeds 100 because multiple responses were possible.

Knowledge and use of health care services. The respondents' understanding of the benefits available to Medicaid recipients was explored in several ways. First, knowledge of prepaid procedures and coverage was assessed for the overall sample of 156 respondents who had ever heard about HMOs. Of those respondents, all who indicated that they knew of the existence of HMOs were asked to rank their knowledge of facets of prepaid plans on a three-point scale (1 = correct; 2 = incorrect, 0 = don't know). As summarized in table 1, the respondents reported that they were most knowledgeable about limitations placed by HMOs on choice of clinics, physicians, and hospitals (64 percent of sample). The least amount of knowledge was evidenced concerning the issues of enrollment and disenrollment (45 percent of sample). The level of incorrect responses ranged from 4 percent for choice of hospital to 40 percent for choice of hospital in an emergency.

A summary of these respondents' understanding of the financing and mission of Medicaid HMOs is presented in table 2. The model response to the

Table 3. Summary of respondents' knowledge of benefits available through Medicaid fee-for-service and prepaid plans as determined by Medicaid standards

Medical benefit	Correct responses about fee-for-service		Correct responses about prepaid plan	
	Number	Percent	Number	Percent
Choice of physician or clinic	119	66.1	53	86.9
Choice of hospitals	113	62.8	54	88.5
Transportation to care	156	86.7	11	18.0
Prescriptions	97	53.9	36	59.0
Dental	92	51.1	30	49.2
Eye care	95	52.8	31	52.5
No charge for care	124	68.9	48	78.7

NOTE: All percentages were calculated based on the total subsamples of respondents who were knowledgeable about fee-for-service (N = 180) and HMO (N = 61) programs. Correct responses were those that accurately identified coverage for recipients in the Illinois Department of Public Aid, Aid to Families of Dependent Children Program.

Table 4. Survey respondents' needs for information about health care ranked in descending order of importance

Issues	Responses	
	Number	Percent
Determination of services reimbursed by Medicaid	94	47.2
Assessment of quality of care from physician or clinic	83	41.2
How to obtain freedom of choice for hospital services	75	37.7
How to obtain freedom of choice for physician or clinic services	61	30.7
Determination of eligibility for Medicaid	59	29.6
Assessment of quality of care from hospital	59	29.6
Procedure for registering complaints about health care received	54	27.1
Payment required from physician or clinic	32	16.1
Payment required from hospital	29	14.6
No information needed	16	8.0

NOTE: Responses were reordered from their listing in the interview according to the percent of respondents who indicated that the specific issue was something they would like to know about. Cumulative percent exceeds 100 because respondents were asked to select the 3 most important topics.

question about the source of revenue for Medicaid HMOs was "don't know." Approximately 40 percent of the respondents selected limiting care to one provider and cost savings as an important Medicaid HMO mission. Of this group 41.2 percent listed both of these objectives as key Medicaid HMO goals. Overall, 18 percent believed that HMOs should continue, 34 percent believed that HMOs should be terminated, and 48 percent had no opinion on the issue of continuation. Ninety people (60 percent) who were not enrolled stated that they would decline an invitation to join a prepaid plan, and another 26 percent had no opinion about becoming a member. The remainder (14 percent) had either already joined a prepaid plan or were willing to join if asked.

A comparison of the accuracy of knowledge of benefits under fee-for-service and prepaid plans is summarized in table 3. Two subsamples were identified for this analysis: one group who claimed to understand specific fee-for-service benefits (N = 180) and a second group who claimed to understand prepaid benefits (N = 61). With one exception—respondents' understanding of the entitlement to transportation to and from a HMO—the level of knowledge about the two health care programs was roughly comparable for these subsamples.

With regard to experience with prepaid plans, 27 percent of the respondents claimed to have been enrolled in a prepaid plan at some time and 98 percent were enrolled at the time of the interview. For these members of a prepaid plan, questions were asked regarding their reasons for joining, satisfaction with care received, and plans for continued enrollment. In this sample of 37 people, more than 80 percent claimed to have been enrolled for at least 12 months. The majority of enrollees (74 percent) claimed to have become members because they felt they would receive better services from a HMO. More personal service, faster service, and free tansportation received almost equal weight in the decision to join (39 percent, 32 percent, and 32 percent of the sample, respectively). More than half of the prepaid enrollees claimed to be unhappy or very unhappy with their prepaid services; 13 percent were very happy or happy with the care they received. Within the dissatisfied group, 100 percent intended to disenroll or had already disenrolled.

Health information needs assessment. The health information needs assessment survey began with a question on what services the respondent would like to know more about. In descending order of importance, people were interested in learning more about the Medicaid program (73.5 percent), the CDOH (73.0 percent), private physicians (66.5 percent), and HMOs (47.5 percent). The most salient issues of concern are summarized in table 4. When the survey participants were asked to choose their three most important information needs from a list of nine health care issues, they listed services covered by Medicaid (47.2 percent), how to determine quality of ambulatory care

provided (41.2 percent), and how to obtain freedom of choice for desired hospital services (37.7 percent). Eight percent of the sample stated that they needed no additional information about any health care issue. The majority (65.2 percent) of the respondents would prefer to talk to someone in person to obtain the desired information. Almost half the sample would seek information from someone in CDOH (46.5 percent); another 27 percent would talk to a public health nurse (who also would be employed by CDOH).

Six factors (geographic location, speed of service, quality of care, attitude of staff, acceptance of Medicaid, and out-of-pocket costs) with the potential to influence choice of health care provider were presented to the respondents, and they were asked to rank the three most important factors. Eighty-six percent of the sample named quality of care as one of the three most important facors influencing the choice of health care provider. Geographic proximity was almost equally important in the decision-making process; 60 percent of the sample ranked it among the top three factors. Acceptance of Medicaid reimbursement was the third most influential factor; it was cited by 54 percent of the sample. When limited to identification of the one feature liked best about health services being received, 50 percent of the sample chose quality of care and 28 percent chose proximity of care. When asked which one feature is liked least about the health care being received, 55.6 percent chose lengthy waiting time and 18.9 percent chose proximity of facility.

Table 5 summarizes the respondents' indices of quality of care. Subjects were asked to respond to the open-ended question, "How can you tell if you are getting good quality health care?" Examination of the 155 responses yielded the 7 categories that are listed in the table. Almost one-third of the definitions of quality of care could be grouped under the category "good communication with provider." Among the responses in this category, the predominant theme is that the quality of care is defined in terms of the dialog between patient and health care provider.

The last component of the health information survey asked participants what changes in the Medicaid program they had heard about and how important they believed those changes would be for themselves and their families. Responses pertaining to eight possible alterations in the Medicaid program indicated that restrictions in the coverage of drugs and vision care and enrollment of Medicaid recipients into prepaid plans were the three most widely known (table 6). The respondents were referred to the list of potential changes and asked to designate the change that would be most significant for themselves and their families. Restricting coverage of medications was cited as the most important change (32 percent). Restricting the choice of provider (physician and clinic) and decreasing the number of providers accepting Medicaid reimbursements were tied in their weights as important changes (each accounted for 13 percent of responses given).

Table 5. Summary of respondents' indices of quality of health care

Category	Responses	
	Number	Percent
Good communications with provider	46	30
Results following treatment	22	14
Tautological definitions of quality care	20	13
Good staff attitude	17	11
Appropriate examination	18	12
Appropriate medications	12	8
Quick service	7	5
Unclassified	6	4
Miscellaneous	7	5

NOTE: Figures are based on 125 responses to "How can you tell if you are getting good quality health care?" Cumulative percent exceeds 100 because multiple responses were possible.

Table 6. Respondents' ranking of importance of changes in the Illinois Department of Public Aid's Medicaid Program

Program change	Responses of survey participants who had heard of changes		
	Number	Percent	Rank
Restrictions in Medicaid's coverage of drugs	130	66.3	1
Restriction of choice of physician or clinic for Medicaid recipients	64	32.7	2
Decrease in acceptance of Medicaid payments by physician or clinic	74	37.8	2
Difficulties in obtaining Medicaid coverage	61	30.5	4
Enrollment of Medicaid recipients in prepaid plans	86	43.9	5
Decrease in acceptance of Medicaid payments by hospitals	70	35.7	5
Restrictions in Medicaid's coverage of vision care	90	45.9	7
Loss of Medicaid coverage	56	28.6	8
Heard of no changes	14	7.1	...

NOTE: Program changes having the same numerical ranks were believed to be the most important by an equal number of respondents.

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Discussion

The results of this survey show that a greater number of a self-selected group of inner-city residents were knowledgeable about fee-for-service health care traditionally available through Medicaid than they were about prepaid health care through the same funding source. Within the two groups claiming knowledge of fee-for-service and prepaid plans, accuracy of understanding of available benefits was roughly comparable.

Admittedly, the sample we report is a self-selected group of health care consumers with a fairly strong preference for services from one provider, namely, the Chicago Department of Health. A larger, stratified random survey of households would be required to ascertain the gamut of knowledge and attitudes in the community. Nonetheless, the people participating in this study are representative of the community overall with respect to their sociodemographic characteristics, their eligibility for Medicaid, and thus the possibility of their becoming a prepaid plan member. As such, we believe that they speak for their community's concerns and hopes for health care services.

Not enough time has elapsed since the introduction of the Illinois Medicaid prepaid program to permit explication of the influence of these concerns and hopes on the course of prepaid enrollment, disenrollment, or cost containment potential. Cumulative experience with middle class, employed persons and families enrolled in HMOs, however, does provide a basis for speculation on the impact of such factors as knowledge of benefits, overall satisfaction with care, and access to services on the success of the Medicaid prepaid experiment. Each of these issues has been shown to be predictive of duration of tenure in a prepaid plan and is discussed as it relates to the feelings expressed by the Medicaid-eligible people we surveyed.

Prior knowledge and greater intimacy with the workings of a prepaid plan appear to be linked with a longer period of enrollment. Presumably, the better people understand what they are getting into, the more comfortable they are with their new situation. The true cause-effect sequence between knowledge and enrollment is unclear. Nonetheless, it could be hypothesized that having additional information about prepaid plans would help people to make a more satisfactory choice of health care plans. The low level of understanding among the respondents in our survey as to the benefits and mission of HMOs indicates that there is a large audience for further education. In a middle class population, the observed correlation between exposure to the prepaid concept and maintenance of enrollment may very well generalize to less affluent populations if additional information on the characteristics of prepaid plans were provided to them. The success of educational programs that introduce the benefits of Medicaid offers a precedent for such efforts (*22*).

Another experiential dimension of prepaid plans that may prove pertinent to Medicaid families is satisfaction with prepaid services. Dissatisfaction with HMO medical services is a key reason for disenrollment (*15,23–25*). Inspection of the average satisfaction with care among middle class persons identifies a number of themes shared with the inner-city Medicaid-eligible families. Residents from Rochester, NY, who were disenrolling voluntarily from a HMO cited these reasons for leaving (*23*): (*a*) time waiting to see the physician was too long, (*b*) treatment was not sufficiently thorough, (*c*) physician did not spend enough time with each patient, (*d*) patient was not given sufficient information about his or her medical problems, and (*e*) HMO staff lacked personal interest.

Similar statements of dissatisfaction were heard from persons disenrolling from a HMO serving several counties in a large metropolitan area (*15*). Those people were not satisfied with the physician's warmth and interest or willingness to make needed referrals, the patients' ability to see the physician they wanted, and the amount of information given to patients about their health. Two other studies have employed longitudinal designs

and a standardized measure of patient satisfaction to assess the likelihood of disenrollment, given varying levels of satisfaction (*24,25*). They too showed that dissatisfaction often led to enrollees leaving the prepaid program.

The premium placed on communication with their health care provider by the inner-city residents surveyed in this study echoes the preferences of other consumer groups. Furthermore, 47 percent of the respondents were regular, satisfied patients of the Chicago Department of Health. Were these persons to switch to another health care provider, they would bring with them this generally satisfactory experience as a yardstick against which to measure their new provider. Looking prospectively to the planning of recruitment for Medicaid HMOs, the convergence of evidence from previous work as well as this survey points to the importance of trying to preserve the interpersonal aspects of patient-provider interactions (*26,27*). Otherwise, a predictable consequence of dissatisfaction for many patients is disenrollment (*28*).

As a last issue in this discussion, we turn to the respondents' attitudes toward the geographic availability of care, particularly hospital care. Restriction of hospital services has been repeatedly reported as a nettlesome feature of prepaid plans. Limiting hospital use can be expected to be especially irksome for an inner-city population such as described here, given that prepaid plans were instituted in the first place because of excess consumption of hospital services. Since hospital services remain free to the Medicaid recipient under either plan, restrictions may seem arbitrary and burdensome if travel times are perceived as long and quality of care poor.

Early experience with the IDPA demonstration prepaid plan did in fact uncover problems with hospital access. Responding to "inappropriate" hospital use (defined contractually), IDPA has expanded the number of hospitals eligible to receive Medicaid prepaid plan patients. These adjustments in the availability of tertiary care has reduced travel time from home to the hospital to be more in line with the conventional 30-minute travel time standard for accessible hospital care (*29*). In turn, adherence to the designated prepaid hospitals has improved.

This type of administrative adjustment undoubtedly has beneficial effects on satisfaction and enrollment. As long as prepaid plan enrollment remains voluntary, however, members will be free to express their displeasure with hospital services, or any other services, by leaving. Again, we return to the recommendation of providing more extensive and intensive information to consumers so that they better understand the contractual terms of enrollment and the potentially negative consequences of disenrollment.

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The ongoing changes in AFDC eligibility and general assistance programs serve only to broaden the consumer's need for information. In Illinois alone, substantial changes were made in 1982 and 1984 in Medicaid eligibility and scope of services covered. Such a state of constant revision of public assistance eligibility rules is seen elsewhere in the nation (*30*). Put another way, the economic uncertainties facing most Medicaid recipients magnify the importance of their becoming knowledgeable about health care services.

In a broader context, the interviews with these Chicago residents raise a host of questions as to the fate of low-income families in a health care system which is ever more cost conscious (*31*). To date, poor people have not fared well in the realignments of public and private health care services (*32,33*). Imposition of funding caps on hospital care for Medicaid patients, as seen in Illinois, removes additional degrees of freedom for both providers and patients (*34*). Left relatively uninformed about the intent of changes going on around them, the poor may do even worse. Supplied with information through a concerted community campaign, however, families caught up in the flux of publicly subsidized care may become more informed consumers. The benefits to patients, recipients, and payors could be substantial.

Editor's Note—Readers interested in securing detailed information about the coding of responses to "How can you tell if you are getting good quality health care?" and in obtaining copies of the survey questions may write to Dr. Lynn Olson, Center for Health Services Research, Northwestern University, 629 Noyes St., Evanston, IL 60201.

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