Development of an Interval-Level Scale to Assess Consumer Satisfaction with Prescription Drug Coverage

by Shane Desselle

The rising cost of health care has prompted radical changes in the organization and delivery of medical care by both government and private market forces. After health care spending began to account for more than 15% of our nation’s gross national product in the mid-1990s, the Health Care Financing Administration became more determined to find ways to reduce the costs of providing care to its beneficiaries without sacrificing quality and access, which resulted in the channeling of those beneficiaries into managed care plans. Additionally, large employers have demanded greater accountability from private insurers to reduce the financial burden of sponsoring the health insurance premiums of their employees. These factors and others have prompted the vertical integration of private insurance companies into large conglomerates. To appease consumer demands for choice in health insurance coverage, these conglomerates offer a wide variety of plans that differ significantly in both cost sharing and freedom to visit health providers of the beneficiary’s own choosing.

The issue of prescription drug coverage is even more complicated. Unlike hospital claims, which are relatively few in number but very expensive, prescription claims are far more numerous but relatively inexpensive on a case-by-case basis. This situation places a significant administrative cost burden on the insurance carrier, which in turn often outsources prescription claims processing to a pharmacy benefits manager (PBM). The patient often has separate insurance cards—and separate rules—for obtaining medical care and prescription benefits.

Despite recent but well-documented success in controlling health care expenditures, one momentous concern that arises from the rapid changes in our health care delivery system is whether patients are satisfied with their health plans and their components, including prescription drug coverage. Some theories have postulated that satisfaction with care actually leads to better health outcomes: patients are healthier, utilize fewer acute care services, and feel better about themselves. Twenty years ago, patient satisfaction was viewed as a desirable result of the provision of health care services; now, patient satisfaction is a principal criterion used to evaluate the quality of health insurance plans. The importance of satisfaction with health plans is evident in the medical literature and in many informal polls conducted by professional associations. Member satisfaction continues to gain a more prominent role in assessing the quality of managed health care on report cards and through more formal programs such as the Health Plan Employer Data and Information Set.

OBJECTIVE: To develop an interval-level scale to measure satisfaction with prescription drug coverage that would transcend typical ordinal measures of satisfaction that apply only in certain situations.

METHODS: The scale was constructed utilizing the technique of paired comparisons. Following their initial generation, items in the scale were compared against one another on the basis of importance. The results were tabulated into a frequency matrix, from which a matrix of probabilities was calculated. The probabilities were converted into a matrix of “Z” scores, from which the appropriate weight for each item was calculated. The internal consistency of the consumer judges was highly significant.

RESULTS: A nine-item interval-level scale was developed to assess consumer satisfaction with prescription drug coverage. Weights ranging from 1.0 to 2.505 were calculated for the scale items.

CONCLUSIONS: An internally consistent interval-level scale was developed to measure satisfaction with prescription drug coverage that may be broadly applied and used for one specific plan, as a means to compare two or more plans, or to assess satisfaction with all plans in a given geographic area.

KEYWORDS: prescription drug coverage, satisfaction, knowledge, pharmacy benefits management, networks

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These informal polls and studies in medical literature suffer, however, from limitations in generalizability and accuracy. The studies have queried patients from only one or two types of plans in a given area without attempts to assess the reliability of the instrumentation or offer generalizable conclusions. Moreover, these surveys dealt with the actual care being rendered; little research has been conducted to determine patients’ reactions to the actual administrative features of a health insurance or prescription drug plan.

Because pharmacy benefits are treated as a separate entity or “carve out” from other benefits, general surveys of patient satisfaction with health insurance programs offer limited information about opinions of prescription drug coverage. The literature contains numerous reports on patient satisfaction with certain pharmaceutical services provided at specific sites. Little has been done to assess patients’ satisfaction with the level of prescription drug coverage and other pharmacy benefits; nor has any attempt been made to ascertain satisfaction with the design of pharmacy benefit programs (i.e., the number of pharmacies participating in the plan, generic drug substitutions, the flexibility to change pharmacies, cost sharing, etc.). A literature search reveals only one study, by Johnson et al., in which patients who were enrolled in both traditional and mail-order pharmacy benefit programs responded favorably to items querying their overall satisfaction with drug coverage and copayments. This paucity of information in the literature exists despite evidence that the design of the prescription drug benefit is a critical factor for employees in selecting an insurance plan.

Most satisfaction scales reported in pharmacy and medical literature are constructed and scored on an ordinal basis, which limits their precision. An instrument may ask patients to respond to a series of items (such as freedom-of-choice and copayment issues) on a Likert-type scale of one to five, with each given equal weight. Respondents’ choices would then simply be summed for a total score. However, such a design does not account for the actual contribution of each item toward a respondent’s satisfaction. For example, a health plan member may be satisfied with the copayment and respond favorably to such an item, while being dissatisfied with the lack of freedom to visit the pharmacy of his or her choice. If freedom of choice is a more important issue to respondents than copayment, this is not reflected in the crude instrumentaton of an ordinal scale.

One way to overcome the shortcomings of ordinal, Likert-type scales is the construction of an interval-level scale, which determines the specific contribution of each item toward the referent object (satisfaction, in this study). This design lends objectivity, accuracy, and longevity to the results.

Study Purpose and Objectives

The overall purpose of this project was to develop an interval-level scale to measure satisfaction with prescription drug coverage. The specific objectives were to:

- generate a list of items comprising the satisfaction scale;
- compare each item in the scale with every other item in pairs in order to calculate the appropriate weights (scale values) for each scale item; and
- determine the internal consistency of assessments by respondent-judges used in calculating the scale values.

Methods

Objective One: Generation of Items Used to Comprise the Scale

The first step in developing the interval-level scale was to generate a list of items to include in the scale. These items are designed to serve as stimuli for respondents to the referent object. An extensive review of the literature using International Pharmaceutical Abstracts and Medline searches was conducted to identify issues involved in patient satisfaction with prescription drug coverage. Key terms used in the initial search included patient, consumer, beneficiary, satisfaction, dissatisfaction, attitude, view, opinion, perception, belief, health benefit, health coverage, health plan, health service, prescription benefit, prescription coverage, prescription plan, benefits design, and drug coverage.

Review of initial abstracts prompted searches with other terms such as survey, enrollment, disenrollment, managed care, health maintenance organization (HMO), PBM, and private insurance, to name a few. Pertinent articles were selected and carefully reviewed to seek factors or concepts that may affect or relate to satisfaction with prescription drug coverage. A particularly useful research paper, presented by Chalisani and colleagues, classified the factors patients consider in the selection of a health plan. Pharmacy-related factors were characterized into two dimensions, one related to the actual scope of services provided by the pharmacy, and the other relating more to the administrative components of the plan.

Second, interviews were conducted with 10 community pharmacy practitioners and a convenience sample of 10 patrons in the local area to identify additional elements that may influence patient satisfaction. Patients were asked open-ended questions to identify factors that contribute to satisfaction with prescription drug coverage, while pharmacists were asked about factors that could differentiate prescription drug insurers on the basis of quality.

Each factor/concept from the literature review was recorded and then reviewed by the investigator. Factor/concepts were reconfigured into items that could serve as appropriate scale components. Several criteria were utilized to construct the actual items, as prescribed by Thurstone and Chave as well as by Likert and by Fink. These procedures resulted in an initial pool of 10 items to comprise the scale. A review by several faculty members in the department of pharmacy administration for clarity and face validity elicited concern about one of the items.
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It was subsequently excluded from the initial pool, resulting in a final list of nine items for inclusion in the scale (see Table 1).

**Objective Two: Calculation of Weights for Each Item in the Scale**

The assignment of numeric weights (scale values) to each item hinges on the perceived importance or contribution of each item toward the entire referent object, satisfaction. To ascertain these contributions, each item was compared by a sample of judges to every other item comprising the scale in a method developed by Thurstone known as the "method of paired comparisons." This method is widely reported in the social sciences literature and has been shown to be a valid and consistent approach for assessing attitudes, ranking occupations, and analyzing consumer choice behavior. Recently, it has also been used as a tool to quantify the significance of drug-drug interactions.

In utilizing this method, a panel of judges was presented with an instrument with each of the nine stimuli paired with every other stimulus, for a total of 36 comparisons. Both the order of the pairs and the order of the items within each pair were completely randomized to prevent any response bias. The judges were asked to select the most important of the two items in determining their satisfaction with any (not their own) health plan.

The composition and number of judges to be used is open to debate. As many as 300 judges have been used; however subsequent research indicates that reliable scale values can be obtained with much smaller groups of subjects. \(^{17,21,32,25,26}\) In fact, Rosander reported correlations as high as 0.99 for scale values obtained independently from two groups with as few as 15 judges in each group. \(^{27}\) Regarding the composition of judges, Edwards suggests that they be representative of the population of interest, and not academicians. \(^{28}\) Therefore, a total of 30 pharmacy patrons selected from two independent and two chain pharmacy stores served as the judges for the study. Judges were interviewed by one of two fifth-year entry-level Pharm.D. students trained in interviewing techniques. Although the judges were selected on a convenience basis, interviewers were instructed to obtain representation from persons of varying sex, age, and race. Additionally, even though there was no process

<table>
<thead>
<tr>
<th>TABLE 1</th>
<th>The Nine Items Comprising the Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Item Number—Item</strong></td>
<td></td>
</tr>
<tr>
<td>1—</td>
<td>The out-of-pocket costs that you have to pay for prescriptions (copays, deductibles)</td>
</tr>
<tr>
<td>2—</td>
<td>The amount of freedom you have to choose your own pharmacy</td>
</tr>
<tr>
<td>3—</td>
<td>The number of pharmacies that accept your prescription insurance</td>
</tr>
<tr>
<td>4—</td>
<td>The location of the pharmacy that accepts your prescription insurance</td>
</tr>
<tr>
<td>5—</td>
<td>Your prescription plan covering any drug that you/your doctor feels that you need</td>
</tr>
<tr>
<td>6—</td>
<td>Your prescription plan covering both brand-name and generic drugs, equally</td>
</tr>
<tr>
<td>7—</td>
<td>The plan providing updates and information on things like changes in the copayment and changes in the drugs that are covered</td>
</tr>
<tr>
<td>8—</td>
<td>The amount of medication (days supply) the plan allows you to have each time you go to the pharmacy</td>
</tr>
<tr>
<td>9—</td>
<td>The effectiveness of a help desk/hot line to solve problems or answer questions that you may have about your prescription drug coverage</td>
</tr>
</tbody>
</table>

![FIGURE 1](The Initial F Matrix)

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for screening potential judges based on education and socio-economic status, two of the stores (one independent and one chain) from which judges were obtained are located in lower-middle-class neighborhoods, while the other two stores are located in suburban areas.

The results of the paired comparisons were tabulated and placed into a frequency (F) matrix, which illustrates the number of times each item stimulus (identified by column) was judged more important than each other stimulus (identified by row) (see Figure 1, previous page). When a statement was compared with itself, an entry of 15 was recorded, assuming a statement would be judged more important than itself one-half of the time. This yields a diagonal of 15s, beginning from the top left corner and extending to the bottom right corner. The column entries were then totaled, and the order of items in the matrix rearranged, beginning with the statement with the smallest total and proceeding to the statement with the largest total. The order of the row items is also reordered, which necessitates rearrangement of each entry within the F matrix. Each value of the reconfigured F matrix was then divided by the number of judges (30) to create a probability (P) matrix. Each value in the P matrix represents the proportion of times that the column statement was judged to be more important than the corresponding row statement. Values in the P matrix were converted to Z scores from a Z table to form a Z matrix, which is shown in Figure 2.

Lastly, the Z matrix was converted to a matrix of columnar differences containing n-1(8) columns in which the first column is a vector of differences between the entries of Column 1 and Column 2 of the Z matrix and the second column is a vector of differences between the entries of Column 2 and Column 3 of the Z matrix, etc. The entries of this matrix are summed and divided by the number of rows to obtain the distances between each item on the scale. The lowest scale item, or lower anchor, can be assigned any value, since the Euclidean distance calculated between each scale item would not change. The scale value for the second-lowest item is then equal to the value of the lower anchor plus the columnar difference between it and the lower anchor. The third value is then the value of the second lowest plus its columnar difference, and so on.

**Objective Three: Determination of the Internal Consistency Among Judges**

The success of an interval-level scale depends on the judgments used in its creation. One potential shortcoming of the method of paired comparisons is a lack of conformity or convergence—that is, failure of the items to validly measure the affective response to the referent object. Item statements that are ambiguous, or not representative of the referent object, or otherwise poorly constructed, could create such a result. A manifestation of this problem would be a disagreement among the judges as to the rankings of the item statements. A statistic developed by Kendall designated as $\mu$, the coefficient of agreement, provides a means of determining the extent to which a group of judges agree in their comparative judgments.

The first step in determining the consistency among the judges is to calculate $\tau$ (tau) by the formula:

$$\tau = \frac{\sum f_{ij}^2 - m \sum f_{ij} + (C_3)}{(C_2) (C_3)}$$

where

- $\sum f_{ij}$ is the sum of the squared $f_{ij}$ entries below the diagonal of the original F matrix
- $m$ is the number of judges
- $\sum f_{ij}$ is the sum of the $f_{ij}$ entries below the diagonal of the original F matrix
- $C_3$ is the number of combinations of the m judges taken two at a time or $m(m-1)/2$
- $C_2$ is the number of combinations of the n stimuli taken two at a time or $n(n-1)/2$. 

Kendall's coefficient is then calculated by the formula:

$$\mu = 2 \tau (C_2) (C_3)$$

Any $\mu$ exceeding zero indicates at least some level of agreement among the judges. To determine whether this agreement is significant, a critical chi-squared statistic is then calculated by the formula:

$$x^2 = \left[ \frac{4}{m-2} \right] \left[ \frac{\tau - 1}{(C_2) (C_3)} \right] \left[ \frac{m-3}{2} \right]$$

Finally, the degrees of freedom for the chi-squared test are calculated by the formula:

$$df = (C_2) m (m-1) (m-2)$$

Additionally, as one last safeguard to ensure the validity of each item, the completed scale was administered to a sample of 43 patients from one independent and one chain pharmacy store. Respondents were asked to indicate their level of satisfaction with their own particular health plan among each of the characteristics represented by the nine item statements on a 10-point scale. Principal-components analysis was performed to ensure that each item would load onto one or more factors.

**Results**

Detailed data on demographic characteristics were not collected from the judges used in the study; however, certain facts regarding their overall composition is known. Of 30 judges, 20 (66.7%) were female and 20 (66.7%) were Caucasian, while 7 (23.3%) were African-American, 2 (6.7%) were Asian, and 1 (3.3%) was Hispanic. While data on the age of judges were not gathered, the judges represented a broad spectrum of age groups.

In meeting Objective One, nine items were generated from a thorough review of the literature and interviews with patients and pharmacists. In meeting Objective Two, the procedures...
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described in the methodology resulted in a scale comprised of nine items whose values were dispersed over 1.505 units of Euclidean distance. The lower anchor may be assigned any value because the Euclidean distance between each scale item does not change. For simplicity, the scale may be anchored at 1 on the lower end, resulting in a value of 2.505 for the item at the higher end of the scale. Table 2 provides an example of the scale items and corresponding weights should the scale be anchored at one.

Objective Three was met by performing a series of calculations to determine whether significant agreement existed among the respondent judges. Substituting the appropriate values into the formula for Kendall’s rank correlation coefficient, τ, we calculated a critical chi-squared statistic of 7.25 with 39.95 degrees of freedom. A critical value of 256.52 with 40 degrees of freedom is highly significant (p<0.001).

Finally, principal-components analysis of data obtained on the pretest revealed that each of the items loaded significantly onto two dimensions, meaning that all nine should be retained for use in the scale.

Item weights were calculated on the basis of their relative contribution toward satisfaction with a prescription drug coverage plan. To utilize the scale, future researchers may query persons within particular populations of interest to indicate their level of satisfaction with their respective plans by responding to each of the items on a Likert-type scale. Their responses would then be multiplied by the appropriate weights and summed to provide their satisfaction score on the index created. For example, the sum of the scale weights provided in Table 2 is 13.29.

**TABLE 2** Items and Corresponding Scale Weights with One (1) as the Lower Anchor Value

<table>
<thead>
<tr>
<th>Scale Value</th>
<th>No.</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.000</td>
<td>9</td>
<td>The effectiveness of a help desk/hot line to solve problems or answer questions that you may have about your prescription drug coverage</td>
</tr>
<tr>
<td>1.102</td>
<td>7</td>
<td>Providing updates and information on changes in coverage (copayment, drugs covered, etc.)</td>
</tr>
<tr>
<td>1.123</td>
<td>3</td>
<td>The number of pharmacies that accept your prescription insurance</td>
</tr>
<tr>
<td>1.246</td>
<td>2</td>
<td>The amount of freedom you have to choose your own pharmacy</td>
</tr>
<tr>
<td>1.401</td>
<td>6</td>
<td>Covering both brand-name and generic drugs, equally</td>
</tr>
<tr>
<td>1.509</td>
<td>4</td>
<td>The location of the pharmacy that accepts your prescription insurance</td>
</tr>
<tr>
<td>1.531</td>
<td>8</td>
<td>The amount of medication (days supply) the plan allows you to have each time you go to the pharmacy</td>
</tr>
<tr>
<td>1.873</td>
<td>1</td>
<td>The out-of-pocket costs that you have to pay for prescriptions (copays, deductibles)</td>
</tr>
<tr>
<td>2.505</td>
<td>5</td>
<td>Covering any drug that you/your doctor feels that you need</td>
</tr>
</tbody>
</table>

**FIGURE 2** The Completed Z Matrix

<table>
<thead>
<tr>
<th>Item 9</th>
<th>Item 7</th>
<th>Item 3</th>
<th>Item 2</th>
<th>Item 6</th>
<th>Item 8</th>
<th>Item 4</th>
<th>Item 1</th>
<th>Item 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item 9</td>
<td>0.000</td>
<td>0.169</td>
<td>0.083</td>
<td>-0.432</td>
<td>0.622</td>
<td>0.169</td>
<td>0.842</td>
<td>0.966</td>
</tr>
<tr>
<td>Item 7</td>
<td>-0.169</td>
<td>0.000</td>
<td>-0.432</td>
<td>0.524</td>
<td>0.432</td>
<td>0.253</td>
<td>0.340</td>
<td>1.112</td>
</tr>
<tr>
<td>Item 3</td>
<td>-0.083</td>
<td>0.432</td>
<td>0.000</td>
<td>0.432</td>
<td>-0.169</td>
<td>0.000</td>
<td>0.524</td>
<td>0.842</td>
</tr>
<tr>
<td>Item 2</td>
<td>0.432</td>
<td>-0.524</td>
<td>-0.432</td>
<td>0.000</td>
<td>0.169</td>
<td>0.253</td>
<td>-0.083</td>
<td>0.729</td>
</tr>
<tr>
<td>Item 6</td>
<td>-0.622</td>
<td>-0.516</td>
<td>0.169</td>
<td>-0.169</td>
<td>0.000</td>
<td>0.169</td>
<td>0.253</td>
<td>1.112</td>
</tr>
<tr>
<td>Item 8</td>
<td>-0.169</td>
<td>-0.253</td>
<td>0.000</td>
<td>-0.253</td>
<td>-0.169</td>
<td>0.000</td>
<td>0.000</td>
<td>0.083</td>
</tr>
<tr>
<td>Item 4</td>
<td>-0.842</td>
<td>-0.340</td>
<td>-0.524</td>
<td>0.083</td>
<td>-0.169</td>
<td>0.000</td>
<td>0.000</td>
<td>0.729</td>
</tr>
<tr>
<td>Item 1</td>
<td>-0.966</td>
<td>-1.112</td>
<td>-0.729</td>
<td>-0.729</td>
<td>-0.253</td>
<td>-0.083</td>
<td>-0.842</td>
<td>0.000</td>
</tr>
<tr>
<td>Item 5</td>
<td>-1.838</td>
<td>-1.282</td>
<td>-1.282</td>
<td>-1.499</td>
<td>-1.112</td>
<td>-0.729</td>
<td>-0.432</td>
<td>-1.112</td>
</tr>
</tbody>
</table>
If respondents were asked to indicate satisfaction with their prescription drug coverage for each of the items on a seven-point scale, possible scores would range from 13.29 to 93.03. Future investigators may, however, select different anchors for the scale or utilize different mechanisms to elicit patient response to each of the items. The interval-level, quantitative properties of the instrument are not lost.

The fact that each item in the scale has a different weight should have added value to administrators evaluating the pharmacy benefit portion of a health plan. In addition to identifying areas where the pharmacy benefit may be improved, the weights assigned to each item denote how critical improvements in that particular area may be in achieving member satisfaction. For example, this study indicates that patients' perceptions of the breadth of drugs covered and the copayments for which they are responsible are highly critical issues. Administrators may want to keep this in mind when communicating with their enrollees and at least provide them with information on these matters, or they may want to stress competitive advantages in these areas when marketing the plans. Finally, the highly quantitative nature of the scale could facilitate benchmarking or goal setting by plan administrators to achieve certain levels of satisfaction by plan enrollees and allows for comparison among variations of plans offered by an insurer.

Discussion

Even though many prescription drugs are covered under pharmacy benefit plans, a significant amount of cost sharing for this benefit results in pharmacies accounting for nearly 30% of all out-of-pocket expenditures for health services. Prescription drug coverage is perceived by consumers as a very desirable benefit in a health insurance plan, ranked second only to coverage for emergency procedures. Hence, beneficiaries may put quite a bit of stock of the structure of their prescription drug benefit.

Consumers are refusing to accept asymmetric information in the health care market, just as they have done in the consumption of other goods. Armed with personal computers, the Internet, and online medical libraries, consumers are becoming more active participants in health care decision making. One possible manifestation of this phenomenon is rapid disenrollment from plans with which beneficiaries are not satisfied.

Recent evidence showing that beneficiary dissatisfaction with prescription drug coverage is a major source of their dissatisfaction with health plans in general clearly illustrates the necessity of maintaining beneficiary satisfaction with prescription drug coverage. An instrument designed to elicit information on member satisfaction that can stand the test of time and be unaffected by the constant changes in health care financing and delivery is a vital tool for those who make decisions about prescription drug benefit design. An MCO or PBM interested in assessing the satisfaction of its members must obtain accurate results. Fielding a poorly designed satisfaction survey can be worse than not measuring patient satisfaction at all; it can actually be harmful, particularly if it provides false-positive results. Institutions may be under the impression that they are doing well "until the day they are forced to close their doors due to unresolved patient satisfaction issues."

Other researchers or policymakers often utilize satisfaction information not only to help target improvements but also as a tool for achieving goals in total quality management efforts. Instrumentation that can accurately assess patient satisfaction—whether studying one plan, comparing the benefit structure of two or more plans, or examining all plans in a specific geographic region—is essential.

Limitations

The results of this study should be interpreted with some caution. One limitation is the sample of judges used. Although interviewers secured judges representing various races and age groups in the Allegheny County, Pennsylvania, area, certain populations may have been underrepresented from a nationwide perspective, particularly Hispanics. Additionally, males comprised one-third of the judges, while a greater proportion of pharmacy patrons may be female. Finally, responses provided by judges may have been biased by their attitudes toward their own prescription drug plans, despite encouragement not to let previous experience color their observations.

Conclusion

This research study resulted in the creation of an internally consistent and valid interval-level scale that may be applied to the measurement of satisfaction in diverse types of populations. Further research is warranted in several areas. Judgments may be obtained from a sample of even more than 30 judges to determine how well the corresponding scale values compare. The scale should also be utilized to determine just how satisfied members are with their prescription drug plans and determine areas for improvement by all third-party payors. Finally, research should also address what factors precipitate a lack of satisfaction with prescription drug coverage. For example, one study determined that persons in poorer health are more likely to respond negatively to cost-cutting features inherent in some managed care plans. Other factors that may contribute to dissatisfaction with prescription drug coverage are members' knowledge of the plan, the amount and type of information they receive about their plans, the presence of specific disease states, and sociological factors such as locus of control. Once these factors are uncovered, interested parties may work to address any gaps in satisfaction that may exist.

References

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