

Medicare CAHPS[®] 2000 Voluntary Disenrollment Reasons Survey: Findings from an Analysis of Key Beneficiary Subgroups

Final Report Executive Summary

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CMS Contract No. 500-95-0061/005
University of Wisconsin Project No. 500-95-0061/005
RTI Project No. 07659.005

November, 2002

*RTI International is a trade name of Research Triangle Institute.

Executive Summary

Introduction

Voluntary disenrollment rates from managed care plans are often viewed as a good “summary” indicator of member satisfaction and plan quality. The Balanced Budget Act of 1997 required that the Centers for Medicare & Medicaid Services (CMS) publicly report two years of disenrollment rates on all Medicare+Choice (M+C) organizations. To ensure that disenrollment rates would be meaningful to beneficiaries in health plan choice, to support quality monitoring activities, and to assist in quality improvement initiatives, CMS funded the development and implementation of an annual national survey to identify the reasons that beneficiaries voluntarily leave plans. Starting in 2000, CMS began the national implementation of the Medicare Consumer Assessment of Health Plans (CAHPS[®]) Disenrollment Reasons Survey.¹

The M+C health plan voluntary disenrollee population is quite heterogeneous. Subgroups of beneficiaries may have very different experiences with, needs from, and expectations of their plans and, thus, may decide to leave for different reasons. The objective of the subgroup analyses discussed in this report is to determine whether beneficiaries with different health status, health care utilization, health insurance, and sociodemographic characteristics choose to leave M+C plans for different reasons. By examining national level variation in reasons for leaving M+C plans by beneficiary subgroup characteristics, CMS is better able to understand beneficiary experience with M+C plans.²

The nationally representative data set for conducting the subgroup analysis of the 2000 Medicare CAHPS[®] Disenrollment Reasons Survey consists of 30,053 Medicare beneficiary respondents who voluntarily disenrolled from approximately 273 M+C organizations during 2000. The primary data collection mode for the survey was a self-administered mail survey with telephone follow-up. The overall response rate among eligible disenrollees was 61%. The data were weighted to account for differences in response rate by age, race, sex, census region, geographic indicators, dual eligibility, plan, and quarter variables.

Subgroup Analysis Methods

To gather information about the reasons for leaving M+C plans, the Disenrollment Reasons Survey asked beneficiaries to indicate all of their reasons for leaving the sampled plan as well as the one most important reason they left their plan. Each specific reason was assigned to one of eight groupings. Consequently, each of the eight dichotomous outcome (reason

¹ The latest voluntary disenrollment rates and reasons results are available on www.Medicare.gov.

² The Medicare CAHPS[®] Disenrollment Reasons Survey project team gratefully acknowledges the advice and insights provided by the Technical Expert Panel in the design of the subgroup analysis activities.

grouping) variables for this subgroup analysis signifies whether or not a respondent cited at least one reason (or a most important reason) for leaving assigned to that grouping.

The 12 beneficiary subgroup variables fall into four main categories: health status, health insurance characteristics, other characteristics, and sociodemographic variables. The disenrollee **health status variables** include: beneficiaries' reports of their health status, health status compared to a year ago, combined health status and one-year health status change, and number of outpatient visits. The **health insurance variables** include: dual eligibility status and non-elderly disabled status (using age as a proxy). **Other disenrollee variables** include: choice of coverage after disenrollment, hospitalization after disenrollment to fee-for-service (FFS), frequency of disenrollment in 2000, length of time in plan before disenrollment, and quarter in which the disenrollee left their plan. Disenrollee **sociodemographic variables** include race and ethnicity, education, and sex. We examined the bivariate relationships between each subgroup variable and outcome variable using the chi square statistic.

Two Ways to Look at Reasons for Voluntary Disenrollment

This report includes two different ways to measure beneficiaries' reasons for disenrollment: (1) **all reasons** each survey respondent gave for leaving and (2) each survey respondent's **most important reason** for leaving. For purposes of analysis, individual survey responses to both the all reasons and most important reasons survey questions were assigned to a set of eight more general categories of reasons for leaving. These categories or "reason groupings," are (1) problems with information from the plan; (2) problems getting doctors you want; (3) problems getting care; (4) problems getting particular needs met; (5) other problems with care or service; (6) premiums or copayments too high; (7) copayments increased and/or another plan offered better coverage; and (8) problems getting or paying for prescription medicines.

The all reasons data are composed of eight variables. The eight all reasons variables are based on responses to these Medicare CAHPS Reasons survey questions: 33 preprinted reason items (i.e., Did you leave health plan X for reason Z...?) and one two-part, "other reasons" fill-in item (i.e., Were there other reasons... if so please describe them.) Respondents could choose as many of the 33 preprinted reasons as they wanted. Twenty percent of respondents chose over 8 reasons and respondents on average chose 5.4 individual reasons. Factor and variable cluster analyses were applied to the 33 preprinted reasons to find items that were highly associated, and the result of those analyses formed the basis for a final determination of the eight reason groupings. Each of the 33 preprinted reasons and responses to the "other reasons" question was assigned to one of the eight reason groupings. A respondent was assigned to a particular all reasons grouping if he/she cited at least one survey item that belonged to that reason grouping or had an "other reason" code that belonged to that reason grouping. Respondents could be assigned to multiple all reasons groupings depending on how many all reason items they cited and the distribution of those items across the eight reason groupings. Subgroup differences in the all reasons variables is often referred to in this report using this convention—"subgroup X is more likely than others to cite Y as **a reason for leaving**."

The most important reason data come from one variable. The single most important reason variable (that contains the eight reason groupings as eight values within the variable) was created from responses to this Medicare CAHPS Reasons Survey fill-in survey question: “What was the one most important reason you left health plan X?” The same eight-reason groupings scheme was used for assigning specific survey responses to a smaller set of aggregated categories, in both the all reasons variables and the most important reason variable. A respondent was assigned to only one of the eight most important reason groupings on the basis of the coding of the single most important reason item the respondent gave on the questionnaire.

These two types of variables contain different types of information.³ As its name implies, the most important reason expresses the beneficiary’s primary reason for leaving a plan, while the all reasons do the same yet also provide accompanying or secondary reasons. At the respondent level, the all reasons variables tend to include a larger set of reasons for disenrollment (than does the most important reason variable), generally inclusive of the most important reason for an individual.

Appendix B provides additional detail about the analyses and the process of assigning survey items to reason groupings. *Exhibit 2-3* in *Chapter 2* shows the assignment of specific reason survey responses to the eight reason groupings. *Section 3.1* discusses the difference between the all reasons variables and most important reason variable in more detail.

Main M+C Voluntary Disenrollee Subgroup Findings and Implications

Among all reasons cited by disenrollees for leaving a plan, the most frequently cited reasons were: increases in copayments (55%), premiums or copayments too high (54%), problems getting to see doctors you want (41%), and problems with plan information (38%).⁴ Between approximately one-quarter to almost one-third of disenrollees cited problems getting or paying for prescription medicines (31%), problems getting care (29%), problems with care or other service (27%), or problems getting particular needs met (23%).

However, numerous differences exist among subgroups of beneficiaries regarding their reasons for leaving. *Exhibit ES-1* gives an overview of statistically significant differences of at least 10 percentage points between the subgroups listed compared to other disenrollees in citing a problem as **a reason for leaving**. A checkmark (X) in any given cell indicates that a particular subgroup is more likely than other disenrollees to cite reasons in that grouping.

³ In *Section 3.5*, we examine how these two ways of measuring reasons for leaving a health plan complement and inform each other.

⁴ *Exhibit 2-3* in *Chapter 2* shows the assignment of specific responses from the Medicare CAHPS® Disenrollment Reasons Survey to the eight reason groupings examined in this report. *Appendix B* describes the background and statistical methods used to identify appropriate groupings of reasons.

- Subgroup differences in citing a reason for leaving occur most frequently for problems with plan information, problems getting care, problems getting particular needs met, and premiums or copayments being too high.
- Vulnerable disenrollees who are in worse health, have more outpatient visits, are dually eligible, or are younger and disabled are more likely than other disenrollees to cite a host of information, access, and/or cost problems (i.e., plan information, getting care, getting particular needs met, and getting or paying for prescription medicines).
- Disenrollees with a greater number of outpatient visits and disabled disenrollees under age 65 cite the most different types of problems, followed by disenrollees whose health has worsened in the past year, disenrollees in fair-to-poor health, and disenrollees hospitalized within 90 days of disenrolling to FFS.

The two reasons most frequently cited as **most important** for leaving a plan are premiums being too high (31%) and problems getting doctors (27%), each cited by almost three-in-ten voluntary disenrollees. The remaining six most important reason groupings are cited by 10% or fewer voluntary disenrollees: problems getting or paying for prescription medicines (10%), copayment increases or better coverage at another plan (10%), problems with information from the plan (8%), problems getting care (7%), other problems with care or service (5%), and problems getting particular needs met (3%).

A few differences exist in the reasons for leaving that subgroups of disenrollees cited as most important. *Exhibit ES-1* also shows statistically significant differences of at least 10 percentage points between the subgroups listed compared to other beneficiaries in citing a problem as the **most important reason for leaving**. Subgroups that were more likely to cite a most important reason in a particular grouping are indicated with a diamond (◊). Many of the differences that appear among subgroups in *all* reasons do not appear when looking only at *most important* reasons for leaving a plan.

- Most subgroup differences occurred for those whose most important reason for leaving was due to problems getting particular doctors or because premiums or copayments were too high.
- Those disenrollees whose most important reason for leaving is cost-related (specifically, premiums or copayments too high) are more likely to choose another managed care plan (possibly because they are seeking a lower cost option and cannot find it in FFS), have been in the plan for a while before leaving (and likely left the plan primarily for cost rather than access reasons), and chose to leave either at the beginning of the calendar year or at the end (possibly after looking at the latest annual cost information on competing plans in the area).

Vulnerable Medicare populations (poorer health status, those needing more care, dually eligible, and younger disabled) are more likely than others to cite a host of access-related problems (to care, to information, to prescriptions) as reasons for leaving their M+C plans. These populations may be leaving M+C plans because they have special needs for care and/or

information about how to get care that are not being met within their plans. In addition to these access-related problems, younger disabled disenrollees are also more likely than other disenrollees to cite concerns about costs and benefits among their reasons for leaving. Less vulnerable beneficiaries, such as those who are white, more educated, or not eligible for Medicaid, are more likely to cite problems getting particular doctors as a reason for leaving.

Beneficiaries who leave M+C plans within a few months after enrolling—a subgroup more likely than those who stay longer to cite problems with plan information and with getting care as a reason for leaving—may not understand how the plan works before joining. In addition to the vulnerable subgroups already mentioned, black and Hispanic disenrollees were more likely than others to cite problems with plan information as a reason for leaving. Those who cite problems with plan information are more likely to disenroll to FFS, perhaps due to a lack of understanding about how managed care works. If managed care is to be a means of providing more comprehensive benefits for poor and minority beneficiaries, there is a need to address the information and access problems that vulnerable disenrollees encountered with M+C plans in 2000.

Most Important Reason Versus All Reasons Groupings

Readers of the report may well wonder, as they look at somewhat disparate results between the all reasons and most important reason groupings, why these two differ, or what these differences might suggest. We undertook a series of bivariate analyses looking at the relationships between these two groupings.⁵ These results elucidate some of the differences and enrich our understanding of these two “sources” of disenrollment reasons. Important findings of this analysis include the following:

- The reason groupings “Problems getting doctors you want,” and “Premiums or copayments too high” seem to be capturing more primary reasons for disenrolling than secondary reasons.
- The reason grouping “Copayments increased and/or another plan offered better coverage,” appears to be capturing many reason citations that are contributory or secondary reasons for disenrolling.
- “Problems getting particular needs met” and “Other problems with care or service” groupings more often contain secondary reasons than primary reasons for disenrollment.

⁵ *Section 3.5* provides more detail on the relationship between the all reasons groupings and the most important reason groupings.

Exhibit ES-1. Summary of Subgroup Differences in All Reasons Cited (✓) and in Most Important Reason Cited (◇)

Subgroups More Likely than Others to Cite Problem	Problems Cited as a Reason for Leaving M+C Plan							
	Plan Information	Getting Particular Doctors	Getting Care	Getting Particular Needs Meet	Other Care or Service	Premiums or Copays Too High	Increasing Copayments	Getting or Paying for Prescriptions
Health status characteristics								
Fair to poor health	✓		✓	✓				✓
Health worsened in past year	✓		✓	✓	✓			✓
Fair to poor health that has worsened	✓		✓	✓	✓			✓
Fair to poor health that is same or better				✓				
Excellent to good health that has worsened	✓							
No outpatient visit in past 6 months	✓							
Only one outpatient visit in past 6 months						◇		
More outpatient visits in past 6 months	✓		✓	✓	✓		✓	✓
Health insurance characteristics								
Dual eligibility	✓		✓	✓				
Non-dual eligibility		◇						
Disabled and < age 65	✓		✓	✓		✓	✓	✓
Age 80 or over		◇						
Other disenrollee characteristics								
Disenrolled to managed care						✓◇		
Disenrolled to FFS	✓		✓					
Hospitalized < 90 days after disenrolling to FFS		✓	✓	✓	✓			
In plan fewer months	✓◇	◇	✓					
In plan more months						✓◇		
Disenrolled in 1 st or 4 th quarter						✓◇		
Disenrolled in 2 nd quarter	✓							
Disenrolled in 3 rd quarter	✓	✓			✓			
Sociodemographic characteristics								
Hispanic	✓							
Non-Hispanic Black	✓							
Non-Hispanic White		◇						
Non-Hispanic other race						✓		
At least 4-year college degree		✓						

x

