

**Medicare CAHPS® 2000 Voluntary Disenrollment Reasons Survey:
Findings from an Analysis of Key Beneficiary Subgroups—
Final Report**

Purpose: 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*. The primary collection mode for the survey was a self-administered mail survey with telephone follow-up. Using the survey results, an analysis of key beneficiary subgroups was conducted to determine whether beneficiaries with different health status, health care utilization, health insurance, and socioeconomic characteristics choose to leave M+C plans for different reasons.

Results: The survey asked beneficiaries to indicate: 1) all of their reasons for leaving their M+C plan; and 2) the most important reason they left the plan.

1. 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%).
- Approximately one-quarter to one-third of disenrollees cited problems getting or paying for prescription medicines (31%), problems getting care (29%), problems with care or other services (27%), or problems getting particular needs met (23%).
- However numerous differences exist among subgroups of beneficiaries regarding their reasons for leaving:
 - 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 drugs).

— 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 Fee-for-Service (FFS) Medicare.

2. Among the reasons cited as most important for leaving a plan:

- The two most frequently cited are premiums being too high (31%) and problems getting doctors (27%).
- The remaining six most important reasons are cited by 10% or fewer disenrollees: problems getting or paying for prescription drugs (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 listed as most important:

— 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

— The disenrollees whose most important reason for leaving was 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 at either the beginning or end of the calendar year (possibly after looking at the latest annual cost information on competing plans in the area).