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

Final Report

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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.

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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

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[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 reason 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 Disenrollment 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 Disenrollment 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.

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[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 1st or 4th quarter						✓◊		
Disenrolled in 2nd quarter	✓							
Disenrolled in 3rd quarter	✓	✓			✓			
Sociodemographic characteristics								
Hispanic	✓							
Non-Hispanic Black	✓							
Non-Hispanic White		◊						
Non-Hispanic other race						✓		
At least 4-year college degree		✓						

1 Introduction

1.1 Medicare CAHPS® Disenrollment Reasons Survey

Voluntary disenrollment rates from managed care plans are often viewed as a good "summary" indicator of member satisfaction and plan quality (US GAO, 1996; US GAO, 1997; US GAO, 1998). The national voluntary disenrollment rate from Medicare+Choice (M+C) plans in 2000 was 11% (ranging from 0%–51%). Two legislative actions caused the Centers for Medicare & Medicaid Services (CMS) to undertake the implementation of a nationwide survey of Medicare voluntary disenrollees from each M+C plan. First, under the Physician Incentive Regulation Act of 1997, all Medicare and Medicaid plans that have contracts with physicians or physician groups that are at high risk of referral to specialists are required to annually conduct an enrollment and a disenrollment survey and report the results of both to CMS. In 1997, CMS pledged to M+C plans that it would develop a disenrollment survey and implement it nationwide to relieve those plans qualified for inclusion in the survey of the burden of conducting their own surveys. Second, the Balanced Budget Act of 1997 required that CMS report two years of disenrollment rates on all M+C organizations.[6]

CMS funded the development and implementation of an annual national survey to identify the reasons that beneficiaries voluntarily leave plans in order to ensure that disenrollment rates would be meaningful to beneficiaries in health plan choice, to support CMS quality monitoring activities, and to assist in plan quality improvement initiatives. Starting in 2000, CMS began the national implementation of the Medicare Consumer Assessment of Health Plans (CAHPS®) Disenrollment Reasons Survey. National public reporting of M+C disenrollment rates began in 2000 and reporting of reasons for disenrollment began in 2002.

1.2 Rationale for Disenrollment Reasons Survey

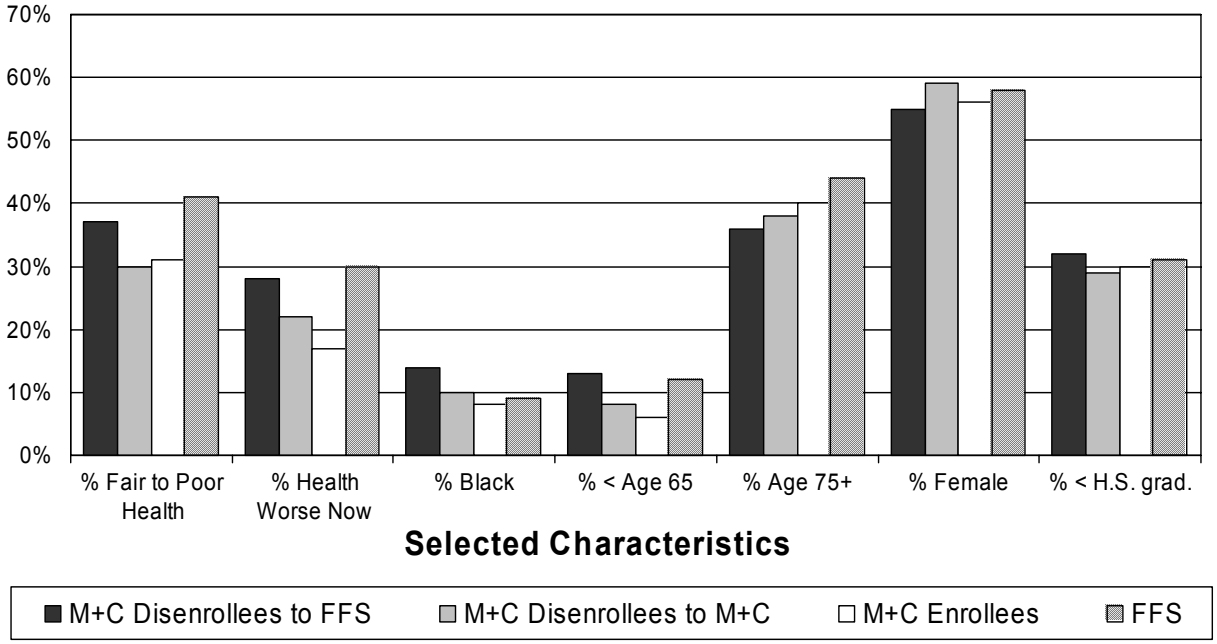
The Medicare CAHPS Disenrollment Reasons Survey data are intended for several uses:

- To provide information to help beneficiaries make more informed health plan choices;
- To assist Quality Improvement Organizations (QIOs) and M+C plans to identify areas in which they can focus their quality improvement activities; and
- To enable CMS to monitor M+C plan performance at different geographic levels and for individual plans.

[6] The Balanced Budget Act also required CMS, formerly known as the Health Care Financing Administration (HCFA), to report other quality performance measures such as consumer satisfaction results. These measures, as well as the latest rates and reasons results, are reported on the www.Medicare.gov web site.

For example, Medicare beneficiaries whose health is fair to poor, whose health has worsened in the past year, who are black, and who are under age 65 with a disability are disproportionately leaving M+C plans and are going to fee-for-service (FFS) (see ***Exhibit 1-1***). The Medicare CAHPS Disenrollment Reasons Survey data can shed light on the reasons these beneficiaries and others leave.

Exhibit 1-1. M+C Voluntary Disenrollees to FFS, M+C Voluntary Disenrollees to M+C, M+C Enrollees, and FFS Beneficiaries on Key Characteristics[a]



[a] These results are based on data from respective 2000 Medicare CAHPS Survey of each population.

1.3 Subgroup Analysis Key Research Questions

The objective of this subgroup analysis is to determine whether beneficiaries with different health status, health insurance, health care utilization, and sociodemographic characteristics choose to leave M+C plans for different reasons.[7] To meet this objective, we conducted analyses to address two main research questions:[8]

[7] ***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.

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

1. For each **reason grouping**, which subgroups of M+C plan voluntary disenrollees are more likely than other disenrollees to leave?[9]

2. For each **subgroup of M+C plan voluntary disenrollees**, for what reasons are they more likely than other disenrollees to leave?[10]

Chapter 3, ***Results***, answers each of these questions. The results are presented in this order to allow the reader to become familiar with the reason groupings and the types of reasons for leaving within each grouping and to understand which beneficiaries experience problems in particular areas. We then go on to examine the experience of each Medicare voluntary disenrollee subgroup across the complete set of reason groupings to see the types of problems that particular populations faced during 2000. To examine each research question, we look at the extent of subgroup differences for two different ways of measuring reasons for leaving. One way is to look at all reasons disenrollees give for leaving, and the other way is to look at disenrollees' one most important reason for leaving. ***Sections 3.1***, ***3.5,*** and ***Appendix B*** provide more details about these two main ways of measuring reasons for leaving and how they differ.

1.4 Relevant Literature on Subgroup Differences in Plan Satisfaction and in Disenrollment

Debate exists over both the relative role that market factors and member dissatisfaction play in explaining voluntary disenrollment rates (Rector, 2000; Riley, Ingber, and Tudor, 1997; Schlesinger, Druss, and Thomas, 1999) and the suitability of disenrollment rates as a valid indicator of plan quality (Dallek and Swirsky, 1997; Newhouse, 2000; Rector, 2000; Riley, Feuer, and Lubitz, 1996); Schlesinger, Druss, and Thomas, 1999; US GAO, 1998). The U.S. Government Accounting Office (GAO) issued a report in October 1996 urging public disclosure of disenrollment rates to help Medicare beneficiaries choose among competing plans (US GAO, 1996). In later testimony to the U.S. Senate, the GAO reiterated the value of disenrollment information as an indicator of health plan quality (US GAO, 1997).

Several studies have examined the relationship between voluntary disenrollment and beneficiary characteristics (e.g., Boxerman and Hennelly, 1983; Meng et al., 1999; Riley, Ingber, and Tudor, 1997; Virnig et al., 1998). For example, Riley, Ingber, and Tudor (1997) found that voluntary disenrollment rates are higher among black and other non-white beneficiaries and dually eligible beneficiaries than other beneficiaries. Further, they found that disenrollees to FFS are much less healthy (as measured by death rates) than disenrollees to other M+C plans.

Other studies have addressed the association between plan dissatisfaction and beneficiary characteristics (e.g., Druss et al., 2000; Riley, Ingber, and Tudor, 1997; Rossiter et al., 1989; Schlesinger, Druss, and Thomas, 1999). However, there is little or no published literature on

[9] This research question is addressed in section 3.3.

[10] This research question is addressed in section 3.4.

reasons for leaving and differences among subgroups in their reasons for leaving. This report contributes to the literature on the relationship between reasons for voluntary disenrollment and subgroup characteristics.

2 Data and Methodology

2.1 Medicare CAHPS® Disenrollment Reasons Survey

Survey methods

The sample population for the 2000 Medicare CAHPS Disenrollment Reasons Survey consisted of Medicare beneficiaries who voluntarily chose to leave their M+C health plan during calendar year 2000. Although the results and findings from the 2000 Reasons Survey are analyzed and reported on an annual basis, we conducted the survey sampling and data collection activities on a quarterly basis. That is, a sample of beneficiaries was selected at the end of each calendar year quarter, with data collection for that quarter taking place the following quarter. Data were collected by a mail survey of sample members with telephone follow-up of mail survey nonrespondents.

Survey sample

The sampling frame consisted of all Medicare beneficiaries who had voluntarily disenrolled from one of 273 M+C organizations and continuing cost contracts in 2000. Only plans that had been in operation for at least one full year were eligible for the survey. To be included in the 2000 sample, M+C health plans were required to have contracts in effect on January 1, 1999. Institutionalized beneficiaries were not eligible for selection and, if identified during data collection, were not included in the survey sample. Our goal for selecting the 2000 Reasons Survey sample was to select up to 388 sample members per plan across all four quarters. However, sampling was not uniform across the quarters, as it was based on the overall distribution of disenrollment during 1999 across all four quarters. In 1999, disenrollment rates followed a pattern of approximately 20% during Quarter 1, 20% during Quarter 2, 20% during Quarter 3, and 40% during Quarter 4. If there were not enough disenrollments in any given quarter, we attempted to make up those cases in subsequent quarters. For some plans, in some quarters, we took a census of disenrollees. Assuming an approximate 63% response rate (respondents per M+C plan) the results, on average, would be accurate within 7 percentage points (at a 95% confidence interval).

A total of 91,988 Medicare beneficiaries were originally selected for the 2000 Reasons survey. Of these, 4,523 beneficiaries were later removed from the sample due to plan closures, mergers, or exemptions from the survey. Therefore, the final sample consisted of 87,465 Medicare beneficiaries. The sampling window, number of beneficiaries selected during each quarter, and the data collection period for each quarter are shown in ***Exhibit 2-1***.

Exhibit 2-1. Sampling Window, Sample Size, and Data Collection Period for the 2000 Reasons Survey

Reasons Quarter	Sampling Window (During which Beneficiaries Disenrolled)	Sample Size (Number Selected)	Data Collection Period
1	Jan–March 2000	19, 958	Jun–Sept 2000
2	April–June 2000	18, 829	Aug–Nov 2000
3	July–Sept 2000	23, 219	Nov 2000–Feb 2001
4	Oct–Dec 2000	25, 459	Mar–May 2001
Total Selected		**87, 465**	

Survey instrument

We collected the data via a mail survey with telephone follow-up of nonrespondents to the mail survey. The questionnaire contained 78 questions, including

- 41 questions about reasons for leaving the health plan, including 6 screening questions to identify *involuntary* disenrollees, 33 preprinted reasons, 1 question asking about any other reasons for leaving the sample health plan, and 1 question asking for the *most important reason* for leaving the plan;[11]
- 2 questions asking the respondent to rate the sample health plan and the care received from that plan, plus a few other questions about the experience with the plan;
- 8 questions about the appeals and grievances process;
- 21 questions about health status and demographic characteristics; and
- 6 screening questions to verify that the respondents were truly voluntary disenrollees.

The all reasons survey items were grouped into seven domains: (1) plan availability; (2) doctors and other health providers; (3) access to care; (4) information about the plan; (5) pharmacy benefits; (6) costs and benefits; and (7) access to hospitals, medical equipment, and home health care.

[11] The preprinted reasons plus the answers to the open-ended question asking for any other reasons provide the data for the eight "all reasons" variables. The question asking for the most important reason for leaving is the basis for the "most important reason" variable. These outcome variables for the subgroup analyses are described in more detail in Section 2.2 and in Appendix B.

The screening questions included in the questionnaire were designed to identify sample members who are considered "involuntary" disenrollees (i.e., they left the sample health plan because they moved out of the plan's service area; the plan withdrew or reduced its service area; or the employer stopped offering the plan). We excluded these sample members from the survey sample as well as those who reported that they never disenrolled from the sample plan, were not enrolled in Medicare, were inadvertently disenrolled from the plan (by a friend or relative or due to an administrative error), and those who were deceased or institutionalized.

We conducted the telephone follow-up survey using a computer-assisted telephone interview (CATI) questionnaire that mirrored the mail survey instrument. Both the mail and telephone survey instruments were customized so that the health plan name was included in nearly every question. We sent a Spanish-language mail survey questionnaire to sample members who requested it and conducted telephone interviews in Spanish with sample members who did not speak English.

Data collection

For each quarterly implementation of the survey, we used the same multi-wave survey process that involved numerous attempts to reach respondents in English and/or Spanish by regular mail, telephone, and overnight mail. Efforts to reach Spanish-speaking beneficiaries included: (1) inserting a Spanish-language postcard into the initial mailing that contained a telephone number for sample members to call to request a Spanish version of the questionnaire and (2) a telephone number for an English- and Spanish-language toll-free hotline. The outreach and follow-up procedures for the Reasons survey were similar to those employed in the Medicare Managed Care-Consumer Assessment of Health Plans Survey (MMC-CAHPS) enrollee survey.

All letters sent to sample members were printed on CMS letterhead, signed by the CMS administrator, and included the name of the RTI data collection coordinator, as well as a toll-free telephone number that sample members could call if they had questions about the survey.

Survey response rates

We achieved an overall response rate of 63.l% for the 2000 Reasons survey. We used the following formula to calculate this response rate:

$$\frac{\textbf{\textit{Numerator:}}\ \text{the number of completed interviews.}}{\textbf{\textit{Denominator:}}\ \text{all sample members included in the sample minus those considered ineligible (i.e., institutionalized, deceased, and involuntary disenrollees).}}$$

The response rate varied by quarter and ranged from 58.4% (in Quarter 3) to 67.5% (in Quarter 4). ***Exhibit 2-2*** contains the demographics of the sample members and of the respondents and the response rate overall and by selected subpopulations.

Exhibit 2-2. Sample Demographics, Respondent Demographics, and Response Rates for the 2000 Reasons Survey

Subpopulation	Total Sample		Respondent Sample		Response Rates Among Eligibles[a]
Overall					
USA	87,465	100.0%	37,336	100%	63.1%
Gender (EDB)					
Male	36,662	41.9%	15,943	42.7%	64.3%
Female	50,803	58.1%	21,393	57.3%	62.1%
Age Group (EDB)					
<65	9,116	10.4%	4,025	10.8%	59.0%
65-69	23,167	26.5%	10,752	28.8%	67.6%
70-74	20,881	23.9%	9,469	25.4%	67.0%
75-79	16,281	18.6%	6,899	18.5%	63.3%
≥80	18,020	20.6%	6,191	16.6%	54.1%
Dual Eligibility (EDB)					
Yes	12,205	14.0%	4,470	12.0%	50.5%
No	75,260	86.0%	32,866	88.0%	65.3%
CMS Region					
I. Boston Regional Office	5,325	6.1%	2,316	6.2%	66.0%
II. New York Regional Office	8,334	9.5%	3,881	10.4%	62.0%
III. Philadelphia Regional Office	7,520	8.6%	3,221	8.6%	64.4%
IV. Atlanta Regional Office	18,019	20.6%	7,924	21.2%	63.1%
V. Chicago Regional Office	13,639	15.6%	5,895	15.8%	64.1%
VI. Dallas Regional Office	10,499	12.0%	3,936	10.5%	59.2%
VII. Kansas City Regional Office	3,038	3.5%	1,423	3.8%	67.4%
VIII. Denver Regional Office	2,004	2.3%	811	2.2%	65.9%
IX. San Francisco Regional Office	12,885	14.7%	5,451	14.6%	61.4%
X. Seattle Regional Office	6,158	7.0%	2,476	6.6%	65.4%
Other	44	<1%	2	<1%	6.1%

[a] 28,274 sample members were ineligible.

This response rate reflects the number of sample members who returned a completed questionnaire, *not* the number of completed surveys that were eligible for inclusion in the subgroup analysis data file. For subgroup analysis purposes, the data were included on the analysis file if the respondent answered yes to at least one of the 33 all reasons questions (not including the screening questions to identify involuntary disenrollees) and/or recorded an entry indicating the most important reason for leaving. We received questionnaires from 40,806 respondents. Of those, 2,750 (6.9%) gave a most important reason for leaving that made them an involuntary disenrollee, thus we received interview data from 37,336 voluntary disenrollees. Of the questionnaires received from voluntary disenrollees, 6,120 (16.4%) did not provide at least

one reason for leaving the sample plan. Another 1,163 (3.1%) left the sample plan because their employer stopped offering the plan.[12] Therefore, the total number of data records included on the subgroup analysis file is 30,053.

Nonresponse analysis and weighting

Nonresponse analysis

Sample members from the 2000 Reasons survey were classified as respondents or nonrespondents. We then modeled response propensities using logistic regression in SUDAAN. Demographics, census region, address variables, dual eligibility status, and design variables were simultaneously added to the model and removed in a backwards-stepwise fashion. We also included two-way interactions. We explored transformations of the continuous variable, age. We retained variables with p-values of 0.20 or less.

The final logistic regression model contained these independent variables—age, race, dual eligibility, and address type (post office box, rural route, and other addresses). In addition, we included the design variables—health plan and quarter—in the model. The response propensity analysis showed that those who were older and non-white were less likely to respond to the survey. Beneficiaries who were *not* dually eligible were more likely to respond. Beneficiary addresses that contained a post office box or rural route were less likely to respond to the survey.

Disenrollee weights

We used the predicted response propensities to adjust the initial design-based weights for respondents upward so that they represented both respondents and nonrespondents; weights for nonrespondents were set to zero. The general approach used to adjust weights for nonresponse is described by Folsom (1991) or Iannacchione, Milne, and Folsom (1991).

For the purposes of nonresponse adjustments, persons who provided information on eligibility status were treated as respondents. Subsequently, those who were ineligible (deceased, institutionalized, involuntary disenrollees, etc.) were also given a weight of zero. We do not know the eligibility status of nonrespondents; this approach allows the sample to estimate the proportion ineligible among the nonrespondents based on the respondent sample.

Additional weights

For the subgroup analysis data set, we constructed a second weight that represents the *proportion* of disenrollees within a plan. We calculated this weight by dividing the weight discussed above by the total number of individuals in that plan during 2000.

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[12] These respondents were excluded from the subgroup analysis file because disenrollments due to changes in employer coverage are not considered voluntary.

2.2 Subgroup Analysis Methodology

Outcome variable creation

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. Beneficiaries were asked to indicate whether or not each of 33 "all reasons" was a reason why they chose to leave their plan. Respondents could cite multiple reasons for leaving. They were then asked to indicate if they had any other reasons for leaving their plan. If so, they were prompted to write in the reason(s) using an open-ended format. Then beneficiaries were asked to write in an answer to the following question: "What was the one most important reason you left [*sample plan name inserted here]*?" The responses to these two open-ended questions were coded using a coding scheme that is similar to the preprinted list of "all reasons."

Analyzing and reporting data on each of the 33 individual reasons for all M+C organizations in a state or region would likely create an overload of information and be difficult to interpret since very few beneficiaries cited some of the reasons. Consequently, CMS decided to use groupings of reasons for comparative data displays in reports prepared for consumers and health plans. The subgroup analyses presented in this report are also based on groupings of reasons. ***Appendix B*** describes the background and statistical methods used to identify appropriate groupings of reasons. As a result of a series of factor and variable cluster analyses, we developed eight reason groupings: five groupings that address problems with care or service and three groupings that address concerns about plan costs.[13] ***Exhibit 2-3*** shows the assignment of reasons survey items and labels to the reason groupings.[14] Each of the eight dichotomous outcome (grouping) variables for the subsequent analyses within this report signifies whether or not a respondent cited a reason for leaving assigned to that grouping.

[13] For reporting to consumers, three groupings (problems getting care, problems getting particular needs met, and other problems with care or service) are combined under the label "Getting care" and two other groupings (premiums or copayments too high and copayments increased and/or another plan offered better coverage) are combined under the label "Premiums, Copayments, or Coverage".

[14] In addition to the preprinted reasons, there were two other reasons that were only collected when respondents cited them as their most important reason for leaving a plan (i.e., these two reasons were not among the preprinted reasons and thus were not included in the individual level analysis upon which we based the groupings: "insecurity about future of plan or continued coverage" and "no longer needed coverage under the plan.") The team manually assigned these two reasons to appropriate groupings.

Exhibit 2-3. Assignment of Reasons for Leaving a Plan to Groupings of Reasons

Reasons Grouping	Reasons for Leaving a Plan
Problems with Care or Service	
Problems with information from the plan	• Given incorrect or incomplete information at the time you joined the plan • After joining the plan, it wasn't what you expected • Information from the plan was hard to get or not very helpful • Plan's customer service staff were not helpful • Insecurity about future of plan or about continued coverage
Problems getting particular doctors	• Plan did not include doctors or other providers you wanted to see • Doctor or other provider you wanted to see retired or left the plan • Doctor or other provider you wanted to see was not accepting new patients • Could not see the doctor or other provider you wanted to see on every visit
Problems getting care	• Could not get appointment for regular or routine health care as soon as wanted • Had to wait too long in waiting room to see the health care provider you went to see • Health care providers did not explain things in a way you could understand • Had problems with the plan doctors or other health care providers • Had problems or delays getting the plan to approve referrals to specialists • Had problems getting the care you needed when you needed it
Problems getting particular needs met	• Plan refused to pay for emergency or other urgent care • Could not get admitted to a hospital when you needed to • Had to leave the hospital before you or your doctor thought you should • Could not get special medical equipment when you needed it • Could not get home health care when you needed it • Plan would not pay for some of the care you needed
Other problems with care or service	• It was too far to where you had to go for regular or routine health care • Wanted to be sure you could get the health care you need while you are out of town • Health provider or someone from the plan said you could get better care elsewhere • You or another family member, or friend had a bad experience with that plan
Concerns about Costs and Benefits	
Premiums or copayments too high	• Could not pay the monthly premium • Another plan would cost you less • Plan started charging a monthly premium or increased your monthly premium
Copayments increased and/or another plan offered better coverage	• Another plan offered better benefits or coverage for some types of care or services • Plan increased the copayment for office visits to your doctor and for other services • Plan increased the copayment that you paid for prescription medicines • No longer needed coverage under the plan
Problems getting or paying for prescription medicines	• Maximum dollar amount the plan allowed for your prescription medicine was too low • Plan required you to get a generic medicine when you wanted a brand name medicine • Plan would not pay for a medication that your doctor had prescribed

Subgroup variable creation

The 12 subgroup variables were selected from items available on the Disenrollment Reasons Survey and/or available from CMS administrative records. In addition to variables that identify the subgroups of Medicare beneficiaries traditionally considered to be particularly vulnerable, we also examined specific types of disenrollees, e.g., those disenrolling to another managed care plan versus those disenrolling to FFS coverage. The subgroup variables chosen for this analysis fall into four main categories: health status, health insurance characteristics, other disenrollee 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 (created from the previous two survey items), and number of outpatient visits in the past six months.

- The **health insurance variables** include: dual eligibility status (derived from the state buy-in indicator from CMS administrative records as a proxy for Medicaid enrollment) and non-elderly disabled status (using age as a proxy).

- **Other disenrollee variables** include: choice of coverage after disenrollment; hospitalization after disenrollment, 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.

All subgroup variables, except dual eligibility status, choice of coverage after disenrollment, hospitalization after disenrollment to FFS, and quarter in which the disenrollee left their plan, are based on respondent-reported survey responses. The non-survey-based variables come from the CMS Enrollment Data Base (EDB).

The nationally representative subgroup analysis data set consists of 30,053 Medicare beneficiary respondents who voluntarily disenrolled from approximately 273 M+C organizations during 2000. For the most important reason analyses, cases were excluded if no most important reason was given or could be imputed (3,207). For the all reasons analyses, cases were excluded if no preprinted reason or other reasons were cited and no most important reason were given from which a reason could be imputed (1,800). For each subgroup analysis, cases were excluded if they had missing data on the subgroup variable. (For this reason, sample sizes vary by table in ***Appendix C***.) ***Exhibit 2-4*** shows frequency distributions of the sample on the subgroup variables.

Exhibit 2-4. Description of Sample

Variables	Weighted Percent
Health Status Characteristics	
Self-assessed Health Status	
Excellent	7
Very good	23
Good	37
Fair	26
Poor	7
Self-assessed Health Status Compared with 1 Year Ago	
Better now	18
About the same	58
Worse now	24
Combined Health Status and 1-Year Health Status Change	
Excellent to good health that is same or better	58
Excellent to good health that is worse	8
Fair or poor health that is same or better	16
Fair or poor health that is worse	18
Number of Outpatient Visits in the 6 Months Before Disenrollment	
None	11
1 to 3	48
4 or more	41
Health Insurance Characteristics	
Dual Eligibility Status	
Yes	12
No	88
Age	
64 or younger	10
65 to 69	26
70 to 74	27
75 to 79	19
80 or older	18
Choice of Coverage After Disenrollment	
Another managed care plan	41
Fee-for-service	59

(Continued)

Exhibit 2-4. Description of Sample (continued)

Variables	Weighted Percent
Other Disenrollee Characteristics	
Hospitalization After Disenrollment to Fee-for-Service[15]	
Hospitalized within 90 days after enrolling into fee-for-service	1
Not hospitalized within 90 days after enrolling into fee-for-service	40
Went to managed care (not fee-for-service)	59
Frequency of Disenrollment in 2000	
More than once	15
Once	85
Length of Time in Plan Before Disenrollment	
Less than 6 months	11
6 months or more	89
Sampling Quarter When Disenrollee Left Plan	
1st: January – March 2000	40
2nd: April – June 2000	18
3rd: July – September 2000	12
4th: October – December 2000	30
Sociodemographic Characteristics	
Race and Ethnicity	
Hispanic	8
Non-Hispanic White	77
Non-Hispanic Black or African-American	11
Non-Hispanic Other	4
Education	
8th grade or less	13
9th – 11th grade	17
High school graduate/GED	33
Some college/2-Year degree	23
Bachelor's degree or more	13
Sex	
Male	43
Female	57

[15] This variable was created, in part, to support a separate CMS research effort on possible selection in Medicare managed care. For this variable, the numerator is the number of respondents in the subgroup analysis file who were voluntary disenrollees to fee-for-service between January and September 2000 and were hospitalized within 90 days of disenrollment (unweighted n = 440; weighted n = 5,543). The denominator is the number of respondents in the subgroup analysis file for whom choice of coverage data were provided by CMS (unweighted n = 29,701; weighted n = 469,859). The numerator does not include disenrollees who went to fee-for-service between October and December 200, because we did not have hospitalization data for 2001 for this analysis.

Statistical approach

We examined the bivariate relationships between each subgroup variable and outcome variable using the chi square statistic. We report differences in ***Chapter 3*** of at least 10 percentage points where $p < .01$ for chi square. ***Appendix C*** contains tables of results for all subgroups. First, we report the national distribution of reasons for leaving and then the results of the bivariate analyses to address the two research questions:

- For each **reason grouping**, which subgroups of M+C plan voluntary disenrollees are more likely than other disenrollees to leave?

- For each **subgroup of M+C plan voluntary disenrollees**, for what reasons are they more likely than other disenrollee to leave?

The results are presented in this order to allow the reader to become familiar with the reason groupings and the types of reasons for leaving within each grouping and to understand which beneficiaries experience problems in particular areas. We then go on to examine the experience of each Medicare voluntary disenrollee subgroup across the complete set of reason groupings to see the types of problems that particular populations faced during 2000.

3 Results

3.1 Two Ways to Examine Voluntary Disenrollment Reasons: Eight All Reasons Variables and One Most Important Reason Variable

This report includes two different ways to measure reasons for disenrollment: (1) **all reasons** each survey respondent gave for leaving and (2) each survey respondent's **most important reason**.

The eight **all reasons** variables are based on responses to these Medicare CAHPS Disenrollment Reasons Survey questions:

- 33 preprinted reason items (i.e., Did you leave health plan X for reason Z…?)
- one two-part, "other reasons" fill-in item (i.e., Are there any other reasons… if so, please describe your other reasons for leaving)

Respondents could cite as many of the 33 preprinted reasons as they wanted to, so the preprinted reasons items can be thought of as a large "choose all that apply" question, though in fact they were 33 individual questions.

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 was assigned to one of the eight reason groupings. ***Exhibit 2-3*** in ***Chapter 2*** shows the assignment of specific reason survey responses to these groupings. ***Appendix B*** provides additional detail about the analyses and the assignment of survey items to reason groupings process.

The "other reason" fill-in question was coded. Each respondent received an "other reason" code for any response they gave to this fill-in item. The codes were based on the 33 preprinted reasons, so each "other reason" code was assigned to the same framework of reason groupings as the preprinted reasons.

A respondent was assigned to a particular **all reasons grouping** if they cited at least one survey item that belonged to that reason grouping or had an "other reason" code that belonged to that reason grouping.[16] Many respondents chose more than one reason. In fact, 20% chose over 8 reasons, and respondents on average chose 5.4 individual reasons (based on both the 33 preprinted reasons and the fill-in "other reason" survey items). Thus, respondents could be assigned to multiple all reasons groupings depending on how many all reason items they cited

[16] Between 2-6% of the respondents assigned to each reason grouping were assigned solely on the basis of an "Other reason" fill-in.

and the distribution of those items across the eight reason groupings. The average number of all reasons cited is 5.4, and these 5.4 reasons fall roughly, on average, into 3 reason groupings per respondent. Therefore, a given individual could, and most often did, have more than one all reasons grouping assignment.

The single **most important reason** variable was created from responses to the following Medicare CAHPS Disenrollment Reasons Survey question:

- one most important reason fill-in item (i.e., What was the one most important reason you left health plan X?)

The most important reason fill-in question was coded in a similar manner to the "other reasons" fill-in. Each respondent received a "most important reason" code for his or her answer to this fill-in item. Those codes were assigned to the same framework of reason groupings as was developed for the 33 preprinted reasons which in turn were assigned to the eight reason groupings. Thus, the most important reason responses were coded and grouped in a manner similar to the all (preprinted and other) reasons. In contrast to all reasons, however, 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.

In a few cases where the most important reason fill-in was left blank, we made the following fairly conservative imputation of the most important reason grouping. If the respondent was assigned to a single all reasons group because they only cited one reason item or all their reasons fell into the same reason grouping, then their most important reasons group assignment was made to that same reason grouping. No imputation of a blank most important reason item was made for a respondent when more than one all reasons grouping was assigned. Only 4.3% of the most important reason assignments were imputed in this manner, and we consider them to be uncontroversial imputations. Mistaken imputations should only arise for respondents who marked preprinted reasons that were not related to their "true" most important reason grouping (i.e., not assigned to the all reasons grouping parallel to their "true" most important reason grouping) and then failed to respond to the most important reason fill-in. Though the prevalence of such instances in unknown, we believe that it is likely rare.

The purpose of the preceding discussion was to point out that the **all reasons** variables and the **most important reason** contain different types of information.[17] The most important reason expresses the beneficiary's primary reason for leaving a plan while the all reasons also provide accompanying or secondary reasons. Consequently, for the purposes of informing beneficiaries about their health plan options, the most important reason is the appropriate variable to report.[18] At the respondent level, the all reasons variables tend to include a larger set

[17] In section 3.5, we examine how these two ways of measuring reasons for leaving a health plan complement and inform each other.

[18] The voluntary disenrollment reasons information posted on the www.Medicare.gov web site is based on the most important reason variable.

of reasons for disenrollment (than the most important reason variable) and are generally inclusive of the most important reason for an individual or set of individuals.

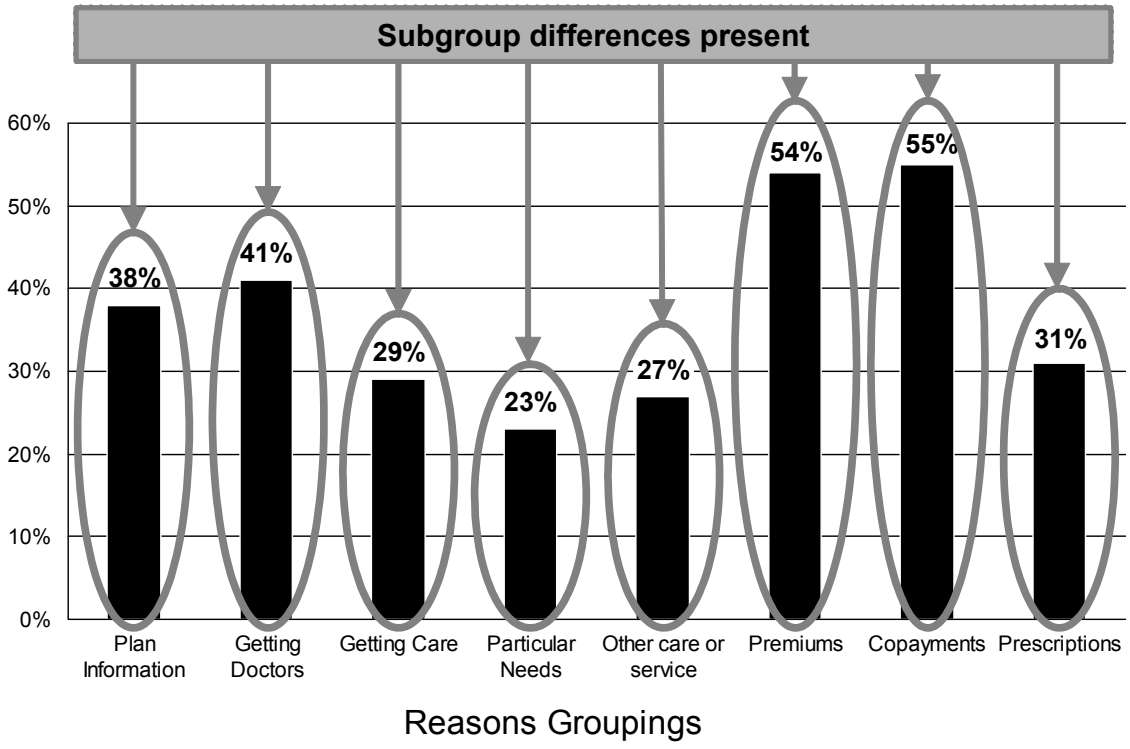
In the next three sections of this report, we present the results of the subgroup analyses, in each case presenting first the results of the larger set of **all reasons** followed by the result of the more focused **most important reason** variable. In the final section of this chapter, we report on results of analyses that investigate the relationship between the all reasons and most important reason variables in greater detail.

3.2 National Distribution of Disenrollment Reasons

All reasons cited

Among all reasons cited for leaving a plan, the most frequently cited reasons were increases in copayments (55%), premiums being too high (54%), problems getting to see particular doctors (41%), and problems getting plan information (38%) (***Exhibit 3-1***). Between about one-quarter to almost one-third of respondents 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%). In ***Sections 3.3*** and ***3.4***, we discuss the numerous differences that exist among subgroups of disenrollees regarding their reasons for leaving.

Exhibit 3-1. National-Level Percent of All Reasons Cited

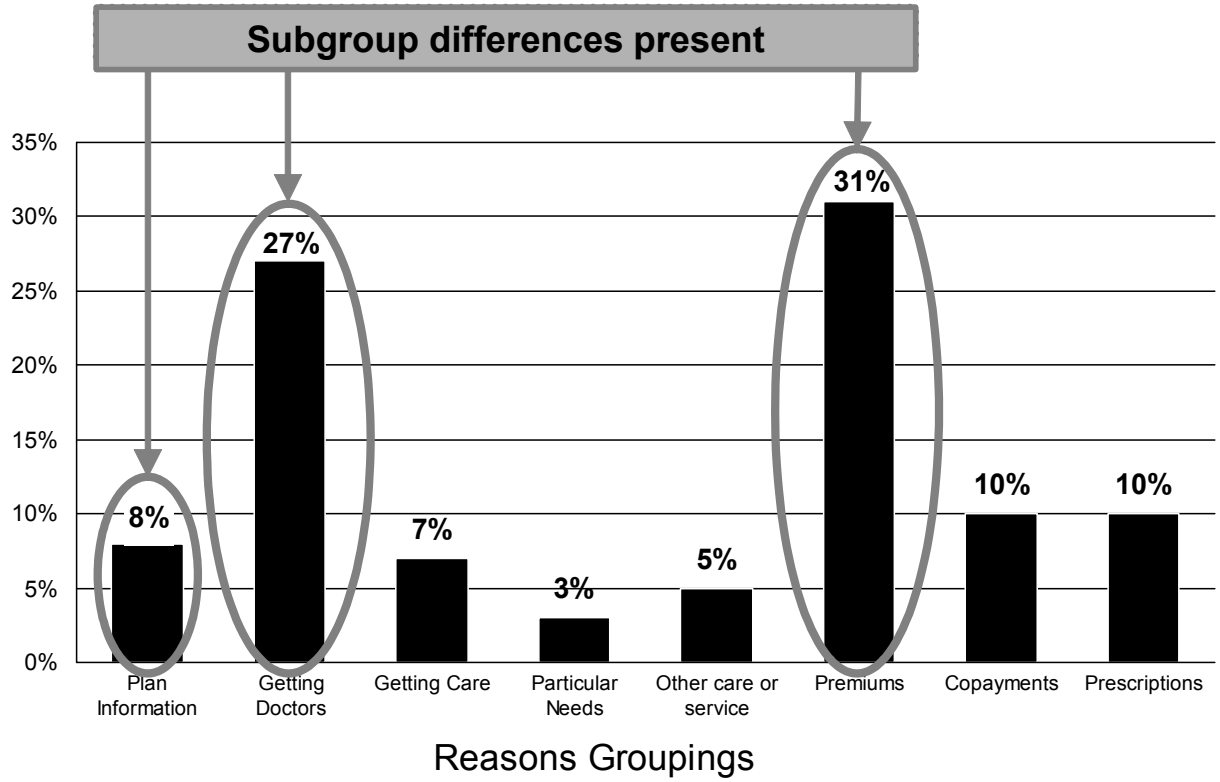


Note: Ovals indicate where subgroup differences occur.

Most important reasons cited

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 (***Exhibit 3-2***). 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%). In ***Sections 3.3*** and ***3.4***, we discuss the subgroup differences that occur in citing problems with plan information, problems getting doctors, and too-high premiums as a most important reason for leaving.

Exhibit 3-2. National-Level Percent of Most Important Reasons Cited



Note: Ovals indicate where subgroup differences occur.

3.3 Subgroup Results: For Each Reason Grouping, Which Subgroups Of M+C Plan Voluntary Disenrollees Are More Likely Than Other Disenrollees To Leave?

All Reasons Cited

In this section, we introduce the all reasons groupings and identify all statistically significant subgroup differences of at least 10 percentage points. We refer to these differences as "meaningful differences" and highlight them in the text and exhibits. Later in the section, we identify the smaller subset of most important reason groupings with statistically significant subgroup differences of at least 10 percentage points. ***Appendix C*** contains the details for all subgroups (those with and without meaningful differences) for the all reasons groupings and the most important reason groupings.[19]

Meaningful differences among all reasons groupings

Problems with plan information. Problems with plan information include being given incorrect or incomplete information when joining the plan, finding that the plan was not what was expected, finding that the information from the plan was hard to get or not helpful, unhelpful plan customer service staff, and uncertainty about the future of the plan or its coverage. A variety of subgroups appear to experience problems with plan information serious enough to affect their decision to leave their plan. The following groups of disenrollees are more likely than others to cite problems with plan information as a reason for leaving (***Exhibit 3-3***):

- Those in fair-to-poor health (46% versus 36% of those in excellent-to-good health)
- Those whose health worsened in the past year (47% versus 35% of those whose health stayed about the same)
- Those whose health is less than optimal (44% with excellent-to-good health that worsened or fair-to-poor health that stayed the same or improved and 49% with fair-to-poor health that worsened versus 34% whose health is excellent-to-good and stayed the same or improved)
- Disenrollees with either no visits (48%) or 10 or more visits (44%) in the past six months before leaving (versus 34% of those with one or two visits)
- Dually eligible disenrollees (49% versus 38% of disenrollees without dual eligibility)

[19] We conducted significance testing to find statistically significant associations between the reasons groupings and the subgroup variable in each table in Appendix C. We performed separate chi square tests for the pooled and unpooled versions of each subgroup variable. In the Series A (All Reasons) tables, Exhibit C-1 in Appendix C shows which subtables had significant associations at the .01 level. All significance tests on Series B (Most Important Reason) tables were significant at a .01 significance level except for the pooled subtable of Table 8b for frequency and choice of coverage after disenrollment.

- Young, disabled disenrollees under age 65 (53% versus about 38% of disenrollees age 65 or older)

- Disenrollees who went to FFS (49% versus 32% of those who went to another managed care plan)

- Disenrollees who left within five months of enrollment (66% versus 36% of those who stayed at least six months)

- Disenrollees who left in the second (46%) or third (44%) quarters (versus 31% of those who left in the fourth quarter)

- Hispanic (49%) and non-Hispanic black or African-American (50%) disenrollees (versus 36% of non-Hispanic whites)

Exhibit 3-3. National-Level Variation in Citing Problems with Plan Information as a Reason

Subgroups	Weighted Percent
Health Status Characteristics	
Self-assessed Health Status	
Excellent to Good	**36**
Fair to Poor	**46**
Self-assessed Health Status Compared with 1 Year Ago	
Better now	41
About the same	**35**
Worse now	**47**
Combined Health Status and 1-Year Health Status Change	
Excellent to good health that is same or better	**34**
Excellent to good health that is worse	**44**
Fair or poor health that is same or better	**44**
Fair or poor health that is worse	**49**
Number of Outpatient Visits in the 6 Months Before Disenrollment	
None	**48**
1	**35**
2	**34**
3	39
4	43
5 to 9	41
10 or more	**44**

(Continued)

Exhibit 3-3. National-Level Variation in Citing Problems with Plan Information as a Reason (continued)

Subgroups	Weighted Percent
Health Insurance Characteristics)	
Dual Eligibility Status	
Yes	**49**
No	**38**
Age	
64 or younger	**53**
65 to 69	**39**
70 to 74	**38**
75 to 79	**37**
80 or older	**36**
Other Disenrollee Characteristics	
Choice of Coverage After Disenrollment	
Another managed care plan	**32**
Fee-for-service	**49**
Length of Time in Plan Before Disenrollment	
1 month or less	**72**
2 months	**71**
3 months	**70**
4 months	**63**
5 months	**53**
6 months or more	**36**
Sampling Quarter When Disenrollee Left Plan	
January – March 2000	40
April – June 2000	**46**
July – September 2000	**44**
October – December 2000	**31**
Sociodemographic Characteristics	
Race and Ethnicity	
Hispanic	**49**
Non-Hispanic White	**36**
Non-Hispanic Black or African-American	**50**
Non-Hispanic other race	43

Problems getting particular doctors. The problems getting particular doctors grouping includes the plan not including doctors in their network that the beneficiary wanted to see, the beneficiary's doctor leaving the plan or retiring, the doctor the beneficiary wanted to see not accepting new patients, and not being able to see the same doctor at each visit. The following groups of disenrollees are more likely than others to cite problems getting particular doctors as a reason for leaving (***Exhibit 3-4***):

- Disenrollees who were hospitalized within 90 days of enrolling into FFS after their disenrollment (59% versus 47% of those who went to FFS but were not hospitalized within 90 days and 38% of those who went to another managed care plan)

- Disenrollees who left in the third (50%) quarter (versus 37% of those who left in the first quarter)

- Disenrollees with at least a four-year college degree (47% versus 37% of those with a 9th to 11th grade education)

Exhibit 3-4. National-Level Variation in Citing Problems Getting Particular Doctors as a Reason

Subgroups	Weighted Percent
Other Disenrollee Characteristics	
Hospitalization After Disenrollment to Fee-for-Service[20]	
Hospitalized within 90 days after enrolling into fee-for-service	**59**
Not hospitalized within 90 days after enrolling into fee-for-service	**47**
Went to managed care (not fee-for-service)	**38**
Sampling Quarter When Disenrollee Left Plan	
January – March 2000	**37**
April – June 2000	46
July – September 2000	**50**
October – December 2000	43
Sociodemographic Characteristics	
Education	
8th grade or less	39
9th – 11th grade	**37**
High school graduate/GED	42
Some college/2-Year degree	42
Bachelor's degree or more	**47**

[20] This variable was created, in part, to support a separate CMS research effort on possible selection in Medicare managed care.

Problems getting care. The problems getting care grouping includes an array of access and timeliness of care issues: not getting an appointment for regular or routine health care as soon as the beneficiary wanted, having to wait too long in the waiting room during an appointment, having a health care provider who did not explain things in an understandable way, having problems with the plan doctors or other health care providers, having problems or delays getting plan approval for specialist referrals, and having problems getting care when it was needed. A variety of subgroups—notably disenrollees in poorer health, who have more outpatient visits, who are dually eligible, and who are younger and disabled—cite problems getting care that contributed to their choice to leave their plan. In particular, the following disenrollees are more likely than others to cite problems getting care as a reason for leaving (***Exhibit 3-5***):

- Those in fair-to-poor health (36% versus 26% of those in excellent-to-good health)
- Those whose health worsened in the past year (37% versus 25% of those who health stayed about the same)
- Those whose health is poorest (38% of those with fair-to-poor health that worsened versus 25% of those whose health is excellent-to-good and stayed the same or improved)
- Disenrollees with five or more visits (34%) in the past six months before leaving (versus 24% of those with two visits)
- Dually eligible disenrollees (38% versus 28% of disenrollees without dual eligibility)
- Disabled disenrollees under age 65 (37% versus 26% of disenrollees age 65 to 69)
- Disenrollees who went to FFS (37% versus 24% of those who went to another managed care plan)
- Disenrollees who were hospitalized within 90 days of enrolling into FFS (52% versus 36% of those who enrolled into fee-for-service but were not hospitalized within 90 days and 24% of those who went to another managed care plan)
- Disenrollees who left within two to four months of enrollment (ranging from 43% for two months to 41% for three months and 46% for four months versus 28% for those who stayed at least six months)

Exhibit 3-5. National-Level Variation in Citing Problems Getting Care as a Reason

Subgroups	Weighted Percent
Health Status Characteristics	
Self-assessed Health Status	
Excellent to good	**26**
Fair to poor	**36**
Self-assessed Health Status Compared with 1 Year Ago	
Better now	31
About the same	**25**
Worse now	**37**
Combined Health Status and 1-Year Health Status Change	
Excellent to good health that is same or better	**25**
Excellent to good health that is worse	34
Fair or poor health that is same or better	34
Fair or poor health that is worse	**38**
Number of Outpatient Visits in the 6 Months Before Disenrollment	
None	30
1	25
2	**24**
3	27
4	33
5 to 9	**34**
10 or more	**34**
Health Insurance Characteristics	
Dual Eligibility Status	
Yes	**38**
No	**28**
Age	
64 or younger	**37**
65 to 69	**26**
70 to 74	29
75 to 79	29
80 or older	31

(continued)

Exhibit 3-5. National-Level Variation in Citing Problems Getting Care as a Reason (continued)

Subgroups	Weighted Percent
Other Disenrollee Characteristics	
Choice of Coverage After Disenrollment	
Another managed care plan	**24**
Fee-for-service	**37**
Hospitalization After Disenrollment to Fee-for-Service	
Hospitalized within 90 days after enrolling into fee-for-service	**52**
Not hospitalized within 90 days after enrolling into fee-for-service	**36**
Went to managed care (not fee-for-service)	**24**
Length of Time in Plan Before Disenrollment	
1 month or less	**34**
2 months	**43**
3 months	**41**
4 months	**46**
5 months	37
6 months or more	**28**

Problems getting particular needs met. The problems getting particular needs met grouping includes a diverse array of issues that seem to often deal with approval and coverage problems: the plan refusing to pay for emergency care or other urgent care, the plan not approving hospital admission when needed, having to leave the hospital before the beneficiary or their doctor thought they should, not getting needed special medical equipment, not getting needed home health care, and the plan not paying for some care the beneficiary needed. The following groups of disenrollees are more likely than others to cite problems getting particular needs met as a reason for leaving (***Exhibit 3-6***):

- Those in fair-to-poor health (32% versus 20% of those in excellent-to-good health)
- Those whose health worsened in the past year (33% versus 20% of those who health stayed about the same)
- Those whose health is fair-to-poor that stayed the same or improved (29%) or worsened (35%) (versus 19% whose health is excellent-to-good and stayed the same or improved)
- Disenrollees with five or more visits in the past six months before leaving (about 30% versus about 18% of those with two or fewer visits)
- Dually eligible disenrollees (36% versus 22% of disenrollees without dual eligibility)
- Disabled disenrollees under age 65 (37% versus 23% of disenrollees age 65 and older)
- Disenrollees who were hospitalized within 90 days of enrolling into FFS (42% versus 29% of those who enrolled into FFS but were not hospitalized within 90 days and 20% of those who went to another managed care plan)

Exhibit 3-6. National-Level Variation in Citing Problems Getting Particular Needs Met as a Reason

Subgroups	Weighted Percent
Health Status Characteristics	
Self-assessed Health Status	
Excellent to good	**20**
Fair to poor	**32**
Self-assessed Health Status Compared with 1 Year Ago	
Better now	27
About the same	**20**
Worse now	**33**
Combined Health Status and 1-Year Health Status Change	
Excellent to good health that is same or better	**19**
Excellent to good health that is worse	27
Fair or poor health that is same or better	**29**
Fair or poor health that is worse	**35**
Number of Outpatient Visits in the 6 Months Before Disenrollment	
None	**18**
1	**20**
2	**17**
3	24
4	25
5 to 9	**29**
10 or more	**32**
Health Insurance Characteristics	
Dual Eligibility Status	
Yes	**36**
No	**22**
Age	
64 or younger	**37**
65 to 69	**21**
70 to 74	**23**
75 to 79	**22**
80 or older	**25**
Other Disenrollee Characteristics	
Hospitalization After Disenrollment to Fee-for-Service	
Hospitalized within 90 days after enrolling into fee-for-service	**42**
Not hospitalized within 90 days after enrolling into fee-for-service	**29**
Went to managed care (not fee-for-service)	**20**

Other problems with care or service. Other problems with care or service include a variety of issues, some of which are not necessarily attributable to specific plan performance: the location of facilities and services offered by the plan being too far away, being concerned about coverage for care while out of town, someone from the plan said the beneficiary could get better care elsewhere, and the beneficiary or someone they know had a bad experience with the plan. The following groups of disenrollees are more likely than other disenrollees to cite other problems with care or service as a reason for leaving (***Exhibit 3-7***):

- Those whose health worsened in the past year (35% versus 25% of those who health stayed about the same)

- Those in the poorest health (37% of those whose health is fair-to-poor and worsened versus 24% of those whose health is excellent-to-good and stayed the same or improved)

- Disenrollees with 10 or more visits (36%) in the past six months before leaving (versus about 15% of those with one or two visits)

- Disenrollees who enrolled into FFS and were hospitalized within 90 days (40% versus 24% of those who went to another managed care plan)

- Disenrollees who left their plan in the third quarter (33% versus 23% of those who left in the fourth quarter)

Exhibit 3-7. National-Level Variation in Citing Other Problems with Care or Service as a Reason

Subgroups	Weighted Percent
Health Status Characteristics	
Self-assessed Health Status Compared with 1 Year Ago	
Better now	28
About the same	**25**
Worse now	**35**
Combined Health Status and 1-Year Health Status Change	
Excellent to good health that is same or better	**24**
Excellent to good health that is worse	33
Fair or poor health that is same or better	32
Fair or poor health that is worse	**37**
Number of Outpatient Visits in the 6 Months Before Disenrollment	
None	33
1	**24**
2	**25**
3	29
4	28
5 to 9	28
10 or more	**36**
Other Disenrollee Characteristics	
Hospitalization After Disenrollment to Fee-for-Service	
Hospitalized within 90 days after enrolling into fee-for-service	**40**
Not hospitalized within 90 days after enrolling into fee-for-service	32
Went to managed care (not fee-for-service)	**24**
Sampling Quarter When Disenrollee Left Plan	
January – March 2000	28
April – June 2000	32
July – September 2000	**33**
October – December 2000	**23**

Premiums or copayments too high. As the name implies, this reason grouping focuses on concerns about premium costs: the beneficiary could not pay the monthly premium, another plan would cost the beneficiary less, and the plan increased its monthly premium. The following groups of disenrollees are more likely than others to cite premiums or copayments too high as a reason for leaving (***Exhibit 3-8***):

- Disenrollees under age 65 who are disabled (63% versus 48% of those age 80 and older)

- Disenrollees who went to another managed care plan (57% versus 44% of those who were hospitalized within 90 days of enrolling into fee-for-service)

- Disenrollees who were in the plan at least five months before leaving (54% of those who left after five months and 57% who left after six or more months versus about 40% who left their plan within four months of enrollment)

- Disenrollees who left their plan in the first (58%) and fourth quarters (59%) (versus those who left in the second (49%) and third (41%) quarters)

- Non-Hispanic disenrollees of races other than black or white (65% versus 51% of Hispanic disenrollees and 54% of non-Hispanic white disenrollees)

Exhibit 3-8. National-Level Variation in Citing Premiums or Copayments Too High as a Reason

Subgroups	Weighted Percent
Health Insurance Characteristics	
Age	
64 or younger	**63**
65 to 69	56
70 to 74	55
75 to 79	55
80 or older	**48**
Other Disenrollee Characteristics	
Hospitalization After Disenrollment to Fee-for-Service	
Hospitalized within 90 days after enrolling into fee-for-service	**44**
Not hospitalized within 90 days after enrolling into fee-for-service	52
Went to managed care (not fee-for-service)	**57**
Length of Time in Plan Before Disenrollment	
1 month or less	**38**
2 months	**40**
3 months	**43**
4 months	**39**
5 months	**54**
6 months or more	**57**
Sampling Quarter When Disenrollee Left Plan	
January – March 2000	**58**
April – June 2000	**49**
July – September 2000	**41**
October – December 2000	**59**
Sociodemographic Characteristics	
Race and Ethnicity	
Hispanic	**51**
Non-Hispanic White	**54**
Non-Hispanic Black or African-American	58
Non-Hispanic other race	**65**

Copayments increased and/or another plan offered better coverage. This reason grouping focuses on out-of-pocket costs resulting from copayments or the need to pay for services that are not covered: another plan offered better benefits or coverage; the plan increased its copayment amount for office visits, prescriptions, or other services; and the beneficiary no longer needed coverage under the plan. The following groups of disenrollees are more likely than others to cite increases in copayments or another plan offering better coverage as a reason for leaving (***Exhibit 3-9***):

- Disenrollees with 10 or more visits in the past six months before leaving (65% versus about 54% of those who had two or fewer visits)

- Disenrollees under age 65 who disabled (65% versus 50% of those ages 80 and older)

Exhibit 3-9. National-Level Variation in Citing Copayments Increased and/or Another Plan Offered Better Coverage as a Reason

Subgroups	Weighted Percent
Health Status Characteristics	
Number of Outpatient Visits in the 6 Months Before Disenrollment	
None	**52**
1	**53**
2	**55**
3	58
4	61
5 to 9	59
10 or more	**65**
Health Insurance Characteristics	
Age	
64 or younger	**65**
65 to 69	58
70 to 74	57
75 to 79	56
80 or older	**50**

Problems getting or paying for prescription medicines. As the name implies, this reason grouping addresses a variety of problems that beneficiaries encounter with prescription medicines: the maximum dollar amount that the plan allowed for prescription drugs was too low, the plan required the beneficiary to get generic medicine when the beneficiary wanted a brand name, and the plan would not pay for a particular medication that the beneficiary's doctor prescribed. The following groups of disenrollees are more likely than others to cite problems getting or paying for prescription medicines as a reason for leaving (***Exhibit 3-10***):

- Disenrollees in fair-to-poor health (39% versus 29% of those in excellent-to-good health)

- Disenrollees whose health worsened in the past year (39% versus 29% of those whose health stayed about the same)

- Disenrollees in poorest health (41% of those with fair-to-poor health that worsened versus 28% of those with excellent-to-good health that stayed the same or improved)

- Disenrollees with three or more visits in the past six months before disenrolling (about 37% versus 22% of those with no visits)

- Disenrollees under age 65 with a disability (46% versus 31% of those age 65 and older)

Exhibit 3-10. National-Level Variation in Citing Problems Getting or Paying for Prescription Medicines as a Reason

Subgroups	Weighted Percent
Health Status Characteristics	
Self-assessed Health Status	
Excellent to good	**29**
Fair to poor	**39**
Self-assessed Health Status Compared with 1 Year Ago	
Better now	33
About the same	**29**
Worse now	**39**
Combined Health Status and 1-Year Health Status Change	
Excellent to good health that is same or better	**28**
Excellent to good health that is worse	35
Fair or poor health that is same or better	37
Fair or poor health that is worse	**41**
Number of Outpatient Visits in the 6 Months Before Disenrollment	
None	**22**
1	**28**
2	**30**
3	**34**
4	**37**
5 to 9	**37**
10 or more	**40**
Health Insurance Characteristics	
Age	
64 or younger	**46**
65 to 69	**32**
70 to 74	**32**
75 to 79	**31**
80 or older	**26**

Most Important Reasons Cited

In this section, we examine each most important reason grouping to identify differences between disenrollee subgroups. For each most important reason grouping where we find statistically significant subgroup differences of at least 10 percentage points, we identify these subgroups in the text and accompanying exhibits. We refer to these differences as "meaningful differences." In the exhibits we highlighted these differences with shading. At the end of this section, we note the most important reason groupings for which we do not find any meaningful subgroup differences. ***Appendix C*** contains tables with the details for all subgroups (i.e., including subgroups with and without meaningful differences) by most important reason grouping.[21]

Meaningful differences among most important reason groupings

Problems with plan information. Length of time spent in the plan prior to leaving is the only characteristic where subgroups of disenrollees show a meaningful difference in their likelihood to cite problems with plan information as their most important reason for leaving: disenrollees who had been in the plan only three (17%) to four (18%) months before leaving are more likely than those who had been in the plan six months or more (7%) to cite problems with plan information as their most important reason for leaving (***Exhibit 3-11***). We find no meaningful differences by any of the other subgroups in their likelihood to cite this problem as their most important reason.

Exhibit 3-11. National-Level Variation in Citing Problems with Plan Information as Most Important Reason

Subgroups	Weighted Percent
Other Disenrollee Variables	
Length of Time in Plan Before Disenrollment	
1 month or less	14
2 months	12
3 months	**17**
4 months	**18**
5 months	10
6 months or more	**7**

[21] We conducted significance testing to find statistically significant associations between the reasons groupings and the subgroup variable in each table in Appendix C. We performed separate chi square tests for the pooled and unpooled versions of each subgroup variable. In the Series A (All Reasons) tables, Exhibit C-1 in Appendix C shows which subtables had significant associations at the .01 level. All significance tests on Series B (Most Important Reason) tables were significant at a .01 significance level except for the pooled subtable of Table 8b for frequency and choice of coverage after disenrollment.

Problems getting particular doctors. The following subgroups of disenrollees are more likely than others to cite problems getting particular doctors as their most important reason for leaving (***Exhibit 3-12***):

- Non-dually eligible disenrollees (29% versus 16% of dually eligible disenrollees)
- Disenrollees age 80 or older (30% versus 19% of disenrollees age 64 or younger with a disability)
- Disenrollees who had been in the plan less than four months (about 33% versus about 21% of those who had been in the plan four or five months)
- Non-Hispanic white disenrollees (29% versus 18% of Non-Hispanic, non-white disenrollees)

Exhibit 3-12. National-Level Variation in Citing Problems Getting Particular Doctors as Most Important Reason

Subgroups	Weighted Percent
Health Insurance Characteristics	
Dual Eligibility Status	
Yes	**16**
No	**29**
Age	
64 or younger	**19**
65 to 79	27
80 or older	**30**
Other Disenrollee Variables	
Length of Time in Plan Before Disenrollment	
1 month or less	**31**
2 months	**33**
3 months	**31**
4 months	**22**
5 months	**21**
6 months or more	27
Sociodemographic Characteristics	
Race and Ethnicity	
Hispanic	20
Non-Hispanic White	**29**
Non-Hispanic Black or African-American	**18**
Non-Hispanic Other race	**18**

Premiums or copayments too high. The following groups of disenrollees are more likely than others to cite premiums or copayments being too high as their most important reason for leaving (***Exhibit 3-13***):

- Disenrollees with only one visit in the past six months before leaving (39% versus about 27% of those with four or more visits)

- Disenrollees who went to another managed care plan (32% versus 22% of those who disenrolled to FFS and were hospitalized within 90 days of disenrollment)

- Disenrollees who were in the plan at least five months before leaving (about 32% versus those who were in the plan four months or less, ranging from 13% to 22%)

- Disenrollees who left in the first (35%) or fourth (36%) quarters (versus those who left in the second, 25%, or third, 19%, quarters)

Exhibit 3-13. National-Level Variation in Citing Premiums or Copayments Too High as Most Important Reason

Subgroups	Weighted Percent
Health Status Characteristics	
Number of Outpatient Visits in 6 Months Before Disenrollment	
None	34
1	**39**
2	34
3	33
4	**28**
5 to 9	**26**
10 or more	**29**
Other Disenrollee Variables	
Hospitalization After Disenrollment to Fee-for-Service	
Hospitalized within 90 days after enrolling into fee-for-service	**22**
Not hospitalized within 90 days after enrolling into fee-for-service	31
Went to managed care (not fee-for-service)	**32**
Length of Time in Plan Before Disenrollment	
1 month or less	**18**
2 months	**13**
3 months	**22**
4 months	**18**
5 months	**31**
6 months or more	**33**
Sampling Quarter When Disenrollee Left Plan	
January – March 2000	**35**
April – June 2000	**25**
July – September 2000	**19**
October – December 2000	**36**

No meaningful differences among these most important reason groupings

We find no meaningful differences among any subgroups in their likelihood to cite these reason groupings as most important: problems getting care, problems getting particular needs met, other problems with care or service, copayments increased and/or another plan offered better coverage, and problems getting or paying for prescription medicines.

3.4 Subgroup Results: For Each Subgroup Of M+C Plan Voluntary Disenrollees, For What Reasons Are They More Likely Than Other Disenrollees To Leave?

All Reasons Cited

In this section, we identify all variables with statistically significant subgroup differences of at least 10 percentage points for each of the all reasons groupings. We refer to these differences as "meaningful differences." We note at the end of each subsection of variables (e.g., health status variables) the subgroups for which we do not find meaningful subgroup differences. ***Appendix C*** contains the detailed subgroup tables for the all reasons groupings.[22]

Meaningful differences by health status characteristics

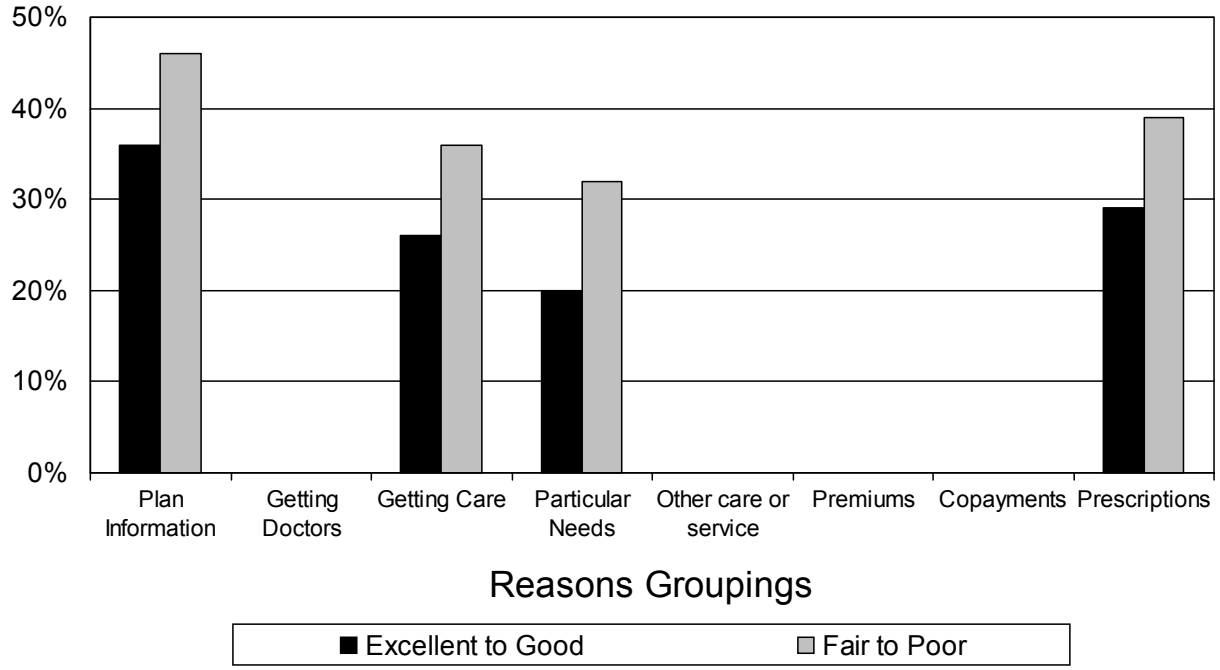
Health status. Disenrollees in fair-to-poor health are more likely than disenrollees in good-to-excellent health to cite the following problems as reasons for leaving their plan (***Exhibit 3-14***):

- Problems with plan information (46% in fair-to-poor health versus 36% in good-to-excellent health cite this as a reason)
- Problems getting care (36% versus 26%)
- Problems getting particular needs met (32% versus 20%)
- Problems getting or paying for prescription medicines (39% versus 29%)

Disenrollees in poor health (39%) are more likely than disenrollees in good-to-excellent health (23% to 25%) to cite other problems with care or service as a reason for leaving (***Appendix C***, ***Table 1a***). Disenrollees in fair-to-poor health (61%) are more likely than disenrollees in excellent health (48%) to cite increasing copayments or another plan offering better benefits as a reason for leaving (***Appendix C***, ***Table 1a***).

[22] We conducted significance testing to find statistically significant associations between the reasons groupings and the subgroup variable in each table in Appendix C. We performed separate chi square tests for the pooled and unpooled versions of each subgroup variable. In the Series A (All Reasons) tables, Exhibit C-1 in Appendix C shows which subtables had significant associations at the .01 level. All significance tests on Series B (Most Important Reason) tables were significant at a .01 significance level except for the pooled subtable of Table 8b for frequency and choice of coverage after disenrollment.

Exhibit 3-14. National-Level Variation in All Reasons Cited by Self-assessed Health Status[a]



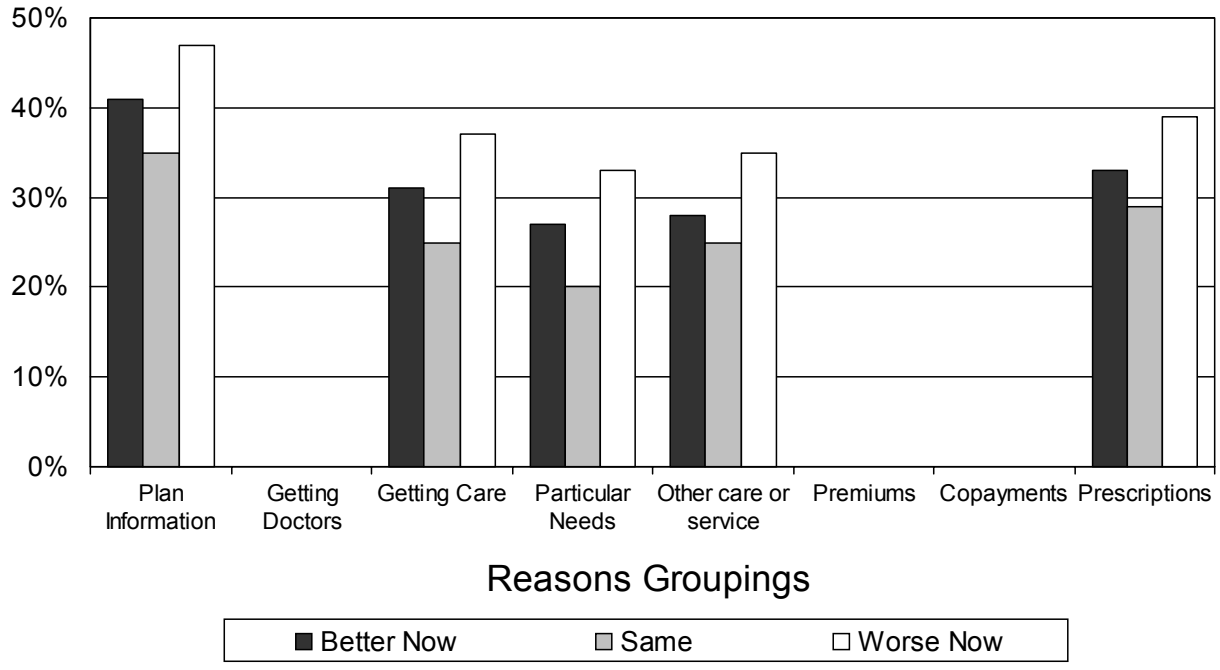
[a] All reported differences in text at $p \leq .01$ and ≥ 10 percentage points

Health status now compared to one year ago. Disenrollees whose health worsened in the past year are more likely than disenrollees whose health remained the same to cite the following problems as reasons for leaving their plan (***Exhibit 3-15***):

- Problems with plan information (47% whose health is worse now versus 35% whose health is the same cite this as a reason)
- Problems getting care (37% versus 25%)
- Problems getting particular needs met (33% versus 20%)
- Other problems with care or service (35% versus 25%)
- Problems getting or paying for prescription medicines (39% versus 29%)

Disenrollees whose health was much worse now than the year before (64%) are more likely than disenrollees whose health was much better now than the year before (54%) to cite increasing copayments or another plan offering better benefits as a reason for leaving (***Appendix C***, ***Table 2a***).

Exhibit 3-15. National-Level Variation in All Reasons Cited by Self-assessed Health Status Now Compared to One Year Ago[a]

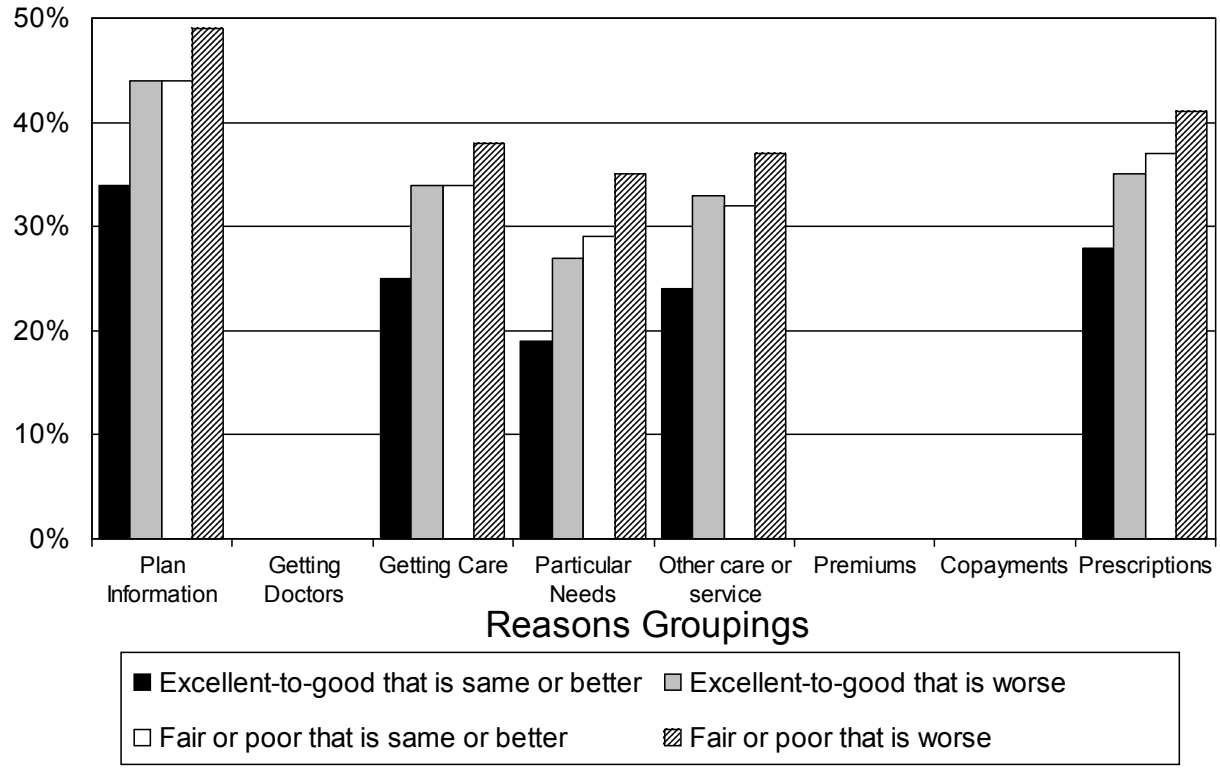


[a] All reported differences in text at p ≤ .01 and ≥ 10 percentage points

Combined health status and one-year health status change. ***Exhibit 3-16*** shows a clear pattern where disenrollees in the worst health (fair-to-poor health whose health worsened in the past year) are more likely to cite the following problems than disenrollees in the best health (good-to-excellent whose health improved or stayed the same in the past year):

- Problems with plan information (49% in fair-to-poor health whose health worsened in the past year versus 34% in good-to-excellent whose health improved or stayed the same in the past year)
- Problems getting care (38% versus 25%)
- Problems getting particular needs met (35% versus 19%)
- Other problems with care or service (37% versus 24%)
- Problems getting or paying for prescription medicines (41% versus 28%)

Exhibit 3-16. National-Level Variation in All Reasons Cited by Combined Self-assessed Health Status and One-Year Health Status Change[a]



[a] All reported differences in text at p ≤ .01 and ≥ 10 percentage points

Outpatient visits. ***Exhibit 3-17*** indicates a general pattern that disenrollees who reported more outpatient visits are more likely than those who reported fewer visits to cite an array of problems as reasons for leaving. Disenrollees reporting 10 or more outpatient visits (and sometimes those with five to nine visits) in the past six months before disenrollment were more likely than those with fewer visits to cite the following problems as reasons for leaving:

- Problems with plan information (however, those with no visits were also more likely to cite this reason) (44% of those with at least ten visits versus 34% of those with only two visits)

- Problems getting care (34% of those with at least ten visits versus 24% of those with only two visits)

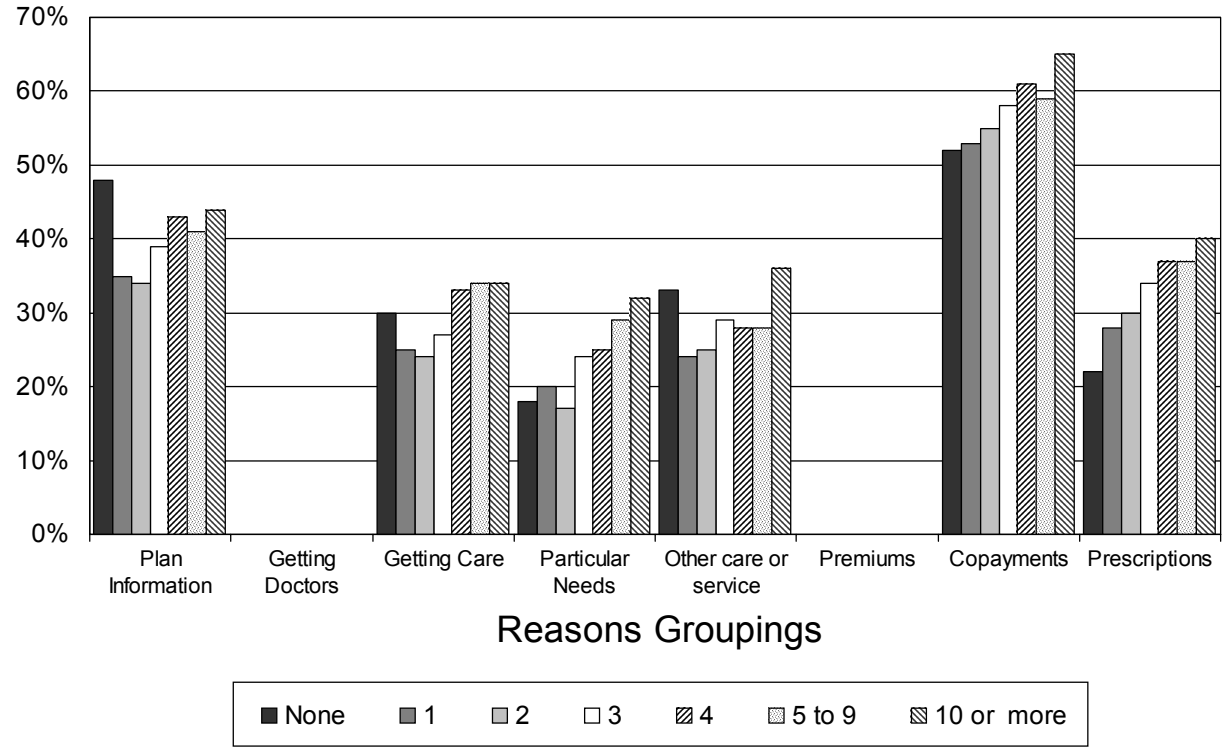
- Problems getting particular needs met (32% of those with at least ten visits versus 17% of those with two visits, 20% of those with one visit, and 18% of those with no visits)

- Other problems with care or service (36% of those with at least 10 visits versus 25% of those with two visits and 24% of those with one visit)

- Increasing copayments or another plan offering better coverage (65% of those with at least 10 visits versus 55% of those with two visits, 53% of those with one visit, and 52% of those with no visits)

- Problems getting or paying for prescription medicines (40% of those with at least 10 visits versus 30% of those with two visits, 28% of those with one visit, and 22% of those with no visits)

Exhibit 3-17. National-Level Variation in All Reasons Cited by Number of Outpatient Visits in Past Six Months Before Disenrollment[a]



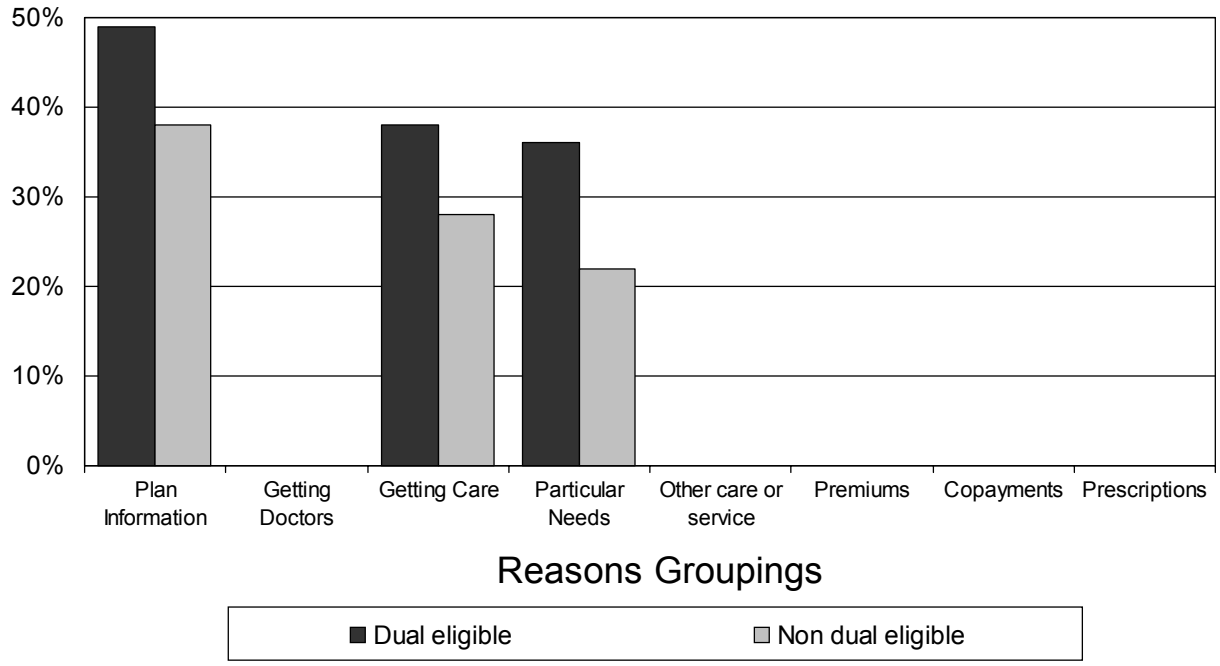
[a] All reported differences in text at p ≤ .01 and ≥ 10 percentage points

Meaningful differences by health insurance characteristics

Dual eligibility status. Disenrollees with dual eligibility are more likely than disenrollees without dual eligibility to cite the following problems as reasons for leaving (***Exhibit 3-18***):

- Problems with plan information (49% of disenrollees with dual eligibility versus 38% of disenrollees without dual eligibility)
- Problems getting care (38% versus 28%)
- Problems getting particular needs met (36% versus 22%)

Exhibit 3-18. National-Level Variation in All Reasons Cited by Dual Eligibility Status[a]



[a] All reported differences in text at $p \leq .01$ and ≥ 10 percentage points

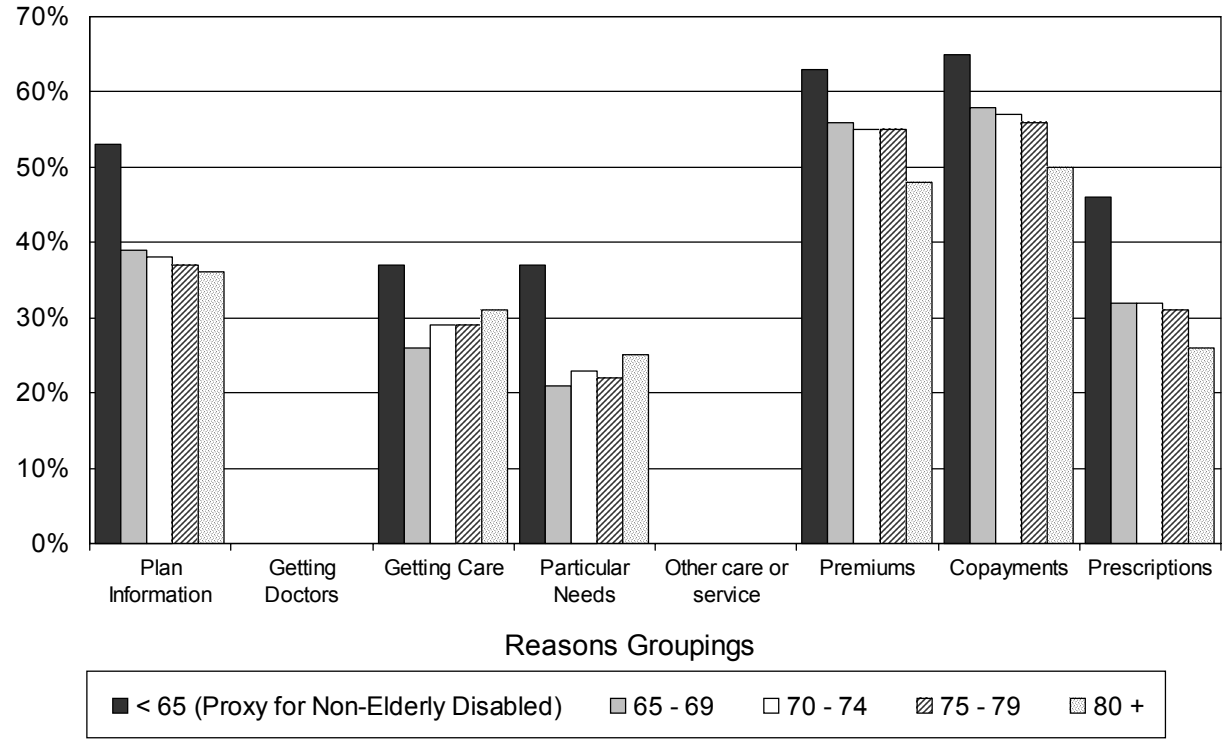
Age. Disenrollees under age 65 with a disability are more likely than older disenrollees to cite the following problems as reasons for leaving (***Exhibit 3-19***):

- Problems with plan information (53% under age 65 versus 37% age 65 or older)
- Problems getting particular needs met (37% versus 23%)
- Problems getting or paying for prescription medicines (46% versus 31%)

Disenrollees under age 65 with a disability (37%) are more likely than those between the ages of 65 and 69 (26%) to cite problems getting care as a reason for leaving. Disenrollees under age 65 with a disability are more likely than those who are 80 years old and older to cite the following problems as a reason for leaving:

- Premiums or copayments being too high (63% under age 65 versus 48% age 80 or older)
- Increasing copayments or another plan offering better benefits (65% versus 50%)

Exhibit 3-19. National-Level Variation in All Reasons Cited by Age[a]



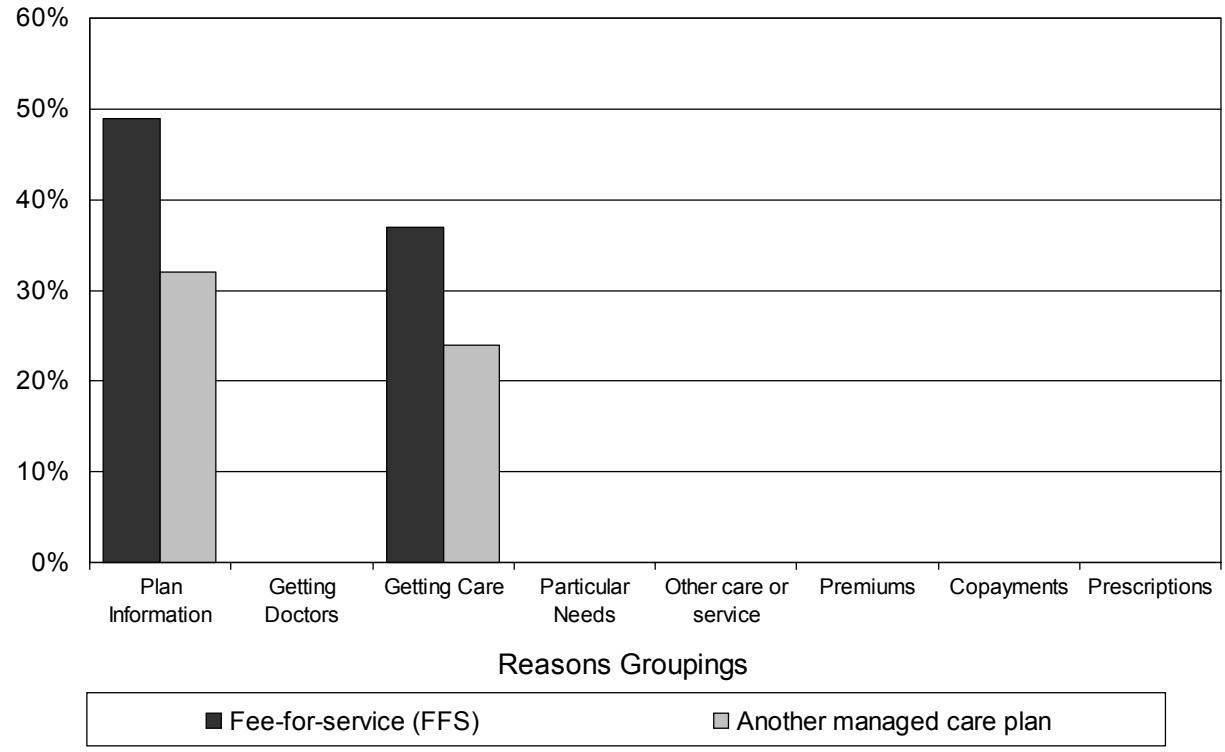
[a] All reported differences in text at p ≤ .01 and ≥ 10 percentage points

Meaningful differences by other disenrollee characteristics

Choice of coverage after disenrollment. ***Exhibit 3-20*** shows that disenrollees who went to FFS are more likely than disenrollees who went to another managed care plan to cite the following problems as reasons for leaving:

- Problems with plan information (49% of those who went to FFS versus 32% of those who went to another managed care plan)
- Problems getting care (37% versus 24%)

Exhibit 3-20. National-Level Variation in All Reasons Cited by Choice of Coverage After Disenrollment[a]



[a] All reported differences in text at $p \leq .01$ and ≥ 10 percentage points

Hospitalization after disenrollment to FFS. ***Exhibit 3-21*** shows that disenrollees who went to FFS and were hospitalized within 90 days of FFS enrollment generally show a different pattern in their reasons for leaving compared to both disenrollees who go to another managed care plan and those who went to FFS but were not hospitalized within 90 days. Specifically, disenrollees who went to FFS and were hospitalized within 90 days are more likely than both those who went to FFS but were not hospitalized within 90 days and those who went to another managed care plan to cite the following problems as reasons for leaving:

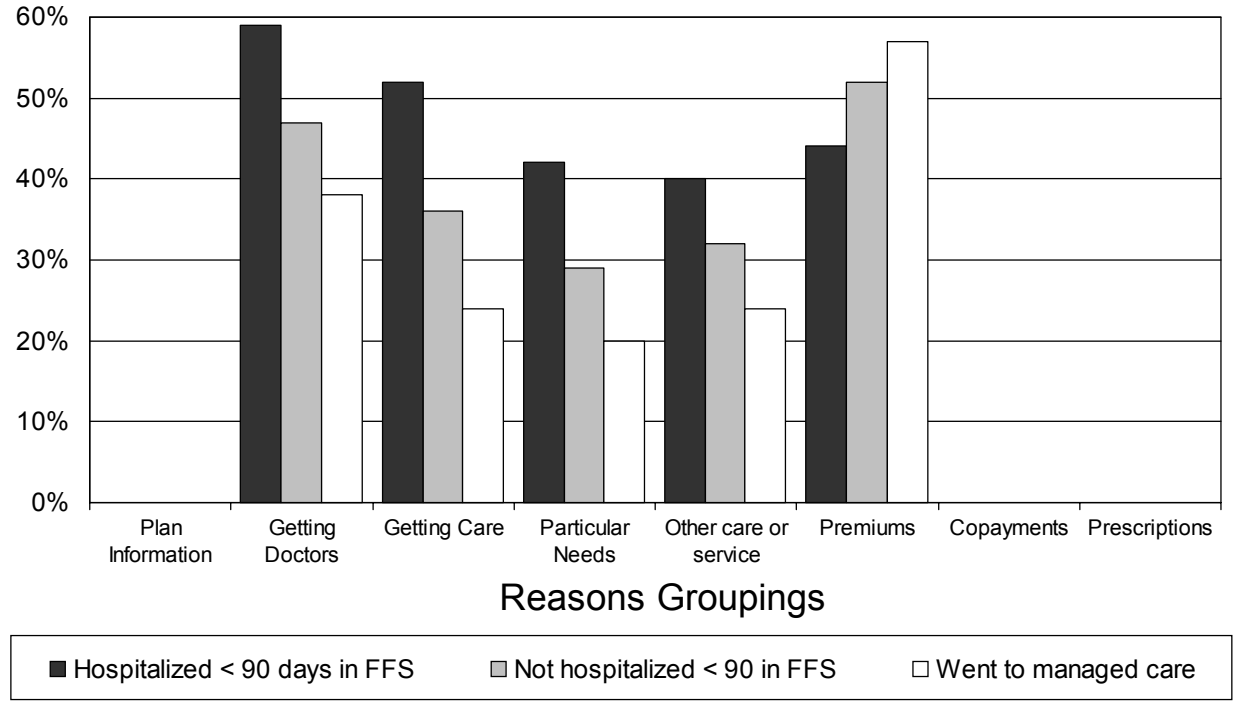
- Problems getting doctors they want (59% of those who disenrolled to FFS and were hospitalized within 90 days versus 47% who disenrolled to FFS but were not hospitalized within 90 days and 38% who disenrolled to another M+C plan, respectively)

- Problems getting care (52% versus 36% and 24%, respectively)

- Problems getting particular needs met (42% versus 29% and 20%, respectively)

Disenrollees who went to FFS and were hospitalized within 90 days (40%) are also more likely than disenrollees who went to another managed care plan (24%) to cite other problems with care or service as a reason for leaving. Disenrollees who disenrolled to another managed care plan (57%) are more likely than those who disenrolled to FFS and were hospitalized within 90 days to cite premiums or copayments being too high as a reason for leaving.

Exhibit 3-21. National-Level Variation in All Reasons Cited by Hospitalization After Disenrollment to FFS[a]



[a] All reported differences in text at p ≤ .01 and ≥ 10 percentage points

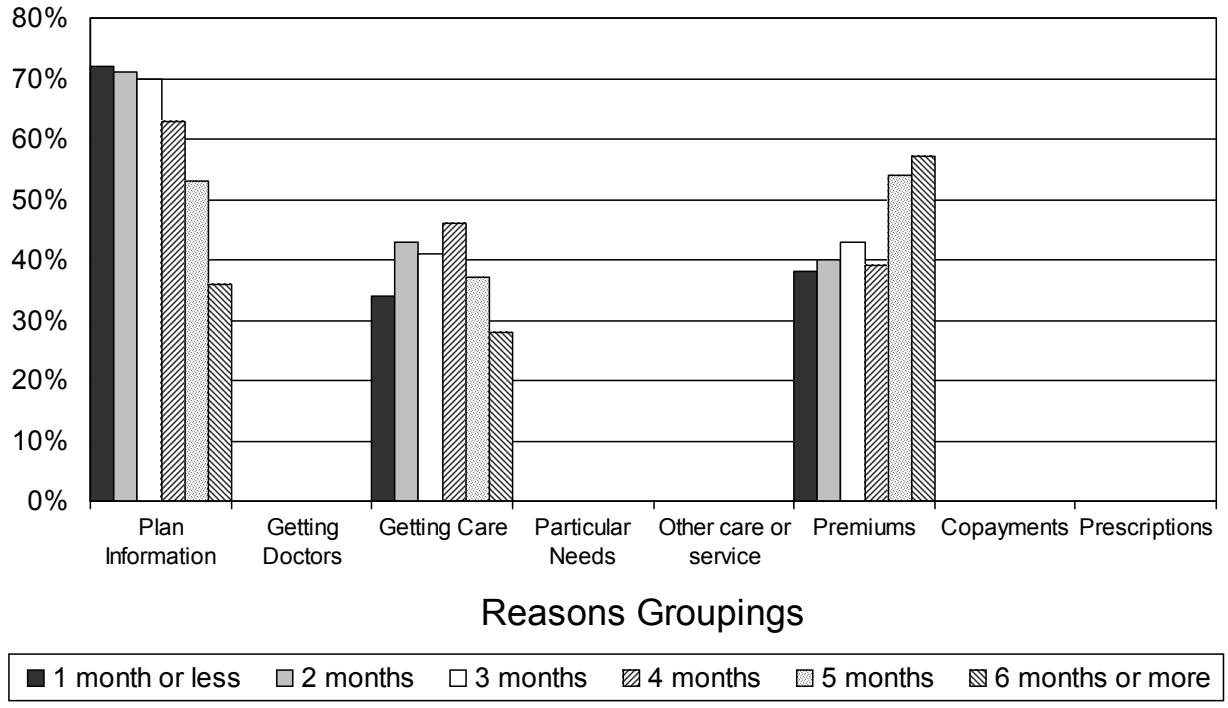
Length of time in plan before disenrollment. As we found with the most important reasons results, there are differences in cited reasons for leaving associated with length of time in plan before disenrolling, but the patterns are not clear cut. Disenrollees who had been in their plan less than six months before disenrolling are more likely than those who had been in their plan at least six months before leaving to cite the following problems as a reason for leaving (***Exhibit 3-22***):

- Problems with information from the plan (66% of those who disenrolled after less than six months in the plan versus 36% of those who were in the plan at least six months before disenrolling)

- Problems getting care (40% versus 28%)

Disenrollees who had been in their plan at least six months (57%) before disenrolling are more likely than those who had been in the plan fewer months (43%) to cite premiums or copayments being too high as a reason for leaving.

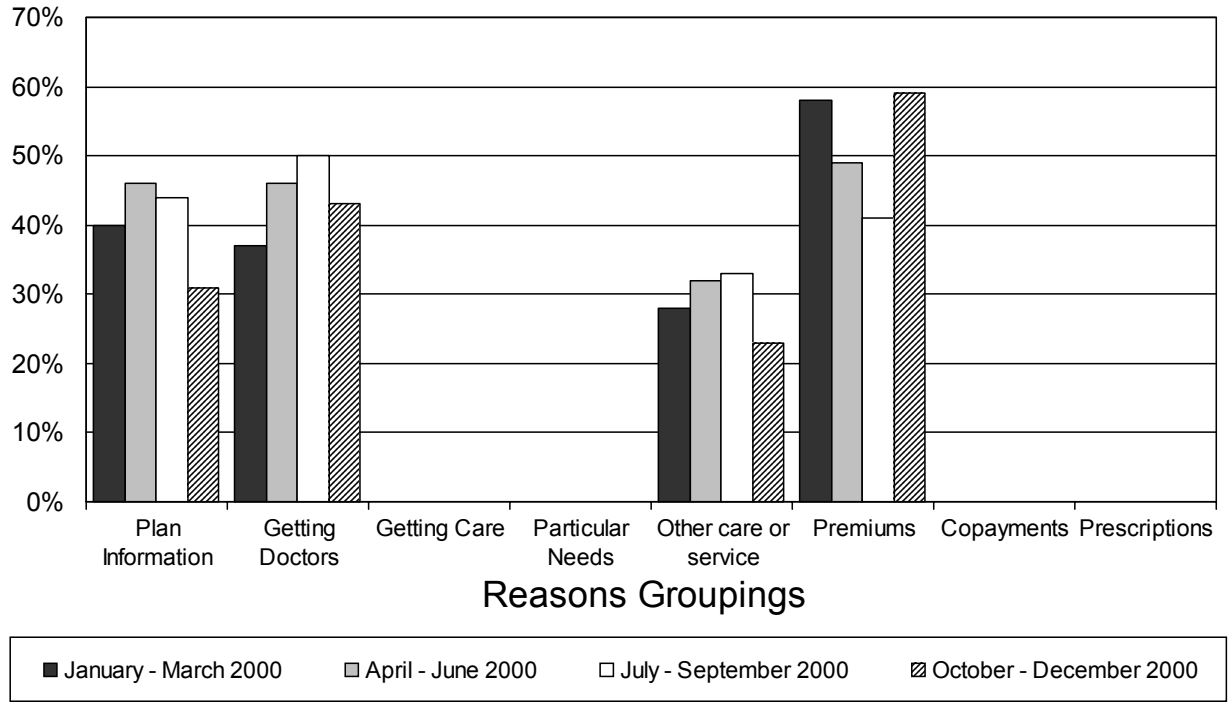
Exhibit 3-22. National-Level Variation in All Reasons Cited by Length of Time in Plan Before Disenrollment[a]



[a] All reported differences in text at p ≤ .01 and ≥ 10 percentage points

Sampling quarter when disenrollee left plan. ***Exhibit 3-23*** shows several differences in reasons for leaving by quarter. Disenrollees who left their plan in the second and third quarters (46% and 44%, respectively) are more likely than those who left in the fourth quarter (31%) to cite problems with plan information as a reason for leaving. Disenrollees who left in the third quarter (50%) are more likely than those who left in the first quarter (37%) to cite problems getting doctors they wanted as a reason for leaving. Disenrollees who left in the third quarter (33%) are also more likely than those who left in the fourth quarter (23%) to cite other problems with care or service as a reason for leaving. Disenrollees who left in the first or fourth quarters (58% and 59%, respectively) are more likely than those who leave in the second or third quarters (49% and 41%, respectively) to cite too high premiums and copayments as a reason for leaving.

Exhibit 3-23. National-Level Variation in All Reasons Cited by Sampling Quarter When Disenrollee Left Plan[a]



[a] All reported differences in text at $p \leq .01$ and ≥ 10 percentage points

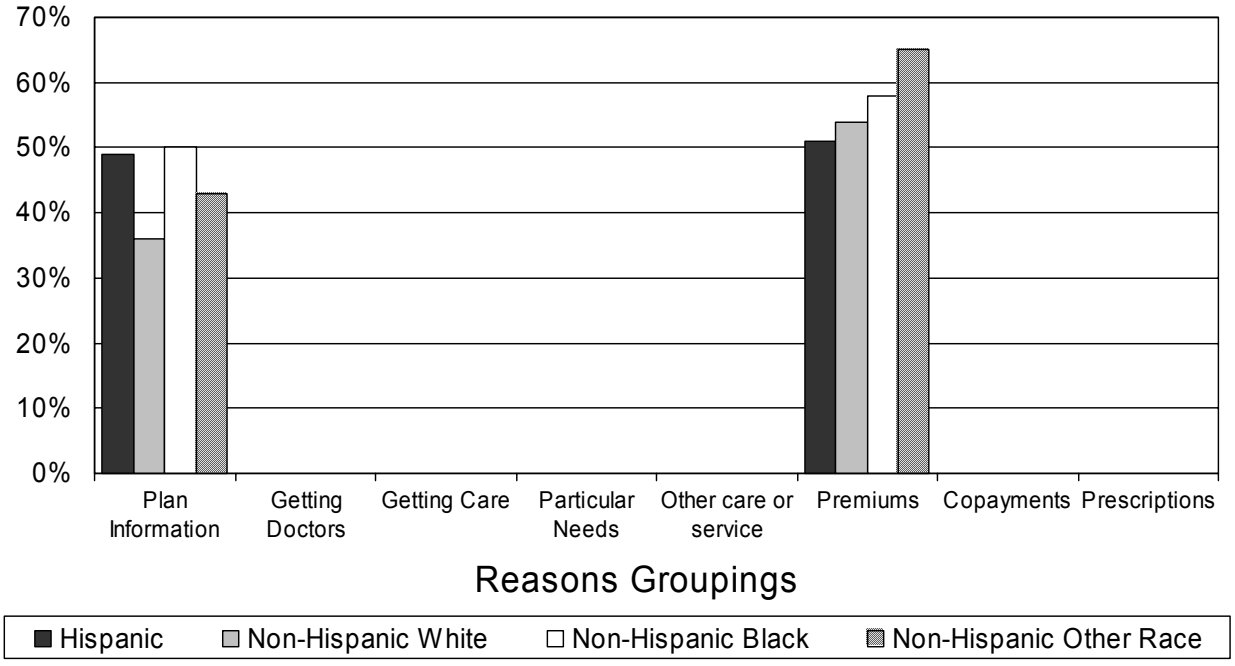
No meaningful differences by other disenrollee characteristics

We find no meaningful differences in all reasons cited by frequency of disenrollment in 2000.

Meaningful differences by disenrollee sociodemographic variables

Race and Ethnicity. Disenrollees who are Hispanic (49%) or non-Hispanic and black (50%) are more likely than non-Hispanic whites (36%) to cite problems with plan information as a reason for leaving their plan (***Exhibit 3-24***). Disenrollees who are non-Hispanic and neither white nor black (65%) are more likely than Hispanics (51%) and non-Hispanic whites (54%) to cite premiums and copayments being too high as a reason for leaving.

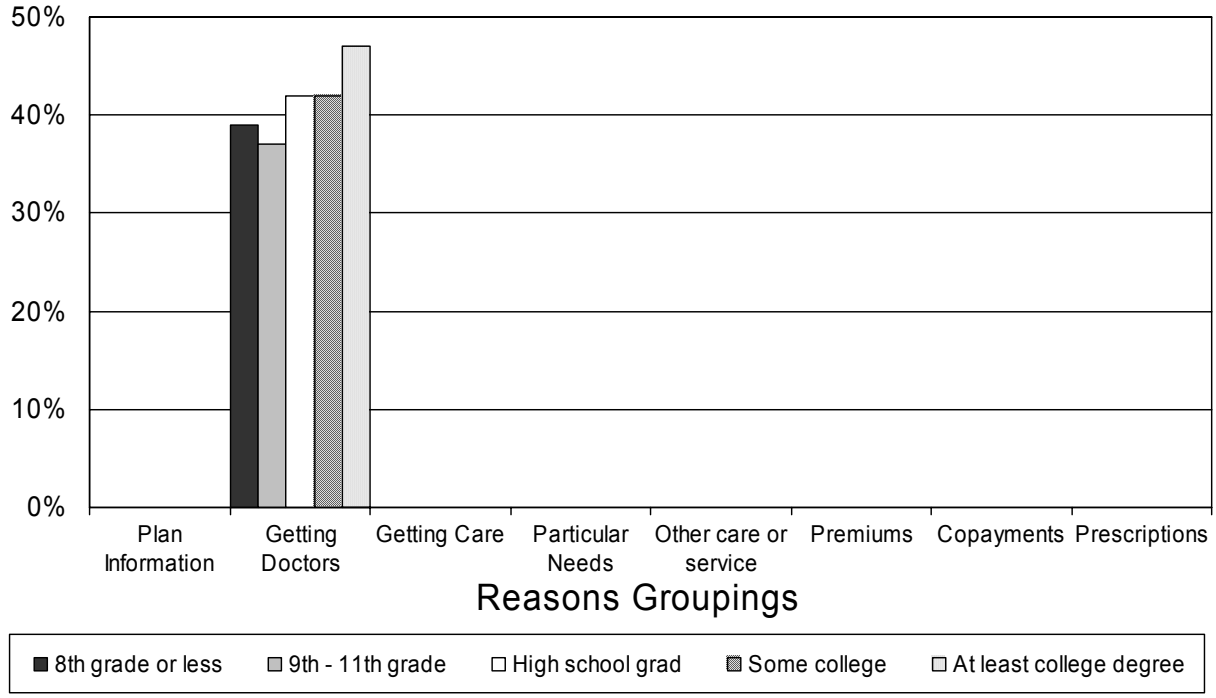
Exhibit 3-24. National-Level Variation in All Reasons Cited by Race and Ethnicity[a]



[a] All reported differences in text at p ≤ .01 and ≥ 10 percentage points

Education. Disenrollees with at least a bachelor's degree (47%) are more likely than disenrollees with only a 9th to 11th grade education (37%) to cite problems getting doctors they wanted as a reason for leaving (***Exhibit 3-25***).

Exhibit 3-25. National-Level Variation in All Reasons Cited by Education[a]



[a] All reported differences in text at p ≤ .01 and ≥ 10 percentage points

No meaningful differences by these disenrollee sociodemographic characteristics

We find no meaningful differences in all reasons cited by sex of disenrollees.

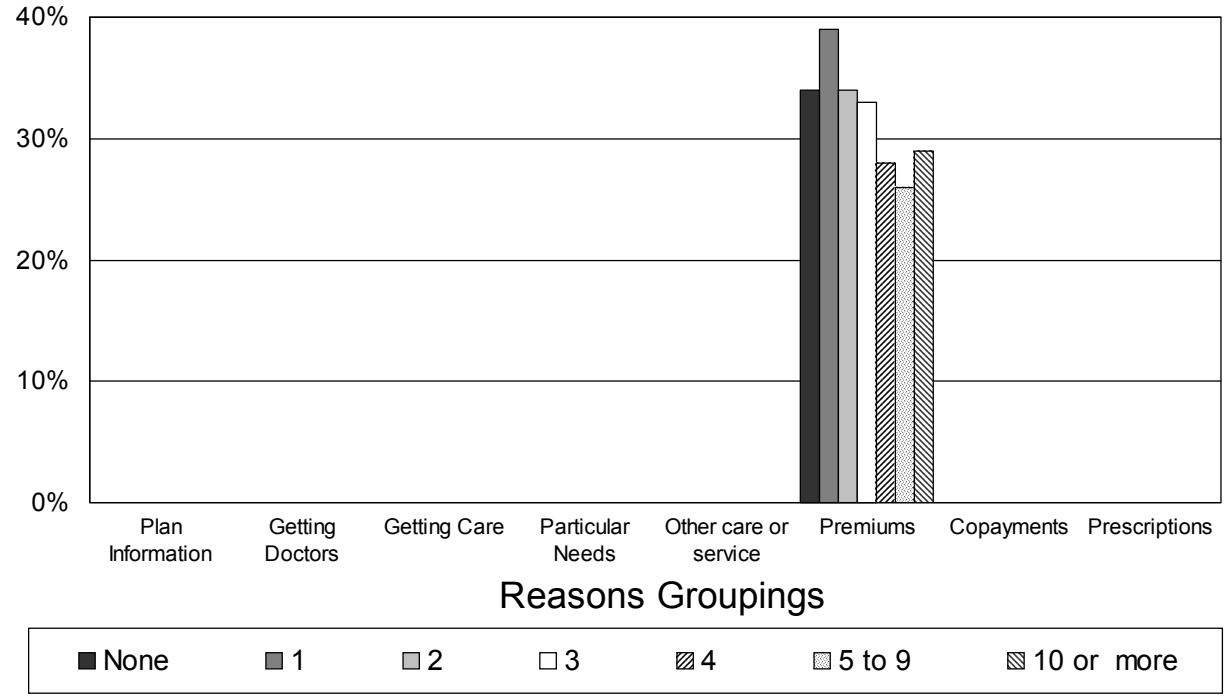
Most Important Reasons Cited

In this section, we report in text and exhibits the statistically significant subgroup differences of at least 10 percentage points for the most important reason groupings. We refer to these differences as "meaningful differences." We note at the end of each subsection of variables (e.g., health status variables) the subgroups for which we do not find meaningful subgroup differences. ***Appendix C*** contains the detailed subgroup tables for the most important reason groupings.[23]

Meaningful differences by health status characteristics

Outpatient visits. Disenrollees who had only one outpatient visit in the six months prior to disenrollment (39%) were more likely than those who had four or more visits (28% for four visits, 26% for five to nine visits, and 29% for ten or more visits) to cite premiums or copayments being too high as their most important reason for leaving (***Exhibit 3-26***).

Exhibit 3-26. National-Level Variation in Most Important Reasons Cited by Number of Outpatient Visits in Past Six Months Before Disenrollment[a]



[a] All reported differences in text at p ≤ .01 and ≥ 10 percentage points

[23] We conducted significance testing to find statistically significant associations between the reasons groupings and the subgroup variable in each table in ***Appendix C***. We performed separate chi square tests for the pooled and unpooled versions of each subgroup variable. In the Series A (All Reasons) tables, ***Exhibit C-1*** in ***Appendix C*** shows which subtables had significant associations at the .01 level. All significance tests on Series B (Most Important Reason) tables were significant at a .01 significance level except for the pooled subtable of ***Table 8b*** for frequency and choice of coverage after disenrollment.

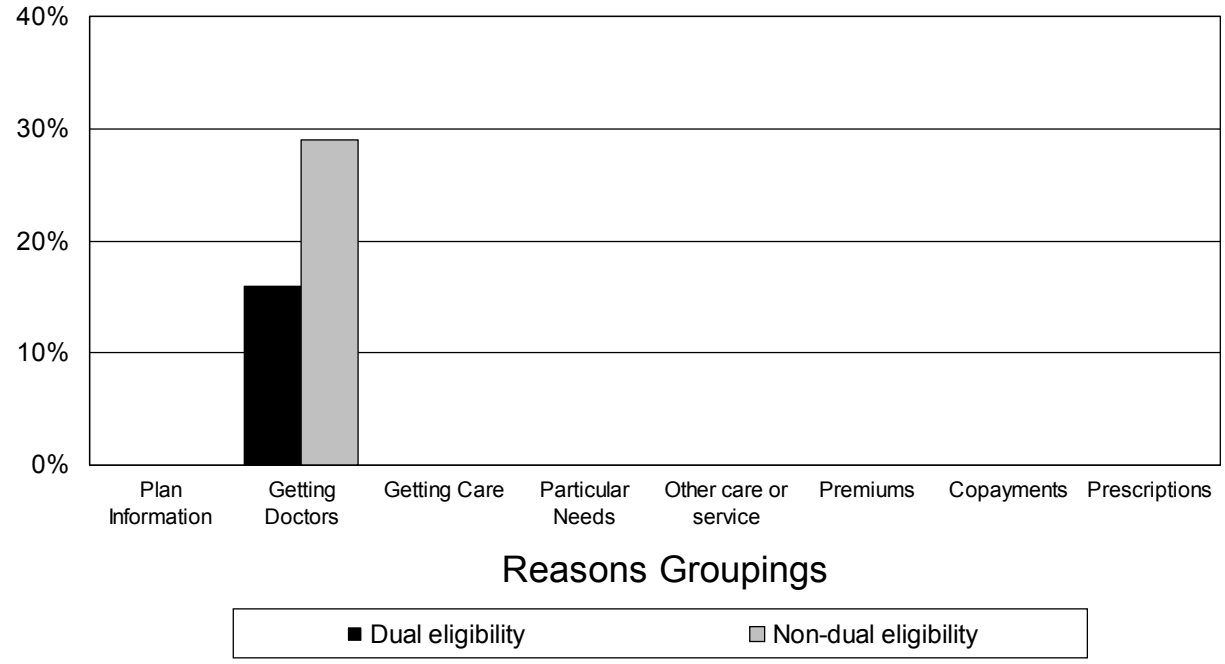
No meaningful differences by these health status characteristics

We find no meaningful differences in most important reasons cited by the health status, change in health status, or combined health status and change in health status variables.

Meaningful differences by health insurance characteristics

Dual eligibility status. Disenrollees without dual eligibility (29%) are more likely than disenrollees with dual eligibility (16%) to cite problems with getting doctors they wanted as their most important reason for leaving (***Exhibit 3-27***).

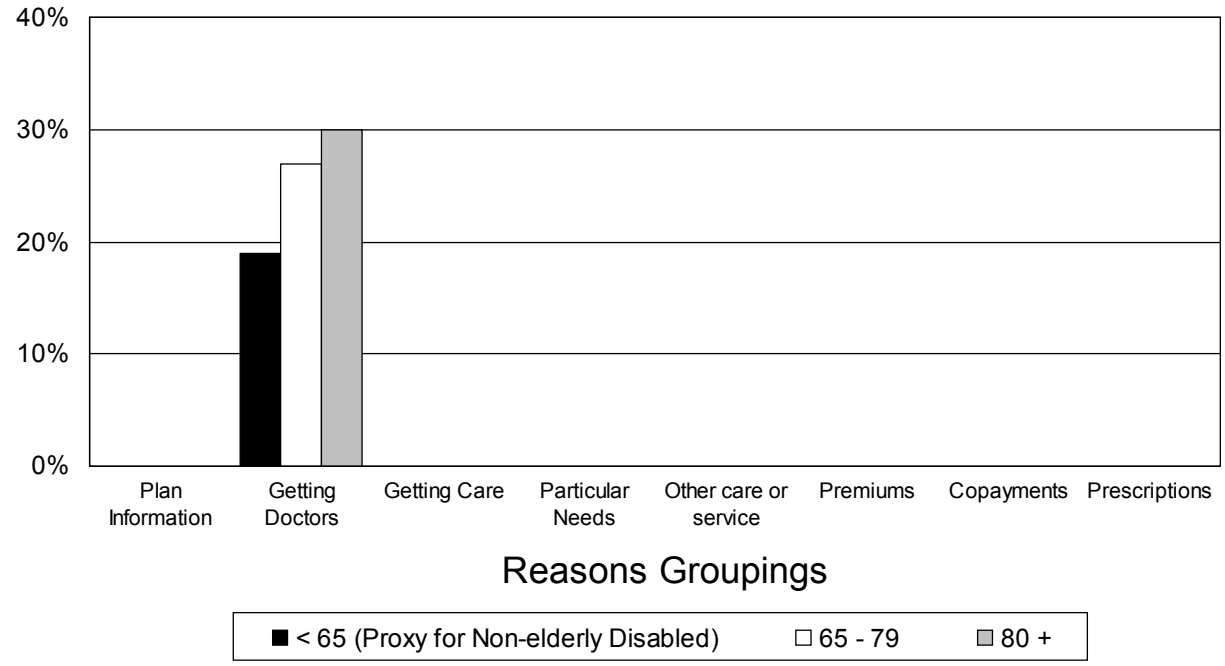
Exhibit 3-27. National-Level Variation in Most Important Reasons Cited by Dual Eligibility Status[a]



[a] All reported differences in text at $p \leq .01$ and ≥ 10 percentage points

Age. Disenrollees who are 80 years old and older (30%) are more likely than those under age 65 with a disability (19%) to cite problems with getting doctors they wanted as their most important reason for leaving (***Exhibit 3-28***).

Exhibit 3-28. National-Level Variation in Most Important Reasons Cited by Age[a]

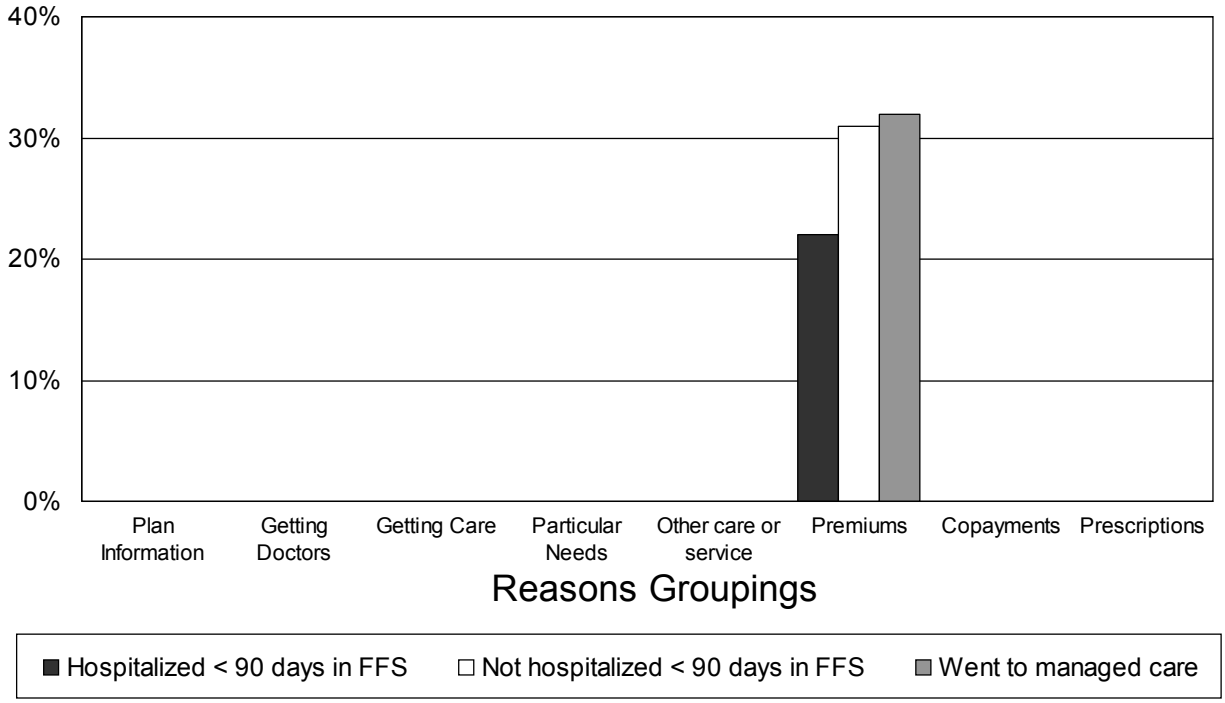


[a] All reported differences in text at p ≤ .01 and ≥ 10 percentage points

Meaningful differences by other disenrollee characteristics

Hospitalization after disenrollment to FFS. Those who disenrolled from their sample plan to another managed care plan (32%) were more likely than those who disenrolled to FFS and were hospitalized within 90 days of disenrollment (22%) to cite premiums or copayments being too high as their most important reason for leaving (***Exhibit 3-29***).[24]

Exhibit 3-29. National-Level Variation in Most Important Reasons Cited by Hospitalization After Disenrollment to FFS[a]

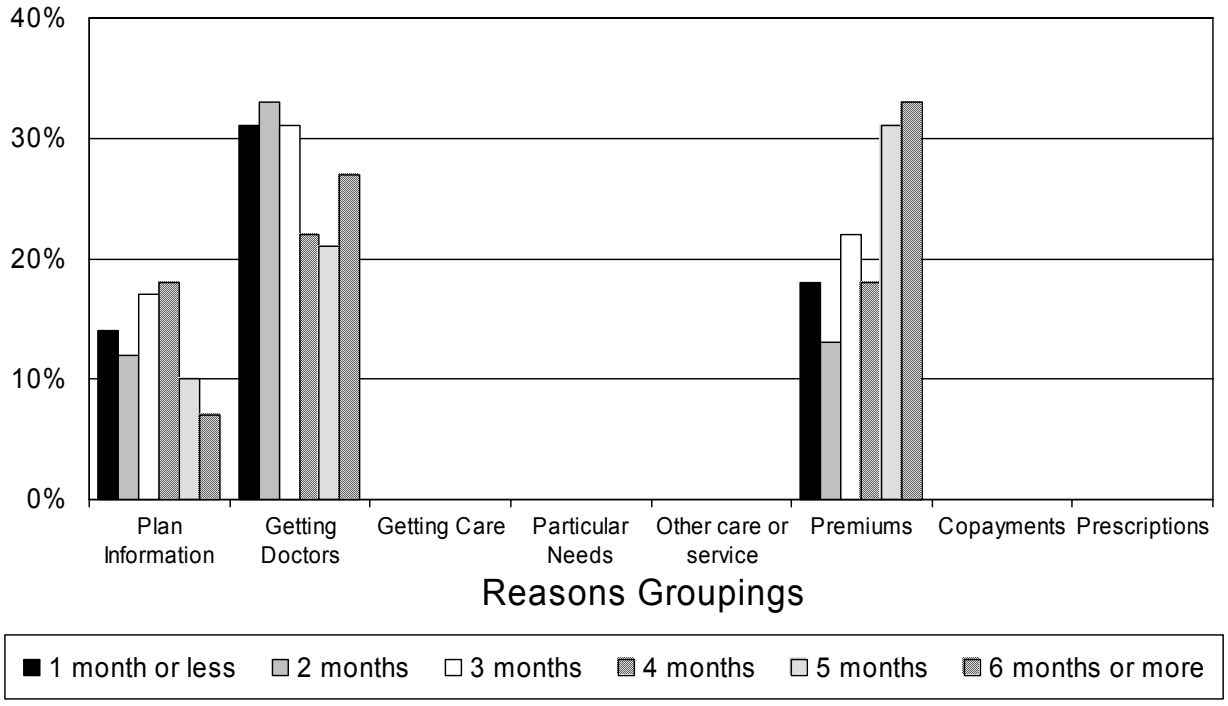


[a] All reported differences in text at p ≤ .01 and ≥ 10 percentage points

[24] The disenrollees to FFS hospitalized within 90 days (22%) differ from disenrollees to FFS who were not hospitalized (31%), though the difference is by 9 percentage points rather than by 10 percentage points.

Length of time in plan before disenrollment. There are several differences associated with length of time in plan before disenrolling (***Exhibit 3-30***). However, while the differences are generally in logical directions, the patterns are not clear cut. Disenrollees who had been in their plan only three (17%) to four (18%) months before disenrolling are more likely than those who had been in their plan at least six months (7%) before leaving to cite problems with information from the plan as their most important reason for leaving. Disenrollees who had been in their plan three months or less (31% to 33%) before disenrolling are more likely than those who had been in their plan four (22%) to five (21%) months before leaving to cite problems getting doctors they wanted as their most important reason for leaving. Disenrollees who had been in their plan five months (31%) or more (33%) before disenrolling are more likely than those who had been in the plan fewer months (13% to 22%) to cite premiums or copayments being too high as their most important reason for leaving.

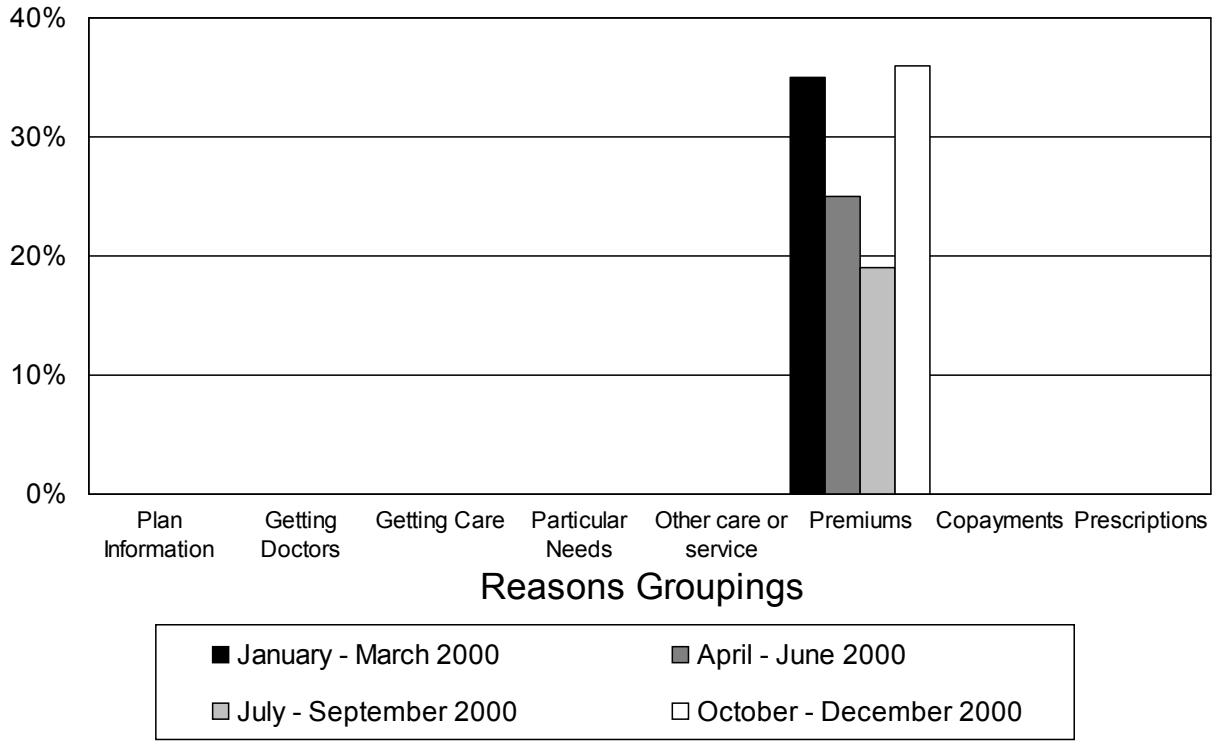
Exhibit 3-30. National-Level Variation in Most Important Reasons Cited by Length of Time in Plan Before Disenrollment[a]



[a] All reported differences in text at $p \leq .01$ and ≥ 10 percentage points

Sampling quarter when disenrollee left plan. Beneficiaries who disenrolled in the first (35%) and fourth (36%) quarters of 2000 were more likely than those who disenrolled in the second (25%) and third (19%) quarters to cite premiums or copayments being too high as their most important reason for leaving (***Exhibit 3-31***).

Exhibit 3-31. National-Level Variation in Most Important Reasons Cited by Sampling Quarter When Disenrollee Left Plan[a]



[a] All reported differences in text at p < .01 and > 10 percentage points.

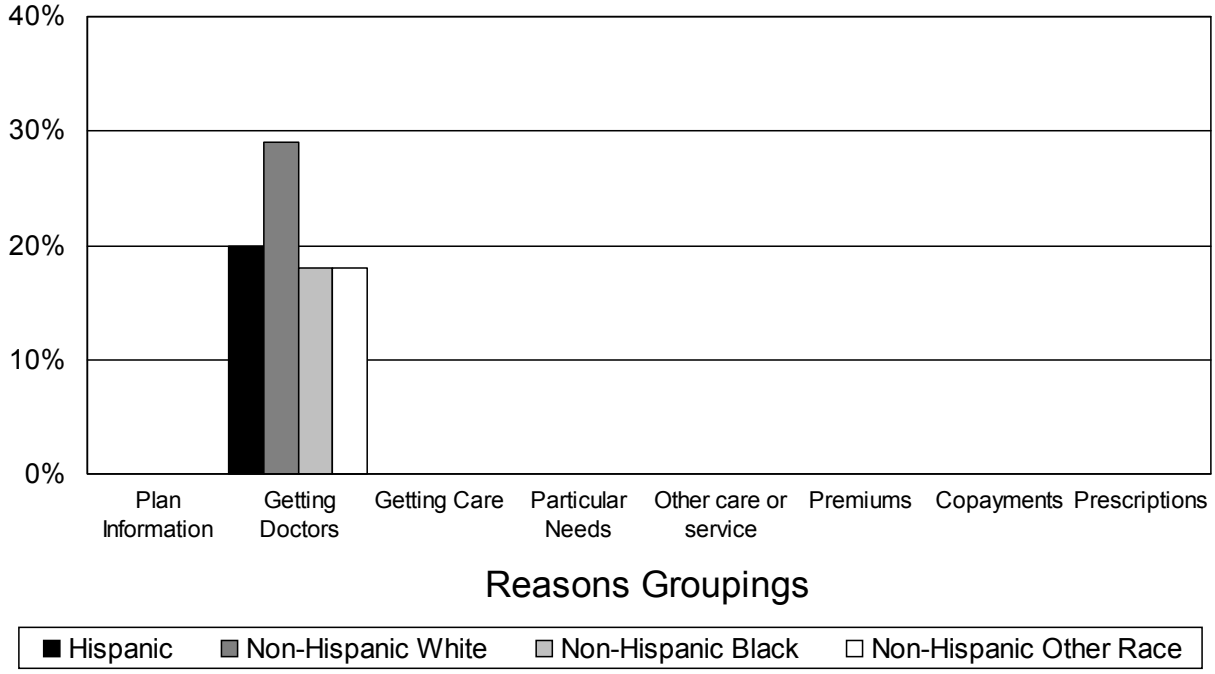
No meaningful differences by these other disenrollee characteristics

We find no meaningful differences in most important reasons cited by choice of coverage after disenrollment or frequency of disenrollment in 2000.

Meaningful differences by disenrollee sociodemographic variables

Race and Ethnicity. Non-Hispanic white disenrollees (29%) are more likely than Non-Hispanic disenrollees of another race (18%) to cite problems getting doctors they wanted as their most important reason for leaving (***Exhibit 3-32***).

Exhibit 3-32. National-Level Variation in Most Important Reasons Cited by Race and Ethnicity[a]



[a] All reported differences in text at $p \leq .01$ and ≥ 10 percentage points

No meaningful differences by these disenrollee sociodemographic characteristics

We find no meaningful differences in most important reasons cited by education or sex.

3.5 Relationship Between Most Important Reasons and All Reasons Cited

This section discusses an exploratory analysis comparing and exploring the relationships between the reasons grouping data of the most important reason variable and the all reasons variables. We focus on three questions in this exploratory analysis:

1. Is the tendency for more subgroup differences among all reasons than among most important reasons related to a tendency for certain subgroups to cite more reasons than others?

2. Do the most important reason groupings and the all reasons groupings provide the same information—i.e., are the distributions similar?

3. Is there additional information to be gained by looking at the reason groupings of the most important reason and all reasons in conjunction with each other?

From reading the preceding sections that discuss the results of subgroup analyses, the reader will likely have noticed that for many of the subgroup variables, there are fewer subgroup differences in the **most important reason** results compared to the **all reasons**. One explanation for this difference is the extra source of variance in the all reasons data reflecting an individual's tendency to cite more than one all reason (compared to only one reason cited per respondent in the most important reason data). If that tendency to respond more frequently is systematically associated with any of the subgroup variables (i.e., if certain subgroups of respondents are more likely than others to cite more reasons), this could explain some of the tendency for more differences appearing among the all reasons groupings than among the most important reason groupings. Namely, if certain groups, such as those with poorer health status, tend to choose more all reasons, there will tend to be more subgroup differences detected in the all reasons grouping variables than in the most important reason grouping variable. To examine this, we counted the number of all reasons groupings assigned to each respondent (which is tied to the number of reasons cited). A mean number of all reasons groupings was then calculated for each value of each subgroup variable. ***Exhibit 3-33*** provides the listings of this analysis for the unpooled version of each subgroup variable.

For example, people with *excellent* self-assessed health status are assigned to 2.59 reason groupings on average while those with *poor* health status are assigned to 3.71, with a clear increasing trend in between. Those with more outpatient visits are assigned to more reasons groupings: those with *one visit* were assigned to 2.76 reason groupings, while those with *10 or more visits* are assigned to 3.45 groupings—again, with a fairly clear increasing trend in between. While other subgroup variables exhibit trends that are less distinct or more complex, many of the subgroup variables have two or more values that vary widely on the mean number of reason groupings assigned.

Exhibit 3-33. Mean Number of All Reasons Groupings Assigned by Each Subgroup Variable

Subgroup Variable	Mean Number of All Reasons Groupings Assigned
Self-Assessed Health Status	
Excellent	2.59
Very Good	2.75
Good	2.90
Fair	3.30
Poor	3.71
Self-Assessed Health Status Compared to One Year Ago	
Much Better Now	2.98
Somewhat Better Now	3.16
About the Same	2.80
Somewhat Worse Now	3.32
Much Worse Now	3.86
Health Status/Health Status Change	
Excellent/good and Same/better	2.77
Excellent/good and Worse	3.18
Fair/poor and Same/better	3.23
Fair/poor and Worse	3.56
Number of Outpatient Visits in the 6 Months Before Leaving Plan	
None	2.89
One	2.76
Two	2.78
Three	3.02
Four	3.21
Five to Nine	3.19
Ten or More	3.45
Dually Eligible	
Yes	3.31
No	2.94
Age	
64 or Younger	3.64
65 to 69	2.95
70 to 74	2.95
75 to 79	2.92
80 or Older	2.79
Destination and Hospitalization	
Disenrolled to FFS and hospitalized within 90 days	3.61
Disenrolled to FFS and not hospitalized within 90 days	3.22
Disenrolled to MC	2.81

(Continued)

Exhibit 3-33. Mean Number of All Reasons Groupings Assigned by Each Subgroup Variable (continued)

Subgroup Variable	Mean Number of All Reasons Groupings Assigned
Frequency and Destination of Disenrollment	
Disenrollment > 1: All to MC	2.86
Disenrollment > 1: All Other	3.07
Disenrollment = 1: To MC	2.80
Disenrollment = 1: To FFS	3.25
Number of Months in Plan Before Leaving	
1 Month or Less	3.13
2 Months	3.52
3 Months	3.37
4 Months	3.30
5 Months	3.40
6 Months or More	2.97
Sampling Quarter When Beneficiary Left Plan	
1st - January – March 2000	2.99
2nd - April – June 2000	3.16
3rd - July – September 2000	3.07
4th - October – December 2000	2.83
Race and Ethnicity	
Hispanic	2.27
Non-Hispanic White	2.91
Non-Hispanic Black or African-American	3.23
Non-Hispanic Other	3.19
Education	
8th Grade or Less	3.16
9th – 11th Grade	3.03
High School Graduate/GED	2.85
Some College/2-Year Degree	3.04
Bachelor's Degree or More	3.12
Sex	
Male	3.09
Female	2.91

We also examined the association between the number of significant ($\geq$ 10 percentage point) subgroup differences in the all reasons and most important tables and the variation in the mean number of reason groupings assigned. ***Exhibit 3-34*** shows the number of significant $\geq$ 10 percentage point subgroup differences (i.e., "meaningful differences") in the all reason and most important reason tables for the subgroup variables. The next column subtracts the number of meaningful differences found in the most important reason table from the number of meaningful differences found in the all reasons table, for each respective subgroup variable. The last column

Exhibit 3-34. Relationship between the Occurrence of Subgroup Differences and the Number of Reason Groupings Assigned by Subgroup Variable

Appendix C Table Number	Subgroup Variable	Number of Significant Differences (> 10%)		All Reasons Minus Most Important Reasons	Largest Difference in Mean Number of Reason Groupings Assigned*
		All Reasons (Series A)	Most Important Reasons (Series B)		
		Unpooled	Unpooled		
1	Health Status (HS)	27	0	27	1.12
2	Health Status Change (HSC)	19	0	19	1.06
3	Combined HS & HSC	8	0	8	0.79
4	Outpatient Visits	21	3	18	0.69
5	Dual Eligibility	3	1	2	0.37
6	Age	15	2	13	0.85
7	Destination & Hospitalization.	11	1	10	0.80
8	Frequency & Destination	10	0	10	0.45
9	Time in the Plan	21	12	9	0.55
10	Quarter	3	4	-1	0.33
11	Race & Ethnicity	4	2	2	0.96
12	Education	1	0	1	0.31
13	Gender	0	0	0	0.18
				r=**	**0.75**

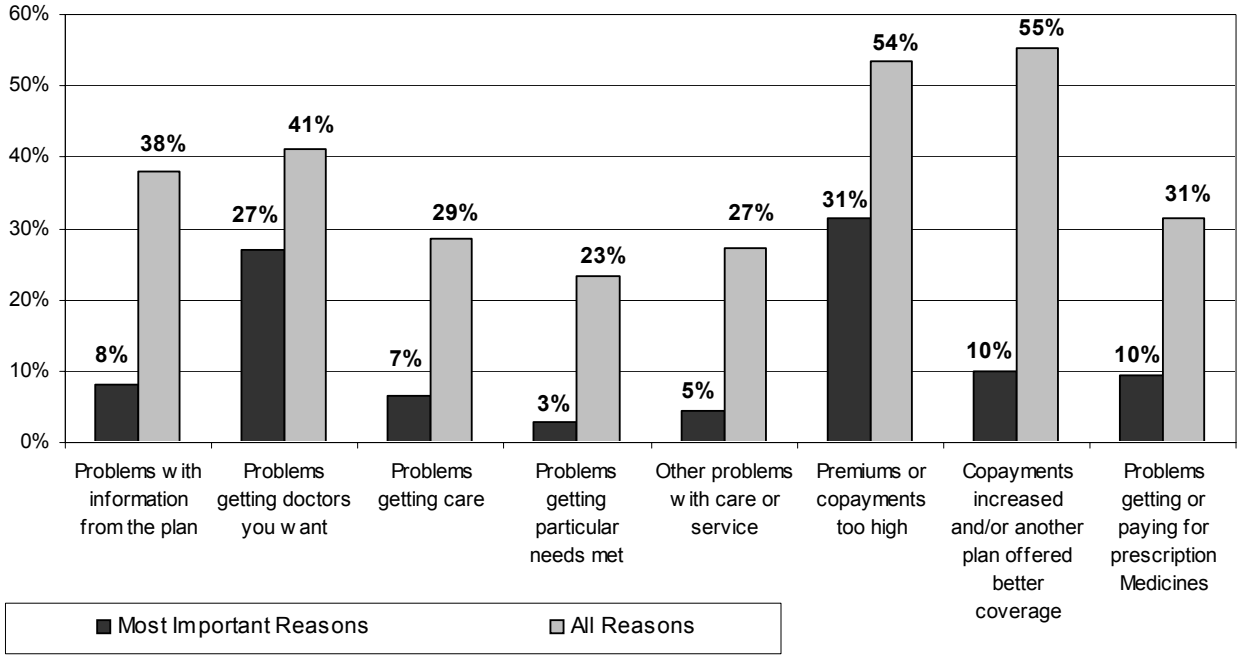
* Within each subgroup variable, these cells show the difference between the largest mean number of all reasons groupings assigned and the smallest mean number of all reasons groupings assigned from Exhibit 3-1. For example, for self-assessed health status, 3.71 (mean number of reason groupings assigned to those in poor health status) minus 2.59 (mean number of reason groupings assigned to those in excellent health status) is 1.12.

** This correlation is between the last two columns on the right.

shows the largest difference in mean number of reason groupings between any two values of each subgroup variable. The correlation between these last two columns is 0.75 indicating a strong association between the tendency of certain subgroups to report more all reasons than other subgroups and the tendency for more meaningful differences to occur in all reasons tables compared to the most important reason tables.

To answer the second research question about most important versus all reasons, i.e., whether or not the two approaches were essentially duplicative, we examined the two distributions across the eight reason groupings. ***Exhibit 3-35*** shows two major differences between the two distributions. The most obvious contrast between the two is that the bars for the all reasons are all taller. This indicates that a higher percent of the sample cited all reasons that fell into each of the eight groupings, than cited most important reasons that fell into each of the respective groupings. This is a direct result of the multiple selections allowed in the all reasons that was discussed in ***Section 3.1***. Thus, if the two distributions were flat, the most important

Exhibit 3-35. Distributions of Most Important Reason and All Reasons Groupings



reason groupings would each have 12.5% (100/8) in each group, whereas the all reasons groupings would each have about 37.5% (300/8).[25]

The multiple selections allowed in the all reasons means there is some dependency among those eight reason groupings. ***Exhibit 3-36*** shows the correlations among these variables and provides some interesting insight into the structure of respondents' reasons for leaving their plans. People with plan information problems also often had problems with getting care in one way or another (groupings 3, 4, and 5). They also had some association with two of the cost problem groupings (groupings 7 and 8), though the association is not as strong. Interestingly, those who had problems in grouping 2 (getting the doctor you want) were more likely to <u>not</u> have problems (a negative association) with premiums or copayments too high (reason grouping 6) as well as to have some association with problems getting care (grouping 3). People citing reasons in one of the three getting care groupings (groupings 3, 4, and 5) were likely to have a problem in one of the other two. Also, those in grouping 4 (problems getting particular needs met) were likely to cite problems in the last two cost reason groupings (groupings 7 and 8). People citing reasons in one of the three cost groupings (groupings 6, 7, and 8) were likely to have a problem in one of the other two, although groupings 6 and 8 ("Premiums or copayments too high" and "Problems getting or paying for prescription") have less association than the other pairs. Many of these associations will be discussed as we identify the important primary reasons

[25] On average, each respondent cited all reasons that were assigned to three all reasons groupings.

Exhibit 3-36. Correlations Among the Eight All Reasons Groupings

All Reasons Groupings	All Reasons Groupings							
	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	8. Problems getting or paying for prescription Medicines
1. Problems with information from the plan	1.00							
2. Problems getting doctors you want	0.10	1.00						
3. Problems getting care	0.45	0.25	1.00					
4. Problems getting particular needs met	0.35	0.07	0.35	1.00				
5. Other problems with care or service	0.36	0.10	0.34	0.28	1.00			
6. Premiums or copayments too high	0.00	-0.35	-0.09	0.04	-0.04	1.00		
7. Copayments increased and/or another plan offered better coverage	0.24	-0.15	0.14	0.27	0.19	0.31	1.00	
8. Problems getting or paying for prescription Medicines	0.23	-0.07	0.13	0.26	0.17	0.16	0.35	1.00

(from the most important reason variable) and attendant secondary reasons (from the all reasons variables).

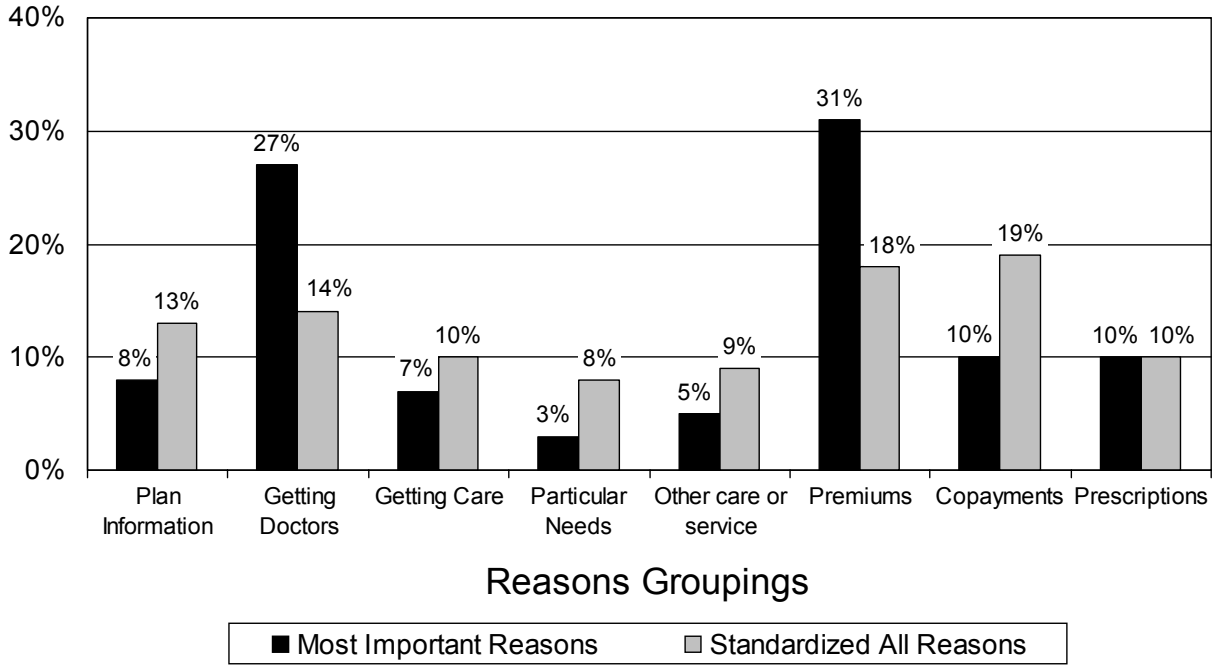
The second major difference between the most important reason and all reasons groupings is the location of the modes of the two distributions (***Exhibit 3-35***). The mode for the most important reason groupings is "Premiums or copayments too high," followed closely by "Problems getting doctors you want," while the mode for the all reasons across the same groupings is essentially a tie between "Copayments increased and/or another plan offered better coverage" and "Premiums or copayments too high." The different modes may be due to the two different ways of measuring reasons for leaving that were used in the all reason variables and in the most important reason variable, respectively (as described in ***Section 3.1***). While we can assume the most important reason groupings are primary reasons (as the name implies), the all reasons groupings are likely to be, in part, combinations of disenrollees' primary and secondary or contributing reasons (i.e., contributing but not primary drivers of the disenrollment decision). Consequently, modes in the all reasons groupings distribution may differ from that for the most important reason distribution because all reasons include both primary reasons and often-cited secondary reasons.

Another way to examine differences between the distributions of most important and all reasons is to standardize the percentages of the all reasons distribution so that it sums to 100% (rather than 300% or three groupings per respondent).[26] This facilitates the comparison between the two distributions since the most important reason distribution inherently sums to 100%[27]. Comparing the most important reason distribution to the standardized all reasons distribution (***Exhibit 3-37***), we find two groupings where the percentage in most important reason far exceeds the percentage in the standardized all reasons: "Problems getting doctors you want" and "Premiums or copayments too high" suggesting that these two groupings are capturing more *primary* than *secondary* reasons for disenrolling. In the other groupings, the all reasons percentage is equal to or exceeds the most important.

[26] This standardization involved dividing the all reason category percentages by approximately three, because on average respondents chose reasons on the survey that were assigned to three all reasons groupings.

[27] The reader should not forget, however, an essential difference still remaining between the all reasons distribution and the most important reason distribution—namely the strong dependency between groupings in the all reasons distribution due to respondents choosing multiple reasons assigned to multiple reason groupings.

Exhibit 3-37. Distributions of Most Important Reason Groupings and Standardized All Reasons Groupings



These differences in the overall distributions of the two types of reasons suggest that the two approaches are, at least in part, capturing different information. This is not surprising given the two different approaches used to identify people's reasons for leaving a plan. In the next set of analyses, we can gain further insights by looking at conditional distributions relating the two types of reasons. We seek to further distinguish and understand relationships between primary and secondary reasons by identifying some of the associations between the two types of reasons. We want to identify associations between specific reason groupings across the two reason types (most important reason and all reasons) in order to more accurately identify disenrollees' main reasons for leaving and more secondary reasons.

Exhibit 3-38 shows the distribution of each all reasons groupings' respondents across the most important reason groupings. That is, for the sample of respondents citing reasons in a given all reasons grouping, we look at how they distribute themselves among the eight most important reason groupings. For example, of the respondents who cited a problem within the "Problems with information from the plan" grouping as a reason for leaving, 17% cited, as their most important reason, a problem that falls into that same grouping, whereas 22% of the respondents cited "Premiums or copayments too high" as their most important reason grouping. Each row sums to 100% within rounding error, because each respondent had only one most important, but note that respondents can, and most often do, fall into more than one row. Thus, some of the similarity in distributions of most important reason groupings across the rows may be due to this dependency between the rows.

Exhibit 3-38. All Reasons Groupings Crossed with Their Most Important Reason Groupings

All Reasons Groupings	Most Important Reason: 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	8. Problems getting or paying for prescription medicines
1. Problems with information from the plan	17%	**20%**	13%	5%	4%	**22%**	9%	11%
2. Problems getting doctors you want	7%	62%	8%	2%	3%	10%	4%	3%
3. Problems getting care	12%	**25%**	22%	4%	6%	18%	7%	6%
4. Problems getting particular needs met	**13%**	**17%**	**11%**	10%	4%	**22%**	**12%**	**13%**
5. Other problems with care or service	**14%**	**22%**	12%	5%	13%	**18%**	8%	8%
6. Premiums or copayments too high	5%	8%	4%	2%	2%	56%	11%	11%
7. Copayments increased and/or another plan offered better coverage	8%	14%	7%	4%	4%	**33%**	15%	14%
8. Problems getting or paying for prescription medicines	9%	14%	7%	3%	2%	**28%**	12%	24%

Note: Off-diagonal cells that had percentages exceeding a row's diagonal cell in each row are shaded.

We can see which reason groupings appear to be more primary and which appear to be more secondary by examining the diagonal cells—the percent of those falling into an all reasons grouping who also provided a most important reason within the same reason grouping. Diagonal

cells with high percentages indicate more primary reason groupings.[28] The two groupings that have the highest percentages, 62% and 56%, are "problems getting doctors you want" and "premiums or copayments too high," while the rest are all under 25%. Of course, it is possible that for some respondents, the reason for leaving is not truly singular but that a combination of multiple and equally important reasons in several reason groupings precipitated the disenrollment. Such complex primary reasons for disenrolling (i.e., aggregates spanning multiple reason groupings) may not have as high a diagonal percentage as would be expected of a primary reason under this analysis.

We shaded diagonal cells that had percentages exceeding the row's diagonal cell in each row of ***Exhibit 3-38***. These shaded cells reveal further most important reason groupings that are highly associated with a given all reasons group. These are most important reason groupings to which the given all reasons grouping is often showing up as an apparent secondary reason. Notice that the second and sixth columns under the most important reason heading contain the most shaded cells. As previously noted, most people had their most important reason in one of these two groupings.[29] Observe the large number of shaded off-diagonal cells and the small percentages in their diagonal cells for the rows: "Problems getting particular needs met" and "Other problems with care or service." In both rows, but especially the first, these respondents are more likely to cite their most important reason in another reason grouping than they are to cite it in the same reason group. This situation reflects that they are much more often associated (secondary) reasons than they are primary reasons for disenrollment.

Exhibit 3-39 is similar to the previous table but with the row and column variables reversed, thus, the conditional percentages change. For each most important reason grouping row, the associated percentage of respondents citing reasons in each of the all reasons groupings is presented. For example, 70% of the respondents whose most important reason was "Problems getting care" also cited one or more reasons in the "Problems with information from the plan" or, down near the end of that row, we see that 56% also cited all reasons in the "Copayments increased/another plan offered better coverage" group. This display allows us to see which all reasons groupings are highly related to a given most important reason grouping from a slightly different angle. Here the subgroupings broken down in each row are exclusive of the groupings in every other row, though a respondent within a row can, and usually does, fall into multiple columns. We shade non-diagonal cells that are greater than 50%, highlighting substantial associations where more than half the people choosing a most important reason grouping also chose another all reasons grouping.

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[28] Note, as was mentioned earlier, some of the most important reasons were imputed from the all reasons, and thus these cases would, by default, fall on the diagonal. However, this should not be seen as illegitimately inflating the diagonal, because the cases where the most important reason was imputed were fairly conservative. Also, since only 4.2% of the most important reason groups were imputed, the inflation from this should not be substantial.

[29] Also, remember the issue of dependency between the rows just discussed, which contributes to similar distributions across rows.

Exhibit 3-39. Most Important Reason Groupings Crossed with Their All Reasons Groupings

Most Important Reason	All Reasons Groupings: 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	8. Problems getting or paying for prescription medicines
1. Problems with information from the plan	76%	33%	40%	34%	44%	36%	**57%**	35%
2. Problems getting doctors you want	27%	92%	24%	14%	20%	17%	29%	15%
3. Problems getting care	**70%**	**50%**	88%	365	48%	33%	**56%**	33%
4. Problems getting particular needs met	**56%**	33%	39%	74%	39%	42%	**74%**	35%
5. Other problems with care or service	34%	30%	33%	20%	75%	25%	43%	15%
6. Premiums or copayments too high	25%	13%	15%	15%	15%	95%	**57%**	27%
7. Copayments increased and/or another plan offered better coverage	32%	17%	19%	26%	22%	**57%**	82%	38%
8. Problems getting or paying for prescription medicines	41%	15%	18%	29%	22%	**59%**	**80%**	79%

Note that in most rows in ***Exhibit 3-39***, the seventh column ("Copayments increased or another plan offered better coverage") is shaded. This is because reasons were often cited in that grouping in conjunction with the most important reason belonging to nearly every most important reason group. This particular grouping of all reasons is frequently cited as a reason for disenrollment, even if reasons within this grouping were not the most important reason.

Exhibit 3-39 also reveals some strong associations among the last three cost-related reason groupings. The sixth most important reason group, "Premiums or copayments too high," is often cited along with the seventh all reasons group, "Copayments increased and/or another plan offered better coverage" and vice versa for the sixth all reason and seventh most important groupings. The eighth most important reason grouping, "Problems getting or paying for prescriptions," is highly associated with both the sixth and seventh all reasons groupings.

This exhibit also shows those who had "Problems getting care" or "Problems getting particular needs met" as a most important reason group, also frequently cited reasons in the "Problems with information from the plan" all reasons group. This may point to problems beneficiaries are having understanding or negotiating the procedures that are required to obtain particular health care services. Another possibility is that, based on plan information, beneficiaries may believe that they should have access to certain care but are having problems getting those "particular needs met."

The other relationship worth noting is between the "Problems getting doctors you want" and "Problems getting care." This might reveal that for some beneficiaries "problems getting care" may arise because they cannot see a particular doctor. Perhaps the "doctor they want" *is* the "care" they are having trouble getting.

The diagonal cells also provide some interesting methodological information. These cells show the percentage of people with a given most important reason grouping that indicated any all reason within the same reason grouping as their most important reason. Aside from the "other reasons" fill-ins, the diagonal cells show how often people with a given most important reason grouping found a preprinted reason that expressed a problem in that same category. Note that two reason groupings, "Problems getting doctors you want" and "Premiums or copayments too high" are quite high in the 90%-plus region, while others are all at least 74%. That these percentages are all fairly high may be an artifact, since the coding of the open-ended most important reason was based on the preprinted reason-based reason groupings. Nonetheless, the lower diagonal percentages might indicate most important reason groupings (and underlying individual reasons) in which many respondents failed to select preprinted reasons of the same grouping as their most important reason. Some examination of the most important reasons in those categories might reveal reasons that are not well represented in the preprinted reasons.

Finally, we multiplied the percents in the cells in ***Exhibit 3-39*** by the percentage of respondents falling into each row (available in ***Exhibit 3-35***), allowing us to pinpoint cells that represent a larger proportion of all respondents (***Exhibit 3-40***). The diagonal elements for the second and sixth reason groupings ("Problems getting doctors," and "Premiums or copayments too high") along with the crossing of the most important reason sixth grouping and all reasons seventh grouping ("Copayments increased and/or another plan offered better coverage") were the only

Exhibit 3-40. Most Important Reason by All Reasons Distribution Multiplied by the Percent Falling into Each Most Important Reason Grouping

Most Important Reason	All Reasons Groupings: 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	8. Problems getting or paying for prescription medicines
1. Problems with information from the plan	0.06	0.03	0.03	0.03	0.04	0.03	0.05	0.03
2. Problems getting doctors you want	0.07	**0.25**	0.07	0.04	0.06	0.05	0.08	0.04
3. Problems getting care	0.05	0.03	0.06	0.02	0.03	0.02	0.04	0.02
4. Problems getting particular needs met	0.02	0.01	0.01	0.02	0.01	0.01	0.02	0.01
5. Other problems with care or service	0.02	0.01	0.02	0.01	0.03	0.01	0.02	0.01
6. Premiums or copayments too high	0.08	0.04	0.05	0.05	0.05	**0.30**	**0.18**	0.08
7. Copayments increased and/or another plan offered better coverage	0.03	0.02	0.02	0.03	0.02	0.06	0.08	0.04
8. Problems getting or paying for prescription medicines	0.04	0.01	0.02	0.03	0.02	0.06	0.08	0.07

three cells exceeding 8%. They represented 25%, 30%, and 18% of the sample respectively.[30] These three pairs of most important reason and all reasons groupings were the most prevalent in the population sampled and may, therefore, merit additional attention. They either represent widespread problems in health plans or reason groupings that are broader than the others, thus capturing a larger percentage of the respondents. If they are simply broad categories, they could be divided in future analyses to provide more detailed insight into those areas.

Finally, we add a few caveats and comments. First, we need to be careful of placing too much weight on labels for the reason groupings while neglecting how respondents really interpreted the reasons assigned to each group. There are likely to be different ways of describing a reason for disenrollment. For example, one person might call it "problem getting the care they needed when they needed it," while someone else looking at the exact same problem may call it a problem in which they "could not see the doctor or other provider they wanted to see on every visit." The former reason would have been assigned to the "Problems getting care" reason group, while the latter falls in the "Problems getting particular doctors." Medicare beneficiaries may classify problems more or less broadly than researchers. It is also the case that some beneficiaries may not be completely sure of the source of their problems. They just know they had problems and decided to leave the plan. It should be noted that some of the reasons express a preference; others, a quality of care issue; and some could be either. The reason groupings are likely mixtures of both types of reasons. Beneficiaries may not always be able to distinguish preference from quality of care issues. We also note that among the population surveyed, there are people who might be labeled as chronically dissatisfied, and others who are "playing" the system to their benefit, for example, leaving a plan when their prescription drug benefits are exhausted. Finally, while we see clear differences in the information captured by the most important reason and the all reasons, the former is still probably a better representation of the primary reason for leaving and, therefore, most appropriate for public reporting.

Section Summary

We have seen that the all reasons groupings capture a wider set of information about disenrollment reasons while the most important reason groupings represents a more focused piece of information. Examining each of these distributions individually with this in mind provides a certain amount of insight into disenrollment reasons nationwide. However, examining the two *together* provides further useful insights. The key observations from this exploratory analysis are summarized below.

- Reason groupings "Problems getting doctors you want," and "Premiums or copayments too high" seem to be capturing more primary reasons for disenrolling

[30] Note that these percentages are not mutually exclusive: a respondent who was part of the 30% who cited a most important reason and all reason in "Premiums or copayments too high" may also have been part of the 18% who cited a most important reason as "Premiums or copayments too high" and a reason within "Copayments increased and/or another plan offered better coverage."

than secondary reasons. They also seem to be fairly focused groupings with fewer strong associations with other groupings of reasons. Indeed, respondents citing their most important reason and all reasons in the same grouping are highly prevalent in this sample (25% and 30% of our sample respectively).

- Reason grouping "Copayments increased and/or another plan offered better coverage," is likely capturing reasons that are contributory or secondary reasons for disenrolling. Respondents citing this all reasons grouping in conjunction with a most important reason in the "Premiums or copayments too high" reasons grouping were also prevalent (18%) in our sample.

- "Problems getting particular needs met" and "Other problems with care or service" appear to be secondary reasons than they are primary reasons for disenrollment.

- The three reason groupings; "Premiums or copayments too high," "Copayments increased and/or another plan offered better coverage," and "Problems getting or paying for prescriptions": have fair levels of association among them likely due to a common concern with cost. Beneficiaries citing reasons for disenrollment in one of these groupings are quite likely to cite additional reasons in another of these three.

- Other highly associated reason combinations include the following:

  – Those who had "Problems getting care" or "Problems getting particular needs met" as a most important reason group, also fell into the "Problems with information from the plan" all reasons group.

  – Beneficiaries citing "Problems getting care" as a most important reason grouping also cited in their all reasons "Problems getting the doctors [they] want."

4 Conclusions

4.1 M+C Disenrollee Subgroup Findings Summary

The previous chapters described an array of subgroup differences in reasons cited by voluntary disenrollees for leaving their plans. In this section, we highlight a few key consistent patterns that stand out from the many subgroup differences found:

- Vulnerable Medicare populations (poorer health status, more doctor visits, dually eligible, and/or with a disability) cite more problems and are more likely than others to cite a host of access-related problems as reasons for leaving their M+C plans.

- Disenrollees who cite cost as a (contributory) driver for leaving (premiums or copayments too high) are more likely than those who cite information or access reasons to go to another managed care plan, to have a disability, to have been in the plan from which they disenrolled longer, to be a non-Hispanic person of a race other than black or White, and to disenroll at either the beginning or end of the calendar year.

- Beneficiaries who leave a plan within a few months of enrolling are more likely to cite problems with plan information and with access to care, possibly suggesting a lack of understanding of how to navigate the managed care system.

The remainder of this section provides more detail on these findings.

Exhibit 4-1 shows statistically significant differences of at least 10 percentage points between the subgroups listed compared to other disenrollees in citing a problem as a reason (or most important reason) for leaving. A checkmark (X) in any given cell indicates that a particular subgroup is more likely to cite reasons in that grouping. Subgroup differences occur most frequently for problems with plan information, problems getting care, problems getting particular needs met, and premiums or copayments being too high. Subgroups that were more likely to cite a most important reason in a particular grouping are indicated with a diamond (◊). The differences that appear among vulnerable subgroups in *all* reasons cited by voluntary disenrollees are less apparent when looking only at *most important* reasons for leaving a plan. Subgroup differences for most important reasons occurred primarily for problems getting particular doctors and premiums or copayments being too high.

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.

A number of particularly vulnerable Medicare populations (those reporting poorer health status, those needing more care, those who are dually eligible for Medicare and Medicaid, and

those who are younger and enrolled in Medicare due to disability) are more likely than others to cite a host of access-related problems (i.e., plan information, getting care, getting particular needs met, and getting or paying for prescription medicines) 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. An alternative interpretation of these findings is that these populations have more experiences trying to access care than those in better health and are thus more likely to experience problems in general. The disenrollees from these vulnerable groups experienced multiple problems and were less likely to cite any particular reason grouping as their *most important* reason for leaving. This in contrast to less vulnerable beneficiaries, such as those who are not eligible for Medicaid, white, or more educated, who are more likely to cite problems getting particular doctors as their most important reason for leaving.

Those disenrollees whose most important reason for leaving is cost-related (specifically, they leave because premiums or copayments are 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 awhile before leaving (and likely left the plan primarily for cost rather than quality 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).

Beneficiaries who leave M+C plans within a few months of 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 are 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.

Medicare's commitment to providing choices to all of its beneficiaries, including vulnerable subpopulations, means ensuring that these groups get appropriate information from M+C plans and access to care from M+C plans to meet their needs. The Medicare CAHPS Disenrollment Reasons Survey effort is one important tool for monitoring plan performance in these areas.

Some important insight into the make-up of all reasons and most important reasons were uncovered in an analysis of the two reason groupings of these reasons. These two approaches to obtaining disenrollment reasons are clearly obtaining somewhat different results, yet also displaying some commonality. While many insights came from this analysis regarding associations among reason groupings, perhaps the most important findings are which reason groups appear to be more primary or more secondary in nature from this analysis. We found the following:

- Reason groupings "Problems getting doctors you want," and "Premiums or copayments too high" are more likely to be primary than secondary reasons for leaving a plan.

- The reason groupings "Copayments increased and/or another plan offered better coverage," "Problems getting particular needs met," and "Other problems with care or service" appear to be secondary reasons for disenrollment.

4.2 Future Research

This report provides results from the first national-level survey of reasons for leaving M+C plans, the 2000 Medicare CAHPS Disenrollment Reasons Survey. This first report from this new survey focuses only on bivariate analyses of disenrollees' reasons for leaving M+C plans during 2000. Reports from subsequent rounds of the Disenrollment Reasons Survey will include additional analyses. We list examples of additional analyses that could be conducted to address specific Medicare populations:

- Future rounds of the survey will enable us to study trends in the reasons that various subgroups give for choosing to leave M+C plans.

- We used a conservative approach in reporting bivariate results; we only reported statistically significant differences of at least 10 percentage points. By looking only at these differences, important differences of low-frequency events may be inappropriately ignored. It may be worthwhile in these instances to consider looking at smaller percentage differences.

- Where sample size permits, these subgroup analyses can be conducted at lower geographic levels, such as region, state, or market.

- Multivariate analyses would increase our understanding of outcomes for specific populations while holding other factors constant. For example, a model, perhaps hierarchical, could be developed that enables us to look at the independent impacts of beneficiary characteristics, plan, market, and region on reasons for leaving.

- Where specific subgroup differences are present for particular groupings of reasons for leaving, it may be helpful to investigate whether these differences occur for specific reasons or across all reasons within a given grouping.

- Additional subgroups could be examined, including M+C plan nonprofit versus for-profit status and M+C plan tenure.

- Persons disenrolling to FFS after a brief period of enrollment were more likely to report problems with plan information. We speculate that many of these enrollees may not have understood how managed care works. Future analyses could examine how many of these enrollees had enrolled in Medicare managed care before the period of enrollment and disenrollment under study. One would expect that most of them had no previous experience with Medicare managed care.

- The subgroup results indicate that disenrollees who have more outpatient visits and whose health is worse are among those who tend to have more problems with their

plan. However, these results do not tell us what health conditions these beneficiaries have, what procedures they had done, or what costs they incurred. Linking the reasons data to claims data would enable CMS to learn whether there are any beneficiary condition, utilization, or cost patterns among disenrollees.

- Future analyses could also examine population-based rates of disenrollment for various reasons. That is, it would be interesting to combine rates of disenrollment with the percent of disenrollees reporting various reasons for disenrollment. That way, one could determine what percent of the population enrolled at a point in time disenrolled over the next year because of problems getting care. This type of information would be interesting both overall and by plan.

- More research needs to be conducted to identify, understand, and address the specific problems that beneficiaries face that cause them to leave their plan. For example, further work is needed to determine whether and how language barriers play a role for Hispanic voluntary disenrollees who cite problems with plan information as a reason for leaving.

- Finally, in view of the interesting findings from analyzing relationships between all reasons and most important reason groupings, it would be of interest to pursue this type of analysis in more detail by examining individual item level (for all reasons) by individual code-level (for most important reason) relationships.

Exhibit 4-1. 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 1st or 4th quarter						✓◊		
Disenrolled in 2nd quarter	✓							
Disenrolled in 3rd quarter	✓	✓			✓			
Sociodemographic characteristics								
Hispanic	✓							
Non-Hispanic Black	✓							
Non-Hispanic White		◊						
Non-Hispanic other race						✓		
At least 4-year college degree		✓						

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Appendix A

2000 Medicare CAHPS
Disenrollment Reasons Questionnaire

OMB No. *0938-0779*

MEDICARE • MEDICAID
Health Care Financing Administration

2000 Medicare Satisfaction Survey -DR

CAHPS®
Consumer Assessment
of Health Plans

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **[0938-0779]**. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data sources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: HCFA, 7500 Security Boulevard, **[N2-14-26]**, Baltimore, Maryland **[21244-1850]**, and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, DC 20503.

Instructions for Completing This Questionnaire

This questionnaire asks about you and your experiences in a Medicare health plan. Answer each question thinking about yourself. Please take the time to complete the questionnaire because your answers are very important to us.

- Please use a BLACK ink pen to mark your answers.
- Be sure to read all the answer choices before marking your answer.
- Answer all the questions by putting an "X" in the box to the left of your answer, like this:

  ☐ Yes
  ☒ No ➔ **Go to Question 3**

- You will sometimes be instructed to skip one or more questions, depending on how you answered an earlier question. When this happens, you will see an arrow with a note that tells you what question to answer next, as shown in the example above.

If the answer you marked is not followed by an arrow with a note telling you where to go next, then continue with the next question, as shown below.

EXAMPLE

1. **Do you wear a hearing aid now?**
   ☒ Yes
   ☐ No ➔ **Go to Question 3**

2. **How long have you been wearing a hearing aid?**
   ☐ Less than 1 year
   ☒ 1 to 3 years
   ☐ More than 3 years
   ☐ I don't wear a hearing aid

3. **In the last 6 months, did you have any headaches?**
   ☐ Yes
   ☒ No

Please go to the top of the next page and begin with Question 1.

1. Our records show that, for part of the last 6 months, you were covered by [MEDICARE HEALTH PLAN NAME], but that you left that Medicare health plan. Is that right?

☐ Yes ➔ **Go to Question 5 on Page 2**

☐ No ➔ **Go to Question 2 below**

2. Are you still covered by [MEDICARE HEALTH PLAN NAME]?

☐ Yes ➔ **Do NOT answer the rest of these questions. Please return this questionnaire in the postage-paid envelope. Thank you.**

☐ No ➔ **Go to Question 3 in the next column**

3. Did you recently leave a <u>different</u> Medicare health plan?

☐ Yes ➔ **Go to Question 4 below**

☐ No ➔ **Do NOT answer the rest of these questions. Please return this questionnaire in the postage-paid envelope. Thank you.**

4. What is the name of the Medicare health plan you recently left?
(Please print neatly.)

_____

We would like to know about your experience with [MEDICARE HEALTH PLAN NAME]. If that plan was <u>not</u> the last health plan you left, answer Questions 5 through 57 thinking about <u>the last plan you left</u>, that is, the plan you named on the line in Question 4 above.

Please go to Page 2 and continue with the information in the left column.

REASONS YOU LEFT [MEDICARE HEALTH PLAN NAME]

The next questions ask about <u>reasons</u> you may have had for leaving [MEDICARE HEALTH PLAN NAME].

Just as it is important for us to learn why you left [MEDICARE HEALTH PLAN NAME], it is also important for us to know what reasons did <u>not</u> affect your decision to leave that plan.

Therefore, please mark an answer to every question below unless the instruction beside the answer that you mark tells you to stop and return the questionnaire, or to skip one or more questions.

PLAN AVAILABILITY

5. Some people leave their Medicare health plan because their former employer no longer offers the plan. Did you leave [MEDICARE HEALTH PLAN NAME] because <u>your former employer no longer offered [MEDICARE HEALTH PLAN NAME] to you</u>?

- ☐ Yes ➔ **Go to Question 8 on Page 3**
- ☐ No
- ☐ I was not enrolled in this plan through a former employer.

6. Some people leave their Medicare health plan because they moved and now live outside the area where the plan is available. Did you leave [MEDICARE HEALTH PLAN NAME] because <u>you moved and now live outside the area</u> where this plan was available?

- ☐ Yes ➔ **Do NOT answer the rest of these questions. Please return this questionnaire in the postage-paid envelope. Thank you.**
- ☐ No

7. Some people leave their Medicare health plan because the health plan stopped offering services to people with Medicare in the area where you live. Did you leave [MEDICARE HEALTH PLAN NAME] because the plan <u>stopped serving people with Medicare</u> who live in your area?

- ☐ Yes ➔ **Do NOT answer the rest of these questions. Please return this questionnaire in the postage-paid envelope. Thank you.**
- ☐ No

8. A premium is the amount that you pay to receive health care coverage from a health plan. Some health plans charge a premium to people on Medicare who are enrolled in that health plan.

This additional premium that the health plan charges is separate from the premium that people on Medicare pay for Medicare Part B, which is usually deducted from their Social Security Check each month.

Some people have to leave their Medicare health plan because they cannot afford to pay the premium. Did you leave [MEDICARE HEALTH PLAN NAME] because you could not pay the monthly premium?

☐ Yes

☐ No

DOCTORS AND OTHER HEALTH PROVIDERS

A <u>doctor or other health care provider</u> can be a general doctor, a specialist doctor, a nurse practitioner, a physician assistant, a nurse or anyone else you would see for health care.

9. Did you leave [MEDICARE HEALTH PLAN NAME] because <u>the plan did not include the doctors</u> or other health care providers you wanted to see?

☐ Yes

☐ No

10. Did you leave [MEDICARE HEALTH PLAN NAME] because the doctor you wanted to see <u>retired or left the plan</u>?

☐ Yes

☐ No

11. Did you leave [MEDICARE HEALTH PLAN NAME] because the plan doctor or other health care provider you wanted to see was <u>not accepting new patients</u>?

☐ Yes

☐ No

12. Did you leave [MEDICARE HEALTH PLAN NAME] because you could not see the plan doctor or other health care provider you wanted to see on <u>every</u> visit?

☐ Yes

☐ No

13. Did you leave [MEDICARE HEALTH PLAN NAME] because the plan doctors or other health care providers did not explain things in a way you could understand?

- ☐ Yes
- ☐ No

14. Did you leave [MEDICARE HEALTH PLAN NAME] because you had problems with the plan doctors or other health care providers?

- ☐ Yes
- ☐ No

15. Specialists are doctors like surgeons, heart doctors, psychiatrists, allergy doctors, skin doctors, and others who specialize in one area of health care.

Did you leave [MEDICARE HEALTH PLAN NAME] because you had problems or delays getting the plan to approve referrals to specialists?

- ☐ Yes
- ☐ No

ACCESS TO CARE

16. Did you leave [MEDICARE HEALTH PLAN NAME] because you had problems getting the care you needed when you needed it?

- ☐ Yes
- ☐ No

17. Did you leave [MEDICARE HEALTH PLAN NAME] because the plan refused to pay for emergency or other urgent care?

- ☐ Yes
- ☐ No

18. Did you leave [MEDICARE HEALTH PLAN NAME] because you could not get admitted to a hospital when you needed to?

- ☐ Yes
- ☐ No

19. Did you leave [MEDICARE HEALTH PLAN NAME] because you had to leave the hospital before you or your doctor thought you should?

- ☐ Yes
- ☐ No

20. Did you leave [MEDICARE HEALTH PLAN NAME] because you could not get special medical equipment when you needed it?

- ☐ Yes
- ☐ No

21. Did you leave [MEDICARE HEALTH PLAN NAME] because you could not get home health care when you needed it?

- ☐ Yes
- ☐ No

22. Did you leave [MEDICARE HEALTH PLAN NAME] because you had no transportation or it was too far to the clinic or doctor's office where you had to go for regular or routine health care?

- ☐ Yes
- ☐ No

23. Did you leave [MEDICARE HEALTH PLAN NAME] because you could not get an appointment for regular or routine health care as soon as you wanted?

- ☐ Yes
- ☐ No

24. Did you leave [MEDICARE HEALTH PLAN NAME] because you had to wait too long past your appointment time to see the health care provider you went to see?

- ☐ Yes
- ☐ No

25. Did you leave [MEDICARE HEALTH PLAN NAME] because you wanted to be sure you could get the health care you need while you are out of town or traveling away from home?

- ☐ Yes
- ☐ No

INFORMATION ABOUT THE PLAN

26. Did you leave [MEDICARE HEALTH PLAN NAME] because you thought you were given incorrect or incomplete information at the time you joined the plan?

- ☐ Yes
- ☐ No

27. Did you leave [MEDICARE HEALTH PLAN NAME] because after you joined the plan, it wasn't what you expected?

- ☐ Yes
- ☐ No

28. Did you leave [MEDICARE HEALTH PLAN NAME] because information from the plan about things like benefits, services, doctors, and rules was hard to get or not very helpful?

- ☐ Yes
- ☐ No

PHARMACY BENEFIT

29. Did you leave [MEDICARE HEALTH PLAN NAME] because the maximum dollar amount the plan allowed each year (or quarter) for your prescription medicine was not enough to meet your needs?

- ☐ Yes
- ☐ No
- ☐ The plan that I left did not cover my prescription medicines.

30. Did you leave [MEDICARE HEALTH PLAN NAME] because the plan required you to get a generic medicine when you wanted a brand name medicine?

- ☐ Yes
- ☐ No
- ☐ The plan that I left did not cover my prescription medicines.

31. Did you leave [MEDICARE HEALTH PLAN NAME] because the plan would not pay for a medication that your doctor had prescribed?

- ☐ Yes
- ☐ No
- ☐ The plan that I left did not cover my prescription medicines.

COSTS AND BENEFITS

32. Did you leave [MEDICARE HEALTH PLAN NAME] because another plan would cost you less?

- ☐ Yes
- ☐ No

33. Did you leave [MEDICARE HEALTH PLAN NAME] because the plan would not pay for some of the care you needed?

- ☐ Yes
- ☐ No

34. Did you leave [MEDICARE HEALTH PLAN NAME] because another plan offered better benefits or coverage for some types of care or services?

- ☐ Yes
- ☐ No

35. A premium is the amount that <u>you</u> pay to receive health care coverage from a health plan. Some health plans charge a premium to people on Medicare who are enrolled in that health plan.

This additional premium that the health plan charges is separate from the premium that people on Medicare pay for Medicare Part B, which is usually deducted from their Social Security Check each month.

Did you leave the plan because [MEDICARE HEALTH PLAN NAME] started charging you a monthly premium, or increased the monthly premium that you pay?

- ☐ Yes
- ☐ No
- ☐ The plan I left did not start charging a premium, nor did it increase my premium.

The next two questions ask about co-pays or copayments, which are the amounts that you pay for certain medical services such as office visits to your doctor, prescription medicines, and other services.

36. Did you leave because [MEDICARE HEALTH PLAN NAME] increased the copayment that you paid for office visits to your doctor and for other services?

When answering this question, do not include copayments that you may have paid for prescription medicines.

- ☐ Yes
- ☐ No
- ☐ The plan I left <u>did not increase</u> my copayment for office visits.

37. Did you leave because [MEDICARE HEALTH PLAN NAME] increased the copayment that you paid for prescription medicines?

- ☐ Yes
- ☐ No
- ☐ The plan I left <u>did not increase</u> my copayment for prescription medicines.

OTHER REASONS

38. Did you leave [MEDICARE HEALTH PLAN NAME] because the plan's customer service staff were not helpful or you were dissatisfied with the way they handled your questions or complaint?

☐ Yes

☐ No

39. Did you leave [MEDICARE HEALTH PLAN NAME] because your doctor or other health care provider or someone from the plan told you that you could get better care elsewhere?

☐ Yes

☐ No

40. Did you leave [MEDICARE HEALTH PLAN NAME] because you or your spouse, another family member, or a friend had a bad experience with that plan?

☐ Yes

☐ No

41. Besides the reasons already asked about in Questions 5-40, are there any other reasons you left [MEDICARE HEALTH PLAN NAME]?

☐ Yes ➔ **Go to Question 42 below**

☐ No ➔ **Go to Question 43 on Page 9**

42. On the lines below, please describe your other reasons for leaving [MEDICARE HEALTH PLAN NAME]. (Please print neatly.)

_____

_____

_____

Go to Question 43 on Page 9

43. What was the one <u>most important reason</u> you left [MEDICARE HEALTH PLAN NAME]? (Please print neatly.)

_____

_____

_____

Go to Question 44 below

YOUR EXPERIENCE WITH [MEDICARE HEALTH PLAN NAME]

The next set of questions is about your experience with [MEDICARE HEALTH PLAN NAME].

If the plan named above is not the last plan you left, please remember to answer the questions about the last plan you left.

44. At the time that you left [MEDICARE HEALTH PLAN NAME], did this plan cover some or all of the costs of your prescription medicines?

- ☐ Yes
- ☐ No

45. For about how many months were you a member of [MEDICARE HEALTH PLAN NAME] before you left?

- ☐ 1 month or less
- ☐ 2 months
- ☐ 3 months
- ☐ 4 months
- ☐ 5 months

See Instruction Box 1 at the top of Page 10.

- ☐ 6 months or more

INSTRUCTION BOX 1:

Questions 46 – 49 ask about the last 6 months you were a member of [MEDICARE HEALTH PLAN NAME].

If you were in [MEDICARE HEALTH PLAN NAME] for less than 6 months, answer these questions thinking about the number of months that you were a member of that plan.

46. In the 6 months before you left [MEDICARE HEALTH PLAN NAME], how many times did you go to a doctor's office or clinic to get care for yourself? Do not count times you went to an emergency room to get care for yourself.

- ☐ None
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5 to 9
- ☐ 10 or more

47. A personal doctor or nurse is the health provider who knows you best. This can be a general doctor, a specialist doctor, a nurse practitioner, or a physician assistant.

Did you get a new personal doctor or nurse when you were a member of [MEDICARE HEALTH PLAN NAME]?

- ☐ Yes
- ☐ No

Go to Question 48 on Page 11

48. Think about all the health care you got from <u>all doctors and other health providers</u> in the 6 months before you left [MEDICARE HEALTH PLAN NAME].

Use <u>any number from 0 to 10</u> where 0 is the worst health care possible, and 10 is the best health care. How would you rate all the health care you got in the 6 months before you left [MEDICARE HEALTH PLAN NAME]?

- ☐ 0 ➔ Worst health care possible
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10 ➔ Best health care possible

49. Think about all your experience with [MEDICARE HEALTH PLAN NAME].

Use <u>any number from 0 to 10</u> where 0 is the worst Medicare health plan possible, and 10 is the best Medicare health plan possible. How would you rate [MEDICARE HEALTH PLAN NAME]?

- ☐ 0 ➔ Worst Medicare health plan possible
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10 ➔ Best Medicare health plan possible

50. When you were a member of [MEDICARE HEALTH PLAN NAME], was there ever a time when you strongly believed that you needed and should have received health care or services that [MEDICARE HEALTH PLAN NAME] or your doctor decided not to give to you?

- ☐ Yes
- ☐ No ➔ **Go to Instruction Box 2 on Page 13**

51. Did you receive information in writing from [MEDICARE HEALTH PLAN NAME] or your doctor on how to file a formal complaint about their decision not to provide the health care or services that you strongly believed that you needed?

- ☐ Yes
- ☐ No
- ☐ I was able to get the health care and services that I thought I needed when I was a member of this plan.

52. The Medicare Program is trying to learn more about the health care or services that Medicare health plan members believed they needed but did not get.

May we contact you again about the health care or services that you did not receive if we need more information?

- ☐ Yes
- ☐ No
- ☐ I was able to get the health care and services that I thought I needed when I was a member of this plan.

Go to Instruction Box 2 on Page 13

INSTRUCTION BOX 2

An appeal is a formal complaint about a Medicare health plan's decision not to provide or pay for health care services or equipment or to stop providing health care services or equipment.

When answering Questions 53 through 57, please think about the time when you were a member of [MEDICARE HEALTH PLAN NAME].

53. As far as you know, did you have the right to appeal if [MEDICARE HEALTH PLAN NAME] decided not to provide or pay for care and services that you believed you needed?

- ☐ Yes
- ☐ No

54. As far as you know, did your doctor have the right to appeal if [MEDICARE HEALTH PLAN NAME] decided not to provide or pay for health care and services that you believed you needed?

- ☐ Yes
- ☐ No

55. As far as you know, if your appeal was denied, would [MEDICARE HEALTH PLAN] automatically refer it to another organization for an independent review?

- ☐ Yes
- ☐ No

56. As far as you know, did you have the right to ask for another review by a judge if this independent organization turned down your appeal to [MEDICARE HEALTH PLAN NAME]?

- ☐ Yes
- ☐ No

57. Did you ever file an appeal with [MEDICARE HEALTH PLAN NAME]?

- ☐ Yes
- ☐ No

ABOUT YOU

This last set of questions asks for your views about your health. These questions will help our researchers understand the characteristics of the group of people who have answered this survey.

58. In general, how would you rate <u>your overall health</u> now?

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

The next two questions are about activities you might do during a typical day.

59. Does <u>your health now limit you</u> in performing <u>moderate activities</u>, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf?

- ☐ Yes, limited a lot
- ☐ Yes, limited a little
- ☐ No, not limited at all

60. Does <u>your health now limit you</u> in climbing <u>several</u> flights of stairs?

- ☐ Yes, limited a lot
- ☐ Yes, limited a little
- ☐ No, not limited at all

The following two questions ask whether your work or other regular daily activities have been affected in the <u>past 4 weeks</u> because of your <u>physical health</u>.

61. During the <u>past 4 weeks</u>, have you <u>accomplished less</u> than you would like as a result of your physical health?

- ☐ Yes
- ☐ No

62. During the <u>past 4 weeks</u>, were you limited in the <u>kind</u> of work or other activities you could do as a result of your physical health?

- ☐ Yes
- ☐ No

63. During the past 4 weeks, how much did pain interfere with your normal work, including both work outside the home and housework?

- ☐ Not at all
- ☐ A little bit
- ☐ Moderately
- ☐ Quite a bit
- ☐ Extremely

The following two questions ask whether your work or other regular daily activities have been affected in the past 4 weeks by any emotional problems, such as feeling depressed or anxious.

64. During the past 4 weeks, have you accomplished less than you would like as a result of any emotional problems?

- ☐ Yes
- ☐ No

65. During the past 4 weeks, have you not done work or other activities as carefully as usual because of any emotional problems?

- ☐ Yes
- ☐ No

The next few questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

66. How much of the time during the past 4 weeks have you felt calm and peaceful?

- ☐ All of the time
- ☐ Most of the time
- ☐ A good bit of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time

67. How much of the time during the past 4 weeks did you have a lot of energy?

- ☐ All of the time
- ☐ Most of the time
- ☐ A good bit of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time

68. How much of the time during the <u>past 4 weeks</u> have you felt downhearted and blue?

- ☐ All of the time
- ☐ Most of the time
- ☐ A good bit of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time

69. During the <u>past 4 weeks</u>, how much of the time has your <u>physical health or emotional problems</u> interfered with your social activities (like visiting with friends, relatives, etc.)?

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time

70. Compared to one year ago, how would you rate your health in general now?

- ☐ Much better now than one year ago
- ☐ Somewhat better now than one year ago
- ☐ About the same as one year ago
- ☐ Somewhat worse now than one year ago
- ☐ Much worse now than one year ago

71. What is your age now?

- ☐ 64 or younger
- ☐ 65 to 69
- ☐ 70 to 74
- ☐ 75 to 79
- ☐ 80 or older

72. Are you male or female?

- ☐ Male
- ☐ Female

73. What is the highest grade or level of school that you have completed?

- ☐ 8th grade or less
- ☐ Some high school, but did not graduate
- ☐ High school graduate or GED
- ☐ Some college or 2-year degree
- ☐ 4-year college graduate
- ☐ More than 4-year college degree

74. Are you of Hispanic or Latino origin or descent?

- ☐ Yes, Hispanic or Latino
- ☐ No, not Hispanic or Latino

75. What is your race? Please mark one or more boxes.

- ☐ White
- ☐ Black or African-American
- ☐ Asian
- ☐ Native Hawaiian or other Pacific Islander
- ☐ American Indian or Alaska Native

76. Did anyone help you complete this questionnaire?

Yes ➔ **Go to Question 77 below**

No ➔ **Go to Question 78 on Page 18**

77. How did that person help you? Please mark all that apply.

- ☐ Read the questions to me
- ☐ Wrote down the answers I gave
- ☐ Answered the questions for me
- ☐ Translated the questions into my language
- ☐ Helped me in some other way ➔ **On the lines below, please tell us how that person helped you.** (Please print neatly.)

_____

_____

_____

Continue with Question 78 on Page 18

78. We would like to be able to contact you in case we have any questions about any of your answers. Please write your daytime telephone number below.

THANK YOU.

Please mail your completed questionnaire in the postage-paid envelope.

Appendix B

2000 Medicare CAHPS Disenrollment Reasons
Reasons Grouping Methodology

Appendix B
2000 Medicare CAHPS Disenrollment Reasons
Reasons Grouping Methodology

As noted previously, one of the primary purposes of conducting the Reasons survey was to report reasons to consumers, via the Medicare web site and other media, to supplement information on the rates at which people voluntarily disenroll from plans. The www.Medicare.gov web pages include information about two major categories of "most important reasons" cited by people who leave Medicare plans. These two main categories were tested by the CAHPS Development team during the development of draft report templates for inclusion of disenrollment rates and reasons in the Medicare and You handbook and on the web. The two categories were given the following labels:

- Members left because of health care or services.
- Members left because of costs and benefits.

CMS reports each plan's disenrollment rate as a total rate and then broken out according to these two main categories. For example, if the overall disenrollment rate for a plan is 10% and 40% of enrollees surveyed cited problems with care or services and 60% cited concerns about costs, the percentages reported will be 10%, 4%, and 6%, respectively.

In addition, CMS wanted to allow consumers interested in more information about either of these categories to be able to "drill-down" to see more detailed subgroupings of reasons. This led to the following guidelines for developing appropriate groupings of disenrollment reasons:

1. The two main categories should address reasons related to care or services and cost or benefits.
2. The two main categories were to be mutually exclusive.
3. Each reason should be classified within either of the two main categories.
4. Each subgrouping should fall within only one of the two main categories.
5. Subgroupings of reasons should be mutually exclusive.
6. The number of subgroupings for reporting to consumers had to fit within the space constraints of a single web page.
7. The number of groupings of reasons for reporting to health plans could be larger than the number of groupings for consumers, but the health plan groupings should be capable of being aggregated to the consumer level.

Early efforts to develop potential groupings of reasons were based on factor analyses of the first two quarters of 2000 reasons data.[31] These efforts produced groupings that appeared to have reasonable face validity thus supporting the use of factor analysis for identifying groupings of reasons. Efforts to update these early results to include data from Quarter 3 yielded similar but not identical groupings of reasons. This suggests that there were some core groupings of reasons that relate to each other consistently and another smaller group of reasons where changes in sample size lead to different or dual factor loadings. In other words, there are some all reasons that could either be interpreted in different ways by respondents or that may be related to several different type of reasons.

When analyzing the full year of 2000 reasons data, we revised our approach to developing groupings of reasons to follow the consumer reporting approach (i.e., to first divide the reasons into two main categories and then to divide each main category into appropriate subgroupings). There were two possible strategies we could follow in performing this initial division into two categories:

1. manually assign each most important/all reason to the two main categories

2. analyze the data for possible groupings

We chose to apply a combination of these strategies to divide the reasons into two categories.

Having allocated the all reasons and most important reasons between the two main categories (CARE or SERVICES and COSTS and BENEFITS), we then proceeded to conduct a series of factor analyses to identify potential subgroupings within each category:

1. individual-level analysis of all reasons

2. plan-level analysis of all reasons

3. plan-level analysis of most important reasons

The remainder of the section describes the background and statistical methods used to identify appropriate groupings of reasons and the results of those analyses. As a result of a series of factor and variable cluster analyses, we developed eight reason groupings: five groupings that address problems with care or service and three groupings that address concerns about plan

[31] These efforts were conducted prior to the decision to follow the consumer reporting approach of dividing the reasons into two main categories and so the results from these efforts are not reported in this report.

costs.[32] ***Exhibit B-1*** shows the assignment of reasons survey items and labels to the reason groupings.[33]

[32] For reporting to consumers, three groupings (problems getting care, problems getting particular needs met, and other problems with care or service) are combined under the label "Getting care" and two other groupings (premiums or copayments too high and copayments increased and/or another plan offered better coverage) are combined under the label "Premiums, Copayments, or Coverage".

[33] In addition to the preprinted reasons, there were two other reasons that were only collected when respondents cited them as their most important reason for leaving a plan (i.e., these two reasons were not among the preprinted reasons and thus were not included in the individual level analysis upon which we based the groupings: "insecurity about future of plan or continued coverage" and "no longer needed coverage under the plan.") The team manually assigned these two reasons to appropriate groupings.

Exhibit B-1. Assignment of Reasons for Leaving a Plan to Groupings of Reasons

Reasons Grouping	Reasons for Leaving a Plan
Problems with Care or Service	
Problems with information from the plan	• Given incorrect or incomplete information at the time you joined the plan • After joining the plan, it wasn't what you expected • Information from the plan was hard to get or not very helpful • Plan's customer service staff were not helpful • Insecurity about future of plan or about continued coverage
Problems getting particular doctors	• Plan did not include doctors or other providers you wanted to see • Doctor or other provider you wanted to see retired or left the plan • Doctor or other provider you wanted to see was not accepting new patients • Could not see the doctor or other provider you wanted to see on every visit
Problems getting care	• Could not get appointment for regular or routine health care as soon as wanted • Had to wait too long in waiting room to see the health care provider you went to see • Health care providers did not explain things in a way you could understand • Had problems with the plan doctors or other health care providers • Had problems or delays getting the plan to approve referrals to specialists • Had problems getting the care you needed when you needed it
Problems getting particular needs met	• Plan refused to pay for emergency or other urgent care • Could not get admitted to a hospital when you needed to • Had to leave the hospital before you or your doctor thought you should • Could not get special medical equipment when you needed it • Could not get home health care when you needed it • Plan would not pay for some of the care you needed
Other problems with care or service	• It was too far to where you had to go for regular or routine health care • Wanted to be sure you could get the health care you need while you are out of town • Health provider or someone from the plan said you could get better care elsewhere • You or another family member, or friend had a bad experience with that plan
Concerns about Costs and Benefits	
Premiums or copayments too high	• Could not pay the monthly premium • Another plan would cost you less • Plan started charging a monthly premium or increased your monthly premium
Copayments increased and/or another plan offered better coverage	• Another plan offered better benefits or coverage for some types of care or services • Plan increased the copayment for office visits to your doctor and for other services • Plan increased the copayment that you paid for prescription medicines • No longer needed coverage under the plan
Problems getting or paying for prescription medicines	• Maximum dollar amount the plan allowed for your prescription medicine was too low • Plan required you to get a generic medicine when you wanted a brand name medicine • Plan would not pay for a medication that your doctor had prescribed

Each of the *all* reasons variables were essentially dichotomous (i.e., "yes" if that was a reason a beneficiary left a plan and "no" if the respondent did not indicate this was a reason why they left the plan). In order to conduct factor analysis at the individual level on these dichotomous variables, we imported the data into Prelis/Lisrel 8.3.[34] For the plan level analysis, values of the dichotomous variables were summed for each CMS contract number and a rate was calculated for each contract where the numerator represents the number of disenrollees who endorsed the item and the denominator was the number of complete interviews. Since this calculation created a variable that was no longer dichotomous, it was appropriate to use a standard statistical package for the factor analyses (we used SPSS v.10).

Since each respondent only indicated one most important reason, it was not possible to conduct individual-level factor analysis for these reasons. For the plan-level analysis of the most important reasons, we first converted the one variable containing the most important reason code into 32 dichotomous variables[35] representing the same reasons as the all reasons.[36] Thus only one of these 32 variables had a value of 1 for an individual indicating their most important reason. Plan-level variables were then calculated in the same manner as the plan-level all reasons variables and factor analyses were conducted using SPSS v.10.

When using factor analysis to determine groupings, the factors represent the common variance of variables, excluding the unique variance. While the technology of factor analysis will provide factors, it is important for the researcher to determine whether the factors make "sense" in light of their knowledge of the topic. It is possible to have nonsensical factors emerge in an exploratory analysis.

The types of factoring used in the analysis also can determine the number of factors. For example, Principal Components Analysis (PCA) will create uncorrelated or orthogonal factors and the number of factors that will be extracted result in the maximum variance. Principal Factor Analysis (PFA) seeks the least number of factors, by estimating the squared multiple correlations of each variable with the remainder of the variables in the matrix. According to Widaman (1993)[37] principal components analysis should not be used to obtain parameters reflecting latent constructs or factors. In this case, we were attempting to obtain latent constructs, and thus used PFA.

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[34] For the individual level data, we normalized the data prior to the factor analysis. While this was not required for factor analysis, standardization scales the data in a sample-specific manner. Given the changing environment in managed care plans and constantly shifting enrollment, it is appropriate to treat this as a sample-specific analysis.

[35] There is one less most important reason code since these codes were created prior to the addition of another reason in the Quarter 2 survey regarding inability pay the premium.

[36] This was performed by aggregating the important reason codes to the 10's level.

[37] Widaman, K.F. (1993). Common factor analysis versus principal components analysis: Differential bias in representing model parameters? Multivariate Behavioral Research 28:263-311.

The correlation matrix used for the analysis depends on the nature of the variables used in the analysis. Because of the dichotomous nature of the all reasons questions, tetrachoric correlations were used in the individual level factor analysis (hence our decision to use PRELIS/LISREL 8.3 which can produce a tetrachoric correlation matrix). A traditional correlation matrix was used for the plan level analysis based upon the continuous nature of the independent variables.

When determining the number of factors that seem important, the researcher generally looks at the eigenvalues. The eigenvalue for a given factor measures the variance in all the variables that is accounted for by the factor. The factor's eigenvalues may be computed as the sum of its squared factor loadings for all the variables. If a factor has a low eigenvalue, then it is contributing little to the explanation of variances in the variables and may generally be ignored. We used the Kaiser-Guttman Rule for dropping factors from the analysis. The rule is to drop all factors that have an eigenvalue below 1.0. Any eigenvalue below 1.0 may be redundant with another more important factor. In addition, we also looked at the amount of variance explained to be sure to keep enough factors.

Factor rotation is important because it is difficult to interpret non-rotated solutions because variables tend to load on multiple factors. In this case we utilized varimax rotation, because it minimizes the number of variables that have high loadings on any one given factor. It assists in identifying the variables associated with a single factor.

When examining the data, one looks at the factor loadings and determines which items load on the factor. The factor loadings are the correlation coefficients between the variables (rows) and the factors (columns). In this case, we followed guidelines suggesting that items should have a factor loading of at least 4.0 to be considered as contributing significantly to the factor. Analogous to a Pearson's r, the squared factor loading is the percent of variance in the variable accounted for by the factor. For exploratory factor analysis it is recommended (by Thurstone) that each factor have a minimum of three items loading on it (see Kim and Mueller, 1978:77).

Individual-level analysis. In the individual-level data we were attempting in the analysis to uncover a latent structure of the 33 all reasons variables. When the reasons had been assigned to each of the two main categories, we ran each category independent of the other. In an iterative fashion, we moved from one to four factors in both categories after normalizing the data. After three factors in the COST and BENEFITS grouping and after four factors in the CARE and SERVICES grouping we no longer had three items loading on each factor, nor did each factor have an eigenvalue of 1.0. In the process, we discovered four items that did not load

significantly on any one factor.[38] We removed the four items from the analysis, as is generally recommended.

The convention used for determining the statistical appropriateness of the extracted factors was the same as that used in the plan level analysis. That is, each factor had to have an eigenvalue over 1.0. Thus, it was first determined statistically that the most appropriate number of factors for the individual level analysis of the all reasons for the COST category was three factors. For the CARE and SERVICES factor analysis, it was a four-factor solution that met these statistical criteria. We then reviewed the factors to assess whether they seemed to make sense in terms of the substantive issues and they clearly are congruent with the literature on disenrollment reasons. The factors were somewhat correlated with each other, suggesting that the factors within each of these categories should be measured together in order to fully understand the construct.

Plan-level analysis. The factor procedure in SPSS allows for any number of factors to be extracted. In this case we used the following two conventions to determine the validity of the factors that were extracted: if the eigenvalue of the factor was over 1.0 (the Kaiser Criterion), and the total amount of variance accounted for by the factors with values over 1.0 reached approximately 70% of the variance. In analyzing reasons at the plan level, we realized that inclusion of plans with low numbers of completed interviews might distort our results due to higher variance. Consequently, for all plan-level analysis we ran analyses twice: for all plans and for those plans with 30 or more completed interviews.

For the reasons in the COSTS and BENEFITS category, we identified an optimal solution with three factors with eigenvalues over 1.0 that together explained 85 percent of the total variance. For the Problems with Care or Service category, we identified a 4-factor solution that accounted for 76 percent of the total variance, after removing the three variables that were excluded from the individual-level analysis.

Similar to the plan-level analysis of all reasons, we used SPSS to identify potential groupings of most important reasons within the two main categories. Applying the same criteria for identifying the validity of factors that were extracted, we were unable to extract more than one factor within either the COSTS and BENEFITS or the CARE and SERVICE categories. The only factor solution with a significant result on the Chi-Square goodness of fit test was a three-factor solution for the most important reasons in the CARE and SERVICE category (among plans with 30 or more completes) but this solution only explained 31% of the total variance.

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[38] You had no transportation or it was too far to the clinic or doctor's office where you had to go for regular or routine health care?

You wanted to be sure you could get the health care you need while you are out of town or traveling away from home?"

Your doctor or other care health provider or someone from the plan told you that you could get better care elsewhere?

You or another family member or a friend had a bad experience with that plan?

When the statistical and substantive criteria had been met, we reviewed the factors and the items loading on the factors to determine whether there were differences between factors identified at the plan level and factors identified at the individual level of analysis. The factors for COST and BENEFITS were identical across the individual and plan-level analyses while there were minor differences in the loading of items in CARE and SERVICES.[39] These minor differences might be explained in terms of data aggregation issues. It is likely that individuals from a specific plan may have had similar experiences that caused them to disenroll, and aggregation of these similar experiences by plan could result in some differences between the individual level factor analysis and the plan factor analysis. The use of two different levels of variables (continuous and dichotomous) could also impact on the results, given the different correlation matrices used in the analysis. As mentioned earlier, in the plan-level analysis the matrix was a Pearson correlation while in the individual-level analysis, we used a tetrachoric correlation matrix.

Conceptually, one could argue either way between whether we are seeking to create groupings at the individual or the plan level—the information is coming from and is to be reported to consumers but the data to be presented and compared will be at the plan level. In choosing between the differences in the individual- and plan-level factor loadings for the CARE and SERVICES, we weighted the individual-level over the plan-level results. It appeared from our review that the individual-level factor analysis had captured the important domains and that the items loading on those domains were in fact appropriate.

Having decided to use the individual-level results in favor of the plan level for deriving appropriate groupings of reasons, we were left with the task of determining how to handle the reasons that had not loaded on to any factors and labeling the factors. The resulting reason groupings, while derived statistically, must also make sense in terms of how one might think about disenrollment from a plan.

Each of the four items that did not load on any factor may have each been measuring something other than the other factors that had been extracted. For example, one of these items, the transportation question, may pull in two substantively different reasons: the respondent's own lack of transportation or the plan's lack of clinics within a close geographic area. Meanwhile, the "care out of town" variable may reflect a more general concern about getting care in managed care plans in general rather than a characteristic of a particular plan. Since none of these reasons could be statistically assigned to a specific grouping, we examined them to see whether they could be assigned based on their substance but there was no existing grouping that captured the essence of any of the four reasons. Consequently, we decided to assign them to an "Other" factor within CARE and SERVICES. While such a "catch-all" category is less desirable than a more specific category, none of these reasons was cited frequently enough to warrant the creation of a single-item grouping. Furthermore, the use of the label "Other" implies that this grouping contains items not otherwise categorized and thus does not mislead users. The final step in the analysis involved reviewing the items within each group and labeling the groupings as

[39] These results were also very similar to those derived from additional variable cluster analyses that were performed.

clearly and succinctly as possible. Such labeling always involves a tradeoff between being able to provide full representation of all the items while maintaining a reasonable length for the label.[40]

[40] While these labels have not been explicitly tested with consumers, we drew upon expertise within the team from those involved in previous consumer testing of disenrollment information.

Appendix C

2000 Medicare CAHPS Disenrollment Reasons
Subgroup Results for Most Important Reasons and All Reasons Cited

Appendix C
Introduction to Table Series A and B: Subgroup Results for All Reasons Cited and Most Important Reasons Cited

Appendix C contains two parallel series of tables:

- **Series A Tables**—features cross-tabulations between the reasons groupings for **All Reasons** and various subgroup variables

- **Series B Tables—**features cross-tabulations between the reason groupings for the **Most Important Reason** and various subgroup variables

Statistically significant differences of at least 10 percentage points are highlighted in both series of tables. Below we provide brief background information about both the reason groupings and both series of tables. ***Section 2.2*** and ***Appendix B*** of the report gives greater details on developing the reason groupings.

All Reasons (Series A) and Most Important Reason (Series B) groupings. The reason groupings structure is the same for both the most important reason data and the all reasons data. The all reasons data are based on the set of 33 preprinted reasons plus an open-ended question asking for any other reasons. For each preprinted reason, respondents were asked to tell whether or not it was a reason they left. Respondents were also given the opportunity to provide any other reasons that were not among the list of preprinted reasons. Respondents could choose as many reasons as they liked for the all reasons data. The most important reason data, in contrast, are based on responses to an open-ended question asking respondents for the *most important reason* they chose to leave the plan. We then coded these responses into 37 categories based on the all reasons categories. We created new categories for most important reasons that did not fit into one of the all reasons codes. For subgroup analysis and public reporting purposes, all of these categories were then aggregated to a smaller set of eight groupings discussed in ***Section 2.2*** and ***Appendix B*** of the report. These eight reason groupings (five on care and service and three on costs) are the basis for the most important reason and all reasons grouping variables.

All Reasons Variables and Most Important Reason variable. In the Series A tables (all reasons), each of the eight rows is a different variable, one for each reason grouping. Since respondents could cite as many reasons as they liked among the all reasons, a given respondent could have provided responses that were allocated to more than one of the eight groupings. As a result, the percentages for each of the eight all reasons variables sum to over 100%. Over two-thirds of the respondents who chose preprinted or other reasons indicated multiple reasons that fell into more than one reason grouping. In the Series B tables, the row variable (most important reason) is a single variable that is cross-tabulated against the various levels (pooled and unpooled) of the subgroup variables. For the single most important reason variable, each respondent could give only one response that was then assigned to one of the eight reason groupings. Each column in the Series B tables sums to 100%, give or take a percent or two due to rounding.

Unpooled and pooled subgroup variables. As indicated, the subgrouping variables in the Series A and B tables are presented in two breakdowns. On the far right portion of each table are columns for each category of the full response set found in the survey (unpooled) with exceptions for race/ethnicity where the sample size in a category is too small to provide accurate estimates. To the left of these columns are two or occasionally three columns that pool various categories of the full response set. The pooled results present a slightly simpler conceptualization of the subgroup variable. In a few tables (e.g., ***Tables 11a***, ***11b***) where the full response set for the subgroup variable has few categories, no pooled grouping is provided.

Minimum subgroup variable sample size. While the size of the disenrollment survey sample is large, it is not large enough to provide accurate estimates for some categories of some of the subgroup variables, specifically some of the race and ethnicity variables. To ensure a 95% confidence interval around an estimate of no more than ±10%, for the majority of the estimates in the table that are in the neighborhood of 50%, a minimum of 475 cases is needed within a subgroup category. Thus in Table***s 11a*** and ***11b*** the non-Hispanic Asian (n = 368 & 383), non-Hispanic Native Hawaiian or Other Pacific Islander (n = 38 & 37), and non-Hispanic American Indian or Alaska Native (n = 103 & 110) were pooled with the non-Hispanic Other races category.

The sample underlying all of the tables is based on a sample size of 30,053. All cases were included in both series of tables, unless they had missing values for the applicable dependent or subgroup variable (on a table-by-table basis). The actual percentages appearing in the tables are based on weighted cell frequencies. These weights were applied to bring the total number of sampled disenrollees up to the total number of actual disenrollees within each of the sampled health plans. All significance testing done on the tables took into account this weighting as well as the design effects present in the sampling design, and was done using Proc Crosstab in SUDAAN.

Statistically significant and meaningful differences. We conducted significance testing to find statistically significant associations between the reason groupings and the subgroup variable in each table. We performed separate chi square tests for the pooled and unpooled versions of each subgroup variable. In the Series A (All Reasons) tables, ***Exhibit C-1*** shows which subtables had significant associations at the .01 level. All significance tests on Series B (Most Important Reason) tables were significant at a .01 significance level except for the pooled subtable of ***Table 8b*** for frequency and choice of coverage after disenrollment.

Exhibit C-1. All Reasons Subtables with Statistically Significant Results (p ≤ .01)

Table in Appendix C	Plan Information		Getting Doctors		Getting Care		Particular Needs		Other Care or Service		Premiums		Copayments		Prescriptions	
	Pooled	Unpooled	Pooled	Unpooled	Pooled	Unpooled	Pooled	Unpooled	Pooled	Unpooled	Pooled	Unpooled	Pooled	Unpooled	Pooled	Unpooled
1a. Self-assessed health status	✓	✓			✓	✓	✓	✓	✓	✓			✓	✓	✓	✓
2a. 1-Year change in health status	✓	✓			✓	✓	✓	✓	✓	✓			✓	✓	✓	✓
3a. Combined health status & health status change	NA	✓	NA		NA	✓	NA	✓	NA	✓	NA		NA	✓	NA	✓
4a. Outpatient visits	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓
5a. Dual eligibility status	NA	✓	NA	✓	NA	✓	NA	✓	NA	✓	NA		NA		NA	
6a. Age	✓	✓			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
7a. Choice of coverage (pooled) and hospitalization after disenrollment to FFS (unpooled)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
8a. Frequency and choice of coverage after disenrollment		✓		✓		✓		✓		✓	✓	✓		✓		
9a. Length of time in plan	✓	✓	✓		✓	✓					✓	✓				
10a. Sampling quarter	NA	✓	NA	✓	NA	✓	NA	✓	NA	✓	NA	✓	NA	✓	NA	
11a. Race & ethnicity	✓	✓		✓	✓	✓	✓	✓	✓	✓		✓	✓	✓		
12a. Education		✓	✓	✓		✓	✓	✓			✓	✓			✓	
13a. Sex	NA		NA		NA		NA		NA		NA	✓	NA	✓	NA	

✓ = Indicates statistically significant results (p ≤ .01).

NA = There is no pooled version of this variable in the table.

Because of the large sample, many of the statistically significant differences found are of little importance because the difference is too small to be of any practical significance. We therefore follow basic social science survey conventions and only highlight in the tables significant differences of at least 10%. The shading in both table series highlights where statistically significant 10% differences exist. We refer to these as "meaningful differences" in the report.

Table 1a. Percent of All Reasons Cited by Self-assessed Health Status

All Reasons Cited by Voluntary Disenrollees
2000 Medicare CAHPS Disenrollment Reasons Survey Subgroup Results

All Reasons Cited (multiple responses possible)	Self-assessed Current Health Status (Q.58)							
		Pooled Responses		Responses				
	Total	Excellent to Good	Fair to Poor	Excellent	Very Good	Good	Fair	Poor
Unweighted sample size	28051	18469	9582	1843	6274	10352	7131	2451
Reasons Groupings								
Total Problems with Care or Service								
Problems with information from the plan	39	**36**	**46**	**30**	**33**	**38**	**45**	**50**
Problems getting doctors you want	42	41	43	40	42	41	43	42
Problems getting care	29	**26**	**36**	**22**	**25**	**27**	**34**	**42**
Problems getting particular needs met	24	**20**	**32**	**19**	**18**	**21**	**29**	**43**
Other problems with care or service	28	25	34	**23**	**26**	**25**	**33**	**39**
Total Concerns About Costs								
Premiums or copayments too high	55	55	55	58	56	54	56	54
Copayments increased and/or another plan offered better coverage	57	55	61	**48**	56	57	**61**	**63**
Problems getting or paying for prescription medicines	32	**29**	**39**	**26**	**25**	**32**	**38**	**43**

The unweighted sample size represents the actual number of survey respondents but the percents in the tables are based on weighted data.

Each column totals to more than 100% because respondents could cite reasons in more than one group.

Table 2a. Percent of All Reasons Cited by Self-assessed Health Status Now Compared to 1 year Ago

All Reasons Cited by Voluntary Disenrollees
2000 Medicare CAHPS Disenrollment Reasons Survey Subgroup Results

	Self-assessed Current Health Status Compared to 1 year Ago (Q.70)								
		Pooled Responses			Responses				
Reasons Cited as Most Important	**Total**	Better Now	About the Same	Worse Now	Much Better Now	Somewhat Better Now	About the Same	Somewhat Worse Now	Much Worse Now
Unweighted sample size	28011	4806	15970	7235	1964	2842	15970	5454	1781
Reasons Groupings									
Total Problems with Care or Service									
Problems with information from the plan	39	41	**35**	**47**	**39**	**42**	**35**	**44**	**58**
Problems getting doctors you want	42	43	41	44	42	44	41	43	46
Problems getting care	29	31	**25**	**37**	**30**	**32**	**25**	**33**	**48**
Problems getting particular needs met	24	27	**20**	**33**	**25**	**28**	**20**	**30**	**43**
Other problems with care or service	28	28	**25**	**35**	**26**	**30**	**25**	34	**41**
Total Concerns About Costs									
Premiums or copayments too high	55	54	56	53	57	52	56	54	51
Copayments increased and/or another plan offered better coverage	57	58	55	61	**54**	61	55	60	**64**
Problems getting or paying for prescription medicines	32	33	**29**	**39**	35	32	**29**	**39**	**39**

The unweighted sample size represents the actual number of survey respondents but the percents in the tables are based on weighted data.

Each column totals to more than 100% because respondents could cite reasons in more than one group.

Table 3a. Percent of All Reasons Cited by Health Status/Health Status Change

All Reasons Cited by Voluntary Disenrollees
2000 Medicare CAHPS Disenrollment Reasons Survey Subgroup Results

Reasons Cited as Most Important	Total	Combined Health Status and 1-Year Change in Health Status: Responses			
		Excellent to Good Health, Whose Health **Stayed the Same or Got Better** in Past Year	**Excellent to Good** Health, Whose Health **Worsened** in Past Year	**Fair or Poor** Health, Whose Health **Stayed the Same or Got Better** in Past Year	**Fair or Poor** Health, Whose Health **Worsened** in Past Year
Unweighted sample size	27622	16106	2104	4389	5023
Reasons Groupings					
Total Problems with Care or Service					
Problems with information from the plan	39	**34**	**44**	**44**	**49**
Problems getting doctors you want	42	41	44	41	44
Problems getting care	29	**25**	34	34	**38**
Problems getting particular needs met	24	**19**	27	**29**	**35**
Other problems with care or service	28	**24**	33	32	**37**
Total Concerns About Costs					
Premiums or copayments too high	55	56	49	55	56
Copayments increased and/or another plan offered better coverage	57	55	59	60	62
Problems getting or paying for prescription medicines	32	**28**	35	37	**41**

The unweighted sample size represents the actual number of survey respondents but the percents in the tables are based on weighted data.

Each column totals to more than 100% because respondents could cite reasons in more than one group.

Table 4a. Percent of All Reasons Cited by Number of Outpatient Visits in the 6 Months Before Leaving Plan

All Reasons Cited by Voluntary Disenrollees
2000 Medicare CAHPS Disenrollment Reasons Survey Subgroup Results

Reasons Cited as Most Important	Number of Outpatient Visits in the 6 Months Before Leaving Plan (Q.44)										
		Pooled Responses			Responses						
	Total	None	1-3	4 or more	None	1	2	3	4	5 to 9	10 or more
Unweighted sample size	25410	2933	12170	10307	2933	3290	4772	4108	3092	5049	2166
Reasons Groupings											
Total Problems with Care or Service											
Problems with information from the plan	40	**48**	**36**	42	**48**	**35**	**34**	39	43	41	**44**
Problems getting doctors you want	42	38	40	45	38	37	41	41	43	45	45
Problems getting care	29	30	25	34	30	25	**24**	27	33	**34**	**34**
Problems getting particular needs met	24	**18**	20	**29**	**18**	**20**	**17**	24	25	**29**	**32**
Other problems with care or service	28	33	26	30	33	**24**	**25**	29	28	28	**36**
Total Concerns About Costs											
Premiums or copayments too high	55	57	57	53	57	58	56	58	53	51	56
Copayments increased and/or another plan offered better coverage	57	52	56	61	**52**	**53**	**55**	58	61	59	**65**
Problems getting or paying for prescription medicines	33	**22**	31	**38**	**22**	**28**	**30**	**34**	**37**	**37**	**40**

The unweighted sample size represents the actual number of survey respondents but the percents in the tables are based on weighted data.

Each column totals to more than 100% because respondents could cite reasons in more than one group.

Table 5a. Percent of All Reasons Cited by Dually Eligible Status

All Reasons Cited by Voluntary Disenrollees
2000 Medicare CAHPS Disenrollment Reasons Survey Subgroup Results

	Dually Eligible		
		Responses	
Reasons Cited as Most Important	**Total**	Yes	No
Unweighted sample size	29309	3486	25823
Reasons Groupings			
Total Problems with Care or Service			
Problems with information from the plan	39	**49**	**38**
Problems getting doctors you want	42	36	43
Problems getting care	29	**38**	**28**
Problems getting particular needs met	24	**36**	**22**
Other problems with care or service	28	34	27
Total Concerns About Costs			
Premiums or copayments too high	55	58	54
Copayments increased and/or another plan offered better coverage	57	55	57
Problems getting or paying for prescription medicines	32	37	31

The unweighted sample size represents the actual number of survey respondents but the percents in the tables are based on weighted data.

Each column totals to more than 100% because respondents could cite reasons in more than one group.

Table 6a. Percent of All Reasons Cited by Age as Proxy for Medicare Eligibility Status

All Reasons Cited by Voluntary Disenrollees
2000 Medicare CAHPS Disenrollment Reasons Survey Subgroup Results

	Age (Q.71)							
		Pooled Responses		Responses				
Reasons Cited as Most Important	**Total**	64 or Younger (Proxy for Disabled)	65 or Older (Aged)	64 or Younger	65 to 69	70 to 74	75 to 79	80 or Older
Unweighted sample size	29309	3305	26004	3305	8110	7600	5481	4813
Reasons Groupings								
Total Problems with Care or Service								
Problems with information from the plan	39	**53**	**37**	**53**	**39**	**38**	**37**	**36**
Problems getting doctors you want	42	38	42	38	41	42	41	46
Problems getting care	29	37	28	**37**	**26**	29	29	31
Problems getting particular needs met	24	**37**	**23**	**37**	**21**	**23**	**22**	**25**
Other problems with care or service	28	33	27	33	27	25	29	28
Total Concerns About Costs								
Premiums or copayments too high	55	63	54	**63**	56	55	55	**48**
Copayments increased and/or another plan offered better coverage	57	65	56	**65**	58	57	56	**50**
Problems getting or paying for prescription medicines	32	**46**	**31**	**46**	**32**	**32**	**31**	**26**

The unweighted sample size represents the actual number of survey respondents but the percents in the tables are based on weighted data.

Each column totals to more than 100% because respondents could cite reasons in more than one group.

Table 7a. Percent of All Reasons Cited by Choice of Coverage and Hospitalization After Disenrollment

All Reasons Cited by Voluntary Disenrollees
2000 Medicare CAHPS Disenrollment Reasons Survey Subgroup Results

Reasons Cited as Most Important	Disenrolled to FFS	Disenrolled to MC	Disenrolled to FFS		Disenrolled to MC
			Hospitalized within 90 days	Not hospitalized within 90 days	
Unweighted sample size	15693	13274	428	15265	13274
Reasons Groupings					
Total Problems with Care or Service					
Problems with information from the plan	**49**	**32**	**55**	**49**	**32**
Problems getting doctors you want	47	38	**59**	**47**	**38**
Problems getting care	**37**	**24**	**52**	**36**	**24**
Problems getting particular needs met	29	20	**42**	**29**	**20**
Other problems with care or service	33	24	**40**	32	**24**
Total Concerns About Costs					
Premiums or copayments too high	52	57	**44**	52	**57**
Copayments increased and/or another plan offered better coverage	54	59	50	54	59
Problems getting or paying for prescription medicines	32	32	32	32	32

The unweighted sample size represents the actual number of survey respondents but the percents in the tables are based on weighted data.

Each column totals to more than 100% because respondents could cite reasons in more than one group.

Table 8a. Percent of All Reasons Cited by Frequency and Choice of Coverage After Disenrollment in 2000

All Reasons Cited by Voluntary Disenrollees
2000 Medicare CAHPS Disenrollment Reasons Survey Subgroup Results

	Frequency and Choice of Coverage After Disenrollment						
		Pooled Frequency		Disenrollment > 1		Disenrollment = 1	
Reasons Cited as Most Important	Total	2000 Disenrollment >1	2000 Disenrollment = 1	All to MC	All Other	To MC	To FFS
Unweighted sample size	28657	4177	24480	2490	1687	10639	13841
Reasons Groupings							
Total Problems with Care or Service							
Problems with information from the plan	39	39	39	**37**	**44**	**31**	**50**
Problems getting doctors you want	42	43	42	41	47	**38**	**48**
Problems getting care	29	29	29	**27**	**33**	**23**	**37**
Problems getting particular needs met	24	21	24	**19**	26	21	**30**
Other problems with care or service	28	29	27	30	29	**23**	**33**
Total Concerns About Costs							
Premiums or copayments too high	55	50	56	51	**47**	**59**	52
Copayments increased and/or another plan offered better coverage	57	54	57	56	51	59	54
Problems getting or paying for prescription medicines	32	32	32	30	35	33	31

The unweighted sample size represents the actual number of survey respondents but the percents in the tables are based on weighted data.

Each column totals to more than 100% because respondents could cite reasons in more than one group.

Table 9a. Percent of All Reasons Cited by Number of Months in Plan Before Leaving (Rapid versus Non-Rapid)

All Reasons Cited by Voluntary Disenrollees
2000 Medicare CAHPS Disenrollment Reasons Survey Subgroup Results

	Number of Months in Plan Before Leaving (Q.45)								
		Pooled Responses		Responses					
Reasons Cited as Most Important	Total	Rapid (5 months or less)	Non-Rapid (6 months or more)	1 Month or Less	2 Months	3 Months	4 Months	5 Months	6 Months or More
Unweighted sample size	26704	3709	22995	887	717	843	606	656	22995
Reasons Groupings									
Total Problems with Care or Service									
Problems with information from the plan	39	**66**	**36**	**72**	**71**	**70**	**63**	**53**	**36**
Problems getting doctors you want	42	46	41	47	48	49	50	39	41
Problems getting care	29	**40**	**28**	**34**	**43**	**41**	**46**	37	**28**
Problems getting particular needs met	24	27	23	21	30	28	22	31	23
Other problems with care or service	28	33	27	29	42	29	28	38	27
Total Concerns About Costs									
Premiums or copayments too high	56	**43**	**57**	**38**	**40**	**43**	**39**	**54**	**57**
Copayments increased and/or another plan offered better coverage	57	54	58	50	57	48	57	59	58
Problems getting or paying for prescription medicines	33	34	32	31	38	33	33	36	32

The unweighted sample size represents the actual number of survey respondents but the percents in the tables are based on weighted data.

Each column totals to more than 100% because respondents could cite reasons in more than one group.

Table 10a. Percent of All Reasons Cited by Sampling Quarter When Beneficiary Left Plan

All Reasons Cited by Voluntary Disenrollees
2000 Medicare CAHPS Disenrollment Reasons Survey Subgroup Results

Reasons Cited as Most Important	Combined Health Status and 1-Year Change in Health Status				
	Total	Responses			
		Jan. – Mar., 2000 1st Quarter	April – June, 2000 2nd Quarter	July – Sep., 2000 3rd Quarter	Oct. – Dec., 2000 4th Quarter
Unweighted sample size	29309	8104	7082	4965	9158
Reasons Groupings					
Total Problems with Care or Service					
Problems with information from the plan	39	40	**46**	**44**	**31**
Problems getting doctors you want	42	**37**	46	**50**	43
Problems getting care	29	29	32	35	26
Problems getting particular needs met	24	24	27	27	22
Other problems with care or service	28	28	32	**33**	**23**
Total Concerns About Costs					
Premiums or copayments too high	55	**58**	**49**	**41**	**59**
Copayments increased and/or another plan offered better coverage	57	59	57	53	55
Problems getting or paying for prescription medicines	32	32	34	33	31

The unweighted sample size represents the actual number of survey respondents but the percents in the tables are based on weighted data.

Each column totals to more than 100% because respondents could cite reasons in more than one group.

Table 11a. Percent of All Reasons Cited by Race and Ethnicity

All Reasons Cited by Voluntary Disenrollees
2000 Medicare CAHPS Disenrollment Reasons Survey Subgroup Results

		Race and Ethnicity (Q.74, Q. 75)					
		Pooled Responses		Responses			
Reasons Cited as Most Important	Total	Hispanic	Non-Hispanic	Hispanic	Non-Hispanic White	Non-Hispanic Black or African-American	Non-Hispanic Other
Unweighted sample size	29306	1760	27546	1760	23423	3221	902
Reasons Groupings							
Total Problems with Care or Service							
Problems with information from the plan	39	**49**	**38**	**49**	**36**	**50**	43
Problems getting doctors you want	42	39	42	39	44	35	36
Problems getting care	29	36	29	36	27	35	32
Problems getting particular needs met	24	31	23	31	22	30	25
Other problems with care or service	28	35	27	35	27	30	30
Total Concerns About Costs							
Premiums or copayments too high	55	51	55	**51**	**54**	58	**65**
Copayments increased and/or another plan offered better coverage	57	63	56	63	56	58	60
Problems getting or paying for prescription medicines	32	34	32	34	31	36	38

The unweighted sample size represents the actual number of survey respondents but the percents in the tables are based on weighted data.

Each column totals to more than 100% because respondents could cite reasons in more than one group.

Table 12a. Percent of All Reasons Cited by Education

All Reasons Cited by Voluntary Disenrollees
2000 Medicare CAHPS Disenrollment Reasons Survey Subgroup Results

	Highest Grade of School Completed (Q.73)							
		Pooled Responses		Responses				
Reasons Cited as Most Important	**Total**	Less Than High School Graduate	High School Graduate or More	8th Grade or Less	9th – 11th Grade	High School Graduate / GED	Some College / 2-Year Degree	Bachelor's Degree or More
Unweighted sample size	27360	8385	18975	3637	4748	9352	6064	3559
Reasons Groupings								
Total Problems with Care or Service								
Problems with information from the plan	39	41	38	44	39	35	40	41
Problems getting doctors you want	42	38	43	39	**37**	42	42	**47**
Problems getting care	29	30	29	33	27	26	30	34
Problems getting particular needs met	24	27	23	29	25	21	23	25
Other problems with care or service	28	30	27	31	29	26	28	29
Total Concerns About Costs								
Premiums or copayments too high	55	59	54	58	60	55	53	51
Copayments increased and/or another plan offered better coverage	57	58	57	58	59	55	59	58
Problems getting or paying for prescription medicines	32	35	31	35	35	30	33	31

The unweighted sample size represents the actual number of survey respondents but the percents in the tables are based on weighted data.

Each column totals to more than 100% because respondents could cite reasons in more than one group.

Table 13a. Percent of All Reasons Cited by Sex

All Reasons Cited by Voluntary Disenrollees
2000 Medicare CAHPS Disenrollment Reasons Survey Subgroup Results

	Sex (Q.72)		
		Responses	
Reasons Cited as Most Important	**Total**	Male	Female
Unweighted sample size	29309	12525	16784
Reasons Groupings			
Total Problems with Care or Service			
Problems with information from the plan	39	41	38
Problems getting doctors you want	42	40	43
Problems getting care	29	30	29
Problems getting particular needs met	24	25	23
Other problems with care or service	28	28	27
Total Concerns About Costs			
Premiums or copayments too high	55	57	53
Copayments increased and/or another plan offered better coverage	57	59	55
Problems getting or paying for prescription medicines	32	33	31

The unweighted sample size represents the actual number of survey respondents but the percents in the tables are based on weighted data.

Each column totals to more than 100% because respondents could cite reasons in more than one group.

Table 1b. Percent of Reasons Cited as Most Important by Self-assessed Health Status

Most Important Reasons Cited by Voluntary Disenrollees
2000 Medicare CAHPS Disenrollment Reasons Survey Subgroup Results

Reasons Cited as Most Important	Self-assessed Current Health Status (Q.58)							
		Pooled Responses		Responses				
	Total	Excellent to Good	Fair to Poor	Excellent	Very Good	Good	Fair	Poor
Unweighted sample size	25738	17079	8659	1713	5846	9520	6474	2185
Reason Groupings								
Total Problems with Care or Service								
Problems with information from the plan	8	8	8	6	8	8	8	9
Problems getting doctors you want	27	28	24	26	31	27	25	22
Problems getting care	7	6	8	4	5	7	8	9
Problems getting particular needs met	3	3	3	3	3	3	3	5
Other problems with care or service	5	4	5	6	4	4	5	5
Total Concerns About Costs								
Premiums or copayments too high	32	32	31	36	32	32	32	28
Copayments increased and/or another plan offered better coverage	10	10	10	8	11	9	10	12
Problems getting or paying for prescription medicines	10	10	10	10	7	11	9	11

The unweighted sample size represents the actual number of survey respondents but the percents in the tables are based on weighted data.

Each column totals to more than 100% because respondents could cite reasons in more than one group.

Table 2b. Percent of Reasons Cited as Most Important by Self-assessed Health Status Now Compared to 1 year Ago

Most Important Reasons Cited by Voluntary Disenrollees
2000 Medicare CAHPS Disenrollment Reasons Survey Subgroup Results

	Self-assessed Current Health Status Compared to 1 year Ago (Q.70)								
		Pooled Responses			Responses				
Reasons Cited as Most Important	Total	Better Now	About the Same	Worse Now	Much Better Now	Somewhat Better Now	About the Same	Somewhat Worse Now	Much Worse Now
Unweighted sample size	25702	4402	14795	6505	1815	2587	14795	4944	1561
Reason Groupings									
Total Problems with Care or Service									
Problems with information from the plan	8	8	8	9	9	7	8	9	9
Problems getting doctors you want	27	28	28	24	28	29	28	24	25
Problems getting care	7	6	6	10	7	5	6	9	10
Problems getting particular needs met	3	4	2	4	3	4	2	4	6
Other problems with care or service	4	4	4	5	3	5	4	5	6
Total Concerns About Costs									
Premiums or copayments too high	31	28	34	28	28	28	34	29	25
Copayments increased and/or another plan offered better coverage	10	11	9	10	9	12	9	10	11
Problems getting or paying for prescription medicines	10	11	9	10	13	10	9	10	8

The unweighted sample size represents the actual number of survey respondents but the percents in the tables are based on weighted data.

Each column totals to more than 100% because respondents could cite reasons in more than one group.

Table 3b. Percent of Reasons Cited as Most Important by Health Status/Health Status Change

Most Important Reasons Cited by Voluntary Disenrollees
2000 Medicare CAHPS Disenrollment Reasons Survey Subgroup Results

Reasons Cited as Most Important	Combined Health Status and 1-Year Change in Health Status				
		Responses			
	Total	**Excellent to Good** Health, Whose Health **Stayed the Same or Got Better** in Past Year	**Excellent to Good** Health, Whose Health **Worsened** in Past Year	**Fair or Poor** Health, Whose Health **Stayed the Same or Got Better** in Past Year	**Fair or Poor** Health, Whose Health **Worsened** in Past Year
Unweighted sample size	25364	14945	1907	4004	4508
Reason Groupings					
Total Problems with Care or Service					
Problems with information from the plan	8	8	7	8	9
Problems getting doctors you want	27	28	27	26	23
Problems getting care	7	5	11	7	9
Problems getting particular needs met	3	3	3	3	4
Other problems with care or service	4	4	6	5	5
Total Concerns About Costs					
Premiums or copayments too high	32	33	26	32	29
Copayments increased and/or another plan offered better coverage	10	10	10	10	10
Problems getting or paying for prescription medicines	10	10	10	10	10

The unweighted sample size represents the actual number of survey respondents but the percents in the tables are based on weighted data.

Each column totals to more than 100% because respondents could cite reasons in more than one group.

Table 4b. Percent of Reasons Cited as Most Important by Number of Outpatient Visits in the 6 Months Before Leaving Plan

Most Important Reasons Cited by Voluntary Disenrollees
2000 Medicare CAHPS Disenrollment Reasons Survey Subgroup Results

	Number of Outpatient Visits in the 6 Months Before Leaving Plan (Q.44)										
		Pooled Responses			Responses						
Reasons Cited as Most Important	Total	None	1-3	4 or more	None	1	2	3	4	5 to 9	10 or more
Unweighted sample size	23340	2718	11256	9366	2718	3082	4418	3756	2812	4594	1960
Reason Groupings											
Total Problems with Care or Service											
Problems with information from the plan	8	10	8	8	10	8	7	9	8	8	8
Problems getting doctors you want	27	21	27	28	21	25	28	27	28	28	26
Problems getting care	6	7	6	7	7	5	6	5	7	7	6
Problems getting particular needs met	3	3	3	3	3	3	2	2	4	3	4
Other problems with care or service	5	6	4	5	6	4	4	5	4	5	6
Total Concerns About Costs											
Premiums or copayments too high	32	34	35	27	34	**39**	34	33	**28**	**26**	**29**
Copayments increased and/or another plan offered better coverage	10	14	9	10	14	8	9	8	11	10	10
Problems getting or paying for prescription medicines	10	6	9	12	6	7	9	11	11	13	11

The unweighted sample size represents the actual number of survey respondents but the percents in the tables are based on weighted data.

Each column totals to more than 100% because respondents could cite reasons in more than one group.

Table 5b. Percent of Reasons Cited as Most Important by Dually Eligible Status

Most Important Reasons Cited by Voluntary Disenrollees
2000 Medicare CAHPS Disenrollment Reasons Survey Subgroup Results

	Dually Eligible		
		Responses	
Reasons Cited as Most Important	**Total**	Yes	No
Unweighted sample size	26838	3168	23670
Reason Groupings			
Total Problems with Care or Service			
Problems with information from the plan	8	11	8
Problems getting doctors you want	27	**16**	**29**
Problems getting care	7	7	7
Problems getting particular needs met	3	4	3
Other problems with care or service	5	6	4
Total Concerns About Costs			
Premiums or copayments too high	31	34	31
Copayments increased and/or another plan offered better coverage	10	12	10
Problems getting or paying for prescription medicines	10	11	9

The unweighted sample size represents the actual number of survey respondents but the percents in the tables are based on weighted data.

Each column totals to more than 100% because respondents could cite reasons in more than one group.

Table 6b. Percent of Reasons Cited as Most Important by Age as Proxy for Medicare Eligibility Status

Most Important Reasons Cited by Voluntary Disenrollees
2000 Medicare CAHPS Disenrollment Reasons Survey Subgroup Results

	Age (Q.71)							
		Pooled Responses		Responses				
Reasons Cited as Most Important	**Total**	64 or Younger (Proxy for Disabled)	65 or Older (Aged)	64 or Younger	65 to 69	70 to 74	75 to 79	80 or Older
Unweighted sample size	26838	3016	23822	3016	7456	6964	5010	4392
Reason Groupings								
Total Problems with Care or Service								
Problems with information from the plan	8	10	8	10	8	8	8	7
Problems getting doctors you want	27	19	28	**19**	26	**29**	27	**30**
Problems getting care	7	6	7	6	6	6	7	8
Problems getting particular needs met	3	3	3	3	2	3	3	4
Other problems with care or service	5	2	5	2	4	4	6	6
Total Concerns About Costs								
Premiums or copayments too high	31	35	31	35	33	31	32	28
Copayments increased and/or another plan offered better coverage	10	11	10	11	11	9	8	10
Problems getting or paying for prescription medicines	10	14	9	14	9	11	9	6

The unweighted sample size represents the actual number of survey respondents but the percents in the tables are based on weighted data.

Each column totals to more than 100% because respondents could cite reasons in more than one group.

Table 7b. Percent of Reasons Cited as Most Important by Choice of Coverage and Hospitalization After Disenrollment

Most Important Reasons Cited by Voluntary Disenrollees
2000 Medicare CAHPS Disenrollment Reasons Survey Subgroup Results

Reasons Cited as Most Important	Disenrolled to FFS	Disenrolled to MC	Disenrolled to FFS		Disenrolled to MC
			Hospitalized within 90 days	Not hospitalized within 90 days	
Unweighted sample size	14318	12213	376	13942	12213
Reason Groupings					
Total Problems with Care or Service					
Problems with information from the plan	10	7	11	10	7
Problems getting doctors you want	27	27	28	27	27
Problems getting care	9	5	9	9	5
Problems getting particular needs met	3	3	5	3	3
Other problems with care or service	4	5	3	4	5
Total Concerns About Costs					
Premiums or copayments too high	30	32	**22**	31	**32**
Copayments increased and/or another plan offered better coverage	10	9	11	10	9
Problems getting or paying for prescription medicines	6	12	11	6	12

The unweighted sample size represents the actual number of survey respondents but the percents in the tables are based on weighted data.

Each column totals to more than 100% because respondents could cite reasons in more than one group.

Table 8b. Percent of Reasons Cited as Most Important by Frequency and Choice of Coverage After Disenrollment in 2000

Most Important Reasons Cited by Voluntary Disenrollees
2000 Medicare CAHPS Disenrollment Reasons Survey Subgroup Results

	Frequency and Choice of Coverage After Disenrollment						
		Pooled Frequency		Disenrollment > 1		Disenrollment = 1	
Reasons Cited as Most Important	Total	2000 Disenrollment >1	2000 Disenrollment = 1	All to MC	All Other	To MC	To FFS
Unweighted sample size	26258	3868	22390	2303	1565	9775	12615
Reason Groupings							
Total Problems with Care or Service							
Problems with information from the plan	8	8	8	8	8	6	10
Problems getting doctors you want	27	29	27	28	30	27	27
Problems getting care	7	7	6	6	8	5	9
Problems getting particular needs met	3	3	3	2	4	3	3
Other problems with care or service	5	6	4	7	5	5	4
Total Concerns About Costs							
Premiums or copayments too high	31	29	32	29	28	33	31
Copayments increased and/or another plan offered better coverage	10	9	10	9	9	10	11
Problems getting or paying for prescription medicines	10	9	10	10	8	12	6

The unweighted sample size represents the actual number of survey respondents but the percents in the tables are based on weighted data.

Each column totals to more than 100% because respondents could cite reasons in more than one group.

Table 9b. Percent of Reasons Cited as Most Important by Number of Months in Plan Before Leaving (Rapid versus Non-Rapid)

Most Important Reasons Cited by Voluntary Disenrollees
2000 Medicare CAHPS Disenrollment Reasons Survey Subgroup Results

	Number of Months in Plan Before Leaving (Q.45)								
		Pooled Responses		Responses					
Reasons Cited as Most Important	Total	Rapid (5 months or less)	Non-Rapid (6 months or more)	1 Month or Less	2 Months	3 Months	4 Months	5 Months	6 Months or More
Unweighted sample size	24768	3401	21367	812	672	774	568	575	21367
Reason Groupings									
Total Problems with Care or Service									
Problems with information from the plan	8	14	7	14	12	**17**	**18**	10	**7**
Problems getting doctors you want	27	28	27	**31**	**33**	**31**	**22**	**21**	**27**
Problems getting care	7	7	7	7	8	5	13	5	7
Problems getting particular needs met	3	3	3	2	3	4	1	3	3
Other problems with care or service	5	7	4	8	6	5	9	9	4
Total Concerns About Costs									
Premiums or copayments too high	32	**20**	**33**	**18**	**13**	**22**	**18**	**31**	**33**
Copayments increased and/or another plan offered better coverage	10	10	10	11	10	8	7	13	10
Problems getting or paying for prescription medicines	10	10	10	9	14	8	11	9	10

The unweighted sample size represents the actual number of survey respondents but the percents in the tables are based on weighted data.

Each column totals to more than 100% because respondents could cite reasons in more than one group.

Table 10b. Percent of Reasons Cited as Most Important by Sampling Quarter When Beneficiary Left Plan

Most Important Reasons Cited by Voluntary Disenrollees
2000 Medicare CAHPS Disenrollment Reasons Survey Subgroup Results

Reasons Cited as Most Important	Combined Health Status and 1-Year Change in Health Status				
	Total	Responses			
		Jan. – Mar., 2000 1st Quarter	April – June, 2000 2nd Quarter	July – Sep., 2000 3rd Quarter	Oct. – Dec., 2000 4th Quarter
Unweighted sample size	26838	7505	6385	4557	8391
Reason Groupings					
Total Problems with Care or Service					
Problems with information from the plan	8	8	8	10	7
Problems getting doctors you want	27	24	28	31	29
Problems getting care	7	5	9	10	6
Problems getting particular needs met	3	3	3	5	3
Other problems with care or service	5	5	6	5	3
Total Concerns About Costs					
Premiums or copayments too high	31	**35**	**25**	**19**	**36**
Copayments increased and/or another plan offered better coverage	10	11	10	11	8
Problems getting or paying for prescription medicines	10	10	12	8	8

The unweighted sample size represents the actual number of survey respondents but the percents in the tables are based on weighted data.

Each column totals to more than 100% because respondents could cite reasons in more than one group.

Table 11b. Percent of Reasons Cited as Most Important by Race and Ethnicity

Most Important Reasons Cited by Voluntary Disenrollees
2000 Medicare CAHPS Disenrollment Reasons Survey Subgroup Results

Reasons Cited as Most Important	Total	Race and Ethnicity (Q.74, Q. 75)					
		Pooled Responses		Responses			
		Hispanic	Non-Hispanic	Hispanic	Non-Hispanic White	Non-Hispanic Black or African-American	Non-Hispanic Other
Unweighted sample size	26835	1601	25234	1601	21524	2889	821
Reason Groupings							
Total Problems with Care or Service							
Problems with information from the plan	8	10	8	10	8	10	7
Problems getting doctors you want	27	20	28	20	**29**	**18**	**18**
Problems getting care	7	8	6	8	6	7	8
Problems getting particular needs met	3	3	3	3	3	3	3
Other problems with care or service	5	9	4	9	4	6	5
Total Concerns About Costs							
Premiums or copayments too high	31	26	32	26	32	34	34
Copayments increased and/or another plan offered better coverage	10	14	9	14	9	12	9
Problems getting or paying for prescription medicines	10	10	9	10	9	10	16

The unweighted sample size represents the actual number of survey respondents but the percents in the tables are based on weighted data.

Each column totals to more than 100% because respondents could cite reasons in more than one group.

Table 12b. Percent of Reasons Cited as Most Important by Education

Most Important Reasons Cited by Voluntary Disenrollees
2000 Medicare CAHPS Disenrollment Reasons Survey Subgroup Results

Reasons Cited as Most Important	Highest Grade of School Completed (Q.73)							
		Pooled Responses		Responses				
	Total	Less Than High School Graduate	High School Graduate or More	8th Grade or Less	9th – 11th Grade	High School Graduate / GED	Some College / 2-Year Degree	Bachelor's Degree or More
Unweighted sample size	25131	7619	17512	3276	4343	8671	5601	3240
Reason Groupings								
Total Problems with Care or Service								
Problems with information from the plan	8	8	8	8	8	7	9	10
Problems getting doctors you want	26	22	28	22	23	28	28	28
Problems getting care	7	6	7	5	6	7	7	7
Problems getting particular needs met	3	3	3	3	3	3	3	3
Other problems with care or service	4	6	4	7	6	4	4	4
Total Concerns About Costs								
Premiums or copayments too high	32	34	31	32	35	33	29	30
Copayments increased and/or another plan offered better coverage	10	11	9	13	10	9	10	10
Problems getting or paying for prescription medicines	10	10	10	10	10	10	11	8

The unweighted sample size represents the actual number of survey respondents but the percents in the tables are based on weighted data.

Each column totals to more than 100% because respondents could cite reasons in more than one group.

Table 13b. Percent of Reasons Cited as Most Important by Sex

Most Important Reasons Cited by Voluntary Disenrollees
2000 Medicare CAHPS Disenrollment Reasons Survey Subgroup Results

	Sex (Q.72)		
		Responses	
Reasons Cited as Most Important	**Total**	Male	Female
Unweighted sample size	26838	11386	15452
Reason Groupings			
Total Problems with Care or Service			
Problems with information from the plan	8	8	8
Problems getting doctors you want	27	25	28
Problems getting care	7	6	7
Problems getting particular needs met	3	3	3
Other problems with care or service	5	4	5
Total Concerns About Costs			
Premiums or copayments too high	31	33	30
Copayments increased and/or another plan offered better coverage	10	11	9
Problems getting or paying for prescription medicines	10	9	10

The unweighted sample size represents the actual number of survey respondents but the percents in the tables are based on weighted data.

Each column totals to more than 100% because respondents could cite reasons in more than one group.