The Medicare CAHPS®
Disenrollment Reasons Survey:
A Summary of Findings Across Survey Years 2000–2003

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Conducted by University of Wisconsin-Madison and
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*RTI International is a trade name of Research Triangle Institute.

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Overview of the Medicare CAHPS® Disenrollment Reasons Survey

The Centers for Medicare & Medicaid Services (CMS) funds the annual implementation of the Medicare CAHPS® Disenrollment Reasons Survey (hereafter called the Reasons Survey) to identify the reasons beneficiaries voluntarily leave their Medicare Advantage (MA) health plans. The primary goals of the Reasons Survey are to:

- Provide Medicare beneficiaries and the general public with information about the comparative performance of MA health plans to help them make more informed health plan choices.
- Assist MA plans in identifying areas where they might focus their quality improvement activities.
- Enhance CMS' ability to monitor quality of care and performance of MA health plans.

Unlike the privately insured, who can usually only switch plans once per year, Medicare beneficiaries who choose to enroll in a private MA plan need only stay in that plan for a minimum of one month. "Voluntary" disenrollment is an important outcome because it may reflect member satisfaction or plan quality (U.S. GAO, 1996; U.S. GAO, 1997; U.S. GAO, 1998; Buchmueller, 2000). Alternatively, voluntary disenrollment may reflect the availability of other plans with preferred characteristics such as lower premiums or better benefits or greater choice of providers. With the continued emphasis in the 2003 Medicare Modernization Act (MMA) on providing private health plan options for Medicare beneficiaries, understanding the determinants of consumers' choices among competing health plans remains an important topic.

The University of Wisconsin and RTI International (RTI) conducted the Medicare CAHPS Disenrollment Reasons Survey for CMS in each year 2000, 2001, 2002 and 2003 under CMS Contract No. 500-900-0061-TO#5. The target population for the annual Reasons Survey consists of Medicare beneficiaries who voluntarily leave their MA organizations and continuing cost contracts during the calendar year. Although data are analyzed and reported on an annual basis, the Reasons Survey is conducted on a quarterly basis to determine the *reasons* Medicare beneficiaries leave their MA plans. A sample of Medicare beneficiaries who disenroll during one quarter is selected at the beginning of the next quarter, with data collection taking place over the next 4 months. The Reasons Survey is administered as a mail survey with telephone follow-up of nonrespondents.

The Reasons Survey is designed to collect information about the reasons why sample members leave their former MA health care plan. The survey questionnaire used in each survey contained a core set of questions designed to identify reasons Medicare

beneficiaries chose to disenroll from their MA plans. However, the questionnaire received minor revisions prior to almost each of the survey years. The 2003 questionnaire contained 80 questions, with topics as follows:

- Four screening questions to verify that the respondents were voluntary disenrollees.
- Thirty-seven questions about reasons for leaving the health plan, including 33 preprinted reasons, one open-ended question about any other reasons for leaving, and one open-ended question that asked for the most important reason (MIR) for leaving the plan.
- Seven questions asking the respondent to rate the sample health plan and about the care received from that plan and the experience with that plan.
- Ten questions about the appeal process.
- Twenty-two questions about health status and demographic characteristics.

There are 33 preprinted reason questions in the survey. Respondents can choose as many of these reasons as desired. The MIR question for leaving the plan is asked at the end of the set of preprinted reasons questions. The top six reasons are derived from respondents' answers to the 33 preprinted reasons questions. The six reasons with the greatest proportion of beneficiaries citing them in the calendar year are designated as the top six (Preprinted) Reasons.

The survey instrument was designed to identify sample members who are considered "involuntary" disenrollees and exclude them from the analysis. Deceased and institutionalized sample members were ineligible for the Reasons Survey. Disenrollees who reported that they left the survey for any of the following reasons were ineligible for the survey:

- Never left the MA plan for any length of time during the survey year.
- Moved out of the area where the MA plan was available.
- MA plan stopped serving Medicare beneficiaries in the sample member's area.
- Enrolled in the plan without his or her knowledge (for example, by a salesperson or family member).
- Accidentally disenrolled from the plan (for example, due to a paperwork or clerical error).

The telephone survey instrument was designed to mirror the mail survey instrument as closely as possible and was conducted using computer-assisted telephone interviewing (CATI). Both the mail and telephone survey instruments were customized so that they were plan-specific for each respondent. The survey instruments were also translated into Spanish and were available upon request, as either a hard copy questionnaire or as a Spanish-language telephone interview.

In each survey year, data from the Reasons Survey are analyzed and the results reported to CMS and the public on the Medicare.gov web site. In addition, comparative plan information is reported to each sample plan included in the survey via Annual MA Health Plan Reports. In addition, in the 2001 and 2002 survey years, reports were prepared and distributed to Medicare Quality Improvement Organizations (QIOs). Starting with the 2003 Reasons Survey, an Annual Report was prepared and distributed to each CMS Regional Office. When analyzing and reporting the results, individual survey responses to both the preprinted (All) reasons were assigned to a set of eight general categories of reasons for leaving. The Most Important Reason responses were also grouped into these same eight categories. These eight categories or "reason groupings" (and the abbreviated labels used in this report to refer to these groupings) are as follows:

- Problems with information from the plan (Plan Information).
- Problems getting doctors you want (Doctor Access).
- Problems getting care (Care Access).
- Problems getting particular needs met (Specific Needs).
- Other problems with care or service (Other Care or Service).
- Premiums or copayments too high (Premium/Costs).
- Copayments increased and/or another plan offered better coverage (Copayments/Coverage).
- Problems getting or paying for prescription medicines (Drug Coverage).

Purpose of this Report

In addition to analyzing data for comparative plan information reported to consumers, health plans and to the public, project staff also conducted quantitative analysis of the data in each survey year 2000, 2001, and 2002 to examine reasons for leaving MA plans among various subgroups of the disenrollee population. The results from the analysis of data from those survey years were reported to CMS in a subgroup analysis report for each survey year (a list of those reports is included in ***Appendix B.)*** For the 2003 Reasons Survey, CMS requested some qualitative data collection and analyses be conducted with MA plan disenrollees to augment and further understand some of the results observed from the quantitative analysis. A report on the methods and results of the qualitative activity is described in the *2003 Medicare CAHPS Disenrollment Reasons Survey: A Qualitative Assessment* which was submitted to CMS in June 2005.

Based on the 2000–2003 estimates from CMS' administrative data and the Reasons Survey, the national voluntary disenrollment rate from MA plans remained relatively stable between 2000 and 2002, decreasing slightly from 11 to 10 percent. In 2003, the national voluntary disenrollment rate dropped to 8 percent, but this drop may be partly due to a change in the way the rates are adjusted to account for people who move out of a plan's service area. We conducted some very limited descriptive analysis of the data from the 2003 survey. The aim of the analysis conducted on the 2003 Reasons Survey data and described in this report is to better understand the determinants of the disenrollment rate and to provide information about any emerging trends over the period 2000–2003 based on analysis of Reasons Survey data.

This report is divided into the following four sections, as noted below. The following contains some of the highlights of information presented in each section.

Survey Summary

Charts in this section show some basic information about the survey, such as the number of MA plans represented in each survey year, the response rates in each survey year, and characteristics of the survey sample. Findings include:

- The number of MA plans from which survey respondents disenrolled during each of 4 survey years decreased from 2000 to 2003 (Chart 1-1).

- The annual response rate for the CAHPS disenrollment survey did not fluctuate much, at about 65 percent across each of the 4 years (Chart 1-2).

- Respondent characteristics are comparable across years (Chart 1-3). However, respondents with disabilities (defined as sample members under age 65) were more likely to be in poor health, have dual eligibility status, be rapid disenrollees, and be more frequent outpatient visitors in 2003 than respondents 65 years old and older. They were also more likely to enroll in Original Medicare after disenrolling from the sample MA plan (Chart 1-4).

Specific Reasons for Disenrollment

- The most frequently cited (top six) preprinted reasons from 2001–2003 addressed concerns about plan costs (premiums in particular), coverage, and which doctors are included (Chart 2-2). This was also true for the most frequently cited MIR reasons (Chart 2-6). "The plan didn't include the doctors (Doctor Access)" was the only non-cost/benefit-related reason which stayed in the top six reasons from 2001 to 2003. More respondents changed their reasons for disenrolling from doctor access to cost and benefits over the 4 survey years. The top six MIRs showed a similar trend as the top six preprinted reasons.

- One-time switchers were more likely to blame the increase in the monthly premium and office visit copayment as their reason for leaving their plan than multiple-time switchers (Chart 2-4).

Reason Groups and Patterns

- The All Reason groups (based on responses to the preprinted reason and the open-ended "other" reason questions) most frequently cited by disenrollees were premiums/costs and copayments/coverage (Chart 3-2). The proportion of beneficiaries who cited a reason in the "Doctor Access" group as their reason (or MIR) for disenrollment decreased over time (Charts 3-1, 3-2).

- "Doctor Access Only" was the most prevalent reason group for beneficiaries citing only reason(s) in that group, between 2000 and 2002. Reasons related to the premium and copayment increased over time. In 2003, these became the most prevalent solely-cited reasons (Chart 3-4).

Reasons cited by beneficiaries with disabilities (sample members under 65 years of age)

- The top six reasons given for disenrollment by the (under age 65) beneficiaries with disabilities mirrored those reported by the respondents as a whole: "another plan offered better benefits" and "another plan cost less" were consistently the reasons given most frequently for disenrollment over time (Chart 4-2).

- The reason "monthly premium increased" for beneficiaries with disabilities was the top reason in 2001 but fell to fourth most important by 2003 (Chart 4-1). More beneficiaries with disabilities reported concerns about premium- and copayment-related issues than the sample as a whole, suggesting that this subgroup was vulnerable to income-related reasons for disenrollment. At the same time, the beneficiaries with disabilities were more likely to cite multiple problems than sample members who were age 65 and older (Chart 4-3).

Reviewers should note that in this report we refer to the reasons that beneficiaries voluntarily disenroll in several ways. "Preprinted reasons" or "33 preprinted reasons" refer to beneficiary responses to the 33 preprinted reasons questions in the survey. The preprinted reasons are also referred to as "All Reasons" to distinguish them from a construct created from one particular survey item, where beneficiaries are asked to state which of the 33 preprinted reasons (or to write in a reason if it isn't among the 33 listed) was the Most Important Reason for leaving their health plan. As indicated, the All Reasons and the Most Important Reasons are grouped into eight broader categories for reporting to Medicare beneficiaries, to CMS and to MA plans. We also use these broader groups in the analysis of broader trends which is the basis of the information in this report. In this report the term 'patterns' indicates the results of the analysis of the propensity for respondents to cite only preprinted reasons in one of the eight broader reason groups (i.e. all of the reasons cited by a respondent are within a specific reason group) and how this propensity changes over time.

1. Survey Summary

General Survey Information

- The number of MA plans whose disenrollees were surveyed decreased steadily over the years 2000 to 2003 (Chart 1-1).
- The annual response rate for the CAHPS disenrollment survey did not fluctuate much in the first 4 years the survey was implemented, remaining at about 65 percent across the 4 years (Chart 1-2).
- Respondent characteristics were comparable across years (Chart 1-3).
- Disenrollees whose health was worse or had worsened in the past year, who were African American, and who had disabilities (under age 65) were disproportionately going to FFS after leaving their MA plans (Chart 1-4).

Chart 1-1

Number of MA plans in the Reasons Survey, 2000–2003

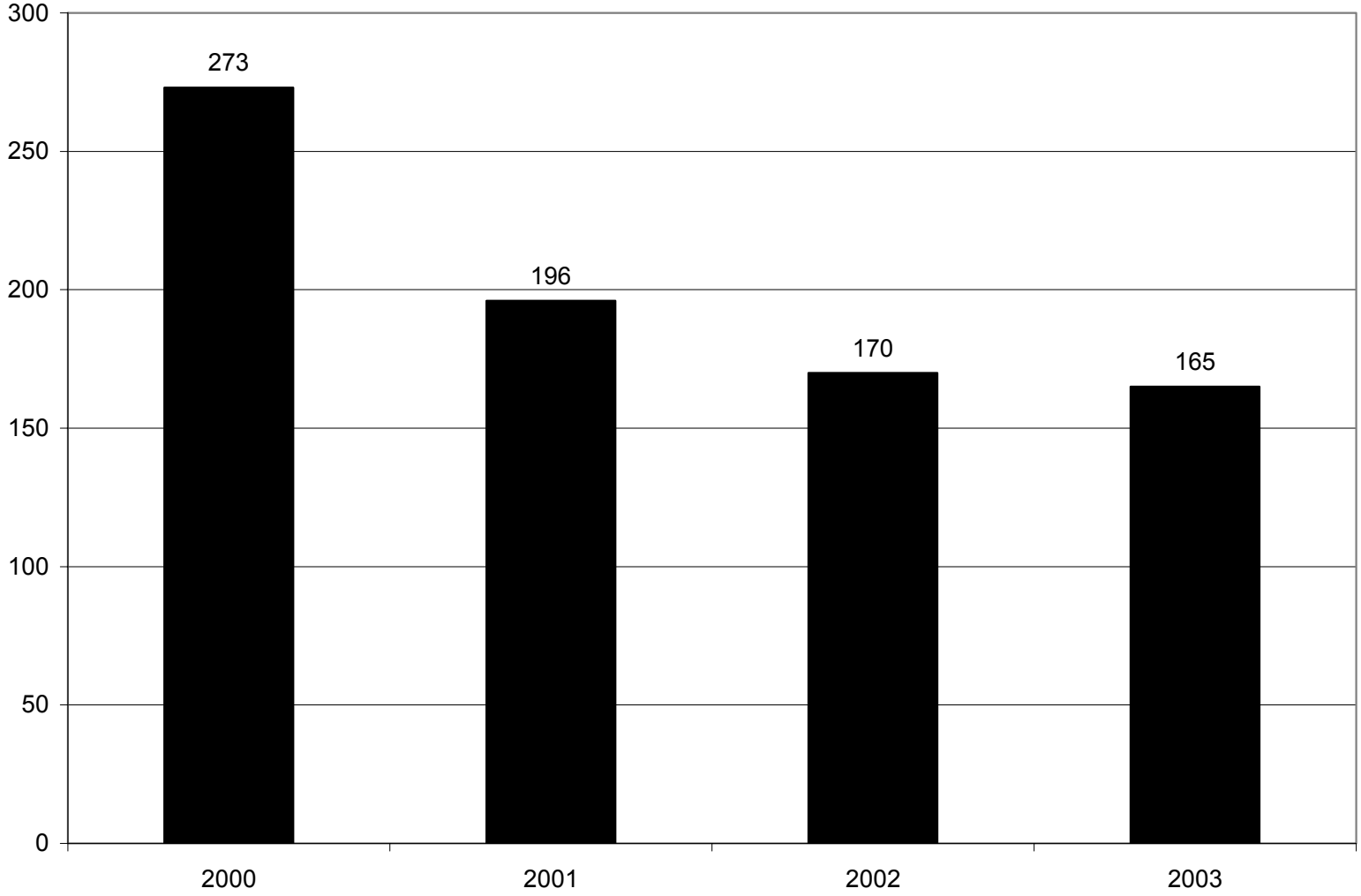


Chart 1-2

Annual response rates for the Reasons Survey, 2000–2003

- Annual response rates remained relatively stable, at around 65 percent between 2000 and 2003.

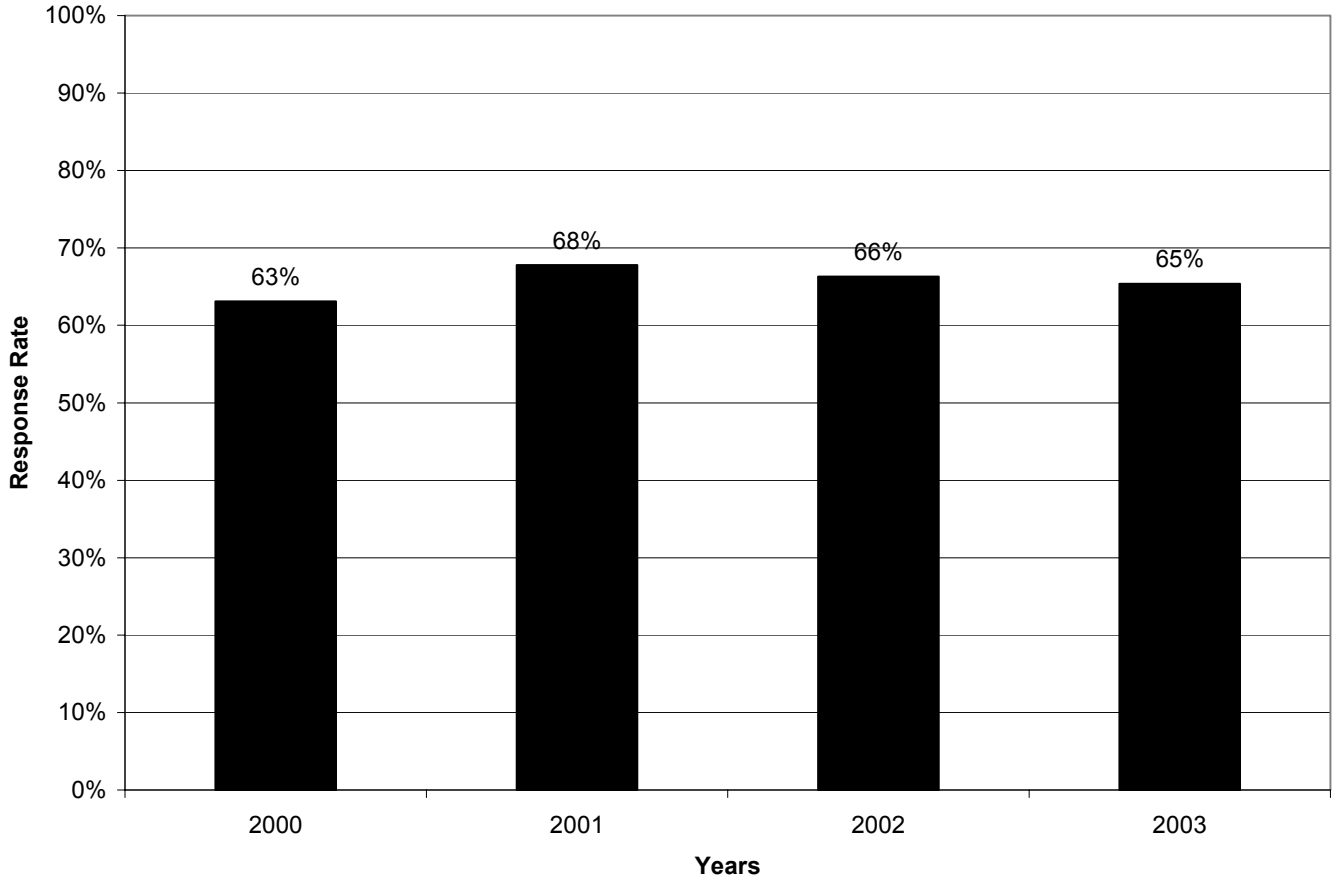


Chart 1-3

Description of beneficiaries in sample in 2001, 2002, and 2003

- Beneficiary characteristics were comparable over the years 2001 to 2003.
- Respondents with fair to poor health represented about 30 percent of each annual sample, those with dual eligibility status represented less than 18 percent of each annual sample, rapid disenrollees were about 10 percent of each sample, those citing problems getting care were around 17 percent of the sample, and non-Hispanic Caucasians were about 30 percent of each annual sample.

Chart 1-3

Selected characteristics of the survey sample in 2001, 2002, and 2003

Variable	Disenrollment weighted percentage, 2001	Disenrollment weighted percentage, 2002	Disenrollment weighted percentage, 2003
Health Status			
Self-assessed health status			
Excellent	8	9	7
Very good	27	27	21
Good	35	34	33
Fair	23	23	26
Poor	7	6	8
Self-assessed health status compared with 1 year ago			
Better now	19	22	19
About the same	58	58	55
Worse now	23	20	21
Combined health status and 1-year health status change			
Excellent to good health that is same or better	63	65	55
Excellent to good health that is worse	7	6	5
Fair or poor health that is same or better	15	15	18
Fair or poor health that is worse	15	14	16

Chart 1-3

Selected characteristics of the survey sample in 2001, 2002, and 2003 (continued)

Variable	Disenrollment weighted percentage, 2001	Disenrollment weighted percentage, 2002	Disenrollment weighted percentage, 2003
Number of outpatient visits in the 6 months before disenrollment			
None	11	10	10
1 to 3	49	44	39
4 or more	40	46	39
Dually Eligible for Medicare and Medicaid			
Yes	15	15	17
No	85	85	83
Choice of coverage after disenrollment			
Another managed care plan	46	50	54
Fee for service	54	50	46
Length of time in MA plan before disenrollment			
Less than 6 months	11	9	10
6 months or more	89	91	82
Sampling quarter when disenrollee left plan			
1st: January–March 2002	26	28	27
2nd: April–June 2002	20	19	20
3rd: July–September 2002	17	15	16
4th: October–December 2002	37	38	37
Got new personal doctor in Sample Plan?			
Yes	37	33	31
No	63	67	63

Chart 1-3

Selected characteristics of the survey sample in 2001, 2002, and 2003 (continued)

Variable	Disenrollment weighted percentage, 2001	Disenrollment weighted percentage, 2002	Disenrollment weighted percentage, 2003
Proxy interview?			
Yes	7	7	3
No	93	93	97
Problems getting care			
Yes	18	15	17
No	82	85	79
Satisfaction with plan			
0—worst	6	5	5
1	2	2	2
2	3	4	3
3	4	5	4
4	5	5	5
5	17	16	14
6	7	7	6
7	9	10	9
8	17	17	16
9	9	10	9
10—best	20	18	16

Chart 1-3

Selected characteristics of the survey sample in 2001, 2002, and 2003 (continued)

Variable	Disenrollment weighted percentage, 2001	Disenrollment weighted percentage, 2002	Disenrollment weighted percentage, 2003
Sociodemographic characteristics			
Race and ethnicity			
Hispanic	11	13	15
Non-Hispanic Caucasians	74	71	68
Non-Hispanic black or African American	11	11	12
Non-Hispanic other	5	5	4
Education			
8th grade or less	12	13	13
9th–11th grade	16	17	15
High school graduate/GED	32	32	30
Some college/2-year degree	24	25	22
Bachelor's degree or more	15	14	13
Gender			
Male	44	43	43
Female	56	57	57
Age			
64 or younger (nonelderly beneficiaries with disabilities)	10	10	10
65 to 69	25	22	23
70 to 74	27	27	25
75 to 79	20	21	21
80 or older	18	20	21

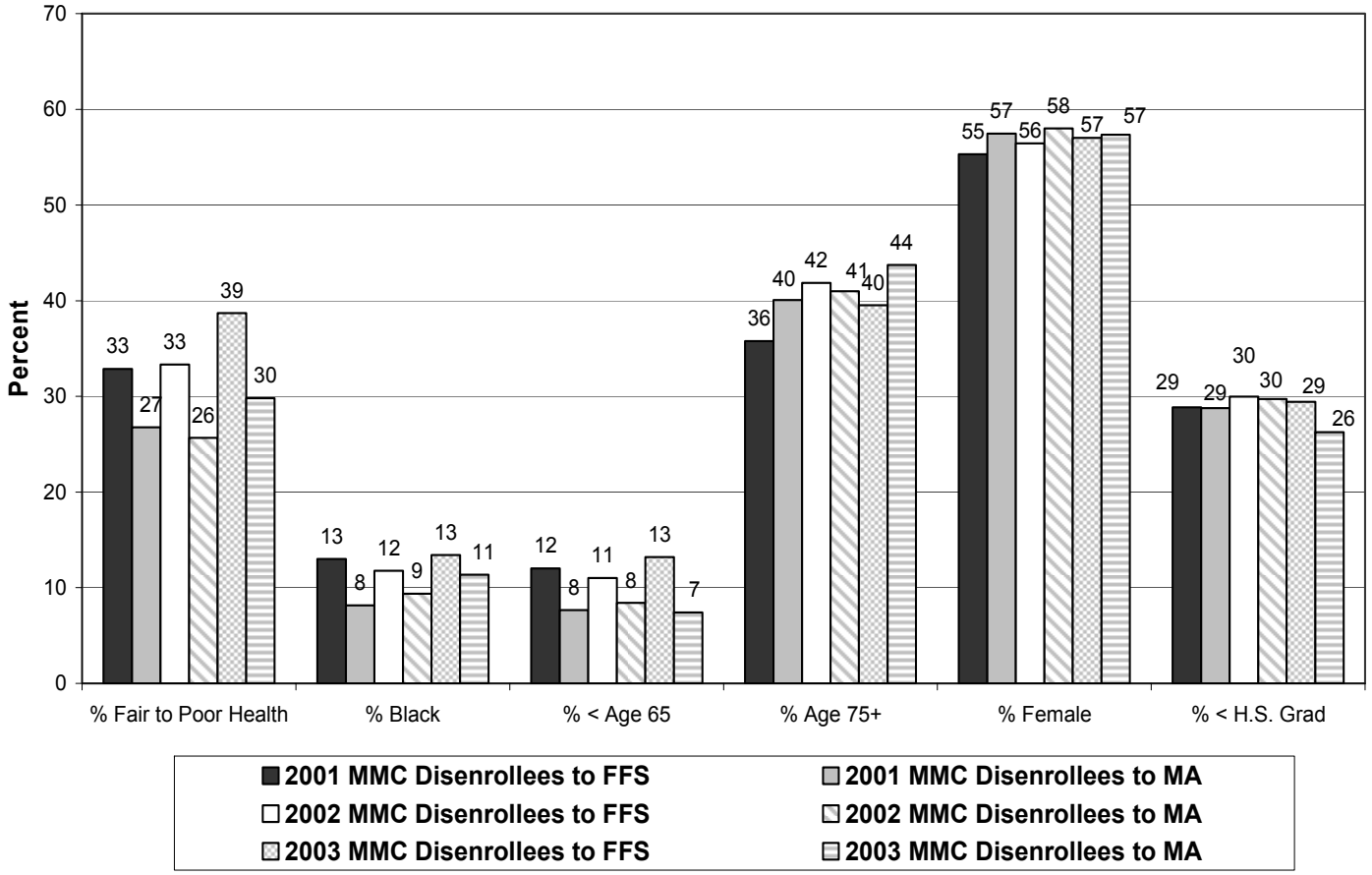
Chart 1-4

Destination after disenrollment, 2001–2003

- Disenrollees whose health was fair to poor, whose health had worsened in the past year, who were African American, and who had disabilities (under age 65) were disproportionately going to Original Medicare (fee-for-service or FFS) after leaving their MA plans.

Chart 1-4

Destination after disenrollment, by plan type, 2001–2003



2. Specific Reasons Given for Disenrollment

Chart 2-1

Frequency of 33 preprinted reasons for leaving a plan and assignment to reason groups, 2001–2003

- Chart 2-1 shows the how the individual reasons were assigned to each of eight major reason groups used for reporting. This chart also shows the percentage of beneficiaries who reported each individual reason in each of the reasons groupings.

- Five reasons persisted in the top six reasons from 2001 to 2003. Four of them are related to Premium/Cost or Copayment/Coverage issues.

- "Plan did not include doctors or other providers you want to see" was the only non-cost/benefit-related reason in the top six reasons across the 3 years.

- The percent of beneficiaries who listed "Another plan offered better benefits" and "Another plan cost less" as their reason for disenrollment, increased from 2001 to 2003. In contrast, the percent of who cited "Monthly premium increased" as their reason for leaving decreased over time.

- The reason "Could not pay the monthly premium" decreased from 29 percent to 23 percent over the 3-year period. This reason was replaced by "Copayments for office visits and other services increased" in the top six reasons cited in both 2002 and 2003.

Chart 2-1

Frequency of 33 preprinted reasons for leaving a plan and assignment to eight reason groups in 2001–2003, with top six reasons in each year bolded and shaded

Major Reason Group	Specific reason given	Disenrollment weighted percentage		
		All 33 preprinted reasons, 2001	**All 33 preprinted reasons, 2002**	**All 33 preprinted reasons, 2003**
Plan Information problems	Given incorrect or incomplete information at the time you joined the plan	10.4	9.3	10.5
	After joining the plan, it wasn't what you expected	25.8	24.2	26
	Information from the plan was hard to get or not very helpful	14.4	14.7	15.2
	Plan's customer service staff were not helpful	15.2	14.8	15.4
Doctor Access problems	**Plan did not include doctors or other providers you wanted to see**	**28.9**	**29.3**	**28.3**
	Doctor or other provider you wanted to see retired or left the plan	15.4	15.6	11.1
	Doctor or other provider you wanted to see was not accepting new patients	5.1	4.1	4
	Could not see the doctor or other provider you wanted to see on every visit	12.8	12.9	13
Care Access problems	Could not get appointment for regular or routine health care as soon as wanted	10.6	8.4	8.7
	Had to wait too long in waiting room to see the health care provider you went to see	9.3	7.3	7.8
	Health care providers did not explain things in a way you could understand	7.6	6.4	7.9
	Had problems with the plan doctors or other health care providers	14	11.6	12.3
	Had problems or delays getting the plan to approve referrals to specialists	13.5	11.9	12.7
	Had problems getting the care you needed when you needed it	18.1	15.6	16.6

Chart 2-1

Frequency of 33 preprinted reasons for leaving a plan and assignment to eight reason groups in 2001–2003, with top six reasons in each year bolded and shaded (continued)

Major Reason Group	Specific reason given	Disenrollment weighted percentage		
		All 33 preprinted reasons, 2001	All 33 preprinted reasons, 2002	All 33 preprinted reasons, 2003
Specific Needs problems	Plan refused to pay for emergency or other urgent care	6.9	7.8	8
	Could not get admitted to a hospital when you needed to	2.6	2.6	2.6
	Had to leave the hospital before you or your doctor thought you should	2.4	2.2	2.4
	Could not get special medical equipment when you needed it	3	3.8	4.1
	Could not get home health care when you needed it	2.2	2.8	3.3
	Plan would not pay for some of the care you needed	15.7	20.5	21.2
Other Care or Service problems	It was too far to where you had to go for regular or routine health care	6.7	6.3	7.1
	Wanted to be sure you could get the health care you need while you are out of town	6.4	7.3	7.4
	Health provider or someone from the plan said you could get better care elsewhere	7.8	9.8	10.5
	You, another family member, or friend had a bad experience with that plan	10.9	10.4	10.8
Premium/ Cost Issues	Could not pay the monthly premium	**29.1**	24.6	23.4
	Another plan would cost you less	**39.7**	**43.8**	**44.1**
	Plan started charging a monthly premium or increased your monthly premium	**39.9**	**37.7**	**34.8**

Chart 2-1

Frequency of 33 preprinted reasons for leaving a plan and assignment to eight reason groups in 2001–2003, with top six reasons in each year bolded and shaded (continued)

Major Reason Group	Specific reason given	Disenrollment weighted percentage		
		All 33 preprinted reasons, 2001	All 33 preprinted reasons, 2002	All 33 preprinted reasons, 2003
Copay/ Coverage Issues	**Another plan offered better benefits or coverage for some types of care or services**	**40.1**	**47**	**49.9**
	Plan increased the copayment for office visits to your doctor and for other services	25.1	**30.7**	**28.2**
	Plan increased the copayment that you paid for prescription medicines	**26.2**	**31.6**	**26.7**
Drug Coverage issues	Maximum dollar amount the plan allowed for your prescription medicine was too low	21.6	24.5	23.1
	Plan required you to get a generic medicine when you wanted a brand name medicine	9.4	11.3	10.8
	Plan would not pay for a medication that your doctor had prescribed	13	17.2	17.1

Chart 2-2

Top six reasons cited from all 33 preprinted reasons, 2001–2003

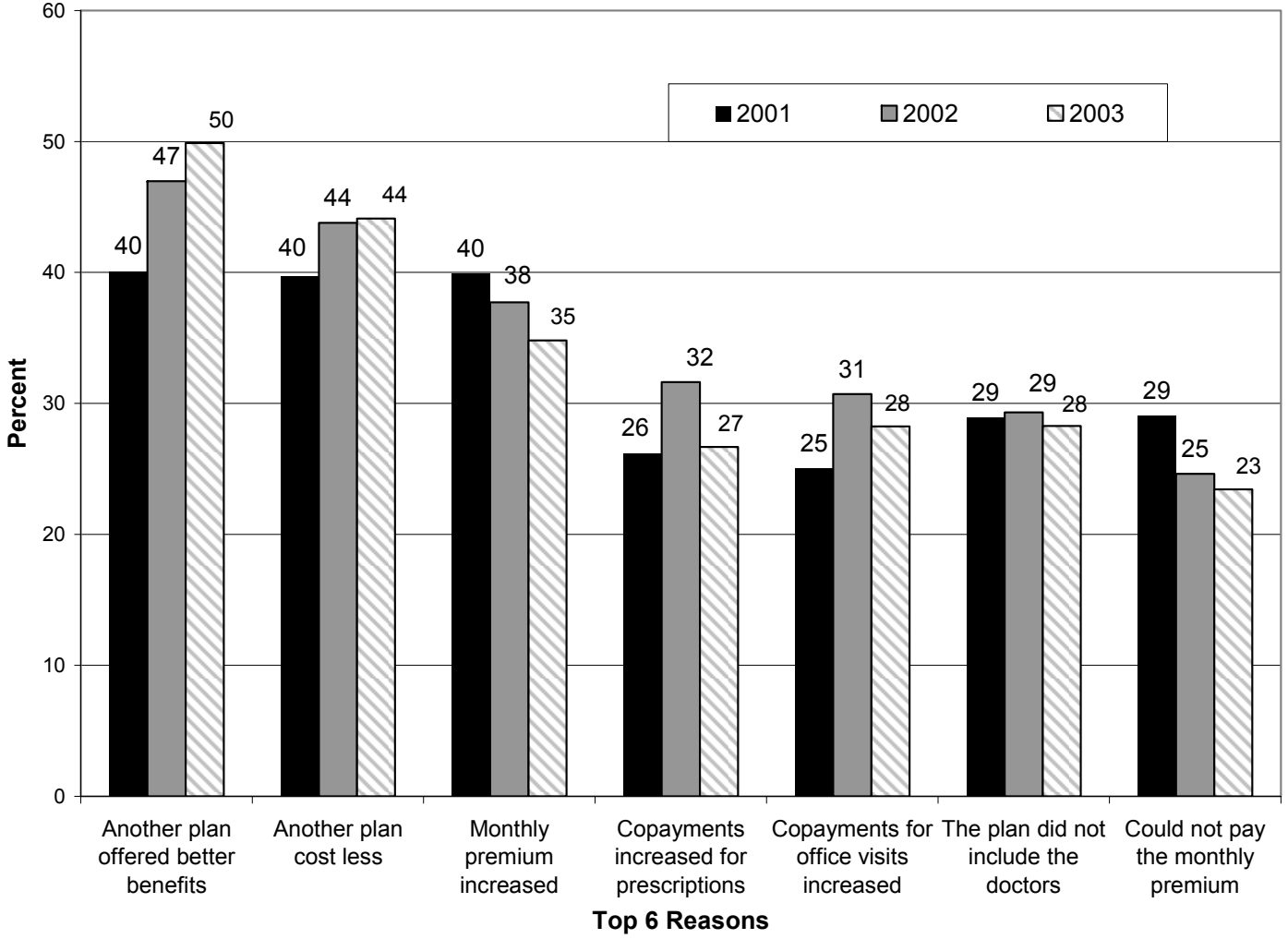


Chart 2-3

Assignment of 33 preprinted reasons to eight reason groups in 2001–2003

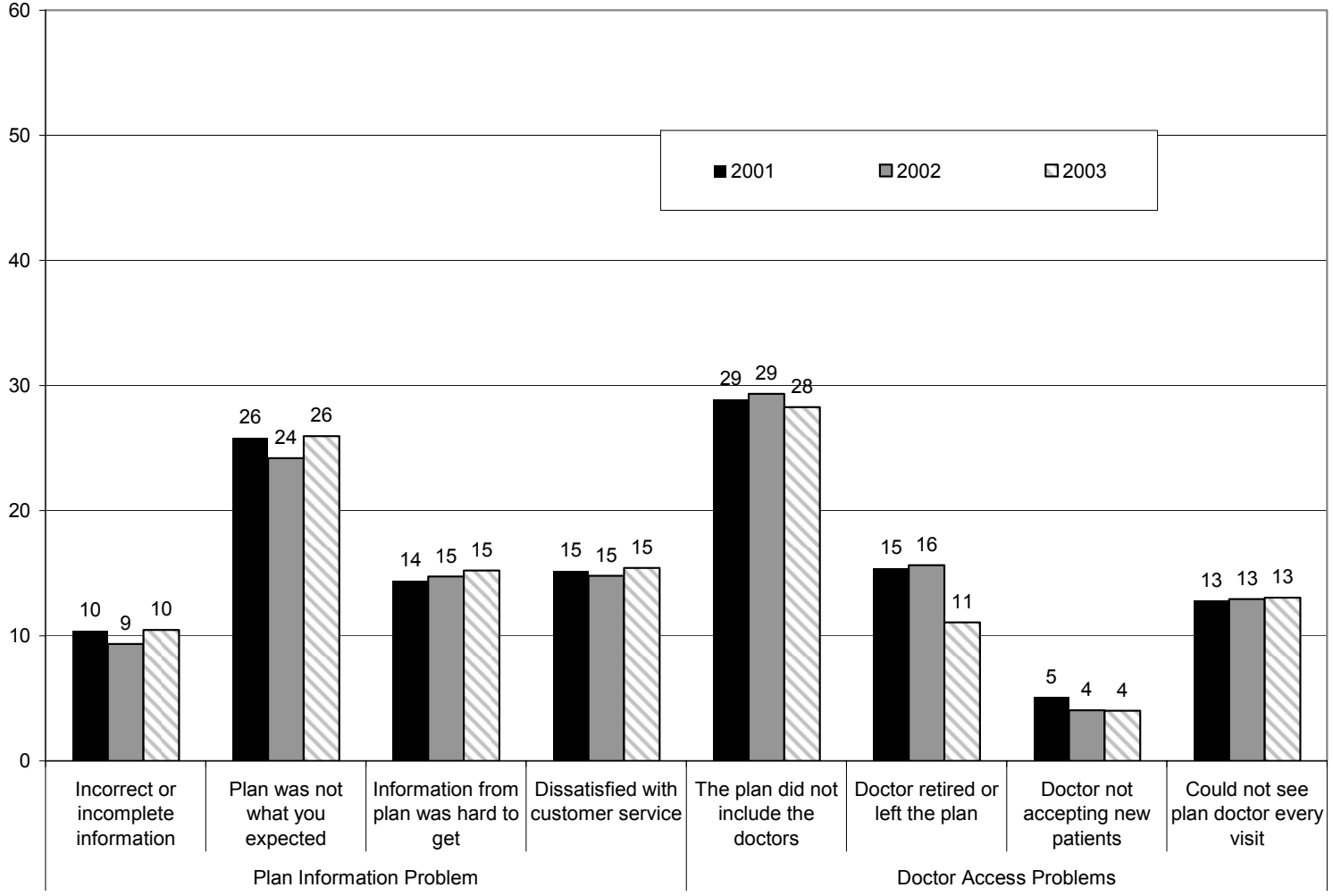


Chart 2-3

Assignment of 33 preprinted reasons to eight reason groups in 2001–2003 (continued)

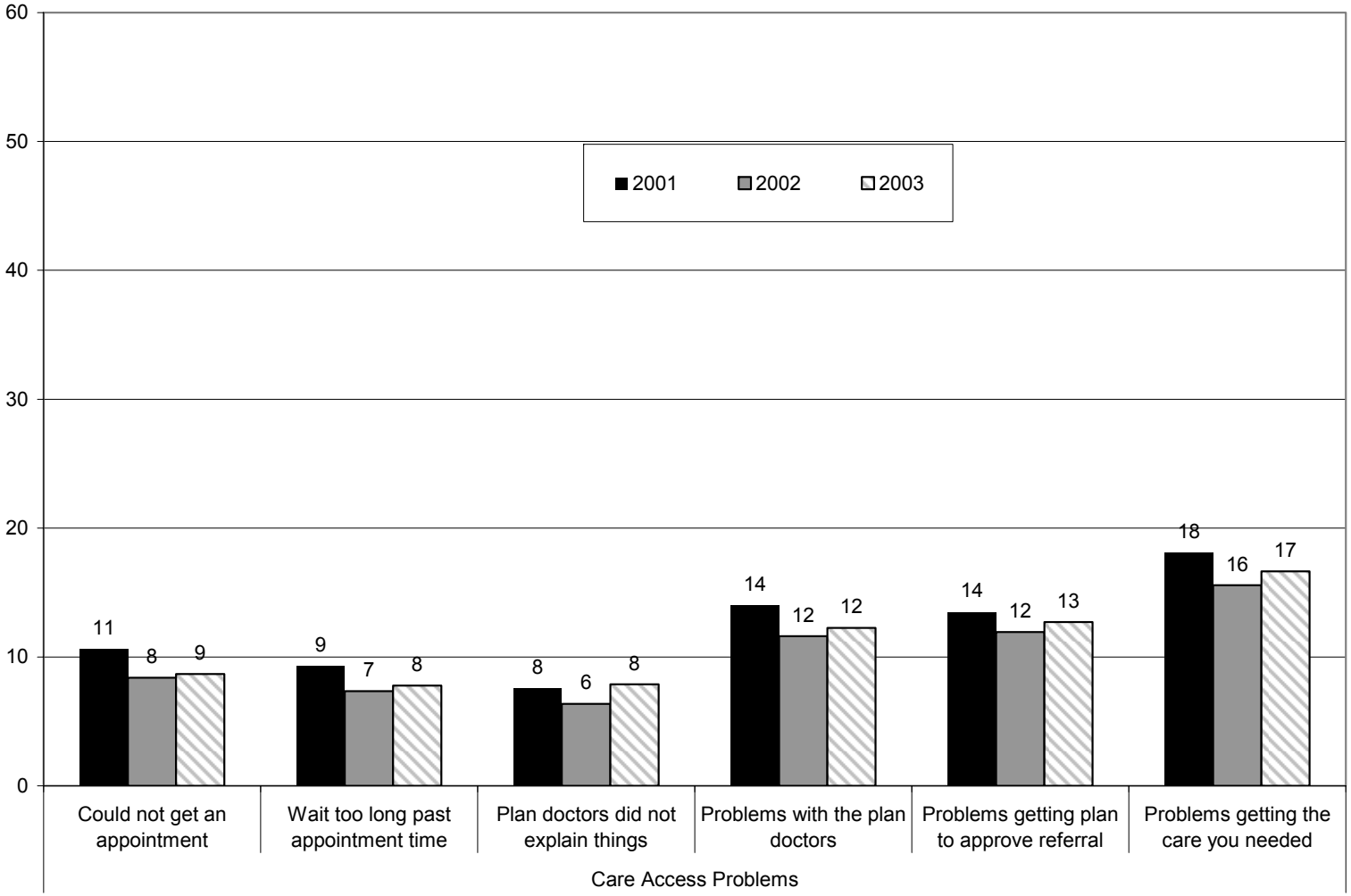


Chart 2-3

Assignment of 33 preprinted reasons to eight reason groups in 2001–2003 (continued)

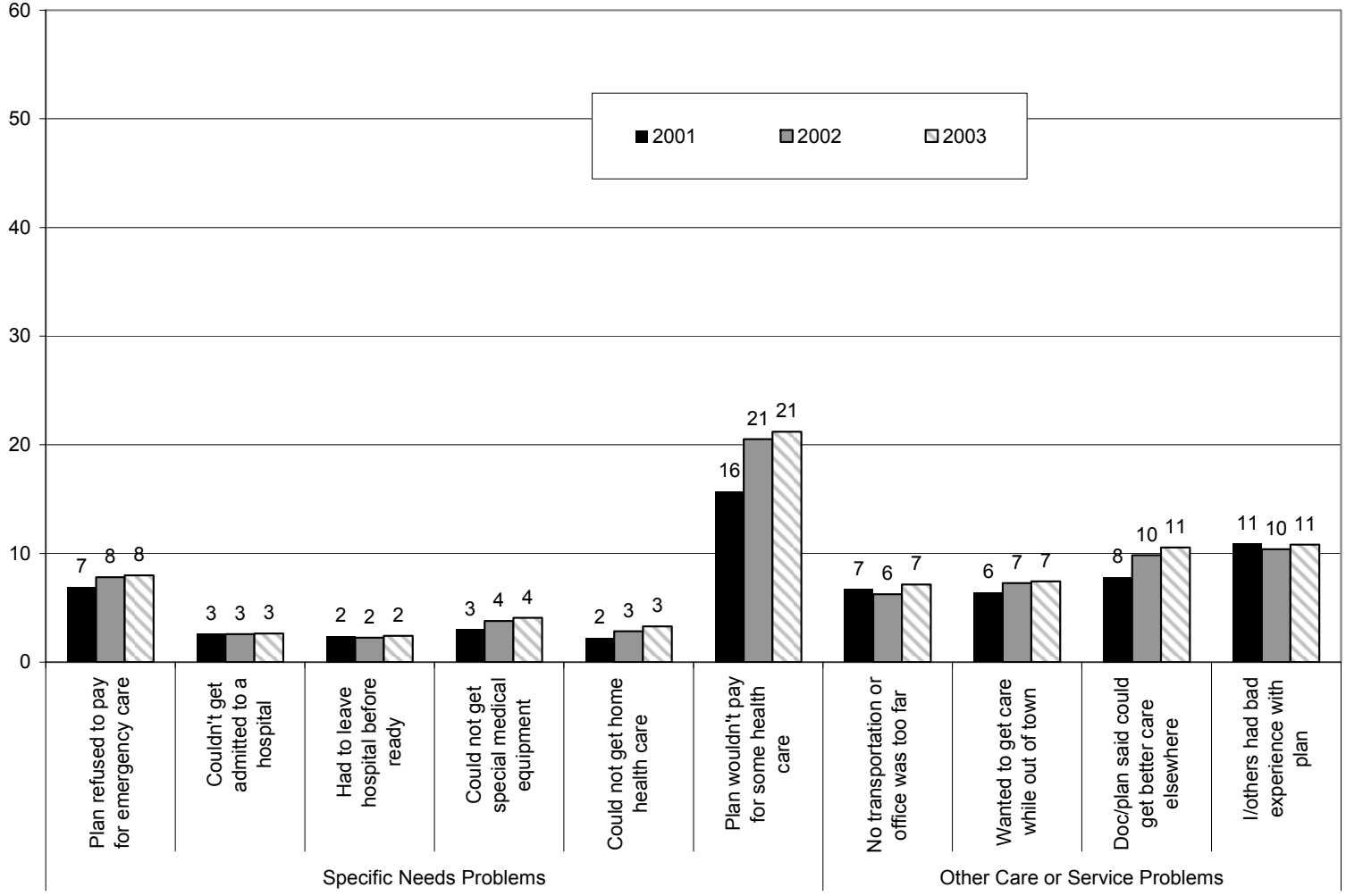


Chart 2-3

Assignment of 33 preprinted reasons to eight reason groups in 2001–2003 (continued)

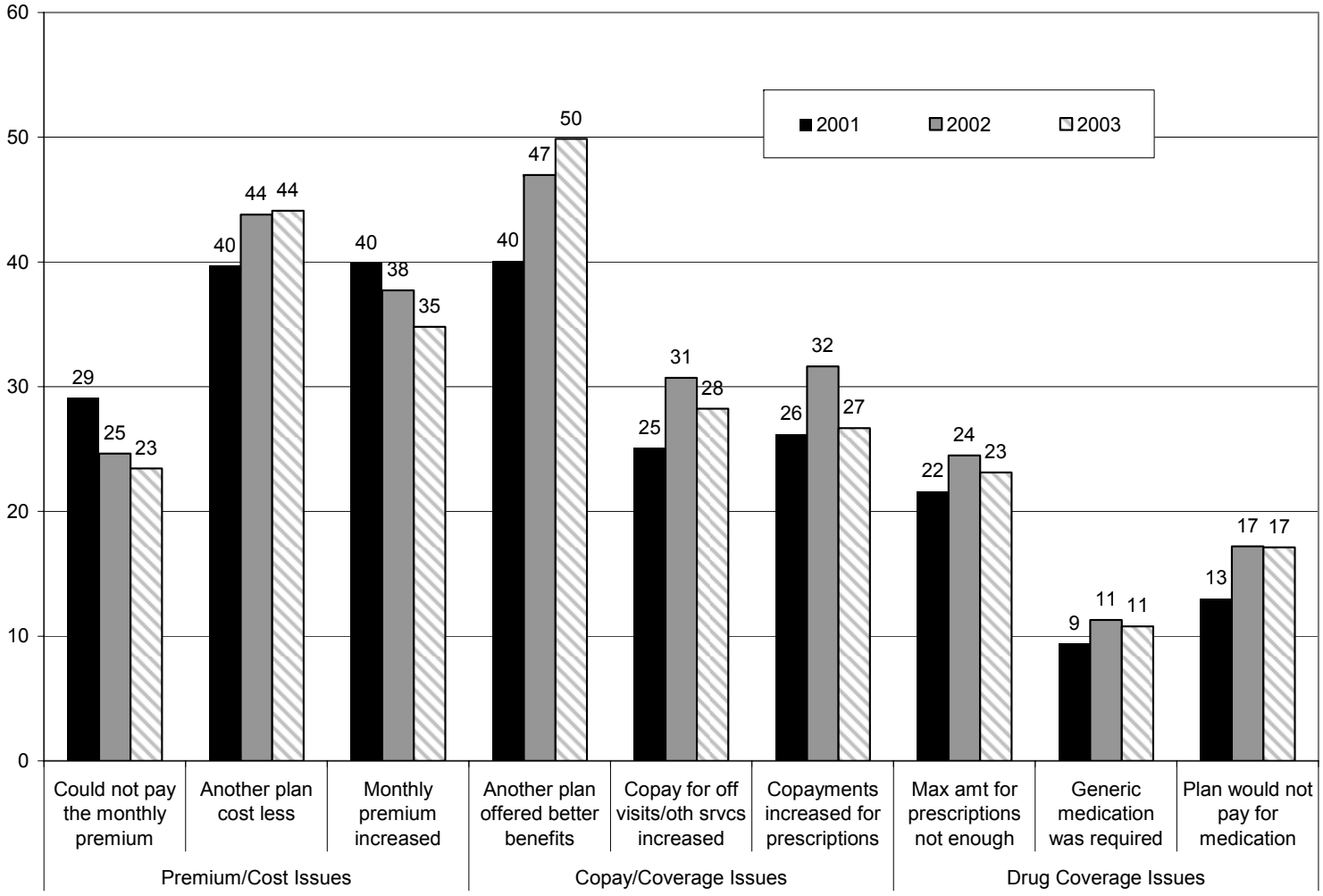


Chart 2-4

Top six reasons cited by one-time versus multiple switchers, 2001–2003

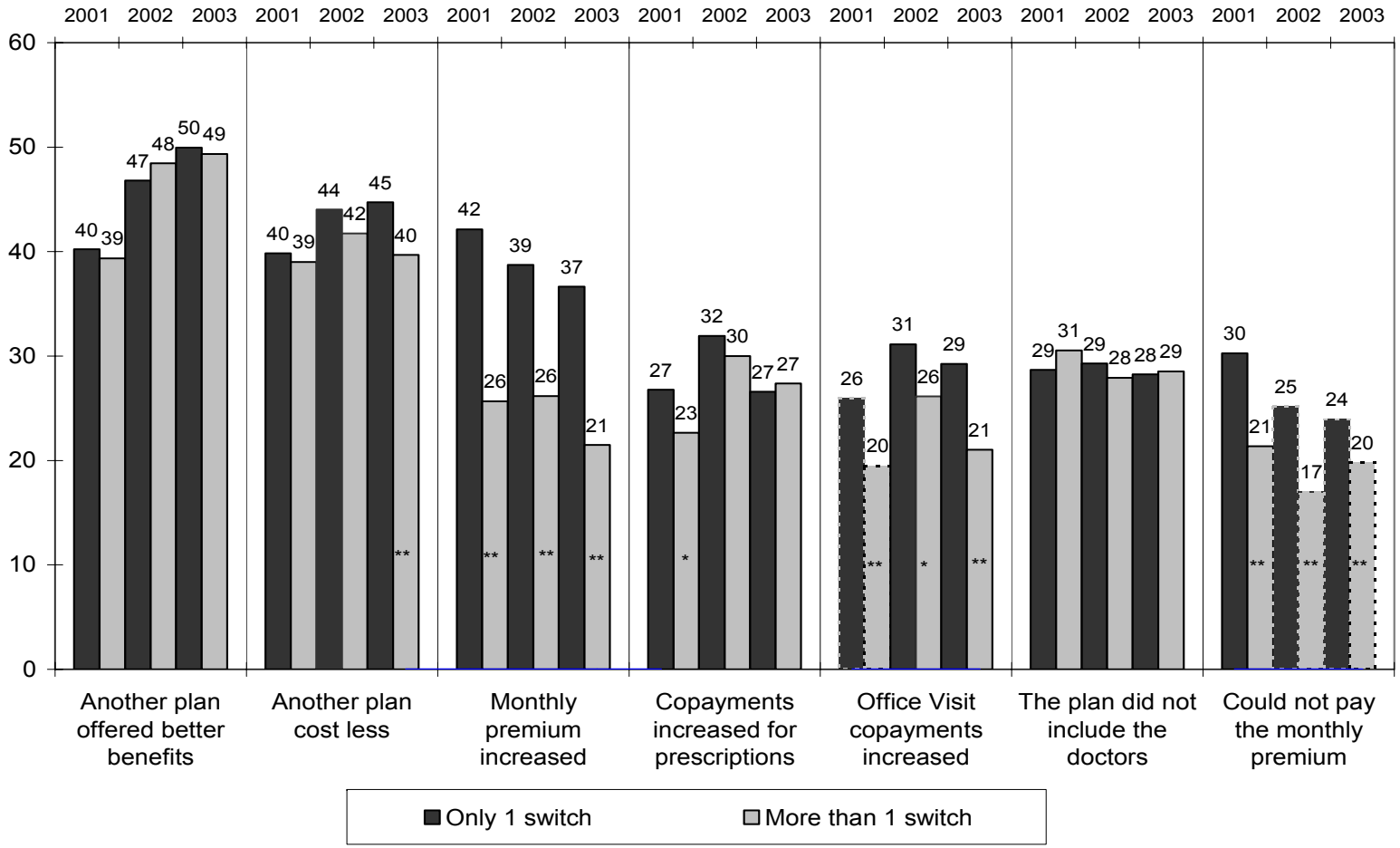
- The greatest difference between respondents who changed plans once during a survey year (referred to as one-time switchers) and those who changed plans more than once (multiple switchers), in the top six reasons for leaving their plans in each year, is evident in the reason, "Monthly premium increased." Single switchers cited this reason more frequently than multiple switchers in 2001, 2002, and 2003 although the rate at which they cited this reason was declining over time.

- The difference between these two groups of disenrollees was statistically significant for the reason "Could not pay the monthly premium," which varied from 4 percent to 9 percent from 2001 to 2003, with one-time switchers being more likely to cite this reason.

- "Office visit and other service copayments increased" was more likely to be cited by one-time switchers than multiple switchers (about 5 percent to 8 percent higher) across the 3 years.

Chart 2-4

Top six reasons cited by one-time versus multiple switchers, 2001–2003



NOTE: Dotted lines indicate reason was not in the top six in that year.
**Significant at the 99% level of confidence.
*Significant at the 95% level of confidence.
Hypothesis tested: Proportions are the same in the two groups (1 switch and multiple switch).

Chart 2-5

Frequency of most important reason (MIR) for leaving a plan, in 2001–2003

- Chart 2-5 shows the most important reasons assigned to each of the eight reason groups used for reporting. This chart also shows the percentage of beneficiaries who reported each individual reason in each of the reasons groupings.

- "Could not pay the monthly premium" was the most prevalent MIR cited by respondents. The proportion of beneficiaries who selected this reason increased from 16 percent to 20 percent from 2001 to 2003.

- The percents of disenrollees who cited "Plan did not include doctors or other providers you wanted to see" and "Plan started charging a monthly premium" decreased from 2001 to 2003.

- "Had problems with the plan doctors or other health care providers" was among the top six MIRs in 2001 but was replaced by "Plan customer service staff not helpful" in 2002 and 2003.

Chart 2-5

Frequency of most important reason (MIR) for leaving a plan and assignment to eight reason groups, in 2001–2003, with top six MIR in each year bolded and shaded

		Disenrollment weighted percentage		
Major Reason Group		**MIR, 2001**	**MIR, 2002**	**MIR, 2003**
Plan Information problems	Given incorrect or incomplete information at the time you joined the plan	0.6	0.78	0.79
	After joining the plan, it wasn't what you expected	0.2	0.17	0.26
	Information from the plan was hard to get or not very helpful	0.2	0.21	0.48
	Plan's customer service staff were not helpful	3.7	**5.31**	**5.37**
	Insecurity about future of plan or about continued coverage	0.5	0.67	0.46
Doctor Access problems	**Plan did not include doctors or other providers you wanted to see**	**14.9**	**11.57**	**10.11**
	Doctor or other provider you wanted to see retired or left the plan	**9.1**	**10.92**	**8.41**
	Doctor or other provider you wanted to see was not accepting new patients	0.1	0.06	0.06
	Could not see the doctor or other provider you wanted to see on every visit	0.4	0.41	0.48
Care Access problems	Could not get appointment for regular or routine health care as soon as wanted	0.1	0.41	0.57
	Had to wait too long in waiting room to see the health care provider you went to see	0.1	0.19	0.19
	Health care providers did not explain things in a way you could understand	0.1	0.05	0.28

Chart 2-5

Frequency of most important reason (MIR) for leaving a plan and assignment to eight reason groups, in 2001–2003, with top six MIR in each year bolded and shaded (continued)

Major Reason Group		Disenrollment weighted percentage		
		MIR, 2001	MIR, 2002	MIR, 2003
	Had problems with the plan doctors or other health care providers	**5.1**	2.85	3.68
	Had problems or delays getting the plan to approve referrals to specialists	1.6	1.78	2.08
	Had problems getting the care you needed when you needed it	1.9	1.14	1.58
Specific Needs problems	Plan refused to pay for emergency or other urgent care	0.3	0.14	0.21
	Could not get admitted to a hospital when you needed to	1.6	2.2	2.38
	Had to leave the hospital before you or your doctor thought you should	0.1	0.06	0.08
	Could not get special medical equipment when you needed it	0.1	0.36	0.4
	Could not get home health care when you needed it	0.1	0.11	0.26
	Plan would not pay for some of the care you needed	1.5	1.11	1.98
Other Care or Service problems	It was too far to where you had to go for regular or routine health care	2.5	1.94	2.63
	Wanted to be sure you could get the health care you need while you are out of town	0.5	0.74	0.91
	Health provider or someone from the plan said you could get better care elsewhere	1.4	1.46	2
	You, another family member, or friend had a bad experience with that plan	0.6	0.89	0.59

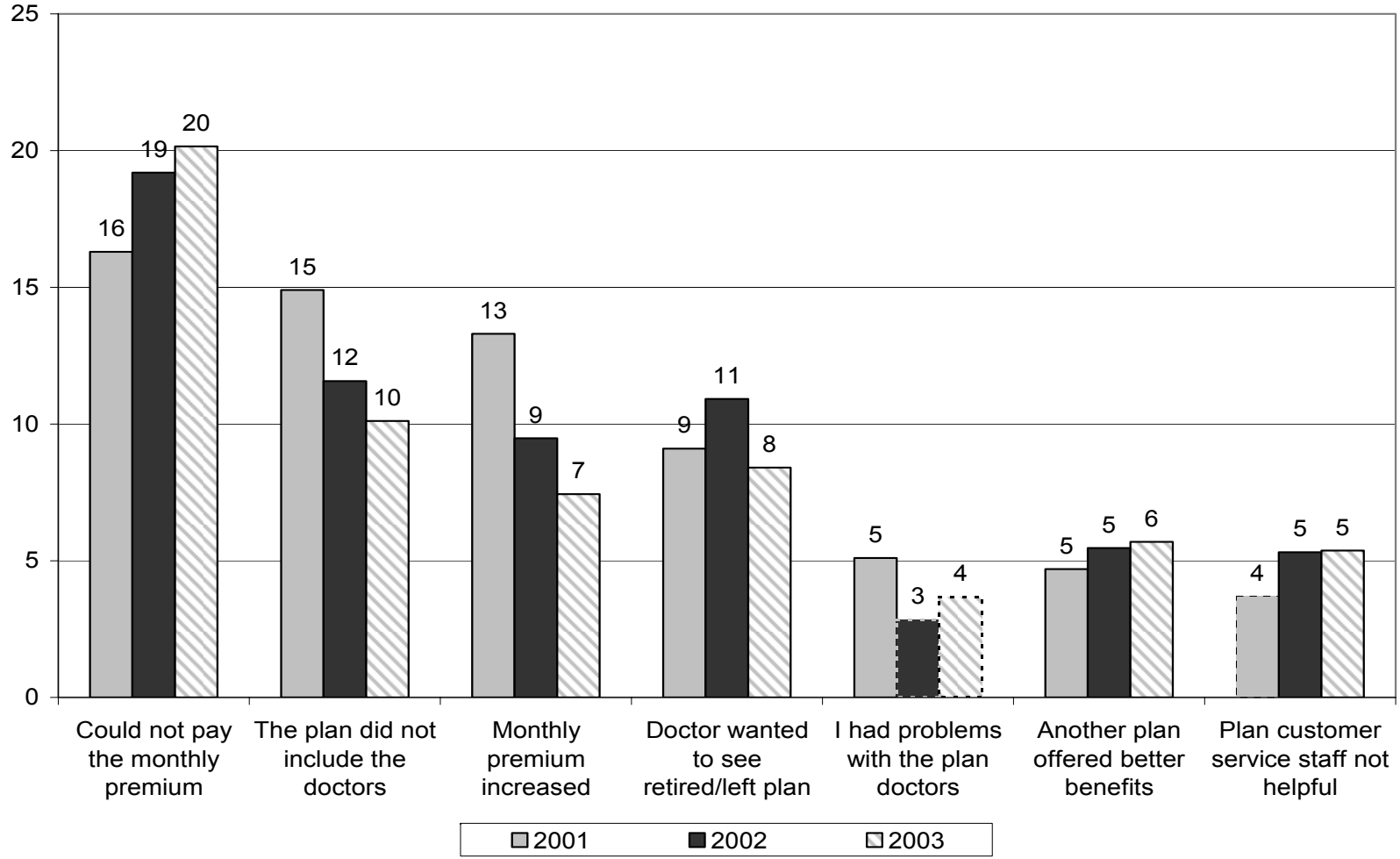
Chart 2-5

Frequency of most important reason (MIR) for leaving a plan and assignment to eight reason groups, in 2001–2003, with top six MIR in each year bolded and shaded (continued)

Major Reason Group		Disenrollment weighted percentage		
		MIR, 2001	MIR, 2002	MIR, 2003
Premium/ Cost Issues	**Could not pay the monthly premium**	**16.3**	**19.19**	**20.15**
	Another plan would cost you less	2.5	3.18	4.75
	Plan started charging a monthly premium or increased your monthly premium	**13.3**	**9.48**	**7.44**
Copayment/ Coverage Issues	**Another plan offered better benefits or coverage for some types of care or services**	**4.7**	**5.46**	**5.69**
	Plan increased the copayment for office visits to your doctor and for other services	1.1	1.32	0.67
	Plan increased the copayment that you paid for prescription medicines	0.7	1.35	0.69
	No longer needed coverage under the plan	2.8	2.54	3.89
Drug Coverage issues	Maximum dollar amount the plan allowed for your prescription medicine was too low	4.1	4.53	3.91
	Plan required you to get a generic medicine when you wanted a brand name medicine	0.8	1.07	0.98
	Plan would not pay for a medication that your doctor had prescribed	3.5	4.77	4.08

Chart 2-6

Top six MIRs for leaving a plan, 2001–2003



3. Reason Groups

Chart 3-1

Most important reason groups cited, 2000–2003

- The most frequently cited of the eight major reason groups for MIRs ,over all 4 survey years, was Premium/Cost issues (around 32 percent).

- "Doctor Access" is the second most prevalent major reason group for the MIRs. However, the proportion of beneficiaries who cited a MIR in this group decreased consistently over time (from 27 percent to 20 percent).

Chart 3-1

MIR groups cited, 2000–2003

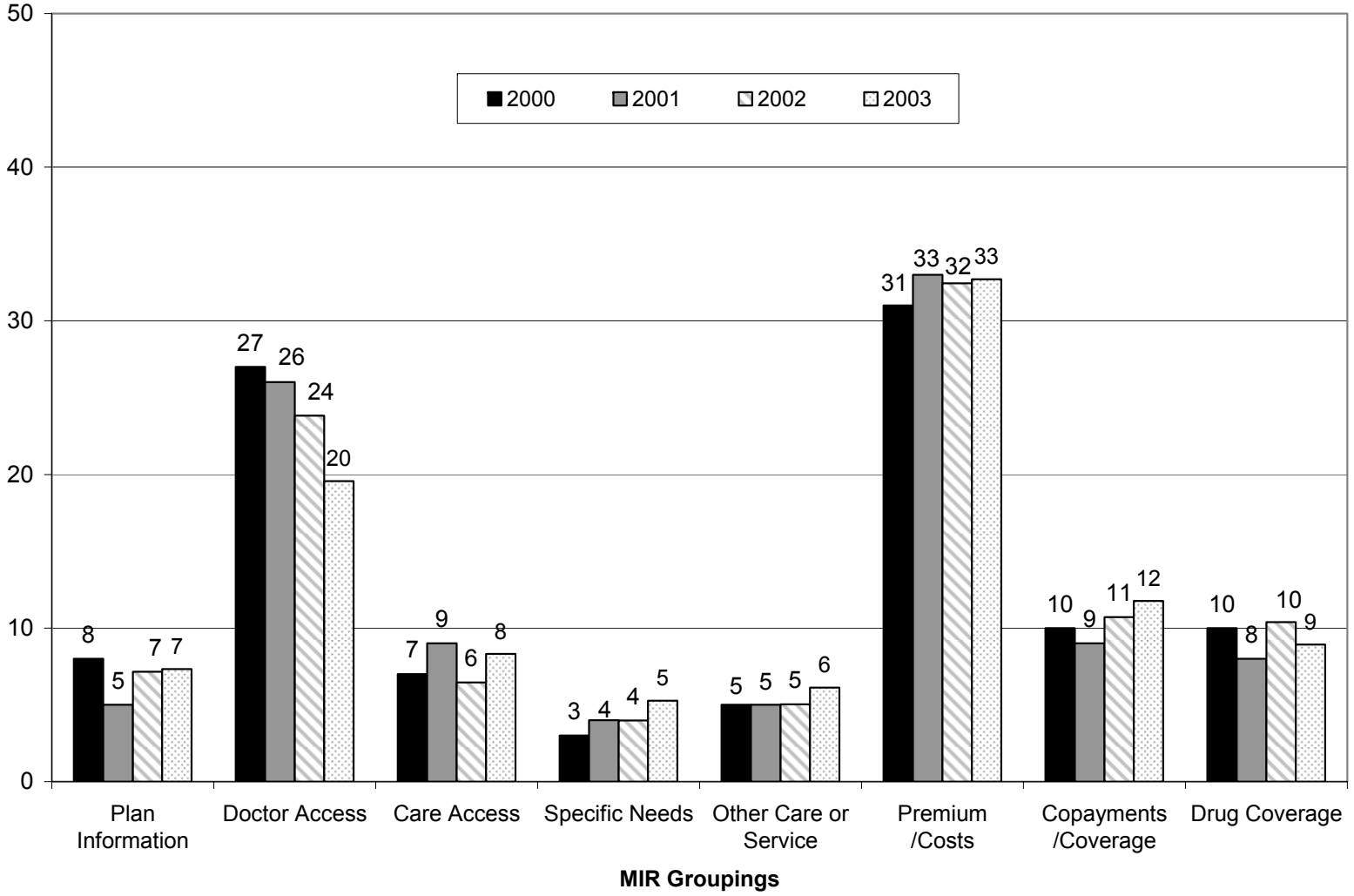


Chart 3-2

All reason groups cited, 2000–2003

- Premiums/costs and copayments/coverage issues were the two most prevalent reason groups for All Reasons cited by beneficiaries as their reasons for disenrolling from their plans.

- The prevalence for citing a preprinted reason in the group ‘copayments/coverage’ increased from 2001 to 2003, with a substantial increase in 2002 (about 8 percent).

- The percent of beneficiaries who cited a preprinted reason in the “Doctor Access” group as their reason for disenrollment decreased slightly over time.

Chart 3-2

All reason groups cited, 2000–2003

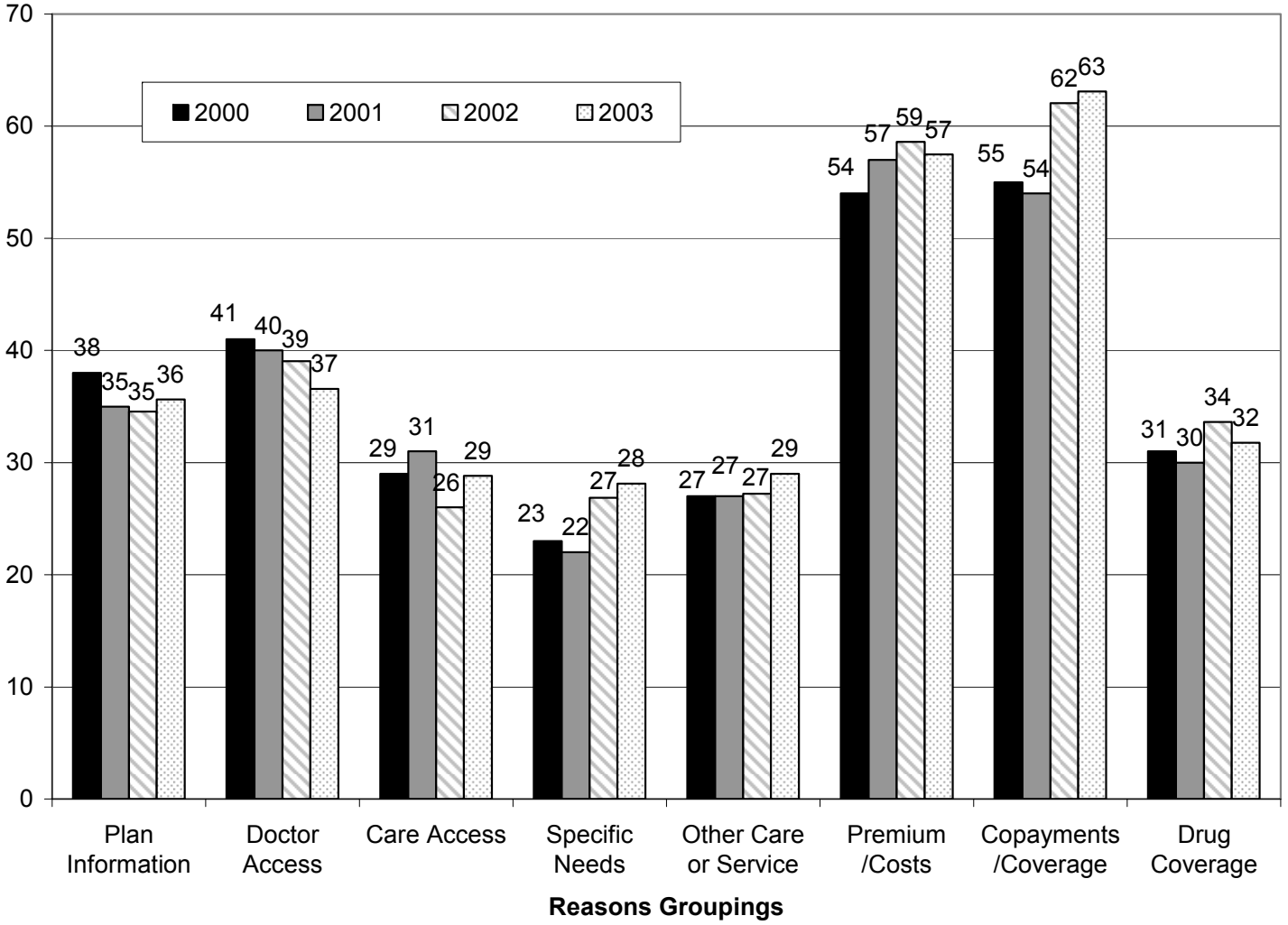


Chart 3-3

All reason groups cited by destination, in areas with more than one MA plan, 2001–2003

- "Premium/Costs" and "Copayments/Coverage" were the two most prevalent reasons cited by the beneficiaries in areas with multiple MA plans.

- The beneficiaries who left to go to another MA plan were more likely to cite Copayments/coverage as their reason for leaving, than those who disenrolled to join a FFS (Original Medicare) plan.

- Disenrollees who subsequently enrolled in a FFS plan were more likely to cite "Plan Information," "Care Access," "Specific Needs," or "Other Care or Service," as their reason for leaving the MA plan.

- Those who left to go to FFS cited the following reasons with increasing frequency over time: "Specific Needs," "Other Care or Service," or "Copayments/Coverage."

Chart 3-3

All reason groups cited by destination after disenrollment, in areas with more than one MA plan, 2000–2003

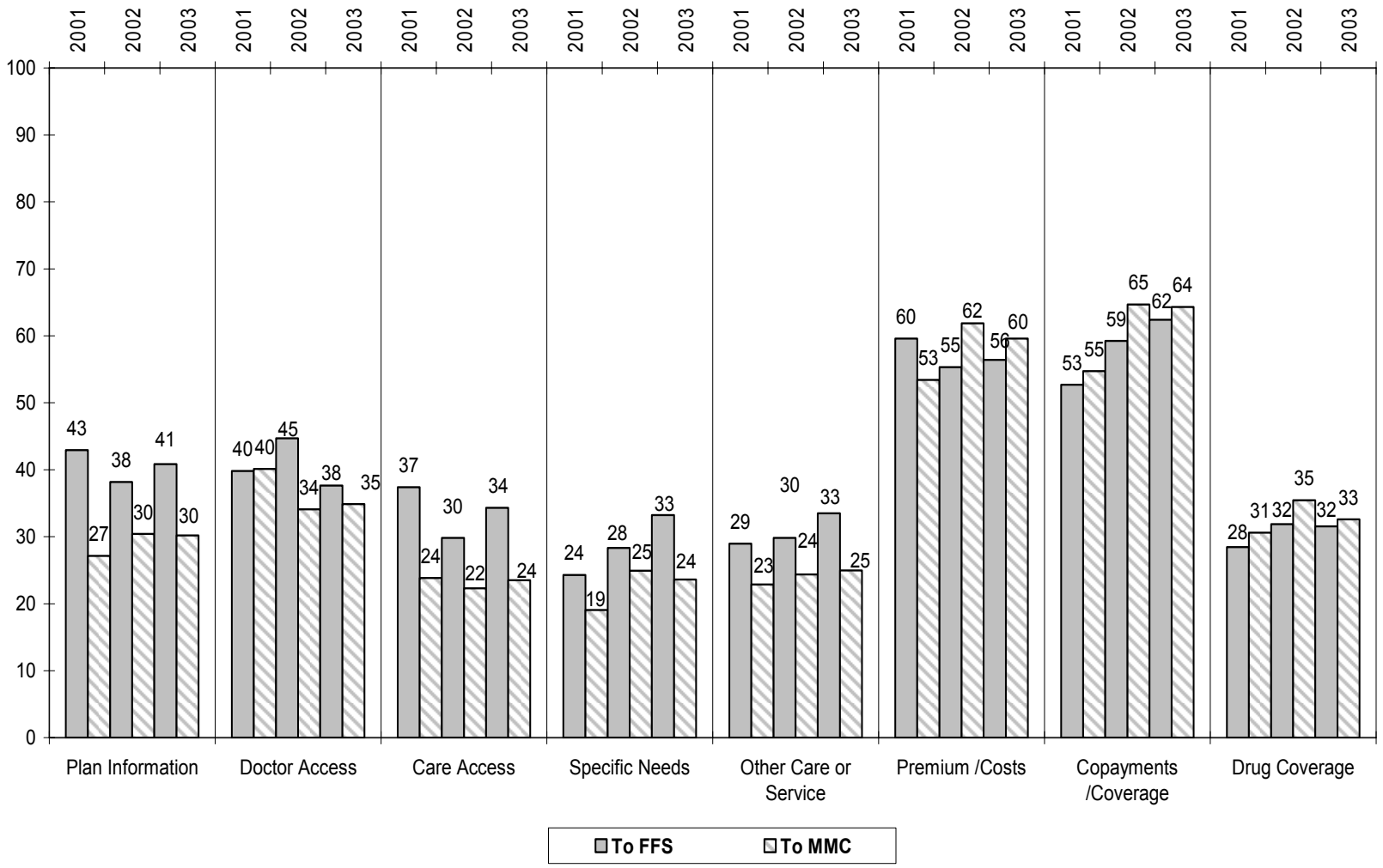


Chart 3-4

Change in the pattern of the top six reason groups cited, 2000–2003

- The *pattern* of citations in a reason group is defined as the proportion of respondents who *only* cited a preprinted reason or reasons in that major group.

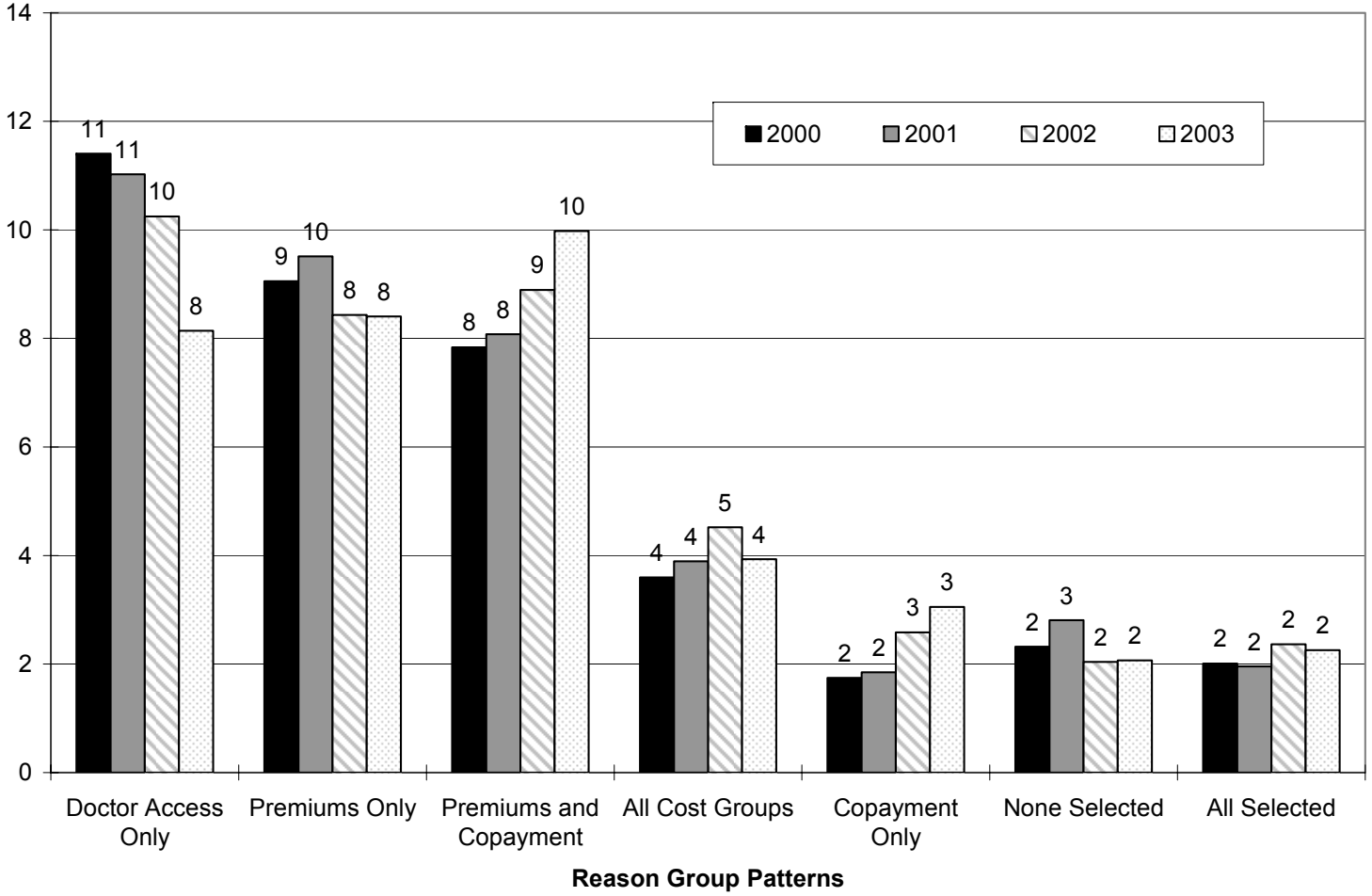
- Chart 3-4 shows change in the pattern of the top six reason groups most frequently cited over four survey years, 2000-2003.

- "Doctor Access Only", i.e, beneficiaries who only cited reasons within the Doctor Access reason group, was the most prevalent reason group solely-cited by respondents from 2000–2002. However, the percentage solely-citing reason(s) in this group decreased consistently over time. So the pattern shifted from 11% of respondents being solely focused on this group to only 8% with this sole focus over time.

- The proportion of beneficiaries who only cited reasons in the group "Premiums/costs and Copayments/coverage" increased over the 4 years. In 2003, this became the most prevalent reason group solely-cited by respondents.

Chart 3-4

Change in the pattern of top six reason groups cited, 2000–2003



NOTE: Bars are varied due to rounding.

4. Reasons Cited by Beneficiaries with Disabilities

Chart 4-1

Top six reasons given by non-elderly beneficiaries with disabilities, 2001–2003

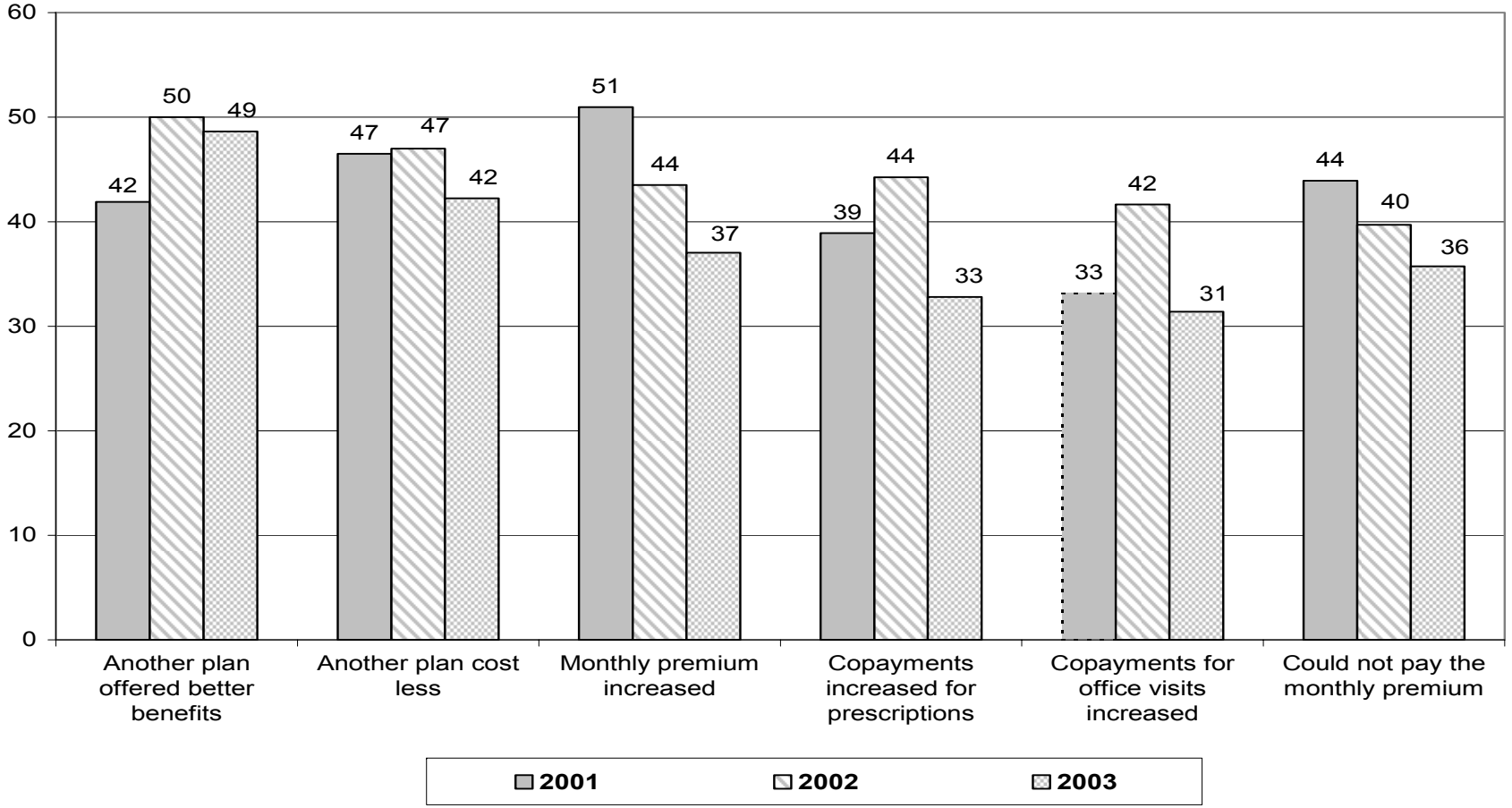
- Five reasons groups ("Another plan offered better benefits," "Another plan cost less," "Monthly premium increased," "Copayments increased for prescriptions," and "Could not pay the monthly premium") persist as the top six reasons cited by nonelderly disenrollees with disabilities. All of them are related to cost.

- The propensity for the nonelderly beneficiaries with disabilities to cite "Another plan cost less," "Copayments increased for prescriptions," and "Copayments for office visit increased" increased from 2001 to 2002, and then dropped in 2003.

- The percentage of nonelderly beneficiaries with disabilities who cited "Monthly premium increased" and "Could not pay the monthly premium" continued to decrease from 2001 to 2003.

Chart 4-1

Top six reasons cited by nonelderly beneficiaries with disabilities, 2001–2003



NOTE: Dotted lines indicate reason was not in the top six in that year.

Chart 4-2

Top six reasons for disenrollment, by nonelderly beneficiaries with disabilities and elderly beneficiaries, 2001–2003

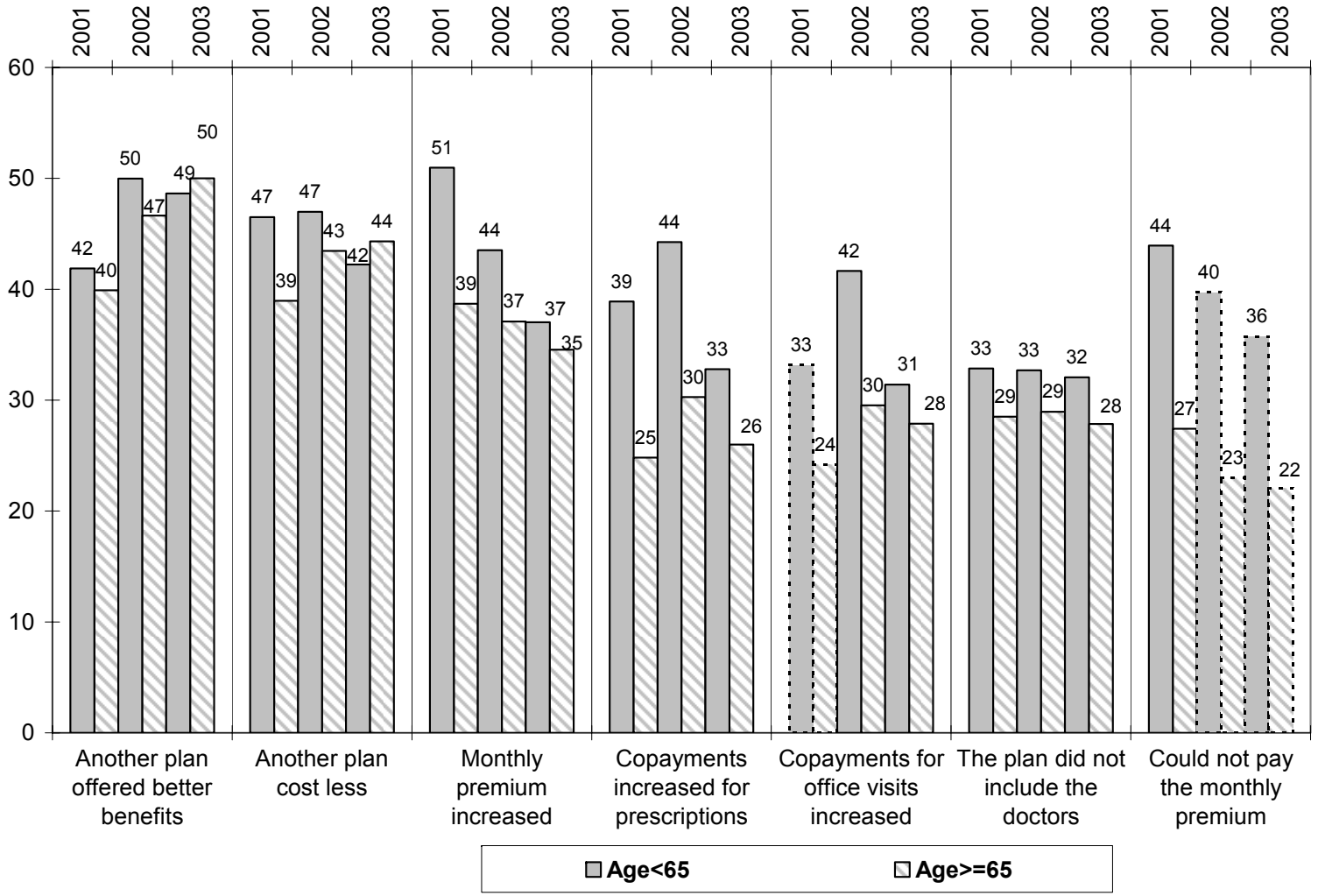
- The largest difference between nonelderly beneficiaries with disabilities and elderly disenrollees was for the reason "Could not pay the monthly premium" (44 percent of the nonelderly with disabilities versus 27 percent of the elderly) in 2001.

- The percentage differences between the elderly and non-elderly groups for the reasons "Another plan cost less" and "Monthly premium increased" narrowed from 2001 to 2003 (from 8 percent to 2 percent and from 12 percent to 2 percent, respectively).

- The percentage difference between the two groups was consistent for the reason "The plan did not include the doctors" and "Could not pay the monthly premium" over the 3 years (about 4 percent and 17 percent).

Chart 4-2

Top six reasons for disenrollment, by nonelderly beneficiaries with disabilities and elderly beneficiaries, 2001–2003



NOTE: Dotted lines indicate reason was not in the top six in that year.

Chart 4-3

All reason groups cited by nonelderly beneficiaries with disabilities and elderly beneficiaries, 2001–2003

- The reasons associated with Premium/Cost issues and Coverage/Copayment issues are the most frequently cited among all beneficiaries, particularly the nonelderly beneficiaries with disabilities.
- In 2003, 66 percent of nonelderly disenrollees, and 63 percent of the elderly, cited reasons related to benefits and copayments as the leading reason for disenrollment.
- Sixty-three percent of nonelderly disenrollees , and 57 percent of those 65 or older cited premium-related reasons as the second most common reason for disenrolment in 2003.
- With the exception of doctor access issues, beneficiaries with disabilities cited more reasons in the seven remaining reason groups than beneficiaries aged 65 or older.

Chart 4-3

All reason groups cited by nonelderly beneficiaries with disabilities and elderly beneficiaries, 2001–2003

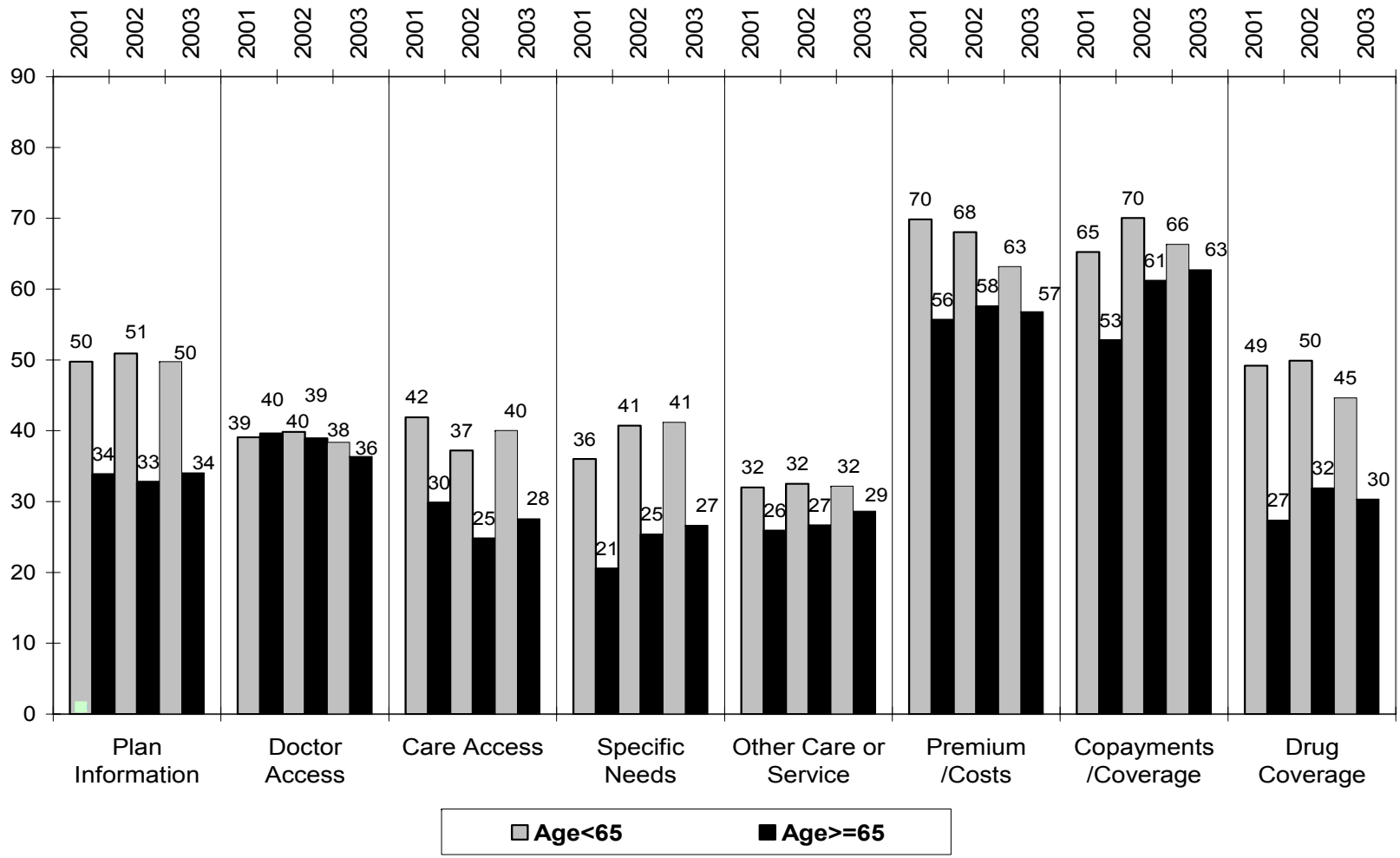


Chart 4-4

Reasons groups cited by destination after disenrollment, for nonelderly beneficiaries with disabilities in areas with more than one MA plan, 2001–2003

- Nonelderly beneficiaries with disabilities who left for a FFS plan were more likely to cite concerns about premiums/costs as their reason for leaving than those who disenrolled for another MA plan. However, this difference decreased from 17 percent to 5 percent over the years 2001-2003.

- For nonelderly beneficiaries with disabilities with subsequent enrollment in a FFS plan, the percentage citing "Copayments/Coverage," "Drug Coverage," and "Doctor Access" as the reasons to leave their plans were less than for those who subsequently joined another MA plan.

- The differences between these two groups of beneficiaries with disabilities (those going to FFS versus those going to MA plans) on the percentages citing "Doctor Access" and "Copayments/Coverage" remained stable over time (about 4 percent and 11 percent) whereas the gap for "Drug Coverage" increased over time.

Chart 4-4

Reasons groups cited by destination after disenrollment, for nonelderly beneficiaries with disabilities in areas with more than one MA plan, 2001–2003

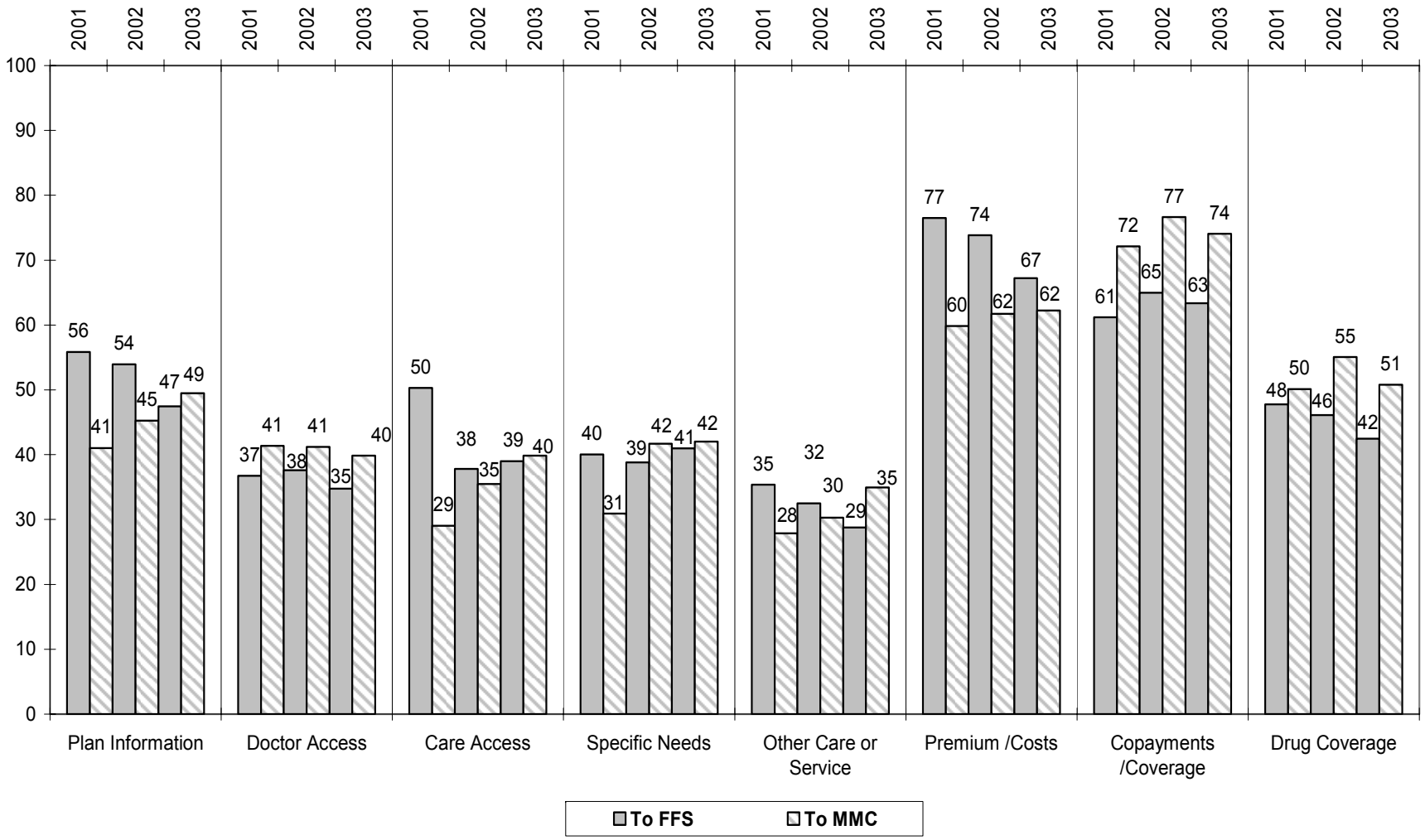


Chart 4-5

Change in the pattern of top six reason groups cited by nonelderly beneficiaries with disabilities

- The *pattern* of citations in a reason group is defined as the proportion of respondents who *only* cited a preprinted reason or reasons in that major group.

- Chart 4-5 shows change in the pattern of the top six reason groups most frequently cited over four survey years, 2001-2003.

- In 2001, "Premiums Only", i.e, beneficiaries who only cited reasons within the Premiums Only reason group, was the most prevalent reason group solely-cited by respondents. In 2002 and 2003, this reason group was replaced by "Premiums and Copayment" as the most prevalent reason group solely-cited by respondents.

- The proportion of beneficiaries with disabilities who solely-cited reasons related to "Doctor Access Only" remained stable over time (about 4 percent).

- The proportion of beneficiaries with disabilities who solely-cited a reason or reasons in "All Cost Groups" decreased substantially from 6.0 percent to 3.5 percent.

- The percentage of beneficiaries with disabilities solely-citing reason(s) in the groups "Premiums and Copayment" or "Copayment Only" increased slightly from 2001 to 2003.

Chart 4-5

Change in the pattern of top six reason groups cited by nonelderly beneficiaries with disabilities, 2001-2003

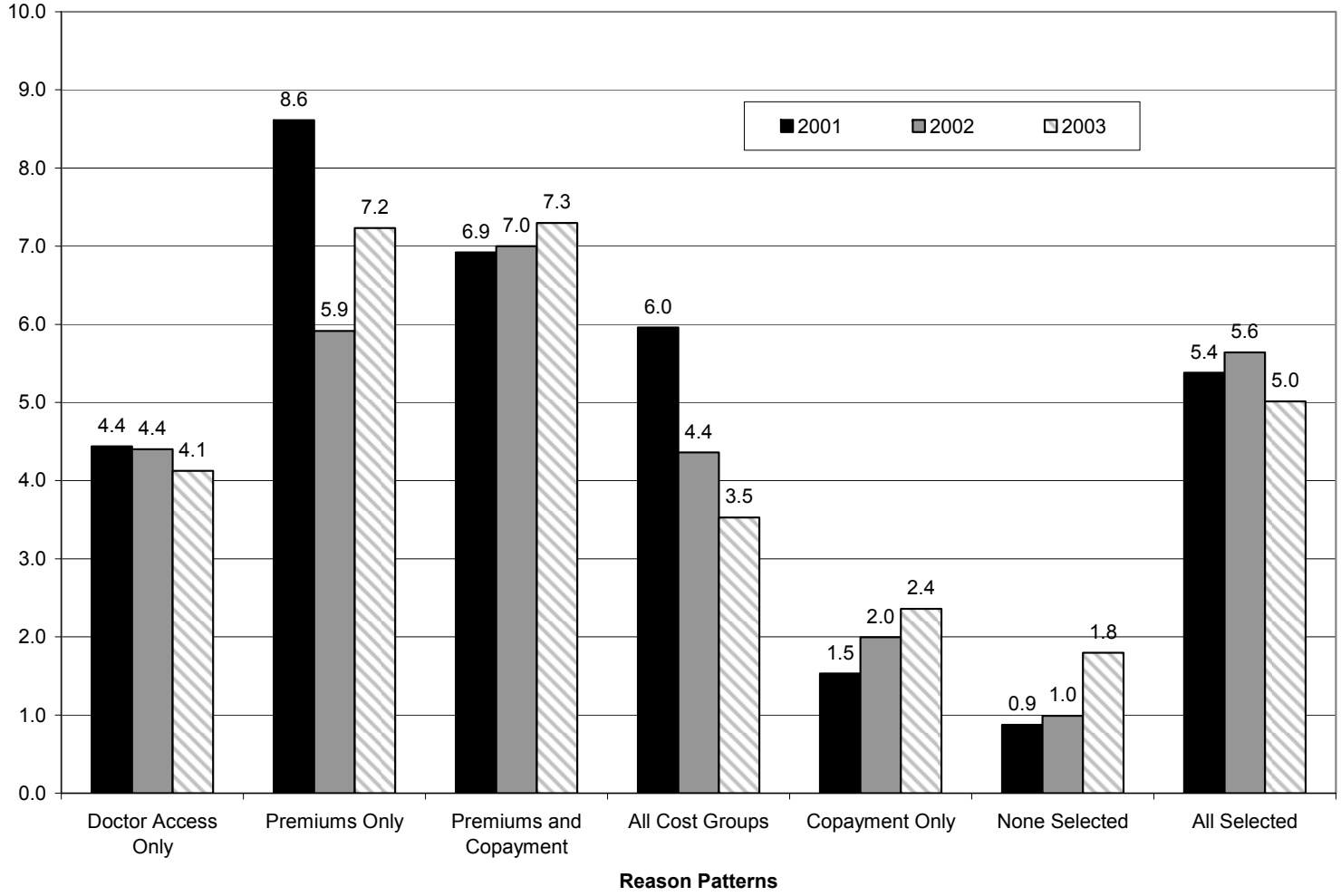


Chart 4-6

Frequency of 33 preprinted reasons for leaving plan cited by nonelderly beneficiaries with disabilities and elderly beneficiaries, 2001–2003

- Inability to pay the monthly premium was cited significantly more often by beneficiaries with disabilities versus elderly beneficiaries from 2001 to 2003, along with the reason "the plan started charging a monthly premium or increased the monthly premium."

- Two other reasons—"plan increased the copayment for office visits to your doctor and for other services" and "plan increased the copayment that you paid for prescription medicines"—were cited more frequently by the beneficiaries with disabilities than by the elderly across the 3 years.

- The beneficiaries with disabilities cited the three drug-coverage reasons more frequently than the elderly.

- Only the "doctor or other provider you wanted to see retired or left the plan" was cited significantly less frequently by beneficiaries with disabilities than the elderly in 2001 and 2002, but the difference narrowed in 2003.

- The largest differences in the frequency of reasons cited by the nonelderly versus the elderly beneficiaries are with respect to premiums, copayments, and the plan being not as expected.

Chart 4-6

Frequency of 33 preprinted reasons for leaving a plan cited by nonelderly beneficiaries with disabilities and elderly beneficiaries, 2001-2003

		Year 2001			Year 2002			Year 2003		
		Age under 65	Age 65 or over	t-test	Age under 65	Age 65 or over	t-test	Age under 65	Age 65 or over	t-test
Plan Information	Given incorrect or incomplete information at the time you joined the plan	17.6	9.6	**	21.5	8.0	**	17.8	9.6	**
	After joining the plan, it wasn't what you expected	38.4	24.4	**	38.3	22.7	**	39.6	24.4	**
	Information from the plan was hard to get or not very helpful	23.3	13.4	**	25.3	13.6	**	23.8	14.3	**
	Plan's customer service staff were not helpful	24.5	14.2	**	24.5	13.7	**	22.4	14.6	**
Doctor Access	**Plan did not include doctors or other providers you wanted to see**	**32.8**	**28.5**		**32.7**	**29.0**		**32.1**	**27.9**	*
	Doctor or other provider you wanted to see retired or left the plan	9.9	16.0	**	11.3	16.1	**	10.7	11.1	
	Doctor or other provider you wanted to see was not accepting new patients	5.5	5.0		5.0	4.0		6.5	3.7	**
	Could not see the doctor or other provider you wanted to see on every visit	14.4	12.6		16.9	12.5	**	16.9	12.6	**
Care Access	Could not get appointment for regular or routine health care as soon as wanted	13.8	10.2		13.7	7.8	**	10.9	8.4	*
	Had to wait too long in waiting room to see the health care provider you went to see	12.7	8.9		13.3	6.7	**	11.0	7.4	**

Chart 4-6

Frequency of 33 preprinted reasons for leaving a plan cited by nonelderly beneficiaries with disabilities and elderly beneficiaries, 2001-2003 (continued)

		Year 2001			Year 2002			Year 2003		
		Age under 65	Age 65 or over	t-test	Age under 65	Age 65 or over	t-test	Age under 65	Age 65 or over	t-test
	Health care providers did not explain things in a way you could understand	9.6	7.3		11.7	5.8	**	11.3	7.5	**
	Had problems with the plan doctors or other health care providers	21.7	13.2	**	18.1	10.9	**	18.6	11.5	**
	Had problems or delays getting the plan to approve referrals to specialists	22.9	12.5	**	18.2	11.3	**	18.5	12.1	**
	Had problems getting the care you needed when you needed it	26.8	17.1	**	24.0	14.7	**	26.0	15.6	**
Specific Needs	Plan refused to pay for emergency or other urgent care	14.5	6.1	**	14.7	7.1	**	11.8	7.6	**
	Could not get admitted to a hospital when you needed to	4.7	2.4		5.2	2.3	**	5.2	2.3	**
	Had to leave the hospital before you or your doctor thought you should	4.4	2.1		3.9	2.1		4.1	2.2	**
	Could not get special medical equipment when you needed it	7.8	2.5	**	11.6	2.9	**	8.9	3.5	**
	Could not get home health care when you needed it	3.9	2.1		6.7	2.4	**	5.0	3.1	*
	Plan would not pay for some of the care you needed	27.4	14.4	**	32.9	19.2	**	32.2	20.0	**

Chart 4-6

Frequency of 33 preprinted reasons for leaving a plan cited by nonelderly beneficiaries with disabilities and elderly beneficiaries, 2001-2003 (continued)

		Year 2001			Year 2002			Year 2003		
		Age under 65	Age 65 or over	t-test	Age under 65	Age 65 or over	t-test	Age under 65	Age 65 or over	t-test
Other Care or Service	It was too far to where you had to go for regular or routine health care	8.3	6.5		9.0	6.0	*	8.3	7.0	
	Wanted to be sure you could get the health care you need while you are out of town	7.9	6.2		7.6	7.3		8.4	7.3	
	Health provider or someone from the plan said you could get better care elsewhere	11.7	7.4		11.1	9.7		11.8	10.4	
	You, another family member, or friend had a bad experience with that plan	16.0	10.4	*	16.0	9.8	**	15.0	10.3	**
Premium/ Costs	**Could not pay the monthly premium**	43.9	27.4	**	**39.7**	**23.0**	**	**35.7**	**22.1**	**
	Another plan would cost you less	**46.5**	**39.0**	*	**47.0**	**43.4**		**42.2**	**44.3**	
	Plan started charging a monthly premium or increased your monthly premium	**51.0**	**38.7**	**	**43.5**	**37.1**	**	**37.0**	**34.5**	
Copayments/ Coverage	**Another plan offered better benefits or coverage for some types of care or services**	**41.9**	**39.9**		**50.0**	**46.6**		**48.6**	**50.0**	
	Plan increased the copayment for office visits to your doctor and for other services	**33.2**	**24.2**	**	41.7	29.5	**	31.4	27.9	*
	Plan increased the copayment that you paid for prescription medicines	**38.9**	**24.8**	**	**44.3**	**30.3**	**	**32.8**	**26.0**	**

Chart 4-6

Frequency of 33 preprinted reasons for leaving a plan cited by nonelderly beneficiaries with disabilities and elderly beneficiaries, 2001-2003 (continued)

		Year 2001			Year 2002			Year 2003		
		Age under 65	Age 65 or over	t-test	Age under 65	Age 65 or over	t-test	Age under 65	Age 65 or over	t-test
Drug Coverage	Maximum dollar amount the plan allowed for your prescription medicine was too low	35.5	20.0	**	38.9	22.9	**	34.8	21.8	**
	Plan required you to get a generic medicine when you wanted a brand name medicine	19.1	8.3	**	19.4	10.4	**	16.8	10.1	**
	Plan would not pay for a medication that your doctor had prescribed	24.0	11.8	**	29.2	15.9	**	30.0	15.7	**