2015 Medicare Advantage Health and Drug Plan Disenrollment Reasons Survey Results

Report for: HMO ABC (HXXXX)

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Contents

Part 1: Highlights of the Report ... 1

Overview ... 2

How This Report Is Organized ... 2

How Scores Are Compared ... 2

How to Use This Report ... 3

Summary Tables ... 3

Disenrollment Rate ... 3

Characteristics of Enrollees and Rates of Disenrollment for Beneficiaries with Certain Characteristics ... 4

Reasons for Disenrollment ... 4

Part 2: Detailed Results ... 8

Financial Reasons for Disenrollment (Composite) ... 9

Financial Reasons: Monthly Premium Went Up ... 10

Financial Reasons: Prescription Co-Payment Went Up ... 11

Financial Reasons: Found a Plan That Costs Less ... 12

Financial Reasons: Could No Longer Afford the Plan ... 13

Problems with Prescription Drug Benefits and Coverage (Composite) ... 14

Problems with Prescription Drug Benefits and Coverage: Change in Drug Formulary ... 15

Problems with Prescription Drug Benefits and Coverage: Refusal to Pay for a Prescribed Medication ... 16

Problems with Prescription Drug Benefits and Coverage: Getting Prescribed Medications ... 17

Problems with Prescription Drug Benefits and Coverage: Getting Brand Name Medications ... 18

Problems with Prescription Drug Benefits and Coverage: Approval Process for Off-Formulary Medications ... 19

Problems Getting Information about Prescription Drugs (Composite) ... 20

Problems Getting Information about Prescription Drugs: Did Not Know Whom to Contact about Filling a Prescription ... 21

Problems Getting Information about Prescription Drugs: Coverage and Cost of Prescription Medications ... 22

Problems Getting Information about Prescription Drugs: Handling of a Question or Complaint ... 23

Problems Getting Information about Prescription Drugs: Getting Needed Information or Assistance....24
Problems Getting Information about Prescription Drugs: Customer Service Staff....25
Problems Getting Needed Care, Coverage, and Cost Information (Composite)....26
Problems Getting Needed Care, Coverage, and Cost Information: Approval for Care, Tests, or Treatment....27
Problems Getting Needed Care, Coverage, and Cost Information: Getting Needed Care, Tests, or Treatment....28
Problems Getting Needed Care, Coverage, and Cost Information: Difficulty Getting Claims Paid..29
Problems Getting Needed Care, Coverage, and Cost Information: Getting Information about Coverage and Cost of Health Services....30
Problems with Coverage of Doctors and Hospitals (Composite)....31
Problems with Coverage of Doctors and Hospitals: Preferred Provider Not Covered by Plan....32
Problems with Coverage of Doctors and Hospitals: Preferred Clinic or Hospital Not Covered by Plan....33
Single Item: Co-Payment for Doctor Visit Went Up....34
Single Item: Low Medicare Star Rating....35
Single Item: Found Plan with a Higher Medicare Star Rating....36
Single Item: Family Member or Friend Recommended Another Plan....37
Single Item: Saw Commercial or Advertisement for Another Plan....38
Single Item: Another Plan Better Met Prescription Needs....39
Single Item: Another Plan Offered Better Benefits or Coverage of Health Services....40
Appendix 1: Background and Methodology....41
Background....42
Methodology....42
The Survey Instrument....42
Calculation of Composite Means....46
Reporting of Composite Means on the Medicare Plan Finder....47
Sample Selection and Eligibility Criteria....48
Survey Implementation....48
Sample Disposition....49

Weighting and Case-Mix Adjustment 49
Significance Testing........ 51
Assessing Reliability of Scores 52
Comparison of Reasons for Disenrollment: January-November versus December Disenrollees.....52
State or Regional Comparisons 55
Contact Information 55
Appendix 2: Frequency Tables........ 56

Part 1: Highlights of the Report

Overview

This report contains results for your contract HXXXX from the 2015 Medicare Advantage and Prescription Drug Plan Disenrollment Reasons Survey, a Centers for Medicare & Medicaid Services-sponsored survey that assesses the reasons for disenrollment among Medicare beneficiaries who have voluntarily disenrolled from their Part C and Part D contracts. The survey period covers disenrollment that occurred between January and December 2015. Although beneficiaries provide ratings of their "plans," **the unit of analysis is not a health and/or prescription drug plan but rather a health and/or prescription drug plan contract**. When considered in conjunction with disenrollment rates, beneficiaries' responses to the survey provide information about the quality of a contract as it is experienced by beneficiaries who have chosen to disenroll from the contract. Currently, detailed results from the 2015 survey are being shared with plans to facilitate quality improvement efforts; CMS plans to display scores for the composite measures on the Part C and D Measure Display Page.

How This Report Is Organized

The remainder of this "highlights" section explains the benchmarks included for comparison and shows your plan's performance on disenrollment rates, several composite (summary) measures of reasons for disenrollment derived from the survey, and individual items from the survey.

Part 2 of the report presents detailed results, including your plan's performance on both composite measures of reasons for disenrollment and on individual survey questions, showing both national and state benchmarks. Appendix 1 of the report provides information about the survey and its contents and describes sample selection and other methodological topics. Appendix 2 of the report contains frequency tables that display unadjusted (i.e., not adjusted for case-mix) responses to all survey questions.

How Scores Are Compared

Your contract's disenrollment rate, mean scores on the composite measures of reasons for disenrollment, and results on individual survey questions underlying the composite measures are each compared to the national average for all MA plans. Each composite measure score is tested against the national average for that composite measure, and a note in the margin of Table 1.3 shows whether the difference is statistically significant. Table 1.4 provides results, including comparisons with the national average, for individual survey items about reasons for disenrollment. In the detailed results provided in Part 2, a state or regional average is also provided as a basis for comparison; because of a lack of statistical power, however, statistical tests of the difference between your contract and the state or regional average were not performed.

How to Use This Report

MA-PD plans can use the information in this report to identify program strengths and opportunities for improvement. Comparing the reasons that beneficiaries give for voluntarily leaving your contract with the reasons beneficiaries give for leaving MA contracts nationally may provide some insight on your contract's strengths and weaknesses.

Summary Tables

Disenrollment Rate – Table 1.1 shows the rate of voluntary disenrollment from your contract for calendar year 2015 (January 2015 to December 2015) as a percentage of your contract's total enrollment. Information on disenrollment comes from patient-level disenrollment files maintained by the Centers for Medicare & Medicaid Services. Voluntary disenrollment refers to a beneficiary either dropping coverage entirely or switching to another contract for coverage. Excluded from this calculation are beneficiaries who involuntarily disenrolled from your contract because they were no longer eligible for coverage, moved out of your contract's service area, switched benefits packages within your contract, were involuntarily re-assigned or passively enrolled in a Medicare-Medicaid Plan, or died. The table also shows the national average rate of voluntary disenrollment for MA contracts in 2015, whether the difference between your contract's rate of voluntary disenrollment in 2015 and the national average rate of disenrollment was statistically ($p < .05$) and practically (at least one percentage point) significant, and your contract's voluntary disenrollment rate in 2014.

Table 1.1

Rates of Voluntary Disenrollment			Significantly Different from National Average in 2015?
Your Contract [redacted], 2014	Your Contract [redacted] 2015	National Average, 2015	
18%	22%	12%	Yes (Higher)

Beneficiaries may disenroll from their Medicare health or prescription drug plans at different times of the year. The majority of beneficiaries who disenroll do so in the month of December as part of the annual Medicare Open Enrollment period.[1] Beneficiaries may switch plans outside the Open Enrollment Period under special circumstances, such as if they move out of the plan's service area, are dually eligible for Medicare and Medicaid, qualify for the Low Income Subsidy, qualify for membership in a Special Needs Plan, or enroll in a plan with a 5-star rating. In 2015, the percent of all disenrollees from MA plans who disenrolled in December was 50.2% whereas the percent of disenrollees from your contract who disenrolled in December was 19.1%. Appendix 1 of this report shows how December disenrollees,

[1] The Medicare Open Enrollment Period is from October 15th through December 7th annually, but disenrollments that occur within the Open Enrollment Period are not effective until December.

nationally, compare with those who disenroll during other times of the year in terms of their reasons for disenrollment.

Characteristics of Enrollees and Rates of Disenrollment for Beneficiaries with Certain Characteristics –

The first two columns in Table 1.2 provide information about the characteristics of beneficiaries in your contract and how they compare to the characteristics of MA beneficiaries nationally. The second two columns show the disenrollment rate for beneficiaries in your contract with certain characteristics and how those disenrollment rates compare with rates observed nationally among beneficiaries with the same characteristics.

Table 1.2

Characteristic	Percent of enrollment		Disenrollment rate	
	National	Your contract (H[redacted])	National	Your contract (H[redacted])
ALL Beneficiaries	100%	100%	12%	22%
Dual-eligible	31%	81%	18%	25%
Eligible for low-income subsidy (LIS) / Not dual-eligible	4%	4%	14%	19%
Not LIS-eligible / Not dual-eligible	65%	16%	11%	16%
Elderly (age ≥ 65)	78%	59%	13%	26%
Non-elderly (age < 65)	22%	41%	14%	20%

Note: The voluntary disenrollment rate for "ALL Beneficiaries" (row 1) is calculated according to the Medicare 2017 Part C & D Star Rating Technical Notes for "Members Choosing to Leave the Plan." For the voluntary disenrollment rates for the subgroup categories (rows 2-6), we were unable to apply all of the same exclusions and therefore these rates may appear slightly higher or lower than the rates for "ALL Beneficiaries."

Reasons for Disenrollment – Responses to individual survey questions were combined to form five composite (summary) measures of reasons for disenrollment. For each composite measure, Table 1.3 shows your contract's mean on a 0-100 scale, the national average for all MA contracts, and whether your contract's mean was significantly different from or not significantly different from the national average. The mean score for your contract is the average percentage of reasons endorsed in a composite multiplied by 100. See Appendix 1: Background and Methodology section of this report (p. 46) for an example of how composite means are calculated. A lower mean on a measure indicates that fewer disenrollees from your contract cited reasons included in the composite as a cause of their disenrollment. Your contract's results on the individual survey questions that are included in each composite, as well as

on other survey questions about reasons for disenrollment that are not included in a composite, are listed in Table 1.4. Your contract's score on an individual survey question is simply the percentage of survey respondents who endorsed the reason as a cause of their disenrollment.

Table 1.3 Composite Measures

Reasons for Disenrollment	Your Contract	National Average	Significantly Different from the National Average?
Financial Reasons	**13.6**	**26.5**	Yes (Lower)
Problems with Prescription Drug Benefits and Coverage	16.4	13.0	No
Problems Getting Information about Prescription Drugs	33.3	13.4	Yes (Higher)
Problems Getting Needed Care, Coverage, and Cost Information	43.1	19.4	Yes (Higher)
Problems with Coverage of Doctors and Hospitals	**48.4**	**27.8**	Yes (Higher)

Note: Scores in bold have adequate reliability (0.70 or higher). Scores that are not in bold have low reliability (below 0.70). N/A means too few disenrollees answered the questions that make up the composite to permit reporting. For information on how we tested for statistical significance, assessed reliability, and adjusted for case-mix, see Appendix 1 of this report, pp. 49-52.

Table 1.4 Individual Items

Reasons for Disenrollment	Your Contract	National Average	Significantly Different from the National Average?
Financial Reasons:			
Monthly premium went up	12.3%	24.5%	Yes (Lower)
Prescription co-payment went up	7.4%	19.2%	Yes (Lower)
Found a plan that costs less	26.3%	43.0%	Yes (Lower)
Could no longer afford plan	8.4%	19.2%	Yes (Lower)
Problems with Prescription Drug Benefits and Coverage:			
Change in drug formulary	14.6%	11.5%	No
Plan refused to pay for a prescribed medication	13.8%	13.7%	No
Problems getting prescribed medication	19.4%	13.2%	No
Difficult to get brand name medications	10.7%	11.0%	No
Frustrating approval process for off-formulary medications	23.9%	15.6%	No
Problems Getting Information about Prescription Drugs			
Did not know whom to contact about filling a prescription	9.9%	7.2%	No
Hard to get information about coverage and cost of prescription drugs	10.2%	11.0%	No
Unhappy with how the plan handled a question or complaint	57.1%	19.9%	Yes (Higher)
Could not get information or help needed from the plan	54.8%	21.2%	Yes (Higher)
Customer service not courteous or respectful	34.4%	8.0%	Yes (Higher)
Problems getting Needed Care, Coverage and Cost Information			
Frustration with approval process for care, tests, or treatment	58.4%	25.3%	Yes (Higher)
Problems getting needed care, tests, or treatment	60.7%	24.3%	Yes (Higher)
Problems getting claims paid	16.9%	13.3%	No
Hard to get information about coverage and cost of health services	36.4%	14.6%	Yes (Higher)

Individual Survey Items (cont.)

Reasons for Disenrollment	Your Contract	National Average	Significantly Different from the National Average?
Problems with Coverage of Doctors and Hospitals			
Preferred provider not in plan	55.3%	32.9%	Yes (Higher)
Preferred clinic or hospital not covered by plan	41.4%	22.8%	Yes (Higher)
Single Items (not in a composite)			
Co-Payment for doctor visit went up	7.2%	18.6%	Yes (Lower)
Low Medicare star rating	3.6%	4.3%	No
Found a plan with a higher Medicare star rating	13.9%	14.4%	No
Family member or friend recommended another plan	32.2%	27.3%	No
Saw commercial or advertisement for another plan that looked better	14.8%	18.1%	No
Another plan better met prescription needs	47.7%	33.6%	No
Another plan offered better benefits or coverage of health services	38.8%	45.2%	No

Note: N/A means too few disenrollees answered the question to permit reporting. For information on how we tested for statistical significance and adjusted for case-mix, see Appendix 1 of this report, pp. 49-51.

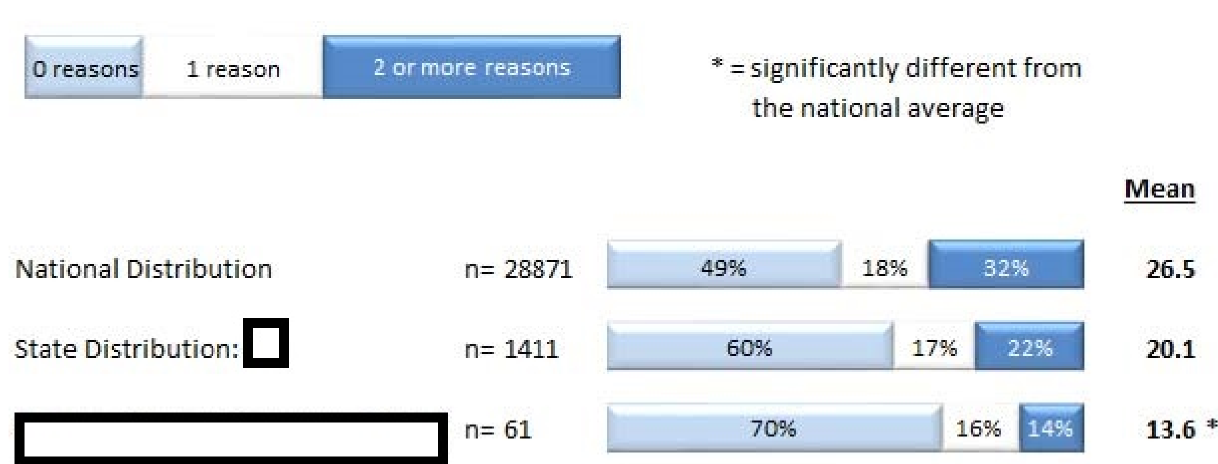
Part 2: Detailed Results

In the following pages, we provide detailed results of the 2015 Medicare Advantage and Prescription Drug Plan Disenrollment Reasons Survey, including your contract's performance on the individual survey questions that make up each of the composite measures and other individual survey questions that may be of interest. Please note that there may be apparent discrepancies in the individual survey item percentages shown based on proper application of the rounding rules. For example, a value of 19.46% would get rounded to 19 in the bar chart (integer value), but would get rounded to 19.5 for the one-decimal value.

Financial Reasons for Disenrollment (Composite)

This figure below shows how your contract performed on the measure "Financial Reasons for Disenrollment," a composite of survey questions 20, 22, 24, and 25. Each of these questions asked about a reason for disenrollment that was related to the cost or affordability of services. The figure shows the number of disenrollees from your contract who answered at least one of these questions and the percentage of those disenrollees who endorsed 0, 1, or 2 or more of the reasons as a cause of their disenrollment. The figure also shows your contract's mean on the composite (the average percentage of reasons endorsed in the composite multiplied by 100) and whether the mean was higher or lower than the national average for all MA contracts. A lower mean indicates that financial reasons were endorsed less frequently by disenrollees from your contract. If the mean for your contract appears in bold, it signifies that the mean has adequate reliability (0.70 or above in a 0 to 1.0 range). Mean scores not appearing in bold have low reliability (below 0.70). N/A signifies that too few disenrollees answered the questions to permit reporting. Results for the individual survey questions that this composite measure comprises are on the following pages.

Financial Reasons for Disenrollment

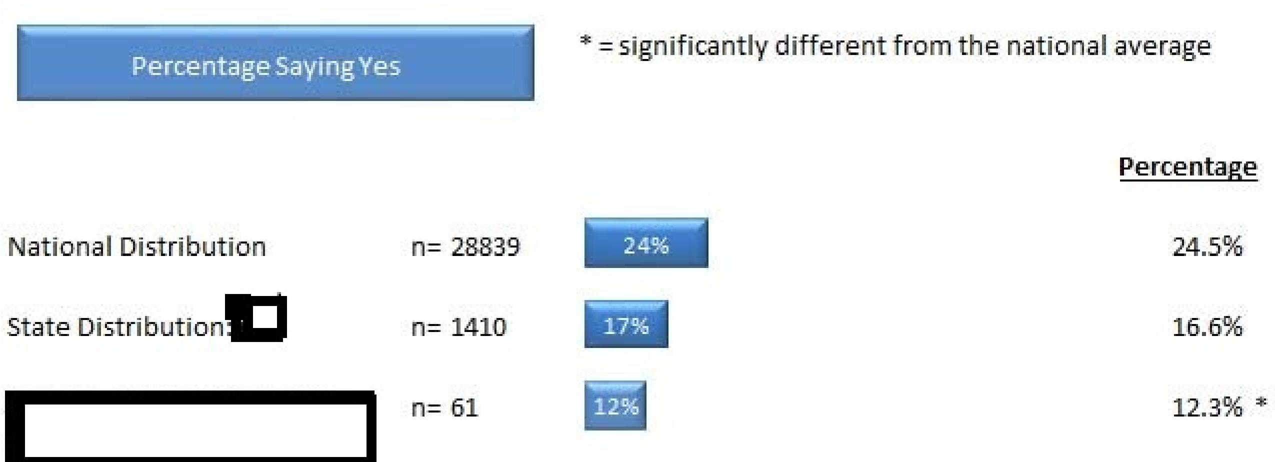


Note: N/A means too few disenrollees answered the questions to permit reporting. Percentages may not add to 100 due to rounding. The mean score is calculated as the average percentage of reasons endorsed in this composite (0 to 100 scale). Contract means appearing in bold have adequate reliability (0.70 or above). For information on how we tested for statistical significance, assessed reliability, and adjusted for case-mix, see Appendix 1 of this report, pp. 49-52.

Financial Reasons: Monthly Premium Went Up

Question 20: Did you leave the plan because the monthly fee that the health plan charges to provide coverage for health care and prescription medicines went up?

Disenrolled Because Monthly Premium Went Up

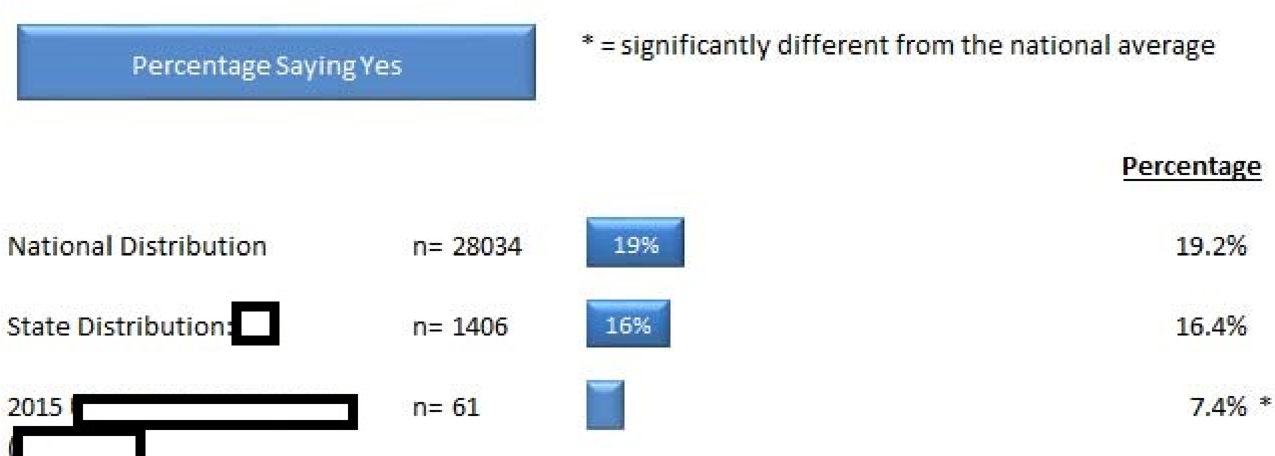


Note: N/A means too few disenrollees answered the question to permit reporting. For information on how we tested for statistical significance, and adjusted for case-mix, see Appendix 1 of this report, pp. 49-51.

Financial Reasons: Prescription Co-Payment Went Up

Question 22: Did you leave the plan because the dollar amount you had to pay each time you filled or refilled a prescription went up?

Disenrolled Because Prescription Co-Payment Went Up

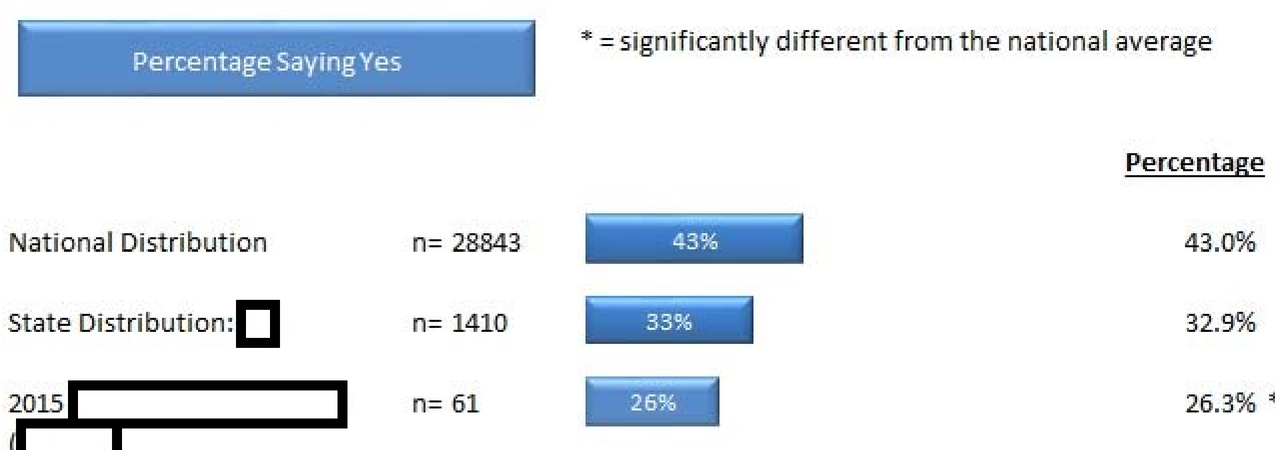


Note: N/A means too few disenrollees answered the question to permit reporting. For information on how we tested for statistical significance, and adjusted for case-mix, see Appendix 1 of this report, pp. 49-51.

Financial Reasons: Found a Plan That Costs Less

Question 24: Did you leave the plan because you found a health plan that costs less?

Disenrolled Because Found a Plan that Costs Less

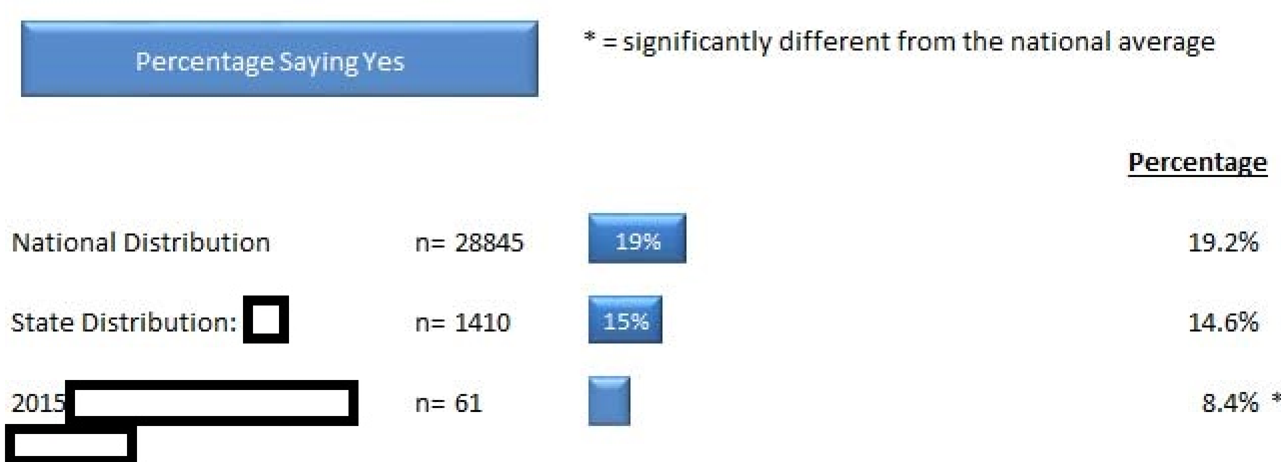


Note: N/A means too few disenrollees answered the question to permit reporting. For information on how we tested for statistical significance, and adjusted for case-mix, see Appendix 1 of this report, pp. 49-51.

Financial Reasons: Could No Longer Afford the Plan

Question 25: Did you leave the plan because a change in your personal finances meant you could no longer afford the plan?

Disenrolled Because Could No Longer Afford the Plan

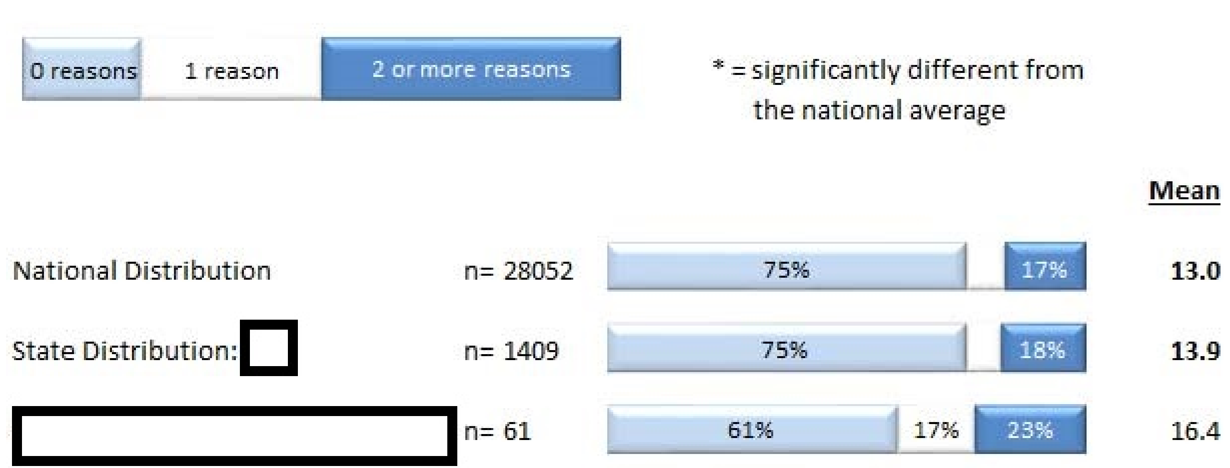


Note: N/A means too few disenrollees answered the question to permit reporting. For information on how we tested for statistical significance, and adjusted for case-mix, see Appendix 1 of this report, pp. 49-51.

Problems with Prescription Drug Benefits and Coverage (Composite)

The figure below shows how your contract performed on the measure "Problems with Prescription Drug Benefits and Coverage," a composite of survey questions 21, 26, 27, 28, and 29. Each of these questions asked about a reason for disenrollment that was related to prescription drug benefits and coverage. The figure shows the number of disenrollees from your contract who answered at least one of these questions and the percentage of those disenrollees who endorsed 0, 1, or 2 or more of the reasons as a cause of their disenrollment. The figure also shows your contract's mean on the composite (the average percentage of reasons endorsed in the composite multiplied by 100) and whether the mean was higher or lower than the national average for all MA contracts. A lower mean indicates that problems with prescription drug benefits and coverage were cited less frequently by disenrollees from your contract. If the mean for your contract appears in bold, it signifies that the mean has adequate reliability (0.70 or above in a 0 to 1.0 range). Means not appearing in bold have low reliability (below 0.70). N/A signifies that too few disenrollees answered the question to permit reporting. Results for the individual survey questions that this composite measure comprises are on the following pages.

Problems with Prescription Drug Benefits and Coverage

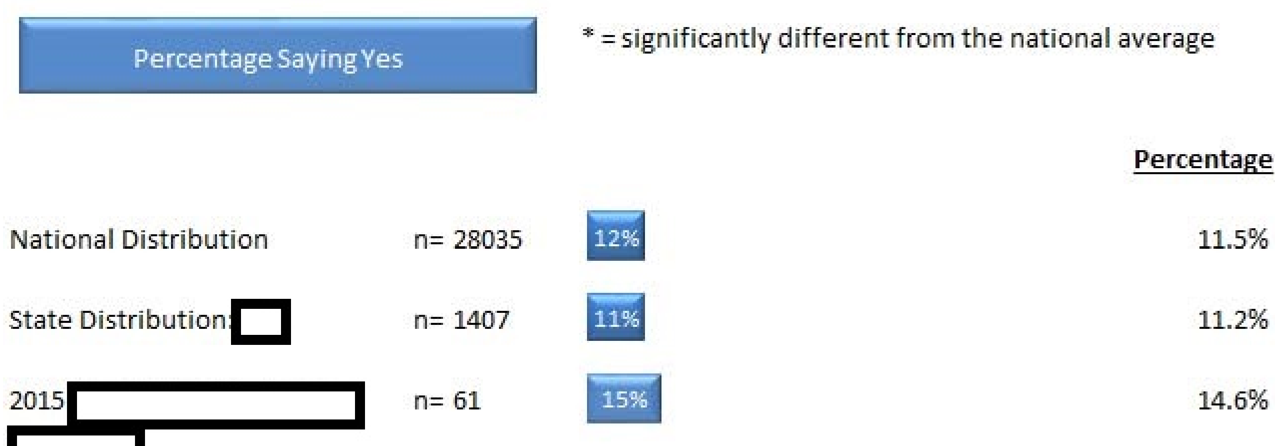


Note: N/A means too few disenrollees answered the questions to permit reporting. Percentages may not add to 100 due to rounding. The mean score is calculated as the average percentage of reasons endorsed in this composite (0 to 100 scale). Contract means appearing in bold have adequate reliability (0.70 or above). For information on how we tested for statistical significance, assessed reliability, and adjusted for case-mix, see Appendix 1 of this report, pp. 49-52.

Problems with Prescription Drug Benefits and Coverage: Change in Drug Formulary

Question 21: Did you leave the plan because they changed the list of prescription medicines they cover?

Disenrolled Because of Change in Drug Formulary

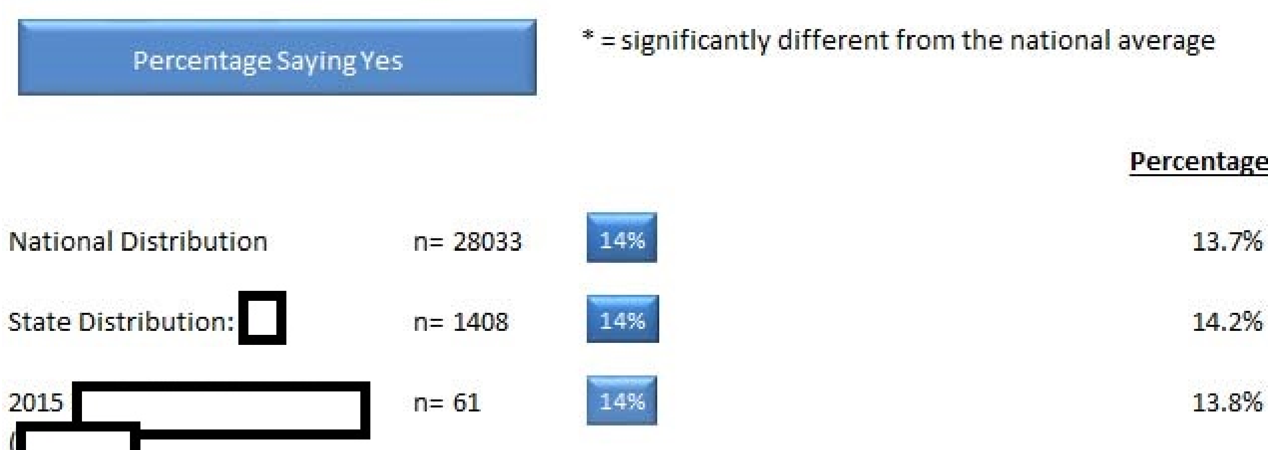


Note: N/A means too few disenrollees answered the question to permit reporting. For information on how we tested for statistical significance, and adjusted for case-mix, see Appendix 1 of this report, pp. 49-51.

Problems with Prescription Drug Benefits and Coverage: Refusal to Pay for a Prescribed Medication

Question 26: Did you leave the plan because the plan refused to pay for a medicine your doctor prescribed?

Disenrolled Because Plan Refused to Pay for a Prescribed Medication

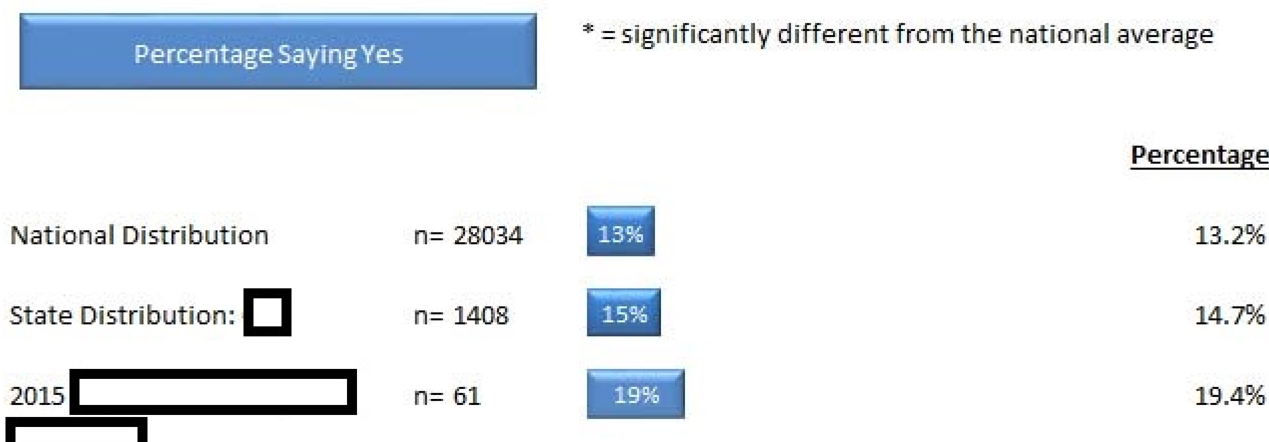


Note: N/A means too few disenrollees answered the question to permit reporting. For information on how we tested for statistical significance, and adjusted for case-mix, see Appendix 1 of this report, pp. 49-51.

Problems with Prescription Drug Benefits and Coverage: Getting Prescribed Medications

Question 27: Did you leave the plan because you had problems getting the medicines your doctor prescribed?

Disenrolled Because of Problems Getting Prescribed Medications

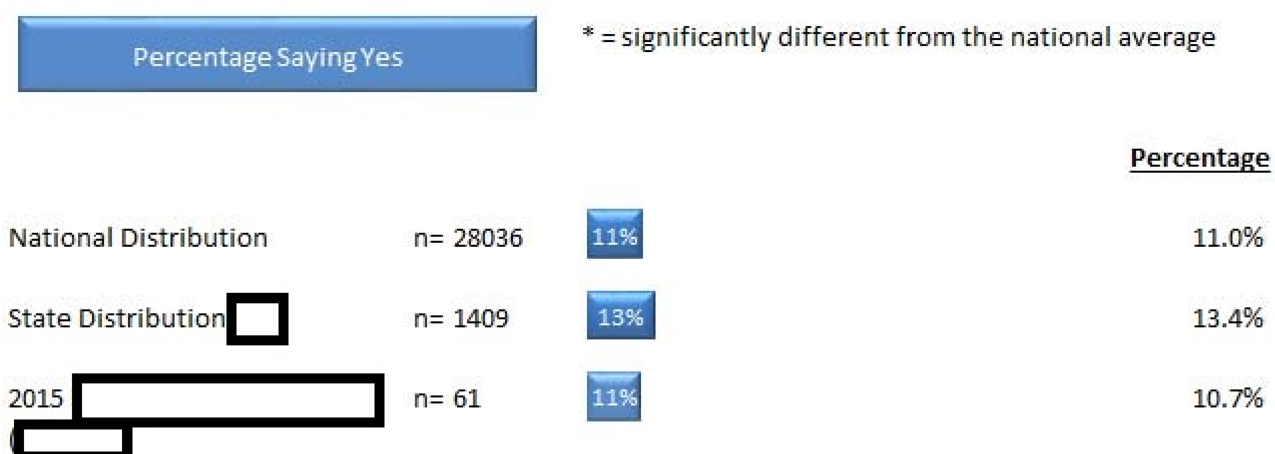


Note: N/A means too few disenrollees answered the question to permit reporting. For information on how we tested for statistical significance, and adjusted for case-mix, see Appendix 1 of this report, pp. 49-51.

Problems with Prescription Drug Benefits and Coverage: Getting Brand Name Medications

Question 28: Did you leave the plan because it was difficult to get brand name medicines?

Disenrolled Because It Was Difficult to Get Brand Name Medications

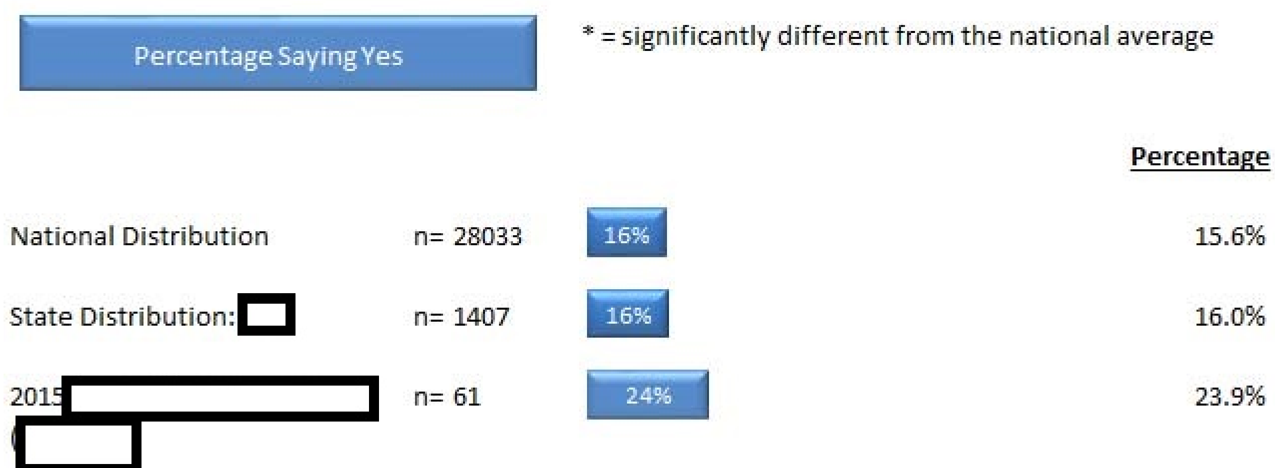


Note: N/A means too few disenrollees answered the question to permit reporting. For information on how we tested for statistical significance, and adjusted for case-mix, see Appendix 1 of this report, pp. 49-51.

Problems with Prescription Drug Benefits and Coverage: Approval Process for Off-Formulary Medications

Question 29: Did you leave the plan because you were frustrated by the plan's approval process for medicines your doctor prescribed that were not on the plan's list of medicines that the plan covers?

Disenrolled Because of Frustrating Approval Process for Off-Formulary Medications

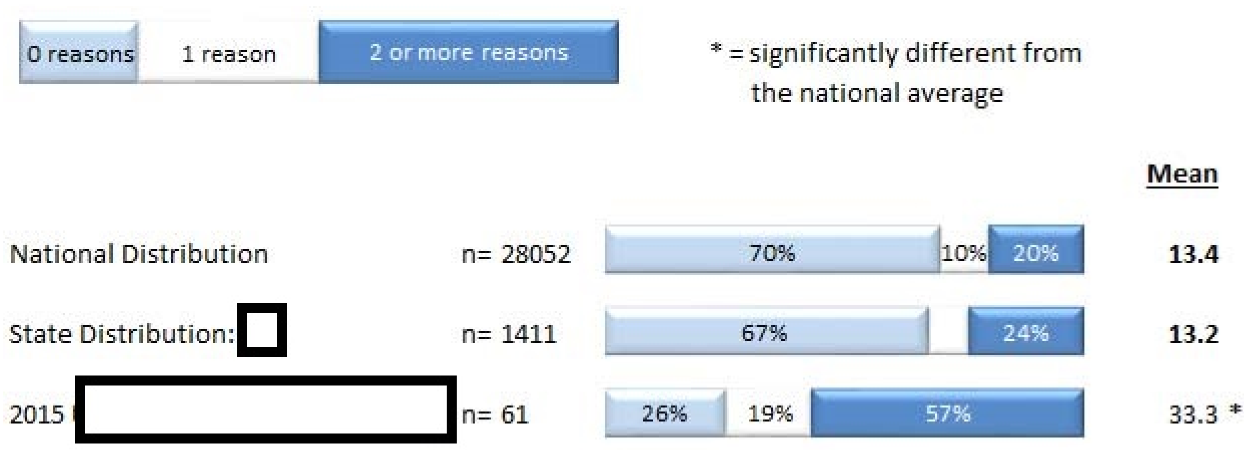


Note: N/A means too few disenrollees answered the question to permit reporting. For information on how we tested for statistical significance, and adjusted for case-mix, see Appendix 1 of this report, pp. 49-51.

Problems Getting Information about Prescription Drugs (Composite)

The figure below shows how your contract performed on the measure "Problems Getting Information about Prescription Drugs," a composite of survey questions 30, 31, 38, 39, and 40. Each of these questions asked about a reason for disenrollment that was related to the beneficiary's experiences with getting information about prescription drugs. The figure shows the number of disenrollees from your contract who answered at least one of these questions and the percentage of those disenrollees who endorsed 0, 1, or 2 or more of the reasons as a cause of their disenrollment. The figure also shows your contract's mean on the composite (the average percentage of reasons endorsed in the composite multiplied by 100) and whether the mean was higher or lower than the national average for all MA contracts. A lower mean indicates that problems getting information about prescription drugs were cited less frequently by disenrollees from your contract. If the mean for your contract appears in bold, it signifies that the mean has adequate reliability (0.70 or above in a 0 to 1.0 range). Means not appearing in bold have low reliability (below 0.70). N/A signifies that too few disenrollees answered the question to permit reporting. Results for the individual survey questions that this composite measure comprises are on the following pages.

Problems Getting Information about Prescription Drugs

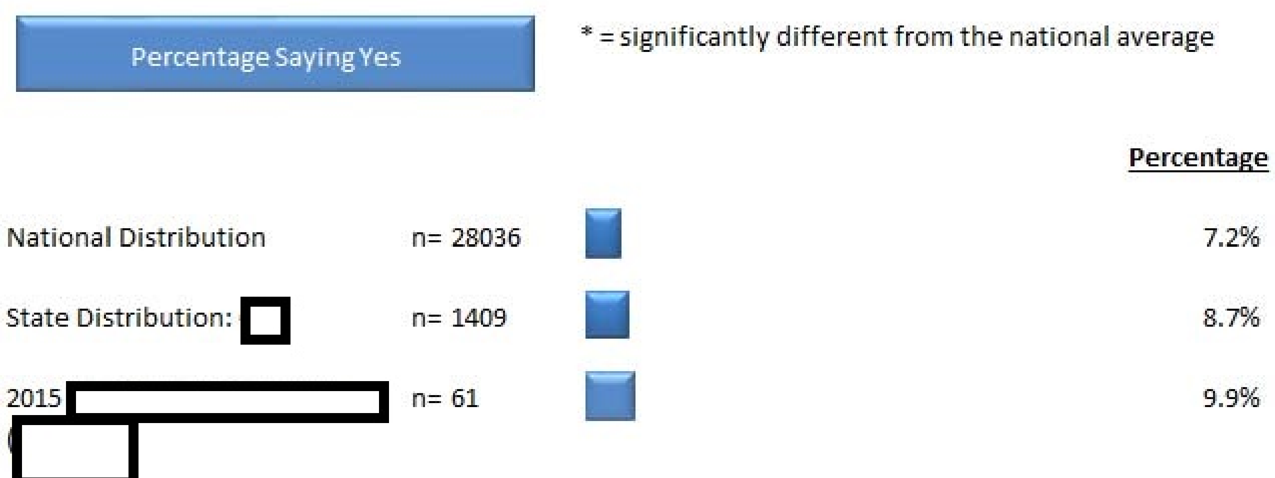


Note: N/A means too few disenrollees answered the questions to permit reporting. Percentages may not add to 100 due to rounding. The mean score is calculated as the average percentage of reasons endorsed in this composite (0 to 100 scale). Contract means appearing in bold have adequate reliability (0.70 or above). For information on how we tested for statistical significance, assessed reliability, and adjusted for case-mix, see Appendix 1 of this report, pp. 49-52.

Problems Getting Information about Prescription Drugs: Did Not Know Whom to Contact about Filling a Prescription

Question 30: Did you leave the plan because you did not know whom to contact when you had a problem filling or refilling a prescription?

Disenrolled Because Did Not Know Whom to Contact about Filling a Prescription



Note: N/A means too few disenrollees answered the question to permit reporting. For information on how we tested for statistical significance, and adjusted for case-mix, see Appendix 1 of this report, pp. 49-51.

Problems Getting Information about Prescription Drugs: Coverage and Cost of Prescription Medications

Question 31: Did you leave the plan because it was hard to get information from the plan – like which prescription medicines were covered or how much a specific medicine would cost?

Disenrolled Because It Was Hard to Get Information about Coverage and Cost of Prescription Drugs

Percentage Saying Yes

* = significantly different from the national average

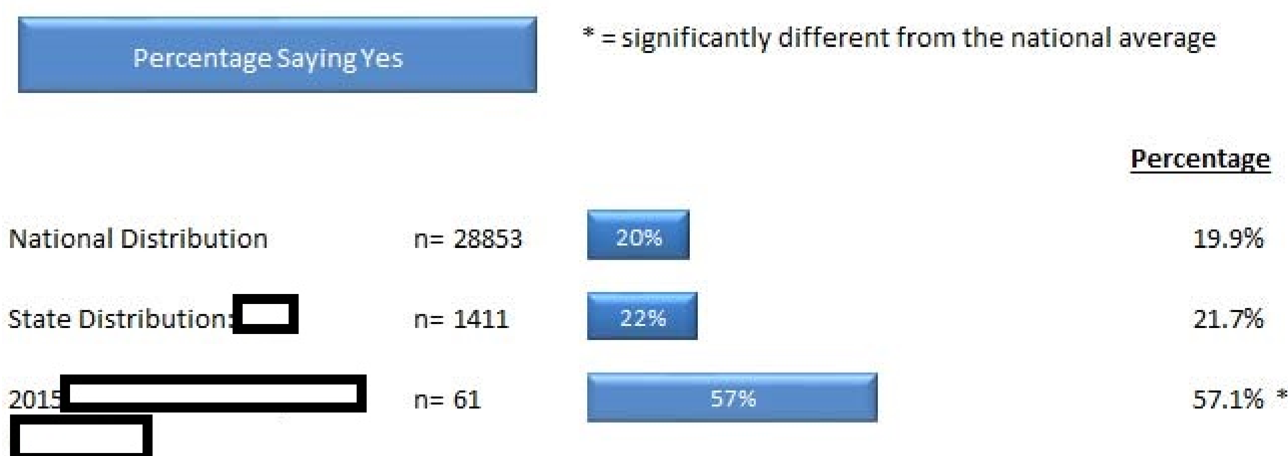
			Percentage
National Distribution	n= 28038	11%	11.0%
State Distribution:	n= 1409	11%	11.4%
2015 (	n= 61	10%	10.2%

Note: N/A means too few disenrollees answered the question to permit reporting. For information on how we tested for statistical significance, and adjusted for case-mix, see Appendix 1 of this report, pp. 49-51.

Problems Getting Information about Prescription Drugs: Handling of a Question or Complaint

Question 38: Did you leave the plan because you were unhappy with how the plan handled a question or complaint?

Disenrolled Because Unhappy with How the Plan Handled a Question or Complaint

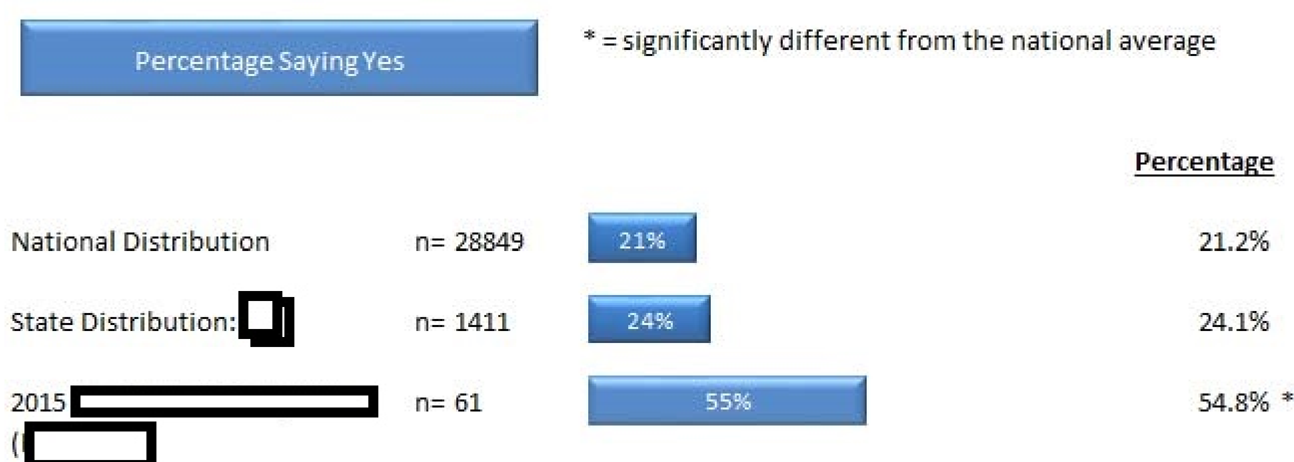


Note: N/A means too few disenrollees answered the question to permit reporting. For information on how we tested for statistical significance, and adjusted for case-mix, see Appendix 1 of this report, pp. 49-51.

Problems Getting Information about Prescription Drugs: Getting Needed Information or Assistance

Question 39: Did you leave the plan because you could not get the information or help you needed from the plan?

Disenrolled Because Could Not Get Information or Help Needed from the Plan

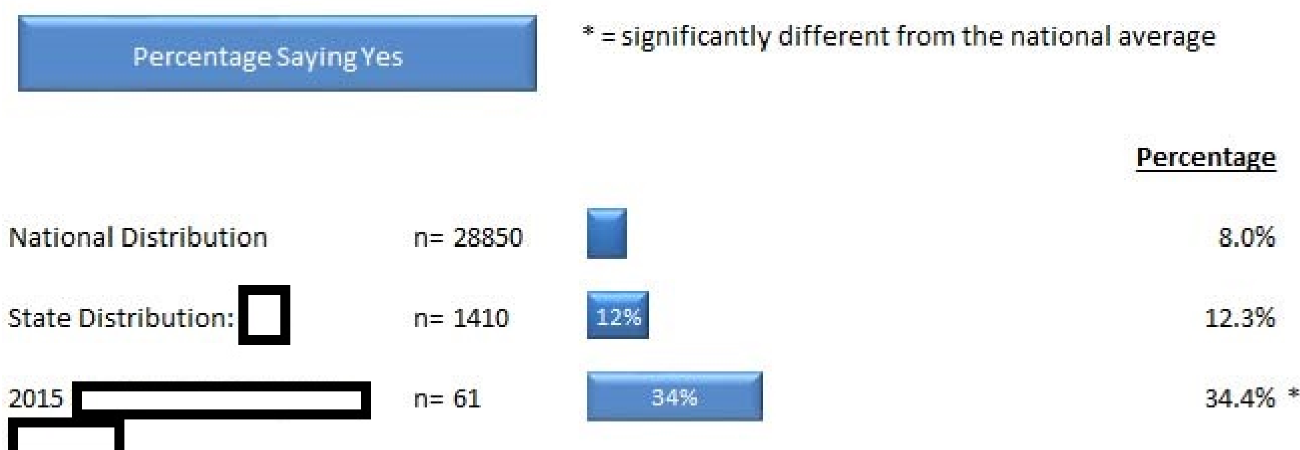


Note: N/A means too few disenrollees answered the question to permit reporting. For information on how we tested for statistical significance, and adjusted for case-mix, see Appendix 1 of this report, pp. 49-51.

Problems Getting Information about Prescription Drugs: Customer Service Staff

Question 40: Did you leave the plan because their customer service staff did not treat you with courtesy and respect?

Disenrolled Because Customer Service Not Courteous or Respectful

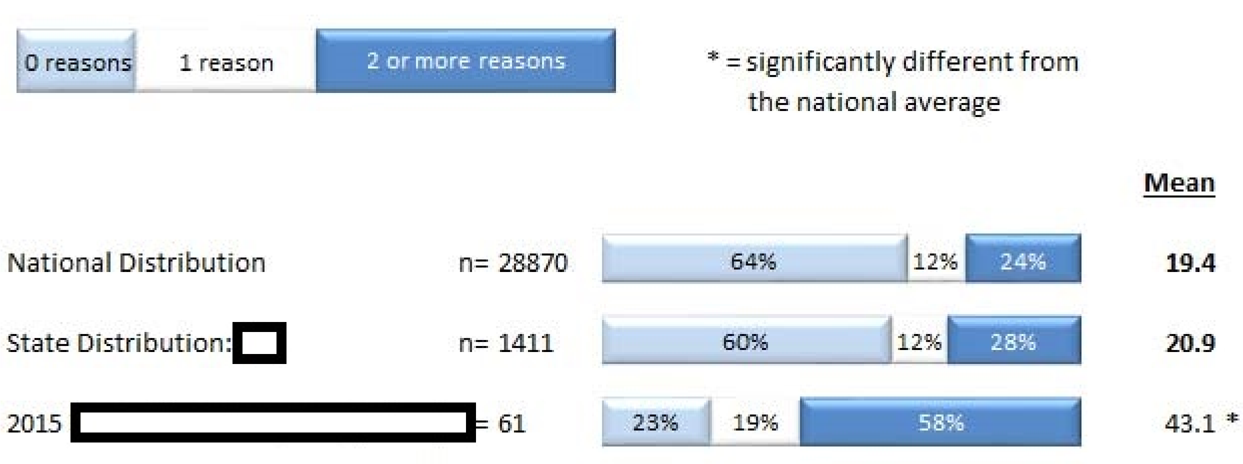


Note: N/A means too few disenrollees answered the question to permit reporting. For information on how we tested for statistical significance, and adjusted for case-mix, see Appendix 1 of this report, pp. 49-51.

Problems Getting Needed Care, Coverage, and Cost Information (Composite)

The figure below shows how your contract performed on the measure "Problems Getting Needed Care, Coverage, and Cost Information," a composite of survey questions 32, 33, 34, and 37. Each of these questions asked about a reason for disenrollment that was related to the beneficiary's experiences with getting needed health care services and cost information and getting claims paid for these services. The figure shows the number of disenrollees from your contract who answered at least one of these questions and the percentage of those disenrollees who endorsed 0, 1, or 2 or more of the reasons as a cause of their disenrollment. The figure also shows your contract's mean on the composite (the average percentage of reasons endorsed in the composite multiplied by 100) and whether the mean was higher or lower than the national average for all MA contracts. A lower mean indicates that problems getting needed care, coverage, and cost information were cited less frequently by disenrollees from your contract. If the mean for your contract appears in bold, it signifies that the mean has adequate reliability (0.70 or above in a 0 to 1.0 range). Means not appearing in bold have low reliability (below 0.70). N/A signifies too few disenrollees answered the question to permit reporting. Results for the individual survey questions that this composite measure comprises are on the following pages.

Problems Getting Needed Care, Coverage, and Cost Information

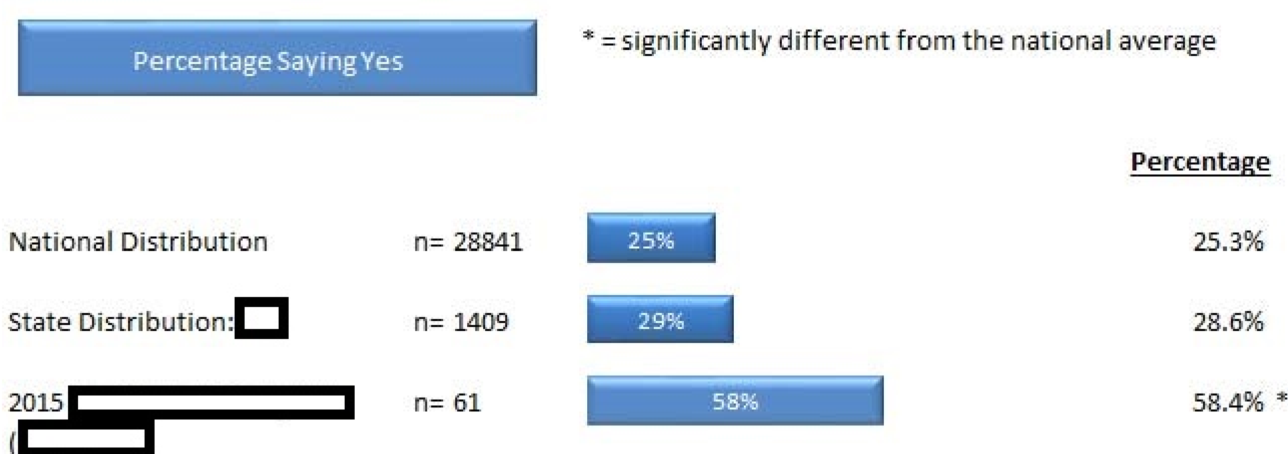


Note: N/A means too few disenrollees answered the questions to permit reporting. Percentages may not add to 100 due to rounding. The mean score is calculated as the average percentage of reasons endorsed in this composite (0 to 100 scale). Contract means appearing in bold have adequate reliability (0.70 or above). For information on how we tested for statistical significance, assessed reliability, and adjusted for case-mix, see Appendix 1 of this report, pp. 49-52.

Problems Getting Needed Care, Coverage, and Cost Information: Approval for Care, Tests, or Treatment

Question 32: Did you leave the plan because you were frustrated by the plan's approval process for care, tests, or treatment?

Disenrolled Because of Frustration with Approval Process for Care, Tests, or Treatment

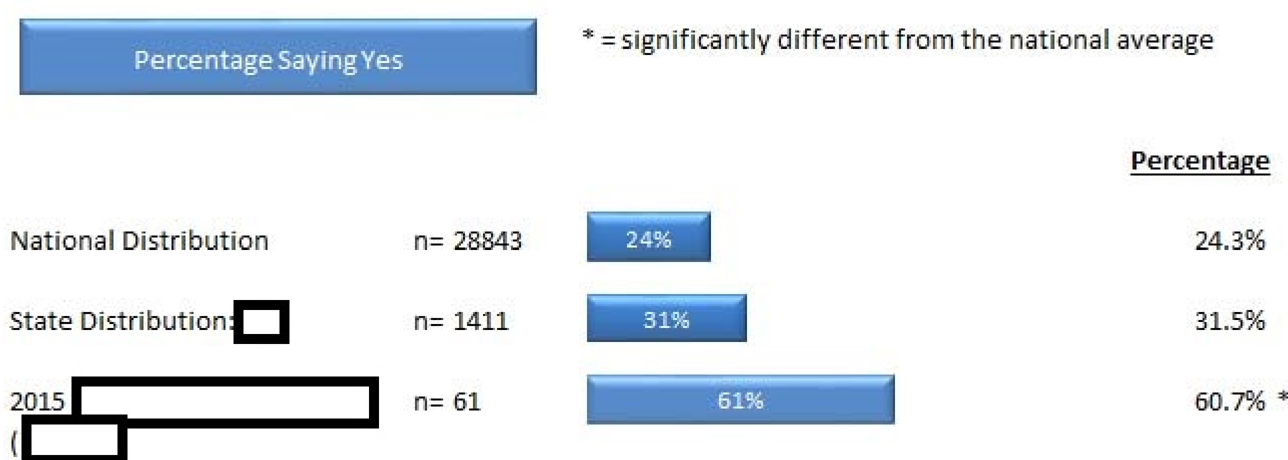


Note: N/A means too few disenrollees answered the question to permit reporting. For information on how we tested for statistical significance, and adjusted for case-mix, see Appendix 1 of this report, pp. 49-51.

Problems Getting Needed Care, Coverage, and Cost Information: Getting Needed Care, Tests, or Treatment

Question 33: Did you leave the plan because you had problems getting the care, tests, or treatment you needed?

Disenrolled Because of Problems Getting Needed Care, Tests, or Treatment

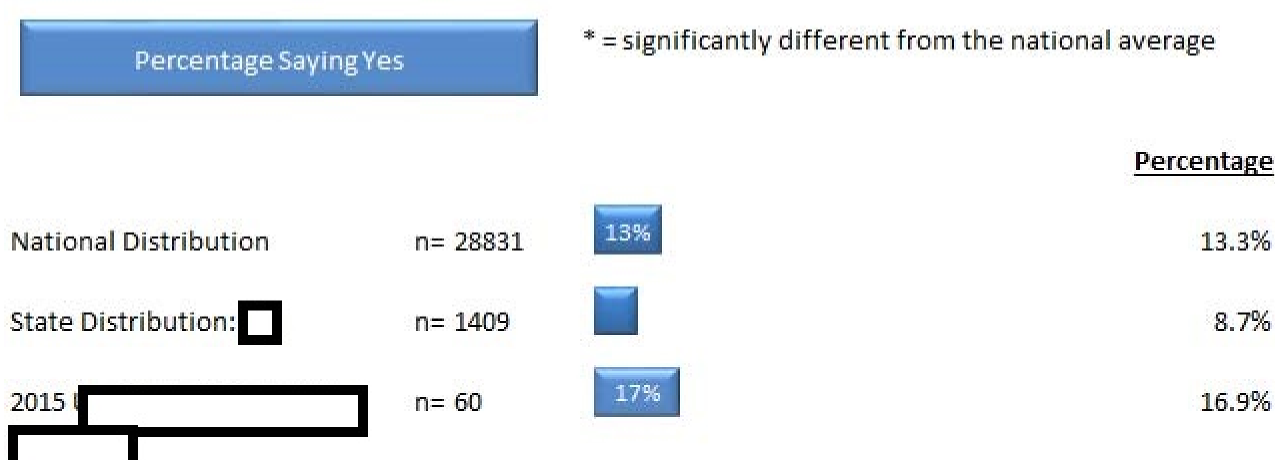


Note: N/A means too few disenrollees answered the question to permit reporting. For information on how we tested for statistical significance, and adjusted for case-mix, see Appendix 1 of this report, pp. 49-51.

Problems Getting Needed Care, Coverage, and Cost Information: Difficulty Getting Claims Paid

Question 34: Did you leave the plan because you had problems getting the plan to pay a claim?

Disenrolled Because of Difficulty Getting Claims Paid

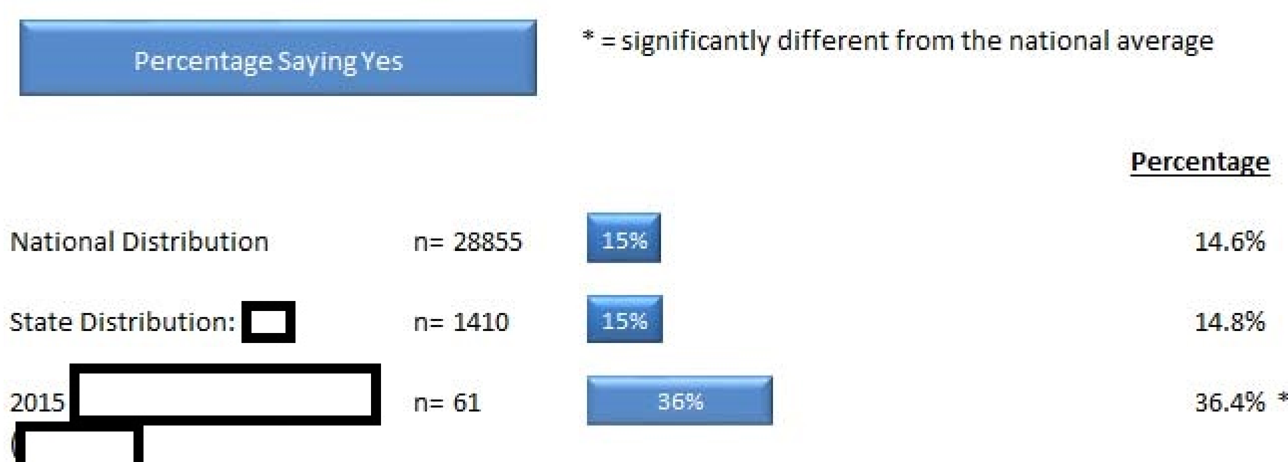


Note: N/A means too few disenrollees answered the question to permit reporting. For information on how we tested for statistical significance, and adjusted for case-mix, see Appendix 1 of this report, pp. 49-51.

Problems Getting Needed Care, Coverage, and Cost Information: Getting Information about Coverage and Cost of Health Services

Question 37: Did you leave the plan because it was hard to get information from the plan – like which health care services were covered or how much a specific test or treatment would cost?

Disenrolled Because of Difficulty Getting Information about Coverage and Cost of Health Services

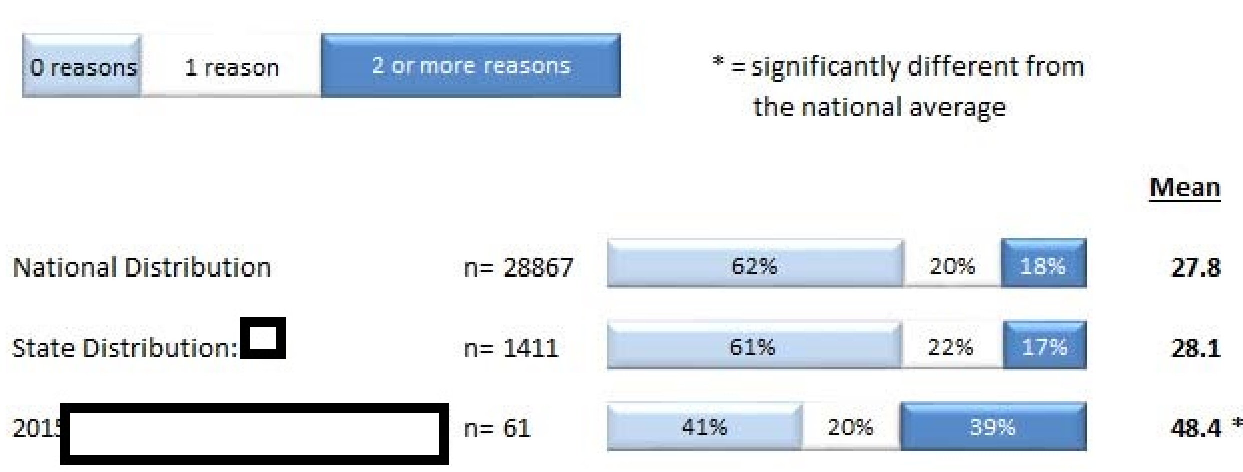


Note: N/A means too few disenrollees answered the question to permit reporting. For information on how we tested for statistical significance, and adjusted for case-mix, see Appendix 1 of this report, pp. 49-51.

Problems with Coverage of Doctors and Hospitals (Composite)

The figure below shows how your contract performed on the measure “Problems with Coverage of Doctors and Hospitals,” a composite of survey questions 35 and 36. Each of these questions asked about a reason for disenrollment that was related to the coverage of doctors and hospitals by the plan. The figure shows the number of disenrollees from your contract who answered at least one of these questions and the percentage of those disenrollees who endorsed 0, 1, or both of the reasons as a cause of their disenrollment. The figure also shows your contract’s mean on the composite (the average percentage of reasons endorsed in the composite multiplied by 100) and whether the mean was higher or lower than the national average for all MA contracts. A lower mean indicates that problems with coverage of doctors and hospitals were cited less frequently by disenrollees from your contract. If the mean for your contract appears in bold, it signifies that the mean has adequate reliability (0.70 or above in a 0 to 1.0 range). Means not appearing in bold have low reliability (below 0.70). N/A signifies that too few disenrollees answered the question to permit reporting. Results for the individual survey questions that this composite measure comprises are on the following pages.

Problems with Coverage of Doctors and Hospitals

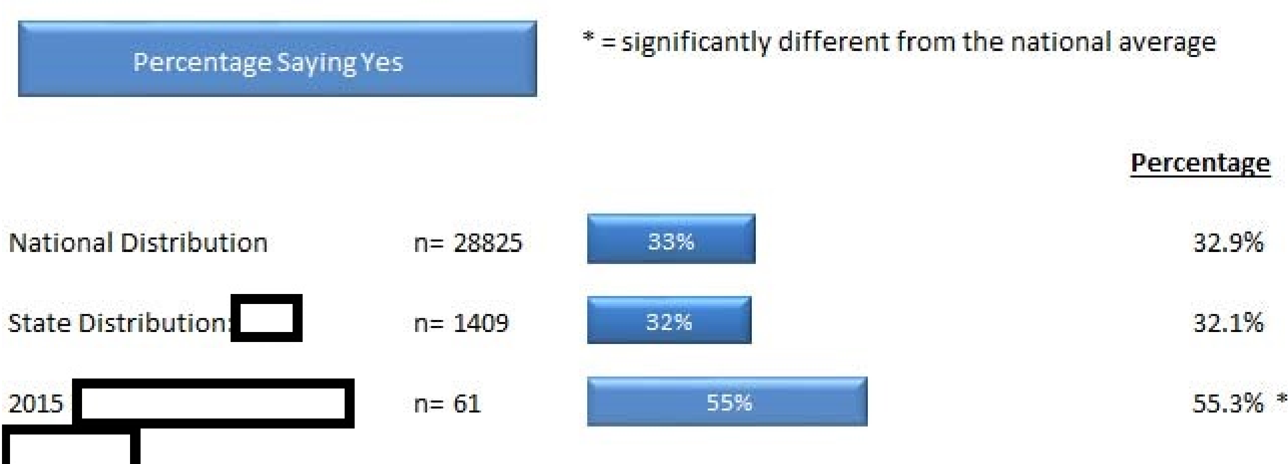


Note: N/A means too few disenrollees answered the questions to permit reporting. Percentages may not add to 100 due to rounding. The mean score is calculated as the average percentage of reasons endorsed in this composite (0 to 100 scale). Contract means appearing in bold have adequate reliability (0.70 or above). For information on how we tested for statistical significance, assessed reliability, and adjusted for case-mix, see Appendix 1 of this report, pp. 49-52.

Problems with Coverage of Doctors and Hospitals: Preferred Provider Not Covered by Plan

Question 35: Did you leave the plan because the doctors or other health care providers you wanted to see did not belong to the plan?

Disenrolled Because Preferred Provider Not in Plan

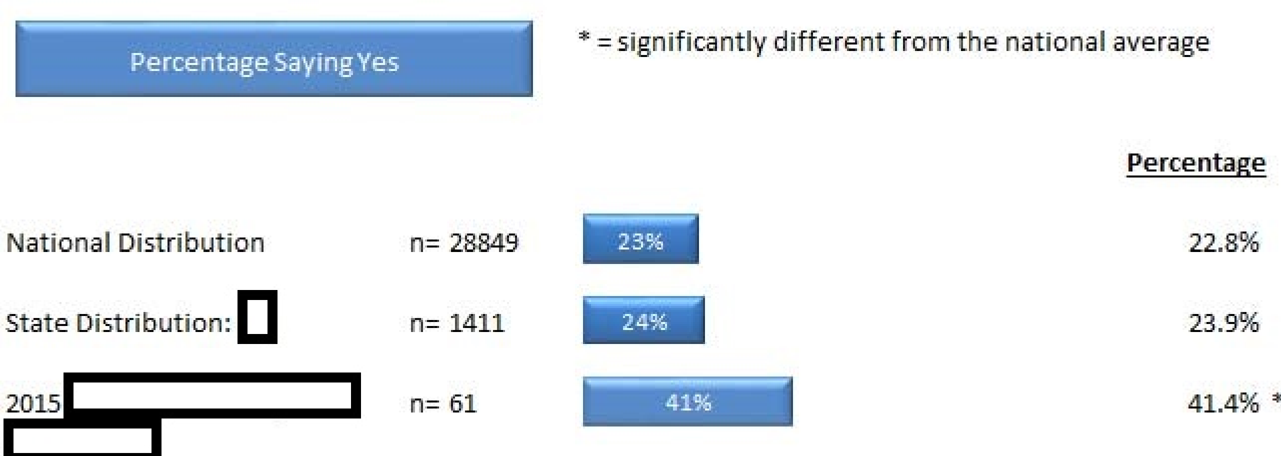


Note: N/A means too few disenrollees answered the question to permit reporting. For information on how we tested for statistical significance, and adjusted for case-mix, see Appendix 1 of this report, pp. 49-51.

Problems with Coverage of Doctors and Hospitals: Preferred Clinic or Hospital Not Covered by Plan

Question 36: Did you leave the plan because clinics or hospitals that you wanted to go to for care were not covered by the plan?

Disenrolled Because Preferred Clinic or Hospital Not Covered by Plan



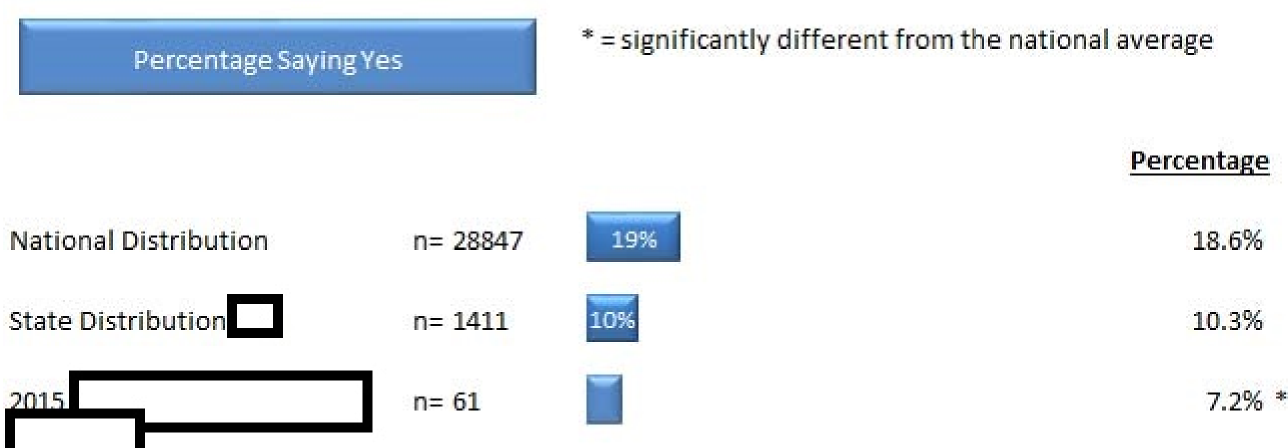
Note: N/A means too few disenrollees answered the question to permit reporting. For information on how we tested for statistical significance, and adjusted for case-mix, see Appendix 1 of this report, pp. 49-51.

Single Item: Co-Payment for Doctor Visit Went Up

(Not included in a composite)

Question 23: Did you leave the plan because the dollar amount you had to pay each time you visited a doctor went up?

Disenrolled Because Co-Payment for Doctor Visit Went Up



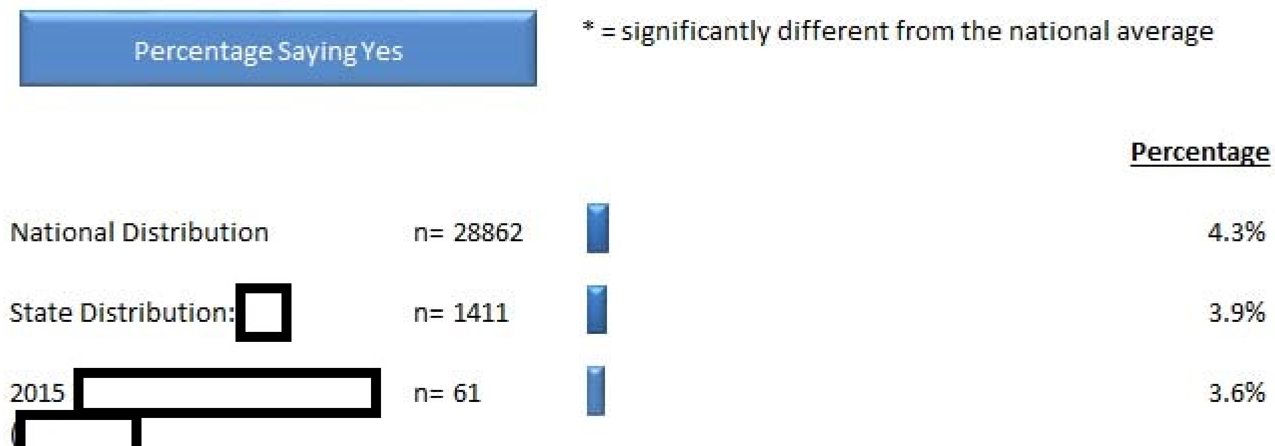
Note: N/A means too few disenrollees answered the question to permit reporting. For information on how we tested for statistical significance, and adjusted for case-mix, see Appendix 1 of this report, pp. 49-51.

Single Item: Low Medicare Star Rating

(Not included in a composite)

Question 41: Did you leave the plan because it got a low Medicare Star Rating?

Disenrolled Because of Low Medicare Star Rating



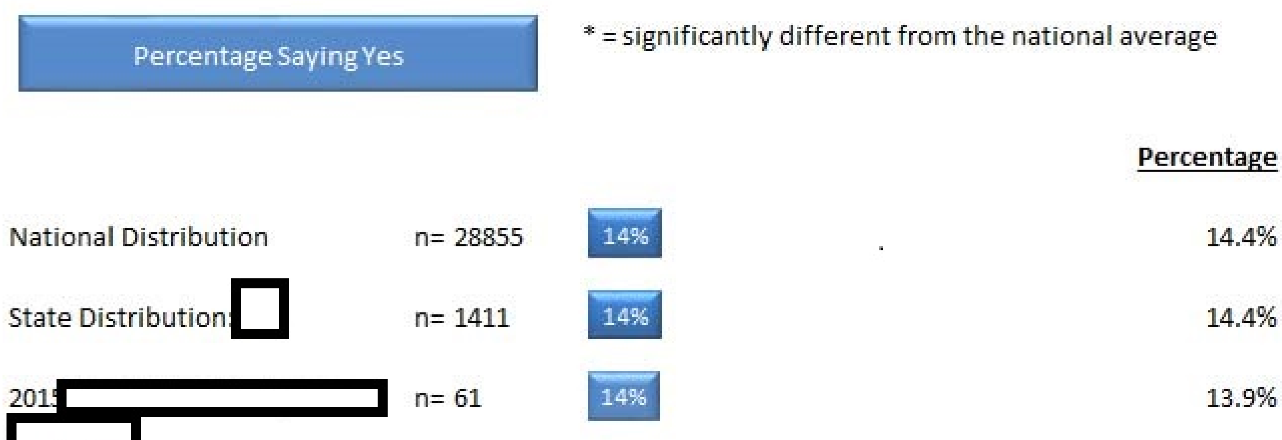
Note: N/A means too few disenrollees answered the question to permit reporting. For information on how we tested for statistical significance, and adjusted for case-mix, see Appendix 1 of this report, pp. 49-51.

Single Item: Found Plan with a Higher Medicare Star Rating

(Not included in a composite)

Question 42: Did you leave the plan because you found another plan with a higher Medicare Star Rating?

Disenrolled Because Found a Plan with a Higher Medicare Star Rating



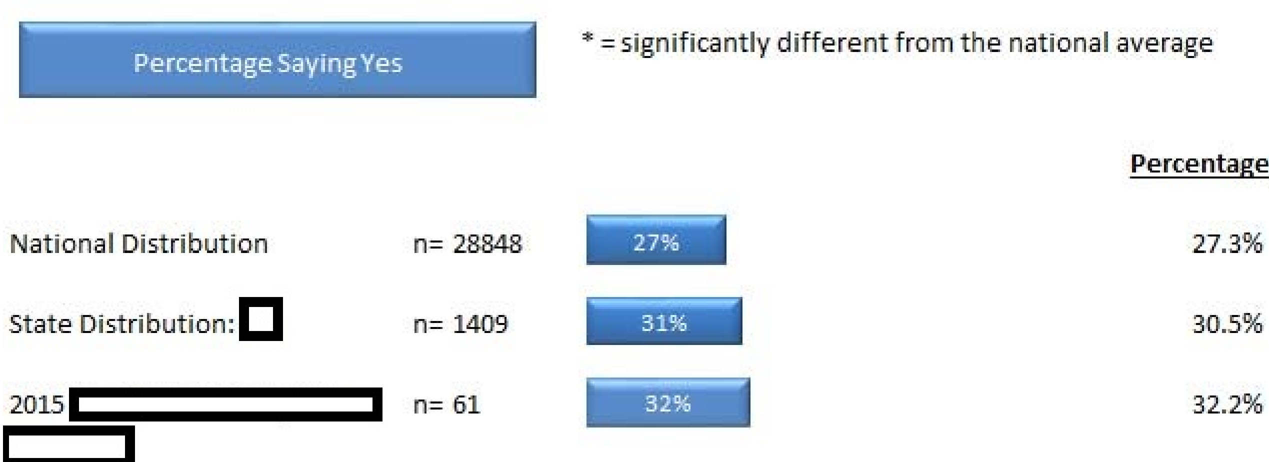
Note: N/A means too few disenrollees answered the question to permit reporting. For information on how we tested for statistical significance, and adjusted for case-mix, see Appendix 1 of this report, pp. 49-51.

Single Item: Family Member or Friend Recommended Another Plan

(Not included in a composite)

Question 44: Did you leave the plan because a family member or friend told you that another health plan was a better plan?

Disenrolled Because Family Member or Friend Recommended Another Plan



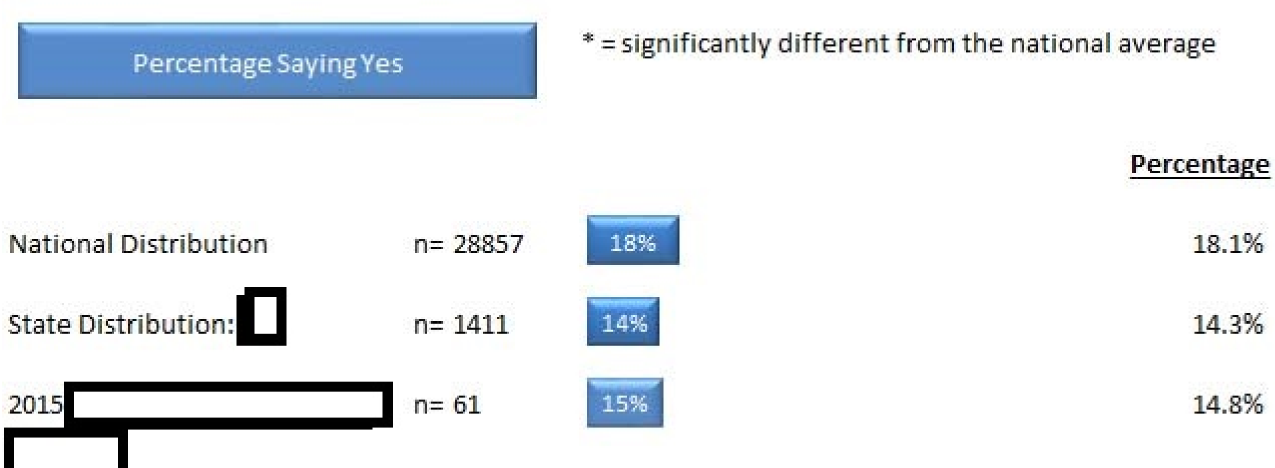
Note: N/A means too few disenrollees answered the question to permit reporting. For information on how we tested for statistical significance, and adjusted for case-mix, see Appendix 1 of this report, pp. 49-51.

Single Item: Saw Commercial or Advertisement for Another Plan

(Not included in a composite)

Question 45: Did you leave the plan because you saw a commercial or advertisement for a health plan you thought you would like better?

Disenrolled Because Saw Commercial or Advertisement for Another Plan



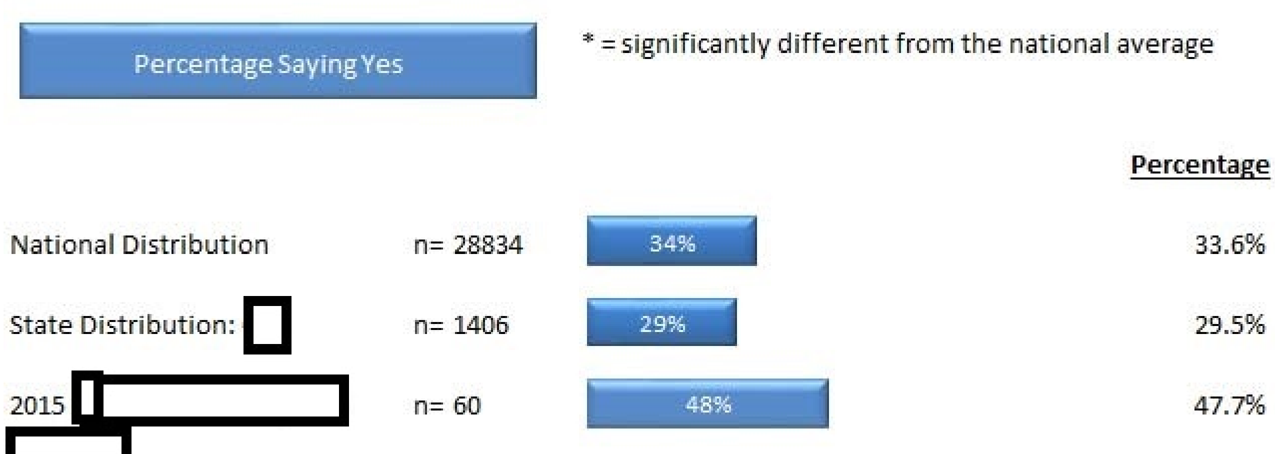
Note: N/A means too few disenrollees answered the question to permit reporting. For information on how we tested for statistical significance, and adjusted for case-mix, see Appendix 1 of this report, pp. 49-51.

Single Item: Another Plan Better Met Prescription Needs

(Not included in a composite)

Question 46: Did you leave the plan because you found another plan that better met your prescription needs?

Disenrolled Because Another Plan Better Met Prescription Needs

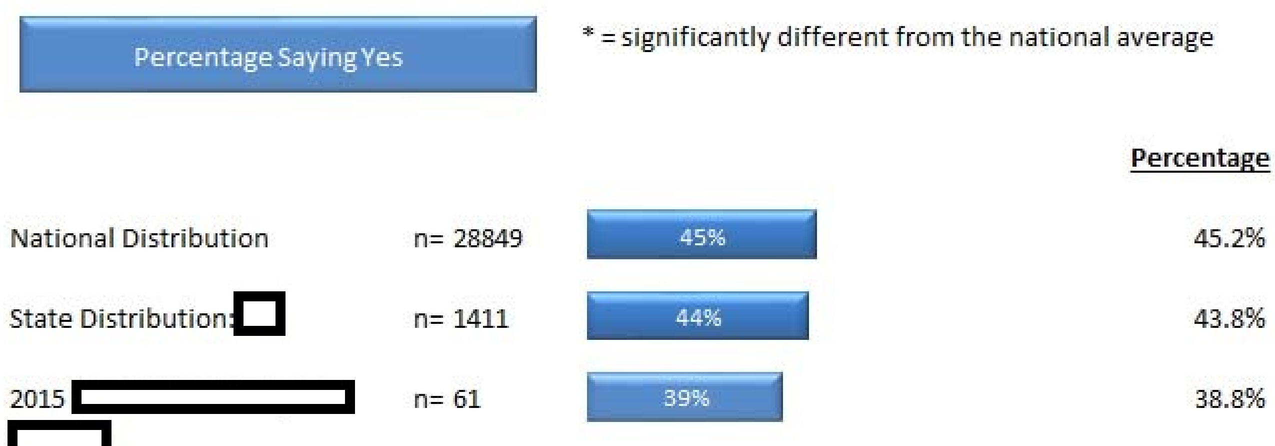


Note: N/A means too few disenrollees answered the question to permit reporting. For information on how we tested for statistical significance, and adjusted for case-mix, see Appendix 1 of this report, pp. 49-51.

Single Item: Another Plan Offered Better Benefits or Coverage of Health Services

(Not included in a composite)

Question 47: Did you leave the plan because another plan offered better benefits or coverage for some type of care, treatment or services (for example, dental or vision care)?



Note: N/A means too few disenrollees answered the question to permit reporting. For information on how we tested for statistical significance, and adjusted for case-mix, see Appendix 1 of this report, pp. 49-51.

Appendix 1: Background and Methodology

Background

Since 2000, CMS has been collecting information on beneficiaries' experiences with health care for Medicare managed care and traditional fee-for-service (FFS) Medicare through the Medicare Consumer Assessment of Healthcare Plans and Systems (MCAHPS) survey. In 2007, a new section was added to the survey to assess prescription drug plans under the new Medicare Part D benefit, including both MA-PDs and PDPs.

In 2012, CMS launched the Medicare Advantage and Prescription Drug Plan Disenrollment Reasons Survey, which is designed to capture the reasons Medicare beneficiaries voluntarily disenroll from their Part C and Part D contracts. The survey excludes beneficiaries who involuntarily disenrolled from contracts for eligibility reasons, moved out of their contract's service area, or died. Voluntary disenrollment occurs when a beneficiary either drops coverage entirely or switches to another contract for coverage.

The survey was tested extensively in a full national implementation conducted between November 2010 and July 2011. Based on experience with this pilot implementation, refinements in sampling, question wording, and administration mode were made for the surveys that were fielded between January and December 2015.

Methodology

The Survey Instrument

The Medicare Advantage and Prescription Drug Plan Disenrollment Reasons Survey includes three versions, directed respectively at disenrollees in three different types of plans:

- Medicare Advantage-only (MA-Only) plans
- Medicare Advantage Health and Drug (MA-PD) plans
- Medicare Prescription Drug Plans (PDPs)

The MA-PD Survey contains 69 questions, organized into the following sections:

- Your Former Health Plan (2 questions)
- Getting Information or Help from Your Former Health Plan (6 questions)
- Getting Health Care and the Prescription Medicines You Needed from Your Former Health Plan (9 questions)
- Reasons You Left Your Former Health Plan (26 questions)
- Other Reasons for Leaving Your Former Health Plan (4 questions)
- Your Experience with Insurance Agents, Brokers or Plan Representatives (5 questions)
- About You (17 questions)

A copy of the Medicare Advantage Health and Drug Plan Disenrollment Reasons Survey instrument is included on the CD along with this report.

Some of the questions on the Medicare Advantage Health and Drug Plan Disenrollment Reasons Survey are preceded by screener questions, so that only those beneficiaries for whom the question is relevant (i.e., those with relevant needs or experiences) are asked to answer those questions.

For scoring and reporting purposes, we combined some questions about reasons for disenrollment into the following five composite measures:

- Financial Reasons for Disenrollment
- Problems with Prescription Drug Benefits and Coverage
- Problems Getting Information about Prescription Drugs
- Problems Getting Needed Care, Coverage, and Cost Information
- Problems with Coverage of Doctors and Hospitals.

Table A1.1 displays the survey questions that go into each of these composites. Table A1.2 contains questions that are not part of composites but that may be helpful for informing quality improvement efforts.

Table A1.1. Medicare Advantage Health and Drug Plan Disenrollment Reasons Survey Composites

Composite Measure	Survey Questions Included in the Composite
Financial Reasons for Disenrollment	Q20: Did you leave the plan because the monthly fee that the health plan charges to provide coverage for health care and prescriptions went up? Q22: Did you leave the plan because the dollar amount you had to pay for each time you filled or refilled a prescription went up? Q24: Did you leave the plan because you found a health plan that costs less? Q25: Did you leave the plan because a change in your personal finances meant you could no longer afford the plan?

Composite Measure	Survey Questions Included in the Composite
Problems with Prescription Drug Benefits and Coverage	Q21: Did you leave the plan because they changed the list of prescription medicines they cover? Q26: Did you leave the plan because the plan refused to pay for a medicine your doctor prescribed? Q27: Did you leave the plan because you had problems getting the medicines your doctor prescribed? Q28: Did you leave the plan because it was difficult to get brand name medicines? Q29: Did you leave the plan because you were frustrated by the plan’s approval process for medicines your doctor prescribed that were not on the plan’s list of medicines that the plan covers?
Problems Getting Information about Prescription Drugs	Q30: Did you leave the plan because you did not know whom to contact when you had a problem filling or refilling a prescription? Q31: Did you leave the plan because it was hard to get information from the plan—like which prescription medicines were covered or how much a specific medicine would cost? Q38: Did you leave the plan because you were unhappy with how the plan handled a question or complaint? Q39: Did you leave the plan because you could not get the information or help you needed from the plan? Q40: Did you leave the plan because their customer service staff did not treat you with courtesy and respect?

Composite Measure	Survey Questions Included in the Composite
Problems Getting Needed Care, Coverage, and Cost Information	Q32: Did you leave the plan because you were frustrated by the plan’s approval process for care, tests, or treatment? Q33: Did you leave the plan because you had problems getting the care, tests, or treatment you needed? Q34: Did you leave the plan because you had problems getting the plan to pay a claim? Q37: Did you leave the plan because it was hard to get information from the plan—like which health care services were covered or how much a specific test or treatment would cost?
Problems with Coverage of Doctors and Hospitals	Q35: Did you leave the plan because the doctors or other health care providers you wanted to see did not belong to the plan? Q36: Did you leave the plan because clinics or hospitals you wanted to go to for care were not covered by the plan?

Table A1.2. Single Survey Questions Not Included in a Composite*

Single Survey Questions Not Included in a Composite	
Co-Payment for Doctor Visit Went Up	Q23: Did you leave the plan because the dollar amount you had to pay each time you visited a doctor went up?
Low Medicare Star Rating	Q41: Did you leave the plan because it got a low Medicare Star Rating?
Found Plan with a Higher Medicare Star Rating	Q42: Did you leave the plan because you found another plan with a higher Medicare Star Rating?
Family Member or Friend Recommended Another Plan	Q44: Did you leave the plan because a family member or friend told you that another health plan was a better plan?
Saw Commercial or Advertisement for Another Plan	Q45: Did you leave the plan because you saw a commercial or advertisement for a health plan you thought you would like better?
Another Plan Better Met Prescription Needs	Q46: Did you leave the plan because you found another plan that better met your prescription needs?
Another Plan Offered Better Benefits or Coverage of Health Services	Q47: Did you leave the plan because another plan offered better benefits or coverage for some types of care, treatment or services (for example, dental or vision care)?

**Responses to these questions were not strongly related to responses to questions included in the composites presented in Table A1.1. Thus, these questions were analyzed individually.*

Calculation of Composite Means

Your contract's mean on a composite measure is calculated as the average percentage of reasons endorsed in the composite multiplied by 100. To understand this calculation, consider a composite measure comprised of four survey questions (i.e., reasons for disenrollment). Suppose that 150 disenrollees from your contract answered these questions, and that 60 of those disenrollees endorsed none of the four reasons in the composite (or 0% of all reasons in the composite), 40 disenrollees endorsed 1 of the 4 reasons (25% of all reasons in the composite), 25 disenrollees endorsed 2 of the 4 reasons (50% of all reasons in the composite), 15 disenrollees endorsed 3 of the 4 reason (75% of all reasons in the composite), and 10 disenrollees endorsed all four reasons (100% of all reasons in the composite). In that case, the average percentage of reasons in the composite that were endorsed by disenrollees from your contract would be 29.2% or [(60*0) + (40*0.25) + (25*0.50) + (15*0.75) + (10*1.00)]/150. Multiplying this average percentage by 100 would yield your contract's mean score on the composite: 29.2.

Reporting of Composite Means on the Medicare Plan Finder

The Medicare Plan Finder on the Medicare.gov website displays your contract's mean scores on the composite measures of disenrollment. These scores are presented on that site so that consumers can see the reasons that beneficiaries gave for disenrolling from your contract in 2015. Unlike in this report, which presents scores to 1 decimal digit, the Medicare Plan Finder presents scores rounded to the nearest integer (whole number). In rounding decimals to integers, we followed these standard rules: If the number beyond the decimal is less than 5, it is rounded down to the next whole number; if the number beyond the decimal is 5 or more, it is rounded up to the next whole number. This can occasionally lead to apparent discrepancies in the table below even though the rounding rules have been properly applied. For example, a score of 19.46 would get rounded to 19.5 to produce a score for this report, but it would get rounded down to 19 to produce a score for the Medicare Plan Finder. For comparison, Table A1.3 shows your contract's composite scores to 1 decimal digit (as they are presented in this report) and to the nearest integer (as they are presented on the Medicare Plan Finder). Table A1.3 also shows the labels used for the composite measures on the Medicare Plan Finder which are different from the labels used in this report.

Table A1.3 Composite Measure Labels and Mean Scores as Presented in This Report vs. the Medicare Plan Finder

This Report		Medicare Plan Finder	
Composite Measure Label	Your Contact Score to 1 Decimal Digit	Composite Measure Label	Your Contract Score Rounded to Nearest Integer
Financial Reasons for Disenrollment	13.6	Problems with the Cost of the Plan	14
Problems with Prescription Drug Benefits and Coverage	16.4	Problems with the Plan's Prescription Drug Coverage	16
Problems Getting Information about Prescription Drugs	33.3	Problems Getting Information and Help from the Plan	33
Problems Getting Needed Care Coverage, and Cost Information	43.1	Problems Getting the Plan to Provide and Pay for Necessary Care	43
Problems with Coverage of Doctors and Hospitals	48.4	Doctors or Hospitals Are Not Covered by the Plan	48

Sample Selection and Eligibility Criteria

The survey was intended to represent the population of beneficiaries who disenrolled voluntarily from Part C or Part D contracts during the period January 2015 through December 2015. To represent that population, 150 cases were sampled from each MA contract's disenrollment for that period and 300 from each PDP. Because beneficiaries who disenroll at different times of the year may tend to do so for different reasons and have somewhat different characteristics, a further goal of the sample design was to be representative of the distribution of each contract's disenrollment across months of the year. Sampling was done month by month over the course the year rather than retrospectively, so that the number of cases to be sampled each month had to be calculated before disenrollment counts from later months were known. Monthly allocations were projected based on historical patterns of the distribution of disenrollment over months and adjusted each month as new disenrollment data were received.

There were some very small contracts that were projected not to attain the target number of disenrollments for sampling over the course of the year. These were excluded from sampling for contract reporting, but were sampled at a 4% rate for national (but not contract) representativeness.

Also for national representativeness, sample sizes were increased in the largest contracts, using sampling rates of 0.50% in PDP contracts and 1.34% in MA contracts when these rates yielded larger samples than 300 and 150, respectively.

In MA plans with some but not all beneficiaries enrolled for the prescription drug (PD) benefit, samples were drawn from both PD enrollees and non-enrollees, and each group was mailed the appropriate questionnaire form. In a few contracts with low rates of PD enrollment, the sampling rate was slightly increased for PD enrollees and reduced for non-PD enrollees. Data from both groups were combined to obtain estimates for non-PD survey items.

Survey Implementation

The 2015 survey of disenrollees was conducted between January and December 2015. It asked about beneficiaries' experiences with their plan and reasons for disenrollment. Data were collected on an ongoing basis and as close as possible to a beneficiary's actual date of disenrollment to help with respondent recall. The majority of voluntary disenrollment occurs in December of each year. Surveys mailed in March 2015 covered disenrollments that happened in the January 2015 time period (approximately a six week lag). Surveys mailed in April 2015 covered disenrollments that happened in February 2015, and so forth. The data collection protocol included mailing of pre-notification letters and up to two mailings of paper surveys. The surveys were available in English and Spanish. Residents of Puerto Rico received a double-stuffed envelope that contained both English and Spanish-language versions of the survey, while the remainder of disenrollees received an English version but could request a Spanish language version of the survey by calling a 1-800 number maintained by the survey vendor.

Sample Disposition

The sample disposition and response rates for the 2015 Medicare Advantage and Prescription Drug Plan Disenrollment Reasons Survey are presented in Table A1.4. Of the 98,912 MA disenrollees in the original sample, 3,569 (3.6%) were classified as ineligible because they were institutionalized, deceased, mentally or physically incapable of responding, or had a language barrier that prevented them from completing the survey. Eligible sample members who refused to take the survey or could not be contacted were considered non-respondents (56.6% of sample members). The adjusted response rate, after accounting for ineligible sample members, is 41.3 percent (39,384 partial or completed surveys divided by 98,912 disenrollees in the original sample minus 3,569 disenrollees deemed ineligible).

Table A1.4. 2015 Medicare Advantage and Prescription Drug Plan Disenrollment Reasons Survey, MA Sample Disposition

Disposition	MA Sample Member Count	Percentage of Sample
Returned Surveys	**39,384**	**39.8%**
Completed mail survey	29,811	30.1%
Screened out or did not answer any substantive items	9,573	9.7%
Ineligible	**3,569**	**3.6%**
Deceased	23	0.0%
Mentally or physically unable to respond or institutionalized	21	0.0%
Did not speak English or Spanish	3	0.0%
Otherwise excluded from survey	3,522	3.6%
Non-respondents	**55,959**	**56.6%**
Total sample	**98,912**	**100.0%**

Weighting and Case-Mix Adjustment

Two adjustments to the data are made to permit fair comparisons among contracts: (1) weighting and (2) case-mix adjustment.

Weighting to the Distribution of Disenrollment between December and Other Months

Our first step is to weight the respondents to be representative of the distribution of disenrollments between December (which accounts for the majority of annual voluntary disenrollment) and the rest of the year. December disenrollments include those under the open enrollment period which for many beneficiaries is the only time when they are allowed to switch to another contract; all such disenrollments take effect at the end of December even if the beneficiary elected the switch in one of the preceding months. The respondent proportions in December typically do not match the

corresponding proportions of the entire disenrollee population because of the general unpredictability of future disenrollments when samples are drawn earlier in the year, and because response rates are almost twice as high in December as in the rest of the year. Given that the weighting scheme must be kept simple to avoid detrimental effects on the precision of estimates, there are several reasons to select December disenrollment as the most important variable. Month of disenrollment reflects an aspect of the beneficiary's response to experiences, and should not have its effects adjusted away by case-mix adjustment like those of characteristics like age and sex that are inherent in the beneficiary. Previous analyses have shown substantial differences between reports of December and other disenrollees (see pp. 52-54 of this report), and these effects differ across contracts. Furthermore, correcting the proportions of December responses by weighting has been shown to improve the proportionality of representation of other groups such as dual eligibles as well.

Adjustment to Address Discrepancies between Each Contract and the Average Contract in Terms of the Characteristics of Enrolled Beneficiaries (Case-Mix Adjustment)

A second adjustment is made to address discrepancies between each contract and the average contract in terms of the characteristics of enrolled beneficiaries. Analyses of CAHPS data have shown that beneficiaries with certain characteristics tend to report more favorable or less favorable experiences, even when they are members of the same contract and have therefore been exposed to the same level of contract quality. Notably, older patients, healthier patients, less educated plan members, and those with lower socioeconomic status (SES) tend to assess their experiences more favorably than younger, sicker, more educated members and those with higher SES. Contracts do not all have the same distribution ("case mix") of enrollees with these characteristics, so these tendencies can bias comparisons among contracts. If a contract has a large number of patients whose characteristics make them a "tough audience," its patients may report less favorable experiences than the contract would receive if it delivered the same care to patients with average characteristics.

We perform a procedure called "case-mix adjustment" to correct for these effects using a statistical model (linear regression) to estimate the scores that would be obtained by each contract if every contract had the same distribution of member characteristics, equivalent to the average across all contracts. Because the overall national mean is the same before and after adjustment, scores for some contracts (those with beneficiaries who tend to provide more favorable assessments) will be adjusted downwards, and others will be adjusted upwards.

The following variables are used in case mix adjustment:

- Age: A self-reported six-category survey variable ranging from 18 to 85 plus; the age group 65-74 was used as the reference category
- Education: A self-reported six-category survey variable ranging from less than eighth grade to more than college; high school diploma was used as the reference category
- Self-reported general health status: Five-category variable (excellent, very good, good, fair, poor), where good was used as the reference category

- Self-reported mental health status: Five-category variable (excellent, very good, good, fair, poor), where excellent was used as the reference category
- Proxy assistance: Included as two indicators—one for receiving any proxy assistance and one for a proxy answering questions for the respondent
- Low income supplement (LIS) eligibility and Medicaid dual eligibility: Three-category variable (dual eligible, Non-dual/LIS, Non-dual/Non-LIS), where non-dual/non-LIS is used as the reference category. This variable comes from the administrative data files.

Significance Testing

For composite measures of reasons for disenrollment, where scores are the mean percentage of items in the composite that were endorsed multiplied by 100, two-tailed t-tests were used to assess whether the case-mix adjusted mean for each contract differed significantly from the overall mean for all contracts in the nation. When, contract scores are significantly different from the national mean at the $p<0.05$ level, this is noted in the last column of Table 1.3 under "Different from National Average?" A "No" entry in this column means that the contract's score was not significantly different from the national average, "Higher" means that it differs significantly from the national mean and is higher, and "Lower" means that it differs significantly from the national mean and is lower. In accordance with confidentiality requirements, "N/A" is reported for any item or composite with fewer than 10 observations (see below). If the minimum sample size is met but the reliability of the measure is below 0.70 (in a 0-1 range), the mean score is shown without bolding. Even when low reliability limits the ability to detect smaller differences from the national mean, the last column of Table 1.3 indicates "Higher" or “Lower” in parentheses whenever differences were sufficiently large to distinguish a contract's score from the national average with $p<0.05$.

Table 1.4 reports results for individual items, again using the last column on the right to indicate whether a score differed significantly from the national mean.

In Part 2 of the report, results are displayed graphically for both composites and individual items. When a contract score is significantly different from the national average, that fact is noted by an asterisk next to the score and with text at the top of the figure.

To compare the contract's disenrollment rate with the national average, we used a chi-square test. To compare rates of endorsement of individual questions underlying the composites with the national average, we used a chi-square test on case-mix-adjusted results. For all tests performed, differences that are significant at the $p<0.05$ level are noted in the table or figure as described above.

Assessing Reliability of Scores

For each composite measure, criteria based on inter-unit reliability (IUR) were applied to classify each contract's data as acceptable or low reliability. Inter-unit reliability is defined by IUR=s2/(SE2+ s2), where s2 = between-contract model variance, and SE = standard error of contract mean. IUR may be interpreted as the fraction of variation in contract mean scores (among those with about the same IUR) that is attributable to actual differences among contracts ("signal") rather than sampling variability ("noise"). Thus IUR close to 1 indicates that sampling variability is negligible, while IUR close to 0 means that we are unable to detect any variation among contracts and differences in the data are only random error. Contracts with fewer than 11 responses for a measure have their scores masked, in conformity with CMS policies on confidentiality of beneficiary data. Contracts for which IUR<.70 are considered to have low reliability. However, no more than 12% of contracts (those with lowest IUR on the corresponding measure) are flagged as low reliability for a given composite measure, after excluding masked scores.

Reliability of the estimates also is affected by a number of other factors, including the fraction of the contract's respondents who are eligible to answer an item based on their experiences, the variability of responses within the contract, and the amount by which contracts differ from each other nationally on that measure. Reliability summarizes the influence of these factors on the precision with which a contract's score can be compared to national distributions.

Within a given measure, low-reliability scores typically are those with fewer respondents, or possibly with more variability in their responses. Across measures, more low-reliability scores will be reported for measures with fewer responses (more respondents for whom the measure does not apply), less variation in scores across contracts, and more variability in scores within each contract.

Comparison of Reasons for Disenrollment: January-November versus December Disenrollees

Analyses of results from the Medicare Advantage and Prescription Drug Plan Disenrollment Reasons Survey have shown that the reasons why beneficiaries report disenrolling from their health or prescription drug plans differ between those who disenroll in the January-November months as compared to those who disenroll in December. Table A1.5 shows national average scores on the composite measures of disenrollment as well as on the items that make up those composite measures broken down between January-November disenrollees and December disenrollees. Table A1.6 shows a similar breakdown of national average scores on the single items that are not included in a composite. Contract-specific scores for January-November and December disenrollees are not reported because of insufficient sample size. Nevertheless, it may be useful to keep the differences shown below in mind when interpreting your own contract's scores.

Table A1.5. National Average Scores on Composite Measures and Their Constituent Items: January-November Disenrollees vs. December Disenrollees

Composite Measures and their Constituent Items	National Average	
	January - November Disenrollees	December Disenrollees
Financial Reasons for Disenrollment	**21.1**	**32.2**
Monthly premium went up	16.7	32.6
Prescription co-payment went Up	15.6	23.1
Found a plan that costs less	33.3	53.0
Could no longer afford plan	18.6	19.8
Problems with Prescription Drug Benefits and Coverage	**15.8**	**10.1**
Change in drug formulary	12.5	10.5
Plan refused to pay for a prescribed medication	16.7	10.6
Problems getting prescribed medication	16.8	9.4
Difficult to get brand name medications	13.3	8.7
Frustrating approval process for off-formulary medications	19.5	11.4
Problems Getting Information about Prescription Drugs	**14.4**	**9.3**
Did not know whom to contact about filling a prescription	9.5	4.8
Hard to get information about coverage and cost of prescription drugs	13.1	8.9
Unhappy with how the plan handled a question or complaint	23.3	16.3
Could not get information or help needed from the plan	26.1	16.1
Customer service not courteous or respectful	10.0	5.9
Problems Getting Needed Care Coverage, and Cost Information	**22.6**	**16.1**
Frustration with approval process for care, tests, or treatment	29.1	21.3
Problems getting needed care, tests, or treatment	29.8	18.5
Problems getting claims paid	14.3	12.4
Hard to get information about coverage and cost of health services	16.9	12.1
Problems with Coverage of Doctors and Hospitals	**29.8**	**25.8**
Preferred provider not in plan	34.9	30.8
Preferred clinic or hospital not covered by plan	24.7	20.8

Table A1.6. National Average Scores on Single Items (not in a composite): January-November Disenrollees vs. December Disenrollees

Single Items (not in a composite)	National Average	
	January - November Disenrollees	December Disenrollees
Co-payment for doctor visit went up	16.0	21.3
Low Medicare star rating	5.6	3.0
Found a plan with a higher Medicare star rating	16.8	11.8
Family or friend recommended another plan	26.6	28.1
Saw commercial or advertisement for another plan that looked better	17.6	18.6
Another plan better met prescription needs	34.9	32.3
Another plan offered better benefits or coverage of health services	46.4	43.9

State or Regional Comparisons

In addition to comparing your contract's results with a national benchmark, it may be useful to compare the results with a state or regional benchmark. We have provided such a benchmark for your contract. For most contracts, the benchmark is the state with the largest number of beneficiaries from that contract in the 2015 Medicare Advantage Health and Drug Plan Disenrollment Reasons Survey. However, we used broader regional benchmarks (census divisions) instead of states when any of the following occurred:

- The reliability of any of the five composite measures was < 0.70 within the state
- The state had no more than one contract with 10 or more respondents represented in the disenrollment survey
- A single contract with large market share accounted for 75% or more of the disenrollments in the state

Under these conditions, state-level benchmarks would not be meaningful or useful.

Because sample sizes for state and regional benchmarks are much smaller than for national benchmarks, we do not provide statistical tests for these comparisons.

Contact Information

If you have questions about the survey or this report, please send them to DisenrollSurvey@cms.hhs.gov.

Appendix 2: Frequency Tables

Frequency Tables

Q1. Our records show that you used to belong to HMO ABC (Contract Number HXXXX), but no longer belong to that plan. Is that right?

	Frequency	Percent	
Yes, I changed or switched health plans	57	100%	100%
I changed or switched a plan but it was not UNIVERSAL CARE, INC.	0	0%	
No, I did not change or switch health plans recently	0	0%	
Total	57	100%	
Missing	4		

Note: The frequencies shown in this appendix are not case-mix adjusted and therefore may not be consistent with means displayed in the body of the report. In addition, percentages may not add to 100 due to rounding. Questions not pertaining to reasons for disenrollment are presented here for general information.

Q2. Did you have to change or drop your former health plan for any of the following reasons?

	Frequency	Percent
I moved outside of the area where the plan was available	0	0%
I was dropped by the plan	0	0%
The plan was cancelled or discontinued in my area	0	0%
The plan was changed or discontinued by the organization that provides my insurance (such as an employer or a union)	0	0%
None of the above	49	100%
Total	49	100%
Missing	12	

Q3. Customer service is information you get from staff about what is covered and how to use the plan. Did you ever try to get information or help from HMO ABC'S customer service?

	Frequency	Percent
Yes	24	44%
No	30	56%
Total	54	100%
Missing	7	

Q4. How often did the plan's customer service give you the information or help you needed?

	Frequency	Percent	
Never	5	21%	21%
Sometimes	8	33%	33%
Usually	5	21%	21%
Always	6	25%	25%
I did not try to get information or help from the plan's customer service	0	0%	
Total	24	100%	
Missing	37		

Q5. Did you ever try to get information from the plan about which prescription medicines were covered?

	Frequency	Percent	
Yes	21	38%	38%
No	35	63%	63%
Total	56	100%	
Missing	5		

Q6. How often did the plan give you all the information you needed about which prescription medicines were covered?

	Frequency	Percent	
Never	1	5%	
Sometimes	5	25%	25%
Usually	8	40%	40%
Always	6	30%	30%
I did not try to get information about which prescription medicines were covered	0	0%	
Total	20	100%	
Missing	41		

Q7. Did you ever try to get information from the plan about how much you would have to pay for a prescription medicine?

	Frequency	Percent	
Yes	20	36%	36%
No	36	64%	64%
Total	56	100%	
Missing	5		

Q8. How often did the plan give you all the information you needed about how much you would have to pay for a prescription medicine?

	Frequency	Percent
Never	1	5%
Sometimes	4	20%
Usually	9	45%
Always	6	30%
I did not try to get information about how much I would have to pay for a prescription medicine	0	0%
Total	20	100%
Missing	41	

Q9. Did you ever try to get any kind of care, tests, or treatment through the plan?

	Frequency	Percent
Yes	42	75%
No	14	25%
Total	56	100%
Missing	5	

Q10. How often was it easy to get the care, tests, or treatment you thought you needed through the plan?

	Frequency	Percent	
Never	10	24%	24%
Sometimes	13	32%	32%
Usually	8	20%	20%
Always	10	24%	24%
Total	41	100%	
Missing	20		

Q11. Did a doctor ever prescribe a medicine for you that the plan did not cover?

	Frequency	Percent	
Yes	20	36%	36%
No	36	64%	64%
Total	56	100%	
Missing	5		

Q12. How often was it easy to use the plan to get the medicines your doctor prescribed?

	Frequency	Percent
Never	4	8%
Sometimes	13	26%
Usually	15	30%
Always	18	36%
I did not use the plan to get any prescription medicines	0	0%
Total	50	100%
Missing	11	

Q13. Did you ever use the plan to fill a prescription at a local pharmacy?

	Frequency	Percent
Yes	43	75%
No	14	25%
Total	57	100%
Missing	4	

Q14. How often was it easy to use the plan to fill a prescription at a local pharmacy?

	Frequency	Percent
Never	1	2%
Sometimes	10	24%
Usually	12	29%
Always	19	45%
I did not use the plan to fill a prescription at a local pharmacy	0	0%
Total	42	100%
Missing	19	

Q15. Did you ever use the plan to fill any prescriptions by mail?

	Frequency	Percent
Yes	12	21%
No	45	79%
Total	57	100%
Missing	4	

Q16. How often was it easy to use the plan to fill prescriptions by mail?

	Frequency	Percent
Never	2	18%
Sometimes	0	0%
Usually	1	9%
Always	8	73%
I did not use the plan to fill a prescription by mail	0	0%
Total	11	100%
Missing	50	

Q17. Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate the plan?

	Frequency	Percent
0 Worst health plan possible	13	23%
1	2	4%
2	5	9%
3	2	4%
4	2	4%
5	8	14%
6	5	9%
7	6	11%
8	6	11%
9	2	4%
10 Best health plan possible	6	11%
Total	57	100%
Missing	4	

Q18. Did you leave the plan because you found out that someone had signed you up for the plan without your permission?

	Frequency	Percent
Yes	7	11%
No	54	89%
Total	61	100%
Missing	0	

Q19. Did you leave the plan because you were accidentally taken off the plan (or because of some other paperwork or clerical error)?

	Frequency	Percent	
Yes	7	11%	11%
No	54	89%	89%
Total	61	100%	
Missing	0		

Q20. Some Medicare beneficiaries have to pay their health plan a monthly fee out of their own pocket for coverage for health and prescription medicines. Did you leave the plan because the monthly fee that the health plan charges to provide coverage for health care and prescription medicines went up?

	Frequency	Percent	
Yes	9	15%	15%
No	52	85%	85%
Total	61	100%	
Missing	0		

Q21. Health plans have a list of the prescription medicines that the plan will cover. Did you leave the plan because they changed the list of prescription medicines they cover?

	Frequency	Percent	
Yes	9	15%	15%
No	52	85%	85%
Total	61	100%	
Missing	0		

Q22. Did you leave the plan because the dollar amount you had to pay each time you filled or refilled a prescription went up?

	Frequency	Percent
Yes	6	10%
No	55	90%
Total	61	100%
Missing	0	

Q23. Did you leave the plan because the dollar amount you had to pay each time you visited a doctor went up?

	Frequency	Percent
Yes	3	5%
No	58	95%
Total	61	100%
Missing	0	

Q24. Did you leave the plan because you found a health plan that costs less?

	Frequency	Percent
Yes	13	21%
No	48	79%
Total	61	100%
Missing	0	

Q25. Did you leave the plan because a change in your personal finances meant you could no longer afford the plan?

	Frequency	Percent
Yes	6	10%
No	55	90%
Total	61	100%
Missing	0	

Q26. Did you leave the plan because the plan refused to pay for a medicine your doctor prescribed?

	Frequency	Percent
Yes	10	16%
No	51	84%
Total	61	100%
Missing	0	

Q27. Did you leave the plan because you had problems getting the medicines your doctor prescribed?

	Frequency	Percent
Yes	10	16%
No	51	84%
Total	61	100%
Missing	0	

Q28. Did you leave the plan because it was difficult to get brand name medicines?

	Frequency	Percent
Yes	9	15%
No	52	85%
Total	61	100%
Missing	0	

Q29. Did you leave the plan because you were frustrated by the plan's approval process for medicines your doctor prescribed that were not on the plan's list of medicines that the plan covers?

	Frequency	Percent	
Yes	12	20%	20%
No	49	80%	80%
Total	61	100%	
Missing	0		

Q30. Did you leave the plan because you did not know whom to contact when you had a problem filling or refilling a prescription?

	Frequency	Percent	
Yes	7	11%	11%
No	54	89%	89%
Total	61	100%	
Missing	0		

Q31. Did you leave the plan because it was hard to get information from the plan -- like which prescription medicines were covered or how much a specific medicine would cost?

	Frequency	Percent	
Yes	8	13%	13%
No	53	87%	87%
Total	61	100%	
Missing	0		

Q32. Did you leave the plan because you were frustrated by the plan's approval process for care, tests, or treatment?

	Frequency	Percent
Yes	33	54%
No	28	46%
Total	61	100%
Missing	0	

Q33. Did you leave the plan because you had problems getting the care, tests, or treatment you needed?

	Frequency	Percent
Yes	34	56%
No	27	44%
Total	61	100%
Missing	0	

Q34. Claims are sent to a health plan for payment. You may send in the claims yourself or doctors, hospitals, or others may do this for you. Did you leave the plan because you had problems getting the plan to pay a claim?

	Frequency	Percent
Yes	13	22%
No	47	78%
Total	60	100%
Missing	1	

Q35. Did you leave the plan because the doctors or other health care providers you wanted to see did not belong to the plan?

	Frequency	Percent
Yes	28	46%
No	33	54%
Total	61	100%
Missing	0	

Q36. Did you leave the plan because clinics or hospitals you wanted to go to for care were not covered by the plan?

	Frequency	Percent
Yes	22	36%
No	39	64%
Total	61	100%
Missing	0	

Q37. Did you leave the plan because it was hard to get information from the plan -- like which health care services were covered or how much a specific test or treatment would cost?

	Frequency	Percent
Yes	20	33%
No	41	67%
Total	61	100%
Missing	0	

Q38. Did you leave the plan because you were unhappy with how the plan handled a question or complaint?

	Frequency	Percent	
Yes	26	43%	43%
No	35	57%	57%
Total	61	100%	
Missing	0		

Q39. Did you leave the plan because you could not get the information or help you needed from the plan?

	Frequency	Percent	
Yes	29	48%	48%
No	32	52%	52%
Total	61	100%	
Missing	0		

Q40. Did you leave the plan because their customer service staff did not treat you with courtesy and respect?

	Frequency	Percent	
Yes	21	34%	34%
No	40	66%	66%
Total	61	100%	
Missing	0		

Q41. Every year Medicare evaluates all Medicare health and prescription drug plans and gives each plan a quality rating. The ratings are referred to as the Medicare Star or Plan Ratings. The ratings provide Medicare beneficiaries information on the quality of services a plan provides. Did you leave the plan because it got a low Medicare Star Rating?

	Frequency	Percent	
Yes	3	5%	
No	58	95%	95%
Total	61	100%	
Missing	0		

Q42. Did you leave the plan because you found another plan with a higher Medicare Star Rating?

	Frequency	Percent	
Yes	14	23%	23%
No	47	77%	77%
Total	61	100%	
Missing	0		

Q43. In the past year, did you think about the Medicare Star or Plan Ratings when making a decision about enrolling in a health plan?

	Frequency	Percent	
Yes	13	24%	24%
No	41	76%	76%
Total	54	100%	
Missing	7		

Q44. Did you leave the plan because a family member or friend told you that another health plan was a better plan?

	Frequency	Percent
Yes	22	36%
No	39	64%
Total	61	100%
Missing	0	

Q45. Did you leave the plan because you saw a commercial or advertisement for a health plan you thought you would like better?

	Frequency	Percent
Yes	13	21%
No	48	79%
Total	61	100%
Missing	0	

Q46. Did you leave the plan because you found another plan that better met your prescription needs?

	Frequency	Percent
Yes	32	53%
No	28	47%
Total	60	100%
Missing	1	

Q47. Did you leave the plan because another plan offered better benefits or coverage for some types of care, treatment, or services (for example, dental or vision care)?

	Frequency	Percent	
Yes	31	51%	51%
No	30	49%	49%
Total	61	100%	
Missing	0		

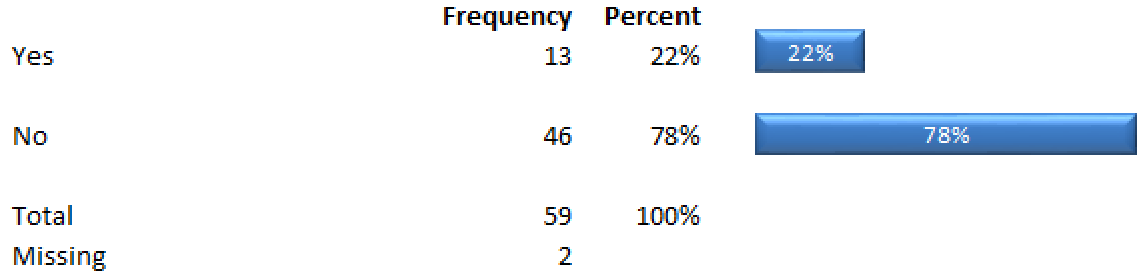
Q48. Different kinds of people sell health insurance. Insurance may be sold by independent insurance agents or brokers who don't work for the health plan OR by plan representatives who work directly for the plan. Did an insurance agent, broker, or plan representative ever call you without your asking them to, to tell you about insurance for health care or prescription medicines?

	Frequency	Percent	
Yes	10	18%	18%
No	45	82%	82%
Total	55	100%	
Missing	6		

Q49. Did an insurance agent, broker, or plan representative ever visit your home without your asking them to, to tell you about insurance for health care or prescription medicines?

	Frequency	Percent	
Yes	8	14%	14%
No	48	86%	86%
Total	56	100%	
Missing	5		

Q50. Did you decide to leave HMO ABC because of information you got from an insurance agent, broker, or plan representative?



	Frequency	Percent
Yes	13	22%
No	46	78%
Total	59	100%
Missing	2	

Q51. Did an insurance agent, broker, or plan representative give you any information that was <u>not</u> correct?

	Frequency	Percent
Yes	11	20%
No	45	80%
Total	56	100%
Missing	5	

Q52. What kind of information was <u>not</u> correct? Please check all that apply.

	Frequency	Percent
What the plan covered	8	28%
What the plan would cost you	4	14%
Which doctors belong to the plan	4	14%
Which pharmacies are covered by the plan	5	17%
Which hospitals are covered by the plan	5	17%
Some other information	3	10%
Total	29	100%
Missing	51	

Q53. In general, how would you rate your overall health?

	Frequency	Percent
Excellent	1	2%
Very good	3	5%
Good	23	39%
Fair	22	37%
Poor	10	17%
Total	59	100%
Missing	2	

Q54. In general, how would you rate your overall mental health?

	Frequency	Percent
Excellent	4	7%
Very good	21	36%
Good	18	31%
Fair	11	19%
Poor	5	8%
Total	59	100%
Missing	2	

Q55. In the last 12 months, how many different prescription medicines did you fill? (Don't count the same prescriptions twice.)

	Frequency	Percent
None	5	9%
1 to 2 medicines	16	29%
3 to 5 medicines	11	20%
6 or more medicines	23	42%
Total	55	100%
Missing	6	

Q56. In the past 12 months, have you seen a doctor or other health provider 3 or more times for the same condition or problem?

	Frequency	Percent
Yes	34	61%
No	22	39%
Total	56	100%
Missing	5	

Q57. Is this a condition or problem that has lasted for at least 3 months?

	Frequency	Percent
Yes	30	91%
No	3	9%
Total	33	100%
Missing	28	

Q58. Do you now need or take medicine prescribed by a doctor?

	Frequency	Percent
Yes	53	93%
No	4	7%
Total	57	100%
Missing	4	

Q59. Is this to treat a condition that has lasted for at least 3 months?

	Frequency	Percent
Yes	46	90%
No	5	10%
Total	51	100%
Missing	10	

Q60. Has a doctor ever told you that you had any of the following conditions?

a. A heart attack?

	Frequency	Percent
Yes	7	12%
No	50	88%
Total	57	100%
Missing	4	

b. Angina or coronary heart disease?

	Frequency	Percent
Yes	4	7%
No	53	93%
Total	57	100%
Missing	4	

c. Hypertension or high blood pressure?

	Frequency	Percent
Yes	39	68%
No	18	32%
Total	57	100%
Missing	4	

d. Cancer, other than skin cancer?

	Frequency	Percent
Yes	6	11%
No	51	89%
Total	57	100%
Missing	4	

e. Emphysema, asthma or COPD (chronic obstructive pulmonary disease)?

	Frequency	Percent
Yes	15	26%
No	42	74%
Total	57	100%
Missing	4	

f. Any kind of diabetes or high blood sugar?

	Frequency	Percent
Yes	28	49%
No	29	51%
Total	57	100%
Missing	4	

Q61. What is your age?

	Frequency	Percent
18 to 24	0	0%
25 to 34	0	0%
35 to 44	4	7%
45 to 54	0	0%
55 to 64	4	7%
65 to 74	36	64%
75 to 79	5	9%
80 to 84	5	9%
85 or older	2	4%
Total	56	100%
Missing	5	

Q62. Are you male or female?

	Frequency	Percent
Male	32	52%
Female	29	48%
Total	61	100%
Missing	0	

Q63. What is the highest grade or level of school that you have completed?

	Frequency	Percent
8th grade or less	22	39%
Some high school, but did not graduate	6	11%
High school graduate or GED	9	16%
Some college or 2-year degree	17	30%
4-year college graduate	1	2%
More than 4-year college degree	1	2%
Total	56	100%
Missing	5	

Q64. Are you of Hispanic or Latino origin or descent?

	Frequency	Percent
Yes, Hispanic or Latino	32	55%
No, not Hispanic or Latino	26	45%
Total	58	100%
Missing	3	

Q65. What is your race? Please mark one or more.

	Frequency	Percent
White	24	53%
Black or African-American	7	16%
Asian	13	29%
Native Hawaiian or other Pacific Islander	0	0%
American Indian or Alaska Native	1	2%
Total	45	100%
Missing	17	

Q66. What language do you <u>mainly</u> speak at home?

	Frequency	Percent
Chinese	1	2%
English	20	38%
Russian	0	0%
Spanish	24	45%
Vietnamese	7	13%
Some other language	1	2%
Total	53	100%
Missing	8	

Q67. Did someone help you complete this survey?

	Frequency	Percent
Yes	19	42%
No	26	58%
Total	45	100%
Missing	16	

Q68. How did that person help you? Please mark one or more.

	Frequency	Percent
Read the questions to me	18	44%
Entered the answers I gave	11	27%
Answered the questions for me	2	5%
Translated the questions into my language	10	24%
Helped in some other way	0	0%
Total	41	100%
Missing	38	

Q69. The Medicare Program is trying to learn more about the health care or services provided to people with Medicare. May we contact you again about the health care services that you received?

	Frequency	Percent
Yes	41	76%
No	13	24%
Total	54	100%
Missing	7	

Note that the two items below appeared only on the Spanish-language version of the survey, which was sent to disenrollees from Puerto Rico and to sample members who requested a Spanish-language version of the survey.

Did you ever need written information from the plan in a language other than English?

	Frequency	Percent	
Yes	3	21%	21%
No	11	79%	79%
Total	14	100%	
Missing	47		

How often did the plan give you written information in a language other than English?

	Frequency	Percent	
Never	1	33%	33%
Sometimes	0	0%	
Usually	1	33%	33%
Always	1	33%	33%
I did not need written information in a language other than English	0	0%	
Total	3	100%	
Missing	58		