Attachment IX:

Redacted Plan Report Sample

2017 Medicare Advantage Health and Drug Plan Disenrollment Reasons Survey Results

Report for: [redacted]([redacted])

Issued August 2018
By the Centers for Medicare & Medicaid Services

Contents

I. OVERVIEW

This report contains results for your contract [redacted] from the 2017 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 2017. Although beneficiaries provide ratings of their "plans," **the unit of analysis is the health and/or prescription drug plan contract, not a health and/or prescription drug plan (i.e., Plan Benefit Package or PBP).** These contract-specific reports are sent to compliance officers on an annual basis.

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. CMS is sharing detailed results from the 2017 survey with contracts to facilitate quality improvement efforts. CMS displays your contract's disenrollment rate and scores on the composite (summary) disenrollment reason measures on Medicare Plan Finder (https://www.medicare.gov/find-a-plan) for use by consumers when selecting contracts (i.e., health and prescription drug plans).

How This Report Is Organized

Section II of this report provides summary results on your contract's disenrollment rate, a comparison of your contract's beneficiary characteristics to the characteristics of Medicare Advantage (MA) beneficiaries nationally, and reasons beneficiaries cited for disenrollment, both composite (summary) measures and individual survey questions. Section III presents detailed results on composite measures of reasons for disenrollment, showing both national and state benchmarks to enable comparisons to your contract's results. Section IV provides information about the survey and its contents and describes sample selection and other methodological topics. A separate Excel file distributed with this 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 (Table 1.1), mean scores on the composite measures of reasons for disenrollment (Table 1.3), and results on individual survey questions underlying the composite measures (Table 1.4) are each compared to the national average for all MA plans. In both Tables 1.3 and 1.4, the results for the composite and individual reasons for disenrollment are ordered from most frequently cited to least frequently cited based on the national average. Each composite measure score is tested against the national average for that composite measure, and a note in the last column of Table 1.3 indicates whether the difference is

statistically significant. Table 1.4 provides results, including comparisons to the national average, for individual survey questions about reasons for disenrollment. For comparison, Tables 1.3 and 1.4 also show a state or regional average; however, because of a lack of statistical power, 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 areas of strong performance and opportunities for improvement. Comparing the reasons beneficiaries give for voluntarily disenrolling from your contract with the reasons beneficiaries give for leaving MA contracts nationally may provide insights about your contract's strengths and weaknesses.

II. SUMMARY RESULTS

Disenrollment Rate

Table 1.1 shows the rate of voluntary disenrollment from your contract for calendar year 2017 (January 2017 to December 2017) and 2016 (January 2016 to December 2016). These disenrollment rates are calculated as a percentage of your contract's total enrollment each year and come from beneficiary-level disenrollment files maintained by the Centers for Medicare & Medicaid Services. The table also shows the national average rate of voluntary disenrollment for MA contracts in 2017 and whether the difference between your contract's rate of voluntary disenrollment in 2017 and the national average rate of disenrollment was statistically ($p < 0.05$) and practically (at least one percentage point) significant.

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 reassigned or passi1vely enrolled in a Medicare-Medicaid Plan, or died.

Table 1.1. Rates of Voluntary Disenrollment

Your Contract ([redacted], 2016	Your Contract ([redacted], 2017	National Average, 2017	Significantly Different from National Average in 2017?
[redacted]	[redacted]	12%	[redacted]

The disenrollment rates shown in Table 1.1 are the same disenrollment rates used in the Medicare Star Ratings. The voluntary disenrollment rate is calculated according to the Medicare 2019 Part C & D Star Rating Technical Notes for "Members Choosing to Leave the Plan." Rates shown for 2017 are based on the first plan preview of 2019 Star Ratings data. These may differ from the final rates, found on Medicare Plan Finder for 2019 Part C & D Star Ratings. If a disenrollment rate is not shown for your contract, it is because your contract had fewer than 1,000 enrollees in the year for which the rate is not shown. Disenrollment rates are not computed for contracts with fewer than 1,000 enrollees.

Beneficiaries may disenroll from their Medicare health (MA-Only or MA-PD) or prescription drug plans (PDPs) 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 (OEP).[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 (LIS), qualify for membership in a Special Needs Plan (SNP), or enroll in a plan with a 5-star rating. In 2017, the percent of all disenrollees from MA plans who disenrolled in December was 55.0% whereas the percent of disenrollees from your contract who disenrolled in December was [redacted]. Table 1.9 (shown in Section IV of the report) contains information to help you understand how beneficiaries who disenroll in December, nationally, compare with those who disenroll during other times of the year in terms of their reasons for disenrollment.

Summary of Characteristics of Enrollees and their Disenrollment Rates

The first two columns in Table 1.2 compare the characteristics of beneficiaries enrolled in your contract to the characteristics of MA beneficiaries nationally. The last two columns of Table 1.2 show the disenrollment rate for beneficiaries in your contract, overall and by certain characteristics, and how the disenrollment rates for your contract compare with rates observed nationally among beneficiaries with the same characteristics.

Table 1.2.

Characteristic	Percent of Enrollment: National	Percent of Enrollment: Your Contract ([redacted])	Disenrollment Rate: National	Disenrollment Rate: Your Contract ([redacted])
ALL Beneficiaries	100%	[redacted]	12%	[redacted]
Dual-eligible	33%	[redacted]	13%	[redacted]
Eligible for Low-Income Subsidy (LIS)/Not Dual-eligible	4%	[redacted]	12%	[redacted]
Not LIS-eligible/Not Dual-eligible	63%	[redacted]	9%	[redacted]
Senior (age 65)	78%	[redacted]	10%	[redacted]
Non-senior (age <65)	22%	[redacted]	11%	[redacted]

Note: The voluntary disenrollment rate for "ALL Beneficiaries" (row 1) is calculated according to the Medicare 2019 Part C & D Star Rating Technical Notes for "Members Choosing to Leave the Plan." The rates shown are based on the first plan preview of 2019 Star Ratings data. These may differ from the final rates, found on Medicare Plan Finder for 2019 Part C and D Star Ratings. For the voluntary disenrollment rates for the subgroup categories (rows 2-6), we were unable to apply all of the same exclusions applied to the disenrollment rate for all beneficiaries; therefore, these rates may appear slightly higher or lower than the rates for "ALL Beneficiaries." If a disenrollment rate is not shown for your contract, it is because your contract had fewer than 1,000 enrollees in the year for which the rate is *not shown. Disenrollment rates are not computed for contracts with fewer than 1,000 enrollees.*

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

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 score on a 0-100 scale, the national average for all MA contracts, a state or regional average, and whether your contract's mean was 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 Section IV, Background and Methodology, of this report (p.16) for an example of how composite means are calculated. A lower mean score on a measure indicates that fewer disenrollees from your contract cited the reasons for disenrollment included in the composite as a cause of their disenrollment.

Table 1.4 displays your contract's results on the individual survey questions that are included in each composite, as well as other individual survey questions about reasons for disenrollment that are not included in the composite measures. 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.

In both Tables 1.3 and 1.4, the composite and individual reasons for disenrollment results are ordered from most frequently cited to at least frequently cited based on the national average.

Table 1.3. Composite Measures of Reasons for Disenrollment

Reasons for Disenrollment	Your Contract ([redacted])	National Average	State Average: [redacted]	Significantly Different from the National Average?
Problems with Coverage of Doctors and Hospitals	[redacted]	27.4	25.6	[redacted]
Financial Reasons	[redacted]	24.3	26.6	[redacted]
Problems Getting Needed Care, Coverage, and Cost Information	[redacted]	18.3	22.4	[redacted]
Problems Getting Information and Help from the Plan	[redacted]	12.8	14.8	[redacted]
Problems with Prescription Drug Benefits and coverage	[redacted]	12.2	12.8	[redacted]

* In previous reports, this measure was labeled "Problems Getting Information about Prescription Drugs."

Note: Scores in bold have adequate reliability (0.70 or higher). Scores that are not in bold have low reliability (between 0.60 and 0.70). Scores in brackets have very low reliability (below 0.60) but are statistically significantly different from the national average and are therefore reported. 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 Section IV for this report, pp. 18-22.

Table 1.4. Individual Survey Questions

Reasons for Disenrollment	Your Contract ([redacted])	National Average	State Average: [redacted]	Significantly Different from the National Average?
Problems with Coverage of Doctors and Hospitals				
Preferred provider not in plan	[redacted]	31.6%	29.2%	[redacted]
Preferred clinic or hospital not covered by plan	[redacted]	23.2%	22.0%	[redacted]
Financial Reason				
Found a plan that costs less	[redacted]	40.3%	43.9%	[redacted]
Prescription co-payment went up	[redacted]	20.5%	21.9%	[redacted]
Monthly premium went up	[redacted]	19.4%	21.5%	[redacted]
Could no longer afford plan	[redacted]	17.2%	19.1%	[redacted]
Problems Getting Needed Care, Coverage, and Cost Information				
Problems getting needed care, tests, or treatment	[redacted]	23.2%	28.1%	[redacted]
Frustration with approval process for care, tests, or treatment	[redacted]	23.2%	28.0%	[redacted]
Hard to get information about coverage and cost of health services	[redacted]	14.3%	17.0%	[redacted]
Problems getting claims paid	[redacted]	12.3%	16.4%	[redacted]
Problems Getting Information and Help from the Plan*				
Could not get information or help needed from the plan	[redacted]	20.3%	24.8%	[redacted]
Unhappy with how the plan handled a question or complaint	[redacted]	18.8%	21.9%	[redacted]
Hard to get information about coverage and cost of prescription drugs	[redacted]	10.7%	12.0%	[redacted]
Customer service not courteous or respectful	[redacted]	7.6%	8.2%	[redacted]
Did not know whom to contact about filling a prescription	[redacted]	6.6%	7.1%	[redacted]
Problems with Prescription Drug Benefits and Coverage				
Frustrating approval process for off-formulary medications	[redacted]	13.5%	15.1%	[redacted]
Problems getting prescribed medication	[redacted]	12.7%	12.8%	[redacted]
Plan refused to pay for a prescribed medication	[redacted]	12.5%	14.6%	[redacted]
Change in drug formulary	[redacted]	11.3%	11.2%	[redacted]
Difficult to get brand name medications	[redacted]	10.9%	10.0%	[redacted]
Individual Survey Questions (not in a composite)				
Another plan offered better benefits or coverage of health services	[redacted]	49.1%	49.7%	[redacted]
Another plan better met prescription needs	[redacted]	34.7%	36.1%	[redacted]
Family member or friend recommended another plan	[redacted]	31.3%	30.5%	[redacted]
Saw commercial or advertisement for another plan that looked better	[redacted]	23.8%	23.9%	[redacted]
Co-payment for doctor visit went up	[redacted]	19.4%	20.4%	[redacted]
Found a plan with a higher Medicare Star rating	[redacted]	15.6%	16.1%	[redacted]
Low Medicare Star rating	[redacted]	5.0%	3.1%	[redacted]

* In previous reports, this measure was labeled "Problems Getting Information about Prescription Drugs."

Note: Scores in bold have adequate reliability (0.70 or higher). Scores that are not in bold have low reliability (between 0.60 and 0.70). Scores in brackets have very low reliability (below 0.60) but are statistically significantly different from the national average and are therefore reported. 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 Section IV of this report, pp. 18-22.

III. DETAILED RESULTS FOR COMPOSITE MEASURES

Problems with Coverage of Doctors and Hospitals

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 (between 0.60 and 0.70). Means appearing in brackets have very low reliability (below 0.60) but are statistically significantly different from the national mean and are therefore reported. N/A signifies that too few disenrollees answered the question to permit reporting. Results for the individual survey questions that this composite measure comprises appear in Table 1.4.

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). Contract means not appearing in bold have low reliability (0.60-0.70). Contract means appearing in brackets have very low reliability (below 0.60) but are statistically significantly different from the national mean. For information on how we tested for statistical significance, assessed reliability, and adjusted for case-mix, see Section IV of this report, pp. 18-22.

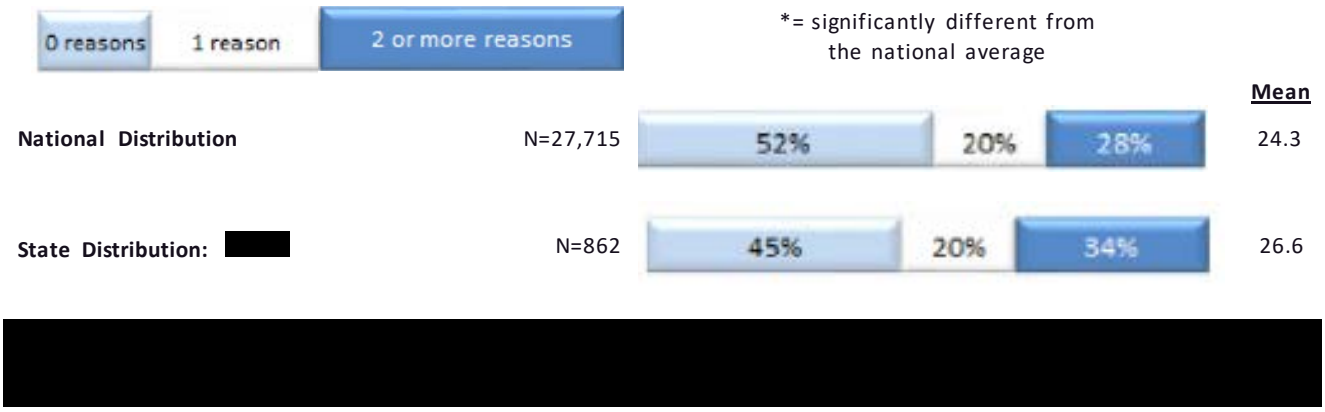
Financial Reasons for Disenrollment

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 disenrollement. 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 (between 0.60 and 0.70). Means appearing in brackets have very low reliability (below 0.60) but are statistically significantly different from the national mean and are therefore reported. N/A signifies that too few disenrollees answered the questions to permit reporting. Results for the individual survey questions that this composite measure comprises appear in Table 1.4.

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). Contract means not appearing in bold have low reliability (0.60-0.70) Contract means appearing in brackets have very low reliability (below 0.60) but are statistically significantly different from the national mean. For information on how we tested for statistical significance, assessed reliability, and adjusted for case-mix, see Section IV of this report, pp. 18-22.

Problems Getting Needed Care, Coverage, and Cost Information

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 (between 0.60 and 0.70). Means appearing in brackets have very low reliability (below 0.60) but are statistically significantly different from the national mean and are therefore reported. N/A signifies too few disenrollees answered the question to permit report ing. Results for the individual survey questions that this composite measure comprises appear in Table 1.4.

Problems Getting Needed Care, Coverage, and Cost Information

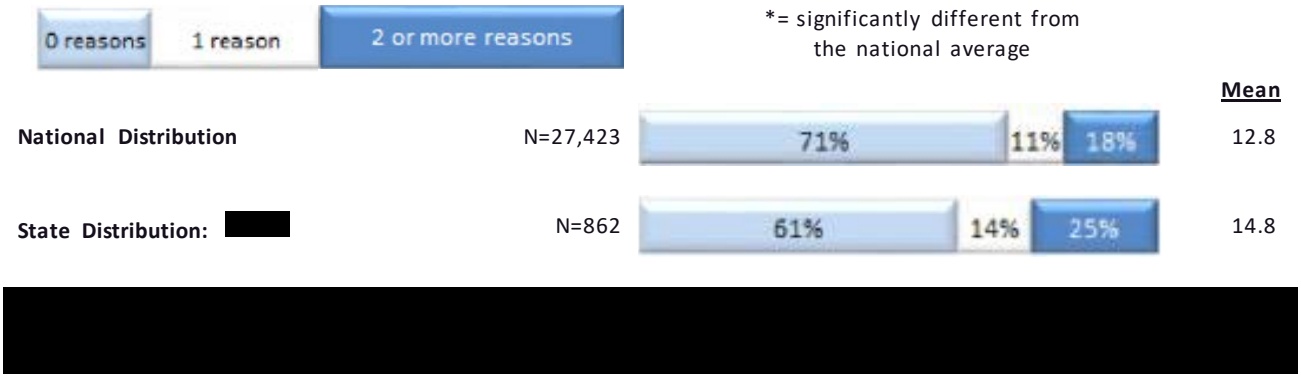
Note: N/A means too few disenrollees answered the questions to permit reporting. Percentages may not add to 100 due to rounding. The mean score is calculated as the average percentage of reasons endorsed in this composite (0 to 100 scale). Contract means appearing in bold have adequate reliability (0.70 or above). Contract means not appearing in bold have low reliability (0.60-0.70). Contract means appearing in brackets have very low reliability (below 0.60) but are statistically significantly different from the national mean. For information on how we tested for statistical significance, assessed reliability, and adjusted for case-mix, see Section IV of this report, pp. 18-22.

Problems Getting Information and Help from the Plan

The figure below shows how your contract performed on the measure "Problems getting Information and Help from the Plan," 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 and help from the plan. In previous reports, this composite was labeled "Problems Getting Information about Prescription Drugs." Although the label has changed, the questions that make up the composite remain the same. 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 and help from the plan 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 (between 0.60 and 0.70). Means appearing in brackets have very low reliability (below 0.60) but are statistically significantly different from the national mean and are therefore reported. N/A signifies that too few disenrollees answered the question to permit reporting. Results for the individual survey questions that this composite measure comprises appear in Table 1.4.

Problems Getting Information and Help from the Plan



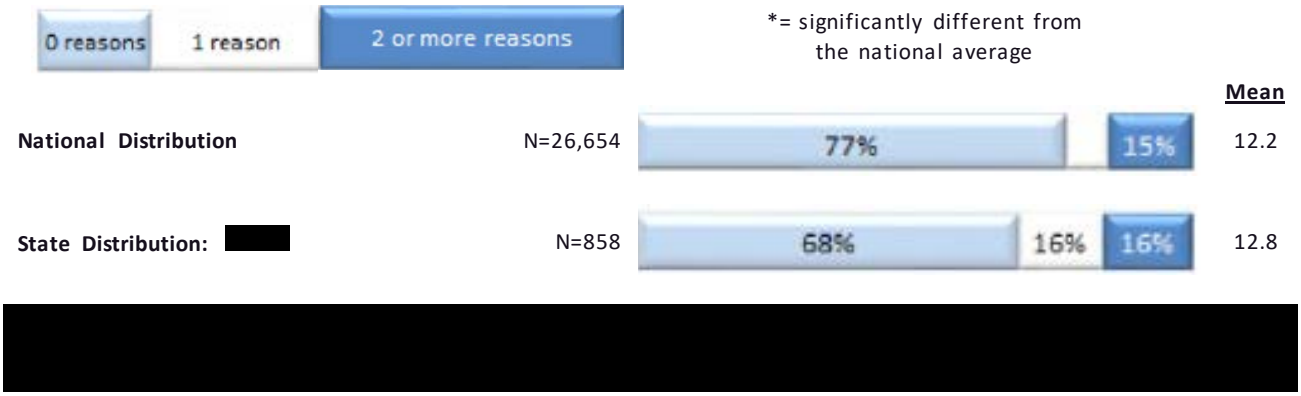
Note: N/A means too few disenrollees answered the questions to permit reporting. Percentages may not add to 100 due to rounding. The mean score is calculated as the average percentage of reasons endorsed in this composite (0 to 100 scale). Contract means appearing in bold have adequate reliability (0.70 or above). Contract means appearing in brackets have very low reliability (below 0.60) but are statistically significantly different from the national mean. For information on how we tested for statistical significance, assessed reliability, and adjusted for case-mix, see Section IV of this report, pp. 18-22.

Problems with Prescription Drug Benefits and Coverage

The figure below shows how your contract performed on the measure "Problems with Prescription Drug Benefits and Coverage," a composite of survey questions 23, 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 (between 0.60 and 0.70).

Means appearing brackets have very low reliability (be low 0.60) but are statistically significantly different from the national mean and are therefore reported. N/A signifies that too few disenrollees answered the question to permit report ing. Result s for the individual survey questions that this composite measure comprises appear in Table 1.4 of this report.

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). Contract means not appearing in bold have low reliability (0. 60-0.70). Contract means appearing in brackets have very low reliability (below 0.60) but are statistically significantly different from the national mean. For information on how we tested for statistical significance, assessed reliability, and adjusted for case-mix, see Section IV of this report, pp. 18-22.

IV. BACKGROUND AND METHODOLOGY

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 to capture the reasons Medicare beneficiaries voluntarily disenroll from their Part C and Part D contracts. Voluntary disenrollment occurs when a beneficiary either drops coverage entirely or switches to another contract. The survey excludes beneficiaries who involuntarily disenrolled from contracts for eligibility reasons, moved out of their 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 survey was tested extensively in a full national implementation conducted between November 2010 and July 2011. Based on experience with this pilot implementation and subsequent fielding of the survey, refinements in sampling, question wording, and

administration mode were made for the surveys that were fielded between January and December 2017.

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 63 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 (27 questions)
- Other Reasons for Leaving Your Former Health Plan (4 questions)
- About You (15 questions)

For scoring and reporting purposes, we combined questions on related issues about reasons for disenrollment into the following five composite (summary) measures.

- Problems with Coverage of Doctors and Hospitals
- Financial Reasons for Disenrollment
- Problems Getting Needed Care, Coverage, and Cost Information
- Problems Getting Information and Help from the Plan
- Problems with Prescription Drug Benefits and Coverage

Table 1.5 displays the survey questions that go into each of these composites. Table 1.6 contains individual survey questions that are not part of composites but that may be helpful for informing quality improvement efforts.

Table 1.5. Medicare Advantage Health and Drug Plan Disenrollment Reasons Survey Composite Measures

Composite Measure	Survey Questions Included in the Composite
Problems with Coverage of Doctors and Hospitals	Q35: Did you leave your former plan because the doctors or other health care providers you wanted to see did not belong to the plan? Q36: Did you leave your former plan because clinics or hospitals you wanted to go to for care were not covered by the plan?
Financial Reasons for Disenrollment	Q20: Did you leave your former plan because the dollar amount you had to pay for each time you filled or refilled a prescription went up? Q22: Did you leave your former plan because the monthly fee went up? Q24: Did you leave your former plan because you found a health plan that costs less? Q25: Did you leave your former plan because a change in your personal finances meant you could no longer afford the plan?
Problems Getting Needed Care, Coverage, and Cost Information	Q32: Did you leave your former plan because you were frustrated by the plan's approval process for care, tests, or treatment? Q33: Did you leave your former plan because you had problems getting the care, tests, or treatment you needed? Q34: Did you leave your former plan because you had problems getting the plan to pay a claim? Q37: Did you leave your former 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 Getting Information and Help from the Plan	Q30: Did you leave your former plan because you did not know whom to contact when you had a problem filling or refilling a prescription? Q31: Did you leave your former 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 your former plan because you were unhappy with how the plan handled a question or complaint? Q39: Did you leave your former plan because you could not get the information or help you needed from the plan? Q40: Did you leave your former plan because their customer service staff did not treat you with courtesy and respect?
Problems with Prescription Drug Benefits and Coverage	Q23: Did you leave your former plan because they changed the list of prescription medicines they cover? Q26: Did you leave your former plan because the plan refused to pay for a medicine your doctor prescribed? Q27: Did you leave your former plan because you had problems getting the medicines your doctor prescribed? Q28: Did you leave your former plan because it was difficult to get brand name medicines? Q29: Did you leave your former plan because you were frustrated by the plan's approval process for medicines your doctor prescribed?

Table 1.6. Individual Survey Questions Not Included in a Composite Measure*

Individual Survey Questions Not Included in a Composite	
Co-payment for Doctor Visit Went Up	Q21: Did you leave your former plan because the dollar amount you had to pay each time you visited a doctor went up?
Low Medicare Star Rating	Q42: Did you leave your former plan because it got a low Medicare Star Rating?
Found Plan with a Higher Medicare Star Rating	Q43: Did you leave your former plan because you found another plan with a higher Medicare Star Rating?
Family Member or Friend Recommended Another Plan	Q45: Did you leave your former plan because a family member or friend told you about a better plan?
Saw Commercial or Advertisement for Another Plan	Q46: Did you leave your former plan because you saw a commercial or advertisement for a health plan you thought you would like better?
Another Plan Better Met Prescription Needs	Q47: Did you leave your former plan because you found another plan that better met your prescription needs?
Another Plan Offered Better Benefits or Coverage of Health Services	Q48: Did you leave your former plan because another plan offered better benefits or coverage for some types of care, treatment or services (for example, dental or vision care)?

** These questions were analyzed individually because responses to the questions were not strongly related to responses to questions included in the composites presented in Table 1.5.*

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 (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 (https://www.medicare.gov/find-a-plan) displays your contract's mean scores on the composite (summary) measures of disenrollment in addition to your contract's voluntary disenrollment rate. These scores are publicly reported so that consumers making plan choices can see the reasons that beneficiaries gave for disenrolling from a contract in 2017.

Unlike the results shown in this report, which presents scores to 1 decimal digit, the Medicare

Plan Finder presents scores rounded to the nearest integer (whole number). Table 1.7 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 1.7 also shows the labels used for the composite measures on the Medicare Plan Finder which are different (i.e., more consumer friendly) than the labels used to describe composite measures in this report.

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.

Table 1.7. 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 Contract ([redacted]) Score to 1 Decimal Digit	Composite Measure Label	Your Contract ([redacted]) Score Rounded to Nearest Integer
Problems with Coverage of Doctors and Hospitals	[redacted]	Doctors or Hospitals are not Covered by the Plan	[redacted]
Financial Reasons for Disenrollment	[redacted]	Problems with the Cost of the Plan	[redacted]
Problems Getting Needed Care, Coverage, and Cost Information	[redacted]	Problems Getting the Plan to Provide and Pay for Needed Care	[redacted]
Problems Getting Information and Help from the Plan*	[redacted]	Problems Getting Information and Help from the Plan	[redacted]
Problems with Prescription Drug Benefits and Coverage	[redacted]	Problems with the Plan's Prescription Drug Coverage	[redacted]

** In previous reports, this measure was labeled "Problems Getting Information about Prescription Drugs"*

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 2017 through December 2017. Samples were drawn to represent that population with targets of 75 completed responses cases from each MA contract's disenrollment population for that period and 150 from each PDP; target sample sizes were calculated based on historical response rates from each contract and also took into account differences in response rate associated with dual eligibility and month of disenrollment. Because beneficiaries who disenroll at different times of the year 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 of the year rather than retrospectively, so 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.

For some contract s, the target number of responses is not reached over the course of the year. Contracts projected to have more than 40 disenrollees over the course of the year but fewer than the target number of disenrollees ("small" contracts) are sampled at a rate of 100%. Contract s that were projected to fall below 40 cases per year were excluded from sampling for contract-level reporting. For these excluded contract s, a floor sampling rate was established to achieve national (but not contract-level) representativeness.

For national representativeness, sample sizes were increased in the largest ("big") contracts, using sampling rates of 0.30% in PDP contracts and 1.50% in MA contracts when these rates yielded larger samples than the targets described above. The terms "small" and "big" here are defined with respect to disenrollment, not enrollment.

In MA contracts with some but not all beneficiaries enrolled in the prescription drug (PD) benefit, samples were drawn from both the MA-PD and MA-Only portions of the contract, and each group of sampled disenrollees was mailed the appropriate questionnaire.

Survey Implementation

The 2017 survey of disenrollees was conducted with beneficiaries who disenrolled between January and December 2017. 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 2017 covered disenrollments that happened in the January 2017 time period (approximately a six-week lag). Surveys mailed in April 2017 covered disenrollments that happened in February 2017, and so forth. The data collection protocol included mailing of pre-notification letters and up to two mailings of paper surveys. Residents of Puerto Rico received a Spanish-language version of the survey. All other disenrollees received an English-language version of the survey but could request a Spanish language version by calling a 1-800 number maintained by the survey vendor.

Sample Disposition

The sample disposition and response rates for the 2017 Medicare Advantage and Prescription Drug Plan Disenrollment Reasons Survey are presented in Table 1.8. Of the 122,746 MA disenrollees in the original sample, 4,911 (4.0%) 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 (66.3% of sample members). The adjusted response rate, after accounting for ineligible sample members, is 30.9% percent (36,426 partial or completed surveys divided by 122,746 disenrollees in the original sample minus 4,911 disenrollees deemed ineligible).

Table 1.8. 2017 Medicare Advantage and Prescription Drug Plan Disenrollment Reasons Survey, MA Sample Disposition

Disposition	MA Sample Member Count	Percentage of Sample
Partial or completed survey	**36,426**	**29.7%**
Completed mail survey	27,899	22.7%
Screened out or did not answer any substantive items	8,527	6.9%
Ineligible	**4,911**	**4.0%**
Deceased	67	0.1%
Mentally or physically unable to respond or institutionalized	28	0.0%
Did not speak English or Spanish	16	0.0%
Otherwise excluded from survey*	4,800	3.9%
Non-respondents	**81,409**	**66.3%**
Total sample	**122,746**	**100.0%**

** These were mainly surveys returned as undeliverable*

Weighting and Case-Mix Adjustment

The survey data are adjusted using regression to remove predictable effects of respondent characteristics on survey scores and therefore make comparisons among contracts fairer. The scores represent *case-mix adjusted* estimates, which approximate the scores that would be obtained if the respondents from each contract had an identical distribution of characteristics.

Adjustments to the Distribution of Disenrollment by Month and Dual Eligibility to Obtain Contract- Representative Scores

In 2017, we adjusted contract-representative estimates for differences in the rate of valid responses per disenrollee by dual status and month of disenrollment. Dual eligibility is an important variable to consider in any analysis of Medicare experience-of-care data—particularly where beneficiary financial factors are under consideration—because the out-of-pocket cost structure for duals is so different from that for nonduals. Duals differ from nonduals in other relevant ways as well, including income, education, and response rates. Furthermore, because rates of dual eligibility differ tremendously across contracts (from 0 to 100%), the impact of any such differences at the individual level is greatly magnified. The month of disenrollment is important because it plays a major role in sample design and because disenrollments in December fall under an open enrollment period and consequently constitute around 60% of the

year's disenrollments, with potentially different predominant reasons than in other months (see pp. 23-25 of this report). For this purpose, we aimed 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. Furthermore, the fraction of disenrollees who are dually eligible is much higher in January to November than in December because disenrollees who are dually eligible are much more likely to switch enrollments outside the open enrollment period than disenrollees who are non-dually eligible.

This adjustment was performed using a combination of weighting and regression adjustment. The weighting adjustment is less model-dependent than the regression adjustment, reducing the potential bias if differences in reasons related to dual eligibility or month of disenrollment differ by contract. A disadvantage of weighting is that it tends to increase the variance of estimates, giving them a variance equivalent to that of an unweighted estimate based on a smaller sample size (i.e., the effective sample size). Consequently, the weighting adjustment was applied first but was constrained not to reduce the effective sample size of estimates based on the entire sample to less than 75 in MA contracts or 150 in PDP contracts. For each contract, the sequence of weighting schemes considered was (1) equal weights [chosen for 149 contracts], (2) half-adjustment to matching dual eligible rate [129 contracts], (3) matching dual status distribution to population total [42 counts], and (4) adjusting to represent the population distribution across the 4 dual-status by month cells [63 contracts]. In the equal-weighting scheme, each response within a contract received a weight equal to the number of disenrollees for the contract-year divided by the number of survey respondents. "Half-adjustment" means that the weights were the mean of the equal weights and the dual-status weights. An additional constraint was that weightings were not adopted if they moved the percent dually eligible in the contract further away from the overall mean rate (about 35%), because contracts with outlying values of percent-dually eligible were the hardest to match for the comparative analyses that are the primary objective of this phase. Thus, a small sacrifice of reduced effective sample size is traded off for the benefit of bringing the (weighted) distribution of respondents closer to the distribution of the entire population, with the remaining discrepancies adjusted for by regression adjustment as part of the case-mix adjustment procedure described below.

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

An additional adjustment was made to address the effects of discrepancies between the distributions of characteristics of enrolled beneficiaries in each contract and the average distribution. 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 plan members, healthier plan members, 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. Similar effects were observed in analysis of reasons for disenrollment. Contracts do not all have the same distribution ("case mix") of enrollees with these characteristics, so these response tendencies can bias comparisons among contracts. If a contract has a large number of enrollees whose characteristics make them a "tough audience," the contract may receive a lower score than it would receive if it delivered the same care to enrollees with an average distribution of characteristics.

We perform "case-mix adjustment" using linear regression to correct for these effects and estimate the scores that would be obtained by each contract if every contract had the same distribution of enrollee characteristics, equivalent to the average across all contracts. This analysis was performed after the weighting adjustment that moved the distribution by month (January-November vs December) closer to the contract's actual proportions by month, subject to an effective sample size constraint (see above). The regression adjustments applied these weights to all analyses. The overall national mean (weighted by number of disenrollees) is the same before and after adjustment, so scores for some contracts (those with beneficiaries who tend to provide more favorable assessments) were adjusted downwards relative to their unadjusted weighted means, and others were 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;
- Education: A self-reported six-category survey variable ranging from less than eighth grade to more than college
- Self-reported general health status: Five-category variable (excellent, very good, good, fair, poor)
- Self-reported mental health status: Five-category variable (excellent, very good, good, fair, poor)
- 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), The LIS and dual eligible variables came from the 2017 CMS enrollment files.

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, low or very low reliability. Inter-unit reliability is defined by $IUR=s^2/(SE^2+s^2)$, where s^2 = 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 for which IUR<0.70 are considered to have low reliability. Contracts for which IUR < 0.60 are considered to have very low reliability.

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 a question 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.

Significance Testing

For composite measures of reasons for disenrollment, where scores are the mean percentage of reasons 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.

Contract means that have adequate reliability (0.70 or higher in a 0-1 range) are shown in bold. Contract means that have low reliability (between 0.60 and 0.70) but meet the minimum sample size are shown without bolding. Contract mean scores with very low reliability (below 0.60) are shown only when the contract mean is statistically significantly lower or higher than the national average ($p<0.05$). In this case, there is strong evidence that the contract is below or above average but the degree to which it is below or above average is imprecisely measured. For that reason, the contract mean is reported but it is shown in brackets. Contract means that have very low reliability (below 0.60) and that are not statistically significantly different from the national average are suppressed because there is not strong evidence that the contract is distinguishable from the national average.

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

In Section III of the report (Detailed Results for Composite Measures), results are displayed graphically for composite measures. When a contract's score is significantly different from the national average, it 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 t-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.

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. Individuals who disenroll during the Open Enrollment Period, which runs from October 15 to December 7, show up as December disenrollees. Individuals who disenroll outside of the Open Enrollment Period, and thus show up as January-November disenrollees, are beneficiaries who qualify both for Medicare and Medicaid (i.e., dual eligibles) or who qualify for a Special Election Period (SEP) (i.e., non-duals who qualify for the Low Income Subsidy). Table 1.9 shows national average scores on the composite measures of disenrollment as well as on the questions that make up those composite measures broken down between January-November disenrollees and December disenrollees. Table 1.10 shows a similar breakdown of national average scores on the individual survey questions 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 1.9. National Average Scores on Composite Measures and Their Constituent Questions: January-November Disenrollees vs. December Disenrollees

	National Average	
	January-November Disenrollees	December Disenrollees
Problems with Coverage of Doctors and Hospitals		
Preferred provider not in plan	34.4	29.6
Preferred clinic or hospital not covered by plan	**26.8**	**20.6**
Financial Reasons for Disenrollment		
Found a plan that costs less	32.5	46.1
Prescription co-payment went up	18.5	21.9
Monthly premium went up	14.5	22.9
Could no longer afford plan	**19.2**	**15.7**
Problems Getting Needed Care, Coverage, and Cost Information		
Problems getting needed care, tests, or treatment	**28.8**	**19.1**
Frustration with approval process for care, tests, or treatment	**27.0**	**20.4**
Hard to get information about coverage and cost of health services	**17.3**	**12.2**
Problems getting claims paid	**14.6**	**10.5**
Problems Getting Information and Help from the Plan		
Could not get information or help needed from the plan	**25.2**	**16.7**
Unhappy with how the plan handled a question or complaint	**23.3**	**15.5**
Hard to get information about coverage and cost of prescription drugs	**12.5**	**9.3**
Customer service not courteous or respectful	**10.2**	**5.7**
Did not know whom to contact about filling a prescription	**8.9**	**4.9**
Problems with Prescription Drug Benefits and Coverage		
Frustrating approval process for off-formulary medications	**16.3**	**11.4**
Problems getting prescribed medication	**15.8**	**10.5**
Plan refused to pay for a prescribed medication	**15.5**	**10.3**
Change in drug formulary	**12.4**	**10.5**
Difficult to get brand name medications	**12.9**	**9.4**

Note: Individuals who disenroll during the Open Enrollment Period, which runs from October 15 to December 7, show up as December disenrollees. Individuals who disenroll outside of the Open Enrollment Period, and thus show up as January-November disenrollees, are predominately beneficiaries who qualify both for Medicare and Medicaid (i.e., dual eligibles) or who qualify for a Special Election Period (i.e., non-duals who qualify for Low Income Subsidy)

Table 1.10. National Average Scores on Single Questions (not in a composite): January-November Disenrollees vs. December Disenrollees

	National Average	
	January-November Disenrollees	December Disenrollees
Other Reasons for Disenrollment		
Another plan offered better benefits or coverage of health services	49.7	48.7
Another plan better met prescription needs	37.0	33.0
Family member or friend recommended another plan	29.4	32.8
Saw commercial or advertisement for another plan that looked better	23.6	23.9
Co-payment for doctor visit went up	20.8	18.5
Found a plan with a higher Medicare Star rating	18.3	13.9
Low Medicare Star rating	7.6	3.3

Note: Individuals who disenroll during the Open Enrollment Period, which runs from October 15 to December 7, show up as December disenrollees. Individuals who disenroll outside of the Open Enrollment Period, and thus show up as January-November disenrollees, are beneficiaries who qualify both for Medicare and Medicaid (i.e., dual eligibles) or who qualify for a Special Election Period.

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 enrollees in that contract in 2017. However, we used broader regional benchmarks (census divisions) instead of states when any of the following occurred:

- 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.