Supporting Statement, Part A
OMB/PRA Submission for Implementation of the Medicare Prescription Drug Plan (PDP) and Medicare Advantage (MA) Plan Disenrollment Reasons Survey

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SUPPORTING STATEMENT

Implementation of the Medicare Prescription Drug Plan (PDP) and Medicare Advantage (MA) Plan Disenrollment Reasons Survey

A. Background

Purpose of the survey: The Medicare Prescription Drug Plan (PDP) and Medicare Advantage (MA) Plan Disenrollment Reasons Survey (Disenrollment Survey) focuses on beneficiaries who voluntarily disenroll from their MA or PDP plan. Beneficiaries can disenroll from plans during the Annual Election Period (AEP) which runs from October 15 – December 7 each year, the Medicare Advantage Open Enrollment Period (MA OEP) that runs January 1 – March 31 each year, , and Special Election Periods (SEPs). The Centers for Medicare & Medicaid Services (CMS) developed the Disenrollment Survey to capture the reasons for disenrollment as close as possible to the actual date of a beneficiary's disenrollment. Through this survey, CMS seeks to: (1) obtain information about beneficiaries' experiences relative to provided benefits and services (for both MA and PDPs) and (2) determine the reasons that prompt beneficiaries to voluntarily disenroll. It is important to include such information from disenrollees as CMS assesses plan performance, because plan disenrollment can be a broad indicator of beneficiary dissatisfaction with some aspect of plan services, such as access to care, customer service, cost, benefits provided, or quality of care. Information obtained from the Disenrollment Survey also supports the quality improvement efforts of individual plans and provides data to assist consumer choice. (Note, when we refer to a "plan" we focus on disenrollment from what CMS calls a contract, or H, R, or S number, not changes at the plan benefit package level.)

Each year, CMS uses the overall rate of disenrollment from MA and PDP plans as a performance measure in the annual Star Rating program for Part C and Part D contracts. In 2021, among plans with at least 1,000 enrolled members, 5.7 million beneficiaries voluntarily disenrolled from a plan, with disenrollment rates varying widely across contracts. MA disenrollment rates ranged from <1% to 60% and PDP disenrollment rates from 2% to 44%. The Disenrollment Survey extends measurement of the overall disenrollment rate to investigate disenrollment reasons nationally, by market/regions, by population subgroups (e.g., beneficiaries who are dually eligible for Medicare and Medicaid vs. non-duals, those with or

without chronic conditions), and by specific plans (i.e., contracts).

The survey is conducted monthly on an ongoing basis. CMS uses the information obtained from the Disenrollment Survey for several purposes. The survey results are an important plan monitoring tool for CMS to ensure that Medicare beneficiaries are receiving high quality services from contracted providers. CMS uses information from the survey to track changes in the reasons Medicare beneficiaries cite for disenrolling to monitor improvements/declines over time nationally and at the plan level. CMS also uses the disenrollment survey results to support the quality improvement efforts of individual plans, by providing plans with a detailed, annual report showing the reasons disenrollees cited for voluntarily leaving the plan and comparing the plan's scores to regional and national benchmarks. Additionally, CMS uses the plan-specific results of the survey to provide Medicare beneficiaries with information (i.e., reasons cited for disenrolling from a plan and the frequency with which disenrollees cite each of the reasons) to assist beneficiaries with their annual consumer choice of plans.

CMS' survey contractor pulls a monthly sample from CMS' monthly disenrollment file (which contains the universe of voluntary disenrollments for that month) over a 12-month period for each contract, with the goal of achieving 75 (MA plans) and 150 (PDP plans) completed responses. CMS does not survey all disenrollees, rather only a sample of disenrollees. The size of the sample was determined by the number needed to generate reliable estimates at the plan-level based on survey response rates, screen-in rates, and variation in responses to survey items. CMS draws a larger sample size for PDP plans due to the fact that there is less variation between PDP plans in the reasons cited for disenrolling, as compared to MA plans. CMS pulls a random sample of disenrollees from each contract each month.

The large sample drawn each year is necessitated by the dual purposes of the survey: to generate national estimates of reasons for disenrollment and to produce reliable plan-level estimates for reporting to plans and Medicare beneficiaries plan-level estimates of reasons for disenrollment. The survey results are intended to represent the population of beneficiaries who disenrolled voluntarily from Part C (MA-Only or MA-PD) or Part D (PDP) contracts during an annual period (i.e., January through December each year). To represent that population, we target 75 completes from each MA plan and 150 completes from each PDP. The 75/150 number of cases were based on analyses the survey contractor performed to determine the

number of completed responses required to achieve reliable estimates (i.e., reliability of 0.70 or greater[1]) of reasons for disenrollment. Beneficiaries who disenroll at different times of the year may do so for different reasons and have somewhat different characteristics (e.g., a higher fraction of dually eligible beneficiaries disenroll outside of the Annual Election Period AEP) as they are eligible to disenroll during the Special Election Period); as such, a further goal of the sample design was to represent the distribution of each contract's disenrollment across months of the year. Sampling is done month-by-month over the course of the year rather than retrospectively once all disenrollment for a contract is known for the year. In each calendar year, we estimate approximately 160,000 sampled cases (plus or minus). Across the 160,000 sampled cases, roughly 147,000 are allocated to disenrollees from MA-Only and MA-PD contracts (approximately 652 contracts, and 13,000 to disenrollees from PDP contracts (approximately 43 contracts). The total allocated annually varies based on several factors including: 1) the total number of MA and PDP contracts, as some contracts terminate and new contracts enter the market; and 2) fluctuations in screen-out rates and response rates.

Historical Context for the Survey: Voluntary disenrollment rates from managed care plans are often viewed as a good "summary" indicator of member satisfaction and plan quality. The Balanced Budget Act of 1997 required that the CMS publicly report two years of disenrollment rates on all Medicare + Choice (M+C) organizations. To ensure that disenrollment rates would be meaningful to beneficiaries in health plan choice, to support quality monitoring activities, and to assist in quality improvement initiatives, CMS funded the development and implementation of an annual national survey to identify the reasons why beneficiaries voluntarily leave health plans. From 2000 through 2005, CMS administered the Medicare Consumer Assessment of Health Plans (CAHPS) Disenrollment Reasons Survey for managed care organization and publicly reported information from this survey.

As the Medicare program had changed significantly since the CAHPS Disenrollment Reasons Survey was administered in 2005 (largely attributable to the 2006 implementation of Medicare's Prescription Drug, or Part D, benefit), CMS funded an effort in 2009 to develop a revised disenrollment survey to focus on beneficiary reasons for voluntarily leaving PDP and

[1]Contract-level reliability is a zero-1 index with values of .7 or higher considered adequate and value of 1 being perfect. The value indicates the proportion of variation in the reported scores that is due to true differences between contracts rather than "noise" from limited sample sizes.

MA plans; the pilot disenrollment survey work occurred between November 2010 - July 2011 (approved under OMB CONTROL NUMBER: 0938-1113 and focused only on beneficiaries who **voluntarily disenrolled** from their MA-PD or PDP plan, excluding those who involuntarily disenrolled from contracts because of ineligibility, movement out of the contract's service area, or death. This initial survey effort served as a large-scale field test of methods (data fielding, sampling, weighting, and composite construction), to understand response rates, identify any issues with the survey tool, and examine the most important reasons for disenrollment. Through this work, several improvements were identified, including refinements to survey wording regarding contract name recognition, efficiencies in the administration of the survey, and refining the sample size required to generate reliable contract-level estimates of reasons for disenrollment.

Starting in 2012, CMS moved to annual implementation of the survey to provide yearly feedback to plans and to support annual choice of plans by beneficiaries. CMS expanded the survey to include disenrollees from MA-only contracts and continued to work with the survey contractor to improve screen-in rates and respondent comprehension regarding the contract from which they disenrolled.

Since 2012, the survey has been implemented nationwide on a continuous basis to generate data to provide CMS with data for contract monitoring, to produce individual plan reports that are used to inform plans' quality improvement efforts, and to produce information for Medicare beneficiaries to use when selecting plans.

To note, CMS has been collecting information since 2000 on beneficiaries' experiences with health care for Medicare managed care and traditional fee-for-service (FFS) Medicare among enrollees in plans through the Medicare Consumer Assessment of Healthcare Plans and Systems (MCAHPS) survey. Starting in 2007, the MCAHPS survey added a new section to assess prescription drug plans under the new Medicare Part D benefit and developed a new MCAHPS survey instrument for beneficiaries enrolled in PDPs. Although CMS was collecting the experiences of enrolled members, outside of consumer complaints (i.e., the Medicare Beneficiary Ombudsman and grievance and appeals process), very little was known about the reasons why beneficiaries disenroll from MA and PDP plans, information that could be used to drive improvements in care and services to Medicare beneficiaries. The Disenrollment Survey was designed to fill that information gap.

Survey Content and Composite Measures: The MA and PDP Disenrollment Reasons Survey includes three versions, directed respectively at disenrollees in three different types of plans:

- Medicare Advantage-only (MA-Only) plans (46 questions)
- Medicare Advantage Health and Drug (MA-PD) plans (59 questions)
- Medicare Prescription Drug Plans (PDPs) (49 questions)

As an example, the MA-PD Survey is organized into the following sections:

- Your Former Health Plan (2 questions)
- Getting Information or Help from Your Former Health Plan (2 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)

CMS combines questions on related reasons for disenrollment into composite (summary) measures, which are reported to plans along with individual survey items. Table 1 describes the composites measures constructed and reported by survey type.

Table 1: Composite Measures by Survey Type

Composite Measures	**MA-Only Survey**	**MA-PD Survey**	**PDP Survey**
Financial Reasons for Disenrollment	Yes	Yes	Yes
Problems Getting the Plan to Provide and Pay for Needed Care	Yes	Yes	No
Problems with Coverage of Doctors and Hospitals	Yes	Yes	No
Problems Getting Information and Help from the Plan	No	Yes	Yes
Problems with Prescription Drug Benefits and Coverage	No	Yes	Yes

Table 2 displays how individual survey questions on the MA-PD survey instrument map into the composite measures.

Table 2: Composite Measures and Individual Items that Map to Composites

Composite Measure	MA-PD Survey Questions Included in the Composite
Financial Reasons for Disenrollment	• 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? (Q16) • Did you leave your former plan because the monthly fee went up? (Q18) • Did you leave your former plan because you found a health plan that costs less? (Q20) • Did you leave your former plan because a change in your personal finances meant you could no longer afford the plan? (Q 21) • Did you leave your former plan because it turned out to be more expensive than you expected? (Q23)
Problems with Coverage of Doctors and Hospitals	• Did you leave your former plan because the doctors or other health care providers you wanted to see did not belong to the plan? (Q33) • Did you leave your former plan because clinics or hospitals you wanted to go to for care were not covered by the plan? (Q34)
Problems Getting the Plan to Provide and Pay for Needed Care	• Did you leave your former plan because you were frustrated by the plan's approval process for care, tests, or treatment? (Q30) • Did you leave your former plan because you had problems getting the care, tests, or treatment you needed? (Q31) • Did you leave your former plan because you had problems getting the plan to pay a claim? (Q32) • 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? (Q35)
Problems Getting Information and Help from the Plan	• Did you leave your former plan because you did not know whom to contact when you had a problem filling or refilling a prescription? (Q28) • 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? (Q29) • Did you leave your former plan because you were unhappy with how the plan handled a question or complaint? (Q36) • Did you leave your former plan because you could not get the information or help you needed from the plan? (Q37) • Did you leave your former plan because their customer service staff did not treat you with courtesy and respect? (Q38)

Problems with Prescription Drug Benefits and Coverage	• Did you leave your former plan because they changed the list of prescription medicines they cover? (Q19) • Did you leave your former plan because the plan refused to pay for a medicine your doctor prescribed? (Q24) • Did you leave your former plan because you had problems getting the medicines your doctor prescribed? (Q25) • Did you leave your former plan because it was difficult to get brand name medicines? (Q26) • Did you leave your former plan because you were frustrated by the plan's approval process for medicines your doctor prescribed? (Q27)

Current OMB/PRA request: CMS received its most recent clearance for the Medicare Prescription Drug Plan (PDP) and Medicare Advantage (MA) Plan Disenrollment Reasons Survey on December 10, 2020 (OMB control # 0938-1113). This clearance expires on December 31, 2023. CMS requests a three-year clearance (01/01/2024 through 12/31/2027) from the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 to continue annual fielding the Medicare Prescription Drug Plan (PDP) and Medicare Advantage (MA) Plan Disenrollment Reasons Survey. CMS requests OMB's approval of the survey included as part of this OMB/PRA request (Attachments IV, V, and VI). CMS has reviewed the survey response data to assess the performance of individual items (e.g., response rates, screen-outs, item skipping) and reviewed comments received from plans and beneficiaries. Based on this information, CMS has made minor survey modifications (i.e., dropped three items and added four items to the MA-PD version; dropped three items and added three items to the PDP and MA-Only versions) in this OMB/PRA update request to the previously approved survey (as shown in our survey item crosswalk document). CMS will field the annual survey in the same manner as it has been doing since the last OMB approval December 10, 2020. CMS will continue to pull monthly samples of voluntary disenrollees from each MA and PDP plans to produce annual reports of reasons for disenrollment to use for plan feedback and improvement and beneficiary choice.

B. Justification

B1. Need and Legal Basis

The Balanced Budget Act of 1997 required that the CMS publicly report two years of disenrollment rates on all Medicare + Choice (M+C) organizations. Disenrollment rates are a

useful measure of beneficiary dissatisfaction with a plan; this information is even more useful when reasons for disenrollment are provided to consumers, insurers, and other stakeholders. Advocacy organizations agree that CMS needs to report disenrollment reasons so that disenrollment rates can be interpreted correctly. (See https://www.medicarerights.org/pdf/Why-Consumers-Disenroll-from-MA.pdf as an example.) The Disenrollment Survey gives CMS, plans, and beneficiaries important information about the reasons members leave Medicare Advantage and Prescription Drug plans.

Further, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) provides a requirement to collect and report performance data for Part D prescription drug plans. Specifically, the MMA under Sec. 1860D-4 (Information to Facilitate Enrollment) requires CMS to conduct consumer satisfaction surveys regarding the PDP and MA contracts pursuant to section 1860D-4(d). Plan disenrollment is generally believed to be a broad indicator of beneficiary dissatisfaction with some aspect of plan services, such as access to care, customer service, cost of the plan, services, benefits provided, or quality of care.

The information generated from the disenrollment survey supports CMS' ongoing efforts to assess plan performance and provide oversight to the functioning of Medicare Advantage (Part C) and PDP (Part D) plans, which provide health care services to millions of Medicare beneficiaries (i.e., 28 million for Part C coverage and 49 million for Part D coverage).[2] Beneficiary experiences of care (as measured in the MCAHPS survey) and dissatisfaction (as measured in the disenrollment survey) with plan performance are both important sources of information for plan monitoring and oversight. The disenrollment survey assesses different aspects of dissatisfaction (i.e., reasons why beneficiaries voluntarily left a plan), which can identify problems with plan operations; performance areas evaluated include access to care, customer service, cost, coverage, benefits provided, and quality of care. Understanding how well plans perform on these dimensions of care and service helps CMS understand whether beneficiaries are satisfied with the care they are receiving from contracted plans. When and if plans are found to be performing poorly against an array of performance measures, including beneficiary disenrollment, CMS may take corrective action.

B2. Information Users

[2] https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-enrollment-update-and-key-trends/
https://www.kff.org/medicare/fact-sheet/an-overview-of-the-medicare-part-d-prescription-drug-benefit/

This data collection complements the enrollee beneficiary experience data collected through the Medicare Consumer Assessment of Healthcare Providers and Systems (MCAHPS) survey by providing information on the reasons for disenrollment from a Medicare Advantage (with or without prescription drug coverage) or Prescription Drug Plan.

The Disenrollment Survey results are an important source of information used by CMS to monitor plan performance and to identify potential problems with plans (e.g., plans providing incorrect information to beneficiaries or creating access problems). CMS uses the results to monitor the quality of service that Medicare beneficiaries get from contracted plans and their providers and to understand beneficiaries' expectations relative to provided benefits and services for MA and PDPs. CMS uses information from the Disenrollment Survey to support quality improvement efforts of individual plans.

Annually, CMS provides each plan with a detailed report showing the reasons disenrollees cited for voluntarily leaving the plan and comparing the plan's scores to regional and national benchmarks. The annual plan reports include results on individual survey items and composite measures of disenrollment reasons (i.e., financial reasons, problems with prescription drug benefits and coverage, problems getting information and help from the plan, problems getting the plan to provide and pay for needed care, and problems with coverage of doctors and hospitals). Plans also see information showing disenrollment rates among subgroups of their enrolled population (e.g., duals/non-duals, elderly vs. non-elderly disabled). Plans can use the information to guide quality improvement efforts. For example, PDP and MA plans (both MA-Only and MA-PD) can identify problem areas, make changes to how medications are covered, to beneficiary costs, and to other plan features that impact beneficiaries, and reduce the likelihood of disenrolling.

CMS gets feedback about the utility and use of the disenrollment reasons survey and annual report through formal means and informally, particularly through the dedicated Disenrollment Survey mailbox. Each year, particularly around the time of annual report distribution, plans reach out through the Disenrollment Survey mailbox to request more information about the survey and the report. This signals that plans are using information from the reports and survey. Notably, when the Disenrollment Survey was discontinued in 2005, CMS received numerous requests from plans to reinstate the survey so that plans could review findings for quality improvement.

CMS also makes results publicly available so consumers and stakeholders can view the overall plan disenrollment rate and the summary composite reasons cited for disenrolling (i.e., financial reasons, problems with prescription drug benefits and coverage, problems getting information and help from the plan, problems getting the plan to provide and pay for needed care, and problems with coverage of doctors and hospitals), showing the frequency with which disenrollees cited for each reason.

B3. Use of Information Technology

The survey vendor collects the data via a mail data collection strategy that involves an initial pre-alert letter notifying the beneficiary that they will receive a survey (mailed 3 days prior to the first survey mailing) followed by two rounds of mailed surveys over an 8-week field period. The first survey is mailed approximately 4 weeks after the date of disenrollment. The mailed survey is formatted for data scanning, and data from all returned surveys is scanned into an electronic data file. CMS uses a mailed survey protocol for several reasons: 1) many seniors, especially older beneficiaries, are not routine, facile users of the Internet; 2) CMS does not collect or maintain email addresses of Medicare beneficiaries that would be required to field a web survey, where CMS is the entity fielding the survey; and 3) plans do not always have or maintain current email addresses (typically email information is collected and updated by physician offices and not transmitted to plans). Mail surveys are less costly to administer than phone surveys (with the exception of Interactive Voice Recognition (IVR) surveys which typically generate very low response rates).

CMS' Disenrollment Survey contractor explored innovations that CMS might consider to improve response rates, improve the representativeness of respondents, and/or reduce costs to the federal government associated with fielding the survey. One area that CMS has and is continuing to explore is the feasibility of augmenting the current fielding methodology to incorporate a web-based survey mode. At present, it would be challenging to implement a web-based survey in the context of the Disenrollment Survey because CMS lacks email addresses for most Medicare beneficiaries. Obtaining email addresses from the MA and PDP plans would be problematic given that beneficiaries disenroll monthly throughout the year and it would be administratively difficult to request monthly lists of email addresses from 600+ plans from which beneficiaries disenrolled. It would be particularly challenging to receive the email files from plans in a timely way so as not to adversely delay getting surveys out to

disenrollees. Such delays between time of disenrollment and survey delivery have a negative impact on response rates.

B4. Duplication of Efforts

This is the only disenrollment reasons survey sponsored by CMS being fielded currently to recent disenrollees from MA and PDP plans. In feedback received from plans, they indicated the information contained in the reports is complementary to other information they compile related to member complaints and member retention efforts.

B5. Small Businesses

Survey respondents are Medicare beneficiaries who disenroll from Medicare Prescription Drug Plans (PDPs), and Medicare Advantage plans (both MA-Only plans and MA-PD plans). The survey should not impact small businesses or other small entities.

B6. Less Frequent Collection

The consequence of not collecting data as soon as possible after a beneficiary disenrolls from a health or prescription drug plan is that the beneficiary will be less able to recall their specific reasons for disenrolling from a PDP or MA plan and their experiences under their previous plan, information that is critical for program improvement. PDP and MA plans (both MA-Only and MA-PD) can make changes to the types of medications covered, to beneficiary costs, and to other plan features that impact beneficiaries. It is therefore useful that CMS survey on an ongoing monthly basis, sampling from the most recent set of disenrollees to enhance recall as to the reasons for disenrollment and the plan the beneficiary has disenrolled from.

Further, it is important that plans, beneficiaries and CMS have access to recent information on reasons for disenrollment to guide decision making. In the last OMB approval, as a term of clearance, OMB requested that when four years of data are available, CMS evaluate the **within plan temporal variability** in quality scores available to consumers and adjust the frequency of the data collection accordingly. Additionally, OMB requested that CMS look at the temporal and geographic variability in the distribution of disenrollment reasons **across all plans** (analyses will include comparisons at the 10th, 25th, 50th, 75th, 90th percentiles) to assess changes over time and the utility of annual surveying.

In response to this request from OMB, CMS examined the following:

(1) contract-level variability in reasons for disenrollment composite scores over time;

(2) geographic-level variability in the distribution of disenrollment reasons over time; and

(3) the degree to which disenrollment reasons composites predict future disenrollment.

The analyses (details of which can be found in Attachment VII) show that annual survey data collection provides timely, contract-specific information to inform contract quality improvement and beneficiary choice of contracts. Because MA and PDP contracts often change from year-to-year in the services and plan benefit package options they provide, it is important that performance data be as current as possible for consumers to make decisions and for contracts to understand how their members rate their performance. We find that performance and disenrollment reason information vary sufficiently year-to-year as to capture information that may not be well represented by using data from even one year before, much less two or three years before. Given the observed changes in the quality scores both at the contract-level and regionally (i.e., changes in percentile categories identified by OMB) across time, there is significant utility to CMS, contracts, and beneficiaries in continuing to collect the disenrollment reasons information on an annual basis. The findings of variability across years between contracts and between states suggest the value of frequent administration and reporting of the disenrollment reasons survey, given that there are often substantial changes for contracts and states in one year. Additionally, there is a demonstrable, predictive link between the proportion of non-financial reasons cited by disenrollees in one year and the subsequent year's disenrollment rate for a contract; this highlights the utility of providing the most recent disenrollment reasons information to contracts, who are focused on minimizing disenrollment.

B7. Special Circumstances

This collection doesn't contain any special circumstances.

B8. Federal Register/Outside Consultation

The Agency's 60-day Federal Register notice was published in the Federal Register (88 FR 7976) on 02/07/2023. The 30-day Federal Register notice published in the Federal Register (88 FR 26311) on 4/28/2023.

B9. Payment/Gifts to Respondents

None. This data collection will not include respondent incentive payments or gifts.

B10. Confidentiality

Individuals contacted as part of this data collection will be assured of the confidentiality

of their replies under 42 U.S.C. 1306, 20 CFR 401 and 422, 5 U.S.C. 552 (Freedom of Information Act), 5 U.S.C. 552a (Privacy Act of 1974), and OMB Circular A-130.

B11. Sensitive Questions

The survey does not include any questions of a sensitive nature.

B12. Burden Estimate (Hours & Wages)

Wages

To derive average costs, we used data from the U.S. Bureau of Labor Statistics' May 2021 National Occupational Employment and Wage Estimates for all salary estimates (https://www.bls.gov/oes/current/oes_nat.htm). In this regard, the following table presents the mean hourly wage for "All Occupations," the cost of fringe benefits (calculated at 100 percent of salary), and the adjusted hourly wage.

Occupation Title	Occupation Code	Mean Hourly Wage ($/hr)	Fringe Benefit ($/hr)	Adjusted Hourly Wage ($/hr)
All Occupations	00-0000	$28.01	$28.01	$56.02

We adjusted our employee hourly wage estimates by a factor of 100 percent to account for fringe benefit costs, which is a rough adjustment because fringe benefits and overhead costs vary significantly from employer to employer, and methods of estimating these costs vary widely from study to study. Nonetheless, there is no practical alternative and we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

Burden Estimates

Exhibit 1 shows the estimated annualized burden for the respondents' time to participate in this data collection. The Medicare Prescription Drug Plan (PDP) and Medicare Advantage (MA) Plan Disenrollment Reasons Survey will be administered to 160,000 beneficiaries in calendar-year 2023 (approximately 145,000 MA-PD and MA-Only disenrollees and 15,000 PDP disenrollees) using three survey versions: Medicare Advantage with Prescription Drug Plan Coverage or MA-PD version (Attachment IV in Supporting Statement B); (2) Stand Alone Prescription Drug Plan or PDP version (Attachment V in Supporting Statement B); and (3) Medicare Advantage Only or MA-Only version (Attachment VI in Supporting Statement B).

We anticipate an annual overall response rate of approximately 20-26% given multiple previous years' experience. In 2021, MA response rates were 20% and PDP response rates were 25%. The estimated average response time of 0.18 hours or 11 minutes for the PDP version of the survey is based on the length of that survey version, a pace of 4.5 items per minute, standardized survey instructions, and CMS' experience with surveys of similar length that were fielded with Medicare beneficiaries. Similarly, the estimated average response time of 0.22 hours or 13 minutes for the two MA versions of the survey (MA-PD and MA-Only) is based on the length of the MA-PD survey version, a pace of 4.5 items per minute, and CMS' experience with surveys of similar length that were fielded with Medicare beneficiaries. Note: although the MA-Only survey instrument is shorter than the MA-PD survey instrument (46 vs. 59 items), for this burden estimate we are assuming that all MA disenrollees will fill out the MA-PD (longer) version because there are only a very small number of MA-Only plans and we know that MA-Only surveys make up a minority of the total MA sample. As indicated below, the total burden hours are estimated to be 7,055 hours.

Exhibit 1: Estimated annualized burden hours

Survey Version	**Number of Respondents**	**Number of responses per respondent**	**Hours per response**	**Total Burden hours**
Medicare Disenrollee Survey, Stand Alone Prescription Drug Plan (PDP) Version	3,750	1	0.18	675
Medicare Disenrollee Survey, Medicare Advantage (MA-PD and MA-Only	29,000	1	0.22	6,380
Total	32,750	1	-	7,055

Note: the number of respondents was computed as follows using response rates from the 2021 sample: (145,000 MA sampled * .20 response rate)= 29,000 respondents. (15,000 PDP sampled * .25 response rate) = 3,750 respondents.

Exhibit 2 shows the survey participants' cost burden associated with their time to complete a survey. The total cost burden is estimated to be $395,221.

Exhibit 2: Estimated annualized cost burden

Survey Version	Number of Respondents	Total Burden hours	Adjusted Hourly Wage Rate*	Total Cost Burden
Medicare Disenrollee Survey, Stand Alone Prescription Drug Plan Version	3,750	675	$56.02	$37,813
Medicare Disenrollee Survey, Medicare Advantage (MA-PD and MA-Only	29,000	6,380	$56.02	$357,408
Total	32,750	7,055	-	$395,221

*Based upon the mean hourly wage for "All Occupations" (Occupation Code 00-000) of $28.01 per hour, as shown on the U.S. Bureau of Labor Statistics website (May 2021 National Occupational Employment and Wage Estimates), plus an estimate of fringe based on 100% of the mean hourly wage https://www.bls.gov/oes/current/oes_nat.htm (last accessed on 12/21/2022).

B13. Capitol Cost

We have no capital costs

B14. Cost to Federal Government

The total cost for design, data collection, analysis, and contract-level report production per year is $1,962,734.

B15. Changes to Burden

This request seeks approval of an estimated 7,055 hours of respondent burden per year to assess reasons for disenrollment from MA and PDP contracts. The actual respondent burden is subject to change between years depending on shifts in number of PDP and MA contracts and/or changes in response rates from year-to-year. It is important to maintain flexibility and consider larger sample sizes that will preserve adequate contract-level reporting reliabilities in the event of increases in the number of PDP and MA contracts and/or declines in response rates.

CMS's contractor analyzed responses to the individual disenrollment survey items to assess the number of beneficiaries screening out of the survey and reasons for screen out, and to identify potential problems with specific survey items (i.e., inappropriate skips or large fraction of missing responses).

CMS proposes to delete the following two items to reduce respondent burden.

- *Q15: Did you leave your former plan because you were taken off the plan by mistake?* This item had low rates of endorsement and low reliability at the contract level.
- *Q22: Did you leave your former plan because a change in your health meant the plan no longer met your needs?* This item had low reliability across all contracts, which means it is difficult to discern differences in contract-level performance.

CMS proposing adding one item.

- *Did you leave your former plan because an insurance agent or broker told you about a better plan?* (New MA-PD Q42; PDP Q31): This item is of importance given the significant role played by brokers and agents in helping Medicare beneficiaries with plan selection and based on feedback CMS has received from plans.

We propose dropping one general cost item and replacing with three more specific cost items to give more useful information to CMS, plans, and beneficiaries.

- *Did you leave your former plan because you found a health plan that costs less? (*MA-PD Q20; PDP QX16. This item will be removed from the Financial Reasons for Disenrollment composite measure.

CMS proposes adding the following three items:

- *"Did you leave your former plan because you found a plan with a lower copayment for prescription drugs?* (MA-PD New Q16; PDP New Q:13)
- *"Did you leave your former plan because you found a plan with a lower copayment for doctors' visits?* (MA-PD New Q18)
- Did you leave your plan because you found a plan with a lower monthly premium? New (MA-PD New Q20; PDP New Q15):

These revisions do not change any requirements and reduce the overall burden estimates.

In summary, the revised MA-PD version has net 1 additional item (3 dropped, 4 added), the MA-Only version has zero net changes (3 dropped, 3 added) and the revised PDP version has zero net changes (3 dropped, 3 added). These changes apply to both the English-language and Spanish-language versions of the survey. The proposed revisions result in no changes in our estimated completion time per survey.

On an annualized basis, the estimate of respondent burden is reduced from the estimate provided in our 2019 OMB application due to a reduction in response rates from ~30% (2019 OMB application assumption) to ~20.3% (based on observed response rates for the survey in 2021).

B16. Publication/Tabulation Dates

The general schedule for publication of results from the PDP and MA plan disenrollment reasons surveys is as follows. (1) Survey fielding for the prior year's disenrollee surveys is completed in April. (2) Data cleaning and processing is completed in May, and (3) calculation of contract-level estimates for reasons of leaving composites and single items is conducted in June/July, including weighting and case-mix adjustment). (4) The survey contractor provides CMS with contract-level scores on reasons for leaving composites in July. (5) Individual contract-level reports on results from surveys from the previous year's disenrollees are distributed to the health and prescription drug plans by e-mail in September of each year.

For surveys of beneficiaries who disenrolled from their contracts in calendar-year 2021 for example, the schedule proceeded as follows:

- April 2022 – finished data collection for surveys from calendar year 2021 (January 2021 through December 2021)
- May-June 2022 – conducted data cleaning and processing of 2021 survey results
- June/July 2022 – computed weights and calculated contract-level estimates of reasons for leaving composites and single items; applied weighting and case-mix adjustment to derive estimates
- July/August 2022 – prepared 2021 contract-level estimates of reasons for leaving composites, which CMS posted to the plan preview page later in the summer and to CMS website in October 2022)

- September 2022 – distributed contract-level reports of survey results from 2021 disenrollees to the plan Medicare Compliance Officers

We anticipate a similar schedule for 2024 for processing and publishing the results of surveys of beneficiaries who disenrolled from their contracts in calendar-year 2023. This process repeats annually.

B17. Expiration Date

The current expiration date is December 31, 2023. CMS will display the new expiration date for OMB approval of this information collection on the survey, once OMB approval has been obtained (see attachments IV, V, and VI) which now include text "The valid OMB control number for this information collection is 0938-1113 (Expires: TBD)."

B18. Certification Statement

There are no exceptions to the certification statement identified in item 19 of OMB Form 83-I associated with this data collection effort.

C. List of Attachments

Attachment I. Prenotification Letter

Attachment II. Wave 1 Cover Letter

Attachment III. Wave 2 Cover Letter

Attachment IV. MA-PD Survey

Attachment V. Stand Alone PDP Survey

Attachment VI. MA-Only Survey

Attachment VII. Analyses Regarding Year-to-Year Variability of Disenrollment Reason Scores