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Involuntary Disenrollment from Medicare+Choice Managed Care Plans: Experiences of Beneficiaries in Six Communities

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Involuntary Disenrollment from Medicare+Choice Managed Care Plans: Experiences of Beneficiaries in Six Communities

Abstract: We examined the experience of Medicare beneficiaries whose health plans discontinued Medicare contracting (involuntary disenrollees) in six communities around the country in 2001. The focus was on the role of information in the insurance transition process, and particularly the role of the public information efforts of CMS' National Medicare Education Program (NMEP). Few involuntary disenrollees made much use of these "official" information resources (Medicare handbook, helpline, insurance counselors), and there was little correlation between use of these resources and beneficiary choice of replacement insurance or satisfaction with the transition process. Minorities appeared more likely than whites to have adverse experiences or outcomes in connection with involuntary disenrollment. Finally, variation across communities was pervasive in both the mechanics and the outcomes of the transition process, reflecting the fundamentally local character of markets for Medicare supplemental coverage.

Background

The steadily increasing cost of health care has magnified the importance of insurance designed to fill gaps in Medicare's core package of Part A and Part B benefits. Most beneficiaries have traditionally purchased Medigap supplemental insurance for this purpose. Beginning in the 1980s, however, a steadily increasing fraction of Medicare beneficiaries obtained supplemental coverage by enrolling in Medicare managed care (MMC) plans under CMS demonstration projects. The Balanced Budget Act of 1997 (BBA) made managed care plans a central feature of the new Medicare+Choice (M+C) system, and in so doing made such plans a regular part of Medicare and brought MMC options to many local markets where they had previously been unavailable.

In addition to launching Medicare+Choice, BBA mandated the creation of an educational campaign to inform beneficiaries about their Medicare options and assist beneficiaries in choosing knowledgeably among them. Almost from the start, however, CMS' National Medicare Education Program (NMEP) found that the most pressing problem faced by many beneficiaries was not how to choose among new M+C options, but how to cope with the loss of existing ones. By the second year of Medicare+Choice, MMC plans began to withdraw from the program in substantial numbers, in response to unsatisfactory business results and managers' perceptions that unfavorable market conditions would persist. The number of M+C plan contracts declined from a peak of 346 in 1998 to 179 in 2001, disrupting coverage for a total of more than 1.5 million

beneficiaries during this period (Gluck and Hansen, 2001), with a further 536,000 projected to be affected by additional plan withdrawals announced for 2002 (CMS Report).

While all beneficiaries whose M+C plans withdraw from the program are assured of retaining at least the core package of Medicare benefits in succeeding years, those who wish to have supplemental coverage on an uninterrupted basis must act within a limited time to identify and enroll in appropriate replacement insurance. The potentially serious financial consequences of a total loss of supplemental coverage make the situation of these involuntary disenrollees a special challenge to the NMEP and its mission of helping beneficiaries to deal effectively with the M+C system.

Accordingly, in 2001, as part of a multi-year assessment of the NMEP conducted for CMS, Abt Associates implemented a special study of the involuntary disenrollment experience. In contrast to previously published reports that have addressed the fate of involuntary disenrollees (Laschober et al. 1999, Gold and Justh 2000, Cook and McCoy, 2001) our work examined in detail the process by which disenrollees made the transition to new Medicare coverage arrangements. Of special focus was the role of information in the transition, including in particular those information interventions implemented or mandated by the NMEP, in order to assess the impact of the NMEP on the process. Our study asked the following questions:

- What choices did disenrollees make about replacement insurance, and what actions did they take in order to reach and implement those choices?

- What information did beneficiaries use during this process, and to what extent did they use the information and resources provided by CMS?

- How satisfied were disenrollees with the information available to help them make their insurance decision, and how confident were they that they had made the best decision, given their individual circumstances?

Communities and Populations Studied

This study focused on the experience of involuntary disenrollees in six communities around the country where plan terminations for 2001 affected either a large percentage of beneficiaries, a large number of beneficiaries, or both: Houston, Tucson, Sarasota, Minneapolis, Nassau County, NY and Centre County, PA. These communities were also selected to reflect a variety of community sizes and types from rural to urban, and variation in the range of Medicare insurance options (managed care and supplemental policies) that remained available for 2001. One of the communities (Sarasota) had no M+C plans remaining for 2001, while another (Houston) had none available for new members after September 30, 2000, when the sole remaining M+C plan reached capacity and closed to new enrollment. The rest had more than one remaining M+C plan to choose from.[1] Some of these communities had had plan terminations in 1998 and/or 1999 as well

[1] In three study communities, the Sterling private fee-for-service plan became available for 2001. The Sterling plan, although classified as a M+C plan, is not an HMO or managed care plan.

as in 2000, such that each year fewer options remained. Tucson, for example, had seven M+C plans in 1998, but by 2001 had only three.

Table 1 summarizes key Medicare insurance market characteristics for the six study communities.

Data Sources

The findings reported here are based on data from three sources:

CMS administrative data, collected in the Enrollment Database (EDB), list every beneficiary, dates of eligibility, and all movements into and out of M+C plans. On March 2, 2001, an EDB extract was drawn containing records for all beneficiaries in the six study communities enrolled as of July, 2000 in plans that announced their withdrawal from Medicare.

A telephone survey was conducted among involuntary disenrollees in these six communities who were enrolled in a terminating M+C plan as of July 1, 2000. Respondents were sampled in December and surveyed in late January/early February 2001, 1-2 months after the M+C plans had withdrawn. Minority beneficiaries were oversampled to assure sufficient respondents for analytic precision. Survey data were post-weighted by the inverse of the sampling fraction, to adjust for this over-sampling; accordingly, numbers in the tables represent unbiased estimates of response frequencies for the survey-eligible

population in the respective communities. Beneficiaries over age 85 were excluded, as were those who did not have a listed telephone number, those whose physical or mental impairments prevented telephone interviews, non-English speakers, and those not available during the study period. Although beneficiaries under 65 were included in the survey, preliminary analysis of response patterns for the under-65 beneficiary population suggested that their information-seeking behavior is fundamentally different from that of over-65 beneficiaries, who are primarily non-disabled. In addition, the under-65 Medicare beneficiary population raises somewhat different policy issues than those over 65. Accordingly, survey data in this paper represent estimates for beneficiaries in the 65-85 age range in six communities where plan withdrawals were a problem in late 2000. Of those with identifiable telephone numbers, 46% completed the survey during the brief six week field period.

A series of focus groups were held during February, 2001 in Minneapolis, Houston, and Nassau County, NY to gain greater qualitative insight than is possible through a survey alone.

Analytic Methods

From the data in the EDB, “histories” were constructed of monthly enrollment status over the period August 2000 through February 2001, from which were tabulated enrollment status at the beginning and end of this period, as well as the frequencies of different patterns of switching among Medicare plan options during the period.

Basic cross-tabulations of the survey data revealed substantial apparent variation in response patterns across sites and across demographic categories. Logistic regression was used to test the statistical significance of these site and demographic variations and to examine the relationship between selected information sources and three disenrollment "outcome" measures (disenrollee attitudes about the information available to help in choosing replacement insurance, disenrollee choice of replacement insurance, and disenrollee attitudes about the replacement insurance they eventually selected). Finally, analyses of the EDB and survey data were reviewed in light of the findings from focus groups, and from other NMEP assessment work conducted for CMS.

Limitations

The most important limitation of our study is that the six communities targeted constitute a convenience sample only, and hence findings should be considered illustrative, and not representative of the national experience in any statistical sense. For reasons explained above, the surveyed sample represents a non-random portion of the Medicare beneficiary population in these communities. The exclusion criteria applied in the 65-and-over population, however, define a subpopulation that is likely to be disproportionately difficult for a public information campaign to reach. As a result any bias in our findings is likely to be in the direction of making NMEP performance appear to be more favorable than it actually is relative to the Medicare beneficiary population as a whole.

Finally, there is one important element needed for a full elucidation of Medicare beneficiaries' insurance choices, which is difficult to address via the data collection approaches used in this study – purchase of Medigap supplemental insurance policies. CMS administrative data do not record whether beneficiaries carry Medigap coverage. Information was collected on beneficiary choices of different types of replacement insurance, including traditional Medicare without supplemental insurance, through one of our survey questions. However, cross-checks of these survey answers about M+C choices, against EDB data for the same individuals were consistent with findings of other investigators: individuals cannot always accurately report the type of health insurance they currently hold. We therefore do not know with certainty, whether respondents who reported having Medigap insurance, did indeed carry this coverage.

Findings

What choices did disenrollees make about replacement insurance, and what actions did they take in order to reach and implement those choices?

Many involuntary disenrollees in the six study sites returned to traditional Medicare (Table 2), even in sites where one or more M+C plans remained available (all sites except Sarasota). As noted previously, the one remaining M+C plan in Houston reached a capacity limit in fall 2000 and closed to new enrollment; this is reflected in the high percentage of Houston beneficiaries who returned to traditional Medicare.

CMS administrative data do not indicate whether beneficiaries in traditional Medicare carry supplemental insurance. However, it is likely that some involuntary disenrollees returned to traditional Medicare without supplemental insurance. At least a few percent of survey respondents from each site reported that they had knowingly returned to traditional Medicare without supplemental insurance, including 9.8% of disenrollees in Sarasota (no remaining M+C plan) and 9.9% of disenrollees in Houston (remaining M+C plan closed to new enrollment after September). Also, a few participants in focus groups in Houston reported that they had returned to traditional Medicare without supplemental insurance while they waited for the remaining M+C plan to reopen.

There was considerable variation in the mechanics of the insurance transition across the study sites (Table 3). Most disenrollees made only one change in their insurance coverage during the interval studied, but a non-negligible fraction of disenrollees in Nassau County, Tucson, and Centre County switched two or more times during August 2000 – February 2001, suggesting problems with availability of satisfactory coverage or problems with understanding the available options. While the majority of disenrollees in all sites switched out of their terminating plan effective Jan. 2001, many disenrollees in each site switched before the end of 2000, with many of these leaving several months early.

What information did beneficiaries use during this process, and to what extent did they use the information and resources provided by CMS?

Roughly nine out of ten involuntary disenrollees in each site were aware that their plans had left Medicare (Table 4), suggesting that the information channels used to alert disenrollees were effective, but not perfect. Involuntary disenrollees who were younger, or who had greater knowledge about managed care in general, were significantly more likely to be aware of the problem; those who were black were significantly less likely to be aware of having been involuntarily disenrolled. Awareness also varied significantly across sites, with those in Sarasota, Tucson and Centre County significantly less likely to be aware of the problem they faced.

All beneficiaries facing involuntary disenrollment were supposed to receive a letter in July, 2000 informing them of this event, followed by a letter in October, 2000 advising them about remaining options, Medigap guaranteed issue protections, and where they could turn for additional information. As seen in Table 4, most involuntary disenrollees did recall receiving a letter from their withdrawing plan, and these letters were the most common source from which disenrollees first heard of their plan's withdrawal. Involuntary disenrollees who were Hispanic or members of another (non-black) minority were significantly less likely to recall receiving a letter from their withdrawing plan. Overall, more than half of those who recalled receiving such a letter found it to be helpful and roughly two-thirds found it easy to understand.

The plan letter suggested places to go for additional information. Roughly one-third to one-half of involuntary disenrollees recalled that the plan letter had suggested

sources for further information on their health care options. Both recall of the letter and recall of the suggestions it offered for additional assistance, varied significantly across the six sites. Roughly one-fifth of involuntary disenrollees made use of the plan letter's suggestions of sources for further information in each site except Sarasota, where only about one-tenth did so. Those who followed some of the letter's suggestions and sought more information, were not more likely to feel that they had enough information when choosing new insurance, and were not more likely to feel that they had obtained the best insurance they could afford. It seems that the additional assistance they sought, following advice in the letters, did not cause them to feel reassured that they had made a good decision with adequate knowledge about their options. Those who reported using the plan letter's suggestions were significantly more likely to select traditional Medicare without a supplement. While this correlation is perhaps counterintuitive at first glance, one possible explanation is that those who could not afford supplemental insurance were more likely to look for information.

Key initiatives sponsored by CMS within the NMEP include a national toll-free Medicare helpline and a Medicare website, the annual *Medicare &* You handbook, and the community-based Senior Health Insurance Program (SHIP) counseling network. Very few beneficiaries used any of these information resources other than the handbook, however; reported use of the other CMS-sponsored resources was too small for any meaningful comparisons and hence is not presented in table 4.

Survey respondents were asked "As you considered your other Medicare insurance options last year, where did you go, or who did you talk to, and what did you read to get information about your options?" In every site, talking to vendors – i.e., to insurance companies, including Medigap vendors, other managed care plans, and the private fee-for-service plan vendor – was the most commonly mentioned activity, usually by a wide margin. Other information sources named with some frequency included "friends and family", the terminating M+C plan, and the *Medicare & You* handbook.

The frequency of this unprompted recall of the handbook as an information source ranged from 6% to about 13% of respondents in the six communities. When asked specifically about the handbook (prompted recall), 32% to 42% recalled using it. In focus group discussions, most of the participants appeared to be aware of the handbook and had saved it as a reference, but few had actually read the handbook or were familiar with its contents, despite the decision problem they faced. Those who recalled using the handbook in the past year were no more likely than other respondents to feel that they had adequate information when choosing new insurance, or that they had obtained the best insurance they could afford. However, respondents who reported use of the handbook were significantly less likely to select another managed care plan to replace the withdrawing plan.

The *Medicare & You* handbook mailed to all beneficiary households in late 2000, contained sections for each area of the country, listing the remaining available M+C

options, their costs, and some quality of care indicators that beneficiaries might use in comparing available options. When prompted, roughly 16% to 24% of disenrollees in our study sites reported noticing the health plan cost and quality comparison sections in the handbook, and roughly 9% to 14% reported using the cost and quality information in the handbook to help choose a new health plan. Again, those few who used this information were no more likely than others to feel that they had adequate information to make a choice, and were no more certain that they had selected the best insurance they could afford. There was also no correlation between use of this information and type of replacement insurance selected; those using this information were no more or less likely to choose managed care than those who did not.

How satisfied were disenrollees with the information available to help them make their insurance decision, and how confident were they that they had made the best decision, given their individual circumstances?

More than half of involuntary disenrollees in all sites except Houston felt that they had enough information to select their new insurance, but black respondents were significantly less likely to report having enough information. As shown in Table 5, the lowest rate of satisfaction with the amount of information was in Houston, which experienced a particular market disruption not seen in the other study sites. Reflecting the uncertainty faced by many disenrollees in Houston, some participants in our Houston focus group told us that they had heard that the capacity-limited plan might reopen early in 2001 or that other M+C options might soon enter the Houston market, but also that they did not have a source of current, reliable information on this important issue.

As Table 5 indicates, most disenrollees (except in Houston) felt that they had obtained the insurance that best met their needs, at an affordable price. In Houston, a much lower percentage of involuntary disenrollees were confident that they had made the best choice and a much higher percentage reported that their situation was still unsettled. Black, Hispanic, and other minority beneficiaries were significantly less likely to be confident that they had chosen the best insurance they could afford. Also noteworthy is the relatively large fraction of involuntary disenrollees in all sites (15% to 22%, data not shown) who indicated that they "don't know" how they feel about their insurance situation. This may reflect an information deficit, in that respondents may feel that they lack the information or understanding needed to judge what constitutes a good insurance choice or whether they have made one.

Discussion

Involuntary disenrollees from M+C plans face a pressing decision about their Medicare coverage, one with potentially substantial consequences. Few of the involuntary disenrollees in our six study sites, however, made much use of the "official" information sources mandated by Congress and/or sponsored by CMS (helpline, website, *Medicare & You* handbook, SHIPs counselors). Even those who used the handbook – with its local health plan cost and quality comparison indicators – as an information resource were not more confident that they had enough information to deal with the problem of involuntary

disenrollment, and did not feel more certain that they had chosen the best insurance they could afford.

Black disenrollees appeared to be less aware of involuntary disenrollment, less likely to feel that they had adequate information and less confident of their insurance choice. Indeed, a variety of differences were observed in cross-tabulations of survey responses by race, though most were not sufficiently robust to survive tests of statistical significance. Even so, there was enough of a pattern overall to suggest that there was something systematically different about minority disenrollees' experience of the transition process, though exactly what and why remains unclear.

Variation across communities was pervasive in both the mechanics and the outcomes of the disenrollee transition process, consistent with a fundamental but often not clearly acknowledged characteristic of the Medicare program. From a statutory perspective, Medicare is defined as a national program with uniform minimum benefits. However, for both financial reasons (health care cost inflation) and substantive reasons (lack of coverage for outpatient pharmaceuticals in Medicare core benefits), supplemental coverage has become an increasingly important part of the Medicare "package". But the market for supplemental benefits is a local one, and a very complex local one at that. Our findings on the involuntary disenrollee transition process underline the extent to which the "ecology" of local markets for supplemental coverage – the variety and price of available

supplemental benefits, and the processes by which beneficiaries become aware of and select among the available options – varies considerably from one community to another.

The NMEP must surmount several hurdles if it is to achieve a meaningful influence on Medicare insurance consumers and markets. It must develop materials on a complicated topic that communicate effectively with audiences that have varied but generally declining cognitive capacities. To get its messages across, it must attract the attention of people who, for the most part, are not interested in the minutiae of health insurance and deal with it only when absolutely necessary. Finally, to be useful to their intended audiences, the materials must accurately reflect highly varied, and often fast changing, local conditions. Our findings suggest that, as of 2001, the NMEP was still having difficulty meeting these challenges.

Table 1 Features of Six Involuntary Disenrollment Study Communities

	Houston	Tucson	Sarasota	Minneapolis	Nassau County, NY	Centre County, PA
# of M+C plans in 2000	4	4	3	3	8	3
# of M+C plans available for 2001*	1	3 (including 1 PFFS)	0	3 (including 1 PFFS)	4	3 (including 1 PFFS)
Capacity Waivers at Remaining M+C Plans?	YES – as of 9/30/2000	NO	N/A	NO	NO	NO
# of beneficiaries affected by plan terminations**	59,184	16,666	9,186	8,621	15,151	5,545
% of beneficiaries in county affected by plan terminations**	21%	13%	9%	6%	7%	36%

**Source: medicare.gov website, August 2000 (for 2000 M+C plans) and November 2000 (for 2001 M+C plans); refers to number of Medicare managed care plans (MCOs), not the number of discrete products offered by the MCOs.*

***Source: CMS EDB data for beneficiaries who, as of 7/2000, were enrolled in withdrawing M+C plans.*

Table 2 Choice of Replacement Insurance by Disenrollees Aged 65-85

	Houston	Tucson	Sarasota	Minneapolis	Nassau County NY	Centre County PA
Insurance status as of Feb. 2001						
M+C plan	27.1%	78.7%	6.4%*	79.9%	67.1%	20.0%
Traditional Medicare	72.9	21.3	93.6	20.1	32.9	80.0
Choice of replacement insurance*						
Switched to another managed care plan	35.5	70.7	11.4	66.3	62.3	23.2
Went back to traditional Medicare with supplement	20.1	6.8	51.1	12.7	12.3	39.8
Went back to traditional Medicare without supplement	9.9	3.3	9.8	1.8	6.5	4.6

Data Sources: CMS EDB (insurance status), Abt Associates community survey (self-reported insurance choice)

** This anomalous value may reflect inaccurate self-reporting of county of residence by M+C plan enrollees who live near the Sarasota county boundary.*

*** Response categories reported here reflect a subset of responses to a question about actions taken in response to learning of disenrollment, and do not sum to 100%.*

Table 3 Mechanics of the Insurance Transition for Disenrollees Aged 65-85

	Houston	Tucson	Sarasota	Minneapolis	Nassau County, NY	Centre County, PA
Switched more than once between 8/2000 and 2/2001						
	1.4%	4.8%	< 0.1%	1.1%	4.6%	12.5%
Switched early (all options)						
effective 10/2000 or earlier	13.6	24.9	7.7	20.6	14.5	11.2
effective 11 or 12/2000	17.5	19.1	8.6	10.1	16.3	2.8
Gap between leaving one M+C plan and joining another						
	0.2	2.3	0	0.7	3.2	0.3

Data Source: CMS EDBs

Table 4 Use of Information in the Insurance Transition by Disenrollees Aged 65-85

	Houston	Tucson	Sarasota	Minneapolis	Nassau County, NY	Centre County, PA
Awareness of disenrollment						
	87.5%	91.1%	88.6%	93.1%	92.0%	87.5%
Source of first news of disenrollment						
Letter from withdrawing plan	48.9	49.1	49.5	70.2	65.0	48.9
Newspaper	16.0	22.2	22.2	3.9	13.9	20.5
TV/radio	5.1	3.7	3.5	1.2	2.3	3.4
Recall of letter from withdrawing plan						
	72.2	82.0	74.6	77.1	74.4	72.8
Awareness of plan letter's suggestions of sources for further information						
	40.9	45.2	36.2	47.6	43.1	52.0
Use of plan letter's suggested sources for further information						
	18.2	21.5	10.5	21.4	17.2	22.3
Use of Medicare & You handbook to find out about insurance options						
	33.2	35.6	34.6	31.6	37.9	41.6
Awareness of cost/quality comparison information in Medicare & You handbook						
	16.6	23.7	18.4	16.3	23.7	22.6
Use of health plan cost/quality comparisons in Medicare & You handbook						
	9.3	11.6	8.9	10.2	14.2	12.2
Information sources used by disenrollees (unprompted recall)						
Insurance companies	23.6	27.0	34.6	21.4	23.9	29.1
Friends and family	12.5	9.9	14.6	16.3	18.6	14.4
Withdrawing M+C plan	9.3	15.8	6.4	12.4	6.6	6.1
Doctor's office	8.0	12.1	7.0	11.8	9.1	4.6
Medicare & You handbook	9.0	12.7	5.7	7.2	10.4	6.1
Seminars / meetings	3.8	3.1	4.8	9.3	2.9	9.8
Newspapers / magazines	8.3	7.9	7.9	0.9	6.3	2.8

Data Source: Abt Associates community survey

Note: Percentages do not sum to 100 because only the most frequent response categories for each item are displayed in the shown.

Table 5: Attitudes of Disenrollees Aged 65-85 about Information and Insurance Outcomes

	Houston	Tucson	Sarasota	Minneapolis	Nassau County, NY	Centre County, PA
Satisfaction with information available to help choose new insurance						
"had enough information"	45.1%	64.1%	60.6%	69.6%	61.7%	57.8%
Satisfaction with insurance status						
"chose the best available insurance that meets needs at affordable price"	40.6	65.3	56.2	71.4	57.6	61.8

Data Source: Abt Associates community survey

CMS FY 2002 Nonrenewal Report, http://www.cms.gov/healthplans/nonrenewal/markprintedoutnew.asp, accessed March 16, 2002.

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