Disenrollment from Medicare Advantage Health Plans: A Qualitative Assessment

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1. Introduction

1.1. Overview of the Medicare CAHPS Disenrollment Reasons Survey

RTI International conducts the Medicare CAHPS® Disenrollment Reasons Survey for the Centers for Medicare and Medicaid Services (CMS) with a sample of Medicare beneficiaries to determine reasons why beneficiaries voluntarily leave their Medicare Advantage (MA) health plans. The primary goals of the "Reasons Survey" are to:

- provide Medicare beneficiaries and the general public with information about the comparative performance of MA plans to help them make more informed Medicare health plan choices;
- enhance CMS' ability to monitor quality of care and performance of MA plans, and
- help MA plans identify problems and improve the quality of care and services they provide to beneficiaries by determining reasons why people leave their plan.

The Reasons Survey has been conducted each year since 2000. Survey results are reported to Medicare beneficiaries and to the public via the Medicare.gov web site. Results are also reported to MA plans and to CMS twice each year.

1.2. Overview of Qualitative Research Task

In addition to analyzing the data for reporting comparative plan information to beneficiaries, the public, health plans and to CMS, researchers from the University of Wisconsin-Madison and RTI also conduct quantitative analyses of Reasons Survey data to examine reasons why specific subgroups decide to leave their MA health plans. The results from these subgroup analyses are summarized in reports submitted to CMS. After the 2003 Reasons Survey was conducted, CMS requested that we conduct some qualitative data collection and analysis activities to augment the quantitative analysis that had been conducted to date. Specifically, we conducted focus groups and triads (smaller focus groups) with a sample of beneficiaries to explore in greater detail why certain vulnerable subgroups are more likely than others to disenroll from their MA plans, and to learn about their experiences during and after disenrollment.

In March and April 2005 the RTI project team conducted this qualitative research with a sample of Medicare beneficiaries who had responded to the 2004 Reasons Survey in each of three sites; Philadelphia, Pennsylvania, Phoenix, Arizona and Birmingham, Alabama. In each site, in addition to conducting groups with elderly beneficiaries aged 65 and over, we also attempted to conduct at least one session with disabled beneficiaries under age 65. We developed and used a Moderator Guide to guide the discussion with participants. Our work resulted in conducting 10 focus groups with 75 Medicare Advantage plan disenrollees distributed across the sites as follows: 18 participants in Philadelphia, 33 in Phoenix, and 24 in Birmingham.

1.3. Overview of this Report

This report describes the methods used and the results of the focus group sessions conducted as part of the Medicare CAHPS Disenrollment Reasons Survey project. ***Section 2*** of this report describes the methods and materials used to recruit participants and to conduct the research. ***Section 3*** includes a summary of the main findings in each of these 3 sites. The results across all three sites are synthesized and summarized in ***Section 4***, and presented along with concluding comments.

2. Data and Methods

In this section, we briefly describe the selection criteria used for identifying the three locations for data collection, the process used to recruit focus group participants, and the methods employed for data collection and analysis.

2.1. Site Selection

Our goal was to conduct focus groups in three different geographic areas in the United States where there were sufficient Reasons Survey respondents who disenrolled from a MA plan in 2004 clustered together to support focus group activities. We also sought to attain representation in the groups from the following types of individuals:

- Disabled beneficiaries, defined as those under age 65 whose original reason for Medicare eligibility was a disability
- Beneficiaries who left their Medicare Advantage health plan and went to another MA plan versus those who returned to Original Medicare (fee-for-service Medicare)
- Beneficiaries who had prescription drug coverage in their former plan (as self-reported in Q43 of the 2004 Reasons Survey) versus those who did not.

We also tried to include geographic areas in this qualitative activity with different types of Medicare managed care markets as well as markets with many plan options and at least one market with only a few plan options. Our goal was to conduct four focus groups in each site for a total of 12 sessions across all three sites. We were able to recruit a sufficient number of participants in two of the three sites to conduct four focus group sessions in each. However, due to the limited number of participants who were available and/or willing to participate in a session, we conducted two focus groups and two triads in the Philadelphia site.

We used a geographic information system (GIS) analyses to select potential sites by tabulating the number of Reasons Survey respondents who met each criterion by county. The following five sites emerged as having the largest number of survey respondents who met the relevant criteria -- Los Angeles, California; Phoenix, Arizona; Philadelphia, Pennsylvania; Miami, Florida; and Birmingham, Alabama. The only one of these area with a limited number of plan choices was Birmingham, so this site was the first selected. Next, we looked in the other four areas for facilities in which to hold the focus group sessions that would be within a 10-mile drive for respondents. In the Los Angeles area, potential respondents were spread out thinly across a large area, and finding a common location for focus groups was not possible. Of the three remaining sites, we chose Phoenix and Philadelphia to achieve geographic balance with Alabama. Therefore the three geographic areas selected were:

- Philadelphia County (Philadelphia), Pennsylvania;
- Maricopa County, (Phoenix) Arizona; and
- Jefferson County (Birmingham), Alabama.

2.2. Participant Recruiting and Characteristics

We recruited participants from survey respondents who completed the 2004 Reasons Survey after leaving an MA plan between January and September 2004. However, due to the limited number of survey respondents in Jefferson County, Alabama, we supplemented the pool of candidates by drawing a sample of beneficiaries from that county who disenrolled in the last quarter of 2004 *who were not included in the 2004 Reasons Survey* (we refer to these as non-survey focus group participants.) For the pool of survey respondents, we removed any beneficiaries who did not give their consent to be re-contacted after the survey, as well as any respondents for whom we were unable to obtain a telephone number. We also excluded beneficiaries who had recently disenrolled from one of three Medicare private fee-for-service plans (H1407, H1804, and H5006). Disenrollees from PPO Demonstration plans remained in the dataset of potential focus group participants.

We invited disenrollees to participate in a focus group via a lead letter followed by a telephone call from an interviewer. The lead letter and Telephone Recruiting Contact Form that we developed and used to recruit respondents are included in ***Appendix A***. If the disenrollees agreed to participate, we then sent them a confirmation letter confirming the date, time and location of their session and directions to the facility in which the focus group sessions were held. Participants received $75 incentive for attending a session plus $10 to help defray the cost of transportation to the site.

We achieved a fair amount of diversity in the types of participants who attended the sessions (see ***Table 1***). It should be noted that two-thirds of the participants in the Birmingham site were non-survey participants, therefore the only demographic information that we had for those participants was that available on CMS' Enrollment Database (EDB). Participants across all three sites ranged from below 45 years old to above 85 years old. The vast majority of the participants in Philadelphia (95 percent) were African American. The opposite was true in Phoenix, where the majority of participants (91 percent) were White. There were equal numbers of African American and White participants in Birmingham. There was a slightly higher proportion of females in Philadelphia, otherwise males and females were equally represented in the other two sites.

More than half (56 percent) of the participants in Philadelphia had not completed high school whereas 88 percent of the participants in Phoenix had at least a high school education or GED. Participants in Phoenix reported better health status than those in Philadelphia: 50 percent of the Philadelphia participants reported their health status as fair, while 42 percent in the Phoenix site reported their health status as good. Seventeen percent of the Philadelphia participants were less than 65 years old and thus eligible for Medicare due to disability, 24 percent of those in the Phoenix site and 25 percent of those in the Birmingham site were disabled. There was a higher proportion of participants dually eligible for both Medicare and Medicaid in Philadelphia relative to Phoenix.

Table 1
Relevant Characteristics of Focus Group/Triad Participants

	Philadelphia		Phoenix		Birmingham	
N	18		33		24	
Variable	***No.***	***Percent***	***No.***	***Percent***	***No.***	***Percent***
Age						
< 45	0	0%	2	6.1%	1	4.2%
45 to 64	3	16.7%	6	18.2%	5	20.8%
65 to 69	2	11.1%	5	15.2%	7	29.2%
70 to 74	6	33.3%	8	24.2%	4	16.7%
75 to 79	7	38.9%	8	24.2%	7	29.2%
80 to 85	0	0%	3	9.1%	0	0%
85<	0	0%	1	3.0%	0	0%
Race						
White	1	5.6%	30	90.9%	11	45.8%
African American	17	94.4%	1	3.0%	11	45.8%
Hispanic	0	0%	1	3.0%	0	0%
Other	0	0%	1	3.0%	0	0%
Missing	0	0%	0	0%	2	8.3%
Gender						
Male	7	38.9%	18	54.6%	12	50.0%
Female	11	61.1%	15	45.5%	10	41.7%
Missing	0	0%	0	0%	2	8.3%
Education Level						
Less Than High School	10	55.6%	3	9.1%	2	8.3%
High School or GED	5	27.8%	16	48.5%	3	12.5%
Some College or 2-year degree	3	16.7%	9	27.3%	1	4.2%
4-year college degree	0	0%	2	6.1%	1	4.2%
More than 4 years of College	0	0%	2	6.1%	1	4.2%
Missing	0	0%	1	3.0%	7	29.7%
Health Status						
Excellent	0	0%	3	9.1%	0	0
Very Good	3	16.7%	7	21.2%	1	4.2%
Good	3	16.7%	14	42.4%	4	16.7%
Fair	9	50.0%	7	21.2%	2	8.3%
Poor	2	11.1%	2	6.1%	1	4.2%
Missing	1	5.6%	0	0%	16	66.7%
Type of Health Plan Currently Enrolled In						
Fee-For-Service	9	50.0%	12	36.4%	1	4.2%
Managed Care	9	50.0%	21	63.6%	7	29.2%
Missing	0	0%	0	0%	16	66.7%
Dual Eligibility						
Not dual eligible	7	38.9%	22	66.7%	4	16.7%
Dual eligible	7	38.9%	4	12.1%	1	4.2%
Missing	4	22.2%	7	21.2%	19	79.2%
Time in Plan before Disenrollment						
1 month or less	1	5.6%	1	3.0%	0	0%
2 months	1	5.6%	0	0%	0	0%
3 months	1	5.6%	2	6.1%	0	0%
4 months	1	5.6%	1	3.0%	0	0%
6 months	14	77.8%	26	78.8%	8	33.3%
Missing	0	0%	3	9.1%	16	66.7%
Prescription Drug Coverage Through Plan						
Yes	11	61.1%	22	66.7%	6	25.0%
No	5	27.8%	10	30.3%	2	8.3%
Missing	2	11.1%	1	3.0%	16	66.7%

In the Philadelphia site, half of the participants returned to Original Medicare (the fee-for-service plan) after leaving their health plan compared to one-third of the participants in the Phoenix site.[1] About two-thirds of participants in Philadelphia and Phoenix had at least some prescription drug coverage, and about three-fourths of beneficiaries in those two sites reported spending six months in their old plan before they disenrolled.

One of the goals of this qualitative activity was to examine MA health plan disenrollment by disabled Medicare beneficiaries under age 65. Therefore in each site we conducted one session with disenrollees under age 65. Some relevant characteristics of the disabled under age 65 beneficiaries are shown in ***Table 2***. The majority of these participants in all three sites were between the ages of 45 and 64. In the Philadelphia site, all of the disabled were African American, but in the other 2 sites the majority of the disabled participants were White. Similarly in Philadelphia, all of the disabled participants younger than 65 were female, but in the other 2 sites the majority was male.

2.3. Data Collection and Analysis

With input from CMS, we developed a structured interview guide for the moderator to use during the sessions. Structured interview guides are generally preferred over topic guides as they tend to increase consistency across groups and allows for structured qualitative analysis. After completing the first round of focus groups in Philadelphia, we revised the guide to address issues uncovered during the sessions in the Philadelphia site to ensure that those issues would be covered in the sessions conducted in the sessions held in Phoenix and Birmingham.

We included the following topics in the moderator's guide (the full moderator's guide is included in ***Appendix B)***.

- Reasons for disenrolling from their health plan.
- How they made a decision to disenroll and what they looked for in a new plan–factors that influenced the decision to disenroll from a plan and those considered in choosing a new plan.
- The role of prescription drug coverage in their disenrollment and enrollment decisions.
- Awareness of and feedback on the Medicare Prescription Drug Plan and its effect on future disenrollment/enrollment decisions.
- The role of different Medicare health plan options (MA HMOs and PPOs, Original Medicare, Medicare Private Fee For Service Plans, etc.) in disenrollment/enrollment decisions.
- Experiences getting health care since disenrolling from the sample plan.

[1] The information on plan choice reflects where participants went immediately after disenrollment. Some participants may have changed plans again by the time the focus groups were conducted.

Table 2
Relevant Characteristics of Disabled Under Age 65 Focus Group/Triad Participants

	Philadelphia		Phoenix		Birmingham		Total	
N	3		8		6		17	
Variable	***No.***	***Percent***	***No.***	***Percent***	***No.***	***Percent***	***No.***	***Percent***
Age								
<45	0	0%	2	25.0%	1	16.7%	3	17.7%
45 to 64	3	100%	6	75.0%	5	83.3%	14	82.4%
Race								
White	0	0%	6	75.0%	3	50.0%	9	52.9%
African American	3	100%	1	12.5%	2	33.3%	6	35.3%
Hispanic	0	0%	0	0%	0	0%	0	0%
Other	0	0%	1	12.5%	1	16.7%	2	11.8%
Gender								
Male	0	0%	5	62.3%	4	66.7%	9	52.9%
Female	3	100%	3	37.5%	1	16.7%	7	41.2%
Missing	0	0%	0	0%	1	16.7%	1	5.9%
Education Level								
Less Than High School	2	66.7%	0	0%	0	0%	2	11.8%
High School/GED	1	33.3%	6	75.0%	0	0%	7	41.2%
Some College or 2-year degree	0	0%	2	25.0%	0	0%	2	11.8%
4-year college graduate	0	0%	0	0%	1	16.7%	1	5.88%
More than 4-year college degree	0	0%	0	0%	0	0%	0	0%
Missing	0	0%	0	0%	5	83.3%	5	29.4%
Health Status								
Excellent	0	0%	0	0%	0	0%	0	0%
Very Good	0	0%	0	0%	0	0%	0	0%
Good	0	0%	6	75.0%	1	16.7%	7	41.2%
Fair	1	33.3%	1	12.5%	0	0%	2	11.8%
Poor	2	66.7%	1	12.5%	0	0%	3	17.6%
Missing	0	0%	0	0%	5	83.3%	5	29.4%
Type of Health Plan Currently Enrolled In								
Fee-For-Service	3	100%	4	50.0%	0	0%	7	41.2%
Managed Care	0	0%	4	50.0%	1	16.7%	5	29.4%
Missing	0	0%	0	0%	5	83.3%	5	29.4%
Dual Eligibility								
Not dual eligible	0	0%	5	62.5%	1	16.7%	6	35.3%
Dual eligible	3	100%	1	12.5%	0	0%	4	23.5%
Missing	0	0%	2	25.0%	5	83.3%	7	41.2%
Time in Plan before Disenrollment								
1 month or less	0	0%	1	12.5%	0	0%	1	5.88%
2 months	0	0%	0	0%	0	0%	0	0%
3 months	3	100%	2	25.0%	0	0%	5	29.4%
4 months	0	0%	0	0%	0	0%	0	0%
6 months	0	0%	4	50.0%	1	16.7%	5	29.4%
Missing	0	0%	1	12.5%	5	83.3%	6	35.3%
Prescription Drug Coverage Through Plan								
Yes	3	100%	3	37.5%	1	16.7%	7	41.2%
No	0	0%	5	62.5%	0	0%	5	29.4%
Missing	0	0%	0	0%	5	83.3%	5	29.4%

Two team members from RTI conducted each focus group or triad. An experienced focus group moderator led each session while an assistant moderator was responsible for note-taking and group support. In addition, each session was attended by either a certified court stenographer or an employee of the focus group facility in which the sessions were held who recorded and later transcribed the discussions. After each session was conducted, the moderator and note-taker held a de-briefing session to review notes, identify important themes or ideas that emerged during the discussions, record observations made during the session, and identify any problems or areas that needed to be addressed in future groups.

After the sessions were conducted in all three sites, the focus group project staff met to discuss major themes and similarities and differences between the groups in each location and then across all three groups. We used both the debriefing forms prepared after each session and conducted extensive reviews of the transcripts to analyze the data for individual topline reports which summarized the findings from each site, as well as for analyzing the data from all three sites.

3. Findings

In this section we describe findings in each of the major categories of the moderator's guide. The findings from the Philadelphia site are presented first, followed by those from the Phoenix site, and then by those from the Birmingham site.

3.1. Findings from the Focus Groups in Philadelphia, Pennsylvania

We conducted two focus group sessions and two triad sessions with 18 participants in Philadelphia, PA on March 30-31, 2005. The following is a summary of findings from those sessions.

Reasons for disenrollment from their health plan

Participants cited a wide range of different reasons for disenrolling from their plan. While cost was an issue for most people, it was cost-related concerns *combined with* other reasons that appeared to drive people to disenroll. Several people mentioned the following other reasons for leaving (in no particular order) – the desire to stay with a provider (either a hospital or an individual doctor), the plan did not reimburse providers in a timely fashion, service issues (mostly wait times), difficulty and frustration getting information, problems with referrals, someone else recommended a better plan, and being swayed by information from insurance agents and/or printed information and oral presentations from health plans.

When cost concerns did arise, there were more frequent references to co-payments than to premiums, perhaps because people understood what premium to expect on a regular basis but were surprised by the amount of periodic co-payments. This may also be due to the participants' more frequent use of services as a result of poorer health status. Several people expressed a desire for coverage for certain services such as medical equipment, dental care, transportation services, and brand-name drugs that are were not covered. A couple of participants reported that they had switched health plans multiple times in search of a better one, "*All we're doing is jumping from plan to plan. Trying to find an edge and it's not working."* For the disabled participants, their reasons for leaving appeared to be linked to an issue regarding their specific health care needs and a strong desire to stay with their current doctor and/or hospital.

Quality of care was also brought up when discussing reasons for disenrolling. Several participants identified quality of care as an important factor for either leaving a plan or choosing a new plan. For example, one participant discussed issues of cost and quality medical care as reasons for changing plans. When asked how she weighed both factors she explained: *"Both was important, but the quality of care is more important."* Another participant said "*You know, he needed better health care. That was most important."*

Several participants thought about quality of care in terms of doctors, hospitals, or both. Some participants, particularly those being treated for a health problem, said that they were not unhappy with the plan they disenrolled from, but left so that they could continue to receive care from the doctors and hospitals they were currently using. For example, one participant who had bladder cancer said that she changed plans in order to continue treatment with the doctors and the

hospital she started with. If not for the cancer, she said she would have stayed with her plan and found a new doctor and hospital. Another participant was being treated by a specialist. When the specialist stopped accepting her insurance, the participant switched plans because she wanted to continue with the doctor that *"knew her condition."*

A minority of participants indicated that they had only one reason for disenrolling from their health plan. But for others, several reasons ultimately led to their decision to leave their plan. These reasons were interrelated for a few, but for others, the reasons were quite distinct. A fair number of people indicated that there were 10 or more reasons contributing to their decision to leave. This is consistent with our quantitative analysis of the Disenrollment Reasons survey, in which the average number of reasons cited by respondents is five.

Most participants had little difficulty articulating a single most important reason (MIR) for leaving their plan, but for a few, this presented a challenge as demonstrated by this remark, *"We are saying we don't have no most important reason. All of them to us are important."* This is consistent with our experience with a subset of survey respondents who give multiple reasons as their MIR and with our earlier qualitative research showing that some respondents think of a collection of several reasons as their "one" most important reason. When given the opportunity to describe their situation, some focus group participants who cited a single reason as their MIR indicated that there was actually a combination of reasons surrounding one situation that caused them to disenroll. When queried whether important information would be missed if we only asked disenrollees to report only their *most important reason* for leaving, most participants agreed that this would be the case.

How they made a decision to disenroll and what they looked for in a new plan

We specifically tried to address how beneficiaries weighed the different factors (e.g., cost, quality, service) when making a decision to disenroll and choosing a new health plan. It seemed that most people did not explicitly weigh the different factors, but that the factors simply added up for them resulting in one culminating event that drove them to leave. This culminating event, however, was different for different people. For several, it was exposure to some outside source of information, including a friend, health care provider ["*Another good way to find out is through your doctor. They have a list of HMOs and insurance plans in the office that you can make a choice"]*, an HMO information session or agent, or brand recognition of a plan's name.

The issue of quality of care also came up in the discussion regarding what people looked for in a new plan. Participants said they valued high quality care, which they defined as good bedside manner, having a rapport with the doctor, feeling the doctor and other providers cared about you as an individual, and explained things so you could understand. Some descriptions of quality follow:

- *"My doctor's bedside manner. That's right. Dr. ____, she comes in there. She's pleasant. She smiles. She sits down and she explains things to you, all right this and this and that and that. We're going to try this medicine… We're going to do this. ….This is what I'm doing. She explained that I got to lose weight and… what I've got to do."*

- *"Not only [the doctor], but the nurses and all, they used to come in, they were so nice, and they helped you, any questions that you had to ask, anything like that – they took time with you"*

- *"They look to the whole person."*

Many participants were familiar with the *Medicare & You* Handbook, but consistent with previous research, they used it as a reference tool (that they "kept on top of the phone book"). A fair number of people appeared to make a quick decision regarding leaving their plan when the time came, although it was something they had been considering doing. When people did approach plan choice more systematically, it was to address their immediate health care needs without a lot of consideration of future needs.

The role of prescription drug coverage in the disenrollment and enrollment decisions

The role of prescription drug coverage in beneficiaries' decision to disenroll from a health plan varied. Most participants had at least some drug coverage and those that had coverage in their old plan were likely to choose a new plan that also offered coverage. Some participants had difficulty understanding how their prescription drug benefits worked (i.e., what it covered, co-pays), which may have contributed to the lack of systematic comparison between the cost of paying for prescription drug benefits versus paying out of pocket for medication. Only three people (including a married couple) across all four groups in Philadelphia said that they calculated these costs when making a decision about their new plan.

Some participants may not have been overly concerned about getting drug coverage through their health plan because they already had coverage through other means. Some participants had coverage through PACE, a prescription drug benefit offered by the state of Pennsylvania to residents. Another participant had coverage through the Veteran's Administration. Some of the participants, particularly those who were disabled, may have been dually eligible for both Medicare and Medicaid. These additional sources of coverage could explain why coverage for prescription drugs did not seem to be a major factor in this site.

Participants across all groups in Philadelphia had a strong aversion for generic medications. Some were in plans that would only pay for generic medications when available. Others were able to get brand name medications, but they either had to make the request themselves, or in some cases, the physician was required to indicate when brand name medications were preferred. Participants found these rules burdensome, as one respondent explained: *"If you're paying and they're taking out money, you should get the best. Why should you have to ask? It shouldn't be. I know you have a choice, but why should you have to ask?"* Participants also disliked having to get some medications pre-approved. They thought that medication decisions should be made by their doctor, not the health plan. One participant explained: *"Certain medications have to be pre-approved. And if it is already falling under a diagnosis of a health condition, why do you have to be pre-approved when it automatically should fall under that category…And if the doctor wrote a prescription for you to have it, why are they questioning it…isn't it the doctor's decision?"*

Awareness and feedback on the Medicare Prescription Drug Plan and its effect on future disenrollment/enrollment decisions

Very few participants in the Philadelphia sessions had heard about the new Medicare prescription drug plan that will go into effect on January 1, 2006. Those that had heard about it did not know any of the details. One participant responded to a question about what he knew about the benefit: *"2006, I believe, they're supposed to start something. They're looking at it. That's all they're doing, looking at it."*

While many participants said they were interested in finding out more, most were a little skeptical and had a wait and see attitude about what they would do when it goes into effect:

- *"Is there going to be an increase in costs, in other words monthly pay fees?"*
- *"It just depends on how much they're going to take out and how much they're going to cover."*

Someone in the disabled group was uncertain about how the new benefits would affect her, *"I really don't think it's going to affect us because of the fact that we don't pay a co-pay now and we're not getting name brand medicine as it is."*

Participants in Philadelphia expected to find out about the benefits through the media, literature, pharmacists, and in some cases, by calling Medicare. As with other insurance issues, many participants were confused about the role of Medicare would play versus that of their health plan *"If Medicare is going to provide it for us, then our insurance company won't have to provide."* There was also some confusion about the new Medicare benefit and the current discount card program that will be phased out. A few participants were also confused about the new drug benefit versus PACE, the state's prescription drug plan.

Participants in Philadelphia who had drug coverage by means outside of their plan may be less likely to have heard about the new benefit or be less interested in finding out about it. One participant explained: *Haven't heard anything about it—like I said, I've been getting my prescriptions paid for. I guess I haven't paid attention to it because I've been getting mine."*

There were several references to faith and health when this and other issues were discussed, in that participants felt that everything would work out for them somehow,

- *"I understand from reading Time magazine and this and that, that they're going to be drastic changes in the Medicare program altogether…For me, I just have to take this life day by day because it's too overwhelming for me to try to cope with what if, and should of, could of…I trust that all that I haven't seen will be ok. It will work out…You can get nuts. It's too much. It's overwhelming."*
- *"I'm like you, I trust my Father."*
- *"If the Lord has provided for me for these 70 years, I think he would do the rest. I'm not going to worry myself and be anxious for nothing. I'm going to be realistic, but I know he will provide a way."*

The role of plan type in disenrollment and enrollment decisions

Across all groups in the Philadelphia site, about half of the participants belonged to an HMO, though many had a negative attitude about them. However, participants seemed largely unaware of other types of insurance plans. For example, one participant asked: *"What other plan is there besides managed [care]? Could we afford it (non-HMO plan)?"* Despite a negative feeling toward HMOs, most participants were more concerned about being able to see the doctor or go to the hospital that they wanted to. This issue was frequently cited as a prerequisite when choosing a new plan. One participant explained that he looked at whether he could see his primary doctor under the plan, regardless of what type of plan it was: *"My main thing, if my primary doctor is under that plan before I make changes, I call him to make sure that he's under that plan before I even make a decision."*

There were differences of opinion whether people wanted more or less choice of plans. One participant said, *"You don't know which is the right one because when you get in, they all act the same."*

Experiences since disenrolling

Participants across all groups in Philadelphia did not appear to be experiencing problems with continuity of care after disenrolling from one plan and joining another. Most were able to stay with the same doctor and hospital (this is likely to be a result of having actively sought out a new plan that enabled them to keep the same providers). A few participants switched providers by choice because they were either dissatisfied with a particular doctor, or more frequently, due to dissatisfaction with the hospital in their network.

When asked whether they were happier since switching to their new plan, responses were mixed. Several participants didn't see much of a difference:

- *"All these HMOs are just about the same. They change a few points here and there, but it all adds up to the same thing."*
- *"The only thing that changed is who's paying the bills."*

Other participants seemed happier with their new plan, but for some, it was a result of switching to a better doctor than because of the plan itself:

- *"His improvement with the physicians came because we personally switched to better doctors (talking about affect of switching plans)."*

A couple of participants were unhappy with their new plan compared to the plan they disenrolled from. In both cases the participants had been happy with their previous plan, and only switched to be able to continue with their doctor or hospital when they stopped accepting their plan.

Other participants in Philadelphia had both positive and negative experiences since switching to their new plan. As one participant explained: *"I'm sort of kind of (happy with new plan). I'm happy they pay for medicine. I'm not happy they don't pay for…they don't pay for the Lyaderm patches. So sort of kind of happy."*

3.2. Summary of Findings from Focus Groups in Phoenix, Arizona

We conducted four focus groups in Phoenix, Arizona on April 11-12, 2005 with 33 survey respondents. The following is a summary of findings from those sessions.

Reasons for disenrollment from their health plan

The majority of the participants in the focus groups in the Phoenix, AZ site noted that they had more than one reason for disenrolling from their health plan. The most commonly cited reason for leaving their MA health plan by participants related to costs. Though participants defined "costs" as the monthly premiums, deductibles, and copays, most of them seemed to refer to increased monthly premiums as the main cost. One participant mentioned that he/she switches plans as soon as he/she finds a plan with a cheaper monthly premium:

- *"I left because they put their prices up. I feel that they get you into their service telling you one figure, one price and monthly fee and as soon as they've got enough people in, they start putting the price up so you change to another plan. The same thing goes on. As soon as they get enough people in, they put their price up and the previous company brings their price down."*

- *"If Sun Health puts its fees up and the other one brings it down, I shall go back."*

Two other reasons frequently listed by participants included prescription drug coverage (specifically, whether or not the drug they needed was on the plan's formulary) and whether or not their doctor was included in the plan's network. Other reasons cited by participants included quality of service (both from the doctor and the health plan), trouble getting referrals, and plans cutting benefits. There were no notable differences between the reasons for leaving cited by the disabled and the non-disabled participants.

Although some participants in Phoenix listed several reasons why they left their plan, overall, the vast majority of the participants did not have trouble choosing their one most important reason for leaving a plan. Most of the participants' reasons for leaving their health plans did not seem multifaceted, which can be attributed to the fact that most chose costs, prescription drug coverage, or whether or not their doctor was included in the plan's network as their most important reason for leaving their plan. Although, after being given a chance to think over the 33 reasons (given to them in a handout), a handful of participants noted that a lot of the 33 reasons for leaving a plan could be applied to most plans.

- *"You can almost write at the bottom of the page, 'Yes, all of the above.' But they're more like inconveniences than they are pivotal to really making a change."*

How they made a decision to disenroll and what they looked for in a new plan

Most participants in the Phoenix site reported that they had specific factors they compared when making the decision to disenroll from one plan and when choosing a new plan or Medicare health plan option. These factors included costs, doctors in their plan, prescription drug coverage, hospital coverage, preventive services, quality of care, customer service, emergency coverage out of the country, and ambulance costs. Regarding customer service, one participant

stated that *"My new plan sent a company rep to my housing community, and she is great at answering my questions."* The vast majority of participants agreed that quality of care is important, however, only a few participants felt quality of care was a large part of their decision to leave their plan. Those participants that noted quality of care as an important factor in the decision to leave their plan and enroll in a new health plan referred to quality as how well the doctor listens to them and whether or not their health care plan will meet their needs.

- *"I think quality of care means if the doctor is listening to you. I was supposed to be taking cholesterol medication and he prescribed Lipitor. I told him, 'I can't afford it. I cannot buy Lipitor. It costs too much money.' He was like, 'But you need it.' I said, 'Aren't there other generic cholesterol medications I can take?' 'But they're not as good.' He did not give me one."*

- *"Quality of care to me means just getting my needs met. I'm relatively physically healthy so I never even required any medical care during the time that I had Humana so that was not a factor in my decision. I had AHCSS beforehand but the minute I got on SSD I was making too much. When I had AHCSS I was in the hospital and they covered me very well."*

While only a minority of participants in the sessions at this site used the *Medicare & You Handbook* to help them make their decision on a new health plan, participants did cite a number of other resources. Resources participants used in choosing a new plan included advertisements in the newspaper, doctor recommendations, health plan pamphlets, former employers, and even calling the health plans themselves. One participant noted, "*I called several plans and asked them what their prescription copays were."* Another participant noted, *"I just went back to my old plan*." Although this participant did not give a reason for re-enrolling in his/her former plan, presumably he/she thought his/her former plan was better than the plan in which he/she was more recently enrolled.

Some participants mentioned speaking with family members, friends, doctors, and health plan representatives about their decision on picking a new health plan.

Many participants felt there should be more plans to choose from. They thought the more plans, the more competition and the more variety, which could mean lower costs. However, some participants in the disabled group felt there should be fewer plans because they don't want to have more plans to research. One participant mentioned, "*It is too much to keep up with when they change their benefits every year*."

The role of prescription drug coverage in the disenrollment and enrollment decision

Prescription drug coverage was listed as one of the most common factors for participants disenrolling from their old health plan. Prescription coverage was conveyed by participants in two themes. First, some of the participants who listed prescription coverage as a reason to leave their plan referred to the fact that their medications were not covered on their old health plan's formulary. Therefore, their decision on which new plan to enroll in was based on whether their medication was on that plan's formulary. Secondly, the copay for their prescription drugs was listed as a reason why they decided to leave their old plan and choose a new one. Many

participants felt they were paying too much for their medications and therefore chose a new plan where the prescription drug copay was less than the plan from which they disenrolled.

Most participants had some kind of prescription drug coverage with both their old plan and their new plan. However, many participants did not know how their prescription drug coverage worked. They only knew the copayment amount that they paid per prescription drug. Only one participant out of the 33 that attended the four sessions in Phoenix did not have drug coverage: this participant is not currently enrolled in a Medicare MA plan, but instead is enrolled in Original Medicare and has a supplemental (Medigap) health plan. She mentioned that the prescription coverage is too expensive under her supplement. This participant also noted that she only takes one prescription medication, and goes to Mexico to get that medication at a discount.

There was some discussion about getting medications from Mexico and a few participants were interested in how to get medications from there. In addition, some of the participants reported getting their prescription drugs from Canada.

- *"There are a lot of people out where I live who have gone down to Mexico for prescriptions."*

- *"If you start having prescriptions and have the big deductible on a couple of brand names that takes care of the deductible. Then you're paying an awful lot for your prescriptions. Actually, I get some of my prescriptions from Canada for that reason."*

Participants in the Phoenix site preferred generic drugs to the brand names. One participant mentioned that doctors "*need to do a better job of knowing which brand names had a generic.*"

Awareness and feedback on the Medicare Prescription Drug Plan and its effect on decision-making

Most participants in Phoenix knew little to nothing about the Medicare prescription drug benefit that is due to come into effect in January 2006. Furthermore, of the four focus group sessions held in this site, participants in only one group seemed moderately interested in the new benefit. This group did not seem as skeptical of the prescription drug benefit as the other groups in this site. The remaining participants seemed confused by the new prescription drug benefit. They wanted to know more about costs and coverage. Many participants thought this Medicare benefit would be too expensive. If their MA plan still is less expensive than the Medicare drug benefit, many participants expressed little interest in the prescription drug benefit.

Those participants in the disabled group who reported that they are knowledgeable about the new prescription drug benefit cited misinformation when probed about the upcoming prescription drug benefits that Medicare will offer.

- *"You made too much money."*

- *"If you made over $600 a year."*

- *"It's for the very indigent."*

The role of plan type in disenrollment and enrollment decisions

Most of the Phoenix participants were enrolled in a managed care plan. When deciding on a new plan, participants noted that plan type (Medicare HMO, PPO, or Medicare fee-for-service) had little impact on why they picked the plan (having the doctor they wanted, prescription drug coverage, and costs seemed to be the important factors).

Some participants thought there was little to no benefits of having a PPO. They saw the PPO as more expensive with little added benefit.

- *"I don't have the PPO anymore because Health Net doesn't have it. Which I'm glad. I didn't get anything with that and it was $68."*

- *"I've looked at some PPOs and they seem like a lot of money for premiums, nearly $200 a month. I don't see that they give you anything except the ability to select your own doctor."*

In the disabled group, all but two participants were currently enrolled in a Medicare HMO plan. Those two participants only claimed to have Medicare. Participants across all four groups indicated interest in having a PPO, but noted that type of plan is too expensive.

- *"Everybody here would love to be on a PPO because you get to choose your own doctor but it's a lot more money."*

Participants in the Phoenix site seemed aware of the other types of insurance options. Out of all the groups only one participant did not know what an HMO or PPO meant. A handful of participants claimed that they did look at some PPO options before they decided to enroll in an MA HMO plan:

- *"I looked at it briefly because it's included in the list from the paper but it was inferior to the HMO's for my situation in terms of cost and service. I think it would depend on what kind of specialized situation around your health that you had where you required certain unique doctors that only you wanted to select. You might be able to better choose that in a PPO but it would be expensive."*

- *"I know it was a higher cost than the standard plan, but then you have to go out and search for your own doctors and I haven't done that since we moved here. We decided to stick with a changed HMO."*

- *"I did but I thought they were too expensive. My wife is never happy so I had her on the AARP one for a while then we went to the Secure Horizons PPO. Then she decided she thought she could get along with my doctor so she got off of that and went from the PPO back to the HMO. She went to her doctor several times on the PPO but it was too complex for me. It looked like they were still taking out the first $250 like they did on regular Medicare. You never knew if they were going to pay anything on prescriptions. It looked like if a PPO doctor had prescribed something they weren't going to pay for it but if an HMO doctor prescribed it then it was too*

complex for the way that Secure Horizons had it. She paid so much into lab stuff. With the HMO it pays all of the lab, PPO pays 80 %. You never really knew how many bills would be rolling in after you got done. I finally talked her into the HMO so she's upset with me now because she doesn't like my doctor as well as she liked hers. I figure it's worth it."

Experiences since disenrolling

Participants across groups in the Phoenix site noted problems with the continuity of care after disenrolling from their old health plan and joining their new plan. Most participants seemed happy with their health care after switching plans. Overall, participants' health care seemed to improve since enrolling in their new health plan. A minority of participants noted a decrease in benefits in their new plan, such as dental coverage, but seemed think that the overall quality of care improved.

Half the participants in this site reported having to switch doctors when they disenrolled from their old plan and joined a new plan. The other half of the participants were able to keep their same doctors when switching plans. Those participants that needed to pick a new doctor knew they would probably have to switch doctors before they joined their new plan.

3.3. Findings from Focus Groups in Birmingham, Alabama

We conducted focus groups in Birmingham, Alabama on April 21-22, 2005 with 24 disenrollees, most of whom were not respondents to the 2004 Reasons Survey. As noted previously, sessions in this site included 16 beneficiaries who had disenrolled from their MA plan in the last quarter of 2004 *who were not included* in the 2004 Reasons Survey sample. The following is a summary of findings from those sessions.

Reasons for disenrollment from their health plan

In the Birmingham area there were four plans frequently mentioned by disenrollees during the groups – two United plans (a HMO Medicare Complete and a PPO Medicare Complete Choice), and two other HMO plans (Seniors First, Viva). Based on the discussions at this site, there was apparently a great deal of competitive outreach and telemarketing by plans attempting to induce other plans' members to switch plans. At least two people in each group had been swayed by representatives that came to their homes to talk with them or via telephone calls from the health plans. It appeared that a substantial amount of churning was occurring as a result of competitive marketing outreach in the Birmingham area. The following are some of the comments made by focus group participants.

- *"There is always a new insurance person coming to talk to you saying they have a better plan and then we would talk to them and maybe change."*

- *"I went to UHC when Medicare Complete came out they said I could get my medication cheaper so I joined them - and then come to find out it was higher instead of cheaper and I was paying $200 a month for medication. And when I went into the hospital to have surgery they didn't pay the bills and now I have the credit bureau*

writing me every day about those bills from Princeton so I went to Seniors First and they said I wouldn't have these problems with prescriptions and hospital bills."

- *"After I left to join Seniors First, then Viva sent the agent that wrote me up years ago and they wanted to know why I left. I told them and he said they had that (those benefits) too. But they never told me about them, and the agent from Seniors First did, so I switched ."*

- *"I went to Medicare Complete and then a lady from Viva came to talk to me and I went back to Viva and then I ended up with no insurance, no nothing - so I went back to Medicare Complete. But I had nothing for two or three months."*

- *"I was with VIVA and Medicare Complete contacted me and said they would pay so much of your medication and that is why I changed, but I think I am going to change back because about a month or two after I changed over to Medicare Complete, I had to go to the doctor and I got a bill from Medicare Complete and I have never gotten a bill with Viva - they sent me a bill for ten dollars and said $100 was being considered so I will have to check on that, so I might go back to Viva."*

- *"We had a call from a representative from VIVA after we changed (to Medicare Complete) and one thing that the representative from Medicare Complete didn't mention was that when you change over (to Medicare Complete from Viva) your co pay on hospital stays is tremendously higher because they base it on a percentage of your hospital cost instead of a flat co pay, and Viva has a flat co pay."*

- *"A representative from Medicare Complete called on the phone and he told me about their better coverage for medications…so I switched."*

- *"We asked him (the United agent) to come out and discuss the difference between Choice (HMO) and Complete (PPO) and the way he explained it to us was that Choice was a test program with UHC, they were going to see if they could charge you a premium and provide enough benefits that were different for people to take it up - it (the PPO) had not performed as they expected so they changed the (PPO) benefits and I can't imagine anyone would have stayed with that."*

Although much of the disenrollment by the focus group participants may have stemmed from competitive marketing efforts by plans in the Birmingham area, this did serve to provide information about alternatives to the beneficiaries. All participants were able to cite particular reasons why they left their health plan. People in Birmingham had a variety of reasons for switching plans, although some could not name a most important reason.

- *"I left UHC for about three reasons, first for poor communication, you may wait a day and a half before you heard anything from them and I didn't like that - I want to hear from somebody right away when I call them. The co-pay kept going up, up, up and the third reason was the agent indicated that they would pay so much on prescriptions and it didn't work out that way, they didn't do what they promised - so those are the three reasons."*

- *"I went to C Plus because I felt the most freedom there and I hope I can continue to afford it."*

- *"I had gotten sick and tired of trying to talk to somebody and then they would give me a number in Pennsylvania to call and then I would call and they would tell me I need to call someone in Washington and then they wouldn't know what I was talking about so I would call three people before I found someone that knew something and it was horrendous."*

- *"I couldn't get a hold of anybody that made any sense. It was aggravating to dial and dial and not get anywhere."*

For some, physician choice was most important:

- *"I left United mostly because I had to find another doctor and drive 30 miles or more to see the doctor - and I had some bad experiences waiting on my appointments…I had an appointment at 1:30 and got in at 15 till four and got out at 4:30, and the second one was no better."*

- *"The bottom line was the doctor is why I switched over. They (United) called me and said my doctors would not be accepting Medicare Complete any more, so I joined up with Seniors First."*

- *"They (Senior First) got into financial trouble and they weren't paying the doctors…we left because the doctor recommended it."*

- *"We compared the physicians and we couldn't find any difference, so we switched (from United PPO to HMO)."*

- *"Some doctors didn't take UHC so I changed to Viva just to keep my primary doctor. I couldn't go to the orthopedic doctor that I wanted to go to – the one who did my knee surgery back in August – I would have to let the new doctor give me another orthopedic doctor that I really didn't want."*

For others in Birmingham, drug coverage was the major reason for switching:

- *"When I went to UHC the first year they paid my drug bills and then President Bush put his plan in with a $600 month co-pay or whatever that is. Then United suddenly decided that that was going to be it next year - all they would be paying would be the $600 and generics only. I go through $500 a month in medicines so that didn't take long - I had to switch to Viva which has no drug care and ask the drug companies to help me pay my drug bills. So I have the major ones being paid for by the drug companies."*

- *"I left VIVA because Viva wanted to be my doctor too. My doctor took me off a certain high blood pressure medication because it was causing my kidneys to leak protein, and the medication he put me on Viva wouldn't pay for and wanted him to*

put me back on the same medication that was doing me harm. I had other dissatisfaction with them but that is what drove me from them."

- *"I remember the (former) insurance was paying an amount a month on my prescription drugs and it was like $80-$90 and now it is less than $25… I was paying $60 for insulin with Medicare Complete and now I get two for $12 (with Seniors First)."*

- *"United had better prescription coverage, the co-pay on the generic was much lower (with United) and with Viva we only got a percentage off on whatever the retail price might be. So our co-pays with generics went down to five dollars."*

A few participants cited premium increases or copays as reasons for disenrollment, but prescription drug copays seemed more important than copays for visits and services. A few cited the paperwork and red tape (which some thought were onerous) associated with necessity for referrals as reasons for disenrolling. Others said that the benefits of the plans didn't pan out as expected – they were presented with unexpected bills for things not covered. Apparently there was some turnover in the provider lists for plans, as beneficiaries complained of confusion about whether their doctor was on/remained on the list and some inconsistencies existed when doctors on the list sent patients to hospitals not on the list.

How they made a decision to disenroll and what they looked for in a new plan

People in Birmingham were aware that there were alternatives and choices available. As previously noted, many disenrollments seemed to have resulted at least in part from information obtained from marketing agents of competing plans. Several beneficiaries in each group complained about not being able to get clear, honest, complete, or straightforward information from the plans. Many were perplexed by the complexity of information and concerned that they were being persuaded to make choices that were not optimal for them. They talked with insurance plan representatives, neighbors and friends, their doctors, and community informants (senior centers).

- *"I was influenced somewhat by my doctor, he did have some influence on me. A lot of these doctors are running into some real clerical problems between the health providers and their offices and they definitely have strong opinions about which ones they deal with because they have to get approvals for procedure and things and some are a lot easier to get through than others."*

A minority of the participants was proactive and sought information, inviting plans to come talk with them, and did their own research on the internet about prescription drug discount cards. The disabled and/or low income beneficiaries had the most difficulty in optimizing their choices because they had options available to them that weren't available to others – and sometimes there were tradeoffs. For example, one person with disabilities put considerable effort into gathering and analyzing information about various options, and ultimately had to give up freedom over physician choice to obtain the best combination of drug coverage and other benefits. She also had to choose a plan with no drug coverage in order to qualify for other drug coverage through the pharmaceutical companies themselves. She said:

- *"Some of our conditions are tied up in our disabilities and tied up in our money which is tied in our doctors and it is all interrelated and when you interrupt one you start knocking things over down the road."*

In some cases beneficiaries disenrolled because benefits changed or their physicians were no longer participating in their plan's preferred provider panel.

- *"They kept changing the benefits, I was only in there a short time and they changed the benefits two or three times and I got to reading when they would send these books out about what your benefits were, I read them and I thought to myself if you have a serious illness and at the wrong hospital you are going to have to get out so that is when I decided it was time to get out of that healthcare (UHC)."*

The role of prescription drug coverage in the disenrollment and enrollment decisions

The role of prescription drug coverage in beneficiaries' decision to disenroll from a health plan varied. Disabled beneficiaries indicated that drug coverage was important but they had trouble pinning down a particular Most Important Reason for leaving their plan. Several participants in each group disenrolled because the drug coverage in their plan was not as expected. Several participants were quite confused about how the prescription coverage worked – they had multiple cards or coverage and no clear understanding of which was optimal in a particular situation. Some pharmacies apparently filled prescriptions at better terms/costs than others, which added to the confusion. Some participants enlisted the aid of pharmacists to help them pick the best card to use and in calling their doctors to convert brand-name prescriptions written by their doctors into generic prescriptions that their plans would pay for.

- *"Every time I go to the doctor they give me another prescription and when I carry it to the drug store they tell me they can't fill it because you can only get generic with Medicare Complete and sometimes I will go to pick it up and they tell me it will be a hundred and something and tell them to put it back. I have a good pharmacist, when I get a prescription I ask him if I have to pay, and if I do I ask if he can call my doctor and have it changed to a generic of the same thing and then I don't have to pay for it. I have the same problem every month because they only pay for generic."*

Several participants shopped around to find a plan that would pay more for the particular drugs they needed.

- *"United had better prescription coverage, the co-pay on the generic was much lower (with United) and with VIVA we only got a percentage off on whatever the retail price might be. So our co-pays with generics went down to five dollars."*

- *"in 2003 Choice had a deal where you could get a brand name prescription drug for $35 maximum and Lipitor cost $100 and you could get it for $35 but they dropped that at the end of 2003 so at the beginning of 2004 they only had generic drugs and it was ten dollars with a maximum of $500. And we were paying $10 for generic and now it is five but before there was a $500 maximum on it but now it unlimited, and*

that is a big factor too, because of the cost of drugs and we don't have any drug coverage outside of Medicare Complete."

All were aware that no drug coverage was available under traditional Medicare and all were in plans or situations that allowed for some drug coverage. Drug coverage was most important for a few participants who had higher demand for drugs because of disability, chronic disease, or brand-name dependency (no generic substitute). Only one participant reported that she took no drugs except aspirin (but allowed that might change, thus availability of drug coverage was still important). One participant chose a plan with no coverage on purpose, in order to get drugs covered directly by the pharmaceutical companies. Another person signed a waiver with UHC so that he/she could get coverage through a more generous employer source. Several married couples had done cost comparisons and calculations when making decisions about their new plan.

Awareness and feedback on the Medicare Prescription Drug Plan and its effect on future disenrollment/enrollment decisions

Only a few participants had heard about the new Medicare prescription drug plan that will go into effect on January 1, 2006. Those that had heard about it did not have a good understanding of the details. Participants responded to a question about what they knew about the new benefit:

- *"Is it basically going to be Medicare with no HMO? Will you have to have an HMO with it?"*
- *"Is that the one that you pay the $35 and if you don't get in on it from the first it will be hard to get in on?"*
- *"Isn't it coupled with earnings which in a lot of cases what your gross income is per year and they tie it into that as to what your benefits will be? I think it is and I don't know if that will be much help for us."*
- *"The Donut Plan is where it is 80/20 up until a certain point and then you take on all of it and then the government takes on 100%. The problem is the Donut hole is huge and there is a little bitty part that is the government on either side, at least that is my interpretation of it and I am not wild about it but I haven't figured it all out."*

While many participants said they were interested in finding out more, most were a little skeptical and had a wait and see attitude about what they would do when it goes into effect. Participants expected to find out about the benefits through the media, literature, pharmacists, their doctors, and the Internet. As with other insurance issues, many participants were confused about the role of Medicare would play versus that of their health plan:

- *"My new doctor said that United and Viva were being done away with. But the girl downstairs didn't know anything about it so I don't know what is going on."*

There was also some confusion about the new Medicare benefit and the current discount card program that will be phased out.

- *"There are so many drug discount cards that people send out and they are not any good…my wife gets them and I think it is just a fraud."*

- *"Is that the one where you get $600 off if you are in a certain category and if you make a penny over that you don't get $600 off?"*

The role of plan type in disenrollment and enrollment decisions

Across all groups, most participants belonged to an HMO, and seemed largely unaware of other types of insurance plans available in the area.

- *"I never heard of it (PPO) before today."*

- *"No…(I haven't heard of PPOs) …I heard of AARP."*

Most participants were quite concerned about being able to see the doctor or go to the hospital that they wanted to. Keeping one's current doctor was frequently cited as a prerequisite when choosing a new plan. Some knew that a PPO offered more choice but that it cost more.

- *"United Health was a PPO when I came in… I paid not only the Part A and B but I also paid some kind of thing up front to wait, like $35 to be able to go to the doctor and hospital of my choice…"*

- *"The older we've gotten we don't travel as much as we used to and in Choice you can go to doctors in other places and they will cover it whereas with Medicare Complete will not, it is strictly a local thing."*

Experiences since disenrolling

In most cases when people left plans they were able to keep their same doctors, but continuity of care was impacted in those situations where that wasn't possible. Two persons with disabilities said:

- *"I just would like to see the doctor that did the surgery but he doesn't even take Senior First... I don't think that is right so I may have to go somewhere else but I would rather see the doctor that did the surgery and that is one thing I don't like about this insurance…"*

- *" Every place you go to has trouble getting your x-rays and you have to go through the same thing over and over, they want to operate on my knee and everywhere I go has to have a new x-ray because they can't get the x-rays you just had at another place and to me too many x-rays are not that good for you so why can't we just get our records to carry with us or they could send them…I am just curious about that."*

Several participants reported that they were caught between insurances when disenrolling from one plan, which left them without access to physicians, services, or drugs for several months.

- *"When I changed from Viva to United, I was having to wait two and three months and couldn't ever get an appointment with the doctor and I was without a doctor and I couldn't go to a walk-in place because I was in-between doctors and I would have to use their doctor, So I was without a doctor and Viva said that when I changed back over to Viva I wouldn't have to worry about that, I could keep my doctor and keep my appointments, wouldn't have no problems and I could stay there and use both places".*

One participant was concerned about who will pay the bills he incurred under the plan he left, who did not pay the hospitalization costs as expected:

- *"I went to UHC when Medicare Complete came out they said I could get my medication cheaper so I joined them - and when I went into the hospital to have surgery they didn't pay the bills and now I have the credit bureau writing me every day about those bills from Princeton - so I went to Senior First and they said I wouldn't have these problems with prescriptions and hospital bills."*

Other participants were concerned that the changes they have made may not be optimal for them:

- *"When I joined (Seniors First) I had to choose a PCP (Primary Care Physician) and you had to choose one without knowing any of them. Then you get it and find out it was a family practice group and now I'm 51 years old and I didn't expect to be in a pediatricians office seeing my doctor…there was just so much you didn't know and you had to make decisions on a lack of knowledge and lack of communication and you get the salesman saying one thing and the people who make the decisions saying another thing and the people in the doctor's office saying another thing."*

Several participants are having second thoughts about leaving their plan, and wishing they had thought about it more before switching. The general consensus was that there were enough plans to choose from and that the more there were, the more confusing it became.

- *"One thing I see on this and it would cut down on competition but to me there should be a little more consistency as far as some of these coverage's and all because one will short you on one thing in order to make another thing look appealing and somewhere along the line you are going to get shorted in every plan you got. Somewhere along the line there should be a balance that could be equitable to everyone. If they were all the same there would be no competition…"*

- *"No (I would not like to see more plans in this area) there are too many now…just like the drug cards and if you pick the wrong one then you are in trouble. None of us are medical experts and you can't trust to go ask someone in that profession because they won't tell the truth."*

- *"We think we made a snap decisions too soon (to change) because we just went on what he was telling us which may have been just the better parts of the program and not the whole program in general so that is why I said there may be a downside that we haven't experienced yet so I will have to reevaluate some of those things."*

- *"We change but we don't know enough about them because every representative that comes out to talk to you says their insurance is the best but they are just another insurance but you always are looking for something better."*

- *"You have to be an attorney to understand what they are saying."*

4. Discussion of Results Across the Three Focus Group Sites

In this final section of the report, we summarize findings across the three focus group sites in the major research areas examined. We conclude by highlighting commonalities and key differences across sites.

4.1. Summary of Findings

Reasons for disenrollment from their health plans

Participants across all sites were able to articulate reasons for leaving their former health plan. Most participants across sites identified more than one reason for leaving their plan, but most were able to choose one most important reason. However, while many participants in Philadelphia seemed to identify a combination of reasons surrounding one situation, most participants in Phoenix cited a single reason.

While cost was a reason for leaving the plan mentioned by participants across sites, different aspects seemed to be more important at one site versus another. For example, while cost was an issue for most participants in Philadelphia, it was cost-related concerns combined with other reasons that appeared to drive people to disenroll. Also, cost concerns were more often related to co-payments than premiums. In Phoenix, the most commonly cited reason for leaving their former health plan was related to cost. However, while participants defined "costs" as monthly premiums, deductibles, and co-payments, most seemed to refer to increased monthly premiums as their main cost concern. In Birmingham, cost was also cited as a reason for disenrollment, but most were thinking about prescription drug co-payments as opposed to premiums and co-payments for visits and services.

Another notable difference across sites was the role of marketing by health plans. While there was some mention of health plan marketers at the other sites, it was most prominent in Birmingham. At least two people in each group had been swayed to join a new plan by representatives that came to their homes to talk with them or via telephone. One reason for this may be due to having fewer choices in Birmingham compared to the other sites, which may create increased direct competition between plans.

How they made a decision to disenroll and what they looked for in a new plan

In Philadelphia and Birmingham few participants seemed to explicitly weigh a set of predetermined factors when making a decision to disenroll from a plan or when choosing a new plan. However, in Phoenix, most participants reported that they had specific factors that they compared when making the decision to leave a plan or choose a new plan. These factors included costs, doctors in their plan, prescription drug coverage, hospital coverage, preventive services, quality of care, customer service, emergency coverage out of the country, and ambulance costs.

Despite this difference, there were some similarities across the sites with respect to how participants made a decision to disenroll. Participants across sites identified many of the same sources that they go to for information about a plan. For example, participants at all three sites identified family members, friends, health care providers, and health plan representatives as good

sources of information. As is consistent with previous research, few participants said they used the *Medicare & You* handbook when researching plans.

The role of prescription drug coverage in the disenrollment and enrollment decisions

Most participants across all sites had at least some drug coverage and those that had coverage under their old plan were likely to choose a new plan that also offered coverage. Another similarity across sites was the confusion surrounding drug benefits. Many participants did not know how their coverage worked. For example, several participants in Birmingham had multiple cards or coverage from more than one source with no clear understanding of which was optimal in a particular situation.

There were also some important differences across sites. While the role of prescription drug coverage in beneficiaries' decision to disenroll from a health plan varied within sites, it seemed to be less important in Philadelphia and Birmingham than in Phoenix. In Phoenix, drug coverage was one of the most common factors cited by participants for disenrolling from their former health plan. Participants based their decision on whether the medication they needed was on a plan's formulary and the amount of the co-payment. In Birmingham and Philadelphia, prescription drug coverage seemed to be less important overall, possibly because some participants got medications through other means (e.g., Philadelphia's PACE program). In Birmingham prescription coverage was more important for a few participants who had higher demand for drugs because of disability, chronic disease, or brand-name dependency (no generic substitute).

Another difference between sites was participants' feelings about generic drugs. In Philadelphia, participants across all groups had a strong aversion to generic medications, while participants in Phoenix preferred generic drugs.

Awareness and feedback on the Medicare Prescription Drug Plan and its effect on future disenrollment/enrollment decisions

Across all three sites few participants had heard about the new Medicare prescription drug plan that will go into effect on January 1, 2006. Those that had heard about it either knew few details or had misinformation. As with other insurance issues, participants across sites were confused about the role Medicare would play versus that of their health plan. While participants across all sites were somewhat skeptical and had a "wait and see" attitude, many participants in Philadelphia and Birmingham were interested in learning more about the benefit, while in Phoenix participants in only one of the four groups seemed moderately interested in the prescription drug benefit.

The role of plan type in disenrollment and enrollment decisions

Across all three sites, a significant number of participants were enrolled in a MA HMO. While most participants in Philadelphia and Birmingham seemed unaware of other types of insurance plans in their area, most of the Phoenix participants were cognizant of other insurance options. Out of all the Phoenix groups only one participant did not know what an HMO or PPO is. This may be because participants in the Phoenix groups were better educated than those in

Philadelphia and Birmingham. Also, many of the Phoenix participants expressed interest in having a PPO, but thought it would be too expensive. Across all three sites being able to see the doctor they wanted or go to the hospital of their choice was more important than type of health plan.

Experiences since disenrolling

Participants' experiences after disenrollment were mixed across sites. For example, few participants in Philadelphia experienced problems with continuity of care. Most participants in Philadelphia that wanted to were able to keep the same doctors and hospitals they had in their former plan (many sought a plan where this would be possible), while in Phoenix, half of the participants had to switch doctors when they switched plans and reported problems with continuity of care. In Birmingham most participants were able to keep their doctors, but those that were not able to reported problems with continuity of care such as lack of access to doctors, services, or drugs for several months after disenrollment.

At all three sites some participants reported being more satisfied with their new plan while others were either less satisfied or felt about the same. As for plan choice, most Birmingham participants were happy with the number of options they had and thought more choices would be confusing. Thoughts on plan choice in Philadelphia and Phoenix were mixed. Some participants wanted more plan choice assuming that more plans would mean increased competition and lower prices, while others preferred fewer options.

4.2. Conclusions

By conducting a series of focus groups with beneficiaries who had recently disenrolled from a MA health plan, we were able to augment the quantitative analysis performed to date to explore in greater detail why certain vulnerable subgroups are more likely than others to disenroll from their MA plans, as well as their experiences during and after disenrollment. Groups were conducted in carefully selected areas to ensure a mixture of beneficiaries with characteristics of interest. Overall, experiences varied by region/site, suggesting that the local market has unique characteristics and some impact on disenrollment decisions. However, several common themes emerged across sites:

- All respondents were able to articulate reasons why they left one plan for another. Though the number and type of reasons differed within and across sites, several reasons were mentioned most often – costs (premiums and co-payments), ability to see desired doctors, ability to choose a hospital, costs (related to services and prescription drugs), and wanting something better in terms of cost, benefits, and/or quality.

- Most participants were able to identify their most important reason for leaving their plan, though in many cases, there was other important information that would have been lost if participants were only asked to list their most important reason in the survey.

- Few participants systematically weighed their options when choosing a new plan and when they did, most considered only immediate concerns.

- Many participants were either actively looking for a better plan or were open to the possibility.

- Few participants had a clear understanding of how Medicare relates to their plan and prescription drug coverage, and few were familiar with the new Medicare drug benefit scheduled to begin in January 2006. Many were concerned that the new Medicare drug benefit would be too expensive.

- Most of the participants had some drug coverage. The importance of getting drug coverage through their Medicare plan varied. Those who got drug benefits through state programs, discount programs offered by drug companies, etc. were less interested in the new drug benefit or in getting coverage through their current plan. Some participants in Phoenix who did not get coverage through other means were very interested in finding a plan that covered prescription drugs.

Appendix A

Focus Group Participant
Recruiting Letter and Telephone Contact Form

Appendix A
Focus Group Participant Recruiting Letter

March 2005

FNAME MNAME LNAME
ADDRESS1
ADDRESS 2
CITY, STATE ZIP

Dear FNAME MNAME LNAME:

The Centers for Medicare & Medicaid Services (CMS) is the Federal Agency that manages the Medicare program, and our responsibility is to make sure that you get high-quality care at a reasonable price. One of the ways we can meet that responsibility is to find out directly from you about the care you are receiving under the Medicare program.

In the last year or so you participated in the **Medicare Satisfaction Survey** and gave us information about your reasons for leaving {PLAN}. We are interested in learning more about your experiences getting health care when you were member of that plan. In late March and early April we will be conducting a series of group meetings in your local area with about 10 Medicare beneficiaries in each group to talk about the reasons why people leave Medicare managed care health plans and their experiences getting health care before and after they left their plan.

A representative from RTI International, the private research organization helping us with this project, may contact you by phone sometime within the next 2 to 3weeks to invite you to take part in one of these meetings. Participation will involve attending a two-hour meeting with our representative to talk about your reasons for leaving {PLAN} and your experiences getting health care after leaving the plan. Other Medicare beneficiaries in the group will share their experiences as well. If you are not contacted by our representative on or before April 8, 2005, please assume that you were not selected for this project.

Your help is voluntary, and your decision to participate or not to participate will not affect your Medicare benefits or your enrollment in your current health plan. While you do not have to take part in this project, we hope that you will choose to help us because your knowledge and experiences will help other people with Medicare make more informed health plan choices. All information you give us will be held in confidence and is protected by the Privacy Act.

If you would like more information about this project please call Stephanie Rizk toll-free at 1-800-334-8571 ext. 7498, Monday through Friday, between 9:00 a.m. and 5:00 p.m. Eastern Time. Thank you in advance for your help with this project.

Sincerely,

Susan Hart
CMS Privacy Officer

Focus Group Participant Telephone Contact Form

Focus Group Recruiting/Screening Form
Medicare CAHPS Disenrollment Reasons Survey
RTI Project 7659.005.107

BOX 1: Assignment Information

RTI ID NO. _____

Name: _____

Address: _____

_____

Phone No.: ___/___/___ - ___/___/___ -___/___/___/___

Sample Type (Check one)

1 = 2004 Survey Participant _____

2 = 2004/2005 Supplemental Sample _____

Health Plan Name: _____

Q1. Hello, may I speak to (Mr./Ms.) [SAMPLE MEMBER NAME]?

01 **R IS AVAILABLE** →GO TO INTRO IN BOX 1 BELOW.
02 **R IS NOT AVAILABLE** → DETERMINE WHEN R WILL BE AVAILABLE AND RECORD IN RECORD OF CALLS. TERMINATE CALL.

BOX 1

Hello, this is **[YOUR NAME]** calling on behalf of the Medicare Program. The Centers for Medicare and Medicaid Services, the Federal agency that manages the Medicare program, is conducting a series of group meetings in your local area to talk to Medicare beneficiaries about their experiences with their former Medicare managed care health plans. You should have recently received a letter about this research project in the mail. We are calling today to find out if you are eligible and willing to take part in this project. But first I have a few questions about you and your experience with your health plan. **GO TO Q2. IN BOX 2.**

BOX 2

Q2. First, our records show that at some point in the last two years, you were a member of **[HEALTH PLAN NAME]**, but that you left that plan. Is this correct?

01 YES → GO TO BOX 3.

02 NO → GO TO Q2a. BELOW

Q2a. At this point in the project, we only want to talk with people who were members of a Medicare managed care plan but who left that plan. Thank you for your time. Have a nice [day/evening]. TERMINATE CALL.

BOX 3

INSTRUCTION. CHECK SAMPLE TYPE AND FOLLOW ROUTING BASED ON SAMPLE TYPE.

- **IF SAMPLE TYPE IS 1, SKIP TO BOX 5.**
- **IF SAMPLE TYPE IS 2, GO TO BOX 4**

BOX 4

The following questions ask about <u>reasons</u> you may have had for leaving [HEALTH PLAN NAME].

3. Did you leave <u>because you moved outside the area where [HEALTH PLAN NAME] was available</u>?

Yes ➔ <u>STOP.</u> GO TO Q7.
No

4. Did you leave [HEALTH PLAN NAME] because <u>the plan left the area</u> or you heard that the plan was going to stop serving people with Medicare in your area?

Yes ➔ <u>STOP.</u> GO TO Q7.
No

5. Did you leave [HEALTH PLAN NAME] because you found out that someone had signed you up for the plan without your knowledge (for example, a relative, salesperson, or someone else)?

Yes ➔ <u>STOP.</u> GO TO Q7.
No

BOX 4 Continued

6. Did you leave [HEALTH PLAN NAME] because of a paperwork or clerical error (for example, you were accidentally taken off the plan)?

Yes ➔ STOP. GO TO Q7
No ➔ GO TO BOX 5.

7. At this point in the project, we only want to talk with people who left their former health plan because of other reasons. Thank you for your time. Have a nice [day/evening]. TERMINATE CALL.

BOX 5

We will be holding group meetings at {SITE} in {CITY} on {DATES}. We are looking for people who left a Medicare managed care health plan to attend one of these meetings to discuss their experiences with their former plan. At the meeting we will first ask participants to complete a brief written form about reasons for leaving a Medicare health plan. After which we will meet with a group of 10 other Medicare beneficiaries to share information about experiences getting care with Medicare health plans. People selected to participate in this project must have transportation to and from the meeting and be willing to talk about their experiences with their former plan.

Q9. If you are invited to take part in this meeting, would you have transportation to and from the meeting location?

01 **Yes**→ GO TO Q10.

02 **No**→ GO TO Q10A.

Q10. Participation in the focus group may require reading and answering some questions on a short questionnaire form as well as answering questions from the group leader. Do you have health problems that may keep you from responding to verbal and written questions?

01 **Yes**→ GO TO Q10A.

02 **No**→ GO TO BOX 6.

Q10A. Thank you very much for your time. At this point we are looking for people who (have transportation to and from the meeting location/who will be able to read and respond to written and verbal questions). Have a nice day. TERMINATE CALL.

BOX 6

We would like to invite you to take part in a group meeting. This will involve coming to the location in which the meeting will be held (in your local area) to discuss your reasons for leaving **[HEALTH PLAN NAME]** and your experience during and after leaving that plan. The group meeting will take about two hours. While our researchers will be taking notes during the meeting, your name and the information you provide during the meeting will be kept completely confidential. After your participation in the meeting, we will mail a check to each person that will include $75.00 as a token of our appreciation for helping with this research project and $10 to help towards the cost of transportation to and from the meeting.

Q11. Are you willing to help us with this project by participating in a group meeting?

01 **Yes** → GO TO Q12.

02 **No** → GO TO Q11A.

Q11A. Thank you for your time. Have a nice [day/evening]. TERMINATE CALL.

Q12. We are holding up to four different meetings in (CITY) on [April 5-6th/April 21-22). We are holding meetings in the mornings and afternoons. Which time of day would be best for you to attend a meeting?

01 Morning Meeting

02 Afternoon Meeting

SCHEDULE RESPONDENT IN ONE OF THE GROUPS AND LET THEM KNOW THE TIME

Q13. We will send a letter with the location, date, and time of the focus group meeting to you by mail and will call you after you receive the letter to confirm that you can attend. There is a possibility that we may need to call you back to reschedule you to a different group session, so if that becomes necessary, we will call to make sure of your availability first. Thank you for your willingness to help us with this project.

TERMINATE THE CALL. RECORD SAMPLE MEMBER'S NAME AND ID ON PARTICIP LOG.

CALL RECORD						
Date	**Day**	**Time**		**Result**	**Code**	**TI ID**
			am pm			
			am pm			
			am pm			
			am pm			
			am pm			
			am pm			
			am pm			
			am pm			
			am pm			

Appendix B

Focus Group Moderator's Guide

Discussion Guide for Focus Groups

Medicare CAHPS Disenrollment Reasons Survey
RTI Project 7659

Introduce project staff and any observers and give a brief overview of the purpose of this meeting, then review the ground rules.

INTRODUCTION: Hello, and thank you for attending this meeting. My name is (YOUR NAME), and this is (NOTE TAKER, ANY OBSERVERS AND STENOGRAPHER'S NAMES). I will be leading the meeting today, and (NOTE TAKER, OBSERVER AND STENOGRAPHER NAMES) will be assisting me with this meeting. I am from RTI International, a private non-profit research company that is helping the Centers for Medicare and Medicaid Services (also known as the Medicare program) with this project. The Medicare program is conducting this study to learn more about the reasons people with Medicare choose to leave their Medicare health plans and their experiences getting health care before and after they leave their former plan.

You may remember filling out a survey for this study awhile back. Today, we'll have a chance to talk about your experiences in a little more depth. Your participation will include answering some questions about your reasons related to leaving your former Medicare health plan. We may not be able to answer some of your questions about Medicare or other insurance you might have. At the end of this meeting, we will give you some suggestions about how you can get help from the Medicare program in answering your questions.

We just have a few ground rules for our discussion:

- Most importantly, there are no right or wrong answers to the questions I will be asking. Everyone's input is equally important and helpful. We are interested in all your ideas, comments, and suggestions. It is ok to disagree with what someone says, but we just ask that you do so respectfully.

- Please avoid side conversations among yourselves. Only one person speaks at a time. This is so our tape recording of the discussion will turn out OK.

- We are taping the session and have a stenographer here so we don't miss anything that is said, but we do not link anyone's names to what they say. We are looking for themes or patterns that come out of the discussion, not only of this groups, but of the 10 or so groups we're doing for the project overall.

- To maintain confidentiality, we're going on a first name basis.

- Please turn off your cell phone or pager during this discussion.

Do you have any questions or comments? [Answer any and proceed.] OK, well let's begin.

IF NECESSARY DURING THE DISCUSSION, NOTES TO MODERATOR/GROUP:
Keep in mind that there are different types of Medicare health plan options available to people with Medicare. During this meeting, you may learn that some one else's experience with their Medicare health plan option is very different from your experience. This means that one person's experience with things like benefits, costs, etc. is different from your experience. For example, some people have a Medicare health plan through their current or former employer, whereas some may pay the monthly premium themselves or they may get assistance from a state or local government program. This is okay.

If relevant, tell participants that we understand that for some of them it has been over 6 months since they left their old health plan so it may be hard to remember some of the things that we're going to ask, but to try and remember as best as they can. We also realize that some people may have more have changed Medicare health plans more than once sine they left the plan that we will be asking about. Tell them to think about the experience in leaving the plan they reported on in the survey. However, if they have left a Medicare health plan more recently, it is okay to talk about their experience with that plan.

ICEBREAKER: Let's go around the room and everyone tell us their first name and the name of the health plan that you left.

<u>Topic 1</u>: REASONS FOR LEAVING A PLAN [Time estimate: About 30 minutes]

- **What are the reason or reasons you left your health plan? [Jot down reasons on easel next to each person's name]**

[After initial discussion, provide handout 1 (listing 33 reasons people may have left for people to look over).]

- **Can you think of any other reasons why you left your plan?**

  Does looking at this list help you to remember other reasons why you left?

- **What was the ONE most important reason why you left?**

  - Were you able to choose one most important reason for leaving your previous plan?
  - How well does the one most important reason you picked explain why you left your old plan?
  - If we just asked people their most important reason for leaving, would we be missing important information? How so?
  - What do you think when you compare what you first said (see easel) with your most important reason – how well do they match?

- **Provide handout 2 (7 reason groupings)**

- If you had to put your one most important reason into one of these seven groups, which of these groups would you put it in?

<u>Topic 2</u>: HOW A DECISION IS MADE TO LEAVE A PLAN [Time estimate: 15 minutes]

- What factors did you consider when making your decision to leave your old plan?

MODERATOR: Probe to determine how participants weighed these, and other factors, in their decision to leave:

  - *Cost (e.g., premiums, co-pays)*
  - *Coverage issues (e.g., plan benefits)*
  - *Access to care issues (e.g., getting appointments as soon as you wanted, problems or delays in getting approval to see a specialist, etc.)*
  - *Problems getting specific needs met (e.g., getting special medical equipment, getting home health care or some other type of care needed)*
  - *Number of plan choices in your areas*
  - *Difficulty in getting to doctor and health care facilities in your plan (travel-distance from home)*

- Who did you talk to about your decision to leave the plan?
- What other resources did you consult (the Medicare program, health plans, insurance agents visited you?)
- How did you compare the plan choices in your areas?
- How much did the amount of plan choice in your area affect your decision to leave?

<u>Quality of care</u>

  - How important was of the quality of care in your decision to leave?
- How do you define quality of care? What do you think of when you hear "quality of care" *(e.g., bedside manner)*?

<u>Topic 3</u>: ROLE OF PRESCRIPTION DRUG COVERAGE IN THE DECISION TO LEAVE A PLAN AND CHOOSE A NEW ONE [Time estimate: 10-15 minutes]

MODERATOR: Try to assess who had at least some prescription drug coverage with their old plan and who has it with their new plan.

- What type of prescription drug coverage, if any, did you have with our old plan?
- How did prescription drug coverage affect your decision to leave?
- If you had prescription drug coverage before, did you try to get it again?
- What kind of prescription drug coverage did the plans you considered offer? How did you compare the different options?
- (If applicable) What are some of the reasons you did not get prescription drug coverage?

Topic 4: IMPORTANCE OF THE NEW MEDICARE DRUG BENEFIT IN PLAN CHOICE [Time estimate: 10-15 minutes]

- What have you heard about the new Medicare drug benefit?

Description of 2006 Drug Plan

Beginning January 1, 2006, Medicare will cover prescription drugs for Medicare beneficiaries through Medicare Prescription Drug Plans. Insurance companies and other private companies will work with Medicare to offer these drug plans. These plans are different from the Medicare-approved drug discount cards, which will phase out by May 15, 2006, or when your enrollment in a Medicare prescription drug plan takes effect, if earlier.

- How will this new Medicare drug benefit affect your decision to stay with your current plan or to go to another one?
- How interested are you in this new benefit? What do you want to know about it?

Topic 5: EFFECT OF TYPE OF PLAN ON DISENROLLMENT AND RE-ENROLLMENT DECISIONS [Time estimate: 5-10 minutes]

Introduction: There are different types of Medicare health plans available to people with Medicare. These include a health maintenance organization (HMO) in which you need to go to doctors and hospitals on the plan's list for your care to be covered. With a PPO (or Preferred Provider Organization), you can you can use doctors and hospitals that are not on the plan's list but for an extra cost. Original Medicare means just having Medicare Parts A and B with no supplement (like from AARP or from a former employer).

- What kind of plan do people have now (HMO, PPO, or just Medicare)?

- How did you choose the type of health plan you went to after leaving your old plan?

- How important is the type of plan to you?

MODERATOR: Probe to determine how participants weighed the different plan options when choosing a new plan.

  - Did your health affect your choice of plan and how you weighed different options? If so, how?

<u>Topic 6</u>: EXPERIENCES SINCE LEAVING OLD PLAN [Time estimate: 10 minutes]

- How did leaving your old plan affect your health care? Were you able to stay with the same doctor or specialists when you changed plans, or did you have to get a new doctor? Did you want to get a new doctor?
- [If you had to change doctors] Did you know before you left your old plan that you'd have to get a new doctor? If not, would you still have changed plans if you knew in advance that you'd have to get a new doctor? Why/Why not?
- [If you had to change doctors] Has changing doctors affected your care? If so, how?

- [LIST BENEFITS AND NEGATIVES ON THE EASEL]
  What are some of the benefits of leaving a plan?
  What are some of the negatives of leaving a plan?

<u>Topic 7</u>: CHANGES PEOPLE WOULD LIKE TO SEE [Time estimate: 5-10 minutes]

- Please tell me about the importance of plan choice. Would you like there to be more or less plans to choose from? What about different types of plans?
- What would make Medicare managed care plans more appealing to you?
- What would you think of a rule that only allowed you to change plans once a year (as opposed to the end of each month)? How would this affect your decision about the type of plan to join?

<u>Wrap-up</u> [Time estimate: 5 minutes]

Those are all of the questions that I have for today's discussion. Is there anything else you think we should know that we didn't ask about? Do you have any questions for me?

Thanks you for taking the time to meet with us. This has been very helpful.

After I turn off the tape recorder, there are a few more things I need to tell you before we are finished. [HAND PARTICIPANTS THE FORM EXPLAINING WHERE TO GO FOR HELP WITH QUESTIONS ABOUT MEDICARE AND HOW THEY WILL GET THE INCENTIVE AND MONEY TO HELP PAY FOR TRANSPORTATION TO THE SESSION]

This form contains some information about where to go for help with questions about Medicare. It also indicates that you will receive $75 for participating in our discussion today as a token of appreciation for your help with this project. We will also give you $10 to help pay for some of your transportation costs to this meeting. RTI International will mail the check to your home address. If you do not receive the check within two weeks from today, please call the toll free number listed on this form.