
Value of Medicare Advantage to Low-Income and Minority Medicare Beneficiaries

By: Adam Atherly, Ph.D. and Kenneth E. Thorpe, Ph.D.

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Executive Summary

Medicare Advantage is a critical link in access to health care for the 5.1 million Medicare beneficiaries who rely on it for protection from Medicare's high out-of-pocket costs. Medicare Advantage enrollees receive Medicare-covered services for much lower out-of-pocket costs and receive additional benefits not covered under traditional Medicare.

This study, sponsored by the Blue Cross and Blue Shield Association, uses data from the *Medicare Current Beneficiary Survey* and the *Medicare Compare* database to address the following questions regarding the Medicare Advantage (MA) program:

- Who enrolls in Medicare Advantage?
- What value does the MA program provide to its enrollees?
- How much does MA enrollment lower Medicaid costs?
- What would enrollees do if they had to find an alternative to MA coverage?

Who Enrolls?

Of Medicare beneficiaries who are “active choosers” — those who do not have supplemental coverage through an employer or Medicaid — 32.9% are enrolled in Medicare Advantage. Of the remainder, 28.9% rely solely on Medicare, and 38.3% purchase Medigap coverage.

Beneficiaries who are lower income are disproportionately likely to enroll in Medicare Advantage. Among beneficiaries earning \$10,000 to \$20,000 a year (without Medicaid or employer insurance) nearly 38% are enrolled in Medicare Advantage. African-American and Hispanic beneficiaries also show a strong preference for Medicare Advantage. Nationally, 40% of African-Americans and 52.9% of Hispanics are enrolled in Medicare Advantage.

Value of the Medicare Advantage program to its enrollees

Medicare Advantage plans will provide Medicare beneficiaries \$3.04 billion dollars in additional benefits in 2005 when compared to traditional Medicare benefits, or an annual average of \$615 per MA enrollee, net of any premiums paid by beneficiaries.

Nearly 90 percent of Medicare HMO enrollees are satisfied with their coverage. Medicare HMO enrollees are also very satisfied with their doctors, have little difficulty getting referrals to other providers, are less likely to have trouble getting care for financial reasons, and are more likely to receive preventive care.

How much does Medicare Advantage lower Medicaid costs?

About 18 percent of all Medicaid-eligible Medicare beneficiaries choose to enroll in a MA plan and forego Medicaid benefits. If these beneficiaries were to disenroll from their MA plans and enroll in Medicaid, federal and state Medicaid spending would increase by about \$792 million annually, or roughly \$4 billion over five years.

Alternatives to Medicare Advantage

This study predicts that if MA plans were no longer available to current enrollees:

- Overall, 39% of MA enrollees would go without supplemental coverage, but 59% of African-American beneficiaries in counties that have MA plans would go without supplemental coverage.
- 22% would enroll in Medicaid, increasing the ranks of Medicaid programs in counties that have Medicare Advantage plans by 35%.
- The remaining enrollees (39%) would purchase Medigap policies.

Enrollee Perception of Medicare Advantage

Nearly 90 percent of Medicare HMO enrollees are satisfied with their coverage and would recommend that their family and friends join a Medicare HMO. Medicare HMO enrollees are also very satisfied with their doctors, have little difficulty getting referrals to other providers, are less likely than those in traditional Medicare to have trouble getting care due to a lack of money, and more likely to receive preventive care.

INTRODUCTION

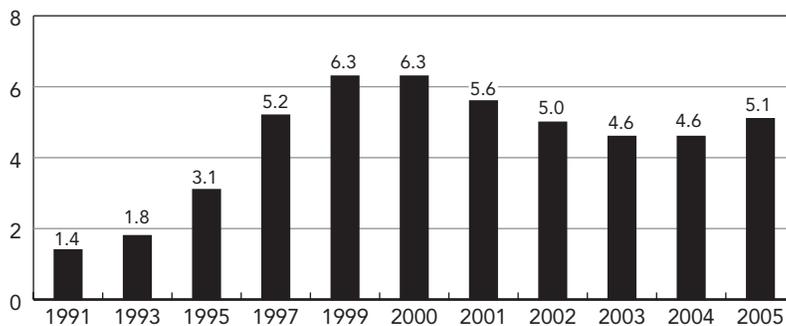
Medicare Advantage (MA) is a critical link in access to health care for the 5.1 million Medicare beneficiaries who rely on it for protection from Medicare’s high out-of-pocket costs. Medicare Advantage enrollees receive basic Medicare-covered services for much lower out-of-pocket costs and receive supplemental coverage for desirable benefits not covered under traditional Medicare.

Evidence that Medicare’s high cost-sharing requirements result in reduced access to care for beneficiaries that rely only on traditional Medicare underscores the importance of supplemental coverage for beneficiaries. The Medicare Payment Advisory Commission (MedPAC) has found that beneficiaries without supplemental coverage are more than three times as likely to have no usual source of care, and almost five times more likely to delay care due to issues of cost.¹

The Medicare Advantage program is the successor to the Medicare+Choice (M+C) program, which was the successor to the TEFRA risk HMO program, originally established in 1983. The Medicare+Choice program provided coverage primarily through local Health Maintenance Organization (HMO) and Point of Service (POS) options, but also permitted coverage through local Preferred Provider Organizations (PPOs), Medical Savings Account (MSA) plans, and private fee-for-service plans. The Medicare Modernization Act of 2003 (MMA) continued and made permanent the existing private coverage options under the renamed “Medicare Advantage” program, created new regional PPOs, “special needs plans” (SNPs) for those who are institutionalized or have severe and disabling conditions, and provided a new prescription drug benefit effective in January 2006.

Enrollment in Medicare health plans peaked in 2000 at 6.3 million beneficiaries. By 2003, enrollment in the program had declined by 1.7 million beneficiaries. The number of plans participating declined from 346 in 1998 to 151 in 2003. Much of the decline in participation resulted when Medicare payments to M+C plans increased by only 2 percent annually for most plans from 1999-2003. During the same period, costs of delivering medical services to enrolled beneficiaries were increasing 5 percent to 9 percent annually. As a result, the dollar value of additional benefits offered by private plans declined, as did enrollment in the programs. Increased funding provided by the MMA helped stabilize and increase MA enrollment to 5.1 million beneficiaries, or about 13 percent of the Medicare population (Figure 1) by August 2005.

Figure 1: Enrollment in Medicare Risk Plans (in millions)



Purpose of this Study

This study addresses five major questions regarding the Medicare Advantage program:

- (1) **Who enrolls in Medicare Advantage?** This section describes the supplemental coverage choices of Medicare beneficiaries and assesses the relative importance of income and ethnicity on those choice decisions.
- (2) **What is the value of the Medicare Advantage program to its enrollees?** This section estimates the value of the supplemental benefits provided to enrollees.
- (3) **What is the value of the Medicare Advantage program to the Medicaid program?** This section estimates the savings that accrue to the Medicaid program from the enrollment in MA plans of beneficiaries who are eligible for both Medicare and Medicaid (dual eligibles).
- (4) **What would Medicare Advantage enrollees do if they had to find an alternative to Medicare Advantage?** This section predicts how many current MA enrollees would go without supplemental coverage entirely, would purchase Medigap coverage, or would rely on Medicaid if they no longer had access to a MA plan.
- (5) **What are beneficiaries' perceptions of Medicare Advantage plans?** This section reviews data on how satisfied Medicare Advantage enrollees are with their health plans and access to medical care.

Methods

This report updates an analysis conducted for the Blue Cross and Blue Shield Association in 2002 as well as an article published in *Health Affairs* later that year.³

The bulk of the data for the analysis are derived from three sources. Data on the characteristics of beneficiaries enrolling in Medicare Advantage plans are derived from the Medicare Current Beneficiary Survey (MCBS), supplemented with information from the 2003 Medicare Compare data set. Enrollment data were collected from the Centers for Medicare and Medicaid Services (CMS).

The MCBS data were used to analyze the characteristics of beneficiaries who “actively choose” to enroll in Medicare Advantage, buy a Medigap policy, or rely on Medicare only. These data were also used to examine Medicare Advantage enrollment by low-income Medicare beneficiaries and to estimate the impact on Medicaid spending if Medicare Advantage plans were not available.

A statistical model of individual choice was used to predict the probability of choice among Medicare only, Medigap, and (for those with incomes under \$20,000) Medicaid, if the Medicare Advantage program were no longer available. (For more information on the methods and data used in this analysis, see Appendix A.)

Section 1: Who Enrolls in Medicare Advantage?

About 82 percent of aged, non-disabled non-institutionalized Medicare beneficiaries have coverage to supplement traditional Medicare, through one of four sources:

- **Employer coverage:** 30 percent (10 million) of beneficiaries have supplemental coverage provided through a former employer or union, although the number of employers offering this benefit has been declining.⁴
- **Medigap:** 25 percent (8 million) purchase individual supplemental policies known as Medigap.
- **Medicare Advantage:** 13 percent (5.1 million) enroll in Medicare Advantage plans.
- **Medicaid:** 13 percent (4.8 million) of Medicare beneficiaries also have Medicaid or other public coverage.

Relative Importance of Medicare Advantage

The 13 percent figure (5.1 million MA enrollees) actually understates the relative importance of Medicare Advantage to Medicare beneficiaries for two reasons. First, not all beneficiaries have the choice of joining a MA plan: only 26 million beneficiaries (75 percent) lived in counties that had a MA plan with more than 50 subscribers in 2002. Second, if one assumes that the Medicare beneficiaries with Medicaid or employer-sponsored coverage find these supplemental benefits preferable to the alternatives, then the “active choosers” comprise only individuals enrolled in Medicare Advantage, covered by Medigap, or with Medicare only. As shown in Table 1, the population of active choosers in Medicare Advantage markets numbers 15 million beneficiaries.

Of these, 32.9 percent enroll in Medicare Advantage plans. This is second to the percentage of beneficiaries choosing to buy Medigap (38.3 percent), but exceeds that of those choosing to rely on Medicare only (28.9 percent).

**Table 1. Projected Supplemental Coverage among Medicare Beneficiaries in 2002:
Nationally and in Counties with a Medicare Advantage Plan**

Source of Coverage	Number of Beneficiaries (in millions)		Percent of Beneficiaries	
	National	Medicare Advantage Markets	National	Medicare Advantage Markets
Medicare Only	6.2	4.3	18%	16%
Medigap	8.3	5.7	25%	23%
Medicare Advantage	4.9	4.9	14%	19%
Total Active Choosers	19.4	14.9	57%	58%
Employer Sponsored Insurance	10.3	7.9	30%	30%
Medicaid*	4.8	3.1	13%	12%
Total Non-Active Choosers	15.1	11.0	33%	42%
Total	34.3	25.9	100%	100%

* Includes SLMB and QMB

Effects of Income and Ethnicity on Choice

Medicare beneficiaries' health coverage choices vary by income and ethnic background. As shown in Table 2, lower income is associated with a preference for Medicare Advantage over Medigap. Beneficiaries with under \$20,000 in income are more likely to enroll in Medicare Advantage than to buy Medigap. Beneficiaries earning more than \$30,000 per year are more likely to buy Medigap (41.8 percent) than to enroll in Medicare Advantage (33.1 percent).

African-American beneficiaries are more likely than white beneficiaries to choose Medicare Advantage (40 percent versus 32.7 percent). Hispanic beneficiaries are much more likely than non-Hispanic white beneficiaries to choose Medicare Advantage (52.9 percent versus 32.7 percent).

In addition to differences in Medicare Advantage enrollment, Table 2 shows striking differences in the proportion of beneficiaries going without any supplemental coverage. While only 24.9 percent of white beneficiaries have Medicare only, 48.6 percent of African-American and 31.2 percent of Hispanic beneficiaries have Medicare only.

Table 2. Medicare Beneficiaries' Active Choices in Counties with a MA Plan

Enrollees	Medicare Only	Medicare Advantage	Medigap	Total
Overall	28.9%	32.9%	38.3%	100.0%
Race/Ethnicity				
White	24.9%	32.7%	42.5%	100.0%
African-American	48.6%	40.0%	11.4%	100.0%
Hispanic	31.2%	52.9%	15.9%	100.0%
Income				
Under \$10K	40.3%	35.6%	24.1%	100.0%
\$10-20K	29.2%	37.8%	33.0%	100.0%
\$20-30K	22.5%	38.0%	39.6%	100.0%
\$30K+	25.1%	33.1%	41.8%	100.0%
Education				
Less than High School	33.9%	37.7%	28.4%	100.0%
High School Graduate	25.5%	35.6%	38.9%	100.0%
Some College/College Graduate	25.3%	33.3%	41.4%	100.0%

In addition to coverage choices varying by income and ethnicity, beneficiaries' preferences differ by educational attainment. For instance, beneficiaries with less than a high school education are more likely than those with higher levels of education to have Medicare with no supplemental coverage (34% versus 25%).

Section 2: The Value of Supplemental Benefits Provided by MA Plans

Medicare Advantage plans are required by law to provide, at a minimum, coverage equivalent to the traditional Medicare benefit package. However, most Medicare Advantage plans offer benefits that exceed that basic benefit package, including coverage for services omitted from the traditional Medicare benefit package, such as vision care and dental services. Most plans also modify the basic benefit package by lowering out-of-pocket costs for covered services, for example, by replacing the 20% Part B co-payment rate under traditional fee-for-service Medicare with a flat \$10 co-payment per physician visit.

In all active markets Medicare Advantage plans offer Medicare beneficiaries who enroll a significant advantage versus traditional Medicare. Medicare Advantage plans will provide their enrollees \$3.04 billion in supplemental benefits in 2005, or an annual average of \$615 per Medicare Advantage enrollee, net of premiums paid by beneficiaries.

In 2006, enrollment in the MA program is expected to grow as more Medicare beneficiaries have access to a broader choice of Medicare Advantage products. Medicare Advantage plans will also play an important role in delivering the new Medicare Prescription Drug benefits, and may offer lower-cost prescription drug benefits than stand-alone prescription drug plans by integrating the drug benefit within their medical benefit package.

Section 3: Medicare Advantage Lowers Medicaid Costs

Low-income Medicare beneficiaries may be eligible for Medicaid in addition to Medicare. These “dually eligible” beneficiaries are allowed to join Medicare Advantage plans on a voluntary basis, just as other Medicare beneficiaries.⁵ The dual eligible population has similar motivations for joining MA plans – reduced out-of-pocket costs and supplemental benefits not covered by traditional Medicare. This section describes why some of these low-income beneficiaries choose to enroll in MA plans rather than Medicaid and quantifies the substantial Medicaid program savings associated with such enrollment.

For fully dually eligible beneficiaries,⁶ Medicaid covers not only Medicare’s cost-sharing, but also additional benefits including prescription drugs and long-term care. For Qualified Medicare Beneficiaries (“QMBs,” with incomes between the federal poverty line and the eligibility cut-off for fully eligible beneficiaries), Medicaid covers Medicare premiums, copayments, and deductibles. For Specified Low-Income Medicare Beneficiaries (“SLMBs,” with incomes between the 100 and 120 percent of the Federal poverty line), Medicaid covers the Part B premium.

In spite of these benefits, limitations in the Medicaid program decrease its appeal to dual eligible beneficiaries and make MA plan enrollment an attractive option. For example, providers are sometimes reluctant to treat Medicaid patients, although access varies depending on state policies regarding payment of providers. About one-third of state Medicaid programs exercise their option not to pay the pay the 20% Medicare Part B co-payment, effectively lowering provider reimbursement for low-income Medicare beneficiaries.⁷ Additionally, most states require providers to enter into formal agreements with state Medicaid programs in order to provide care to dually eligible beneficiaries, which may further reduce the number of providers willing to treat low income beneficiaries.

Approximately 18% of all Medicaid eligible beneficiaries enroll in a MA plan⁸. This figure varies by eligibility status: only 14.5% of full dual eligibles enroll, but nearly one in four SLMB eligibles — who must pay full Medicare cost-sharing — select a MA plan.

Table 4. Enrollment in Medicare Advantage by Medicare Beneficiaries Eligible for Medicaid Coverage

Type of Medicaid Eligibility	Eligible Medicare Beneficiaries (in millions)	Enrolled in Medicare Advantage Plan (in thousands)	Percentage Enrolled in Medicare Advantage Plan
SSI Eligible	1.81	263	14.5%
QMB Eligible	2.78	439	15.8%
SLMB Eligible	2.17	516	23.8%
Total	6.76	1,217	18.0%

Source: 2001 MCBS Cost and Use File. Data updated to 2005 using CMS enrollment data. Includes only non-institutionalized, age-eligible beneficiaries.

There is a substantial Medicaid program savings associated with the enrollment of these low-income beneficiaries in Medicare Advantage plans. Medicaid-eligible Medicare beneficiaries who enroll in a MA program cost the Medicaid program only \$30 on average to cover benefits for inpatient and outpatient services per year (Table 5).⁹ If these same Medicare beneficiaries were to disenroll from the MA program and enroll in the Medicaid programs for which they are eligible, it is projected that the Medicaid program would expend \$1,128 per capita for covered services.¹⁰ That would lead to an increase in annual Medicaid spending of approximately \$792 million overall, and increase state Medicaid spending by nearly \$345 million.¹¹ Over a five-year period, Medicaid spending would increase by roughly \$4 billion if these Medicare beneficiaries were to disenroll from their Medicare Advantage plans.

Table 5. Current and Projected Medicaid Spending for Dually Eligible Beneficiaries Currently Enrolled in Medicare Advantage Plans

	Number of Beneficiaries (in thousands)⁺	Current Mean Medicaid Expenditures⁺⁺	Projected Per Capita Medicaid Expenditures	Total Medicaid Expenditures (in millions)	Federal Share (56.6%)	State Share (43.4%)
SSI and QMB Enrollees in FFS	2,634	\$1,270	N/A	\$3,356.6	\$1,899.8	\$1,456.8
SSI and QMB Eligible in MA Plan	702	\$ 30	\$1,128	\$ 791.9	\$ 448.2	\$ 343.7

Source: 2001 MCBS Cost and Use File Data updated to 2005 using CMS enrollment data and health expenditure growth rates.

+ Includes non-institutionalized, age-eligible SSI and QMB enrollees

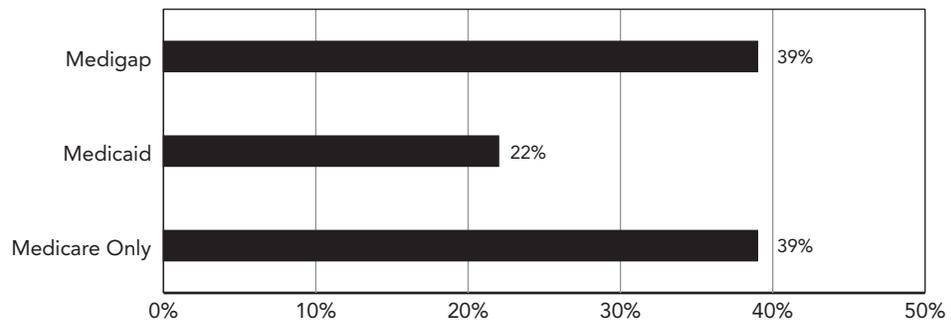
++ Excludes spending on prescription drugs, long term care and facility based medical expenditures

The level of MA plan payment has been shown to impact enrollment among dual eligibles, with higher MA payment rates leading to higher MA enrollment among low-income Medicare beneficiaries — no doubt because plans receiving higher payments are more likely to offer additional benefits and reduce cost-sharing and/or premiums. In a recent study, Atherly and Dowd (2005) found that every \$10 increase in MA payment reduces the probability that a dully eligible individual will enroll in Medicaid by about 4%. The same \$10 increase in MA payment reduces the probability that a dual eligible will remain in the FFS sector by 11%. Increased funding for the MA program provided under the MMA thus is likely to result in increased enrollment of dual eligible beneficiaries in MA plans.

Section 4: Effect on Choice if Medicare Advantage were not Available

To assess how Medicare beneficiaries would respond if they no longer had access to a Medicare Advantage plan, a statistical model of individual choice was used to predict the probability of choice among Medicare only, Medigap, and (for those with incomes under \$20,000) Medicaid. Results are representative for Medicare Advantage markets: overall, 39% of current Medicare Advantage enrollees would go without any supplemental coverage (i.e., they would have Medicare only), 39% would purchase Medigap coverage, and 22% would enroll in Medicaid as dual eligibles.

Figure 2. Predicted Coverage Among Medicare Advantage (MA) Enrollees If MA Program were Ended



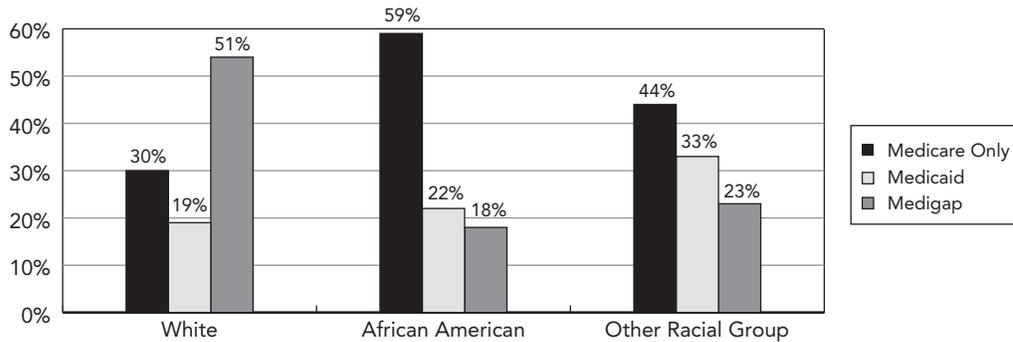
Medicare-only coverage

If Medicare Advantage were not available, the model predicts that 39 percent of the 5 million current Medicare Advantage enrollees (2 million beneficiaries) would rely on Medicare only, without supplemental coverage.

By shifting 2 million beneficiaries to Medicare only, the disappearance of Medicare Advantage would raise the total number of beneficiaries without supplemental coverage by 32 percent. Because enrollment in the Medicare Advantage program is not distributed evenly, the effects on some markets would be dramatic. Overall, in Medicare Advantage markets, the total number of beneficiaries without supplemental coverage would rise by 47 percent.

The effect on the Medicare-only population would be especially dramatic for low-income and minority communities (see Figures 3 and 4). In counties that now have Medicare Advantage, the number of African Americans with Medicare only would rise to 59 percent.

Figure 3. Predicted Coverage Among Medicare Advantage (MA) Enrollees by Race, if MA Program were Ended



Loss of Medicare Advantage coverage would not only decrease access to care for beneficiaries that turned to Medicare only (as noted earlier, Medicare’s high cost-sharing results in reduced access to care for those with no supplemental coverage), it would also result in higher out-of-pocket spending. In an April 2005 press release, CMS noted that “On average, enrollees in Medicare Advantage plans now save nearly \$100 in out-of-pocket expenditures each month because average cost sharing for Medicare-covered services is lower than in traditional Medicare, and because the plans cover additional services that most Medicare beneficiaries would otherwise have to pay for out of their own pockets.”¹³

Medicaid

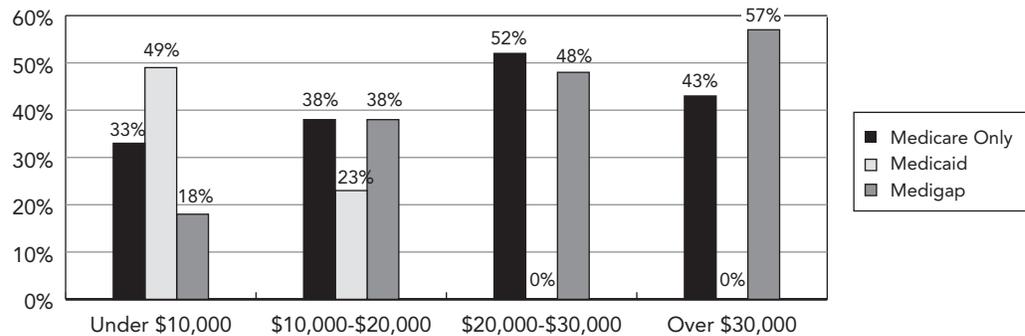
Ending access to Medicare Advantage would also shift many current Medicare Advantage enrollees to fiscally beleaguered state Medicaid programs. About 22 percent of Medicare Advantage enrollees (1.1 million beneficiaries) would enroll in Medicaid or the QMB/SLMB programs. Among MA enrollees with incomes below \$10,000, nearly half (49 percent) would shift to Medicaid. Overall, the withdrawal of Medicare Advantage could raise Medicaid enrollment in counties with a Medicare Advantage plan by 35 percent.¹⁴

In light of widespread budgetary shortfalls, it is not clear that state Medicaid programs would be able to accommodate such an enrollment increase. States are facing significant pressure to limit Medicaid spending and may not make aggressive outreach efforts to enroll these beneficiaries. As a result, many in this category might move to the Medicare-only category.

Medigap

Finally, the model predicts that about 39 percent of Medicare Advantage enrollees (2 million beneficiaries) would purchase Medigap policies, although this choice would vary significantly by income. For example, less than one in five beneficiaries earning less than \$10,000 would buy Medigap, while 57 percent of those with incomes over \$30,000 would do so. This income differential in choosing Medigap reflects the fact that most beneficiaries switching to Medigap may have to pay higher premiums.

Figure 4. Predicted Coverage of Medicare Advantage (MA) Enrollees, by Income, if MA Program were Ended

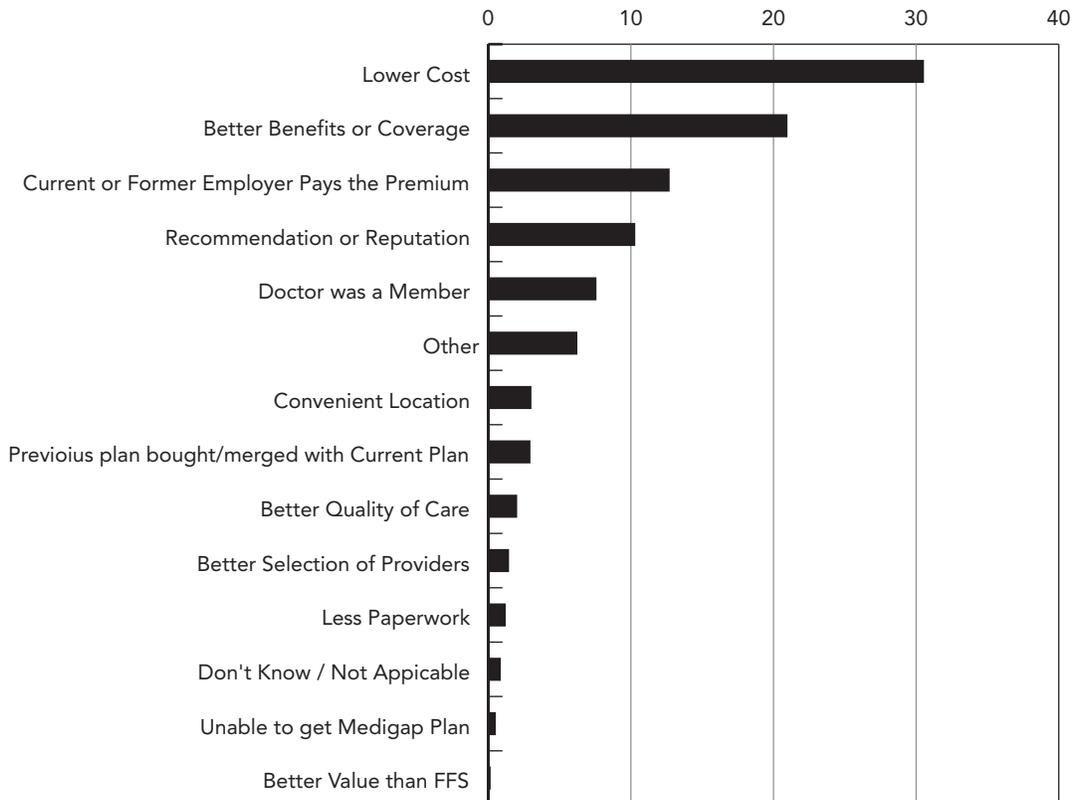


The value the MA program provides to its enrollees is underscored by the negative impact of lost access to Medicare Advantage coverage. The preceding analysis illustrates how beneficiaries who lost access to Medicare Advantage coverage would be worse off regardless of the subsequent coverage choice they make: those who choose to forego any supplemental coverage would face higher cost-sharing and decreased access to care; those choosing Medigap coverage may face higher premiums; and those looking to Medicaid to fill their coverage gaps may find themselves without any supplemental coverage if budgetary pressures prevent States from adequately serving these beneficiaries.

Section 5: Beneficiary Perception of Medicare Advantage Plans

As discussed in earlier sections, the primary reason Medicare beneficiaries join Medicare Advantage plans is to lower the cost of care and to receive better benefits. Indeed, over half of Medicare beneficiaries who enrolled in a Medicare HMO listed Lower Cost (30.5%) or Better Benefits or Coverage (20.9%) as the number one reason they joined.

Figure 5. Beneficiaries' Primary Reason for Joining a Medicare HMO



Source: Data drawn from the 2003 MCBS Access to Care file

Most Medicare beneficiaries who join HMOs are satisfied with their coverage and would recommend a Medicare HMO to their family or friends. Nearly 90 percent of current Medicare HMO enrollees are satisfied enough with their Medicare HMO that they would recommend to their friends and family that they should join a Medicare HMO.

Table 6. Beneficiary Responses to Questions about whether they would Recommend a Medicare HMO to Family / Friends and whether they have Difficulty Getting Referrals

Question	Yes	No
Would you recommend a Medicare HMO to your Family or Friends?	89.9%	10.1%
Do you have difficulty getting referrals through your Medicare HMO?	4.1%	95.9%

Source: Data drawn from the 2003 MCBS Access to Care file. Sample includes only Medicare HMO enrollees

Medicare HMO enrollees overwhelmingly report that they have little difficulty getting referrals to other providers through their Medicare HMO. Medicare HMO enrollees were also less likely to have trouble getting care due to a lack of money and are more likely to receive preventive care, such as flu shots (Table 7).

Table 7. Beneficiary Responses to questions about Access to Care and Satisfaction with Providers

Question	Traditional Medicare		Medicare HMO	
	Yes	No	Yes	No
Did you have trouble getting care due to a lack of money?	17.7%	82.3%	14.3%	85.7%
Did you receive a flu shot this year?	69.6%	30.4%	73.5%	26.5%

Overall, Medicare beneficiaries reported a high level of satisfaction with both their doctor and with the availability of care by specialists. Overall, 89 percent of Medicare HMO enrollees reported that they were satisfied or very satisfied with their doctor’s concern for their overall health and 83 percent reported satisfaction with the availability of care by specialists — similar to the high satisfaction levels reported in the traditional Medicare program.

Conclusions

Medicare beneficiaries continue to turn to Medicare Advantage to fill in the gaps in Medicare. When beneficiaries have an active choice among Medicare Advantage, Medigap, or Medicare-only, nearly one in three (32.9 percent) chooses to enroll in a Medicare Advantage plan. The Medicare Advantage option is particularly important to lower-income beneficiaries, and to beneficiaries who are African-American or Hispanic.

Medicare Advantage plans provide substantial value to Medicare beneficiaries as well as savings to State Medicaid programs: MA plans will provide Medicare beneficiaries \$3 billion in supplemental benefits in 2005, or an annual average of \$615 per Medicare Advantage enrollee, while enrollment of Medicaid-eligible Medicare beneficiaries in MA plans saves the Medicaid program an estimated \$792 million per year.

If Medicare Advantage were no longer available, 2 million beneficiaries — more than half of whom earn less than \$20,000 a year — would have to rely on Medicare only. African-American beneficiaries would be disproportionately affected. Regardless of the subsequent coverage choice they made, beneficiaries who lost access to Medicare Advantage coverage would be worse off than they are today, facing either higher cost-sharing and decreased access to care, higher premiums, or reliance on State Medicaid programs whose financial pressures may prevent them from adequately serving these beneficiaries.

The effects of these changes would be highly concentrated, possibly leading to significant disruption in markets with high Medicare Advantage penetration. For example, doubling the number of Medicare beneficiaries without supplemental insurance could put a heavy burden on health care providers struggling to balance their expenses (i.e., additional uncompensated care).

Appendix A: Methods

This report updates an analysis conducted for the Blue Cross and Blue Shield Association in 2002 as well as an article published in *Health Affairs* later that year. The methods section of the *Health Affairs* article is reproduced below.

Data And Methods¹⁶

“We rely on several sources of data for our analysis. Characteristics of beneficiaries purchasing the M+C product are derived from the 1998 Access to Care component of the Medicare Current Beneficiary Survey (MCBS), supplemented with information from the March 2001 Current Population Survey (CPS). M+C enrollment data were collected from the Centers for Medicare and Medicaid Services (CMS). Data used to tabulate the dollar value of additional benefits provided M+C enrollees rely on the 2001 Medicare Compare data set. These data provide information on every M+C plan’s cost sharing for Medicare-covered services, supplemental benefits, and premiums. With this information, the Actuarial Research Corporation (ARC) used its actuarial rate structure model to calculate the actuarial value of the traditional Medicare program compared with the actuarial value of the benefits (that is, the value of the reduction in cost sharing for Medicare-covered services plus the dollar value of supplemental benefits) actually provided by M+C plans. We used these data to calculate the dollar value, by plan, of these supplemental benefits provided in 2001. This value was then adjusted using the process to calculate the national standardized M+C rates for blend counties.

“We project enrollment in M+C plans under current law and under three options for reforming the M+C program. The analysis tabulates the change in supplemental benefits in an M+C plan and the change in the Part B premium over time as a percentage of dollar value of the traditional Medicare benefit package. This figure is multiplied by a switching elasticity to estimate changes in enrollment for each M+C plan.

“In addition to modeling changes in M+C enrollment, we also assess how Medicare beneficiaries would respond if they no longer had access to the M+C program. We predict whether current M+C enrollees would purchase a Medigap plan, enroll in Medicaid (if eligible), or rely solely on Medicare. Our predictions are based on a limited information maximum likelihood (two-step) nested logit model, with the “nests” defined by traditional Medicare and M+C. Within the traditional Medicare nest, we stratified the data by income, then we estimated the individual predicted probability of joining traditional Medicare only, buying a Medigap plan, or enrolling in Medicaid (for those earning under \$20,000).^{14”}

- 1 *Report to the Congress: Medicare Payment Policy*, Medicare Payment Advisory Commission, March 2000.
- 2 Kaiser Family Foundation: Medicare Advantage Fact Sheet, April 2005, available at: www.kff.org/medicare/upload/Medicare-Advantage-April-2005-Fact-Sheet.pdf
- 3 Thorpe, Kenneth E. and Atherly, Adam, “Medicare + Choice: Current Role And Near-Term Prospects,” *Health Affairs* Web Exclusive, July 17, 2002, <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w2.242v1/DC1>
- 4 The percentage of large firms offering health benefits to their retirees declined from 66% in 1998 to 36% in 2004 (Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2004).
- 5 Walsh, E. and Clark, W. “Managed Care and Dually Eligible Beneficiaries: Challenges in Coordination.” *Health Care Financing Review*. Fall 2002; 24(1): 63-82.
- 6 Full Dual Eligibles (also referred to as Supplemental Security Income (SSI) eligible beneficiaries) generally have incomes below 73 percent of the federal poverty line, with various asset requirements.
- 7 States are allowed to set provider reimbursement for dual eligibles equal to the Medicaid payment rate. As a result, if the State Medicaid payment rate is lower than the Medicare payment rate, States may pay nothing for physician services. See Atherly, A., and Dowd, B. “The Effect of Medicare Advantage Payments on Dually Eligible Medicare Beneficiaries”, *Health Care Financing Review*, Spring 2005; 26(3): 93-103 for details.
- 8 Note that this is Medicaid eligible, not Medicaid enrolled. Some beneficiaries who are eligible for Medicaid coverage decline to enroll in the program.
- 9 Because the SLMB program does not pay for Medicare cost sharing, we excluded the SLMB eligibles from this analysis.
- 10 Excluding prescription drug spending.
- 11 This does not include any federal savings associated with the repeal of the supplemental payments to MA plans initiated as part of the Medicare Modernization Act.
- 12 Our goal was to predict what Medicaid expenditures on inpatient and outpatient covered Medicare services would have been for Medicaid eligible MA enrollees had they remained in the FFS sector and enrolled in Medicaid. We modeled expenditures using a generalized linear model (GLM) with a log link function. In our equation, we controlled for age, income, race, gender, health status, chronic illness and region of residence.
- 13 “Medicare Beneficiaries to See Bigger Savings with Medicare Advantage Health Plans than Ever Before,” CMS Release, April 5, 2005 <http://www.cms.hhs.gov/media/press/release.asp?Counter=1411>

- 14 The large number of current Medicare Advantage enrollees eligible for Medicaid may indicate that some beneficiaries prefer to be covered through Medicare Advantage, perhaps due to improved access to providers through their current plan.
- 15 These savings need to be compared to payments the Medicare program makes to MA plans that exceed 100% of a risk adjusted fee-for-service equivalent payment. The net benefit of the MA program to Medicare is the difference between any additional payments and the dollar value of the supplemental benefits provided by MA plans.
- 16 Thorpe, Ken and Atherly, Adam, "Medicare + Choice: Current Role And Near-Term Prospects," *Health Affairs* Web Exclusive, July 17, 2002, <http://content.healthaffairs.org/cgi/content/full/hlthaff.w2.242v1/DC1>