

Medicare+Choice: Current Role And Near-Term Prospects

If M+C were eliminated, nearly one-third of its members would end up with Medicare coverage only, lacking supplemental benefits entirely.

by Kenneth E. Thorpe and Adam Atherly

ABSTRACT: With the enactment of the Balanced Budget Act in 1997, the Medicare+Choice (M+C) program has been beset by plan withdrawals and declining enrollment. Despite this, M+C provides coverage to more than 12 percent of the Medicare population, a group that is disproportionately poor and minority. Under current law and the Medicare Payment Advisory Commission (MedPAC) M+C reform option, M+C enrollment will decline by one million over the next three years, while the new Bush administration proposal would stabilize program enrollment. If M+C were eliminated, nearly a third of its members would end up in traditional Medicare without any additional coverage, and 18 percent would enroll in Medicaid.

THE BALANCED BUDGET ACT (BBA) of 1997 dramatically expanded the goals and expectations of the Medicare risk-contracting program (which the legislation renamed Medicare+Choice). Before the passage of the BBA, the program was evaluated primarily (although not solely) on its ability to generate savings for the Medicare program. Yet the potential for these savings (assuming perfect risk adjustment) was always limited by the payment system, which established plan payments at 95 percent of fee-for-service (FFS) spending. In practice, plans generally experienced favorable selection, which resulted in higher Medicare spending. Indeed, the bulk of the literature examining this issue concluded that prior to the BBA, the risk-contracting program increased Medicare spending by 5–7 percent.¹

In creating the Medicare+Choice (M+C) program, the BBA retained the goal of budget savings but added several new goals. Payments under the new program were set as the greater of a payment floor (set well above FFS spending and largely affecting smaller-population markets), a minimum update of 2 percent, and a blend of local and national rates. This complex payment system was designed to generate budget savings in heavily populated M+C markets (by providing only a 2 percent update) and redistribute savings (assuming that FFS spending increased

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by more than 2 percent) to markets with little or no M+C penetration. In addition to its redistributive goals, the BBA expanded the types of plans available to beneficiaries (medical savings accounts, private FFS plans, and other forms of coordinated care), encouraged plans' entry into markets without a risk contract, and expanded monitoring and measurement of plan quality and reporting.

Recent analyses have concluded that none of these new objectives have been met and that the program continues to increase overall Medicare spending. Contrary to the BBA's policy intent, access to M+C plans has decreased since 1998. In 1999, 72 percent of Medicare beneficiaries had access to an M+C plan, compared with only 61 percent in 2002.²

The M+C program generates strong reactions among its detractors and supporters. Critics of the program note that M+C plans are typically "subsidized" as payments exceed FFS Medicare, that plans benefit from favorable selection, and that plans serve only selected subpopulations (both geographically and by eligibility, such as the disabled). Critics also cite the uncertainty seniors face as plans continue to leave the program. Indeed, plan withdrawals since 1999 have left more than 377,000 additional Medicare beneficiaries in counties where no M+C plan remains.³ Reflecting these problems, M+C enrollment declined from 6.3 million in December 1999 to 5 million by February 2002. In light of these trends, detractors question whether the program generates benefits that exceed these costs and question the policy justification for adding resources to it.

Proponents of the program highlight the additional benefits M+C plans provide enrollees. In the absence of the program, most current M+C enrollees would either receive no supplemental benefits or pay much higher monthly premiums for a Medigap plan.⁴ Some advocates of the program also believe that M+C plans will play a central role in market-based Medicare "reforms" such as competitive bidding. From this vantage point, interim reforms of the M+C program are necessary to assure their continued participation in Medicare until these structural reforms are adopted.

The purpose of this paper is not to evaluate the impact of the BBA on the M+C program or to document the substantial exodus of plans from the program and enrollment declines. These trends are already well documented in the literature. We are also not attempting to "resolve" the debate over the desirability of retaining the M+C program. In light of this debate, our focus is to report on its current state and near-term prospects—the next three years or so.

During this period some modest reforms will likely transpire, although comprehensive reforms appear unlikely. Comprehensive reforms are likely to prove expensive and, unless phased in over time, potentially quite disruptive. For example, the federal cost of a universal Medicare drug benefit that provides at least a 50 percent premium subsidy will exceed \$400 billion over the next ten years.⁵ Moreover, competitive reforms aimed at generating large federal savings through the M+C program are likely to occur only by greatly raising the premiums paid by

beneficiaries to enroll in traditional Medicare.⁶ Thus, more modest reforms of the program appear likely over the next couple of years.

We start by examining the characteristics of Medicare beneficiaries who enroll in M+C and quantify the dollar value of the supplemental benefits received in 2001. We then estimate the impact on enrollment of payment reforms of the M+C program outlined by President George W. Bush in his 2003 budget, a proposal similar to one recently advanced by Rep. Nancy Johnson (R-CT), as well as an option developed by the Medicare Payment Advisory Commission (MedPAC). Finally, we examine the likely fate of current M+C enrollees if plans continue to withdraw or if the program is eliminated.

Data And Methods

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).⁷ Data used to tabulate the dollar value of additional benefits provided M+C enrollees rely on the 2001 Medicare Compare data set.⁸ 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.⁹ 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.¹⁰

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.¹¹ This figure is multiplied by a switching elasticity to estimate changes in enrollment for each M+C plan.¹²

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.¹³ 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

Who Relies On Medicare+Choice?

The M+C program enrolls relatively lower income Medicare beneficiaries.¹⁵ More than 36 percent of enrollment in M+C plans is among beneficiaries with incomes between \$10,000 and \$20,000 per year (Exhibit 1). This is six percentage points higher than the overall share of Medicare beneficiaries in this income bracket. Overall, 55 percent of all M+C enrollees live in households with less than \$20,000 in income.

Nearly 16 percent of all M+C enrollees are racial or ethnic minorities, similar to the overall profile of the Medicare population. African Americans are the largest share of this group, accounting for nearly 9 percent of all M+C enrollment. The most notable difference by race and ethnicity concerns enrollment in M+C plans relative to Medigap. Racial and ethnic minorities account for 16 percent of M+C plan enrollment, but only 5.7 percent are enrolled in a Medigap plan.

How Important Is M+C In Local Markets, And What Additional Benefits Do M+C Beneficiaries Receive?

Nationally, five million Medicare beneficiaries (12.5 percent) were enrolled in the M+C program during February 2002. Since 30 percent of the Medicare population does not have access to a M+C plan, this overall penetration figure greatly understates the importance of the M+C program in many major markets (Exhibit 2). Nearly a quarter of all M+C enrollees are concentrated in the top ten markets. M+C plans in these markets enroll 35 percent of all Medicare beneficiaries, compared with only 16 percent in the remaining markets having an M+C plan. In several major markets M+C plans enroll nearly half of all Medicare beneficiaries. For

EXHIBIT 1
Characteristics Of Enrollees In Markets With Medicare+Choice Plans, By Type Of Coverage, 1998

	Employer coverage	Medigap	Medicaid	Medicare+ Choice	Medicare only	Total
Income						
Under \$10,000	8.5%	18.4%	84.1%	19.2%	39.0%	25.6%
\$10,000-\$19,999	28.3	34.5	13.5	36.2	35.2	30.4
\$20,000-\$29,999	29.2	22.1	1.4	21.6	10.9	20.5
\$30,000 or more	34.0	25.1	1.0	23.1	14.9	23.5
Race/ethnicity						
White	91.7	94.3	56.6	84.5	71.8	84.4
Non-Hispanic black	5.4	2.9	20.5	8.9	17.5	8.8
Asian	0.7	1.1	9.1	1.9	3.5	2.3
Hispanic	0.7	0.6	9.5	2.7	3.2	2.4
Other	1.5	1.2	4.3	2.0	4.0	2.2

SOURCE: Medicare Current Beneficiary Survey, 1998.

EXHIBIT 2 Benefits Received By Medicare+Choice Beneficiaries, National Totals And Enrollment By Major Market, 2001

Top ten (by enrollment) M+C markets, 2001	M+C enrollment		Weighted average annual value of benefits per enrollee		
	Number	Percent	Total	Net of premium ^a	Drugs
Los Angeles	352,218	34.0%	\$1,872	\$1,728	\$1,260
Phoenix	161,668	41.9	804	804	300
San Diego	160,608	45.1	1,836	1,716	1,260
Miami	148,025	45.8	992	992	402
Ft. Lauderdale	116,803	46.1	1,323	1,323	705
Orange County, CA	109,778	35.8	1,843	1,735	1,212
Riverside, CA	98,681	45.8	1,493	1,393	930
Chicago	92,517	13.4	802	468	331
Philadelphia	88,849	37.1	710	512	149
Pittsburgh	85,778	35.1	547	394	60
All markets with M+C plans	5,342,203	18.9	1,004	749	471

SOURCE: Authors' tabulations of supplemental benefits from the Medicare microsimulation model. M+C and total Medicare beneficiary enrollment is derived from Centers for Medicare and Medicaid Services, "Medicare Managed Care Market Penetration for All Medicare Plan Contractors—Quarterly State/County Data Files," www.hcfa.gov/medicare/mpsct1.htm (2 April 2002).

NOTE: Enrollment totals reflect data from December 2001.

^a Dollar value of supplemental benefits less the monthly premium charged by M+C plans.

example, M+C plans enroll approximately 38 percent of all Medicare beneficiaries in the major urban markets in southern California. When one examines the percentage of Medicare beneficiaries actually choosing between M+C, purchasing Medigap, or relying solely on Medicare, the importance of M+C rises.¹⁶ Using this market definition, M+C penetration comprises more than half of all urban Medicare beneficiaries in southern California. This suggests that in these major markets the majority of Medicare beneficiaries who are making a choice between Medigap plans, Medicare alone, or the M+C option select M+C.

The reason beneficiaries join M+C plans is because they provide substantial, although declining, supplemental benefits to enrollees. Nationally, M+C plans provided approximately \$6 billion worth of supplemental benefits to their enrollees in 2001. After the supplemental premiums charged enrollees for these benefits by M+C plans are deducted, net total benefits were approximately \$4.5 billion. This latter figure amounts to approximately \$750 in additional benefits per M+C enrollee (Exhibit 2).

The value of these additional benefits varies widely even within the largest markets. The top five markets (measured by total M+C enrollment) in 2001 were in Southern California, Phoenix, and South Florida.¹⁷ Benefits net of premiums remain high in these markets, generally exceeding \$1,700 per year. The bulk of the supplemental benefits are provided through the outpatient prescription drug benefit. In the Southern California markets, the value of the drug benefit is \$1,260 per beneficiary per year. These supplemental benefits contrast sharply with those

available in Philadelphia County, Pennsylvania. Although M+C plans there enroll 37 percent of all beneficiaries, the typical plan provides only \$512 in additional benefits per year and a \$150 per year supplemental drug benefit.

What Are The Short-Term Prospects For M+C Enrollment?

Here we examine the short-term prospects for M+C under four scenarios: current law (no changes in the program), full implementation of the proposal advanced in President Bush's 2003 budget submission, a proposal similar to one advanced by Representative Johnson (H.R. 3584), and a recent option advanced by MedPAC.¹⁸ Our analysis focuses on changes in supplemental benefits provided by M+C plans over the next three years and on changes in M+C enrollment.

■ **The proposals.** Exhibit 3 presents the short-term growth in payments to M+C plans under current law and several current proposals. Under current law, payments to M+C plans are expected to rise by 2 percent per year in virtually every county through 2004. By 2005 growth in M+C payments for floor and blend counties is projected to rise by 4.5 percent.¹⁹

In its March 2002 report MedPAC noted substantial differences between M+C payments and FFS spending per capita in several counties.²⁰ The MedPAC option would realign FFS spending and M+C payments per capita in each county over the next four years. For instance, in the first year 75 percent of the M+C payment would be based on what the plan would receive under current law, and 25 percent would be set at 100 percent of FFS spending in the county. This would result in faster payment growth in some counties (where the ratio of current M+C payments is less than 100 percent of FFS) and slower (than under current law) in others.

The Johnson proposal would set M+C payment rates in 2003 at 100 percent of Medicare FFS spending in the county or payment increases expected under current law, whichever is greater.²¹ Our model extends this logic to 2004 and 2005 as well.

EXHIBIT 3
Average Annual Rates Of Growth In Medicare+Choice Plan Payments, By Floor, Minimum Update, And Blend Counties, Under Four Scenarios, 2003–2005

Year	Current law	MedPAC option ^a			Johnson-style proposal			Bush proposal
		Floor	Minimum update	Blend	Floor	Minimum update	Blend	
2003	2.0%	-1.6%	0.6%	0.5%	2.3%	3.0%	3.5%	6.50%
2004	2.0	-1.1	1.1	1.1	2.1	2.3	2.4	3.27
2005	2.6 ^a	0.0	2.3	2.2	2.2	2.6	2.7	3.99

SOURCE: Authors' calculations. Projected growth in U.S. per capita costs from Centers for Medicare and Medicaid Services, Memo to Medicare+Choice Organizations and Other Interested Parties, 1 March 2002, www.hcfa.gov/stats/hmorates/cover03/cover2003.pdf (10 April 2002).

NOTE: Growth rates are weighted by Medicare+Choice enrollees. MedPAC is Medicare Payment Advisory Commission.

^a Current-law growth rates are 2 percent for all counties in 2003 and 2004 and 3.18 percent for floor counties in 2005.

Finally, as part of his fiscal year 2003 budget submission, President Bush has proposed an increase in M+C plan payments. This proposal would increase payments by 6.5 percent for all plans in counties that had received a 2 percent increase in 2002, followed by increases equal to U.S. per capita costs, less 0.5 percentage points.

■ **Short-run changes in M+C plan enrollment.** Exhibit 4 presents estimated M+C enrollment nationally and by plans in minimum-update, floor, and blend counties in 2001 and in 2005 under each of the three proposals. The starting point for our analysis is M+C enrollment during December 2001. Under current law we project that enrollment will decline from 5.3 million (18.9 percent of beneficiaries in markets with an M+C plan) to approximately 4.1 million (14.3 percent of beneficiaries in M+C markets) by 2005. The most substantial decline in enrollment is projected to occur in the minimum-update counties, with M+C enrollment declining by 30 percent by 2005. Most of the major M+C markets, including the urban California and Florida markets, fall in this category.

M+C enrollment would decline to approximately 3.3 million by 2005 under the

EXHIBIT 4
Projected Trends In Medicare+Choice (M+C) Enrollment And Market Share, In Counties With An M+C Plan, Under Four Scenarios, 2001–2005

Plan/proposal	Medicare+Choice enrollment (thousands)		Medicare+Choice enrollment as percent of total beneficiaries	
	2001	2005	2001	2005
Current law (no policy change)				
Blend counties	705	623	21.7%	18.4%
Floor counties	1,738	1,421	14.9	9.8
Minimum-update counties	2,899	2,006	21.7	14.3
Total	5,342	4,050	18.9	14.3
MedPAC proposal				
Blend counties	705	604	21.7	17.8
Floor counties	1,738	932	14.9	6.4
Minimum-update counties	2,899	1,805	21.7	12.9
Total	5,342	3,341	18.9	11.8
Johnson-style proposal				
Blend counties	705	669	21.7	19.7
Floor counties	1,738	1,461	14.9	10.1
Minimum-update counties	2,899	2,142	21.7	15.3
Total	5,342	4,272	18.9	15.2
Bush proposal				
Blend counties	705	645	21.7	19.0
Floor counties	1,738	1,744	14.9	12.0
Minimum-update counties	2,899	2,694	21.7	19.2
Total	5,342	5,113	18.9	18.1

SOURCE: Projections from Medicare simulation model.

NOTE: MedPAC is Medicare Payment Advisory Commission.

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MedPAC option. The substantial reduction in M+C enrollment is traced to the low, and for floor counties negative, increases in payments (Exhibit 3). The MedPAC option would align M+C payments to FFS spending over the next four years. Overall, M+C payments are expected to be 8.9 percent higher than average FFS payments by 2003. This high level is traced to recent revisions in the actual and projected growth in Medicare FFS spending developed by the CMS. For instance, the CMS projects only a 0.9 percent growth in FFS spending per capita during calendar year 2003. Thus, aligning these payment rates would dramatically slow the growth in M+C plan payments. M+C enrollment in floor counties, where the BBA sought to increase enrollment by boosting payments above FFS spending, would decline by an average of 50 percent under the MedPAC option by 2005. Since M+C payments in floor counties are projected to be 16 percent higher than FFS payments per capita in 2003, the MedPAC proposal would result in lower M+C payments in 2005 than plans receive today.

Enrollment in the minimum-update counties would decline by more than one million by 2005. Payments to M+C plans in these counties would, on average, increase 1.3 percent, lower than current-law increases of 2 percent per year. Finally, M+C enrollment in the blend counties would decline by 14 percent, from 705,000 today to 604,000 by 2005.

Under the president's proposal, M+C payments would rise by an average annual rate of 4.6 percent between 2002 and 2005. This higher payment rate would result in higher levels of plan participation in the program and increased supplemental benefits and M+C enrollment compared with current law. The Bush proposal would essentially stabilize enrollment in the M+C program at around five million enrollees but would still result in a slight reduction in M+C market share nationally.

The “Johnson-style” proposal also results in a decline in M+C enrollment of approximately one million by 2005. However, expected enrollment would be approximately 200,000 higher than under current law. The higher enrollment is traced to the slightly higher average annual growth in M+C payments between 2002 and 2005 (approximately 2.5 percent per year).

The Demise Of Medicare+Choice? Implications For Enrollees

Here we focus on plan choices made by current M+C beneficiaries, assuming that the M+C option is eliminated. As noted above, we use a statistical analysis to predict whether current M+C enrollees would rely solely on Medicare, purchase a Medigap plan, or enroll in Medicaid (if eligible).

The results indicate that in the absence of the M+C program, 30.3 percent of

current M+C enrollees, or 1.5 million persons, would rely solely on Medicare. This would raise the number of beneficiaries without any supplemental coverage from approximately 5.0 million to 6.5 million, a 30 percent increase. Approximately 52 percent (2.6 million) of current M+C beneficiaries would purchase a Medigap plan. Finally, 17.9 percent (approximately 900,000) of current M+C beneficiaries are eligible for and would enroll in Medicaid (or the Qualified Medicare Beneficiary, QMB, or Specified Low-Income Beneficiary, SLMB, program).²² This would result in higher federal and state Medicaid spending for such beneficiaries.

Conclusion

The M+C program continues to languish under substantial, and often conflicting, expectations from policymakers. These conflicting goals and expectations make evaluation of its performance difficult. In light of Medicare's current approach for paying M+C plans, it does not appear reasonable to simultaneously expect the program to deliver savings to Medicare, provide a stable volume of supplemental benefits, and expand into currently underserved areas.²³ Under current law, M+C plans cannot fulfill these conflicting goals articulated under the BBA. Looking ahead, by keeping the growth in M+C payments below the growth in FFS Medicare, the M+C program will actually produce savings for the Medicare program over the next decade. At the same time, keeping the growth in M+C payments below the growth in the cost of providing Medicare-covered services will continue to erode the value of supplemental benefits provided and result in fewer M+C plans. Our analysis indicates that these trends could reduce M+C enrollment by nearly one million over the next three years. A proposal similar to the one developed by Representative Johnson would result in similar, although slightly lower, reductions in M+C enrollment. The analysis reveals that the approach recently advanced by MedPAC would deliver even larger reductions in enrollment—two million M+C enrollees. In contrast, the Bush proposal would likely stabilize M+C enrollment at five million in the near term, although the share of beneficiaries in the M+C program would decline by 2005. These projected enrollment declines will continue to raise concerns about the program's stability.

Yet in some ways the M+C program has been successful. In a handful of markets it has become the dominant provider of care for Medicare beneficiaries. It has also assumed an important role as a safety net for lower-income Medicare beneficiaries, allowing those who find Medigap policies too expensive to receive some supplemental benefits and reduced cost sharing. The program has even proved appealing to low-income beneficiaries eligible for Medicaid, providing relief for strained state budgets.

Arguably, the M+C program could assume an important role in the context of broader Medicare reforms, including the provision of an outpatient prescription drug benefit. However, for M+C to be a successful and attractive element of a broader reform package, future expectations should be more clearly defined and focused.

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 We acknowledge the input from two anonymous reviewers.

NOTES

1. G. Riley et al., "Health Status of Medicare Enrollees in HMOs and Fee-for-Service in 1994," *Health Care Financing Review* (Summer 1996): 65–76.
2. M. Gold, "Medicare+Choice: An Interim Report Card," *Health Affairs* (July/Aug 2001): 120–138. Our analysis projects that on average, M+C plan reimbursement will be 108.9 percent of FFS spending by 2003.
3. M. Gold and J. McCoy, "Choice Continues to Erode," Mathematica Policy Research Fast Facts no. 7, January 2002, www.mathematica-mpr.com/PDFs/fastfacts7.pdf (24 May 2002).
4. In 2002 the supplemental premium for a "typical" M+C plan is approximately \$30 per month in our data, compared with \$130–\$150 per month for the most popular Medigap plan (Plan F), which does not provide any outpatient prescription drug coverage. These quotes come from the Quotesmith Web site, www.quotesmith.com (5 May 2002).
5. Letter from Dan Crippen, director, Congressional Budget Office, to members of Congress, 11 June 2001, www.cbo.gov/showdoc.cfm?index=2873&sequence=0&from=1 (10 June 2002).
6. K.E. Thorpe and A. Atherly, "Reforming Medicare: Impacts on Federal Spending and Choice of Health Plans," 10 October 2001, www.healthaffairs.org/Web_Exclusives/Thorpe_WE_101001.htm (10 June 2002).
7. Centers for Medicare and Medicaid Services, "Medicare Managed Care Contract (MMCC) Plans—Monthly Summary Report," www.hcfa.gov/stats/mmcc.htm (10 March 2002).
8. CMS, "Medigap Compare," www.medicare.gov/MGCompare/MPPFRedirect.asp (7 August 2001).
9. This model runs each M+C plan's design through an expenditure distribution of M+C enrollees. It then calculates the actuarial value of each plan (the ratio of payments paid by the plan to total spending—plan payments plus out-of-pocket expenses). The model also calculates the actuarial value of the core set of Medicare services. We subtract each plan's actuarial value from the actuarial value of a plan that provides just the core Medicare services. This difference is multiplied by a mean monthly total "possible" (that is, total beneficiary spending for all services covered—core Medicare services plus prescription drugs, hearing aids, eyeglasses, dental care, and so forth) spending for M+C enrollees in each county. This provides a dollar value of the additional benefits.
10. An example of this calculation can be found in Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (Washington: MedPAC, March 1999), 139, Table A-3.
11. The dollar value of the supplemental benefits over time is calculated as the difference between the M+C payment rate in 2003–2005 (which varies by each of our scenarios) and the growth in the cost of providing the core Medicare benefits by the managed care plan. We assume that plans with negative supplemental benefits will exit the market.
12. Our method is identical to that used in Thorpe and Atherly, "Reforming Medicare." Briefly, the model takes the change in benefits (as described in Note 11, with a dollar of benefits valued at 80 cents) less the expected increase in FFS premiums. We then use a switching elasticity of –0.2. This is based on our own unpublished work but is similar to results in T. Buchmueller, "The Health Plan Choices of Retirees under Managed Competition," *Health Services Research* (December 2000, Part 1): 949–976.
13. We originally estimated a mixed logit, but the model violated the Independence of Irrelevant Alternatives (IIA) assumption, so we instead used a nested logit. Complete regression details are available on request from the author; contact Ken Thorpe at kthorpe@sph.emory.edu.
14. In the predictions we controlled for age, sex, ethnicity, health status, region, and veteran status plus the county M+C payment rate, per capita income, total population, number of physicians per capita, and the estimated 2002 Medigap premium.
15. For additional information concerning the characteristics of Medicare beneficiaries selecting supplemental coverage in selected local markets, see K.E. Thorpe, A. Atherly, and K. Howell, "Medicare+Choice: Who Enrolls?" 25 April 2002, www.bcbshhealthissues.com/relatives/19526.pdf (10 June 2002).
16. This definition looks at beneficiaries who are not provided supplemental coverage by a third party (the government or a former employer). That is, this analysis examines those that do not have access to an employment-based plan or Medicaid. On the other hand, our results likely include some that are enrolled in the M+C program through a retiree health plan. The extent of such enrollment is not known, however.
17. The market-level averages here rely on our estimate of the dollar value of supplemental benefits provided by each M+C plan in a county weighted by their (county) share of M+C enrollees during 2001.

18. MedPAC, *Report to the Congress: Medicare Payment Policy* (Washington: MedPAC, March 2002), chap. 4. The MedPAC proposal recommends a financially neutral payment system for M+C plans that sets rates equal to 100 percent of local FFS spending in each county. As the ratios of FFS spending and M+C payments vary widely across counties, MedPAC recommends a four-year transition toward these rates. For a brief description of the Bush proposal, see “Strengthening Medicare’s Coverage Options: Affordable Health Care to Improve Lives,” 17 May 2002, www.whitehouse.gov/news/releases/2002/05/20020517-2.html (10 June 2002).
19. The CMS recently revised its estimated growth in U.S. per capita costs (USPCC), with the most recent estimate suggesting a negative update for floor and blend counties. CMS, Memo to Medicare+Choice Organizations and Other Interested Parties, 1 March 2002, www.hcfa.gov/stats/hmorates/cover03/cover2003.pdf (10 April 2002). The CMS projects that the USPCC will rise by 0.9 percent in 2003, 3.77 percent in 2004, and 4.49 percent in 2005. Payments in the floor and blend counties in each year will be a 2 percent update or the growth in the USPCC, whichever is greater. Using these data, the CMS projects that floor payments (in the larger urban markets) will total \$547.54—lower than the floor amounts in 2002 (\$553). Thus, the 2 percent update for 2003 and 2004 will be higher than the update using the USPCC until 2005. As a result, the 2 percent minimum update will result in a larger update than the revised projection from the USPCC through 2004 for virtually all floor and blend counties.
20. Our analysis reaches similar conclusions. As of 2003, in the floor counties, we find that M+C payments (for aged enrollees) average 116 percent of FFS spending per aged Medicare enrollee. Data on FFS spending by county for the aged are from CMS, “Medicare Preferred Provider Organization Demonstration,” www.hcfa.gov/research/ppodemo.htm (30 May 2002). These averages are weighted by the number of M+C enrollees in each plan. In the blend and minimum-update counties, this ratio is approximately 106 percent of FFS. Nationally, M+C payments average 108.9 percent of FFS spending per M+C beneficiary.
21. The Johnson proposal also eliminates the “budget-neutrality” requirement for blend counties as well. This requires that M+C spending, including the blended payments, equal the plan payments that would occur if rates in each county were trended by the USPCC.
22. A caveat is in order here. Our own work indicates that the MCBS and other surveys (such as the CPS) generate a different income distribution of the elderly. Counts from the MCBS appear to generate a higher count of the elderly in poverty than generated by the CPS. This could result in higher estimates of the elderly eligible for Medicaid.
23. The Medicare, Medicaid, and SCHIP Benefits Improvement Act (BIPA) of 2000 increased the minimum growth in M+C payments to plans from 2 percent to 3 percent in 2001. Payments to plans in floor counties increased from \$415 per month to \$475 or \$525, depending on the local market population. Analysis by the U.S. General Accounting Office found that approximately 25 percent of plans improved their benefits, while another 12 percent placed some of the additional funding in a benefit stabilization fund. Most plans used the additional dollars for stabilizing access to care within their networks. This latter finding reflects the fact that in markets with the greatest M+C enrollment (the minimum-update markets), costs to the plans of providing core Medicare benefits increased 7 to 10 percent, while plan payments increased 3 percent. Thus, virtually all of the additional revenue was used to finance the higher hospital and physician costs facing M+C plans. See General Accounting Office, *M+C: Recent Payment Increases Had Little Effect on Plan Availability in 2001*, Pub. no. GAO-02-202 (Washington: GAO, November 2001).