Beneficiaries with Chronic Conditions More Likely to Actively Choose Medicare Advantage

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SEPTEMBER, 2018

BETTER MEDICARE ALLIANCE

Funding for this research was provided by Better Medicare Alliance

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Introduction

Foreward

Congresswoman Allyson Y. Schwartz

President & CEO, Better Medicare Alliance

Better Medicare Alliance (BMA) is a community of over 115 ally organizations, as well as almost 400,000 beneficiaries, who value the option of Medicare Advantage. Together, our alliance of health plans, provider groups, and research organizations share a commitment to ensuring Medicare Advantage is a high-quality, cost-effective option for current and future beneficiaries.

Over 10,000 baby boomers are aging into Medicare each day. Those over 65 years will nearly double in the next 2 decades and the population of those aged 85 and older will nearly triple. Almost all of them will have a chronic condition and many will have multiple conditions that require ongoing care management. It is paramount that we ensure that Medicare-eligible individuals have the necessary information and decision-making tools to make informed enrollment decisions.

BMA has been engaged in efforts to ensure that beneficiaries have this information and support tools to make an informed choice for themselves. As a result, we have seen progress in new language and placement of information in the federal government's written materials and in training of government-funded programs which offer free counseling on Medicare enrollment. Nonetheless, more needs to be done. Recent polling has shown that 65% of individuals in FFS Medicare do not know about the option of Medicare Advantage and either choose or default into FFS Medicare.[1]

To continue to understand this issue, BMA was interested in answering the question of who is currently most likely to choose the managed care option in Medicare. Dr. Thorpe's research studied these "active choosers" and calculated the likelihood an individual would actively choose Medicare Advantage based on various demographic and clinical characteristics.

As the President of BMA, I'm proud to have sponsored the research conducted by Dr. Ken Thorpe, Chair of the Health Policy and Management Rollins School of Public Health at Emory University, on those Medicare-eligible beneficiaries who actively choose Medicare Advantage. The following report offers insights on this question, including the finding that beneficiaries with one or more chronic condition are more likely to enroll in Medicare Advantage

compared to those with no chronic conditions, and the likelihood increases with the number of chronic conditions.

Given recent findings in a separate report by Avalere Health that those with multiple chronic conditions had improved outcomes in Medicare Advantage, it is interesting to consider that beneficiaries with chronic conditions are actively choosing Medicare Advantage. Beneficiaries appear to have found that an integrated care system, with a dedicated network of providers, enhanced benefits, focus on primary care and care management is most beneficial for them.[2]

In addition, this report includes findings on income and education levels of likely active choosers that suggests the need to improve materials and processes to be more accessible and understandable for all eligible beneficiaries. This particularly includes those individuals with low literacy skills, lack of understanding of insurance products, lack of family supports or access to an agent, broker or counselor to provide guidance, or other reasons to find it difficult to use current sources of information on the choice between Medicare Advantage and FFS Medicare.

This research adds to the findings that support the value of Medicare Advantage for individuals with chronic conditions. The research also offers insights that can inform changes needed to ensure all beneficiaries have understanding and access to the right health coverage for them. Both of these findings support the goal of a healthier future for Medicare beneficiaries.

Abstract

Medicare-eligible beneficiaries have a choice between FFS Medicare and Medicare Advantage, the private managed care option that typically provides health care benefits through a Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO).

Over one-third of beneficiaries are enrolled in Medicare Advantage. Twenty percent of enrollees have health benefits sponsored by their previous or current employer in Medicare Advantage Employer Group Waiver Plans and 20% are dually eligible for Medicare and Medicaid. Individuals under 65 years old who are eligible for Medicare due to disability who choose Medicare Advantage are not included in the study population. The remaining beneficiaries – 60 percent – are individuals who actively chose Medicare Advantage. While reports have analyzed the characteristics of enrollees in Medicare Advantage, this report provides insights into the characteristics of the group of beneficiaries actively choosing Medicare Advantage.

Data from the Medical Expenditure Panel Survey (MEPS) was analyzed to better understand the characteristics of beneficiaries who actively choose Medicare Advantage. The MEPS provides the type of Medicare coverage as well as any supplemental coverage in which beneficiaries are enrolled. Significantly, the analysis found chronically ill patients, minority populations and beneficiaries with low and moderate incomes are more likely to enroll in Medicare Advantage health plans. While the analysis did not identify a causal relationship, it is likely that Medicare Advantage is attractive to chronically ill patients because the health plans provide broader benefits, lower cost sharing, and more coordinated care than FFS Medicare. Medicare Advantage is also a simpler, and often more affordable option for beneficiaries. As the number of Medicare beneficiaries with multiple chronic conditions continues to rise, Medicare Advantage enrollment is expected to grow, and the option of Medicare Advantage for individuals with chronic conditions is likely to continue to be recognized as high value for older adults and those eligible for Medicare due to disability.

Background

Approximately 20 million beneficiaries are enrolled in Medicare Advantage. In 2018, the average monthly premium of a Medicare Advantage health plan was $30 and over 80% of beneficiaries had the choice of at least one plan that did not charge a monthly premium.[3,4]

In contrast, the monthly premium for the most popular Medigap plan (Plan F) is approximately $150 in most states. Plan F is the most comprehensive Medigap plan and pays for the Part A and B coinsurance and deductibles. While Medigap plans reduce out-of-pocket costs, they do not provide additional supplemental benefits like vision, hearing, or dental coverage found in the majority of Medicare Advantage health plans.[5] Medicare Advantage health plans often provide additional benefits not covered by FFS Medicare and offer lower cost-sharing. In addition, most Medicare Advantage health plans include prescription drug coverage, known as MA-PD health plans. For beneficiaries who choose FFS Medicare, prescription drug coverage (Part D), must be purchased separately.

Medicare Advantage achieves cost-effective care and better outcomes for beneficiaries with chronic conditions relative to FFS.

Medicare Advantage also provides care coordination services to help keep chronically ill patients healthy and out of the hospital or emergency room. Care coordination in the Medicare program is important, given the high prevalence of chronic conditions among Medicare beneficiaries. According to the MEPS, over 95%of Medicare spending is on beneficiaries with chronic conditions. Today over half of all Medicare patients are treated for five or more chronic health care conditions. To address this challenge, evidence-based care coordination has been shown to reduce costs.[6] Indeed, it is one of the reasons HMOs in Medicare Advantage can bid to provide core Medicare benefits at 12% less than spending under FFS Medicare.[7] These care coordination services are generally not available in the FFS Medicare program. While there are CPT-4

codes that allow providers to bill for care coordination and transitional care in FFS Medicare, they are rarely used. Only a reported 700,000 FFS Medicare beneficiaries have received some form of care coordination, for which they must also pay a 20% coinsurance per the policy under Part B of FFS Medicare.

This paper examines the characteristics of "active choosers", who are those deciding between Medicare Advantage, FFS Medicare or the FFS Medicare program plus a Medigap plan. This population excludes dually eligible beneficiaries, as well as Medicare Advantage beneficiaries with employer-sponsored coverage, as they do not actively choose their Medicare coverage. To examine the odds of actively choosing Medicare Advantage, a logistic regression was used to estimate the likelihood that Medicare beneficiaries by key demographics -- such as age, gender, race/ethnicity, education, and income (as a percent of poverty), and number of chronic conditions treated -- chose Medicare Advantage.

It is useful to understand the characteristics of beneficiaries in FFS Medicare and Medicare Advantage based on utilization, cost, outcomes and consumer satisfaction given Medicare's spending on beneficiaries with multiple chronic conditions. However, it is not known how many beneficiaries actively choose FFS Medicare, because those who do not make a choice are automatically enrolled into FFS Medicare. Many Medicare beneficiaries report being unaware of the option of Medicare Advantage.[8]

SECTION II

Findings

Results

An estimated 12.5 million beneficiaries actively chose Medicare Advantage. Approximately 4.8 million FFS Medicare beneficiaries purchased a Medigap plan.

While 13.9 million individuals relied solely on FFS Medicare, there is no way to know whether they were active choosers. The results from the statistical modeling are presented and summarized in the **Appendix**. The model estimates the likelihood or odds of enrolling in Medicare Advantage compared to enrolling in FFS Medicare holding all other factors constant.

Chronic Disease

Medicare beneficiaries with at least one chronic condition were more likely to choose Medicare Advantage over FFS Medicare (Table 1). Specifically, those with one chronic condition were 55% more likely to choose Medicare Advantage compared to those with no chronic conditions. The likelihood of choosing Medicare Advantage was higher among beneficiaries with multiple chronic conditions. For instance, those with three or four chronic conditions were 75 to 80% more likely to enroll in Medicare Advantage. Those with five or more chronic conditions were 70% more likely to enroll in Medicare Advantage.

Patients with five or more chronic conditions are 70% more likely to enroll in Medicare Advantage compared to those with no chronic conditions.

Table 3 presents the top ten most prevalent and expensive chronic conditions in Medicare. These include hypertension, hyperlipidemia and arthritis. For eight of these conditions, the prevalence was similar among FFS Medicare and Medicare Advantage enrollees. However, the prevalence of hyperlipidemia was six percentage points higher (51% compared to 45%) among Medicare Advantage enrollees. Similarly, hypertension prevalence was slightly higher at four percentage points higher (62% versus 58%) among Medicare Advantage enrollees compared to those in FFS Medicare.

There were also some differences in chronic disease prevalence among those in FFS Medicare that purchased a Medigap policy and Medicare Advantage enrollees. The prevalence of heart disease was nearly seven percentage points higher among those with Medigap compared to Medicare Advantage enrollees. However, diabetes prevalence was six percent higher (24% vs 18%) in the Medicare Advantage population compared to those with Medigap.

Enrollment patterns among chronically ill beneficiaries are critical given the fact that chronic disease is a leading cause of morbidity, mortality and a key driver of health care spending.

The enrollment pattern findings among chronically ill Medicare beneficiaries are important given Medicare's spending on beneficiaries with multiple chronic conditions, and the impact of these conditions on morbidity and mortality. Seven of the top ten causes of death are due to chronic diseases, including heart disease, cancer, chronic respiratory disease, stroke, Alzheimer's, diabetes and chronic liver disease.[7] These conditions also account for the vast majority of health care spending. According to MEPS data as of 2015 over half of all Medicare beneficiaries were treated for five or more chronic conditions which accounted for over 75% of Medicare spending.

Race and Ethnicity

There were also differences in the likelihood of enrolling in Medicare Advantage based on race (Table 1). Hispanics were twice as likely to enroll in Medicare Advantage as opposed to FFS Medicare compared to non-Hispanic whites. In addition, African Americans were nearly 20% more likely to enroll in Medicare Advantage compared to non-Hispanic whites, though the results were of marginal statistical significance.

The analysis found minority populations, including Hispanics and African-American seniors, are more likely to enroll in Medicare Advantage health plans.

Income

Low and moderate-income beneficiaries were also more likely to actively choose Medicare Advantage (Table 1). Families with income between 100 and 200% of the Federal Poverty Limit (FPL), with incomes between approximately $12,000 and $23,500, were 18% more likely to enroll in Medicare Advantage than FFS Medicare. Moreover, Medicare beneficiaries with incomes between 200 and 400% of the FPL, with incomes between approximately $23,500 and $47,000 were 33% more likely to enroll in Medicare Advantage compared to FFS Medicare.

Education

Overall, Medicare Advantage beneficiaries were more educated. Medicare beneficiaries with some college or a college degree were more likely to choose Medicare Advantage compared to those with no higher education (Table 1). Those with some college or a college degree were 20% more likely to enroll in Medicare Advantage than FFS Medicare. Other categories of educational levels showed similar rates of enrollment between Medicare Advantage and FFS Medicare.

Gender and Marriage Status

Female beneficiaries were 18% more likely to enroll in Medicare Advantage compared to male beneficiaries. Married beneficiaries were 16% more likely to choose Medicare Advantage compared to single beneficiaries. Finally, there were no differences in the likelihood of enrolling in Medicare Advantage by age (Table 1).

Conclusion

The analysis shows notable characteristics of older adults who are likely to actively choose Medicare Advantage based on key demographics and underlying health status. Minority populations, including Hispanics and African-American seniors, are more likely to enroll in Medicare Advantage health plans. Low and moderate-income beneficiaries are also more likely to actively choose Medicare Advantage. Importantly, chronically ill beneficiaries are more likely to enroll in Medicare Advantage compared to those with no chronic conditions. In fact, patients with five or more chronic conditions are 70% more likely to enroll in Medicare Advantage compared to those with no chronic conditions. Enrollment patterns among chronically ill beneficiaries are critical given the fact that chronic disease is a leading cause of morbidity, mortality and a key driver of health care spending.

Medicare Advantage may be attractive to chronically ill patients due to the availability of additional benefits, lower cost sharing, and more coordinated care. The coordinated care offered through Medicare Advantage is not typically available in the FFS Medicare program or through Medigap plans. As the share of beneficiaries with chronic disease continues to rise, Medicare Advantage health plans will continue to be called upon to meet the needs of beneficiaries with multiple chronic conditions.

Data & Methods

This analysis was conducted with Medical Expenditure Panel Survey (MEPS) data. A detailed description of the MEPS can be found here. The MEPS tracks individual and household demographic, socioeconomic, and health-related characteristics, providing a nationally representative sample of the U.S. civilian non-institutionalized population (the study population of inference). The Household Component of the Medical Expenditure Panel Survey (MEPS-HC) is a nationally representative survey of the U.S. civilian non-institutionalized population. The sampling frame is drawn from respondents to the National Health Interview Survey, which is conducted by the National Center for Health Statistics. The MEPS-HC collects data from a nationally representative sample of households through an overlapping panel design.

A new panel of sample households is selected each year, and data for each panel are collected for two calendar years. The two years of data for each panel are collected in five rounds of interviews that take place over a 2.5-year period. This provides continuous and current estimates of health care expenditures at both the individual and household level for two panels for each calendar year. To provide estimates that are representative of a national U.S. population, the MEPS-HC panels have oversampled subgroups of individuals such as Hispanics, African-Americans, Asians, low-income households, and those likely to incur high medical expenditures. At the time of the analysis, the most recent available file was for 2015. The 2011–2015 MEPS full-year consolidated, medical, and pharmacy utilization data files were combined to generate an analytical cohort with robust sample size.

SECTION III

Appendix

Table 1. Percent More Likely to Choose Medicare Advantage Relative to FFS Medicare

Race (Compared to Non-Hispanic White)	Percent
Non-Hispanic Black	19.6%
Hispanic	96.8%
Education (Compared to high school)	
Some College	19.5%
College Graduated	19.9%
Income (Compared to those in poverty)	
200-399% ($23,510 - $47,025)	33.2%
Number of Chronic Conditions (Compared to those with no chronic disease)	
1	54.9%
2	64.6%
3	79.3%
4	74.0%
5+	69.4%
Females (Compared to males)	18.4%
Married (Compared to single)	16.3%

Table 2. Logistic Regression for Odds of Selecting Medicare Advantage

	Odds Ratio	Std. Err	t	P>|t|	95% Conf Interval	
Age						
Under 65	0.922	0.089	-0.840	0.403	0.762	1.116
70_74	1.028	0.084	0.340	0.735	0.876	1.207
75_84	1.063	0.084	0.770	0.441	0.909	1.242
85+	1.048	0.101	0.490	0.627	0.867	1.267
Female	1.184	0.050	3.990	0.000	1.089	1.288
Race						
NH Black	1.196	0.132	1.620	0.108	0.961	1.487
NH Other	1.181	0.162	1.210	0.227	0.901	1.549
Hispanic	1.968	0.216	6.180	0.000	1.585	2.442
Married	1.163	0.077	2.290	0.023	1.021	1.325
Education						
Less than HS	1.043	0.084	0.520	0.602	0.890	1.223
Some college	1.195	0.093	2.300	0.023	1.026	1.392
College grad	1.199	0.120	1.820	0.071	0.984	1.461
Percent of poverty						
100-199%	1.176	0.110	1.740	0.084	0.978	1.413
200-399%	1.332	0.120	3.190	0.002	1.116	1.590
400+%	1.177	0.120	1.600	0.12	0.962	1.440
Number of Chronic Conditions						
1_chronic	1.549	0.149	4.540	0.000	1.281	1.874
2_chronic	1.646	0.177	4.620	0.000	1.331	2.036
3_chronic	1.793	0.173	6.030	0.000	1.481	2.170
4_chronic	1.740	0.186	5.180	0.000	1.410	2.149
5+_chronic	1.694	0.162	5.500	0.000	1.402	2.046

NOTE: NH is non-Hispanic

Table 3. Percent With Key Chronic Conditions Among Active Medicare Choosers

	FFS Medicare Only	FFS Medicare - Medigap	Medicare Advantage^	Total
	13,879,028	4,771,504	12,526,481	31,177,013
High Blood Pressure				
No	42.35%	39.88	38.13	40.27
	[40.48,44.24]	[35.8,44.11]	[36.17,40.12]	[38.88,41.68]
Yes	57.65%	60.12	61.87*	59.73
	[55.76,59.52]	[55.89,64.2]	[59.88,63.83]	[58.32,61.12]
Hyperlipidemia				
No	55.13%	50.28	48.82	51.85
	[53.05,57.19]	[45.83,54.73]	[46.75,50.89]	[50.09,53.61]
Yes	44.87%	49.72	51.18*	48.15
	[42.81,46.95]	[45.27,54.17]	[49.11,53.25]	[46.39,49.91]
Arthritis				
No	67.15%	67.14	67.60	67.33
	[65.28,68.97]	[63.57,70.52]	[65.89,69.27]	[66.07,68.57]
Yes	32.85%	32.86	32.40	32.67
	[31.03,34.72]	[29.48,36.43]	[30.73,34.11]	[31.43,33.93]
Heart Disease				
No	72.02%	65.26	71.94	70.96
	[70.36,73.63]	[62,68.37]	[70.14,73.69]	[69.72,72.16]
Yes	27.98%	34.74	28.06	29.04
	[26.37,29.64]	[31.63,38]	[26.31,29.86]	[27.84,30.28]
Endocrine Disorders				
No	73.90%	67.74	71.94	72.17
	[72.14,75.58]	[64.63,70.69]	[69.86,73.94]	[70.81,73.49]
Yes	26.10%	32.26	28.06	27.83
	[24.42,27.86]	[29.31,35.37]	[26.06,30.14]	[26.51,29.19]

Table 3. Continued

	FFS Medicare Only	FFS Medicare - Medigap	Medicare Advantage^	Total
Mental Health				
No	76.05%	75.19	78.10	76.74
	[74.4,77.63]	[72.18,77.98]	[76.42,79.69]	[75.49,77.95]
Yes	23.95%	24.81	21.90	23.26
	[22.37,25.6]	[22.02,27.82]	[20.31,23.58]	[22.05,24.51]
Diabetes				
No	77.35%	82.25	76.30	77.68
	[75.73,78.9]	[79.48,84.71]	[74.65,77.87]	[76.49,78.82]
Yes	22.65%	17.75	23.70	22.32
	[21.1,24.27]	[15.29,20.52]	[22.13,25.35]	[21.18,23.51]
Pulmonary Disorders				
No	78.70%	78.87	79.30	78.97
	[77.08,80.23]	[76.09,81.4]	[77.62,80.9]	[77.83,80.06]
Yes	21.30%	21.13	20.70	21.03
	[19.77,22.92]	[18.6,23.91]	[19.1,22.38]	[19.94,22.17]
Upper GI				
No	80.08%	77.74	80.32	79.82
	[78.43,81.63]	[74.17,80.94]	[78.56,81.98]	[78.56,81.02]
Yes	19.92%	22.26	19.68	20.18
	[18.37,21.57]	[19.06,25.83]	[18.02,21.44]	[18.98,21.44]
Cancer				
No	82.85%	77.35	82.84	82.00
	[81.1,84.46]	[73.91,80.45]	[81.26,84.31]	[80.7,83.23]
Yes	17.15%	22.65	17.16	18.00
	[15.54,18.9]	[19.55,26.09]	[15.69,18.74]	[16.77,19.3]

SOURCE: Tabulations from the Medical Expenditure Panel Survey
* Significantly different from FFS Medicare

Endnotes

[1] Morning Consult, on behalf of the Better Medicare Alliance, conducted an online survey of 1,999 Seniors from July 24 -July 26, 2017. Results from the full survey have a margin of error of +/- 2%

[2] https://www.bettermedicarealliance.org/sites/default/files/2018-07/BMA_Avalere_MA_vs_FFS_Medicare_Report_0.pdf.

[3] https://www.kff.org/medicare/issue-brief/medicare-advantage-2017-spotlight-enrollment-market-update/

[4] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-09-29.html

[5] https://www.healthaffairs.org/do/10.1377/hblog20160121.052787/full/

[6] See for example, http://www.ajmc.com/journals/issue/2015/2015-vol21-n5/care-fragmentation-quality-costs-among-chronically-ill-patients?p=2

[7] http://medpac.gov/docs/default-source/reports/mar17_medpac_ch13.pdf?sfvrsn=0, Table 13-6.

[8] https://www.cms.gov/mmrr/Downloads/MMRR2011_001_03_A03.pdf

[9] https://www.cdc.gov/nchs/data/nvsr/nvsr66/nvsr66_06.pdf

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