Medicare Enrollment and Default Effect

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1. Introduction

1.1 Overall View of Medicare

Medicare is health insurance for people age 65 or older, under age 65 with certain disabilities, and any age with End-Stage Renal Disease (DSRD). Medicare includes Part A (Hospital Insurance such as inpatient hospital care, skilled nursing facility care, blood, health services, hospice care, home health care), Part B (Medical Insurance including Medicare preventive services such as abdominal aortic aneurysm screening, ambulance services, ambulatory surgical centers, bone mass measurement, diabetes screening), Part C (Medicare Advantage Plans-a health coverage option that combines Part A, Part B, and generally Part D coverage) and lastly Part D (Medicare prescription drug coverage). Most of people are automatically enrolled in Medicare Part A and Part B in the first place, but they can make several adjustments to make the plan optimal for them. They are encouraged to make active choices as follows.

① Decide if they want to keep Part B
② Decide how to get their Medicare coverage: whether from Original Medicare(run by the Federal government) or from Medicare Advantage Plan (run by a private insurance company)
③ Decide if they want or need Medicare prescription drug coverage
④ Decide if they want or need Medigap (Medicare Supplement Insurance) policy.

For the most part, standard Medicare Part A and Part B leaves the beneficiary with a large amount of risk, often without dental, vision, long-term care, preventative care or prescription drug coverage. Parts A and B also require rather substantial deductibles and co-payments and do not place a maximum on out-of-pocket expenses. They must have both Medicare Part A and Part B to join a Medicare Advantage Plan. If they choose to join a Medicare Advantage Plan, the plan will generally include Medicare drug coverage and can't use a Medigap policy.

Table 1 shows the Medicare enrollment statistics for 2006. We can see that more than 90% of people choose to keep Plan A and Plan B which is the default option. Among these people who choose to have both Plan A and B, they have an option to choose how to get their Medicare coverage by comparing several different federal and private plans. I went into the official government site for Medicare http://www.medicare.gov/ and tried to see what kind of decision making process 65 age old people have to go through in order to find a Medicare plan they like. By entering zip code 19104, age 65-69, health status good, without drug specifications, they showed 40 plans to compare from. The summary of benefits shows monthly premium, estimated annual cost, drug coverage, doctor choice, vision services, dental services, health plan quality rating, and prescription drug plan quality rating which already overwhelmed me even without looking into the specific detailed terms and policies for each of these plans.

Table 2 shows the enrollment statistics for Medicare + Choice Plans(Former name for Medicare Advantage Plans) between 1995-2003 and Table 3 shows the enrollment monthly statistics summary for 2010 Apr. We can see that most people stay with the government provided Original Medicare (Part A + Part B) and the enrollment rate for Medicare Advantage Plans is only around 3.1%~6.3% (estimated calculation for 2010 is around 3.4%) which is far below our expectation. Because, despite the extra premium, most Medicare Advantage Plans offer significantly more benefits than the Original Medicare do. In fact, in some data set, around 33% of Medicare Advantage Plans charge no additional premium and still offer more benefits.

1.2 Motivation for this paper

This default effect in Medicare is significant and plays an important role in designing the Optimal Health Insurance. The fundamental question that needs to be answered, and has not been answered, is "What are the reasons behind the default effect?". After knowing the reasons for default effect and what reasons play significant role in Medicare choice context, then only we can discuss whether choosing the default option is a rational, optimal choice by the individual or not and talk about the magnitude of the inefficiency in making choices. Further only then, we can run welfare analysis and come up with different prescriptive implications depending on the different reasons for default effect when designing Optimal Medicare System.

2. Literature

2.1 Previous Literature

According to the standard economics, if the default is arbitrarily chosen and if opting out of the

default is easy then defaults should not matter. As long as transaction or switching costs are small and preferences are well defined, the consumer will pick the option that maximizes her utility, irrespective of the design of the choice problem. In practice defaults tend to be sticky. Brigitte Madrian and Dennis F. Shea(2001) consider the effect on the contribution rates in 401(k)s of a change in default. Before the change, the default is nonparticipation in retirement savings; after the change, the default is participation at a 3 percent rate in a money market fund. In both cases, employees can override the default with a phone call or by filing a form; which incurs only a small transaction cost. Nevertheless they find that the change in default has a very large impact; one year after joining the company, the participation rate in 401(k)s is 86 percent for the treatment group and 49 percent for the control group. James J. Choi et al(2004), Henrik Cronqvist and Thaler(2004) show that these findings are robust. They generalize to six companies in different industries and to choices of retirement funds in Sweden respectively.

The literature is less clear-cut on the reasons behind the attractiveness of default options. Why is it that individuals are so much attracted to the defualt? Many potential explanations have been suggested from previous works, and the reasons, most relevant to Medicare plan choice context where elderly people make decisions, could be categorized into four broad groups.

First, the agents with present-biased preferences ("Philps and Pollak 1968; Laibson 1997; O'Donoghue and Rabin 1999b, 2001) may procrastinate in their decisions to opt out of the default. A sophisticated person is correctly pessimistic about her future behavior, while a naive person believes she will behave herself in the future. With immediate costs, even a small present bias can severely harm naive people, making them suffer welfare loss by procrastinating activities. Further providing non-procrastinators with additional choices might induce procrastination in important tasks, since they wish to collect information and reflect on choices with major implications.

Second, it can be due to the cost incurred. There is "Opting Out Cost". The process of opting out of the default may be more or less costly at different times; the health statuses as well as the health related expenditures differ each period and this creates option value of waiting for a low-cost time to take action. Further there is "Searching Cost". Medicare policy relies heavily on beneficiaries making informed choices about their care and their coverage. It is assumed that with information to explain the options, beneficiaries will be able to make choices that fit their individual needs and preferences. However to the extent that gathering information consumes time and money, not all Medicare beneficiaries will make fully informed decisions when choosing among alternative Medicare health plans. The trade-off between spending time and effort on making a decision or on other perhaps more appealing activities, emphasizes the role of complexity of the problem in relation to cognitive ability when determining the attractiveness of default options (Tversky and Shafir (1992), Iyengar and Lepper (2000), Iyengar and Kamenica (2008), Huberman and Jiang(2006)). For example, Agnew and Szykman(2005) provide experimental evidence of financially illiterate participants facing higher costs being more likely to choose the default in complicated exercises and show aversion to taking decisions. Mccarthy and Tchernis(2009) on the other

hand focus on the information gathering cost distribution. Using empirical search model, they estimate the actual determinants of individual consumer's heterogeneous search cost. Lastly Judith H. Hibbard et al point out that beneficiaries view having more choices as a burden.

Third is "Status Quo Bias". Samuelson and Zeckhauser(1988) use this term to describe the tendency for individuals to stick either to their original choices or to the current situation. The basic idea is that this preference is driven by loss aversion and the fact that the status quo serves as a reference point for their loss evaluation. Ritov and Baron(1992) claim that individuals prefer inaction above action, regardless whether the status-quo is maintained or not. This type of inertia is also supported by Kahneman and Tversky(1982) and Landman(1987) who document evidence of individuals regretting an unfortunate situation more if it is the result of an active decision than if it happens becuase the person did not make an active choice.

Lastly, another important motivation for the importance of default options is that the default is seen as an advice or endorsement (Madrian and Shea(2001), Beshears, Choi, Laibson and Madrian(2009)) Individuals who are more sensitive to advice or in general relying more on advice might also be inclined to go along with the default option.

Caroll et al. (2009) introduce a model that can explain heterogeneity in default decisions in 401(k) savings problem. The model is based upon two key assumptions: consumers have present-biased preferences and they trade off costs and benefits of opting out now against opting out later. Federica Teppa and Maarten van Rooij(working paper) try to find the reasons for the default effect in organ donation, voting, having a will, no-consent decisions in marketing and retirement savings. They use of DNB Household survey data in Netherlands to elicit information on the relation between personal traits and choices made in situations with a default option.

2.1 Contribution of this Paper

This paper contributes to the existing literature in a number of ways. First, this is the first paper to look at default effect in Medicare context. The default effect in Medicare significantly differs from that in 401(k) or in organ donation, voting, having a will, no-consent decisions. In 401(k), the savings rate can be changed while working and the uncertainty about the expenditure is realized after retirement. In Medicare the uncertainty about health status and the medical expenditure is realized each period and at the same time the choice over plans can be switched as well. Changes in health status and available choice set characteristics should be Bayesian updated in order to find the optimal contract each period, but if the person fails to recognize new information by mistake or due to high cost in processing the information, default effect will likely to occur.

Further in this paper, the default effect is considered in a dynamic optimization problem model in order to capture the persistency of default effect over time. The conventional literature related to

procrastination assumes onetime cost at the beginning and still shows how agent can delay their actions. In Medicare plan choice problem, uncertainty about health expenditure and health status are realized each period, thus the cost of analyzing the information occurs every period. The procrastination in this case can be even larger. People are eligible to switch their Medicare Advantage Plans between Jan 1-Mar 31 each year without penalties and they can also sign up for or drop from Medicare Advantage Plans as well. However the enrollment statistics show stable trends which indicate that people do not usually change their choices over time and stick to the default effect persistently. (This argument can be proved only after fully running the individual's longitudinal data and structurally estimating the model)

Finally this paper tries to build one testable model incorporating different reasons for default effect in Medicare and tries to find out which reasons play more significant role in explaining the default effect in Medicare context. Despite the standard descriptive theoretical predictions, the default option turns out to be relevant for individual decision making. Thus policy makers need to be careful in framing choice situations as their design is not neutral. Moreover, since the role of default is not driven by a unique determinant, the optimal design of defaults should take into account which reasons plays more important role.

3. Data

The data I will use are Health and Retirement Studies (HRS) and the data collected by Centers for Medicare and Medicaid Services (CMS). I will combine the county code data with the benefit structure data to get one data set consisting of the Medicare plan contract, the plan id, the country code from which this contract operates and the benefit structure of each plan. The variables include,

Premium
Inpatient hospital care
Skilled nursing facility
Co-pay
Hearing services
Home health
Prescription drug coverage
Dental, vision
Physical exam

Medicare Current Beneficiary Survey (MCBS) from CMS provide individual beneficiary characteristics and HRS data also provide a rich source of variables, including longitudinal information.

By merging two data sets, I will be able to exploit the rich information set needed for the model. The relevant data needed are as follow,

Demographic Characteristics (age, race, employment status)
Income
Savings
Medicare Enrollment and Premiums
Other Health Insurance Enrollment and Premiums
Medical Expenditure
Self reported Health Status

Especially State of residence (restricted part of HRS) is required in this research since the Medicare Advantage Plans available for each individual differ state by state.

4. Model

The model is based on Ian M. Mccarthy and Rusty Tchernis (2009) and Eckstein and Wolpin(1989). There are $i=1,\ldots,N$ beneficiaries choosing between $j=1,\ldots,J_i$ different health care plans, where each beneficiary has some search cost, $s_{ti}>0$ each period and the numbers and types of plans available vary by county code. Everyone has information on some characteristics but must engage in costly search in order to become fully informed. Since utilities and search costs are heterogeneous across beneficiaries and also across time, not everyone finds it beneficial to search each period. I assume that those who do not search choose the default plan which is Plan A+B.

The model represents a decision problem of an old individual whose optimization problem begins at age 65. At each age t, shocks to health, income, and medical costs are realized. Upon the realization of these shocks, the agent makes joint decision on whether to search or not p_t, and consumption c_t to maximize the expected life time utility. After deciding how much to consume, the agent saves the remainder. The choice set, D_t, is therefore $D_t=\{p_t, c_t\}$. The timing of the process is as follows:

① Individuals form beliefs about their own benefit of search, b_{it}, determined by the difference between the maximum utility available to them through search and the default option utility without search.
② Buyers decide to search or not, depending on their search cost s_{ti} and discount factor β, δ.
③ If beneficiary i is completely informed after searching, he chooses the highest utility available. Otherwise he chooses the default option.

4.1 Utility Specification

(1) Preference

The per-period utility function is represented by

$$u_t = u(c_t, p_t; t, s_t, H_t, h, \varepsilon_t, K_{t-1}, x_t)$$

where c_t is consumption, p_t decision for search, s_t cost, H_t health status, ε_t the vector of shocks at age t, K_{t-1} the number of prior periods the agent searched and h is unobserved permanent heterogeneity across individuals in their preferences and constraints. Also x_t represents plan characteristics where $x_{jt} = (x_{1j},\ldots,x_{zj})'$ is the Zx1 vector and Z is the number of plan characteristics relevant for the beneficiaries. A period consists of two years in accordance with the Health and Retirement Study (HRS) data interview span. I adopt the following functional form for period-specific utility, which, is not separable in consumption.

$$u_{jt} = \alpha_1 p_t + c_t + \alpha_2 p_t c_t + \alpha_3 p_t K_{t-1} + x_j \beta + h + \varepsilon_t$$

(2) Budget Balance Constraint

$$W_{t+1} = (1+r)W_t + I_t - p_t c_t - s_t - e_t$$

where W_t is her asset level at age t, $I_t = I(i,t;\varepsilon_t)$ is her income, e_t is the medical expenditure at each period including premium and the payment beyond the Medicare coverage. e_t is modeled as a stochastic process of age, income, health status and unobserved permanent heterogeneity.

$$e^*_t = e(t, I_t, H_t, p_t; h, \eta_t)$$

4.2 Search Rule

The assumption is that buyers know their maximum utilities prior to search, but not which plan offers which utility, the beneficiaries need to search to get benefit of

$$b_i = \max\{u_{i1},\ldots,u_{iJ}\} - u_{i0}$$

where u_{i0} is the per period utility from the default option. The cost of searching is assumed to be a function of prior number of searching, years of education.

$$s_{it} = \phi_1 K_{i,t-1} + \phi_2 edu_i + \eta_{it}$$

If $s_{it} < b_{it}$ then the beneficiary I searches and $p_{it} = 1$

4.3 Decision Rule

The objective of the household, then, is to maximize

$$V_{it}(c_{it}, p_{it}, s_{it}; t, H_{it}, h_i, \varepsilon_{it}, K_{it-1}) = \max[u_{it} + \beta(J)\delta EV_{it+1}(c_{it+1}, p_{it+1}, s_{it+1}; t+1, H^{\varepsilon}{}_{it+1}, h^{\varepsilon}{}_i, \varepsilon^{\varepsilon}{}_{it+1}, K^{\varepsilon}{}_{it+1})]$$

$$V_{it+1}(c_{it+1}, p_{it+1}, s_{it+1}; t+1, H^{\varepsilon}{}_{it+1}, h^{\varepsilon}{}_i, \varepsilon^{\varepsilon}{}_{it+1}, K^{\varepsilon}{}_{it}) = \max[u_{it+1} + \delta EV_{it+2}(c_{it+2}, p_{it+2}, s_{it+2}; t+1, H^{\varepsilon}{}_{it+2}, h^{\varepsilon}{}_i, \varepsilon^{\varepsilon}{}_{it+2}, K^{\varepsilon}{}_{it+2})$$

In this paper, the prospective utility function has been used with discount factor $\beta(J)$ in function of number of plan choices.

5. Comparison: Normative Theory vs. Descriptive Theory

In the model I am considering, there are heterogeneous agents and in each period the agents' different health status and searching cost are realized. For each health status, there is uncertainty about health expenditure with probability having MLRP(Monotone Likelihood Ratio Property), There is a default option Plan A+B and the agent decides whether to search for optimal Medicare plan each period.

In normative model where agents fully incorporate the history of health status (including this period) and use exponential utility function, they will choose to search if the benefit of searching for the optimal insurance contract exceeds the searching. The solution to the dynamic optimization problem will depend heavily on the new information; updated belief on the benefit and the realization of searching cost for each period.

However in descriptive theory model, where agents have bounded rationality in Bayesian updating and use hyperbolic utility function, they will likely to procrastinate searching even though the searching cost is smaller than the expected benefit. Hence they will stick to the default plan and this default effect will likely to persist as searching cost function depends on the number of prior searching (reflecting experience or learning effect).

6. Hypothesis Testing

Normative Model: $U_t = E[u_t + \delta u_{t+1} + \delta^2 u_{t+2} + ...]$

Descriptive Model: $U_t = E[u_t + \beta(J)(\delta u_{t+1} + \delta^2 u_{t+2} + ...)]$

The first hypothesis test would be whether $\beta(J) = 1$ or $\beta(J) < 1$. In the latter case, the agent suffers from dynamic inconsistency. The second hypothesis is that

$\frac{\partial \beta(J)}{\partial J} < 0$ i.e. the agent becomes more impatient about future payoffs as the number of available plan choices increases. Therefore at the end, the magnitude of people choosing default effect (not searching) will increase as the number of available plan choice set increases. These hypotheses will be tested by structurally estimating the parameters of the model mentioned above.

7. Prescriptive Implications

Default Suggestions can be socially desirable when a large majority of agents have a shared optimum and the default option leads them to choose it. But even a well-chosen default may be undesirable if agents' optimal choices depend on highly heterogeneous health status shocks and searching costs which the government doesn't know.

In this paper, with the structurally estimated the parameters of the model, we can run counterfactual analysis to discuss the pros and cons of the current Medicare Health Insurance. If both of the hypotheses turn out to be true, then the number of plan choice would affect the default effect in great extent. Increase in choice set might not be a good idea as the normative theory predicts. By varying the number of choices available to individuals, we can find the optimal number of plan choices. Further is it turns out that searching cost is the main reason for the persisting default effect, we need to focus more on the ways to decrease this cost, for example helping people processing the information.

Moreover this study can guide the government in designing the optimal Default plan. We can consider default options that are tailored to each beneficiary based on observable health expenditure and demographic characteristics. However it should be kept in mind that unobserved heterogeneity, for example private information on health status and searching cost, may limit the helpfulness of such beneficiary-specific defaults. Though such differentiated defaults might seem against equal treatment, easiness of switching between the plans with no penalty and aiding old people's decision process by giving suggestions can support the reasons for tailored defaults.

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9. Appendix

9.1 Table 1

Medicare Enrollment - All Beneficiaries: as of July 2006

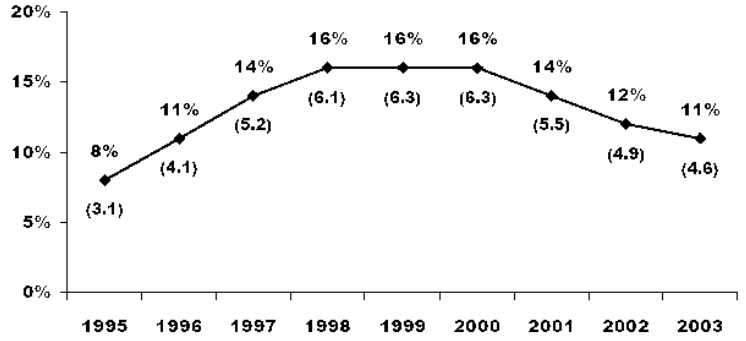
AREA OF RESIDENCE	A and/or B	A ONLY	B ONLY	A and B
[1]U S AND OTHER AREAS	43,313,626	2,922,337	363,040	40,028,249
UNITED STATES	42,020,086	2,366,979	350,725	39,302,382
ALABAMA	765,618	37,267	5,407	722,944
ALASKA	53,897	4,068	158	49,671
ARIZONA	805,398	45,999	7,656	751,743
ARKANSAS	480,392	22,163	500	457,729
CALIFORNIA	4,241,144	257,510	134,843	3,848,791
COLORADO	532,633	33,133	8,394	491,106
CONNECTICUT	526,910	36,767	2,997	487,146
DELAWARE	130,092	7,264	558	122,270
DISTRICT OF COLUMBIA	73,322	10,381	2,198	60,743
FLORIDA	3,063,638	128,407	5,636	2,929,595
GEORGIA	1,063,239	51,650	11,657	999,932
HAWAII	184,344	13,694	738	169,912
IDAHO	196,478	9,069	193	187,216
ILLINOIS	1,701,984	103,292	21,994	1,576,698
INDIANA	914,943	47,459	725	866,759
IOWA	491,147	21,893	982	468,272
KANSAS	403,239	19,353	1,204	382,682
KENTUCKY	689,226	32,262	7,100	649,864
LOUISIANA	615,631	32,081	2,160	581,390
MAINE	238,296	14,075	1,147	223,074
MARYLAND	704,289	58,129	3,094	643,066
MASSACHUSETTS	975,973	79,987	1,116	894,870
MICHIGAN	1,501,655	69,350	1,240	1,431,065
MINNESOTA	708,081	38,931	906	668,244
MISSISSIPPI	458,556	18,485	1,474	438,597
MISSOURI	922,364	50,719	3,146	868,499
MONTANA	150,483	6,591	227	143,665
NEBRASKA	262,576	13,337	414	248,825
NEVADA	303,653	22,239	920	280,494
NEW HAMPSHIRE	190,961	15,664	258	175,039
NEW JERSEY	1,236,113	81,599	19,774	1,134,740
NEW MEXICO	272,594	17,760	4,347	250,487
NEW YORK	2,796,399	208,299	35,797	2,552,303
NORTH CAROLINA	1,300,408	48,788	1,373	1,250,247
NORTH DAKOTA	103,654	5,262	449	97,943
OHIO	1,766,243	92,467	14,401	1,659,375
OKLAHOMA	548,759	26,727	873	521,159
OREGON	547,344	30,639	5,255	511,450
PENNSYLVANIA	2,144,311	135,613	5,287	2,003,411
RHODE ISLAND	173,078	15,915	2,562	154,601
SOUTH CAROLINA	664,399	26,255	4,306	633,838
SOUTH DAKOTA	125,616	6,377	97	119,142
TENNESSEE	937,856	43,042	2,956	891,858
TEXAS	2,597,780	132,050	8,860	2,456,870
UTAH	242,228	15,743	2,465	224,020

9.2 Table 2

Figure 1

Enrollment in Medicare Managed Care/ Medicare+Choice Plans by Beneficiaries, 1995–2003

Percent of Medicare beneficiaries enrolled (and number in millions)



Sources: Gold and Achman, *Medicare+Choice 1999–2001: An Analysis of Managed Care Plan Withdrawals and Trends in Benefits and Premiums,* The Commonwealth Fund, February 2002; Centers for Medicare and Medicaid Services (CMS) Medicare Managed Care Contract Report; CMS 2002 Data Compendium, 2003; and CMS Medicare Enrollment: National Trends, 1966–2001, 2002. 2003 data are for May.

9.3 Table 3

Medicare Advantage, Cost, PACE, Demo, and Prescription Drug Plan Contract Report - Monthly Summary Report (Data as of April 2010)

		Drug Plan Enrollment			Special Needs Plan Enrollment			Employer Plan Enrollees		
Current Contract Summary:	Number of Contracts	MA Only Enrollees	Drug Plan Enrollees	Total Enrollees	SNP Enrollees	Non-SNP Enrollees	Total Enrollees	Employer Plan Enrollees (800 Series Plans)	Non-Employer Plan Enrollees	Total Enrollees
Total *"Prepaid"* Contracts (1)	**699**	**1,551,095**	**10,011,964**	**11,563,059**	**1,280,573**	**10,282,486**	**11,138,555**	**2,040,688**	**9,522,371**	**11,563,059**
Local CCPs	511	578,363	8,081,678	8,660,041	1,190,974	7,469,067	8,660,041	1,303,299	7,356,742	8,660,041
PFFS	47	514,010	1,155,433	1,669,443	0	1,669,443	1,669,443	398,539	1,270,904	1,669,443
MSA	1	597	0	597	0	597	597	0	597	597
Employer Direct PFFS	2	11,633	2,169	13,802	0	13,802	13,802	13,802	0	13,802
Regional PPOs	13	245,391	549,281	794,672	86,394	708,278	794,672	224,237	570,435	794,672
MA Subtotal	***574***	***1,349,994***	***9,788,561***	***11,138,555***	***1,277,368***	***9,861,187***	***11,138,555***	***1,939,877***	***9,198,678***	***11,138,555***
Demos	15	996	4,838	5,834	3,205	2,629		0	5,834	5,834
1876 Cost	22	124,393	200,532	324,925	0	324,925		100,811	224,114	324,925
1833 Cost (HCPP)	12	64,227	0	64,227	0	64,227		0	64,227	64,227
PACE	73	0	18,033	18,033	0	18,033		0	18,033	18,033
Pilot (2)	3	11,485	0	11,485	0	11,485		0	11,485	11,485
Other Subtotal	***125***	***201,101***	***223,403***	***424,504***	***3,205***	***421,299***	***0***	***100,811***	***323,693***	***424,504***
Total PDPs	**93**	**0**	**17,584,086**	**17,584,086**	**0**	**17,584,086**	**17,584,086**	**1,056,293**	**16,527,793**	**17,584,086**
Employer/Union Only Direct Contract PDP	9	0	153,721	153,721	0	153,721	153,721	153,721	0	153,721
All Other PDP (1)	84	0	17,430,365	17,430,365	0	17,430,365	17,430,365	902,572	16,527,793	17,430,365
TOTAL	**792**	**1,551,095**	**27,596,050**	**29,147,145**	**1,280,573**	**27,866,572**	**28,722,641**	**3,096,981**	**26,050,164**	**29,147,145**

Totals reflect enrollment as of the April 1, 2010 payment. The April payment reflects enrollments accepted through March 12, 2010.

(1) Totals include beneficiaries enrolled in employer/union only group plans (contracts with "800 series" plan IDs).

Where a beneficiary is enrolled in both an 1876 cost or PFFS plan and a PDP plan, both enrollments are reflected in these counts.

(2) Pilots refer to contracts to provide care management services for fee-for-service beneficiaries with chronic conditions. The data for this product is being included since they are part of the total monthly Medicare payment.

Table3.xls