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Can Medicare Advantage help contain Medicaid costs? Evidence from dual eligibles

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Abstract

Medicaid spending reached $880 billion in fiscal year 2023, straining federal and state budgets and intensifying efforts to cut costs. Dual eligibles—individuals enrolled in both Medicaid and Medicare—comprised 14% of Medicaid enrollment in 2021 but accounted for 29% of expenditures. This paper studies the intersection of Medicaid and Medicare by comparing not just costs and utilization, but also quality for dual eligibles enrolled in public Traditional Medicare versus those in private Medicare Advantage plans. The results suggest that steering dual eligibles toward Medicare Advantage could yield annual government savings of up to $53.5 billion across Medicare and Medicaid, including $19.8 billion in Medicaid alone, without reducing eligibility. The results also suggest that these cost savings may not come at the expense of quality as measured by annual emergency room visits and beneficiary satisfaction. However, an analysis of switchers between plans reveals 6.36% lower beneficiary satisfaction with quality under Medicare Advantage, and cost savings are dependent on accurate government reimbursements to private insurers.

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1 Introduction

Medicaid, the primary government healthcare program for low-income individuals in the United States, is costly to federal and state governments—$880 billion dollars in fiscal year 2023 (State Health Facts 2025c)—and recently has been targeted for spending cuts. In 2025, the U.S. House of Representatives called for $880 billion in cuts over a decade from the Energy and Commerce Committee, which oversees Medicaid (Rubin 2025).[1] A significant portion of Medicaid beneficiaries are so-called "dual eligibles" who are also enrolled in Medicare, which is primarily for those 65 and older, and who have the option to choose the public Traditional Medicare (TM) or a private Medicare Advantage (MA) plan that is reimbursed by the government. In 2021, dual eligibles made up 14% of total Medicaid enrollment (State Health Facts 2025a) but accounted for a disproportionate 29% of total Medicaid spending (State Health Facts 2025b).

A common proposal for reducing Medicaid costs is to set stricter eligibility requirements and simply eliminate coverage for a large number of beneficiaries. A version of this is what is expected to be achieved by work requirements imposed by the "One Big Beautiful Bill Act" of 2025.[2] Our question is whether future reforms targeted specifically at dual eligibles can provide a source of cost savings that lessens the need to remove beneficiaries' coverage altogether. Additionally, we ask what this might mean for dual eligibles' own satisfaction with their care. Thus, this paper studies not just the costs, but also the quality of care for the dual-eligible population using Medicare Current Beneficiary Survey (MCBS) data from the Centers for Medicare & Medicaid Services (CMS). Specifically, we focus on differences between dual eligibles in MA and TM and consider their implications for cost savings and beneficiary satisfaction under potential policy reforms.

This paper contributes to the literature comparing MA and TM in several ways. While some studies have examined differences in costs, utilization, and selection between Medicare Advantage (MA) and Traditional Medicare (TM) (Brown et al. 2014; Newhouse et al. 2015; Park et al. 2020; Schwartz et al. 2021), most concentrate on the broader Medicare population and do not disaggregate findings for dual eligibles—or if they do, dual eligibles are not the primary focus (Curto et al. 2019; DeDad et al. 2025). By focusing on dual eligibles, we provide important context for a population that is a major driver of costs in both Medicare and Medicaid and is among the most medically complex and vulnerable groups in either program. Some studies have focused on dual eligibles (Coughlin et al. 2012; Roberts and Mellor 2022; Roberts et al. 2024), however, they have had a narrower scope rather than providing an overall assessment of costs and quality in MA vs. TM. Also, most existing studies have been primarily descriptive, reporting unconditional

[1] The Congressional Budget Office determined that, from 2025-2034, 93% of the non-Medicare spending overseen by the committee would be accounted for by Medicaid. See https://www.cbo.gov/system/files/2025-03/61235-Boyle-Pallone.pdf.

[2] See Hinton et al. (2025).

differences, whereas we provide more precise estimates that control for beneficiary risk, time, and a large number of demographic variables.

We also contribute by focusing on more than just cost savings by coupling our analysis of costs and utilization with a study of quality, allowing us to examine how potential cost savings may affect beneficiary experiences. Our baseline analysis compares costs and quality for dual eligibles enrolled in MA versus TM, controlling for observable characteristics to produce conditional estimates of differences across plan types. To assess the influence of selection on these results, we complement this analysis with a within-beneficiary comparison of individuals who switched between MA and TM. Although the number of switchers is small and switching behavior itself is likely endogenous, this approach helps to evaluate how outcomes change when the same beneficiary moves between plan types, offering insight into the role of time-invariant unobserved factors such as preferences or unobserved dimensions of health that influence plan choice.

There are several reasons to expect differences between dual eligibles in MA and those in TM. First, MA plans frequently include additional benefits, such as dental, vision, and hearing coverage, that are not available under TM. Furthermore, MA plans include annual out-of-pocket maximums, providing greater financial predictability compared to TM, which lacks this feature. MA also offers Special Needs Plans (SNPs) and Medicare-Medicaid Plans (MMPs) for dual-eligible individuals, which coordinate care and streamline access to both Medicare and Medicaid benefits (Social Security Administration 2026). Conversely, TM may appeal to those who value flexibility in provider choice, as MA plans have restricted provider networks.

While Medicare is administered at the federal level, Medicaid is administered at the state level but is jointly funded by federal and state governments. Thus, the exact structure of Medicaid varies from state-to-state, which has resulted in large differences in TM vs. MA enrollment, ranging from only 25% of full-benefit dual eligibles in Arizona being enrolled in TM in 2021 to 99% in Alaska (Peña et al. 2024). Nationally, of the 11.6 million dual eligibles in 2022, 7 million were enrolled in MA plans and 4.6 million were enrolled in TM (Ochieng et al. 2024). While MA plans are privately administered, they are reimbursed by the government, and overpayment is an ongoing concern (Medicare Payment Advisory Commission 2025) that inflates the government's total costs. Thus, the exact nature of sorting into MA and TM is key for federal and state government budgets. In this study, however, we control for risk to provide a fairer comparison of program fundamentals rather than the influence of favorable selection.

2 Data

We use data from the MCBS Cost Supplement and Survey files for years 2015 through 2019 and include in our sample beneficiaries who qualified for Medicare based on the

traditional age-based eligibility requirements. The data include a comprehensive set of beneficiary socioeconomic and health characteristics as well as health care expenditures at both the annual and specific health care event levels. We classify a beneficiary as having Medicaid if they had coverage at any time in a given year and, following Brown et al. (2014), as having MA or TM based on the coverage they possessed for the majority of their eligibility period that year. We also control for risk based on chronic conditions and perceived health using survey data, which helps to avoid errors in scoring due to upcoding (e.g., see Nicholas et al. 2024). Details about variable construction and summary statistics are reported in appendix tables AI and BI, respectively. On average, Medicaid beneficiaries in MA are slightly younger, more likely to be racial minorities, have higher risk scores, and are less highly educated than those in TM.

As an initial investigation into how the distributions of observed medical events and costs differed for Medicaid beneficiaries in MA vs. TM, we conducted Mann-Whitney U tests for annual total events, prescribed medicine (PM) events, non-PM/emergency room (ER) events, and ER events. We also analyze annual differences between total costs and out-of-pocket (OOP) costs for each beneficiary to measure the cost to all payers other than the beneficiary (i.e., the government and/or private insurers). The results in Table I provide initial, unconditional evidence that the overall number of medical events was lower for Medicaid beneficiaries in MA than for those in TM, while PM events were higher and ER events were not significantly different. Median annual total costs to all payees other than the beneficiary were almost three times higher for those in TM+Medicaid and almost five times higher for non-PM/ER events, specifically. We also find that per-event total and OOP costs for Non-PM/ER events were both slightly higher for those in MA than those in TM.

Table I: Mann-Whitney Tests
Medians for MA vs. TM, 2015-2019

	MA + Medicaid	Difference	TM + Medicaid
Annual Totals	(N=3,552)		(N=4,827)
Events			
Total Events$_{it}$	53 (72.8)	$<^{***}$	72 (103)
PM Events$_{it}$	34 (46.3)	$>^{***}$	22 (42.9)
Non-PM/ER Events$_{it}$	11 (26.3)	$<^{***}$	38 (59.9)
ER Events$_{it}$	0 (0.281)	=	0 (0.288)
Total-OOP Cost			
Total Events$_{it}$	\$5,944 (\$15,789)	$<^{***}$	\$15,023 (\$30,329)
PM Events$_{it}$	\$1,571 (\$4,832)	=	\$1,586 (\$4,794)
Non-PM/ER Events$_{it}$	\$1,689 (\$10,056)	$<^{***}$	\$8,002 (\$24,859)
ER Events$_{it}$	\$178 (\$681)	$<^{***}$	\$370 (\$1,003)
Per Event	(N=50,732)		(N=224,690)
Total Cost			
Non-PM/ER Events$_{it}$	\$80.00 (\$850)	$>^{***}$	\$75.27 (\$625)
OOP Cost			
Non-PM/ER Events$_{it}$	\$0 (\$142)	$>^{***}$	\$0 (\$98)

Note: Means in parentheses. The middle column indicates the direction of inequality, and asterisks indicate the level of statistical significance from two-sided Mann-Whitney tests of differences in distributions. = indicates failure to reject the null hypothesis of no shift in the distributions. *p<0.1; **p<0.05; ***p<0.01.

3 Empirical Methodology and Results

3.1 Annual Medical Events

In our formal empirical analysis, we first focus on annual medical events of dual eligibles. To model the count of medical events, we use a negative binomial model rather than a Poisson model due to significant overdispersion. We estimate a negative binomial (NB2) model with conditional mean for the number of events e given by equation (1) allowing for overdispersion through the variance specification $\text{Var}(e_{i,p,t}) = \mu_{i,p,t} + \alpha\mu^2_{i,p,t}$, where

$\mu_{i,p,t} = E(e_{i,p,t})$:

$$E(e_{i,p,t}) = \exp\left[\log(M_{i,t}) + \boldsymbol{\delta'_{i,t}} + \beta R_{i,t} + \sum_p \rho_p \left(R_{i,t} \times \mathbb{1}_{i,p,t}\right) + \sum_p \gamma_p \mathbb{1}_{i,p,t}\right] \quad (1)$$

for all individuals i enrolled in plan p in year t, where p is either MA+Medicaid or TM+Medicaid. $\boldsymbol{\delta'_{i,t}}$ is a vector of controls summarized in Table BI, $R_{i,t}$ is the risk score as described in Table AI, and $\mathbb{1}_{i,p,t}$ is a dummy variable equal to 1 if beneficiary i in time t is enrolled in plan p and to 0 otherwise. MA+Medicaid is the base category. $M_{i,t}$ is the number of months the beneficiary i is eligible for medicare in year t. It is the offset variable to allow for difference in the duration of observation. We also include the interaction of risk and the TM dummy variable to quantify how the association between risk and the number of events differs for those in TM vs. MA. At the same level of risk, if MA attracts beneficiaries with lower utilization, we would expect this coefficient to be positive.

Included in the vector $\boldsymbol{\delta'_{i,t}}$ are several key controls. We include an indicator for Part D prescription drug coverage, since Part D participation may affect prescription drug event utilization and substitution across event types. Although both TM and MA beneficiaries are eligible for Part D, MA plans more often bundle drug coverage. Controlling for Part D participation helps prevent confounding in comparisons between TM and MA by explicitly estimating differences in the propensity to utilize healthcare associated with prescription drug coverage. Additionally, as some beneficiaries are only enrolled in MA or TM for part of the year, we include a control for the number of months eligible and dummy variables for age 65 and death, circumstances which account for 85% of part-year observations.

The results in Table II indicate that, among beneficiaries with average risk, those enrolled in TM experienced 53% more total events and 144% more non-prescribed-medicine (non-PM), non-ER events than those in MA.[3] However, the number of ER events did not significantly differ between the two. Higher risk was associated with more events, but the interaction term indicates that this relationship was not significantly different for MA relative to TM.

[3]To calculate these numbers, we exponentiate the sum of the TM+Medicaid coefficient and the TM+Medicaid×Full Risk interaction evaluated at the average risk score of 16.6, subtract 1, and multiply by 100. For example, the estimated difference in total events between TM and MA is as follows: $(\exp(0.509 + (-0.005 \times 16.6)) - 1) \times 100 \approx 53\%$.

Table II: Impact of Medicare Coverage on Annual Medical Events

	Dependent variable:			
	Total Events$_{it}$	PM Events$_{it}$	Non-PM/ER Events$_{it}$	ER Events$_{it}$
	(1)	(2)	(3)	(4)
TM + Medicaid$_{it}$	0.509***	−0.211**	1.057***	0.090
	(0.079)	(0.086)	(0.125)	(0.240)
Part D$_{it}$	0.631***	1.405***	0.338***	0.141
	(0.065)	(0.087)	(0.073)	(0.189)
Full Risk$_{it}$	0.053***	0.050***	0.053***	0.070***
	(0.003)	(0.003)	(0.006)	(0.011)
TM + Medicaid$_{it}$ × Full Risk$_{it}$	−0.005	0.014***	−0.010	−0.006
	(0.004)	(0.004)	(0.007)	(0.012)
Constant	−0.301	−1.035***	−1.410***	−6.112***
	(0.188)	(0.181)	(0.272)	(0.677)
Demographic Controls	Y	Y	Y	Y
Year FE	Y	Y	Y	Y
Observations	8,379	8,379	8,379	8,379

Note: Estimation performed using negative binomial regression. Full risk measure determined by survey responses to questions of chronic risk, perception of health risk, and mental health status as described in Table AI. Demographic controls include age (demeaned), racial minority status, annual income (in logs, transformed as log(1 + x)), education level relative to high school diploma, gender, CBSA designation, number of months eligible in the year, age 65 dummy variable, and death dummy variable. Survey weights are used for the ever-enrolled Medicare population. Robust standard errors in parentheses. *p<0.1; **p<0.05; ***p<0.01.

3.2 Annual Differences between Total and Out-of-Pocket Costs

To analyze differences in annual per beneficiary costs to the government and/or private insurers, we estimate the following equation, with the difference between total and out-of-pocket costs ($\overline{C} - \overline{c}$) as the dependent variable:

$$\overline{C}_{i,p,t} - \overline{c}_{i,p,t} = \boldsymbol{\delta}'_{\boldsymbol{i,t}} + \beta R_{i,t} + \sum_p \rho_p \left(R_{i,t} \times \mathbb{1}_{i,p,t} \right) + \sum_p \gamma_p \mathbb{1}_{i,p,t} + \epsilon_{i,p,t}, \tag{2}$$

where the variables on the right-hand side are as defined under equation (1), and months of eligibility $M_{i,t}$ is now included in $\boldsymbol{\delta}'_{\boldsymbol{i,t}}$.

Column (1) of Table III shows that annual cost differences per average-risk TM beneficiary were $11,621 higher compared to those of the same risk in MA.[4] This implies that the 4.6 million Medicaid beneficiaries in TM cost roughly $53.5 billion more than would

[4]To calculate this number, we add the TM+Medicaid coefficient and the TM+Medicaid×Full Risk interaction evaluated at the average TM risk score of 16.2 (i.e., $9{,}580 + (126 \times 16.2) \approx 11{,}621$).

be expected had they been enrolled in MA. With 37% of spending on dual-eligibles coming from Medicaid (MedPAC/MACPAC 2024), this represents $19.8 billion in potential annual cost savings to Medicaid if all dual eligibles were enrolled in MA plans. Thus, over 10 years, unadjusted for expected inflation, total savings could be up to $198 billion. These national aggregates hide heterogeneous policy effects across states. The differences in savings across states would depend on existing state-level differences in MA and TM enrollment. While we reach this result by including many controls, it should be interpreted as an upper bound, since unobserved factors and preferences may still explain part of the higher utilization among those in TM and may lead to higher utilization even if they switched to MA. Lastly, while Table II showed no difference in the quantity of ER events, Table III shows that ER costs were significantly higher under TM.

Table III: Impact of Medicare Coverage on Annual Cost Differences

	Dependent variable:			
	Total Diff.$_{it}$	PM Diff.$_{it}$	Non-PM/ER Diff.$_{it}$	ER Diff.$_{it}$
	(1)	(2)	(3)	(4)
TM + Medicaid$_{it}$	9,580***	−23	11,074***	1,132**
	(2,001)	(958)	(1,812)	(475)
Part D$_{it}$	5,715***	2,737***	3,423***	368
	(1,267)	(384)	(1,312)	(334)
Full Risk$_{it}$	140**	231***	−206***	44**
	(69)	(46)	(49)	(18)
TM + Medicaid$_{it}$ × Full Risk$_{it}$	126	35	11	−48**
	(112)	(54)	(97)	(22)
Constant	−16,037***	−6,462***	−7,096	723
	(4,671)	(1,812)	(4,547)	(1,052)
Demographic Controls	Y	Y	Y	Y
Year FE	Y	Y	Y	Y
Observations	8,379	7,745	8,121	1,573

Note: Estimation performed using OLS regression. Full risk measure determined by survey responses to questions of chronic risk, perception of health risk, and mental health status as described in Table AI. Demographic controls include age (demeaned), racial minority status, annual income (in logs, transformed as log(1 + x)), education level relative to high school diploma, gender, CBSA designation, number of months eligible in the year, age 65 dummy variable, and death dummy variable. Survey weights are used for the ever-enrolled Medicare population. Columns (2) and (4) have fewer observations, because not all beneficiaries report PM or ER events, and column (3) has fewer observations because some beneficiaries report only PM or ER events. Robust standard errors in parentheses. *p<0.1; **p<0.05; ***p<0.01.

3.3 Quality of Care

If cost savings are sought by increasing enrollment in MA, it is important to consider what impact this might have on the quality of care. The observed similarity in ER events between TM and MA suggests comparable quality along this dimension. However, regarding beneficiaries' satisfaction with quality, we estimate a modified version of the specification in equation (2) using the Reverse Quality Index (RQI) of DeDad et al. (2025) as the dependent variable. The RQI uses beneficiaries' ratings of their perception of the quality of care on a $\{1, 2, 3, 4\}$ scale, where 1 represents "very satisfied," 2 "satisfied," 3 "unsatisfied," and 4 "very unsatisfied." Thus, lower values represent higher quality. Specifically, we estimate the following equation:

$$Q_{i,p,t} = \boldsymbol{\delta'_{i,t}} + \beta R_{i,t} + \sum_p \rho_p \left(R_{i,t} \times \mathbb{1}_{i,p,t} \right) + \sum_p \gamma_p \mathbb{1}_{i,p,t} + \epsilon_{i,p,t}, \tag{3}$$

where $Q_{i,p,t}$ is the RQI for beneficiary i in plan p in year t, and all other variables are as defined under equation (1), with the exception of age 65 and death dummies that were used in the models for annual totals.

We consider one sample that includes the full cross-section of beneficiaries and another that only includes a balanced panel of beneficiaries who appear in two consecutive years from 2015–2019. The results in Table IV show no significant difference in beneficiary satisfaction between MA and TM in both the full cross-section and a two-year balanced panel. However, we also analyze switchers between TM and MA, as they have experienced both plans and have a constant process of quality assessment. Column (2) of Table V reports RQIs for switchers from MA to TM in the years before and after the switch. The mean RQI decreased by roughly 7% (from 1.75 to 1.63), indicating greater satisfaction with quality after switching to TM. Likewise, Table VI shows that switchers from TM to MA were roughly 7% less satisfied with quality after the switch (from 1.62 to 1.73). Combining the results for all switchers in Tables V and VI, the weighted average of RQI of TM among switchers was 6.36% lower than that of MA, indicating a 6.36% greater satisfaction with the quality of care in TM than in MA.[5] It is important to note, however, that the number of switchers is small in each direction, with 16 beneficiaries switching from MA to TM and 74 switching from TM to MA. As a result, these estimates should be interpreted with caution and may not be representative of the broader dual-eligible population.

[5]The average RQI for switchers to or from TM when they were in TM is calculated as $\frac{(16\times 1.63+74\times 1.62)}{16+74} = 1.62$, and the average RQI for switchers to or from MA when they were in MA is calculated as $\frac{(16\times 1.75+74\times 1.73)}{16+74} = 1.73$.

Table IV: Impact of Medicare Coverage on Satisfaction with Quality of Care

	Cross-Section	*Two-Year Panel*
	Quality_{it}	
	(1)	(2)
$\text{TM + Medicaid}_{it}$	0.063	0.020
	(0.060)	(0.070)
Part D_{it}	0.011	0.005
	(0.044)	(0.066)
Full Risk_{it}	0.013^{***}	0.012^{***}
	(0.002)	(0.003)
$\text{TM + Medicaid}_{it} \times \text{Full Risk}_{it}$	-0.003	-0.001
	(0.003)	(0.004)
Constant	1.528^{***}	1.465^{***}
	(0.158)	(0.167)
Demographic Controls	Y	Y
Year FE	Y	Y
Observations	5,320	4,635
R^2	0.041	0.036
Adjusted R^2	0.038	0.033

Note: Full risk measure determined by survey responses to questions of chronic risk, perception of health risk, and mental health status as described in Table AI. Demographic controls include age (demeaned), racial minority status, annual income (in logs, transformed as log(1 + x)), education level relative to high school diploma, gender, and CBSA designation. Survey weights are used for the ever-enrolled Medicare population (2-year longitudinal weights for Column (2)). Column (1) has fewer observations than the utilization analysis due to a smaller number of responses to satisfaction with care questions, and column (2) is further restricted due to the requirement that beneficiaries appear in the data for two consecutive years. Robust standard errors in parentheses. $^{*}p<0.1$; $^{**}p<0.05$; $^{***}p<0.01$.

Table V: Quality of Care Satisfaction: MA+Medicaid in Year 0

MA+Medicaid in Year 0	Non-Switchers	Switchers	All
	(N=895)	(N=16)	(N=911)
Year 0 (before switching)			
Mean (SD)	1.60 (0.610)	1.75 (0.577)	1.61 (0.609)
Median [Min, Max]	2.00 [1.00, 4.00]	2.00 [1.00, 3.00]	2.00 [1.00, 4.00]
Year 1 (after switching)			
Mean (SD)	1.62 (0.613)	1.63 (0.619)	1.62 (0.613)
Median [Min, Max]	2.00 [1.00, 4.00]	2.00 [1.00, 3.00]	2.00 [1.00, 4.00]

Note: Sample constructed as the two-year balanced panel of beneficiaries. Quality_{it} refers to satisfaction with the quality of medical care received within the year, with responses that range from very satisfied (1) to very dissatisfied (4). Other responses to these survey questions, such as a beneficiary not knowing or refusing to answer, are considered missing.

Table VI: Quality of Care Satisfaction: TM+Medicaid in Year 0

TM+Medicaid in Year 0	Switchers	Non-Switchers	All
	(N=74)	(N=907)	(N=981)
Year 0 (before switching)			
Mean (SD)	1.62 (0.566)	1.63 (0.610)	1.63 (0.606)
Median [Min, Max]	2.00 [1.00, 3.00]	2.00 [1.00, 4.00]	2.00 [1.00, 4.00]
Year 1 (after switching)			
Mean (SD)	1.73 (0.688)	1.62 (0.572)	1.63 (0.582)
Median [Min, Max]	2.00 [1.00, 4.00]	2.00 [1.00, 4.00]	2.00 [1.00, 4.00]

Note: Sample constructed as the two-year balanced panel of beneficiaries. Quality_{it} refers to satisfaction with the quality of medical care received within the year, with responses that range from very satisfied (1) to very dissatisfied (4). Other responses to these survey questions, such as a beneficiary not knowing or refusing to answer, are considered missing.

4 Conclusion

This study finds that dual eligibles enrolled in TM experience higher annual total event counts and costs compared to those in MA. The annual difference in the government and/or private insurers costs was estimated to be up to $53.5 billion higher for TM beneficiaries than if they were enrolled in MA. Thus, if reimbursements to private insurers are closely aligned with actual costs, this implies that significant cost savings for Medicare and Medicaid could be achieved, without dropping beneficiaries from Medicaid, if all

dual eligibles were in MA plans. The results also suggest that these cost savings may not reduce quality, as measured by ER visit frequency and beneficiary satisfaction. However, an analysis of switchers indicates 6.36% lower satisfaction with quality of care under MA. It is important to note that, even with the many controls in our analysis, there could still be unobserved differences between those who choose MA or TM that might prevent them from fully changing their behavior if they were forced to switch to MA. Thus, our results should be interpreted as an upper bound. Additionally, any policies encouraging MA enrollment would likely induce heterogeneous responses across states, as some already have high MA enrollment among dual eligibles. In such cases, opportunities for policy reform and cost savings related to enrollment in MA versus TM would be more limited. Taken together, however, these findings have important implications for future Medicaid policy.

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Appendices

A Risk Score

Table AI: Construction of Full Risk Score Measure

Survey Question	Lowest Risk Response	Highest Risk Response
General Health Survey		
General health compared others same age	0	4
General health compared to one year ago	0	4
How rate health 6 months from now	0	4
Limited social activities (past month)	0	3
BMI Categories (kg/m^2)	0	3
Demographic Survey		
Income to Poverty Ratio	0	4
Chronic Conditions Survey		
Hysterectomy (ever)	0	1
Hardening of arteries (ever)	0	1
Hypertension/high BP (ever)	0	1
MI/heart attack (ever)	0	1
Angina pectoris/CHD (ever)	0	1
Congestive heart failure (ever)	0	1
Problems with heart valves (ever)	0	1
Problems with heart rhythm (ever)	0	1
Other heart conditions (ever)	0	1
Stroke/brain hemorrhage (ever)	0	1
High cholesterol (ever)	0	1
Skin cancer (ever)	0	1
Body part cancer (ever)	0	1
One for each: colon/bowel/rectum, breast, uterus, prostate, bladder, ovary, stomach, cervix, brain, kidney, throat, head, back, female organs, other		
Rheumatoid arthritis (ever)	0	1
Non-rheumatoid arthritis (ever)	0	1
Mental retardation (ever)	0	1
Alzheimer's (ever)	0	1
Dementia (ever)	0	1
Depression (ever)	0	1
Mental disorder (not depress) (ever)	0	1
Osteoporosis/soft bones (ever)	0	1
Broken hip (ever)	0	1
Parkinson's disease (ever)	0	1
Emphyseman/asthma/COPD (ever)	0	1
Complete/partial paralysis (ever)	0	1
Lost an arm or a leg (ever)	0	1
Enlarged prostate (ever)	0	1
Diabetes/high blood sugar (ever)	0	1
How often felt sad/depressed (past year)	0	4
Lost interest (past year)	0	1
How often lost urine control (past year)	0	7
Told on 2+ visits had high BP (ever)	0	1
SUM TOTAL: Full Risk Score Measure	0	78

B Summary Statistics

Table BI: Demographic Summary by Coverage

	MA + Medicaid	TM + Medicaid
	(N=3552)	(N=4827)
Year		
2015	652 (18.4%)	1204 (24.9%)
2016	578 (16.3%)	1019 (21.1%)
2017	686 (19.3%)	944 (19.6%)
2018	742 (20.9%)	840 (17.4%)
2019	894 (25.2%)	820 (17.0%)
Part D Coverage **(Indicator)**		
0	38 (1.1%)	647 (13.4%)
1	3514 (98.9%)	4180 (86.6%)
Full Risk **(Aggregated Health Score)**		
Mean (SD)	17.2 (6.32)	16.2 (6.63)
Median [Min, Max]	16.0 [4.00, 42.0]	14.0 [2.00, 45.0]
Age **(Years)**		
Mean (SD)	78.8 (8.79)	79.6 (9.86)
Median [Min, Max]	79.0 [65.0, 104]	80.0 [65.0, 107]
Death (Indicator)		
Mean (SD)	0.147 (0.354)	0.202 (0.401)
Median [Min, Max]	0 [0, 1.00]	0 [0, 1.00]
Number of Months Eligible		
Mean (SD)	10.7 (2.92)	10.0 (3.35)
Median [Min, Max]	12.0 [1.00, 12.0]	12.0 [1.00, 12.0]
Age 65 (Indicator)		
Mean (SD)	0.0659 (0.248)	0.112 (0.315)
Median [Min, Max]	0 [0, 1.00]	0 [0, 1.00]
Race **(Indicator)**		
Unknown	19 (0.5%)	35 (0.7%)
White	1733 (48.8%)	3103 (64.3%)
Black	677 (19.1%)	698 (14.5%)
Other	26 (0.7%)	46 (1.0%)
Asian	76 (2.1%)	166 (3.4%)
Hispanic	1004 (28.3%)	723 (15.0%)
NA Native	17 (0.5%)	56 (1.2%)
Income **($)**		
Mean (SD)	20584 (28716)	24984 (38289)
Median [Min, Max]	13252 [0, 713300]	13300 [0, 1004000]
High School Education **(Categorical)**		
1 (<HS)	1577 (44.4%)	1903 (39.4%)
2 (HS)	959 (27.0%)	1390 (28.8%)
3 (>HS)	1016 (28.6%)	1534 (31.8%)
Sex **(Categorical)**		
Male	1247 (35.1%)	1710 (35.4%)
Female	2305 (64.9%)	3117 (64.6%)
CBSA Designation		
Metro	3038 (85.5%)	3340 (69.2%)
Micro	341 (9.6%)	909 (18.8%)
Rural	173 (4.9%)	577 (12.0%)

Note: The sample includes the ever-enrolled Medicare beneficiaries in the 2015-2019 Medicare Current Beneficiary Survey. MA + Medicaid and TM + Medicaid status determined by which coverage beneficiaries possessed through the majority of their eligibility period in a given year. Part D status equals 1 if covered for majority of eligibility period in a given year. Full risk measure determined by survey responses to questions of chronic risk, perception of health risk, and mental health status as described in Table AI.