CHAPTER 4

The Medicare Advantage program

RECOMMENDATIONS

(For previous recommendations on improving the Medicare Advantage program, see text box on p. 261.)

CHAPTER 4

The Medicare Advantage program

Chapter summary

The Medicare Advantage (MA) program allows Medicare beneficiaries to receive benefits from private plans rather than from the traditional fee-for-service (FFS) program. The Commission supports private plans in the Medicare program; beneficiaries should be able to choose between the traditional FFS Medicare program and the alternative delivery systems that private plans can provide. Private plans have greater potential to innovate and to use care management techniques and, if paid appropriately, would have more incentive to do so.

The Commission also supports financial neutrality between FFS and the MA program. Financial neutrality means that the Medicare program should not pay MA plans more than it would have paid for the same set of services under FFS. Currently, Medicare spends more under the MA program than under FFS for similar beneficiaries. This higher spending results in increased government outlays and higher beneficiary Part B premiums (including higher premiums for beneficiaries in FFS) at a time when both the Medicare program and its beneficiaries are under increasing financial stress.

Most indicators of program performance—enrollment, plan availability, and quality of care—are generally positive or stable, but another measure—costliness—precludes MA from achieving its goal to be efficient relative to

In this chapter

FFS. MA enrollment continued to grow through 2009. Compared to 2008, when 22 percent of beneficiaries were enrolled in MA plans, as of November 2009, 24 percent of Medicare beneficiaries—10.9 million—were enrolled in nearly 4,890 MA plans. Payments to MA plans increased from $93 billion in 2008 to $110 billion in 2009. This amount represents 26 percent of all Medicare expenditures in 2009. In 2009, Medicare spent roughly $14 billion dollars more for the beneficiaries enrolled in MA plans than it would have spent if they had stayed in FFS Medicare. To support the extra spending, Part B premiums were higher for all Medicare beneficiaries (including those in FFS). CMS estimated that the Part B premium was $3.35 per month higher in 2009 than it would have been if spending for MA enrollees had been the same as in FFS.

In 2010, an MA plan of some type is available to all Medicare beneficiaries and a coordinated care plan is available to almost all. Eighty-five percent of beneficiaries have access to an MA plan that includes Part D drug coverage and has no premium (beyond the Medicare Part B premium), and access to MA special needs plans is greater than in 2009. On average, beneficiaries can choose from 21 different plans in their county of residence. ■

Previous Commission recommendations on the Medicare Advantage program

Medicare Advantage (MA) recommendations from the June 2005 report are summarized below:

The Congress should set the benchmarks that CMS uses to evaluate MA plan bids at 100 percent of the fee-for-service (FFS) costs. The Commission has consistently supported the concept of financial neutrality between payment rates for the FFS program and private plans.

In conjunction with the preceding recommendation, the Commission recommended that **the Congress should also redirect Medicare's share of savings from bids below the benchmarks to a fund that would redistribute the savings back to MA plans based on quality measures.** Pay-for-performance should apply in MA to reward plans that provide higher quality care.

The Secretary should calculate clinical measures for the FFS program that would permit CMS to compare the FFS program with MA plans. The Commission believes more can be done to facilitate beneficiary choice and decision making by enabling a direct comparison between the quality of care in private plans and quality in the FFS system. ■

Current status of the MA program

By some measures, the Medicare Advantage (MA) program appears to be successful, but excessive payment rates preclude the program from achieving desired efficiencies. MA enrollment continues to increase, MA plans are widely available to beneficiaries, and plans provide enhanced benefits for their members. However, taxpayers and beneficiaries in traditional FFS Medicare subsidize these benefits, often at a high cost. Therefore, over the past few years the Commission has made several recommendations to improve the MA program (see text box).

Our analysis of the MA program uses the most recent data available and reports results by plan type. The plan types are:

- HMOs and local preferred provider organizations (PPOs)—These plans have provider networks and can use tools such as selective contracting and utilization management to coordinate and manage care. These plans can choose to serve individual counties and can vary their premiums and benefits across counties.
- Regional PPOs—These plans are required to offer a uniform benefit package and premium across designated regions made up of one or more states. They are the only plan type required to have limits, or caps, on out-of-pocket expenditures. Regional PPOs have less extensive network requirements than local PPOs.
- Coordinated care plans (CCPs)—This category includes all HMOs, local PPOs, and regional PPOs.
- Private FFS (PFFS) plans—These plans typically do not have provider networks. They use Medicare FFS payment rates, have fewer quality reporting requirements, and have less ability to coordinate care than other plan types.

Two additional plan classifications cut across plan types. First are special needs plans (SNPs), which offer benefits packages tailored to specific populations (i.e., beneficiaries who are dually eligible for Medicare and Medicaid, institutionalized, or have a chronic condition). SNPs must be CCPs. Second are employer-group plans, which are available only to Medicare beneficiaries who are members of employer or union groups that contract with those plans. Employer-group plans may be any plan type. Both SNPs and employer-group plans are included in our plan data, with the exception of plan availability figures, as these plans are not available to all beneficiaries.

Plan enrollment grew in 2009

From November 2008 to November 2009, enrollment in MA plans grew by 10 percent, or 1.0 million enrollees, to 10.9 million beneficiaries, or 24 percent of all Medicare beneficiaries (Table 4-1, p. 262).

TABLE 4–1

Medicare Advantage enrollment grew rapidly in 2009

	MA enrollment (in millions)		Percent change	2009 MA enrollment as a share of total Medicare
	November 2008	November 2009		
Total	9.9	10.9	10%	24%
Urban	8.5	9.3	9	26
Rural	1.4	1.6	14	15
Plan type				
CCP	7.6	8.4	12	18
HMO	6.5	7.0	7	15
Local PPO	0.7	1.0	42	2
Regional PPO	0.3	0.4	42	1
PFFS	2.3	2.4	7	5
Restricted availability plans included in totals above				
SNPs*	1.3	1.4	5	3
Employer group*	1.7	1.9	12	4

Note: MA (Medicare Advantage), CCP (coordinated care plan), PPO (preferred provider organization), PFFS (private fee-for-service), SNPs (special needs plans). CCP includes HMO, local PPO, and regional PPO. Totals may not sum due to rounding.
* SNPs and employer group plans have restricted availability and their enrollment is included in the statistics by plan type and location. They are presented separately to provide a more complete picture of the MA program.

Source: MedPAC analysis of CMS enrollment files.

Enrollment patterns differed in urban and rural areas. A larger share of urban Medicare beneficiaries are enrolled in MA (26 percent) than beneficiaries residing in rural counties (15 percent), even though plan enrollment grew at a faster rate in rural areas (about 14 percent) than in urban areas (9 percent) between 2008 and 2009.[1] As of last year, 54 percent of rural MA enrollees were in PFFS plans, compared with about 17 percent of urban enrollees (not shown in Table 4-1).

The percentage of Medicare beneficiaries enrolled in MA plans varies widely by local area. In some metropolitan areas, fewer than 2 percent of Medicare beneficiaries are enrolled in MA plans. Meanwhile, more than 50 percent of Medicare beneficiaries are enrolled in MA plans in other areas. (Pittsburgh, PA, has 59 percent of beneficiaries enrolled in plans; in Puerto Rico, in some areas 70 percent of Medicare beneficiaries are enrolled.)

Among plan types, HMOs continued to enroll the most beneficiaries, with 15 percent of all Medicare beneficiaries in HMOs in 2009. All plan types (HMO, PPO, and PFFS) had enrollment growth between 2008 and 2009: In 2009, PFFS had about 2.4 million enrollees, an increase of 7 percent; CCP enrollment grew 12 percent, or by about 800,000 enrollees; and SNP enrollment and employer-group enrollment also continued to grow.

Enrollment growth in 2009 continued a trend begun in 2003 (Figure 4-1). Enrollment more than doubled in the last five years. Some plan types grew more rapidly than others. Since 2005, PFFS grew 11-fold compared with 65 percent for CCPs.

Plan availability remains high for 2010

Access to MA remains high in 2010, and Medicare beneficiaries have access to a large number of plans, with the total number of plans offered at 4,890 as of November 2009. While almost all beneficiaries have had access to some type of MA plan since 2006, local CCP plans are more widely available in 2010 than in previous years (Table 4-2). In 2010, 91 percent of Medicare beneficiaries have an HMO or local PPO plan operating in their county of residence, up from 88 percent in 2009 and 67 percent in 2005. In contrast, access to regional PPOs decreased between 2009 and 2010, from 91 percent down to 86 percent. The decrease was the result of the only insurer in two regions deciding to withdraw its regional PPO product for 2010. PFFS plans continue to be available to almost all beneficiaries.

In 2010, 85 percent of Medicare beneficiaries have access to at least one MA plan that includes Part D drug coverage and has no premium (beyond the Medicare Part B premium) compared with 94 percent in 2009.

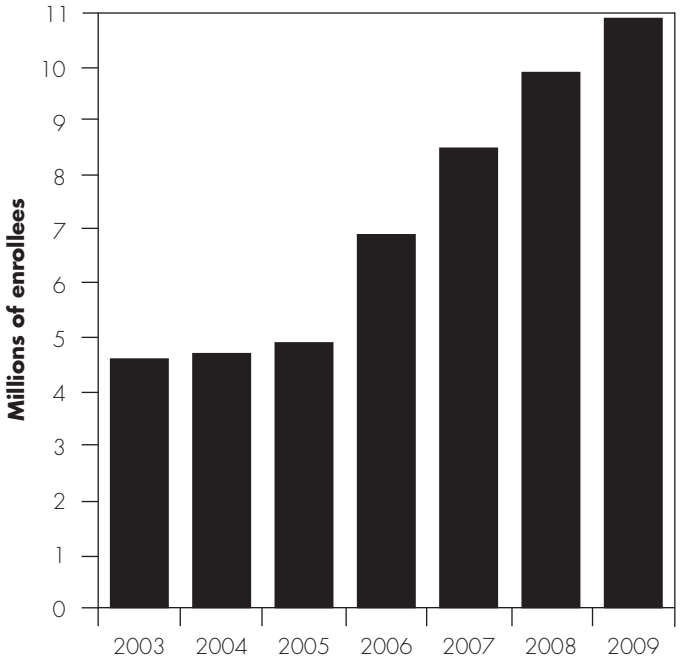
The availability of SNPs (not shown in Table 4-2) has changed slightly and varies by type of special needs population served. In 2010, 79 percent of beneficiaries reside in areas where SNPs serve beneficiaries who are dually eligible for Medicare and Medicaid (up from 76 percent in 2009), 49 percent live where SNPs serve institutionalized beneficiaries (down from 53 percent), and 63 percent live where SNPs serve beneficiaries with chronic conditions (down from 72 percent).

A large number of plans are available to beneficiaries

In most counties, a large number of plans are available to beneficiaries, although the number varies by county. For example, in Broward County, FL, beneficiaries can choose from 69 plans, while a few counties in the country have none (they represent less than 0.5 percent of the beneficiary population). On average, 21 plans are offered in each county in 2010, down from 34 plans in 2009. There are two principal reasons for this decrease. First, CMS has made an effort to decrease the number

FIGURE 4–1

Medicare Advantage enrollment has grown rapidly over the past four years



Source: CMS monthly Medicare Advantage enrollment reports.

TABLE 4–2

Access to Medicare Advantage plans remains high

	Percent of beneficiaries with access to MA plans by type					
Type of plan	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**
All plan types*	84%	100%	100%	100%	100%	100%
CCP						
HMO or local PPO	67	80	82	85	88	91
Regional PPO	N/A	87	87	87	91	86
PFFS	45	80	100	100	100	100
Zero-premium plans with Part D	N/A	73	86	88	94	85
Average number of MA plans open to all beneficiaries in a county	5	12	20	35	34	21

Note: MA (Medicare Advantage), CCP (coordinated care plan), PPO (preferred provider organization), N/A (not applicable), PFFS (private fee-for-service). These figures exclude special needs plans and employer-only plans. A zero-premium plan with Part D includes Part D coverage and has no premium beyond the Part B premium. Regional PPOs were created in 2006. Part D began in 2006.
*Statistics for medical savings account plans (MSAs) are not shown. Only one MSA plan is offered in 2010 (and only in Pennsylvania). In 2009 there were only about 3,500 MSA enrollees nationwide.

Source: MedPAC analysis of plan bids to CMS, 2009.

of low-enrollment plans (CMS found a large number of plans with fewer than 10 enrollees) and duplicative plans (Centers for Medicare & Medicaid Services 2009b). CMS defined a duplicative plan as one that did not offer meaningful differences from other plan choices. Usually, such plans belonged to a family of plans from the same insurer with small differences among the benefit packages.

The second reason for the decrease involves the effects of provisions in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). One MIPPA provision was designed to prohibit non-network PFFS plans in certain types of areas. Although an average of 13 PFFS plans remain available in each county in 2010, there are fewer plans than in 2009. MIPPA requires that, by 2011, PFFS plans develop provider networks in areas where there are two or more CCPs. Some PFFS withdrawals—particularly by certain organizations—may have occurred in anticipation of this deadline.[2] PFFS plans, because they have not needed networks thus far, have been able to enter many markets and grow very rapidly. In 2009, PFFS enrollment was about 22 percent of MA enrollment. PFFS plans can also withdraw from markets rapidly. Plan bids project that PFFS enrollment will fall to about 17 percent of MA enrollment in 2010. Even when PFFS was growing rapidly, there was a substantial rate of voluntary disenrollment by beneficiaries. The Government Accountability Office (GAO) found that in 2007 the voluntary disenrollment rate for PFFS plans was 21 percent, much higher than the rate for other plan types, which averaged 9 percent voluntary disenrollment (Government Accountability Office 2008a). Because of the current round of PFFS plan withdrawals, many enrollees will need to either join a different MA plan in 2010 or obtain care through FFS. Most (99 percent) will have the opportunity to join a CCP. Some others will be able to join a different PFFS plan, and fewer than 400 enrollees will have no choice other than to obtain care through FFS Medicare. In comparison, only about 5 percent of CCP enrollees will need to switch plans in 2010, and all of them will have another plan available.

Payment to plans continues to exceed Medicare FFS spending for similar beneficiaries in 2010

Plan payment rates are determined by the MA plan "bid" (the dollar amount the plan estimates will cover the Part A and Part B benefit for a beneficiary of average health status) and the "benchmark" in the payment area (the maximum amount of Medicare payment set by law for an MA plan to provide Part A and Part B benefits). If a plan's bid is above the benchmark, the plan's MA payment rate is equal to the benchmark, and enrollees have to pay an additional premium equal to the difference. If a plan's bid is below the benchmark, the plan's MA payment rate is its bid plus 75 percent of the difference between the plan's bid and its benchmark. Because benchmarks are often set well above what it costs Medicare to provide benefits to similar beneficiaries in the FFS program, MA payment rates usually exceed FFS spending. In last year's report, we examined why benchmarks are above FFS spending and what the ramifications are for the Medicare program (Medicare Payment Advisory Commission 2009a). (Actual plan payments, as opposed to payment rates, are risk adjusted. A more detailed description of the MA program payment system can be found at http://www.medpac.gov/documents/MedPAC_Payment_Basics_09_MA.pdf.)

Benchmarks lower in 2010 than in 2009

When CMS calculated MA benchmarks for 2010, services subject to the Medicare sustainable growth rate (SGR), including physician services, were to be cut by 21 percent in 2010 according to then-current law. CMS estimated that the 21 percent reduction would result in a 4 percent decrease in overall FFS spending for 2010. The assumption of a 21 percent reduction due to the SGR was one of the factors that led to MA benchmarks in 2010 being about 0.5 percent lower than in 2009. The total change in benchmarks is the result of several payment factors:

- the overall expected growth in FFS spending, which reflects the 21 percent SGR cut;
- the phase-out of hold-harmless payments to plans (a decrease of approximately 0.8 percentage points);[3] and
- the phase-out of the inclusion in MA rates of the payments made to teaching hospitals on behalf of MA beneficiaries for indirect medical education.

The overall 0.5 percent benchmark decrease varies slightly by county, depending on the percentage of a county's FFS spending attributable to indirect medical education payments to teaching hospitals.

This decrease in benchmarks may well be temporary. Benchmarks will increase if, when CMS computes the 2011 benchmarks, FFS spending per capita has grown in 2010 and there is no large SGR cut in law for 2011. For example, if FFS per capita spending grew by 6 percent from 2009 to 2010 and there were no SGR cut in law for 2011, benchmarks for 2011 would grow by about 10 percent.

The average benchmark by plan type will vary depending on the counties the plans serve and where they draw their enrollment. By law, certain counties were given higher benchmarks with the intent to increase plan availability. Local PPOs and PFFS plans tend to operate in counties with higher benchmarks relative to FFS than other plan types. SNPs have high benchmarks relative to FFS because a large share of total SNP enrollment is in Puerto Rico, where benchmarks are very high relative to FFS (180 percent). (See the Commission's 2009 report for further discussion of Puerto Rico (Medicare Payment Advisory Commission 2009a).)

MA benchmarks, bids, and payments relative to Medicare FFS

Estimates of MA benchmarks, bids, and payments relative to Medicare FFS payments in 2010 hinge on a crucial assumption concerning the level of FFS expenditures in 2010. As discussed, when CMS made its calculation of projected FFS expenditures, services subject to the SGR, including physician services, were to be cut by 21 percent in 2010 according to then-current law. Once CMS publishes MA benchmarks each year (in April, for the following calendar year), the published benchmarks cannot be recomputed without specific legislation authorizing a new computation of benchmarks. If the Congress were to mandate that physicians be paid the same Medicare rates in 2010 as in 2009 (as is currently law for the first two months of 2010 (Department of Defense Appropriations Act of 2010)), the CMS actuaries suggest that their FFS spending estimates for 2010 would rise by about 4 percent. FFS payments would increase, but MA benchmarks, bids, and payment rates would not because they have already been determined based on the April 2009 announcement of MA rates. Therefore, any legislation forestalling SGR cuts in 2010 would cause a decrease in the estimates of the ratio of MA benchmarks, bids, and payments relative to FFS (compared with estimates under the original assumption of an SGR-based reduction).

Because of the magnitude of the baseline SGR reduction in 2010, we have calculated MA bids, benchmarks, and payments relative to FFS payments in two ways: first, accepting the initial CMS assumption of the full 21 percent cut in physician fee schedule payments (shown in Table 4-3a, p. 266); second, assuming no cut in physician fee schedule payment rates (i.e., physician fee schedule payment rates are the same in 2009 and 2010). The results following the latter assumption are shown in Table 4-3b (p. 266). Note that the results in Table 4-3b essentially reflect a timing issue in that the 2010 benchmarks were set based on an assumed SGR reduction, but potential congressional action to restore payments would be occurring after benchmarks have already been set.

Following the first assumption—SGR cuts take effect for all of 2010—we estimate that, on average, 2010 MA benchmarks, bids, and payments would be 117 percent, 104 percent, and 113 percent of FFS spending, respectively (Table 4-3a). (Benchmarks, bids, and payments are weighted by plans' projected enrollment by county to estimate overall averages and averages by plan type.) Last year, we estimated that, for 2009, these figures would be 118 percent, 102 percent, and 114 percent, respectively.

Under the second assumption (Table 4-3b), that SGR cuts are postponed for 2010 and physician fee schedule payments remain the same as in 2009, all the MA-to-FFS comparisons would be lower. Bids as shown in Table 4-3b would be 100 percent of FFS for MA plans in aggregate. HMOs' bids in aggregate would be 97 percent of FFS, and PFFS plans' bids would be 111 percent of FFS. These bid ratios are similar to those we reported for 2009 when HMOs bid 98 percent of FFS and PFFS bid 113 percent of FFS. Because MA plans' bids reflect their expected costs, one could surmise that MA plans expect their costs to change more in line with the assumption of steady payments to physicians rather than a 21 percent cut in payments to physicians. If that is true, then their efficiency compared with FFS (as represented by their bids) would be similar to that for last year. (As discussed, in 2011, if the timing of the benchmark calculation allows it to accurately reflect FFS spending, the relative values will likely be similar to 2009 levels. For example, benchmarks were estimated to be 118 percent of FFS in 2009.)

In 2010, the ratio of payments to MA plans relative to FFS spending also varies by plan type, but the ratios for all plan types in both tables are substantially higher than 100 percent. In 2010, overall payments to plans average an estimated 113 percent of FFS spending in Table 4-3a or 109 percent of FFS in Table 4-3b. These payment ratios are lower than the 114 percent we estimated for 2009.[4] In general, we attribute the slightly lower payment ratios to the combination of benchmarks growing slower than FFS growth and plans maintaining similar levels of efficiency (bidding) relative to FFS Medicare. Overall, payments to MA plans rose from $93 billion in 2008 to $110 billion in 2009, representing 26 percent of program spending in Medicare.

TABLE 4–3

Payments exceed FFS spending for all plan types in 2010

Plan type	Percent of FFS spending in 2010		
	Benchmarks	Bids	Payments
Table 4-3a: Data assuming SGR cuts occur			
All MA plans	117%	104%	113%
HMO	116	100	112
Local PPO	119	112	117
Regional PPO	113	109	112
PFFS	118	116	117
Restricted availability plans included in totals above			
SNP*	119	106	116
Employer groups*	117	112	115
Table 4-3b: Data assuming SGR cuts do not occur			
All MA plans	112%	100%	109%
HMO	112	97	108
Local PPO	115	108	113
Regional PPO	109	104	108
PFFS	114	111	113
Restricted availability plans included in totals above			
SNP*	115	102	111
Employer groups*	113	107	110

Note: FFS (fee-for-service), SGR (sustainable growth rate), MA (Medicare Advantage), PPO (preferred provider organization), PFFS (private fee-for-service), SNP (special needs plan). Benchmarks are the maximum Medicare program payments for MA plans. FFS spending by county is estimated using the 2010 MA rate book. Spending related to the double payment for indirect medical education payments made to teaching hospitals was removed. Totals may not sum due to rounding. *SNPs and employer-group plans have restricted availability and their enrollment is included in the statistics by plan type. They are presented separately to provide a more complete picture of the MA program.

Source: MedPAC analysis of data from CMS on plan bids, enrollment, benchmarks, and fee-for-service expenditures.

We separately analyzed bids and payments to SNPs and employer-group plans, because their bidding behavior differs from that of other plan types. Payments to SNPs are estimated to average well above FFS spending because the plans are located in areas that have high benchmarks relative to FFS. Notably, 87 percent of SNP enrollees are in HMOs, but the average SNP payment is higher than that of HMOs as a group because, in 2008, about 18 percent of all SNP enrollees lived in Puerto Rico, where benchmarks relative to FFS are high. (The text box provides additional information on SNPs.)

Employer-group plans consistently bid higher than plans that are open to all Medicare beneficiaries. In aggregate, employer-group plan bids and payments are well above FFS spending. The dynamic of the bidding process for employer-group plans is more complicated than for other MA plans, because the employer-group plans can negotiate specific benefits and premiums with employers after the Medicare bidding process is complete. Conceptually, the closer the bid is to the benchmark—that is, the maximum Medicare payment—the better it is for the plans and the employer, because a higher bid brings in more revenue from Medicare, potentially offsetting expenses that would have required a higher pay-in from employers.

An additional factor to consider: Risk scores reflect coding intensity

An additional factor that should be taken into account is coding intensity. Actual payments to MA plans are risk adjusted using relative factors based on expenditures in the FFS program. Because plans are paid on a risk-adjusted basis, they have a financial incentive to make sure the providers that serve their enrollees report all diagnoses

The current status of special needs plans in Medicare Advantage

The Congress created a new Medicare Advantage (MA) plan type known as a special needs plan (SNP) in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 to provide a common framework for existing plans (in particular those operating under demonstration authority) for special needs beneficiaries and to expand beneficiaries' access to and choice among MA plans. Targeted populations include dual (Medicare and Medicaid) eligibles, the institutionalized, and beneficiaries with severe or disabling chronic conditions. SNPs function essentially like (and are paid the same as) any other MA plan but they must be coordinated care plans (HMOs or preferred provider organizations) and they must provide the Medicare Part D drug benefit. Unlike other MA plans, however, they must limit their enrollment to their targeted populations.

In its March 2008 report, the Commission addressed issues with SNP plans and made seven recommendations (Medicare Payment Advisory Commission 2008). Most of the recommendations were implemented by CMS or enacted into law through the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). Among the changes that have been made to the SNP program that reflect the Commission recommendations are:

- development of additional performance standards that apply to SNPs;
- improved information about SNPs being made available to beneficiaries;
- development of a clearer, more appropriate definition of the chronic conditions appropriate for the SNP model;
- a requirement that new dual-eligible SNP plans enter into contracts with states to coordinate Medicare and Medicaid coverage;
- a moratorium in 2010 on designating plans as SNPs that serve a disproportionate share of special needs individuals (as opposed to exclusively serving such individuals); and
- extending through 2011 SNP authority to limit enrollment to specific populations.

Rules that allow for continuous open enrollment and disenrollment of dual eligibles and special enrollment rules applying to other SNP types remain in place, although the Commission recommended altering the provisions to limit enrollment opportunities.

MIPPA also required that Medicare cost sharing for dual eligibles in SNPs be limited to the levels allowed by the state Medicaid program, a requirement that CMS extended to dual eligibles in all MA plans through regulations. ■

and other information that can increase their enrollees' risk scores. This more complete coding can inflate the risk scores of beneficiaries in MA plans relative to similar beneficiaries in FFS, whose providers in some cases lack a financial incentive to code so completely. CMS has recognized this phenomenon and, in its rate announcement for 2010, reduced reported risk scores by 3.41 percent (Centers for Medicare & Medicaid Services 2009a). Future reductions may be taken as well if risk score inflation continues.

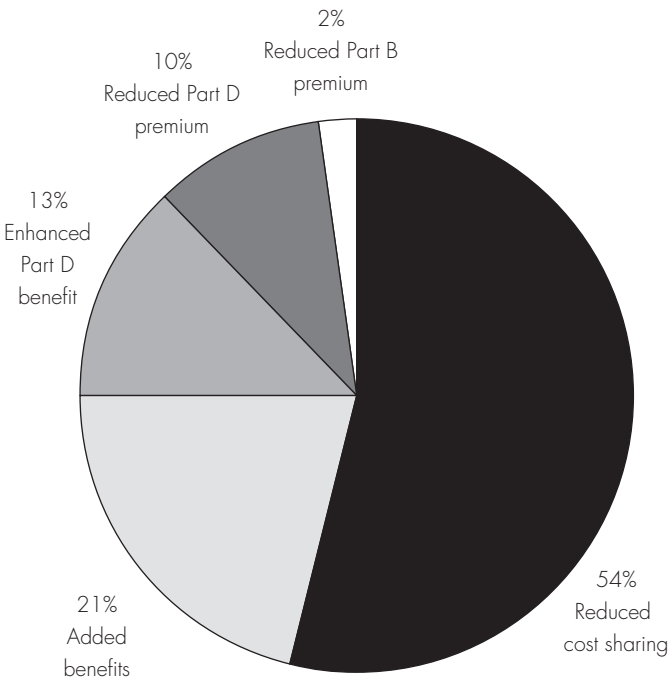
Table 4-3 assumes an average risk score of 1.0 for all MA plans and for FFS—essentially assuming the CMS adjustment is accurate. Possible uncorrected inflation in plans' risk scores resulting from increased coding intensity would tend to increase actual MA payments above the levels shown in Table 4-3. Similar to last year, the actual difference between MA payments and FFS spending in 2010 will vary from the estimate because of the eventual enrollment distribution by geography and type of plan and actual FFS spending levels.

Enhanced benefits are common but costly for Medicare

Enhanced benefits—benefits beyond those provided under traditional FFS Medicare—are built into the MA program payment system. As described above, when a plan bids below the payment area benchmark, Medicare pays the

FIGURE 4–2

Majority of rebate dollars finance reduced cost sharing for Medicare Part A and Part B benefits in Medicare Advantage plans in 2010



Note: Distribution of dollar amount of benefit enhancements financed by rebate dollars, weighted by projected enrollment in 2010. Part B-only plans excluded.

Source: MedPAC analysis of CMS plan bids for 2010.

plan 75 percent of the difference between the bid and the benchmark, with both the bid and benchmark adjusted for the health status of the plan's projected enrollees. The plan must use this amount (the "rebate" dollars) to fund benefit enhancements for its enrollees.[5] The remaining 25 percent is retained by the Medicare program. (For example, if a payment area's benchmark is 110 percent of FFS and a plan serving the area bids 100 percent of FFS, 7.5 percentage points of the difference would be used to fund benefit enhancements and 2.5 percentage points would be retained by Medicare, yielding a payment to the plan of 107.5 percent of FFS.) Benefit enhancements that are allowed by statute are:

- reduction of cost sharing for Medicare Part A and Part B services;
- provision of added, non-Medicare benefits, such as routine dental and vision care;
- enhancement of the drug benefit in an MA–Prescription Drug (MA–PD) plan;
- reduction of the Part D premium in an MA–PD plan; and
- reduction of the Part B premium.

By far, the most common benefit enhancement by dollar value is the reduction of cost sharing for Medicare Part A and Part B services—that is, lower out-of-pocket spending at the point of service or lower premiums (in lieu of cost sharing at the point of service) charged for Medicare cost sharing (Figure 4-2). This use of rebate dollars constitutes 54 percent of the total rebate dollars across all plans. The reduction of cost sharing has traditionally been a benefit that Medicare private plans have offered to make plan enrollment attractive compared with the level of cost sharing in FFS Medicare. In 2010, the enrollment-weighted average level of rebate dollars applied toward cost sharing across all MA plans is projected to be $38, compared with the $132 figure that CMS projects is the actuarial value of cost sharing in FFS Medicare for Part A and Part B benefits (Centers for Medicare & Medicaid Services 2009a).[6] While most beneficiaries in FFS have supplemental coverage that can cover all or some of their cost sharing (Medicaid, employer retiree coverage, and individually purchased medigap coverage), about 9 percent of Medicare beneficiaries in FFS do not have any supplemental coverage (Medicare Payment Advisory Commission 2009c). Such beneficiaries can obtain partial coverage of their Medicare cost sharing through an MA plan.

A plan's bid has three components: medical expenses (estimated costs of providing Medicare Part A and Part B services to the expected enrollee population), various administrative costs, and the plan margin (profit or loss).[7] The last two components—administrative costs and the plan margin—together are referred to as the "load" or loading factor. Across all MA plans for 2010, the enrollment-weighted average loading factor accounts for an estimated 13 percent of the bid. A "fully loaded" cost includes all three bid components. Thus, on average, medical expenses are an estimated 87 percent of the bid. (The 2010 loading factor estimate could be understated. GAO found that, in 2006, actual profits among MA plans were 6.6 percent and nonmedical expenses were 10.1 percent, for a load totaling 16.7 percent. At the time of the bid submissions for 2006, the load was projected to be 13.1 percent. A similar result was found for 2005 projected and actual profits and nonmedical expenses (Government Accountability Office 2008b).)

TABLE 4–4

Enhanced benefits and Medicare subsidy differ by plan type, 2010

Plan type	Payment above FFS (per member per month)	Enhanced benefit (per member per month)		Medicare subsidy per dollar of enhanced benefits
		Benefit plus load	Benefit only	
All MA plans	$68	$70	$63	$1.08
HMO	62	91	82	0.76
Local PPO	83	37	34	2.44
Regional PPO	72	32	30	2.40
PFFS	80	20	18	4.44

Note: FFS (fee-for-service), MA (Medicare Advantage), PPO (preferred provider organization), PFFS (private fee-for-service). Load is the sum of projected administrative costs and profits from plan bids. Medicare subsidy is the payment above FFS divided by benefit. The "benefit-only" column slightly overstates the net value because the load is included in the Part D load when the benefit enhancement is a drug benefit enhancement. Data exclude Part B-only (fewer than 8,000 enrollees). Projections assume physician fee schedule rates in fee-for-service Medicare are not reduced in 2010.

Source: MedPAC analysis of data from CMS on plan bids, enrollment, benchmarks, and fee-for-service expenditures.

When a plan's bid requires the addition of enhanced benefits, such benefits have a load factor applied. The load factor is the same for the reduction of Medicare Part A and Part B cost sharing and for the added, non-Medicare benefits as it is for Part A and Part B medical expenses in the bid. For the reduction in the Part B premium, no load factor applies. In the case of Part D benefits—premium reduction or benefit enhancement—a load factor is a component of the Part D bid, not the Part A and Part B bid.

Table 4-4 shows the cost to the Medicare program of MA benefit enhancements assuming there is no SGR reduction to the physician fee schedule in 2010. (This assumption is incorporated in Table 4-3b, p. 266.) On average, all plan types are receiving total payments that exceed Medicare FFS expenditure levels, as shown in the first column of numbers of Table 4-4. Average payment to MA plans overall is $68 per member per month (PMPM) more than Medicare FFS, all of which is used to finance enhanced benefits through rebate levels averaging $70 PMPM (benefits plus load). The amount spent on enhanced benefits varies by plan type. HMOs have the highest rebate levels, at $91 PMPM (benefit plus load)—more than four times the $20 PMPM for PFFS plans. Adjusting for the average loading factor (subtracting the average amount of administrative costs and margin associated with the enhanced benefits) reduces the all-plan $70 PMPM average to $63 PMPM. The $63 amount is the estimated value of the enhanced benefits the average enrollee will receive in 2010.[8]

The last column in Table 4-4 shows payment above FFS divided by the value of the enhanced benefit; this value represents the Medicare subsidy per dollar of enhanced benefit—$1.08 for all plans. In the case of HMOs, shown in the second row, because their bids for the Medicare benefit package are below Medicare FFS spending, the program subsidy is 76 cents for each $1.00 of enhanced benefits. In the case of PFFS plans, on average, the program subsidy is $4.44 for each dollar of enhanced benefits. In other words, HMOs are the only MA plan type that finances any part of enhanced benefits through plan efficiencies: 24 cents of every dollar. Enhanced benefits in other plan types are completely subsidized by Medicare. CMS estimates that the subsidy and the added program costs for Part B benefits in MA result in an increase of $3.35 in the Part B premium that all beneficiaries pay.

Quality trends remained stable

Each year we examine the level of, and trends in, the quality of care for beneficiaries enrolled in MA plans using the data that health plans or CMS collects and reports. Little changed between 2008 and 2009 with respect to quality measures, but there were several instances of positive performance. For example, the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey results for MA enrollees, discussed below, showed that Medicare beneficiaries reported high satisfaction with their plans and the care they received. Also, CMS gave two new HMOs top ratings in overall plan quality based on a composite of performance on clinical and patient experience measures

and administrative standards. Achieving a high rating is atypical for newer plans, which tend to score lower on quality measures than established plans. Finally, most MA beneficiaries continue to be enrolled in plans with better performance on quality indicators relative to other plans.

The data sources the Commission used to make its assessment, which are described in greater detail in past reports (Medicare Payment Advisory Commission 2008, Medicare Payment Advisory Commission 2009b) and in Chapter 6 of this report (the MIPPA-mandated report on comparing quality in MA and FFS Medicare), include:

- the clinical process and intermediate outcome measures that comprise the Healthcare Effectiveness Data and Information Set (HEDIS®), which health plans report to CMS;[9]
- measures that reflect beneficiary experience of care from the MA CAHPS survey;
- outcome results from the Health Outcomes Survey (HOS) administered to MA enrollees through their health plans; and
- the CMS star rating system, which is a combination of results from the three preceding sources, along with CMS data on customer service (some of which are based on plan reports through HEDIS), plan performance on appeals, plan disenrollment rates, and plans' operational and regulatory compliance status.

Overall change in level of quality indicators in 2009

For 2009, the MA program showed slight improvement in quality indicators over the preceding year. As a class, cost-reimbursed HMOs had the best performance among plan types, with higher average scores on clinical quality indicators for 2009 and high performance in CMS's overall rating system in 2009.[10] Among plan types, regional PPOs and PFFS plans continued to be the poorest performing plans on quality measures—except for flu and pneumonia vaccination rates among their enrollees. It continued to be the case that newer plans generally had lower scores on quality measures than more established plans, with some notable exceptions. For example, three MA HMO plans had five-star ratings in overall health plan quality in CMS's star rating system this year compared with none last year. Two of the three were newer plans that began their Medicare contracts in 2006; the other was a plan that had participated in Medicare since 1983. A caveat is that certain changes in the CMS star rating system do not make the results entirely comparable between this year (2009) and last year (2008), the first year of CMS's star rating system.

HEDIS results

HEDIS is a product of the National Committee for Quality Assurance (NCQA), which reports on health plan results annually. The organization's most recent report was issued in October 2009, reporting on health plan results for care rendered in 2008 (National Committee for Quality Assurance 2009). NCQA reported that 2008 was the third consecutive year in which the performance of Medicare health plans was "flat" in relation to the preceding year. Unlike in past years, commercial health plans also showed similar performance in the 2009 report, as did Medicaid plans. For Medicare, NCQA reported that 7 of the 46 Medicare "effectiveness of care" measures showed statistically significant improvement between the 2008 and 2009 reports, and one measure showed a statistically significant decline (but it is a measure that CMS has stopped using in its star rating system, as we discuss in Chapter 6 of this report).

For the 38 remaining HEDIS measures that Medicare plans report, 4 measures are currently at relatively high levels, making significant improvement less likely: lipid profiles and blood glucose monitoring for diabetics and cholesterol screening for patients with cardiovascular conditions have rates exceeding 86 percent—as does the overall measure for monitoring persistent medications. Two additional measures for which low HEDIS scores indicate better performance also would appear to be less susceptible to improvement: one of three drug–disease interaction measures for the elderly (the use of certain drugs by enrollees with renal disease) and one of two measures of the use of high-risk drugs among the elderly. The averages for the remaining 32 measures range from 4.3 percent (engagement in alcohol and drug abuse treatment) to 74.1 percent (prescriptions for bronchodilator)—among 26 measures for which higher rates are better—and range from 16.2 percent (drug–disease interaction, enrollee with accidental fall or hip fracture, and use of certain drugs) to 29.5 percent (poor blood glucose control among diabetics) for the 6 measures for which lower HEDIS rates indicate better performance.

When making its overall statement about health care quality in MA plans, NCQA computes its results by taking a simple average of the HEDIS measures across all MA HMO plans (only HMOs are included and all HMO plans are weighted equally, not by enrollment).

PPOs are reported on separately because of the different reporting standards that apply to such plans, which we discuss in greater detail in Chapter 6 of this report. The main difference between HMO and PPO reporting is that CMS currently does not allow PPOs to use medical record review as a component in determining their HEDIS results for the so-called "hybrid" measures, while HMOs can use medical record review in determining their rates for such measures.[11] Beginning in 2010, CMS will allow PPOs to use medical record data in reporting HEDIS results for hybrid measures (Centers for Medicare & Medicaid Services 2009c).

NCQA does not currently report results for PFFS plans. PFFS plans will be required to report HEDIS results in 2011 (for care rendered in 2010); however, many PFFS plans report HEDIS results on a voluntary basis already. Unlike HMOs and PPOs, the PFFS HEDIS data are not necessarily audited by NCQA-certified auditors.

New, smaller plans affect averages In the March 2009 report, we noted a number of caveats pertaining to the reporting of HEDIS measures on the basis of plan averages. One caveat is that many plans in the 2009 data are new, and newer plans tend to have lower performance on many measures. Of the 267 Medicare HMO plans reporting in the 2009 HEDIS data, 45 plans did not participate in HEDIS 2008 reporting. The 45 newly reporting plans are very small, with a total enrollment of 134,000 in 2008, or an average of about 3,000 members. Such small enrollment prevents plans from reporting certain measures. The reporting rate among these plans for 31 of 46 HEDIS measures is 60 percent or less.[12] For the 15 remaining measures, it is more than 90 percent. In addition, eight plans that reported in 2008 did not do so in 2009. Thus, the set of plans reporting in the two years is not exactly the same, and results for the two reporting years are therefore not entirely comparable.

One way to control for the exit and entry of large numbers of plans from year to year, and for the learning curve of new plans in reporting HEDIS results, is to examine a cohort of plans that have reported a value in each of the two measurement years (HEDIS reporting years 2008 and 2009, in this case). This approach yields a slightly different result from one that compares the simple average of all plans in 2008 with that of all plans in 2009 (Table 4-5, p. 272). Of the 46 HEDIS measures, the all-plan approach shows a statistically significant improvement in 7 measures, while the cohort approach shows an improvement in 9 measures.

Variation across plans in HEDIS measures As in prior years, our analysis of the HEDIS public use files released by CMS shows great variation among plans in HEDIS scores for individual measures, even among established plans (those that have served as Medicare managed care plans since before 2004). Table 4-6 (p. 273), which shows the HEDIS results for the percentage of MA HMO enrollees with diabetes who received an eye exam, illustrates the variability in scores.

Table 4-6 also shows that the number of HMO plans is now nearly evenly divided between established plans and plans that began participating in MA in 2004 or more recently. In contrast, the number of enrollees in more established plans is greater than in newer plans by a six-to-one ratio. To the extent that the main concern about the state of quality in MA is how well beneficiaries are faring in MA plans, the dominant position of established plans in terms of enrollment (at least in this category of plan type—HMOs) means that most enrollees are in the higher performing plans.

About 10 percent of CCP enrollment is in local PPOs. The performance of these plans in HEDIS is similar to that of HMOs on most measures that can be compared between the two plan types (i.e., the 33 administrative-only HEDIS measures that do not involve medical record review). For nine measures, there are statistically significant differences between the two plan types. Averages for local PPOs are better than HMO averages for seven measures (engagement in alcohol and drug abuse treatment, use of disease-modifying antirheumatic drugs (DMARD therapy) for rheumatoid arthritis, three measures of drug monitoring, and a measure of osteoporosis testing among older women). HMOs have better average scores in managing osteoporosis for women with a fracture and managing the risk of falling. We have noted in the past that the PPO scores may be higher than HMO scores because PPOs may have better administrative record systems as claims-based operations with fewer capitated arrangements with physicians. We have also noted that at least half of the local PPOs in MA are operated by plans that have HMOs in the same market area.

The Consumer Assessment of Healthcare Providers and Systems

CAHPS is a survey instrument that provides information on respondents' experiences with their health plan and their providers. CAHPS was developed by the Agency for Healthcare Research and Quality (AHRQ). For MA, the

TABLE 4–5

Medicare Advantage HEDIS® measures with statistically significant changes from 2008 to 2009

HEDIS® measure	Type of averaging approach: All plan	Type of averaging approach: Cohort	All plan average rate, 2009
Measures that improved			
Diabetes care:			
Medical attention for nephropathy	✓	✓	87.8%
<100 LDL-C level		✓	48.6
Control of blood pressure among hypertensives		✓	58.5
Colorectal cancer screening rate	✓	✓	53.0
Fall risk management:			
Discussion (from Health Outcomes Survey)	✓		31.3
Management (from Health Outcomes Survey)	✓		57.8
Monitoring of persistent medications:			
Digoxin	✓	✓	90.4
Diuretics	✓	✓	87.1
ACE inhibitors or ARBs		✓	86.7
Anticonvulsants		✓	67.5
Persistence of beta blocker use after a heart attack*	✓	✓	79.7
Measure that declined			
Initiation of alcohol or drug addiction treatment*	✓	✓	45.8

Note: HEDIS® (Healthcare Effectiveness Data and Information Set), LDL–C (low-density lipoprotein cholesterol), ACE (angiotensin-converting enzyme), ARB (angiotensin receptor blocker). All-plan average rates are the 2009 levels for the measures (e.g., the percent of diabetics receiving medical attention for nephropathy—either a screening test or evidence of nephropathy being treated). All-plan averaging includes results for any HMO plan reporting in either year. Cohort averaging uses only results from plans reporting in both the 2008 and 2009 reporting period. Statistical significance determined by two-tailed t-test ($p \leq 0.05$).
*CMS does not use these measures in its star rating system because they apply to so few enrollees.

Source: MedPAC analysis of CMS HEDIS® data.

CAHPS survey consists of questions aggregated into the following six domains:

- how well doctors communicate
- getting care quickly
- getting needed care without delays
- health plan information and customer service
- overall rating of health care quality
- overall rating of health plan quality

For each of these domains, the 2009 CAHPS results showed little or no change from 2008 results. Medicare plan results were generally equal to or better than commercial (adult) plan results. For example, in both 2008 and 2009, 90 percent of MA plan enrollees surveyed said they "usually" or "always" got needed care, compared with 86 percent among commercial plan enrollees. On "how well doctors communicate," the result for MA enrollees reporting in both years was "usually" or "always" 94 percent of the time, which was the same rate for commercial plan adult enrollees in 2009. MA enrollees rated their plans higher overall than commercial enrollees. In both 2008 and 2009, 59 percent of MA enrollees gave their plan a rating of 9 or 10, compared with 36 percent and 38 percent of the adult commercial enrollees in the respective years (Agency for Healthcare Research and Quality 2009).

CAHPS is the source of the MA HEDIS measure for flu vaccinations for enrollees age 65 and over, and pneumonia vaccination rates (enrollees age 65 and over who report ever having been vaccinated for pneumonia) for the 2008–2009 period (Table 4-7). The Medicare.gov website reports these rates for FFS Medicare as well as for plans. There is wide variation in the rates of vaccination across

geographic areas in FFS and wide variation across plans and plan types.[13] Unlike their performance on other quality indicators, some PFFS plans had high rates of immunization among their enrollees that were comparable to rates in coordinated care plans.

Health Outcomes Survey

The HOS is a longitudinal survey of self-reported health status among MA enrollees over a two-year period. For each plan in the MA program, a randomly selected sample of enrollees is surveyed in a given year and are resurveyed two years later to measure changes in physical and mental health. Two-year-change scores are calculated and beneficiaries' physical and mental health status is categorized as better, the same, or worse than expected based on a predictive model, taking into account risk-adjustment factors and death. When results are reported, a plan is deemed to have better or poorer outcomes if the plan's results on the physical or mental health measures are significantly different from the national average across all plans.

The most recent HOS results for the 2006–2008 cohort show that no plans were classified as outliers in physical health status changes for their enrollees—that is, the physical health status changes were within expected ranges and not significantly different from the average across all plans. For mental health, 2 of the 187 reporting plans showed better-than-expected mental health outcomes and 10 showed worse-than-expected mental health outcomes.

HOS results are posted at the Medicare.gov website in a different format than on the HOS website. The Medicare.gov Medicare Options Compare website presents the HOS results as a star rating and as the percentage of beneficiaries reporting maintained or improved health. At this site, across 176 plans, HOS results ranged from 57 percent to 73 percent of plan enrollees reporting maintenance or improvement of physical health. Although a CMS-sponsored analysis of

TABLE 4–6

Rates of eye exams for diabetics in Medicare HMOs, 2009

	Established HMO plans	New HMO plans
Rate of eye exams for diabetics, HEDIS®		
Average	67%	54%*
Median	67	54
Minimum	36	9
Maximum	89	89
Number of plans		
Reporting this measure	143	133
Not reporting this measure	2	3
Enrollment**	5,876,640	930,136
Average enrollment per plan	53,141	5,140

Note: HEDIS® (Healthcare Effectiveness Data and Information Set). Established HMOs are plans beginning Medicare operations in 2003 or earlier; new HMOs are plans beginning as Medicare contractors in 2004 or later.
*Statistically significant difference ($p<0.01$).
**Data as of mid-2009.

Source: MedPAC analysis of CMS HEDIS® data.

TABLE 4–7

Ranges of vaccine rates by MA plan type

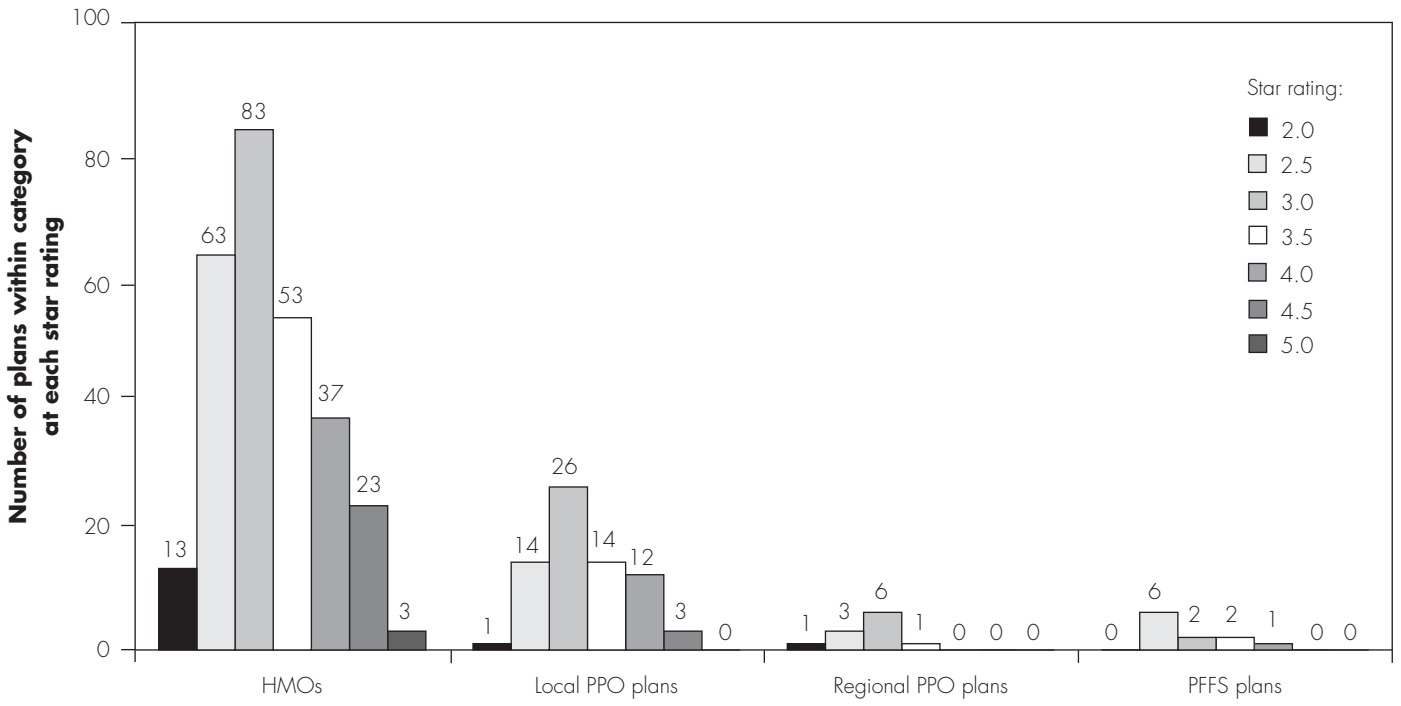
	Flu		Pneumonia	
Plan type	**Minimum**	**Maximum**	**Minimum**	**Maximum**
MA plans				
Cost-reimbursed HMOs	73%	87%	73%	92%
Other HMOs	23	88	13	88
Local PPOs	20	79	16	80
Regional PPOs	57	77	58	79
PFFS	53	83	51	79

Note: MA (Medicare Advantage), FFS (fee-for-service), PPO (preferred provider organization), PFFS (private fee-for-service). Rates are given at the plan contract level for MA and by geographic area in Medicare FFS.

Source: MedPAC analysis of CMS downloadable medicare.gov data for Medicare Options Compare.

FIGURE 4–3

About 40 percent of HMO and local PPO plans have high star ratings for overall plan quality as of 2009



Note: PPO (preferred provider organization), PFFS (private fee-for-service).

Source: MedPAC analysis of CMS star ratings for overall plan quality.

HOS results showed no statistically significant difference among plans at the 95 percent confidence level for enrollees' physical health changes, the Medicare.gov website distinguishes two levels of performance in the physical health category. All but four plans received a 4-star rating for "improving or maintaining physical health." The four plans in the lower range—those with only 57 percent to 59 percent of their enrollees reporting improved or maintained physical health—received a 3-star rating in this category.

CMS star ratings for overall plan quality

In 2008, CMS instituted a star rating system for MA plans and stand-alone drug plans. One category of stars is for "overall health plan quality," which in 2008 was composed of measures or results from HEDIS, CAHPS, and HOS and appeals information from an independent review entity. Because of two changes in the rating system, this year's overall star ratings are not directly comparable to the star ratings given to plans last year. First, the components of the star rating system were expanded for the 2010 open enrollment period to include information about complaints that CMS tracks and CMS-required corrective action plans. Second, a subset of HEDIS measures is used to determine the star ratings, and CMS has removed from the star rating system several HEDIS measures owing to small numbers and the consequent lack of statistical reliability (as we discuss in Chapter 6). The measures previously used but no longer included are depression medication management, mental illness measures, and persistence of beta blocker use after a heart attack.

CMS assigns star ratings in each of the subdomains of the larger "overall plan quality" category through algorithms comparing performance across plans. Plans are not necessarily penalized for not being able to report particular measures. Within each subdomain a tolerance level is set for the number of measures that can be absent but that will still permit the plan to be assigned a star rating for the subdomain. CMS also takes sustained good performance over time into account. The subdomains have the following descriptive labels in the Medicare Options Compare data:

- staying healthy: screenings, tests, and vaccines;

TABLE 4–8

Among the three plans with 5-star ratings in overall quality for 2009, two have many individual components of quality that are unrated

Components by plan	Star ratings for individual components: Components with 5 stars	Components with fewer than 5 stars	Percent of rated components at 5 stars	Number of unrated components	Percent of components with no rating
Individual clinical quality of care and outcome components (19 measures)					
Plan A	9	8	53%	2	11%
Plan B	6	4	60	9	47
Plan C	2	5	29	12	63
Adding the 14 nonclinical components (33 cumulative total measures)					
Plan A	18	12	60	3	9
Plan B	17	4	81	12	36
Plan C	11	8	58	14	42

Note: Plans can receive a maximum of 5 stars for each component of the overall rating. The maximum overall rating is 5 stars, consisting of an average of each component, with some adjustments by CMS.

Source: MedPAC analysis of CMS star rating data.

- managing chronic (long term) conditions;
- ratings of health plan responsiveness and care;
- health plan members' complaints, appeals, and choosing to leave the health plan; and
- health plans' telephone customer service.

As indicated by the labels for each subdomain, the overall plan quality star rating is not exclusively a rating of clinical quality but includes patient experience measures, customer service results, and level of adherence to regulatory requirements. We illustrate this point below in discussing the three plans with the highest overall quality star ratings.

The star ratings for 2009 range from 2 to 5 (on a 0 to 5 scale), with 3 plans—all of them HMOs—having an overall quality star rating of 5. In addition, a little more than 40 percent of HMO plans—constituting about half of the MA HMO enrollment—had ratings of 3.5 stars or higher (Figure 4-3, enrollment distribution not shown). A similar situation held for local PPO plans (41 percent of plans with 47 percent of local PPO enrollment were at 3.5 or above).

As in past years, cost-reimbursed HMO plans as a class had the best results on quality indicators, as indicated by their star ratings for the current year (all 280,000 enrollees of rated plans in this class were in plans with star ratings of 3.5 or higher (not shown in Figure 4-3)). PFFS plans and regional PPOs had the poorest results in the CMS star ratings. One of 11 rated regional PPOs had a rating of 3.5 stars (and none was higher), with 9 percent of regional PPO enrollment. One PFFS plan had a 4-star rating (2 percent of enrollment), 2 were 3.5-star plans (2 percent of enrollment), and 2 were 3-star plans (1 percent of enrollment). The 6 PFFS plans with a 2.5-star rating in overall quality included 95 percent of the PFFS enrollment in rated plans. PFFS plans also had the largest proportion of enrollees in plans that were either too new to be rated or had insufficient data for a star rating—45 percent of PFFS enrollees as of late 2009 were in such plans (compared with 8 percent among local PPOs and about 1 percent among HMOs and regional PPO plans; data not in figure). Thirty PFFS plans were classified as not having enough data for an overall quality score, which in part reflects the small number of plans reporting HEDIS data on a voluntary basis and the consequent inability of CMS to determine an overall quality score because of the absence of HEDIS data.

How the final star rating is determined can be illustrated with the example of the three plans that in 2009 had a 5-star rating for overall plan quality (Table 4-8). The

overall rating is composed of several quality measures, each of which is rated. The clinical quality components that make up the rating system include measures that CMS designates as "screening, tests, and vaccines" (12 measures, such as HEDIS screening measures) and "managing chronic conditions" (7 measures, such as HEDIS measures of care for diabetics). The three highly rated plans did not report, or were not required to report, certain measures. One plan was primarily at the 5-star level because of its good performance in nonclinical components, such as responsiveness to member complaints and CAHPS ratings of care. That plan (shown as Plan C in Table 4-8) received a 5-star rating for only 2 of 19 clinical quality measures, had fewer stars for 5 measures, and had no rating for 12 measures. In contrast, the plan received a 5-star rating for 9 nonclinical measures. For the cumulative total of clinical and nonclinical measures, the plan received 5 stars for slightly more than half its ratings (58 percent) and no rating for a substantial proportion (42 percent) of the star system's measures, either because of insufficient data or because the plan was not required to report the measure. ■

Endnotes

1 We define urban counties as those in a metropolitan statistical area; all other counties we classify as rural. To match more closely the designation of nonfloor and floor counties (including the urban floor), we use the metropolitan statistical area status of counties as of 2002, before changes in the designation of counties in 2003.

2 Mike McCallister, chief executive officer of Humana as quoted in the *Wall Street Journal*: "For example, we got very big very fast in a product called private fee-for-service in Medicare Advantage. We knew it would be the first product to come under pressure, because it was more of an insurance approach than a management approach. So … we also began the process of building networks across the U.S. And sure enough, on Jan. 1, 2011, private fee-for-service as we know it by and large will disappear. Second stick in the ground, we realized we won't be paid above-Medicare rates forever, so how do we make the business work if that's the case? At the end of the day we have to be able to deliver services to these seniors at 15% under the traditional Medicare program." (*Wall Street Journal* 2009).

3 The hold-harmless payments are required by the Deficit Reduction Act of 2005 as a phase-out of extra payments made to plans to compensate for lower payments under the current risk-adjustment system. The hold-harmless payments added 0.9 percent to benchmarks in 2009 and 0.1 percent in 2010. After 2010, the hold-harmless payments will be eliminated.

4 There is some interaction between FFS and MA that can affect the comparisons. The MA program can reduce expenditures in the Part D program. Since bids for both stand-alone prescription drug plans and MA drug plan bids make up the overall national average Part D bid and affect Medicare's payments to drug plan sponsors, lower average bids by MA plans somewhat reduce federal program spending for Part D. There can also be interaction between the two sectors in the form of spillover. For example, many physicians care for both MA enrollees and beneficiaries in traditional FFS. Physicians who practice in a managed care setting as well as in FFS Medicare may adopt more efficient practices as plan providers and could use the same practices in providing care to FFS enrollees, potentially reducing FFS costs (see discussion in Chapter 6).

5 A plan can also choose to offer benefits beyond the traditional Medicare benefit package funded by beneficiary premiums. The discussion of enhanced benefits in the text does not include premium-funded benefits.

6 The $132 figure for FFS is for beneficiaries without end-stage renal disease, a very small proportion of whom are enrolled in MA plans. The figure given for cost-sharing reduction in MA plans is before adjustment for administration and profit. The MA figure is not strictly comparable to the FFS cost-sharing figure because the MA figure represents an actuarial value that is applied toward a plan's cost of providing the Medicare Part A and Part B benefit, a cost that can be lower than FFS costs in a given area. The FFS figure is the national average actuarial value of cost sharing. However, the two figures are roughly comparable, and a comparison serves to indicate that MA enrollees do have reduced cost sharing in MA plans, but there is still cost sharing associated with the Part A and Part B benefit in MA.

7 A plan's administrative costs include items such as member service activities, provider contracting, provider relations, medical management, quality improvement activities, information systems, claims processing, marketing, and other nonmedical costs. Administrative costs vary from plan to plan. PFFS plans are likely to have high administrative costs associated with claims processing but little if any costs associated with provider contracting. Generally, an HMO with salaried physicians that owns its own hospitals may have little in the way of claims processing costs, while a PPO has both claims processing and provider contracting costs. Plans that serve employer-group enrollees exclusively generally have much lower marketing costs than plans that enroll Medicare beneficiaries individually.

8 Because we do not take into account the loading factor for Part D benefits that is determined through the Part D bid, the $63 net figure is slightly higher than if we had applied the Part D loading factor to the benefit enhancements of drug coverage. If the Part D loading factor is similar to the MA bid loading factor, the net value of enhanced benefits would be in the range of $61 across all plans.

9 HEDIS reporting also includes measures that are collected through the two beneficiary surveys. HEDIS results for flu vaccination rates, pneumonia vaccines, and smoking cessation advice are from the CAHPS survey; HEDIS includes HOS results for fall risk management, osteoporosis testing, management of urinary incontinence, and advice on physical activity.

10 The discussion of quality in the Medicare health plan program includes cost-reimbursed plans authorized under section 1876 of the Social Security Act. The payment section of this chapter does not include section 1876 cost plans. All section 1876 cost plans are HMOs, as required by law. Such plans are paid the reasonable cost of providing services to their

Medicare enrollees, based on cost reports the plans submit. Quality requirements apply to cost plans and both NCQA and CMS track and report the performance of these plans.

11 Although a statutory provision permits Medicare PPOs to report only on the care rendered through network providers, CMS staff have indicated that PPOs report HEDIS measures for both in-network and out-of-network providers.

12 For example, only 1 of the 45 newly reporting HMO plans, with 33,000 enrollees, reports a result for the percentage of enrollees with persistent use of beta blockers after a heart attack. It is one of the measures for which NCQA found a statistically significant improvement in results for Medicare plans between 2008 and 2009, but it is also one of the measures that CMS has stopped including in the plan star rating system because the measure applies to so few enrollees within a plan.

13 The flu and pneumonia vaccine rates are reported for FFS at the state level in CAHPS. Some states report at the substate level. For example, California and New York have rates reported for six areas. Eleven states show substate reporting in the Medicare.gov CAHPS data. The flu vaccination rates within the FFS geographic areas nationwide reported at Medicare.gov ranged from 29 percent to 77 percent; pneumonia vaccination rates ranged from 26 percent to 76 percent.

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