

RESEARCH BRIEF

Analysis of the Variation in Efficiency of Medicare Advantage Plans

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ABSTRACT

This paper presents findings from an analysis of public data from 2009 on the Medicare Advantage (MA) program. The purpose of the analysis was to use bids submitted by MA plans to the federal government as well as other characteristics of plans to assess their efficiency relative to costs for similar beneficiaries in the same service area who were enrolled in the traditional Medicare program, or Medicare fee-for-service (FFS). The bids are the plans' estimates of their costs for providing Part A and Part B benefits to enrollees in their service areas (taking into account medical and administrative costs, and any profit or reserve). We gave special emphasis to the question of how relative efficiency varies by plan type across payment quartiles established by the Patient Protection and Accountable Care Act (ACA) of 2010. This issue is important because under the legislation, MA payments will ultimately be reduced to 95 percent of traditional Medicare spending in counties that receive the highest payments and to 115 percent in counties that receive the lowest payments.

The analysis indicates that there is considerable variation in relative efficiency across plans—both within and across plan types and pay quartiles. On average, plans in higher-payment areas were relatively more efficient than plans in lower-payment areas, though only HMOs, on average, were more efficient than traditional Medicare in any of the payment quartiles. The effects of relative efficiency were greater and more consistent in highest-payment areas, in which plans passed their savings on to beneficiaries in the form of lower out-of-pocket costs and premiums. These findings suggest that it is possible to make MA more efficient, either relative to traditional Medicare or to plan peers. The findings are also consistent with support for policies that distinguish higher- from lower-paid areas.

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A. OVERVIEW

The federal government pays Medicare Advantage (MA) plans more than what it pays for Part A and B benefits in the traditional Medicare program, or Medicare fee-for-service (FFS). This discrepancy has long been a point of contention in public policy (Gold 2012). Although the Patient Protection and Accountable Care Act (ACA) of 2010 was intended to shrink this difference over time, much is still unknown about how plan costs compare not only to payments under MA but also to costs in Medicare FFS.

To receive payment, MA plans submit “bids” to the federal government. The bids are estimates of a plan’s costs for providing Part A and Part B benefits to enrollees in its service area (taking into account medical and administrative costs, and any profit or reserve). This report examines what these bids reveal about plan costs and what MA payment levels and plan efficiency imply for beneficiaries.¹ The report focuses on bids from 2009, the year before ACA was passed and thus an appropriate benchmark for monitoring future change under the legislation² (MedPAC 2010).

Our analysis indicates that MA plan costs, as reflected in their bids, vary considerably within and across plan types and pay quartiles. On average, only HMOs cost less than the average cost in traditional Medicare, adjusting for location and enroll mix. This comparison is what we refer to as “relative efficiency.” In areas where traditional Medicare costs are high, indicating the potential for inefficiency, higher payments to MA plans make it easier for them to outperform the Medicare FFS benchmark and use the extra funds to make benefits more attractive to beneficiaries. Such variation provides justification for setting MA payment policy differently across high- and low-payment areas. However, the analysis findings also show considerable variation in the relative efficiency of plans that otherwise appear to be similar in type, enrollee mix, and payment quartile. This suggests that there is the potential to make the MA sector more efficient.

B. POLICY CONTEXT

Before ACA, payments to MA plans were based on benchmarks established for each county; the benchmarks reflected a mix of historical FFS costs in the county and prior payment policies (e.g., urban and rural floors, annual updates, and so on.) Plans were paid the higher of either the benchmark (if their bid was equal to or greater than the benchmark) or their bid plus 75 percent of the difference between it and the benchmark (if their bid was lower than the benchmark). The latter is termed a “rebate,” and plans were required to use it to improve benefits, reduce cost sharing, or limit premiums (MedPAC 2009).

Independent analysts generally agree that the Medicare Modernization Act of 2003 (MMA) resulted in substantial increases in payments to MA plans. According to the Medicare Payment Advisory Commission (MedPAC 2009), average 2009 payments were expected to be 114 percent of

¹ Bids take into account administrative costs and profit or fee to the extent allowed by federal bidding rules. The definition used here is valuable in comparing plans to one another and to the costs in the traditional program but may differ from some economist’s concepts of “technical efficiency.”

² While 2010 could also be used, benchmarks from that year reflect an assumed 21 percent cut in the Medicare sustainable growth rate for physician services and thus were about 0.5 percent lower than in 2009, a decline expected to be temporary. (MedPAC 2010).

2009 spending in Medicare FFS. This estimate reflects all types of MA plans, including special needs plans and employer group plans, and all locales, including Puerto Rico.

Payments to MA plans in 2009 also exceeded what bids reveal about a plan's anticipated costs in providing Part A and B benefits. On average, the bids were 102 percent of the payments in Medicare FFS in 1999, ranging from 98 percent for HMOs to 113 percent of private FFS plans. Therefore, in addition to MA payments being higher than Medicare FFS payments, the average MA plan was no more efficient than traditional Medicare.

This particular confluence of conditions worked to the advantage of MA enrollees, who gained from overpayments because plans are required to use the funds to enhance benefits or reduce out-of-pocket costs. On the other hand, the payments add to Medicare costs and lead to inequities between MA and the traditional program, which cannot compete because it receives no additional funds and is not allowed to offer supplementary benefits. Because plans are paid administrative costs, and because they profit by such benefits (the "load"), Medicare spent an estimated \$1.30 for each dollar in enhanced benefits in 2009 (MedPAC 2009). Biles et al. (2009) estimated that these outlays amounted to an average of \$1,138 per MA plan enrollee, or \$11.4 billion in 2009.

In ACA, Congress sought to reduce MA payments so that they would more closely correspond to costs in Medicare FFS (Congressional Budget Office 2010). However, the changes were to be both phased in over time and made to vary across counties to limit the adverse impact resulting from beneficiaries residing in counties with different FFS costs. To achieve this goal, Congress divided counties across the nation into four quartiles based on their average per capita FFS costs (MedPAC 2011). Payments to counties in the highest-payment quartile would ultimately be reduced to 95 percent of FFS. Payments to counties in the lowest-payment quartile would be capped at 115 percent of FFS. Payments to counties in the middle two quartiles would be reduced to 100 percent and 107.5 percent, respectively.

Congress froze payments in 2011, setting the stage for the new policies to be implemented starting in 2012 and continuing over a two- to six-year phase in period, depending on the extent of payment change involved. The proportion of "bid-to-benchmark" savings (the rebate) received by MA plans would be reduced, and payment levels would be adjusted on the basis of performance, giving plans an incentive to improve on aspects of performance captured by the metrics. The changes were estimated to save Medicare \$132 billion over 10 years (Biles et al. 2012). The actual amount of savings is likely to be less because CMS made an administrative decision to begin performance-based incentives earlier and to make them more expansive initially (GAO 2012).

Payments aside, the question of the relative efficiency of MA plans versus traditional Medicare has also been a topic of policy interest as proposals for Medicare premium support are considered (The Henry J. Kaiser Family Foundation 2012). While there are alternative techniques for assessing efficiency (such as HEDIS indicators), (Landon et al. 2012) bid data have been the first choice for addressing this question in the policy arena because comprehensive claims or clinical data are lacking. The bid data come from information that MA contractors must submit to CMS in order for their plan to be approved (CMS 2013). Because bid data are considered proprietary, CMS does not readily make the information available for research by nongovernment agencies, so most of what we know about bids comes from information reported annually by MedPAC in its reports to Congress. The U.S. Government Accountability Office also analyzes bid data (GAO 2011).

Under a Freedom of Information Act request from lawyers associated with researchers at George Washington University in Washington, DC, CMS made selected data from these bids

available to Dr. Brian Biles at the university and ultimately to the public at large via the web at <http://www.cms.gov/Plan-Payment/PPData/list.asp> (Biles et al. 2011). The files include data by county and by plan. With support from The Commonwealth Fund, Dr. Biles used the county files to examine geographic variation in MA payments. In this paper, we take a complementary tack and examine variation in bid data by plan. As far as we know, this is the first publicly reported analysis by any entity other than MedPAC of variation in MA payments across plans rather than geographic locales. The paper was prepared by Mathematica under contract to the Commonwealth Fund, and it is one of a number of projects funded by the foundation to analyze the new bid data.

C. RESEARCH QUESTIONS

Our analysis of variation in the relative efficiency of MA plans and its implications for beneficiaries addresses two questions:

1. How much variation is there in the efficiency of different types of health plans, and how does this variation in efficiency differ across plans serving counties with different levels of FFS costs?
2. To what extent are differences in efficiency and payment level associated with differences in MA premiums and benefit levels?

The answers to these questions will support the work not only of policy analysts who are interested in the potential effects of a change in MA plan payments but also of others in the policy arena who may be interested in alternative ways to structure Medicare.

D. METHODS

The analysis is based on data from MA plan bids in 2009—before any changes in payment were introduced under ACA.³ (See the technical appendix for additional details on data sources and methods.) The unit of analysis is the “plan”; that is, a specific type of MA option (e.g., HMO or PPO) and the associated benefit package available in a specific service area, as defined by CMS in the bid approval process. For the most part, service areas are defined by some aggregation of counties. We restricted the analysis to MA plans available for general enrollment in the individual market and offering a Part D benefit (MA-PDs). This definition is more restrictive than previous studies have used and was selected to eliminate some extraneous sources of variation stemming from unique eligibility requirements or payments.

1. Key Variables and Data Sources

Estimated per capita FFS costs. We estimated per capita FFS costs for beneficiaries living in the same locale as the MA plan. County scores were normalized for average risk by dividing the county-adjusted FFS rate by the 2009 mean elderly and disabled risk score for that county. We aggregated these rates to develop FFS cost estimates weighted specifically for the service area of each plan, using as weights for each county the share of plan enrollment in that county.

³ 2009 also precedes the shift away from PFFS plans as the Medicare Improvements for Patients and Providers Act requirements for networks were phased in. The selection of 2009 is also consistent with other CMWF work.

Risk-adjusted estimated plan costs for MA Plans We compared risk-adjusted plan costs to provide Medicare Part A and Part B benefits (that is, what the statute refers to as “Part C” for MA plans). We estimated plan costs from the plan bid and risk-score information provided by CMS in its 2009 release. The average per-member, per-month Part C payment (payments less rebate) was divided by the plan’s risk score. As we mentioned, the bid for most plans reflects their estimate of the cost for Part A and B services (taking into account administrative costs and fee). Five percent of plans reported getting no rebate because they submitted bids that exceeded the benchmark. For this segment of plans, the payments could understate their costs (see the Technical Appendix, Table A.1). This situation was more likely for PFFS and regional PPO plans: cost estimates for these plans (and therefore relative plan efficiency) could be understated and should be interpreted more cautiously.

Relative plan efficiency. We measured relative plan efficiency by expressing risk-adjusted plan costs for Part C as a percentage of risk-adjusted FFS costs (Part A and B) for the plan’s service area. Percentages less than 100 indicate that, in 2009, the plan was more efficient than FFS Medicare in that same area, adjusted for patient mix. Percentages above 100 indicate that the plan was less efficient than FFS Medicare in that same area, adjusted for patient mix.

Estimating plan payment quartiles from county-based assignments. Under ACA’s payment reform for MA, payments vary by county, and counties are ranked by per capita cost and divided into four equal quartiles. Because plans develop their bids for their entire service area, not counties, we assessed the effect of payment quartiles on plans by first weighting the quartile assignment for each of the counties that a plan served by the share of the plan’s enrollment in that county and then summing the results. Using this metric, we classified the relative payment levels for plans into four groups based on their weighted quartile score. We used this metric to identify how plan payments would ultimately be affected by ACA changes. (See the Technical Appendix for additional detail).

Plan benefits and premiums. These two variables were created from the data file that shows plan benefits and premiums, and that supports the Medicare Plan Finder on the CMS consumer website (www.medicare.gov). MedPAC’s analysis for 2009 indicates that reducing cost sharing was the most common way for plans to use savings, accounting for 60 percent of the average value of all benefit enhancements (Biles, et al., 2009). One of the variables captures this dimension of the benefit package, and the other captures premiums; these are two of the four areas to which MA plans can apply extra payments.

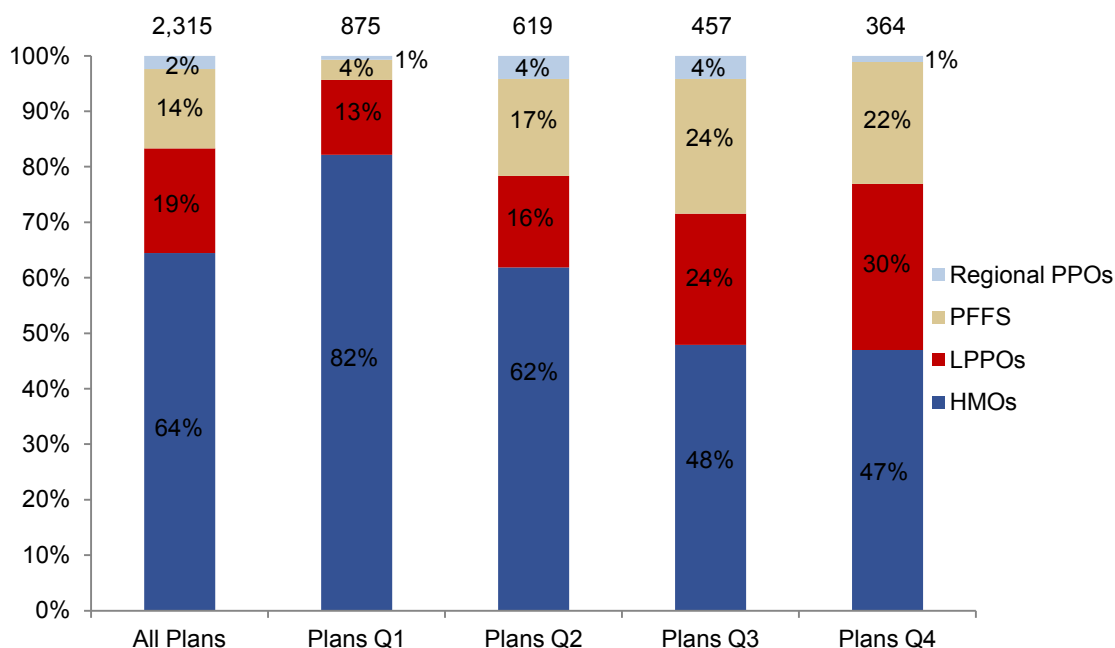
To summarize plan-to-plan variation in Medicare FFS cost sharing for Part A and B benefits, we used the HealthMetrix summary measure of the effects of a plan’s cost-sharing structure on out-of-pocket physician and hospital costs for beneficiaries; our assumptions about utilization reflect lower, moderate, and heavier use of physician services and hospital care. While these metrics do not necessarily provide a good estimate of the absolute value of out-of-pocket costs actually incurred by beneficiaries, they do provide a standardized, consistent way to look at variation in benefit packages.

In addition to this measure, we also examined three basic measures of MA-PD premiums because research shows that low- or zero-premium plans are an important strategic consideration for both MA plans and beneficiaries. We looked at average Part C premiums, total premium (Part C and D), and percent of MA-PDs with a zero total premium (other than what Medicare charges) within the particular plan category.

2. Plan Characteristics and Approach to Analysis

The 2,315 plans in our analysis had a combined enrollment of 7.4 million in 2009. Consistent with the market at that time, HMOs heavily dominated the plans in the analysis, accounting for 64 percent of all the plans we looked at and 73 percent of all enrollees in MA-PDs (Figure 1). Plans other than HMOs were fewer in number but have contributed disproportionately to growth in the MA market since 2006 (Gold et al. 2012). Although PFFS plans had the second largest share of enrollment in 2009, their role diminished after they were required to establish provider networks in most counties in 2011 as a result of the Medicare Improvements and Patient Protection Act of 2008. In 2012, HMOs accounted for 65 percent of MA enrollment, local PPOs for 21 percent, PFFS plans for 4 percent, and regional PPOs for 7 percent. Because of these trends and characteristics, our analysis of the effects of relative efficiency on benefits and premiums focused heavily on HMOs and local PPOs.

Figure 1. Distribution of MA-PDs by Type and Payment Quartile, 2009



Source: Mathematica's analysis of selected publicly available CMS data compiled from several sources, 2009. Total number of plans was 2,315, and total enrollment was 7.38 million.

Note: Q = payment quartile based on enrollment by counties in service area.

In 2009, MA-PDs were not evenly distributed geographically across quartiles that differed from one another in payment level. HMOs represented a larger share of plans in the higher-payment areas than in the lower-payment areas. Conversely, in lower-payment areas, alternatives to HMOs were a larger share of the market.

On a risk-adjusted basis, plan payments varied across the payment quartiles we constructed (Table 1). Mean monthly Part C payments for enrollees in the highest quartile were 8.3 percent, 14.0 percent, and 22.1 percent higher, respectively, than they were in the second, third, and fourth quartile plans. However, payments varied within each quartile, resulting in considerable overlap in payments in the middle of the range, i.e., the interquartile range of 25 to 75 percent.

Table 1. Risk Adjusted Part C Payment per Enrollee Per Month by Plan Payment Quartile, 2009

All MA-PD	All Quartiles	Highest Pay Quartile ^a (up to 1.25)	1.26 to 2.25	2.26-3.25	Lowest Pay Quartile (3.26 to 4)
Mean Payment	\$716.07	\$772.47	\$713.76	\$677.74	\$632.53
25th Percentile	\$668.76	\$731.22	\$685.24	\$652.00	\$598.76
50th Percentile	\$710.47	\$764.86	\$711.81	\$677.96	\$636.09
75th Percentile	\$756.95	\$810.17	\$740.40	\$705.89	\$663.82
Range (low-high)	\$502-\$959	\$632-\$958	\$632-\$958	\$566-\$828	\$502-\$823
Number of Plans	2,315	875	619	457	364

Source: Mathematica's analysis of selected publicly available CMS data compiled from several sources.

^aPayment quartiles were defined by weighting the CMS assigned quartile for a county (1-4) by the share of plan MA-PD enrollment from that county.

E. FINDINGS

1. Efficiency of MA Relative to Traditional Medicare

The analysis shows that in 2009, there was considerable variation in relative efficiency both within and across MA-PDs of different types (Table 2). On a risk-adjusted basis, MA-PD bids were, on average, 104 percent higher than costs in FFS Medicare in the same service area.

Table 2. Distribution of MA-PDs in Relative Efficiency by Type, 2009 (Percentages)

All MA-PD	All Plans	HMOs	Local PPOs	PFFS	Regional PPOs ^a
Mean Efficiency	104.1	96.6	118.7	119.4	100.2
25th Percentile	87.2	80.5	103.0	109.5	70.3
50th Percentile	104.5	96.7	119.2	118.5	108.3
75th Percentile	121.4	121.4	134.5	129.1	121.7
Range (low-high)	34-216	34-216	34 - 202	66-179	54-150
Number of Plans	2,315	1,492	437	331	55

Source: Mathematica's analysis of selected publicly available CMS data compiled from several sources.

Note: Relative efficiency measures the risk-adjusted Part C costs for the plan (as reflected in bids) as a proportion of the risk-adjusted FFS costs for enrollees in traditional Medicare with the same geographic distribution. (100% is equal efficiency; under 100% means that MA-PD is more efficient; and over 100% means that MA-PD is less efficient.)

^aData on Regional PPOs should be interpreted with caution because their rates are set in unique ways.

MedPAC found that HMOs were relatively more efficient than both traditional Medicare and MA plans other than HMOs. Our analysis adds to MedPAC's analysis both by providing results for a more homogeneous set of plans and by showing that relative efficiency varies not just across plan types but among plans of the same type. Some of the variation in relative efficiency is probably "noise," i.e., random variation reflecting small numbers that lead to instability in risk scores and FFS costs on a county basis.

To gain insight into the variation in relative efficiency across high- and low-payment areas, we compared the relative efficiency of MA-PDs of each type by payment quartile

(Table 3). On average, MA-PDs plans in the highest-payment areas were relatively more efficient, compared with FFS Medicare, than MA-PD plans in the areas with lower per capita payments (Table 2). However, no plan type other than an HMO was more efficient, on average, than the traditional Medicare program in any payment quartile. On average, MA plan bids were 95 percent of FFS Medicare payments in the highest quartile, compared with 118 percent in the lowest quartile. But again, no plan type other than an HMO was more efficient than FFS in any payment quartile, even the highest-payment quartile. HMOs on average were about 90 percent as expensive as FFS in the highest-payment quartile. Local PPOs cost the most, in relative terms, at 113 percent in the highest-payment quartile. For most types of plans, medians were relatively similar to means.

Table 3. Relative Efficiency of MA-PDs by Plan Type and Mean Quartile, 2009 (Percentages)

	All Quartiles	Highest-Payment Quartile			Lowest-Payment Quartile
Mean					
All plans	104.1	95.0	103.8	110.8	118.2
HMOs	96.6	91.4	97.9	103.1	107.1
Local PPOs	118.7	112.9	110.3	121.2	120.2
PFFS	119.4	106.3	117.9	119.6	126.4
Regional PPOs	110.2	109.9	106.2	121.2	120.2
Median					
All plans	104.5	94.7	104.8	114.4	120.0
HMOs	96.7	90.8	97.5	103.9	107.1
Local PPOs	119.1	112.1	114.0	123.2	132.2
PFFS	118.5	106.4	114.2	118.7	128.0
Regional PPOs	108.3	**	112.1	71.1	**
Number of Plans	2,315	875	619	457	364

Source: Mathematica's analysis of selected publicly available CMS data compiled from several sources.

Note: Relative efficiency measures the risk-adjusted Part C costs for the plan (as reflected in bids) as a proportion of the risk-adjusted FFS costs for enrollees in traditional Medicare with the same geographic distribution. (100% is equal efficiency; under 100% means that MA-PD is more efficient; and over 100% means that MA-PD is less efficient.) Data on regional PPOs should be interpreted with caution because their rates are set in unique ways.

**Data were omitted because there were only six regional PPOs in quartile 1 and four in quartile 4, leading to potentially unreliable findings.

Data on regional PPOs should be interpreted with caution. Under bidding rules, regional PPOs do not have the flexibility to tailor benefit packages to specific markets. Instead, they must offer a standard benefit package with the same premium for an entire region, which CMS defines as one or many states. (Under this definition, there are 26 regions in the nation.) The benchmarks assume that enrollment in regional PPOs will be proportionate to the number of people eligible for Medicare in each county. However, when plans bid, they make assumptions about where enrollment will be generated because their actual payments are influenced by both the county in which enrollees reside and the bids of competing regional PPOs. Analysts have cited the requirement for uniform benefits and premiums across regions that include counties with widely varying costs of care as a factor that limits the growth of regional PPOs and influences how the market evolves under the MMA (Pizer et al. 2005). These complications are another reason for focusing our analysis on the two types of plans that are most common and unencumbered by this—requirement: HMOs and local PPOs.

2. Variation in Benefits by Payment Quartile and Efficiency

Given how MA plans are paid, we would expect that both payment levels and the plan's relative efficiency would be associated with both the premium and the generosity of the benefit package. That is, in areas where payments are higher, MA plans have more room to outperform traditional Medicare on costs and potentially more money to generate savings that can be used to enhance the benefit package. But some otherwise similar plans are likely to be more efficient and better able to capture these savings and apply them to benefits. In each case, plans are likely to be strategic in allocating savings, trading off high premiums (which affect all enrollees and thus enrollment levels) and out-of-pocket costs for services (which may be disproportionately important to enrollees using many services.)

We examined the relationship of the plan payment level to benefits and premiums for plans of each type. With that as a control, we then looked at how relative efficiency affects benefits and premiums, holding pay quartile constant. For the latter analysis, we focused specifically on HMOs and local PPOs because these are the most common plans. This approach also allowed us to exclude plans for which our methods would be more likely to be problematic (e.g., plan types in which a larger share of plans had bids above benchmark and plans with region-wide premiums).

a. Effect of Payment Quartile by Plan Type

Out-of-pocket costs. Table 4 shows the variation in estimated out-of-pocket costs for MA-PDs by payment quartile and plan type, taking into account both cost-sharing requirements and annual limits. (Cost-sharing requirements generally assume in-network use.) HMOs clearly had lower expected out-of-pocket costs than do other plan types, which is consistent with other research as well (GAO 2011; Gold et al. 2010). Our analysis shows that out-of-pocket costs were lower in the highest pay quartiles than in other pay quartiles and that this relationship is true for enrollees of any health status. Out-of-pocket costs were generally low for healthy enrollees regardless of the HMO's pay quartile. Plans in the highest-payment quartile had the lowest out-of-pocket costs. Plans in the second highest quartile had higher out-of-pocket costs than plans in lower-payment quartiles. This pattern is the same in local PPOs. Out-of-pocket costs in PFFS appeared to vary less by payment quartile than did out-of-pocket costs in HMOs or local PPOs.

Premiums. Table 5 shows the variation in premiums for MA-PDs by plan type and payment quartile. Regardless of the payment quartile into which they fall, HMOs clearly had lower premiums than other plan types. As one might expect, however, the level of premium (and the offering of zero-premium plans) was lower for plans whose payments fall into the highest-payment quartile. Compared with quartile 1, premiums were higher in quartiles 2 and 3, but they remained relatively unchanged in the lowest-payment quartile compared with quartile 3.

Table 4. Estimated Average Out-of-Pocket Costs for Physician and Hospital Services by Health Status by Plan Type Within Weighted Plan Quartile, 2009

Plan Type and Enrollee Health Status	All Quartiles	Highest Pay Quartile			Lowest Pay Quartile
Number of Plans	2,315	875	619	457	364
All	\$385.78	\$296.03	\$451.26	\$455.80	\$402.25
HMOs	\$260.49	\$222.40	\$311.61	\$291.88	\$265.96
Local PPOs	\$572.97	\$634.64	\$672.53	\$550.38	\$435.52
PFFS	\$646.66	\$599.57	\$646.99	\$656.26	\$651.73
Regional PPOs	\$727.17	**	\$827.30	\$636.55	**
Healthy	\$132.44	\$106.95	\$152.36	\$157.68	\$128.15
HMOs	\$59.71	\$58.27	\$56.85	\$69.16	\$60.03
Local PPOs	\$280.56	\$350.81	\$365.36	\$247.24	\$158.17
PFFS	\$241.49	\$253.50	\$242.98	\$241.85	\$238.19
Regional PPOs	\$272.35	**	\$347.23	\$177.16	**
Episodic Needs	\$725.08	\$545.22	\$848.68	\$855.97	\$782.88
HMOs	\$527.05	\$438.25	\$652.81	\$582.72	\$547.44
Local PPOs	\$1,019.46	\$1,028.03	\$1,125.80	\$1,041.48	\$888.85
PFFS	\$1,117.26	\$1,014.03	\$1,116.28	\$1,137.52	\$1,131.75
Regional PPOs		\$1,368.33	\$1,535.31	\$1,306.26	\$982.50
Chronic Needs	\$1700.77	\$1,286.04	\$2,008.88	\$2,001.38	\$1,796.36
HMOs	\$1,307.69	\$1,082.76	\$1,634.00	\$1,463.74	\$1,322.78
Local PPOs	\$1,974.44	\$2,078.80	\$2,178.11	\$1,943.50	\$1,700.46
PFFS	\$2,902.41	\$2,580.09	\$2,896.21	\$2,963.65	\$2,954.73
Regional PPOs	\$2,957.71	**	\$3,181.35	\$2,905.74	**

Source: Mathematica's analysis of selected publicly available CMS data compiled from several sources.

**Data were omitted because there were only six regional PPOs in quartile 1 and four in quartile 4, leading to potentially unreliable findings.

The relationship between premiums and pay quartiles was not as consistent in other plan types as it was in HMOs. Among local PPOs, average premiums were highest (and zero-premium plans were lowest) in the highest-payment quartile. PFFS plans had higher premiums in the two highest-payment quartiles than they did in the two lowest-payment quartiles.

We can think of at least two reasons for the difference between the HMO patterns and the patterns for the other plan types. First, the highest-payment quartile included more HMOs and a higher share of enrollment than other plan types, thus spanning a wider range of prices. It is possible that, on average, local PPOs and PFFS plans are located in the lower-payment portion of the quartile. Second, plans structure premiums and benefits to reach the target market for different products. In high-payment quartiles in which HMO offerings are common, it is possible that local PPO and PFFS competitors are seeking to attract enrollees who, when selecting a plan, place more weight on provider choice.

Table 5. Selected Characteristics of Premiums for MA-PDs by Plan Type within Weighted Payment Quartile, 2009

Plan Type and Premium Measure	All Quartiles	Highest Pay Quartile			Lowest Pay Quartile
Number of Plans	2,315	875	619	457	364
Mean Part C Premium					
All plans	\$22.07	\$15.40	\$26.91	\$28.85	\$21.38
HMOs	\$14.70	\$8.43	\$16.94	\$23.92	\$24.25
Local PPOs	\$29.81	\$41.37	\$24.23	\$30.37	\$21.94
PFFS	\$41.29	\$61.75	\$61.57	\$34.21	\$15.52
Regional PPOs	\$44.95	**	\$40.40	\$45.68	**
Mean Total Premium (C and D)					
All plans	\$41.29	\$30.93	\$46.35	\$52.92	\$42.96
HMOs	\$29.77	\$20.84	\$31.54	\$44.89	\$44.00
Local PPOs	\$56.13	\$71.72	\$47.84	\$56.86	\$46.27
PFFS	\$68.12	\$89.30	\$91.95	\$60.56	\$37.95
Regional PPOs	\$74.36	**	\$69.16	\$78.48	**
% Zero Premium Plan (C and D)					
All plans	34.6%	44.7%	34.2%	23.0%	26.9%
HMOs	44.3%	52.3%	43.9%	29.2%	30.1%
Local PPOs	20.4%	11.0%	26.5%	19.4%	25.7%
PFFS	12.7%	6.3%	6.5%	16.2%	18.8%
Regional PPOs	14.6%	**	15.4%	10.5%	**

Source: Mathematica's analysis of selected publicly available CMS data compiled from several sources.

**Data were omitted because there were only six regional PPOs in quartile 1 and four in quartile 4, leading to potentially unreliable results.

b. Relative Efficiency as an Influence on Out-of-Pocket-Costs and Premiums

To assess the effects of relative efficiency on out-of-pocket costs and premiums, holding payment quartile constant, we looked within plan types by payment quartile at the variation in out-of-pocket costs and premiums for plans divided into four evenly sized quartiles of relative efficiency. This part of the analysis focused on HMOs and local PPOs, the two most common types of plans.

Table 6 shows the distribution of plans on which this part of analysis was based by type, payment quartile, and relative efficiency. Specifically, the 1,492 HMOs were divided into four evenly sized quartiles of 373 plans each based on their distribution on our relative efficiency measure; the 437 local PPOs were similarly divided into four evenly sized quartiles of about 109 plans. The table then shows how these plans, grouped by relative efficiency, were divided across payment quartiles. If efficiency were equally likely in high- and low-quartile payment areas, one would expect 50 percent of all plans of a certain type in any given payment quartile to be in the top two efficiency categories. Instead, however, 60 percent of HMOs in the highest-payment quartile and 65 percent of local PPOs in the highest-payment quartile are in the top half of the range in relative efficiency.

At the other extreme, the lowest-payment quartile includes 65 percent of HMOs and 72 percent of local PPOs in the bottom half of the distribution by relative efficiency. We interpreted this to mean that, within each plan type, relative efficiency is easier to achieve in higher-payment areas than in lower-payment areas.

Table 6. Distribution of HMOs and Local PPOs by Quartile and Relative Efficiency

	All Quartiles	Highest Pay Quartile			Lowest Pay Quartile
Number of HMOs	1,492	719	383	219	171
Most efficient	373	232	85	32	24
	373	198	102	48	25
	373	172	103	52	46
Least efficient	373	117	93	87	76
Number of Local PPOs	437	118	102	108	109
Most efficient	109	35	34	21	19
	109	42	34	22	12
	110	23	20	39	28
Least efficient	109	19	14	26	50

Source: Mathematica's analysis of selected publicly available data from CMS compiled from several sources.

Note: Relative efficiency measures the risk adjusted Part C costs for the plan (as reflected in bids) as a proportion of the risk adjusted fee for service costs for Medicare traditional program enrollees with the same geographic distribution. Plans of the same type are divided into even size quartiles based on this metric.

Out-of-pocket costs. Table 7 shows how average annual per capita out-of-pocket costs for physician and hospital services in 2009 varied for plans by relative efficiency within payment quartiles. As noted, the estimated cost metrics were created by making assumptions about how enrollees who vary by health status use health care to create standardized comparisons of out-of-pocket costs for the benefit package of each plan. Assumptions about utilization were drawn from Healthmetrix models and involve assumptions about physician visits and hospital use for beneficiaries who vary in health status.

Among HMOs, out-of-pocket costs varied considerably within payment quartiles based on the relative efficiency of the plan. In particular, higher out-of-pocket costs are associated with less efficient plans. These effects are particularly noteworthy for enrollees who require more services regardless of whether the services are for episodic or chronic needs. Enrollees with chronic needs in an HMO paid, on average, more than three times as much for plans in the least efficient quartile as in the most efficient quartile. Such differences persist across high- and low-payment areas. Local PPOs also showed an efficiency gradient. However, out-of-pocket costs, on average, were higher across the board. On the basis of out-of-pocket costs alone, enrollees needing a lot of care did better in an HMO than in a local PPO, on average.

Table 7. Estimated Average Out of Pocket Costs for Physician and Hospital Services in HMOs and Local PPOs by Health Status and Relative Plan Efficiency within Mean Payment Quartile, 2009

	All Quartiles	Highest Pay Quartile			Lowest Pay Quartile
Number of HMOs	1,492	719	383	219	171
All Enrollees	\$260.49	\$222.40	\$311.61	\$291.88	\$265.96
Most efficient	\$115.25	\$110.15	\$121.56	\$162.17	\$79.60
	\$223.06	\$212.07	\$283.48	\$168.73	\$167.82
	\$298.10	\$254.53	\$374.71	\$304.54	\$281.09
Least efficient	\$405.57	\$414.81	\$446.29	\$399.96	\$347.93
Healthy Enrollees	\$59.71	\$58.27	\$56.85	\$69.16	\$60.03
Most efficient	\$21.06	\$20.21	\$21.00	\$29.16	\$19.63
	\$51.26	\$56.01	\$47.57	\$33.23	\$71.44
	\$56.76	\$51.34	\$66.58	\$59.02	\$52.52
Least efficient	\$109.75	\$147.78	\$91.22	\$109.75	\$73.90
Enrollees with Episodic Needs	\$527.05	\$438.25	\$652.81	\$582.72	\$547.44
Most Efficient	\$241.00	\$229.78	\$255.93	\$332.28	\$174.88
	\$451.54	\$417.65	\$602.00	\$346.42	\$307.90
	\$619.03	\$524.77	\$787.95	\$624.40	\$587.19
Least efficient	\$796.63	\$759.31	\$921.60	\$780.29	\$719.84
Enrollees with Chronic Needs	\$1,307.69	\$1,082.76	\$1,634.00	\$1,463.74	\$1,322.78
Most efficient	\$604.99	\$578.72	\$644.19	\$869.66	\$367.25
	\$1,118.23	\$1,029.45	\$1,518.67	\$880.13	\$644.80
	\$1,555.64	\$1,316.55	\$1,972.89	\$1,597.94	\$1,467.52
Least efficient	\$1,951.91	\$1,828.73	\$2,289.82	\$1,924.03	\$1,759.95
Number of Local PPOs	437	118	102	108	109
All Enrollees	\$572.97	\$585.80	\$672.53	\$550.38	\$435.42
Most efficient	\$315.70	\$248.63	\$357.17	\$288.82	\$215.79
	\$657.19	\$653.51	\$829.28	\$492.67	\$284.76
	\$651.22	\$691.78	\$795.00	\$662.34	\$483.35
Least efficient	\$667.04	\$768.42	\$882.75	\$642.53	\$528.20
Healthy Enrollees	\$280.56	\$260.28	\$365.36	\$247.24	\$158.17
Most efficient	\$108.57	\$66.82	\$120.47	\$43.19	\$51.32
	\$356.34	\$458.84	\$520.88	\$226.27	\$90.50
	\$294.57	\$340.10	\$408.55	\$294.85	\$150.93
Least efficient	\$362.63	\$525.97	\$520.71	\$358.39	\$219.08

Table 7 (continued)

	All Quartiles	Highest Pay Quartile			Lowest Pay Quartile
Enrollees with Episodic Needs	\$1,019.46	\$1,066.18	\$1,125.80	\$1,041.48	\$888.85
Most efficient	\$1,365.03	\$485.45	\$690.15	\$677.43	\$441.05
	\$2,111.98	\$1,273.42	\$1,308.88	\$901.36	\$577.08
	\$2,336.52	\$1,185.57	\$1,326.25	\$1,256.28	\$1,090.00
Least efficient	\$2,080.92	\$1,085.40	\$1,500.00	\$1,130.39	\$1,026.80
Enrollees with Chronic Needs	\$1,974.44	\$2,181.31	\$2,178.11	\$1,943.50	\$1,700.46
Most efficient	\$1,365.03	\$1,206.46	\$1,594.29	\$1,437.43	\$1,058.95
	\$2,111.98	\$2,508.47	\$2,289.00	\$1,765.46	\$1,225.00
	\$2,336.52	\$2,468.92	\$2,769.75	\$2,352.10	\$1,887.86
Least efficient	\$2,080.92	\$2,043.31	\$2,481.43	\$1,890.00	\$1,953.40

Source: Mathematica's analysis of selected publicly available CMS data compiled from several sources.

Note: Relative efficiency measures the risk-adjusted Part C costs for the plan (as reflected in bids) as a proportion of the risk-adjusted FFS costs for enrollees in traditional Medicare with the same geographic distribution. (100% is equal efficiency; under 100% means that MA-PD is more efficient; and over 100% means that MA-PD is less efficient.)

Premiums. When we controlled for payment quartile, the relative efficiency of HMOs also translates into differences in premiums across plans (Table 8). This effect is most obvious in Part C premiums (which cover Part A and B benefits) and consistent among plans in the highest-payment quartile. While total premiums increased as relative efficiency decreased in the two higher-payment quartiles, this relationship did not carry through to the lower payment quartiles. One explanation could be that many plans, regardless of their efficiency or payment quartile, strive, when feasible, to limit premiums (so called “zero-premium plans”). In higher-payment quartiles, relative efficiency had little influence over a plan’s ability to pursue this strategy if it chose to do so; in the two highest-payment quartiles, there was little consistency in the relationship between relative efficiency and the share of plans with “zero premiums.” In the two lowest-payment quartiles, however, the less efficient plans were more likely not to charge a premium. With payments being tight, it could be that less efficient plans were more likely to apply rebates to reduce premiums so they could attract enrollees who might not be interested otherwise. However, it may also be that our analysis is too global to tease out individual market-level influences on particular plan strategies.

Among PPOs, the effects of relative efficiency on premiums also appeared to be strongest and most consistent in the highest-payment quartile, and these effects apply both to Part C and total plan premiums. Zero-premium plans are less prevalent in local PPOs, and relative efficiency, as measured here, was not associated with use of zero-premium plans.

Table 8. Selected Characteristics of Premiums for HMOs and Local PPOs by Relative Plan Efficiency Within Mean Payment Quartile, 2009

	All Quartiles	Highest Pay Quartile			Lowest Pay Quartile
Number of HMOs	1,492	719	383	219	171
Mean Part C Premium					
All HMOs	\$14.70	\$8.43	\$16.94	\$23.92	\$24.25
Most efficient	\$8.03	\$2.45	\$15.12	\$25.01	\$14.27
	\$12.31	\$7.20	\$12.27	\$23.72	\$34.81
	\$19.13	\$12.96	\$19.39	\$45.54	\$32.47
Least efficient	\$19.33	\$15.74	\$21.01	\$47.76	\$18.97
Mean Total Premium (C and D)					
All HMOs	\$29.77	\$20.84	\$31.54	\$44.89	\$44.00
Most efficient	\$22.94	\$14.71	\$29.95	\$54.75	\$35.29
	\$26.72	\$17.99	\$26.20	\$45.54	\$61.82
	\$34.83	\$26.78	\$34.26	\$47.76	\$51.63
Least efficient	\$34.58	\$29.06	\$35.84	\$39.19	\$36.26
% Zero Premium Plan (C and D)					
All HMOs	44.3%	52.3%	43.9%	29.2%	31.0%
Most efficient	41.0%	50.4%	32.9%	6.3%	25.0%
	45.0%	56.6%	45.1%	16.7%	8.0%
	46.4%	52.9%	49.5%	32.7%	30.4%
Least efficient	44.7%	47.9%	46.2%	42.5%	40.8%
Number of Local PPOs	437	118	102	108	109
Mean Part C Premium					
All Local PPOs	\$29.81	\$41.37	\$24.23	\$30.73	\$21.94
Most efficient	\$19.86	\$29.59	\$12.34	\$22.02	\$13.01
	\$33.39	\$33.09	\$24.90	\$40.14	\$46.13
	\$24.98	\$48.80	\$13.44	\$25.69	\$12.66
Least efficient	\$41.04	\$71.97	\$66.86	\$35.87	\$24.73
Mean Total Premium (C and D)					
All Local PPOs	\$56.13	\$71.72	\$47.84	\$56.86	\$46.27
Most efficient	\$41.27	\$55.87	\$27.57	\$43.00	\$36.96
	\$64.11	\$64.07	\$51.10	\$71.87	\$86.88
	\$52.33	\$82.20	\$44.63	\$53.12	\$32.20
Least efficient	\$66.83	\$104.74	\$93.74	\$60.96	\$47.93

Table 8 (continued)

	All Quartiles	Highest Pay Quartile		Lowest Pay Quartile	
% Zero Premium Plan (C and D)					
All Local PPOs	20.4%	11.0%	26.5%	19.4%	25.7%
Most efficient	26.6%	11.4%	44.1%	23.8%	27.3%
	18.4%	12.2%	23.5%	18.2%	25.0%
	19.1%	8.7%	10.0%	20.5%	32.1%
Least efficient	17.4%	10.5%	14.3%	15.4%	22.0%

Source: Mathematica's analysis of selected publicly available CMS data compiled from several sources.

Note: Relative efficiency measures the risk-adjusted Part C costs for the plan (as reflected in bids) as a proportion of the risk-adjusted FFS costs for enrollees in traditional Medicare with the same geographic distribution.) Plans of the same type were divided into evenly sized quartiles based on this metric.

F. CONCLUSION

The analysis reported here has inevitable limitations. In reality, plans compete against plans in their specific market, not against the universe of plans, even within a given payment quartile. Although our methods of risk adjustment mirror those used in Medicare, they could fail to account for critical differences across MA plans or between MA and traditional Medicare. We assessed effects on out-of-pocket costs for Part A and B quite generally and did not consider other potential uses for rebates or efficiency savings; the Part D benefit and supplemental benefits are good examples. Although we have attempted to control for differences in plan types, quartiles are broad and likely to cover areas with diverse payment levels and characteristics. Some of the findings are difficult to interpret solely with the data available.

Nonetheless, the analysis of 2009 bids—the payment changes brought about by ACA—shows that there is considerable variation in relative efficiency across plans of the same type, of different types, and across payment quartiles. The variation in efficiency across plans of the same type within geographic areas with similar FFS Medicare costs suggests that it is possible to improve the efficiency of many plans. However, on average, only HMOs are more efficient than traditional Medicare in any of the payment quartiles. Therefore, as plan payments are reduced, it could be more difficult for other types of plans to compete for price-conscious enrollees.

Historical MA payment levels have not provided plans with strong incentives to become more efficient. In areas with high FFS Medicare payments, MA plans appear to have found it easier to outperform FFS Medicare on a cost basis. Consequently, MA benefit packages can be designed with less cost sharing and lower premiums. The variation in relative efficiency provides support for policies that vary payment on the basis of differences in FFS costs across counties, setting benchmarks at 95 percent of FFS Medicare in the highest-cost areas and 115 percent in the lowest-cost areas.

TECHNICAL APPENDIX

1. Unit of Analysis

The unit of analysis is the MA “plan” as defined by CMS on the web spreadsheets that provide information on plan-level payments, rebates, and risk scores (see <http://www.cms.gov/Plan-Payment/PPData/list.asp>). This definition of “plan” encompasses the plan’s service area. Firms that offer MA plans enter into a contract with Medicare by plan type, but they structure individual bids for plans that have distinct service areas and benefit package designs. The plan-level data from bids are distinct from the county-level files also available on the web.

a. Eligible Plans

We restricted the analysis to MA-PDs that were both available for individual enrollment in 2009 and offered in the 50 states and the District of Columbia. We excluded plans serving Puerto Rico because Congress established unique payment rules for the territory that result in considerably higher payments to MA plans. Including them in the analysis could distort the findings.

We deliberately chose certain plans for the study so that we could compare results by plan type without extraneous sources of variation that might complicate both the analysis and the interpretation of results. The following types of plans were excluded:

- **MA-only plans.** The absence of Part D could affect how these plans applied any Part C rebate in structuring premiums and benefits. Only a small share of MA enrollees are in MA-only plans (about 10 percent), often because of special circumstances—other sources of supplemental coverage, for example—that affect their decisions about Part D.
- **Special needs plans.** Medicare beneficiaries must meet specific eligibility requirements to join these plans, and many of those enrolled are dually eligible for Medicare and Medicaid, thus affecting how MA benefits are structured in these plans.
- **Group plans.** To enroll in these plans, Medicare beneficiaries must be members of a specific group (e.g., retirees from a specific firm, members of a union, members of a religious order). The structure of benefits is often limited to what can be financed through Medicare, with employers then negotiating for “wrap around” supplemental benefits that are paid for either by them or the enrollees.
- **Cost, HCPP, demonstration, PACE, and other types of plans.** These plans have unique histories and typically somewhat different payment and coverage requirements.

These exclusions yielded 2,315 plans that were eligible for the analysis.

2. Estimating Risk-Adjusted FFS Costs for Beneficiaries in a Plan's Service Area

We constructed estimates of per-beneficiary FFS costs in each county from information on the CMS website for counties in the service area of each plan.⁴ County scores were normalized for average risk by dividing the county-adjusted FFS rate by the 2009 mean elderly and disabled risk score for any given county.⁵

We weighted each county by its share of plan enrollment in order to develop a plan-specific estimate of per-beneficiary FFS costs for beneficiaries living in the same locale as the plan. Counties with zero enrollment were dropped

3. Estimating Plan-Level Quartiles from County-Based Quartiles

Because ACA modified MA payments on the basis of county quartiles, we wanted to analyze efficiency as it varied across these quartiles. ACA also classified counties into quartiles according to their rank order of FFS costs. Counties in the top quartile have the highest FFS costs and will ultimately have their rates reduced to 95 percent of FFS after the change in ACA payment policies is phased in. Counties in the lowest quartile have the lowest FFS rates and will ultimately be paid 115 percent of FFS after the phase-in period.

We initially planned to assign plans to quartiles on the basis of the quartile assigned to the county with the highest share of enrollment. However, our analysis showed that the county with the largest share of enrollment share had, on average, only 60 percent of a plan's enrollment. Furthermore, there was considerable variability across plans, with the largest county having a median of 57 percent of the plan enrollment and the interquartile range running from 98 to 34 percent. (The minimum was 2 percent, and the maximum was 100 percent.)

As an alternative, we calculated the mean quartile per plan by weighting each of the counties according to its enrollment share and calculating a mean quartile. After reviewing the distribution, we classified plans in four groups based on their mean quartile score:

- Highest cost: average quartile is 1.25 or less (n=875)
- Next highest: average quartile is 1.26 to 2.25 (n=619)
- Next highest: average quartile is 2.26 to 3.25 (n=457)
- Lowest cost: average quartile is 3.26 or more (n=364)

⁴ We used the file at <http://www.cms.gov/Health-Plans/MedicareAdvtgSpecRateStats/Rebatebooks-and-Supporting-Data-Items/2009Rates.html>. For each county, we began with its 2009 FFS rate and adjusted it to remove the share of payments for the GME carve-out factor that were not included in rates. (These costs are not typically high.) The calculation was: $\text{Adjusted FFS}_{09} = [1 - (\text{carveoutfactor}_{09} * .65)]$, consistent with Biles et al. 2009.

⁵ These data were taken from <http://www.cms.gov/Health-Plans/MedicareAdvtgSpecRateStats/FFSData.html>. We mapped the few counties that were not in the data set. We assigned Broomfield the same risk score as Boulder because it was nearby. For Los Angeles, we added a duplicate record to account for differences in coding across the county (the county had only one risk score).

This classification results in a somewhat greater concentration of plans in the higher-cost areas because that is where more MA-PDs are located. Readers may also note that although many plans fell into the same quartile regardless of whether we used this averaging method or the county with the largest share of enrollment, a substantial share did not. This indicates that bids include counties that may differ in FFS cost experience.

4. Risk-Adjusted Estimated Plan Costs for Part C

The risk-adjusted estimated plan costs for Part C variable was constructed from CMS's publicly released plan-level data by dividing the *Average Per Member, Per Month Part C Payment (payments net of rebate)* by the *Plan Risk Score* (2009Part CPlanLevel2.xlsx)

For most plans, Part C payments less the “rebate” is an estimate of what a plan expects to provide in Medicare Part A and B benefits.⁶ The rebate refers to the residual funds resulting from plan costs (including administrative cost and profit) being lower than payments. Plans must use the rebate (subject to standard profit margins) to enhance benefits, reduce cost sharing, or offset premiums. Thus, Plan C payments less the rebate are an estimate of the plan's costs.

Five percent of plans (123) get no rebate, which means that their costs are equal to or above the benchmark for their service area (see Table A.1). We do not know the estimated costs for these plans, only what they were paid, which is no more than their costs and probably less. In all types of plans, there are some with no rebates, but this circumstance is much more common among regional PPOs and PFFS plans (22 percent each) than among local PPOs (4.4 percent) and HMOs (1.2 percent).

⁶ *A note on regional PPO estimates:* In contrast to local MA plans, in which service areas are defined by aggregations of counties, regional PPO service areas were formed by CMS and consist of 26 single- or multi-state aggregations. Plans in these areas are open to any eligible beneficiary in those counties. CMS payments to regional PPOs differ from its payments to other MA plans because the regional PPO benchmarks are set by region and reflect a blend of FFS costs and the regional PPOs bids. However, Medicare pays regional PPO rates based on the county in which an enrollee is located. In structuring bids (estimated costs), regional PPOs estimate the distribution of enrollees across counties. These unique features mean that the interpretation of estimated costs and payments in this report is more complex for regional PPOs than for local PPOs. We have not attempted to modify our analysis to reflect this complexity because regional PPOs do not enroll a large share of enrollees.

Table A.1. Percentage of Plans with No Rebate, by Plan Type and Mean Payment Quartile

Plan Type	All	Highest Mean Payment Quartile		Lowest Mean Payment Quartile	
All MA	2,315	875	619	457	364
No rebate	123	33	57	27	6
% no rebate	5.3%	3.8%	9.2%	5.9%	1.7%
All HMO	1,492	719	383	219	171
No rebate	18	9	7	2	0
%no rebate	1.2%	1.3%	1.8%	0.9%	0%
All Local PPOs	437	118	102	108	109
No rebate	19	13	5	1	0
% no rebate	4.4%	11.0%	4.9%	0.9%	0%
All Regional PPOs	55	6	26	19	4
No rebate	12	3	5	4	0
% no rebate	21.8%	50.0%	19.2%	21.0%	0%
All PFFS	331	32	108	111	80
No rebate	74	8	40	20	6
% no rebate	22.4%	25.0%	37.0%	18.0%	7.5%

Source: Mathematica's analysis of selected publicly available CMS data compiled from several sources.

5. Relative Plan Efficiency

We estimated relative plan efficiency by expressing risk-adjusted plan costs for Part C as a percentage of risk-adjusted Part A and B costs in traditional Medicare for the plan's service area. Percentages under 100 indicate that the plan was more efficient than FFS Medicare in that same area, adjusted for patient mix. Percentages above 100 indicate that the plan was less efficient than the FFS Medicare in that same area, adjusted for patient mix.

The comparison does not account for any payments that CMS may have made beyond the FFS costs in the county (e.g., floor payments and other adjustments that are factored into the benchmark and potentially affect the size of the rebate as well). Although such sources of variation in spending for the MA sector play an important role in what it costs Medicare to offer MA, they are extraneous to our goals, which are to compare what MA plans say it costs them to provide Part C benefits to beneficiaries with what Medicare pays for those same beneficiaries in the same county.

Relative efficiency in 2009 also reflects the incentives built into the MA payment system. To the extent that traditional Medicare costs are high, with FFS providing little encouragement to providers to practice efficiently, the traditional Medicare program may have set the bar relatively low, especially in more highly paid counties, for MA plans to compete, limiting the incentives for these plans to become as efficient as they might be.

6. Plan Benefits and Premiums

These two variables were taken from the data file that is used to support Health Plan Compare on the CMS consumer website (www.medicare.gov). We had downloaded this file and analyzed it for other purposes (Gold and Hudson 2009).

CMS allows plans to introduce some variation into benefits for geographic “segments” within a service area. However, 90.3 percent of all plans in 2009 had only one segment. Most of the rest of the plans (164, or 7.1 percent) had two. For simplicity, if a plan had more than one segment, we assumed that the benefits and premiums were equal to the segment with the highest share of enrollment. We analyzed how sensitive our definition was to the algorithm by comparing premiums across segments for plans with the highest variability. In general, the difference was minimal.

Organizations offering MA plans make strategic decisions in developing their benefit packages, taking into account payments, enrollee expectations, and market competition among other factors. MedPAC’s analysis for 2009 indicates that reducing cost sharing is the most common benefit enhancement, accounting for 60 percent of the average value of benefit enhancements.⁴

To assess variation across plans in Medicare cost sharing for Part A and B benefits, we used the HealthMetrix summary measure of the effects of a plan’s cost sharing structure on out-of-pocket physician and hospital costs for beneficiaries with lower, moderate, and heavier use of physician services and hospital care (Gold 2008). The metrics for out-of-pocket-costs incorporate licensed assumptions obtained from Healthmetrix on the use of physician visits and hospital services in three health subgroups that we applied to the data file showing plan benefit design. (Estimates do not include spending on prescription drugs.) “All enrollees” assumes that there is a standardized mix of about 72 percent healthy beneficiaries, 19 percent with episodic needs, and 90 percent with chronic needs based on the distribution of noninstitutionalized Medicare beneficiaries in the Medicare Current Beneficiary Survey (Table 7), corresponding to at least good health, fair health, and poor health. Although these metrics do not necessarily provide a good estimate of the absolute value of out-of-pocket costs actually incurred by beneficiaries, they do offer a standardized, consistent way to look at variation in benefit packages.

In addition to this measure, we also examined three basic measures of MA-PD premiums because research shows that low- or zero-premium plans are an important strategic consideration for both plans and beneficiaries. We examined average Part C premiums, total premiums (C and D), and percent of MA-PDs with a zero total premium (other than what Medicare charges) within the particular plan category.

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