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McKinsey Center for U.S. Health System Reform

Intelligence Brief

Assessing the 2015 MA Star ratings

On October 10, 2014, CMS released the Medicare Advantage (MA) Star ratings for 2015. We analyzed CMS's data covering 691 MA plan contracts across the 50 states to determine which types of products had achieved the highest average Star ratings. Three key observations emerged from our analysis:

- Average Star ratings differ by product type. Health maintenance organization (HMO) products performed the best, with an enrollment-weighted average Star rating of 3.96
- Plans built around integrated delivery networks (IDNs)[1] continue to receive a higher weighted average rating (4.43) than commercial plans (3.81) and Blues plans (3.76)
- The weighted average Star rating for plans offered by commercial and Blues carriers is rising, but commercial carriers are improving at nearly twice the rate of the Blues carriers

Average Star ratings vary by product type

Overall, about 40 percent of the plans achieved a Star rating of 4 or higher. HMO products achieved the highest enrollment-weighted average Star rating (3.96).[2] However, if Kaiser Permanente, which received a 5-Star rating, is removed from the analysis, the HMO average drops by 0.15, and local PPO plans have a higher enrollment-weighted average Star rating (3.87). Regional PPO plans achieved an enrollment-weighted average rating of 3.53, a significant improvement from their 2012 rating of 2.99 (*Exhibit 1*).

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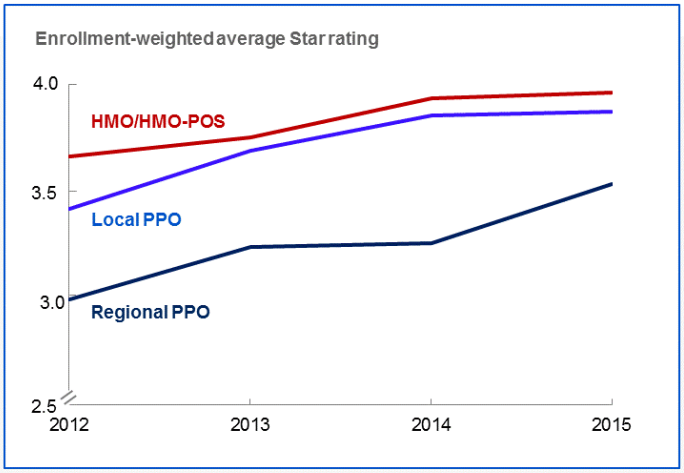
1 Includes both provider-led integrated delivery networks (IDNs) as well as payor-led IDNs. The analysis includes Kaiser Permanente as an integrated carrier.

2 Methodology used to calculate enrollment-weighted average is described in the appendix.

EXHIBIT 1

MA quality performance by product design type



FFS, fee for service; HMO, health maintenance organization; POS, point of service; PPO, preferred provider organization.

SOURCE: McKinsey analysis of CMS's 2015 Part C & D Medicare Star Rating Data (released October 10, 2014)

A county-contract level regression analysis[3] showed that HMO and local PPO plans are associated with a 0.2 to 0.3 improvement in the enrollment-weighted average Star rating compared with regional PPOs.

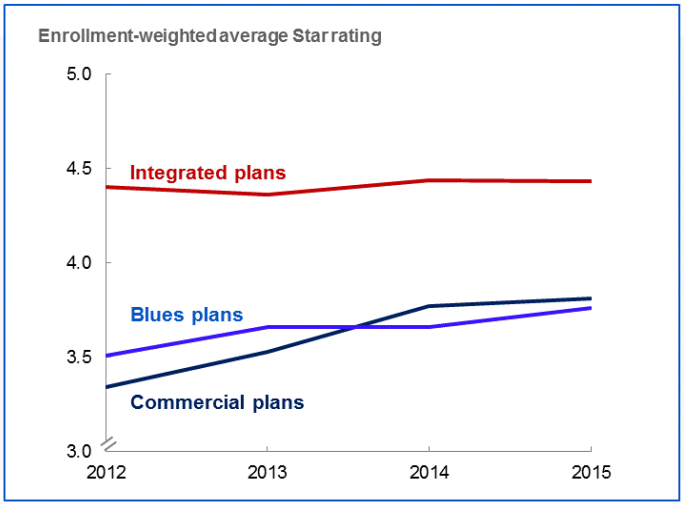
Plans built around IDNs received higher ratings

Plans built around IDNs outperformed both commercial and Blues plans. Their enrollment-weighted average Star rating was 4.43. Of the 110 plans built around IDNs offered for 2015, 85 percent have a Star rating of 4 or more. These plans have maintained this relative position since 2012, when their enrollment-weighted average was 4.4 (*Exhibit 2)*. Once again, the 5-Star rating achieved by Kaiser elevates the average for these plans (*Exhibit 3*). Absent Kaiser, the 2015 enrollment-weighted average for IDN-based plans drops to 3.98, which is still above both the average ratings for commercial and the Blues carriers.

[3] A multiple linear regression model was developed to explain 2015 Star rating for a contract at a given county, using CMS historical MA plan data. Key independent variables considered in the model are plan type, carrier type, contract age, urbanity, low-income subsidy, plan size and growth rate, county-level Medicare size, and MA penetration. Weighted least square was used for variable coefficient estimate. The weight variable was 2014 MA enrollment size for a contract at a given county. Only variables with p-value <0.01 are retained in the final model.

EXHIBIT 2

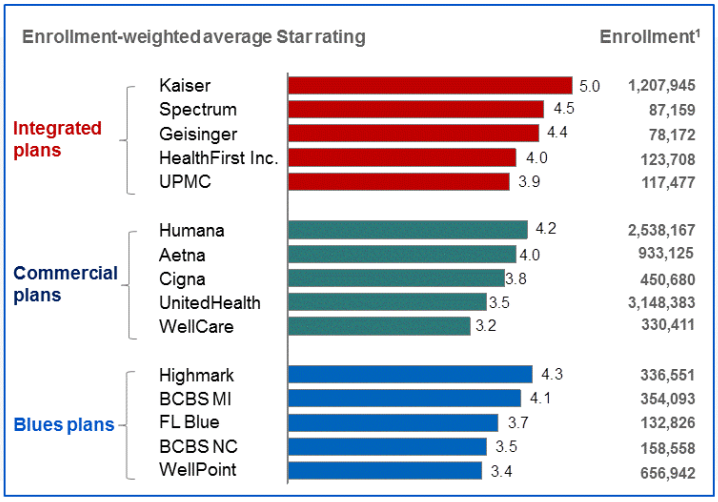
MA quality performance by carrier type



SOURCE: McKinsey analysis of CMS's 2015 Part C & D Medicare Star Rating Data (released October 10, 2014)

EXHIBIT 3

MA quality performance, top 5 carriers by enrollment



1 Based on April 2014 data from CMS

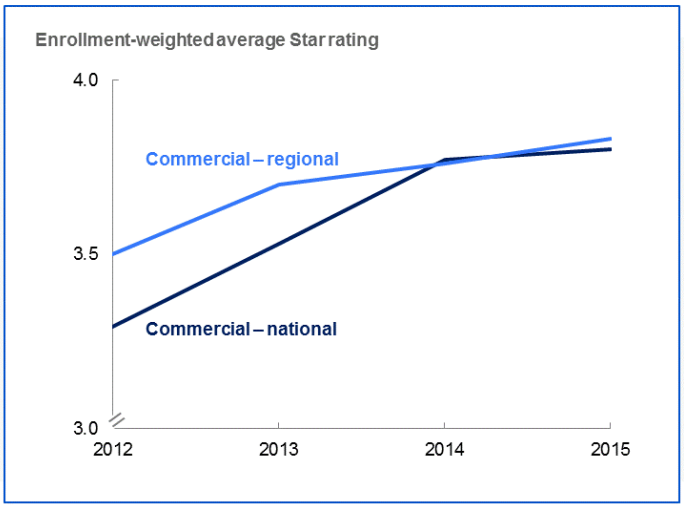
SOURCE: McKinsey analysis of CMS's 2015 Part C & D Medicare Star Rating Data (released October 10, 2014)

Commercial and Blues plan performance is improving

Collectively, commercial MA plans earned an enrollment-weighted average Star rating of 3.81 for 2015, a 0.47 improvement over 2012. The performance of regional commercial plans[4] and national commercial plans was comparable, with weighted averages of 3.83 and 3.80, respectively (*Exhibit 4*). However, national carriers have improved their Stars performance more rapidly than have regional carriers. Blues plans achieved a 3.76 weighted average Star rating, an increase of 0.25 points over 2012.

EXHIBIT 4

Quality performance of commercial MA plans



SOURCE: McKinsey analysis of CMS's 2015 Part C & D Medicare Star Rating Data (released October 10, 2014)

Other factors associated with Stars performance

A county- and contract-level regression analysis of the CMS data disclosed other factors significantly[5] associated with Stars performance:

- Each 100,000-member increase in plan size within a county correlates with a 0.14 increase in Star rating
- Rural counties correlate with a 0.1 point increase in Star rating[6]

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[4] National commercial carriers are defined as those offering Medicare Advantage products in 25 states or more, and commercial plans are defined as those offering products in 24 states or less.

[5] At the 99-percent confidence level.

[6] The comparison is with urban counties. We used the US Office of Management and Budgets 2013 classifications of Core Basic Statistical Areas, which defines urban counties as those that are both metropolitan and central (vs. outlying).

Evolution of the Stars program

In 2008, CMS inaugurated its quality rating program for private carriers offering MA plans using a Stars rating system. In 2012, it began awarding MA carriers a bonus payment based on their products' previous year's performance across a set of objective clinical, customer satisfaction, and contract performance metrics.[7] Since then, the Stars rating system has continued to evolve.

In particular, CMS has increased the role clinical performance metrics play in determining the overall Star rating. Only 49 percent of the metrics used to calculate the first-year bonus payments were related to clinical quality, and their weighting was equivalent to the contract performance and customer satisfaction metrics.[8] At present, 63 percent of the metrics are based on clinical quality, and there is much greater emphasis on outcome, rather than process, metrics—outcome metrics carry three times the weight of other metrics in the overall scoring.[9]

For carriers, Stars performance is important not only because others have shown that it correlates with market share, but also because it results in higher payments, contributing to healthy plan economics, richer benefit packages, and the ability to invest in new plan capabilities. Through 2017, CMS will continue to reset the MA premium level closer to the fee-for-service expense equivalent. As well, the eligibility for Star bonuses is now bi-modal—only plans achieving 4 or more Stars will be awarded bonus payments.[10] We estimate that 2015 plans with fewer than 4 Stars will forfeit $3.47 billion in bonus payments[11] and could potentially experience a 250 basis-point reduction in margin.[12] Among other things, this lost revenue will inhibit carriers' ability to invest in care coordination innovation and offer attractive benefit packages to seniors.

CMS has proposed additional changes to its Stars methodology starting in the 2016 rating year, including:

- Abandoning pre-determined 4-Star thresholds (a priori expectations for high performance), which accounted for 60 percent of all measures in the 2014 rating year. CMS has identified more significant levels of improvement for measures without pre-

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7 The full set of metrics used to determine Star ratings may be found on the CMS website: http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html.

8 MedPAC. Report to Congress: Medicare Payment Policy. March 11, 2011.

9 MedPAC 2014 Report to Congress: Medicare Payment Policy. March 14, 2014.

10 New plans receive a 3.5-percent quality bonus until performance data is available.

11 This estimate is based on the average bonus payment and the number of MA consumers enrolled in plans with a rating below 4 Stars. The estimate is conservative because it does not take into account MA enrollment growth.

12 2015 Medicare Advantage rates: Perspectives for payors (McKinsey white paper). April 2014.

determined thresholds[13] and aims to increase both the rate of improvement and its measurement accuracy

- Potentially using the actual rate for a given measure, rather than the Stars assigned to the measure, to prevent information loss from premature rounding and increase the accuracy of measure aggregation
- Rapidly adopting and integrating clinical quality evidence by tying measures and guidelines more closely to updates from source quality agencies (e.g., National Committee for Quality Alliance, or NCQA)

In addition, CMS will be modifying some metrics and retiring others (e.g., low-density lipoprotein cholesterol screening and control, based on the 2015 Health Effectiveness Data and Information Set (HEDIS) released by the NCQA).

Star ratings are not a perfect measure of carrier performance, but they do offer seniors a standardized basis for judging the quality of care delivered through a given plan. Evidence is emerging that the ratings influence seniors' purchasing decisions (albeit they are not necessarily the sole determinant of those decisions). A cross-sectional study of seniors enrolling in MA for the first time, or switching MA plans, found that each incremental Star was associated with a 9.5 percent increase in the probability of plan selection.[14] In 2009, only 17 percent of MA members were enrolled in plans with 4 or more Stars. If enrollees stay in their current MA plans in 2015, that number will be approximately 60 percent.[15]

□ □ □

The findings in this Intelligence Brief provide a perspective on how CMS is rating carrier performance on the MA plans being offered for 2015. The information is based on publicly reported data released on October 10, 2014.

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[13] 32 percent of contracts improved significantly across Part C measures with 4-Star thresholds, compared with 52 percent of contracts for measures without 4-Star thresholds. The gap is larger for Part D measures.

[14] Rachel O. Reid et al. Association between Medicare Advantage Star ratings and enrollment, *JAMA*. 2013;309(3):267-274.

[15] CMS. 2015 Part C & D Medicare Star Rating Data. October 10, 2014.

Appendix

Methodology

Enrollment-weighted average: On October 10, 2014, CMS released data on Medicare Advantage contracts and plans offered for 2015 in advance of the annual enrollment period. McKinsey calculated enrollment-weighted averages by taking the total number of enrollees in contracts and plans for 2014, assigning higher weights to plans with higher enrollment. These were used to calculate the enrollment-weighted average for 2015 Star ratings. The enrollment-weighted average demonstrates Stars performance among carriers and products with the highest level of participation and thus allows us to understand overall trends.

Enrollment: The October 2014 summary Star rating data from CMS was used as a filter for the April 2014 CMS Medicare Advantage enrollment by state, county, and contract. Therefore, enrollment in contracts that did not exist in the October 2014 ratings file are not included in the enrollment data in this brief.

Glossary

Integrated delivery network (IDN). A health plan model, either provider-led or payor-led, with close alignment between the payor and provider functions

Health maintenance organization (HMO). A plan model centered around a primary care physician who acts as gatekeeper to other services and referrals; it provides no coverage for out-of-network services except in emergency or urgent-care situations

Preferred provider organization (PPO). A health plan model that allows members to see physicians and get services that are not part of a network, but the out-of-network services require a higher copayment

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October 2014

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