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How Competition Improves Quality: The Case of Medicare Advantage

Kathryn Nix

Abstract: *In 2003, the Medicare Modernization Act created the Medicare Advantage program, which allowed seniors to choose coverage from private health plans. Both recent research published in* The American Journal of Managed Care *by Niall Brennan and Mark Shepard and another analysis by America's Health Insurance Plans use HEDIS measures and state-based data on hospital utilization, respectively, to compare the quality of care received by enrollees in Medicare Advantage and traditional Medicare fee-for-service. The studies found the new program performed better than traditional Medicare on a number of measures, including delivery of care and hospital utilization.*

Since 2005, seniors have had the option to receive their Medicare benefits through a private plan of their choice offered under Medicare Advantage (MA). Participating health plans are required to offer the same benefits offered under traditional Medicare's Parts A and B (Medicare fee-for-service, FFS), which, respectively, cover inpatient and outpatient services. MA plans can include additional benefits, including prescription drug coverage otherwise available under Medicare Part D. Payment for MA plans is determined by benchmarks that reflect per-beneficiary spending in FFS and other factors.

Since its enactment, MA has emerged as a clearly popular alternative to traditional Medicare. In 2010, close to 25 percent of the Medicare population was enrolled in an MA plan. Enrollment has more than doubled from its initial 5.3 million and continues to grow.[1]

The introduction of a robust and popular private marketplace for seniors to receive their health benefits offered the opportunity to compare the performance of participating private plans to that of traditional Medicare. Medicare Advantage's success has been a subject of debate since the onset of the program, but recently available data on quality of care in MA has revealed its performance. Research conducted by Niall Brennan, Acting Director of the Office of Policy at the Centers for Medicare and Medicaid Services (CMS),

[1] See Kathryn Nix, "A Recipe for Reform: Success of Consumer-Driven Principles in Medicare Programs," Heritage Foundation *WebMemo* No. 3340, August 10, 2011, at *http://www.heritage.org/Research/Reports/2011/08/Consumer-Driven-Medicare-Reform-Models-for-Success.*

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214 Massachusetts Avenue, NE
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(202) 546-4400 • heritage.org

and Mark Shepard, a Harvard University Ph.D. candidate in economics, shows that, based on several widely accepted measures of quality, MA plans outperform FFS to offer higher quality care. Separate research conducted by America's Health Insurance Plans (AHIP) also shows quality improvements for enrollees in the Medicare Advantage program.

The Medicare Payment Advisory Commission (MedPAC) has long recommended a quality comparison of MA and FFS. Brennan's and Shepard's research follows an approach similar to the methods put forth by MedPAC, looking at 11 measures of the underuse of effective care from the Healthcare Effectiveness Data and Information Set (HEDIS) for 2006 and 2007.[2] Thanks to a special CMS project that allowed for a head-to-head comparison based on evidence-based measures, 2006 marked the first year that these data were available for traditional Medicare.

Brennan and Shepard limited their study to Medicare Advantage managed care plans, since private fee-for-service (PFFS) plans were exempt from the quality reporting requirements. The measures they used revealed how many of the patients who were recommended to receive a particular treatment or screening actually did so. For eight of the 11 measures, MA performed substantially better than FFS. On one of the measures, MA performed slightly better, and it performed worse than FFS on just two of the 11 measures.

The researchers observed that all eight of the measures for which MA achieved superior performance were long-established standards for care. Though FFS did better or nominally worse on the three newer measures introduced in 2004 and 2005, MA rapidly improved its performance on these more recently introduced measures in the following year. According to the authors:

> If this dichotomy is not coincidental, it suggests a learning effect in MA, or less favorably a "teaching to the test" effect. Newly introduced measures may have lower scores in MA initially, but these scores quickly increase as plans learn to ensure effective care delivery and complete measurement of existing care.

Separately, in a series of working papers comparing MA and FFS using hospital utilization data, AHIP's Center for Policy and Research also found superior quality in MA. According to the authors, while HEDIS data for Medicare Advantage provide information on specific preventive screenings and recommended measures, they "do not address broader patterns of health care use or outcomes" for which measures of hospital utilization are better suited. However, this type of comparison, too, was not possible until data from 2005 and 2006 became available for both MA and FFS. The AHIP findings, then, complement the work by Brennan and Shepard.

The first paper in the series looked at utilization by diabetes and heart disease patients in eight MA Health Maintenance Organizations (HMOs) representing different regions in the United States and FFS in the same area.[3] Hospital utilization was compared using measures of inpatient hospital stays, inpatient hospital admissions, emergency room visits, hospital readmissions within the same quarter for the same Diagnosis-Related Group (DRG), and potentially avoidable hospital admissions in the 13 categories identified by the Agency for Healthcare Research and Quality (AHRQ).

For each of these measures, lower rates can signal better care management and coordination. The findings showed that for diabetes patients, all of the MA plans had fewer inpatient days and readmissions than FFS had. The vast majority of the plans had fewer emergency room visits, fewer admissions overall, and fewer potentially avoidable admissions. Heart disease

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[2] Niall Brennan and Mark Shepard, "Comparing Quality of Care in the Medicare Program," *The American Journal of Managed Care*, Vol. 16, No. 11 (November 2010), at *http://www.ajmc.com/media/pdf/AJMC_10nov_Brennan841to848.pdf.*

[3] America's Health Insurance Plans, Center for Policy and Research, "Working Paper: A Preliminary Comparison of Utilization Measures Among Diabetes and Heart Disease Patients in Eight Regional Medicare Advantage Plans and Medicare Fee-For-Service in the Same Areas," Revised September 2009, at *http://www.ahipresearch.org/pdfs/MAvsFFS.pdf.*

patients displayed the same trends, though the differences between MA and FFS were not as consistent. The authors concluded that "these comparisons imply that MA plans are likely to help patients avoid inpatient hospital stays and ER visits among their diabetes and heart disease patients, sometimes by substituting additional outpatient or office visits."

In a follow-up study, AHIP compared data for two multi-state MA HMOs and Medicare FFS in the same operating areas.[4] Of the two companies, one provided data for three operating areas and the other for seven, bringing the total number of areas of comparison to 18 in combination with the first study. Based on averages of all 18 areas, the MA plans showed a 20 percent reduction in hospital days, an 11 percent reduction in admissions, a 24 percent reduction in emergency room visits, a 39 percent reduction in readmissions, and a 10 percent decrease in potentially avoidable admissions.

For 11 of the comparison sets, data on outpatient and office visits were also available. In these areas, outpatient visits were comparable for Medicare Advantage and FFS, but MA plans had an average increase in office visits of 25 percent and a median increase of 9 percent, supporting the suggestion that MA plans might do a better job of avoiding inpatient stays by increasing other types of care.

Next, AHIP compared hospital utilization rates in California and Nevada using AHRQ data for all hospital discharges in 2006, allowing for direct, risk-adjusted comparisons of all MA enrollees, not just those enrolled in a specific subset of MA plans, and FFS.[5] The authors examined inpatient days, same-quarter readmissions, and potentially avoidable admissions.

The findings showed that inpatient days for MA were 30 percent lower than FFS in California and 23 percent lower in Nevada. MA rates of same-quarter readmissions for the same DRGs were 15 percent lower than FFS in California and 33 percent lower in Nevada. Potentially avoidable readmissions were 6 percent lower in both states. The authors pointed out that, according to a previous study, "in half of the readmissions studied among FFS patients, there was no physician contact billed to Medicare prior to the readmission." Based on this information, they suggested that MA plans may have lower rates of readmissions because private insurers place greater emphasis on discharge planning and coordinated care following a hospital stay.

AHIP then extended its study of readmission rates using AHRQ data in California and Nevada to include additional states and to add another year of data, also refining their methodology.[6] This study focused specifically on readmissions, since reducing their frequency is a national health care priority. The data were compared in three different ways and showed that, for the nine states for which available data were the most reliable, risk-adjusted readmission rates were 27 percent–29 percent lower in Medicare Advantage per enrollee, 16 percent–18 percent lower per person with an admission, and 14 percent–17 percent lower per hospitalization. The authors note that per-enrollee comparisons are a good way to measure the performance of different types of health plans, while measuring per-hospitalization readmissions allows for evaluation of specific hospitals.

Finally, AHRQ's "Revisit" data for several of the states that were assessed in the previous studies made it possible for a final study of both same-quarter and 30-day readmission rates. Before, AHIP focused solely on same-quarter readmissions due to a lack of neces-

[4] America's Health Insurance Plans, Center for Policy and Research, "Working Paper: Comparisons of Utilization in Two Large Multi-State Medicare Advantage HMOs and Medicare Fee-for-Service in the Same Service Areas," December 2009, at *http://www.ahipresearch.org/pdfs/MAvsFFS-CO9and10.pdf.*

[5] America's Health Insurance Plans, Center for Policy and Research, "Reductions in Hospital Days, Re-Admissions, and Potentially Avoidable Admissions Among Medicare Advantage Enrollees in California and Nevada, 2006," Revised October 2009, at *http://www.ahipresearch.org/pdfs/CAvsNV.pdf.*

[6] America's Health Insurance Plans, Center for Policy and Research, "Working Paper: Using State Hospital Discharge Data to Compare Readmission Rates in Medicare Advantage and Medicare's Traditional Fee-for-Service Program," May 2010, at *http://www.ahipresearch.org/pdfs/9State-Readmits.pdf.*

sary information with which to compute 30-day readmissions.[7] The new data made it possible to recalculate readmissions for four of the states, and similar data were used to include Texas.

The results reinforced the earlier findings. Risk-adjusted 30-day readmission rates per hospitalization were 12 percent–18 percent lower in MA than in FFS, 12 percent–27 percent lower per patient with an admission, and 22 percent–43 percent lower per enrollee. The same magnitude of difference was also found for same-quarter, 60-day, and 90-day readmission rates.

Together, these studies provide a well-rounded body of information on quality of care under Medicare Advantage and fee-for-service. The results support the conclusion that MA plans outperform FFS based on several different measures of health care quality. Lawmakers should apply this information as they contemplate reform to improve quality and reduce spending within the traditional Medicare program.

[7] America's Health Insurance Plans, Center for Policy and Research, "Using AHRQ's 'Revisit' Data to Estimate 30-Day Readmission Rates in Medicare Advantage and the Traditional Fee-for-Service Program," October 2010, at *http://www.ahipresearch.org/pdfs/AHRQ_revisit_readmission_rates_10-12-10.pdf.*

SUMMARY OF FINDINGS

- Medicare Advantage performed better than Medicare fee-for-service on most measures reflecting patients' receipt of appropriate care.
- MA displayed rapid improvement on more recently introduced measures, suggesting a learning effect.
- MA also performed better than FFS when assessed using discharge data on hospital utilization.
- MA plans may be doing a better job of preventing unnecessary inpatient care by increasing use of outpatient services and office visits.
- MA plans may be avoiding unnecessary readmissions through superior discharge planning and coordination of care following an inpatient episode of care.

*—**Kathryn Nix** is a Policy Analyst in the Center for Health Policy Studies at The Heritage Foundation.*