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Intelligence Brief

Assessing the 2017 Medicare Advantage Star ratings

On October 12, 2016, the Centers for Medicare and Medicaid Services (CMS) released the Medicare Advantage (MA) Star ratings for 2017. Given the multiple sources of volatility in the MA market, including the recent election results, we wanted to understand how payors are performing on these metrics, because delivering quality programs that receive a Star bonus is an important lever payors can use to improve their MA performance.

We therefore analyzed CMS's data covering 530 MA health plans—from the 50 states, the District of Columbia, and Puerto Rico—to develop a perspective on the payor industry's Stars performance. We also compared this year's results against the Star ratings CMS released in previous years. We found that the overall enrollment-weighted average Star score in 2017 was largely unchanged from 2016, although, on average, contracts[1] did improve their underlying performance on the Star measures. We also uncovered trends indicating it will be critical for payors to continue to invest in their capabilities. For example, contracts with a 4-Star rating or higher (4+ rating) appear to be more likely to survive in the market and to experience much stronger enrollment growth than lower-performing competitors.

More specifically:

- The industry-wide enrollment-weighted average Star rating was 4.03 in 2016 and 4.00 in 2017.[2] This year, like last year, the enrollment-weighted average score for contract performance improved by 0.10 Stars. However, changes in cut points and the addition of the Categorical Adjustment Index[3] offset the increase.
- Health maintenance organizations (HMOs) outperformed the market, with an enrollment-weighted average Star rating of 4.08 in 2017. The score for preferred provider organizations (PPOs) decreased to 3.80.

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1 Star ratings are awarded at the contract level. Contracts can contain multiple plans and multiple plan designs.

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

3 The Categorical Adjustment Index (CAI) is a factor that is added to (or subtracted from) a contract's Star rating to adjust for the within-contract disparities in performance associated with a contract's percentages of beneficiaries with low-income subsidy/dual-eligible and disability status.

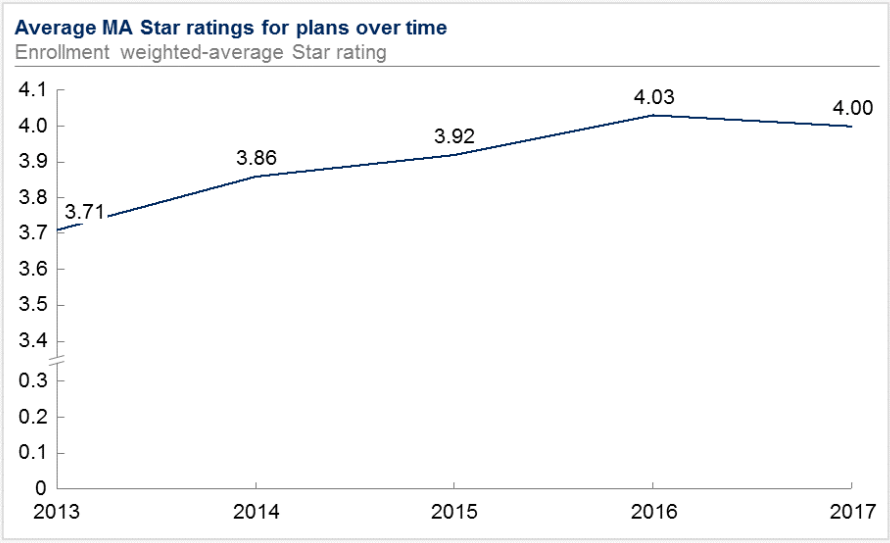
- Contracts built around integrated delivery networks (IDNs)[4] received a higher rating (4.45) than did contracts offered by commercial carriers[5] (3.89) or Blues carriers (3.93).
- Star ratings correlate with enrollment growth rates. Among the 2014 contracts that remained in the market in 2016, those that retained a 4+ Star rating experienced 40.9% growth. However, contracts that lost a 4+ Star rating had much slower growth (7.8%), and contracts with consistent performance below 4 Stars had only 0.9% growth.
- On a member-weighted basis, 90% of contracts that left the market between 2013 and 2016 were below 4 Stars.
- Plan maturity is associated with higher Star ratings: scores were 3.42 for contracts that have been in the program for fewer than five years, 3.72 for those with 5 to 10 years' participation, and 4.09 for those in the program for more than 10 years.
- A plan's ability to handle member complaints, manage chronic conditions, and deliver preventive care had the strongest correlation with overall performance changes.

Star ratings have remained flat since last year

Between last year and this year, the enrollment-weighted average MA Star rating remained essentially flat—changing from 4.03 to 4.00 (*Exhibit 1*). This is the first time in six years the score did not increase. Similarly, the proportion of contracts that received 4+ Stars did not change from 2016 to 2017 (*Exhibit 2*).

EXHIBIT 1

Average enrollment-weighted MA Star ratings have remained flat



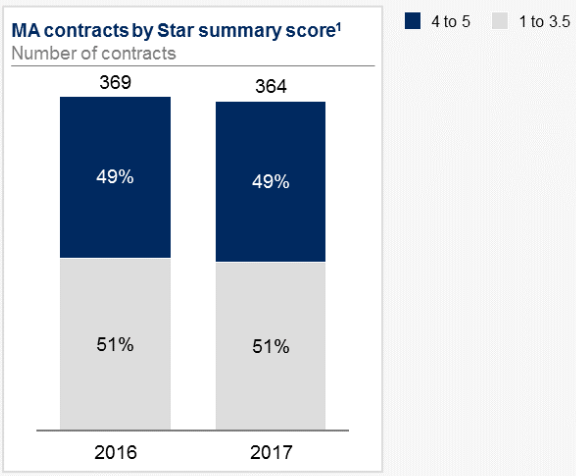
SOURCE: CMS Star ratings fact sheet (2016-2017)

[4] Includes both provider-led IDNs and payor-led IDNs.

[5] Commercial carriers are defined as those operated by for-profit entities that are not part of the Blue Cross Blue Shield Association and not considered part of an integrated delivery network (IDN).

EXHIBIT 2

The number of contracts above and below four stars remained constant

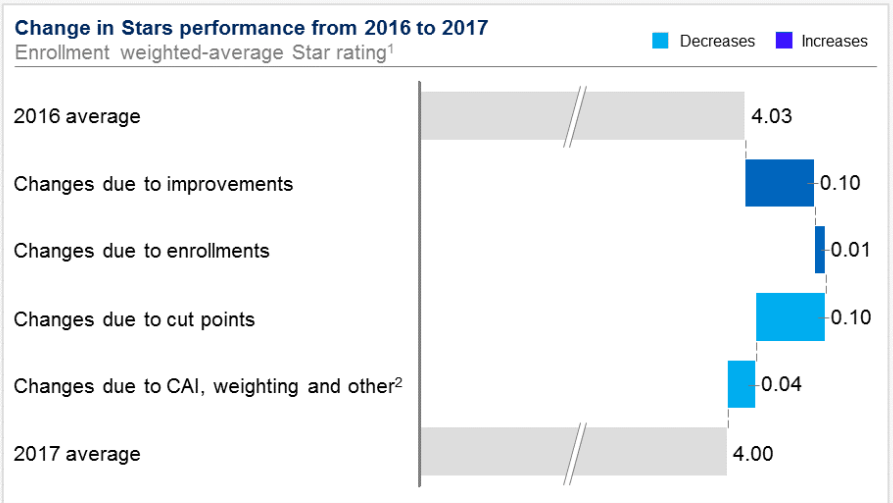


1 Excludes MA-PD contracts that were not rated, PD-only contracts, and MA-only contracts.
SOURCE: McKinsey analysis of CMS Medicare Star ratings data (2016-2017)

To better understand the 2017 Star ratings, we isolated specific independent variables that influence those ratings, including changes in performance, enrollment, and cut points (CMS's cut-off scores for each rating), as well as the Categorical Adjustment Index (CAI) it introduced this year. The enrollment-weighted average score for performance rose 0.10 this year (the same level of improvement that was seen last year). Enrollment changes also created a slight uplift. However, these gains were offset by changes in cut points, the addition of the CAI, and other factors (*Exhibit 3*).

EXHIBIT 3

CMS changes negated plan improvements



1 Based on CMS published averages for 2016 and 2017 rating years.
2 Changes due to the addition of the Categorical Adjustment Index (socio-demographic and disability adjustment), weighting changes for some measures, addition/deletion of contracts (-0.004 impact for new contracts), improvement measures, and r-factor bonuses

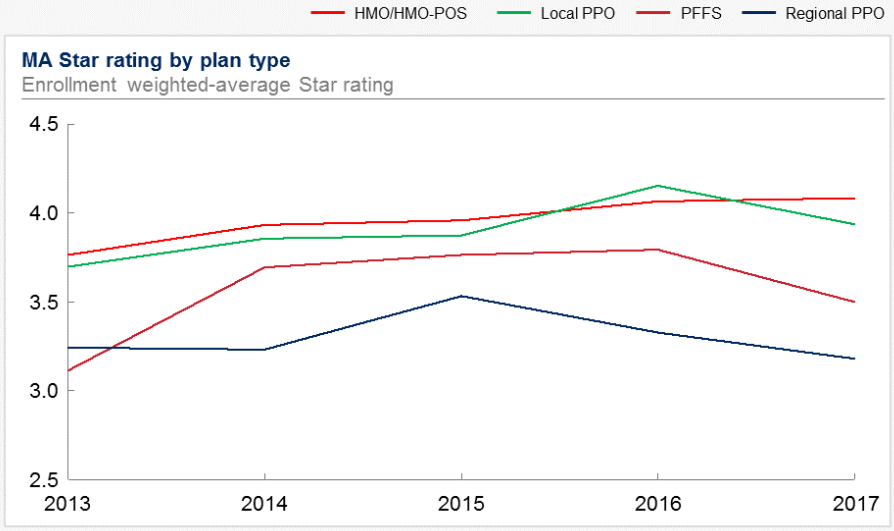
SOURCE: McKinsey analysis of CMS Medicare Star ratings data (2016-2017), CMS April enrollment files (2015-2016)

HMOs outperformed the market

Among all MA contracts, HMOs received the highest enrollment-weighted average 2017 Star rating (4.08), on par with last year's 4.07 and higher than the overall average. PPO scores declined from last year. Local PPO contracts dropped from 4.16 to 3.94, and regional PPO contracts decreased from 3.33 to 3.18 (*Exhibit 4*).

EXHIBIT 4

PPO performance declined, whereas HMOs outperformed the market



HMO, health maintenance organization; PFFS, private fee for service; POS point of service; PPO, preferred provider organization.
SOURCE: McKinsey analysis of CMS Medicare Star ratings data (2013-2017), CMS April enrollment files (2012-2016)

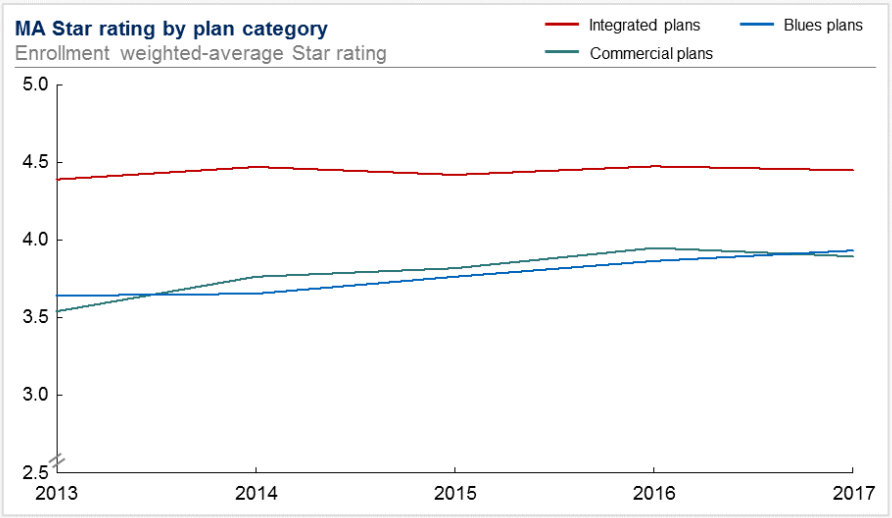
IDNs continue to outperform Blues and commercial contracts

Between the 2016 and 2017 ratings, the enrollment-weighted average score for Blues plans rose slightly (from 3.86 to 3.93), whereas commercial plans experienced a small decline (from 3.95 to 3.89); 2017 was the first time since 2013 that Blues plans had a higher score than commercial plans. The 2017 rating for IDNs was much higher (4.45) but was largely unchanged from the previous year (4.47). IDNs have held the lead position for the past five years (*Exhibit 5*). However, if Kaiser Permanente is excluded, the enrollment-weighted average 2017 score for IDNs drops to 4.02, significantly closer to the national average for all plans without Kaiser (3.92).

One factor contributing to the Blues' performance improvement was the rating given to Aware's (BCBS Minnesota's) 1876 contract, which was too new to be rated last year. Aware, which received a rating of 4.5 stars, includes 7% of all Blues enrollment this year. If that contract is excluded, the Blues' enrollment-weighted average score would be 3.89, on par with the rating for commercial plans. The slight improvement from last year's 3.86 was driven primarily by the higher ratings given this year to three of Anthem's HMO plans and two of Guidewell's plans (one HMO and one regional PPO).

EXHIBIT 5

Blues performed on par with commercial plans, but IDNs remain dominant

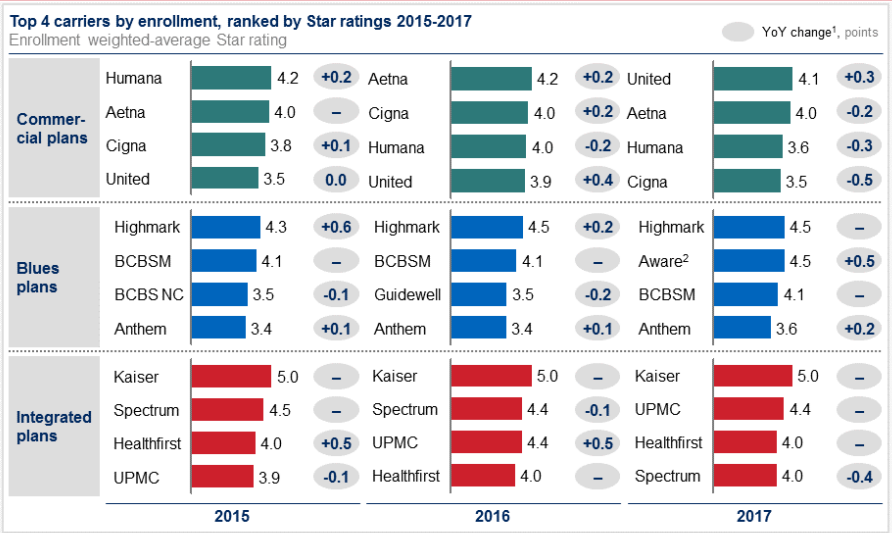


SOURCE: McKinsey analysis of CMS Medicare Star ratings data (2013-2017), CMS April enrollment files (2012-2016)

The small decline in performance for commercial plans can be partially explained by the large drops in the enrollment-weighted Star ratings from top payors (*Exhibit 6*). If the payors affected most this year (Cigna and Humana) are excluded, the enrollment-weighted average Star rating for commercial plans would have been 4.05 in 2017 and 3.94 in 2016.

EXHIBIT 6

Top carriers show consistent performance, except for commercial plans



1 YoY changes reflect actual differences, not rounded differences.
2 Includes 1876 cost contract.

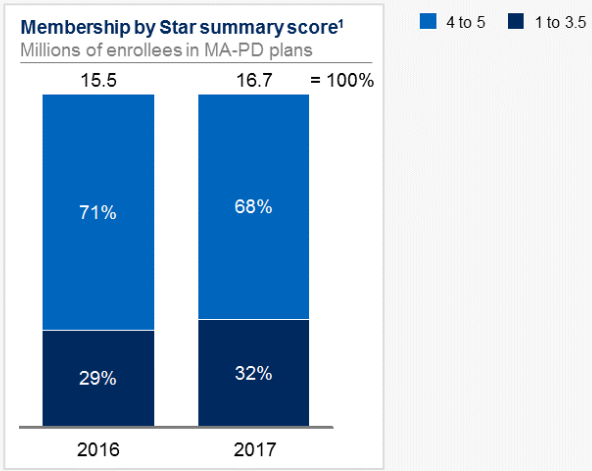
SOURCE: McKinsey analysis of CMS Medicare Star ratings data (2014-2017), CMS April enrollment files (2013-2016)

Ratings appear to affect member attraction more than retention

Since last year, MA market membership has grown by almost 8%, from 15.5 million to 16.7 million.[6] Although the percentage of all MA members who are enrolled in contracts with 4+ Stars decreased from 71% last year to 68% this year, the change does not reflect a decrease in the number of people who enrolled in the higher-rated contracts. Rather, its primary cause is the high volume of members retained by contracts that dropped from 4+ Stars to lower ratings (*Exhibit 7*).

EXHIBIT 7

Percentage of enrollees in 4+ Star plans fell slightly



1 Excludes MA-PD contracts that were not rated, PD-only contracts, and MA-only contracts.
SOURCE: McKinsey analysis of CMS Medicare Star ratings data (2016-2017), CMS April enrollment files (2015-2016)

To better understand the potential implications of rating changes on future enrollment, we first analyzed the association between the 2016 Star ratings (issued in October 2015) and 2016 enrollment. The analysis revealed that contracts with 4+ Stars saw a 13.1% increase in enrollment between October 2015 and October 2016, whereas contracts with fewer than 4 Stars saw only a 5.9% increase. The difference in enrollment cannot entirely be attributed to consumer awareness of the ratings, however. Our research has shown that only about one in five consumers are aware of the significance of plan ratings.[7] Other factors probably also contribute, including the ability of higher-rated contracts to lower premiums and increase benefits because of their bonus payments and rebate dollars. Thus, it appears likely that contracts receiving fewer than 4 Stars in 2017 will have relatively slower enrollment growth than plans with 4+ Stars.

In addition, we analyzed enrollment changes between 2014 and 2016 to further understand the impact over time of losing a 4+ rating. We found that over those two years, contracts that lost a

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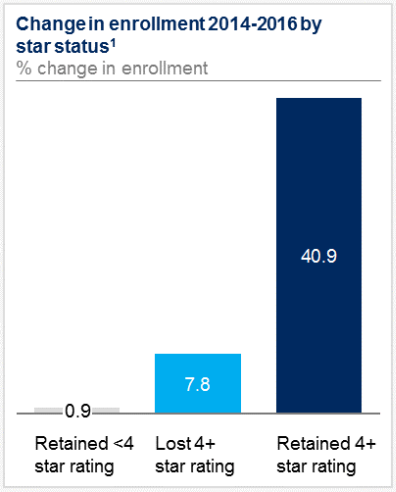
6 Based on April 2016 and 2017 enrollment figures. Totals exclude people in plans that were too new to be rated.

7 Based on McKinsey's 2015 Medicare Advantage consumer insights survey. For more information on customer experience, see: "Great customer experience: A win-win for consumers and health insurers" at http://healthcare.mckinsey.com/great-customer-experience-win-win-consumers-and-health-insurers.

4+ rating experienced only 7.8% membership growth, compared with 40.9% for contracts that retained the high rating (*Exhibit 8*).

EXHIBIT 8

Enrollment changes favor plans retaining 4+ star ratings



1 Change in overall star ratings 2014-2015.

SOURCE: McKinsey analysis of CMS Medicare Star ratings data (2014-2016), CMS October enrollment files (2014-2016)

Contracts that left the market have low Star ratings

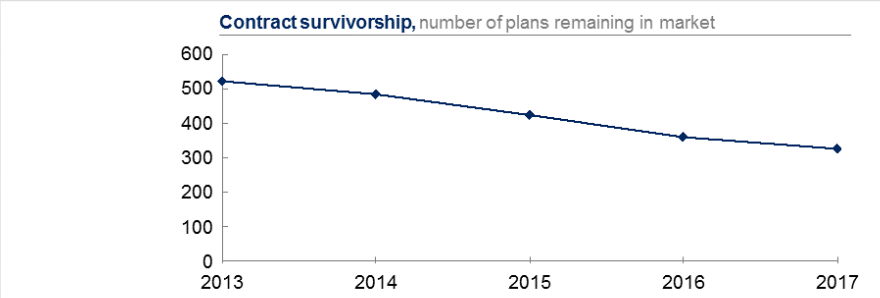
We also wanted to understand the correlation between low Star ratings and the likelihood that contracts remain in the market. To investigate this, we analyzed all contracts that have left the market since 2013, either because coverage was terminated or contracts were consolidated.[8] On a member-weighted basis, over 90% of the contracts that left each year had fewer than 4 Stars. Furthermore, of the 320 contracts that had fewer than 4 Star ratings in 2013, 46% had been terminated or were consolidated into other contracts by 2017.

Exhibit 9 provides more detailed insights into the impact of low ratings. For example, 7% of the contracts offered in 2013 had been terminated or consolidated by 2014, and 98% of the people enrolled in those contracts had been in contracts with fewer than 4 Stars. Furthermore, the weighted average score of the terminated/consolidated contracts was 2.98.

[8] We considered a plan to be terminated if it was no longer offered or its contract was not renewed. We defined plans as consolidated whenever two or more plans were combined into one.

EXHIBIT 9

The vast majority of plans that left the market scored below 4 stars



	Transition year	2013 - 2014	2014 - 2015	2015-2016	2016 -2017
For plans that left the market[1]	Percentage of all plans, %	7	12	15	10
	Enrollees in <4 star plans, %	98	91	95	100
	Weighted average Star score	2.93	3.37	3.43	3.35

1 Includes plans that were consolidated into other plans and plans that were terminated.
SOURCE: McKinsey analysis of CMS Medicare Star ratings data (2013- 2017), CMS April enrollment files (2012-2016)

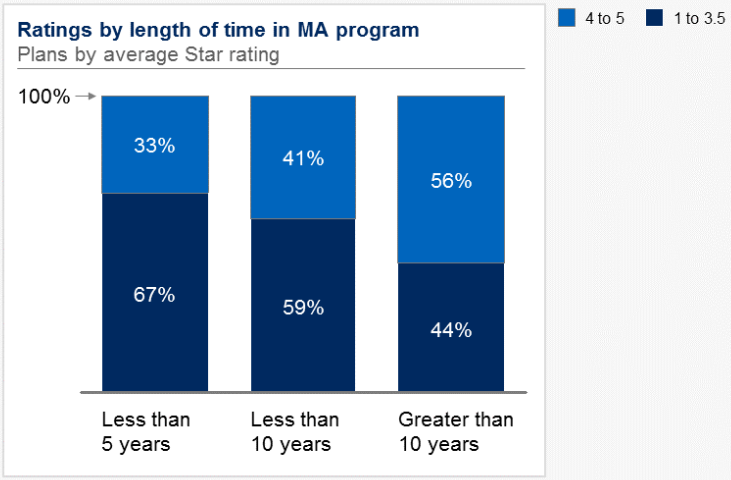
Among the contracts that left the market, termination was more common initially, but consolidation predominated in the last two years. For example, consolidated contracts accounted for 41% of the enrollees whose contract left the market in 2014 but 95% of those enrollees in 2016. Among the large commercial payors, consolidation accounted for close to 100% of the enrollees whose contract left the market in 2016, compared with 72% in 2014.

Plan maturity is associated with higher Star ratings

Plans with more experience in the MA program tend to have higher enrollment-weighted average 2017 Star ratings (*Exhibit 10*), a pattern consistent with previous years' results. This appears to be true even for IDNs. Integrated plans accounted for 33% of the market entrants in the past five years (31% on an enrollment basis), and those new entrants had a weighted average score of 3.43. Another 33% of the entrants were commercial plans, whose average rating was 3.43. The remaining 34% of the entrants were Blues plans, with an average score of 3.41. Thus, it appears that all new entrants need time to reach higher performance levels.

EXHIBIT 10

Length of time in the MA program is associated with higher Star ratings



SOURCE: McKinsey analysis of CMS Medicare Star ratings data (2017), CMS April enrollment data (2016)

Some performance factors correlate with positive Star performance

To identify where MA plans should target their improvement efforts, we ran a regression analysis to determine how performance on specific measure domains affected their overall Star ratings. CMS groups the measures into nine domains. The top three domains that influenced scores (ranked in order of correlation with positive Star performance) are:

- HD4: Member Complaints and Changes in the Health Plan's Performance
- HD2: Managing Chronic (Long Term) Conditions
- HD1: Staying Healthy: Screenings, Tests and Vaccines

Exhibit 11 lists, in order, all nine domains. An explanation of which metrics fall within these domains is provided in the appendix.

EXHIBIT 11

Certain domains affect Star ratings more than others

1 Ordered in terms of impact on overall Star ratings based on a regression analysis comparing the change in domain score relative to the change in overall Star rating.
2 See the Appendix for a list of measures included in each domain.

SOURCE: McKinsey analysis of CMS Medicare Star ratings data (2016-2017)

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The findings in this Intelligence Brief provide a perspective on how CMS is rating the performance of the MA plans offered for 2017. The information is based on publicly reported data released on October 12, 2016.

—Monisha Machado-Pereira, Erica Coe, Dan Jamieson, Ananya Banerjee, Rebecca Hurley, and Cara Repasky

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Appendix

Methodology

Enrollment-weighted average. On October 12, 2016, CMS released data on Medicare Advantage contracts and plans offered for 2017, in advance of the annual enrollment period. McKinsey calculated enrollment-weighted averages by taking the total number of enrollees in contracts and plans for 2016, assigning higher weights to plans with higher enrollment.

The results were used to calculate the enrollment-weighted averages for 2017 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 2016 summary Star rating data from CMS was used as a filter for the April 2016 CMS Medicare Advantage enrollment by state, county, and contract.

Therefore, enrollment in contracts that did not exist in the October 2016 ratings file are not included in the enrollment data in this Intelligence Brief.

Sanctioned plans. Sanctioned plans (e.g., Cigna) were included in the analysis because they received ratings and were included in CMS's overall figures.

Domain measures. Exhibit 12 (below) includes a full list of the measures included in each domain.

EXHIBIT 11 (Appendix)

Certain domains drive Star rating changes more than others

Domains ranked by impact of rating changes on average Star rating[1]

1. HD4: Member Complaints and Changes in the Health Plan's Performance
   - C26: Complaints about the Health Plan
   - C27: Members Choosing to Leave the Plan
   - C28: Beneficiary Access and Performance Problems
   - C29: Health Plan Quality Improvement
2. HD2: Managing Chronic (Long Term) Conditions
   - C08: Special Needs Plan (SNP) Care Management
   - C09: Care for Older Adults – Medication Review
   - C10: Care for Older Adults – Functional Status Assessment
   - C11: Care for Older Adults – Pain Assessment
   - C12: Osteoporosis Management in Women who had a Fracture
   - C13: Diabetes Care – Eye Exam
   - C14: Diabetes Care – Kidney Disease Monitoring
   - C15: Diabetes Care – Blood Sugar Controlled
   - C16: Controlling Blood Pressure
   - C17: Rheumatoid Arthritis Management
   - C18: Reducing the Risk of Falling
   - C19: Plan All-Cause Readmissions
3. HD1: Staying Healthy: Screenings, Tests and Vaccines
   - C01: Breast Cancer Screening
   - C02: Colorectal Cancer Screening
   - C03: Annual Flu Vaccine
   - C04: Improving or Maintaining Physical Health
   - C05: Improving or Maintaining Mental Health
   - C06: Monitoring Physical Activity
   - C07: Adult BMI Assessment
4. DD3: Member Experience with the Drug Plan
   - D08: Rating of Drug Plan
   - D09: Getting Needed Prescription Drugs
5. DD1: Drug Plan Customer Service
   - D01: Call Center – Foreign Language Interpreter and TTY Availability
   - D02: Appeals Auto–Forward
   - D03: Appeals Upheld
6. DD4: Drug Safety and Accuracy of Drug Pricing
   - D10: MPF Price Accuracy
   - D11: High Risk Medication
   - D12: Medication Adherence for Diabetes Medications
   - D13: Medication Adherence for Hypertension (RAS antagonists)
   - D14: Medication Adherence for Cholesterol (Statins)
   - D15: MTM Program Completion Rate for CMR
7. HD5: Health Plan Customer Service
   - C30: Plan Makes Timely Decisions about Appeals
   - C31: Reviewing Appeals Decisions
   - C32: Call Center – Foreign Language Interpreter and TTY Availability
8. HD3: Member Experience with Health Plan
   - C20: Getting Needed Care
   - C21: Getting Appointments and Care Quickly
   - C22: Customer Service
   - C23: Rating of Health Care Quality
   - C24: Rating of Health Plan
   - C25: Care Coordination
9. DD2: Member Complaints and Changes in the Drug Plan's Performance
   - D04: Complaints about the Drug Plan
   - D05: Members Choosing to Leave the Plan
   - D06: Beneficiary Access and Performance Problems
   - D07: Drug Plan Quality Improvement

1 Ordered in terms of impact to overall Star ratings based on a regression comparing change in domain score relative to change in overall Star rating
NOTE: Sub-metrics are not ranked by impact. They are listed as context on the measures that makeup of the domain

SOURCE: McKinsey analysis of CMS Medicare Star Ratings Data (2016-2017)

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 on 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 receive services that are not part of a network, but the out-of-network services require a higher copayment. Local PPOs serve specific counties that the plan chose to include in its service areas. Regional PPOs serve one of twenty-six regions decided by Medicare, usually one or more states.

1876 contract. A plan that is operated by an HMO or competitive medical plan (CMP) based on a cost reimbursement contract. Enrollees are not restricted to the HMO or CMP network, and can receive coverage through original Medicare as well. Medicare payments to the HMO/CMP are based on the reasonable cost of providing services to the Medicare beneficiaries.

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