Project Summary / Abstract

Our project asks whether some Medicare Advantage plans improve beneficiary health more than others and whether consumers take this into account when selecting plans. We document extremely large variation in mortality rates across plans, even after controlling for patient observables and adjusting for statistical noise. This variation could arise from differences in relative plan health effects as well as unobserved differences in the underlying health of enrolled beneficiaries. To distinguish between these sources, we analyze the change in beneficiary mortality after plans with different mortality rates are discontinued. When high or low mortality plans exit a market, enrollees tend to choose plans which look more typical. Concurrently, we find that when plans terminate, mortality falls for cohorts from high mortality plans and mortality rises for cohorts from low mortality plans by an amount similar to what we would expect if the mortality measures were causal. There is no comparable change among plans with similar ex ante mortality which do not terminate. This suggests variation in our adjusted plan mortality rates strongly predicts the causal health effects of MA plans. A similar strategy allows us to estimate the overall mortality effect of MA relative to traditional Medicare (TM); we study whether mortality improves more when MA plans terminate in counties where fewer alternative MA options are available, leveraging variation in the share of beneficiaries that switch to TM. We also investigate whether plans that are good on average tend to improve the health of all beneficiaries or whether plans tend to specialize in the quality of care delivered to different diagnostic classes. We further explore heterogeneity in MA plan effects by beneficiary demographics, such as age, gender and diagnosis based on pharmaceutical claims.

To investigate mechanisms, we construct variables measuring plan cost-sharing, utilization patterns, and provider networks and ask whether these explain why some plans reduce mortality more than others. When we include our "mortality-added" measure as a covariate in plan choice models, along with other measures of plan differentiation, we find an implicit value of a statistical life that is several orders of magnitude less than typically measured. This suggests that while some plans extend life more than others, consumers do not meaningfully internalize these differences when selecting plans. We conclude by simulating how plan choices and subsequent health outcomes would change if consumers were made fully aware of differences in plan quality, or if all plans were made to be as good as the best set of plans in terms of their mortality-added.