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Health insurers see sharp decline in 2023 Medicare Advantage and Part D star ratings

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The Buzz This Week

The Centers for Medicare and Medicaid Services (CMS) released its 2023 Star Ratings for Medicare Advantage (Part C) and Prescription Drug (Part D) plans earlier this month, with ratings falling shorter of last year's. Each plan is rated on a scale of 1 to 5, with 5 being the highest score. Medicare Advantage with prescription drug coverage contracts (MA-PD) are rated on up to 38 quality and performance measures. Medicare Advantage contracts without prescription drug coverage (MA) are rated on up to 28 measures. Prescription Drug-only contracts (PD) are rated on up to 12 measures. The ratings are meant to help seniors select plans and are released just ahead of open enrollment, which began October 15.

In the 2022 ratings, 68% of MA-PD contracts had 4 or more stars. In the 2023 ratings, only 51% of MA-PD contracts achieved 4 or more stars. The removal of a COVID-19 provision, which allowed adjustments to 28 measures, is a key driver behind the decline. If a plan received a lower score on one of those measures in 2022 compared to 2021 due to "extreme and uncontrollable circumstances rules as a result of the COVID-19 PHE," the higher score from 2021 was retained. This year, only 3 measures are subject to such an adjustment. In addition, the weighting on the patient experience/consumer complaint and access measures were doubled this year.

Although the post-COVID ratings drop was expected for many plans, some of them have declined more than anticipated. Furthermore, the market reaction has been unfavorable.

Why It Matters

While star ratings are intended to summarize quality and performance measures in an easy-to-interpret scale to help seniors select better performing plans, past data has shown that only 8% to 10% of enrollees in MA-PD plans voluntarily switch to other MA-PD plans or to traditional Medicare in a given year. Arguably, the more damaging effect of a lower star rating is the financial implication for government payments to the plans.

Per the Affordable Care Act, star ratings determine 2 components of the plan's payment: eligibility for a quality bonus, which can reach into the billions of dollars for larger plans, and the portion of the difference between the "benchmark" and the plan's "bid." Per the Kaiser Family Foundation, the benchmark is the "maximum amount the federal government will pay for a Medicare Advantage enrollee, and is the percentage of estimated spending in traditional Medicare in the same county... The bid is the plan's estimated cost for providing services covered under Medicare Parts A and B." Plans that invest in improving health outcomes and member experience, reflected in at least 4 stars in their rating, have their benchmarks increased. Plans that receive low ratings do not have their benchmarks increased, and those with very low ratings are not eligible for quality bonus payments.

A low star rating can also mean a plan is not eligible to expand. Plans that receive very low ratings in 2023 (2.5 stars or lower) must improve their ratings in 3 months or less, or risk being barred from expanding not only in 2024 but also in 2025. While there is a possibility that CMS does not enforce this restriction for all low-rated plans, Jack Hoadley, Research Professor Emeritus in the health policy institute of Georgetown University's McCourt School of Public Policy, underscored in a recent Modern Healthcare piece, "Plans that earned 2.5 or 2 stars are well below the norm. That should not be taken lightly."

The changes to the star rating calculations this year may not be the last major shift. Some have expressed concern that the quality bonus payments (or lack thereof, for low rated plans) don't actually result in quality improvement, voiced that quality measures are not always reliable, and pointed out that bonus payments have increased every year since 2015. MedPAC recommended in 2020 that the current approach be replaced with an alternative Medicare Advantage value incentive program (MA-VIP), which would include a smaller set of quality measures, evaluate plan quality at the local level, and stratify plans by enrollee characteristics when making comparisons.

It is doubtful, however, that the increased emphasis on patient satisfaction in the scoring will go away. Patient experience will continue to move into center stage. Payers will need to start or continue to increase their focus on and attention to customer service and enhancing enrollees' experience, and taking a member-centric approach. That means, for example, that a drop in star ratings and the loss of quality bonus payments shouldn't translate into a reduction in benefits to make up for the loss in revenue. That not only would likely lead to enrollees switching insurers but also to a further decline in satisfaction ratings. Bank of America analysts supported that idea in a reaction to CVS Health's press release about their drop in star ratings: "...our expectation would be that [CVS Health] is more likely to look to alternative products and cost offsets (as well as [stock] buyback...) rather than cut benefits."

For hospital and nursing home providers, changes in the MA star ratings may impact patient volumes and outcomes. A study in [Health Affairs](#), published in 2021, found that patients enrolled in an MA plan with a higher MA star rating were more likely to choose a hospital or nursing home with a higher CMS star rating and less likely to be readmitted within 90 days. The authors state that their “finding of a relationship between star rating and provider rating may suggest that provider networks are indeed a pathway used by MA contracts to improve outcomes.” As recently lower-rated MA plans seek to increase their star rating to regain quality bonus payments and raise the difference between their benchmark and bid, higher-rated hospitals and nursing homes may see a slight increase in volume of MA patients enrolled in such plans. Similarly, providers who are in risk-based agreements in which outcomes are tied to health plan star performance could see disruption to their revenue until the health plan improves their MA star rating.

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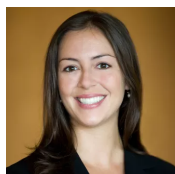
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