Quality Bonus Payments in Medicare Advantage

How Access to Highly Rated Plans Varies across Enrollees and Counties

Adele Shartzer, Avani Pugazhendhi, and Bowen Garrett

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Summary

Medicare Advantage (MA) enrollment and spending are growing as a share of the Medicare program. Meanwhile, the Medicare program at large faces financial pressures as overall enrollment grows and health spending outpaces inflation. MA's quality bonus program (QBP) provides payments to plans based on a quality-based star rating system, but the Medicare Payment Advisory Commission (MedPAC) and others have flagged important problems with the design of the QBP, noting that the QBP is one of several factors contributing to overpayments in MA.

To enhance understanding of the QBP, including its design, issues around increases in star ratings, differences in access to high-quality plans, growth in QBP payments over time, and variations in QBP payments per enrollee, we use publicly available data from the Centers for Medicare & Medicaid Services (CMS) on MA plan characteristics and quality, merged with information on beneficiaries from the Medicare Current Beneficiary Survey. We also examine county- and state-level changes in QBP payments.

Average star ratings and QBP payments per enrollee increased from 2015 to 2023, substantially boosting payments to MA plans. In 2023, QBP payments totaled $12.9 billion. Although other value-based payment programs in Medicare are budget-neutral, QBP only provides bonuses ("upside-only") and does not include any penalties for poor performance to balance the substantial rewards it provides to MA plans.

The QBP supports additional benefits for MA enrollees, so differences in access to the higher-scoring plans that get higher QBP payments can exacerbate health disparities. We find differences in enrollment by enrollee socioeconomic characteristics between higher- and lower-scoring MA plans, which means that QBP bonus payments disproportionately go to contracts with more advantaged beneficiaries. In addition, we find geographic differences in access to higher-scoring plans, so some beneficiaries do not have access to the additional benefits funded by QBPs. Furthermore, there have been substantial shifts in QBP payments across states over this period. Within states, some regions had particularly high QBP payments per enrollee.

Introduction

The MA program is an increasingly popular option among Medicare beneficiaries, with enrollment growing steadily from 19 percent in 2007 to 51 percent of total Medicare enrollment in 2023. In MA, beneficiaries choose a private health plan available in their area, and CMS pays plans a risk-adjusted amount per member per month (described in more detail below). The Affordable Care Act of 2010 introduced quality-related payments to plans under the QBP to incentivize MA plans to deliver higher-quality care for Medicare beneficiaries. MedPAC and others have criticized the approach to payments in MA, noting that the current approach—including the QBP—leads to overpayments for MA beneficiaries relative to comparable beneficiaries in traditional Medicare. As MA enrollment grows, the impact of these overpayments grows and places additional pressure on Medicare finances.

In this brief, we provide an overview of the MA QBP and highlight concerns that have been raised about its design. We then use a combination of publicly available datasets, building on previous work, to examine the following research questions:

- What is the association between Medicare beneficiary characteristics and access to high- versus low-quality MA plans?
- How much does Medicare spend on the QBP program? How do QBP payments to plans vary across the country, such as by state or county?

We assess the distribution of contracts' star ratings in 2015 and 2023 to show how average star ratings have increased over time. Our analysis uses the distributions to determine thresholds for defining "high-scoring" and "low-scoring" plans. Others have argued persuasively that the MA star rating is a questionable measure of quality (Berenson and Skopec 2024; Skopec and Berenson 2023). At the same time, it is the current mechanism for distributing payments, and it is relevant for policy to understand how these payments are distributed.

We examine the characteristics of beneficiaries in 2015 through 2020 with access to high-scoring (as defined by star ratings) versus low-scoring plans. For this analysis, we define access to a high-scoring plan as a beneficiary living in a county where a high-scoring plan is available. We add to the growing understanding that access to higher-quality MA plans may explain socioeconomic differences in enrollment (Park, Werner, and Coe 2022). In addition, we use county-level maps to examine geographic

variation in access to high-quality MA plans and help identify regions across and within states where access to high-quality plans is comparatively more limited.

We also produce estimates of QBP payments per MA enrollee, matching other published estimates and expanding on available information by reporting how these payments vary geographically. This analysis indicates the parts of the country that are benefiting most and least from the QBP as it is currently designed.

How the QBP Works

STAR RATINGS

MA plans receive star ratings based on their performance on a number of quality measures that capture clinical quality, beneficiary experience, administrative effectiveness, and star rating improvement. An MA parent organization (like Humana or UnitedHealth) can have one or more contracts with CMS for MA, and each contract may offer one or more plans in an area. Star ratings are assigned at the contract level, so all plans covered by the same contract receive the same star rating. CMS specifies the measures and the methodology for calculating the star ratings through the regulatory process, with updates and revisions occurring annually. In 2023, there were 28 measures for MA performance and an additional 12 measures applicable to prescription drug coverage in MA.

CMS awards stars ranging from 1 to 5 based on a contract's performance on each measure relative to other contracts submitting data. CMS then weights the measures and makes additional adjustments to generate an overall star rating for each contract. Most quality measures used in the star ratings are not adjusted for patient characteristics, but some of the measures from the Consumer Assessment of Health care Providers and Systems survey are adjusted for age, education, physical and mental health, income, and state of residence.

QUALITY BONUS PAYMENTS

CMS uses the star ratings to adjust payments to MA plans in two ways:

- by adjusting a plan's benchmark and
- by adjusting the percentage of the rebate a plan retains.

MA plans submit bids against a county-level benchmark. The benchmark represents the average county-level Part A and B spending on traditional Medicare beneficiaries with average health risk (score of 1.0). Plans with a star rating of 4 or higher receive a 5 percent increase to the benchmark, and new plans receive a 3.5 percent increase to the benchmark. There are some exceptions to this formula—in some counties with high MA enrollment and low traditional Medicare spending, the benchmark bonus is doubled to increase competition (Markovitz et al. 2022). Additionally, the Affordable Care Act put benchmark caps in place in certain counties, so plans in those counties cannot receive bonus benchmarks.

Plans that bid above the benchmark must charge enrollees the difference, and plans that bid below the benchmark get to keep a percentage of the difference—the "rebate"—ranging from 50 to 70 percent. The percentage of the rebate retained by the plan also depends on its star rating. Plans with a star rating of 3.0 or below keep 50 percent of the rebate; plans with a star rating of 3.5 or 4.0 keep 65 percent of the rebate; and plans with a star rating of 4.5 or 5 keep 70 percent of the rebate. Plans with low enrollment are assigned a star rating of 4.5, and new plans are assigned a star rating of 3.5 to determine their rebate percentage. Table 1 illustrates how star ratings impact quality bonus payments for three contracts with the same baseline benchmark and bids in a typical county and a county eligible for a double bonus based on high MA enrollment and low traditional Medicare spending.

TABLE 1

Illustrative Example of Star Ratings in Quality Bonus Payments

	County 1 Baseline benchmark: $1,000	County 2 "Double bonus" county baseline benchmark: $1,000
Contract A: star rating of 5, bid $900		
Quality-adjusted benchmark	$1,050 (5% bonus over baseline based on star rating)	$1,100 (10% bonus over baseline based on star rating and county double bonus
Rebate percentage (based on star rating)	70%	70%
Rebate (Rebate percentage times the quality-adjusted benchmark minus bid)	$105 =0.7*($1,050-$900)	$140 =0.7*($1,100-$900)
Quality bonus payment (Rebate for high-quality plan minus rebate all plans receive)	$55 = $105 -$50	$90 =$140 - $50
Contract B: star rating of 4, bid $900		
Quality-adjusted benchmark	$1,050 (5% bonus)	$1,100 (10% bonus)
Rebate percentage based on star rating	65%	65%
Rebate	$97.50 =0.65*($1,050-$900)	$130 =0.65* ($1,100-$900)
Quality bonus payment	$47.50	$80
Contract C: star rating of 3, bid $900		
Quality-adjusted benchmark	$1,000 (No bonus)	$1,000 (No bonus)
Rebate percentage based on star rating	50%	50%
Rebate payment	$50 = 0.5*($1,000-$900)	$50 = 0.5*($1,000-$900)
Quality bonus payment	$0	$0

Source: Urban Institute analysis of Medicare Advantage quality bonus program 2023 regulations.

Current Issues with the MA QBP

Despite its intentions of improving quality and helping beneficiaries select high-quality plans, the QBP, as currently implemented, has several fundamental problems. In its June 2019 *Report to Congress*, MedPAC noted the following flaws of the QBP:

1. It scores quality at the contract level, even for contracts covering disparate areas, meaning star ratings do not necessarily indicate local plan quality relevant to the enrollee.
2. It has allowed companies to consolidate contracts to maximize star ratings and QBP payments.
3. It does not appear to adequately account for differences in enrollee social risk.
4. It scores too many measures, including insurance function and administrative measures.
5. It includes moving performance targets that do not allow plans to know in advance how their quality rating translates to QBP payments.
6. It is not budget neutral (MedPAC 2019). MedPAC subsequently proposed replacing the QBP with a budget-neutral value-based incentive program (MedPAC 2020).

In addition, star ratings have increased over time, yet research does not indicate these increases in star ratings are linked with increases in clinical quality, population health, or administrative effectiveness (Markovitz et al. 2021; Layton and Ryan 2015; Meyers et al. 2021a, 2021b; Agarwal et al. 2021; Ochieng and Biniek 2022; MedPAC 2023). Despite the goal of helping beneficiaries enroll in higher-quality plans, beneficiaries do not use star ratings to make plan selections (Darden and McCarthy 2015). Some research suggests that beneficiaries respond to plan benefits offered by plans with higher star ratings, such as lower premiums and cost sharing, that are financed through QBPs but not to the star ratings themselves (Li and Doshi 2016; Reid et al. 2016). Measures of beneficiary experience in the QBP also do not meaningfully distinguish between plans, in part because the range of scores is narrow (Skopec and Berenson 2023). Another issue identified by researchers is that the measures included in the star ratings do not capture the major issues in health care access and quality within MA, such as inappropriate prior authorization denials, network adequacy, difficulty accessing high-quality post-acute care, and high rates of switching to traditional Medicare among seriously ill beneficiaries. There are also issues with the underlying Healthcare Effectiveness Data and Information Set and Consumer Assessment of Healthcare Providers and Systems measure sets used to generate star ratings, including a focus on attainment of clinical quality outcomes (rather than improvement) over which the plans have limited control and limited applicability of some measures to a broad and diverse Medicare population.

Data and Methods

We used the 2015–20 Medicare Current Beneficiary Survey (MCBS) and CMS MA Star Rating Data to examine beneficiary characteristics by high- and low-quality plans. The CMS data provides information on contracts, including star ratings, enrollment, and plans; the MCBS provides beneficiary information.

This analysis restricts MCBS data to MA enrollees. Because the MCBS reports MA enrollees' associated contracts at the monthly level, we use the plan in which beneficiaries were enrolled for the longest period during the relevant year. Using contract identifiers for beneficiaries' plans, we determined which enrollees belonged to high-scoring (star rating of 4 or higher) and low-scoring (star rating of 3.5 or lower) contracts.

To calculate QBP payments, this analysis combines publicly available MA data from CMS with the MCBS. Specifically, we used the MA contract/plan/state/county enrollment file, Part C and Overall Star Ratings, county and regional benchmark data, and Plan Crosswalk files from 2015–23.[11]

To calculate federal spending on QBP payments, we used star ratings from the previous plan year, which determine the plan's benchmark. Each plan's benchmark is determined using data from the MA ratebook rate calculation data, which provides the benchmark for county and regional plans with a 5 percent, 3.5 percent, and 0 percent bonus rate. We calculate the QBP payment per enrollee as the difference between a plan's quality-adjusted benchmark and the benchmark if the plan had no bonus (0 percent bonus rate), multiplied by the plan's rebate percentage. A more precise calculation of the QBP requires plan-specific bid data, which is not publicly available. Our approach is consistent with other methods used in research. However, this approach does not account for plan behavior in response to a higher benchmark, though evidence suggests plans increase their bids in response to higher benchmarks (Zuckerman, Skopec, and Guterman 2017). The bonus per enrollee is multiplied by enrollees in June of each year to determine total annual QBP spending per enrollee at the county, state, and national levels.

Findings

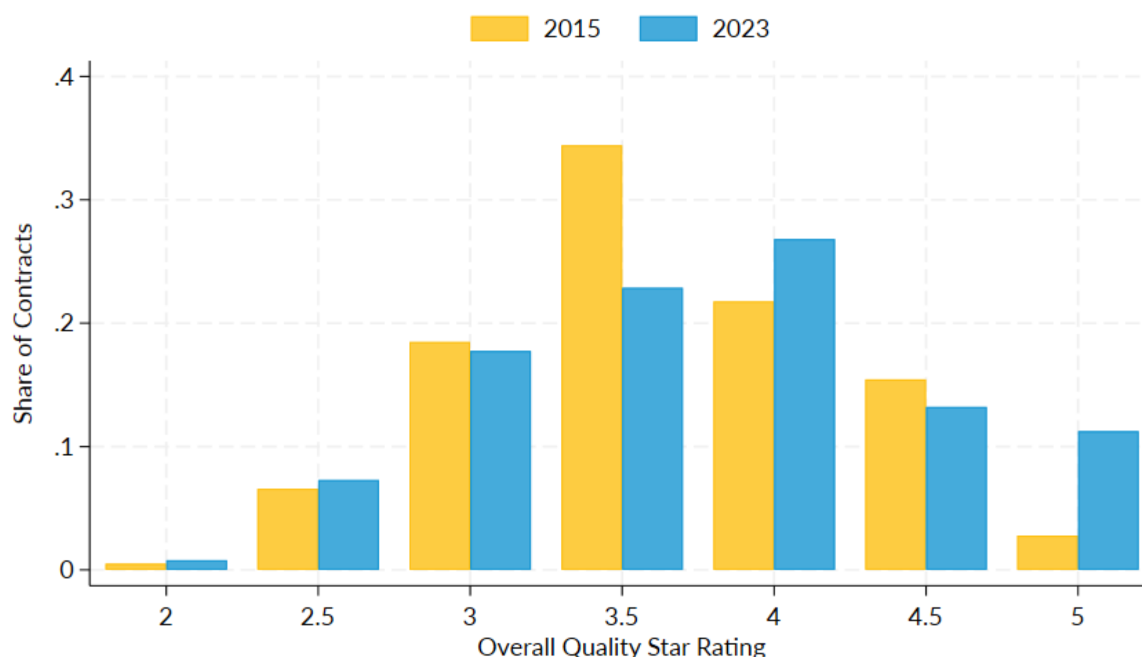
Star Ratings and Contract Quality

DISTRIBUTION OF STAR RATINGS, 2015 AND 2023

Figure 1 examines the distribution of star ratings in 2015 and 2023. In 2023, the median star rating was 4.0, compared with 3.5 in 2015. A similar number of contracts received 4.5-star ratings in 2015 and 2023, but a larger number of contracts received the highest 5-star rating. Very few contracts received 2- or 2.5-star ratings in both years, and no contract has ever received a star rating below 2.0. Based on these distributions, we classify high-scoring plans in our analysis as those receiving a 4 or higher rating and low-scoring plans as those with 3.5 stars or lower.

FIGURE 1

Distribution of Star Ratings, 2015 and 2023



URBAN INSTITUTE

Source: Urban Institute analysis of Centers for Medicare & Medicaid Services Medicare Advantage Overall Part C Star Ratings, 2015 and 2023.

Note: Distribution of overall Medicare Advantage star ratings in 2015 and 2023. Plan types include special needs plans; employer group health insurance plans; local and regional preferred provider organization, health maintenance organization, and point-of-service plans; and private fee-for-service plans.

ACCESS TO HIGHER- VERSUS LOWER-SCORING PLANS

In our dataset of merged 2015–20 MCBS and CMS data, beneficiaries were enrolled in 290 contracts with a star rating of 4 or higher and 129 contracts with a star rating of 3.5 or lower (data not shown). We find significant differences in access to higher-scoring plans—defined as whether beneficiaries lived in a county with an MA plan of four stars or higher—by health status, age, poverty level, and race/ethnicity (table 2). Compared with the 89 percent of beneficiaries in excellent health with access to a high-scoring plan, only 74 percent of beneficiaries in good, fair, or poor health had access to a high-scoring plan. Beneficiaries under age 65 were also significantly less likely to have access to a high-scoring MA plan in their county than those aged 65–69, which may reflect different market dynamics for nonelderly Medicare beneficiaries who qualify based on a disability instead of age or the challenge of attaining higher star ratings for a more medically complex population.

About 7 in 10 beneficiaries with family income at or below 100 percent of the federal poverty level (FPL) had access to a high-scoring MA plan; all other income groups had greater access to high-scoring plans. Nine in 10 beneficiaries with family income at or above 200 percent of FPL had access to a high-

scoring plan. Similarly, non-Hispanic Black and Hispanic beneficiaries were less likely than white non-Hispanic beneficiaries to have access to a high-scoring MA plan in their county.

TABLE 2

Access to High- and Low-Scoring MA Plans, by Beneficiary Characteristics

	Access only to low-scoring plans (<3.5 stars)	Access to high-scoring plans (≥4 stars)	Significant difference	
Self-reported health status			p-value	
Excellent^	11.3%	88.7%		*
Very good	11.3%	88.7%	0.99	*
Good	16.0%	84.0%	0.00	
Fair	20.7%	79.3%	0.00	*
Poor	25.9%	74.1%	0.00	*
Age				
Under 65	27.1%	72.9%	0.00	*
65–69^	13.9%	86.1%		
70–74	13.9%	86.1%	0.99	
75–79	13.9%	86.1%	0.97	
80–84	12.3%	87.7%	0.14	
85+	11.9%	88.1%	0.06	
Gender				
Male^	15.2%	84.8%		
Female	15.4%	84.7%	0.79	
Income-to-poverty ratio				
<=100% of FPL^	28.9%	71.1%		
>100% and <=125% of FPL	23.1%	76.9%	0.00	*
>125% and <=150% of FPL	18.1%	81.9%	0.00	*
>150% and <=200% of FPL	16.7%	83.3%	0.00	*
>200% of FPL	8.9%	91.1%	0.00	*
Race				
Non-Hispanic white^	11.2%	88.8%		
Non-Hispanic Black	29.2%	70.8%	0.00	*
Hispanic	23.8%	76.3%	0.00	*
Non-Hispanic other	14.4%	85.6%	0.01	*
Dual enrollment in Medicare and Medicaid				
Not dually enrolled	11.9%	88.1%		
Dually enrolled	25.0%	75.0%	0.00	*

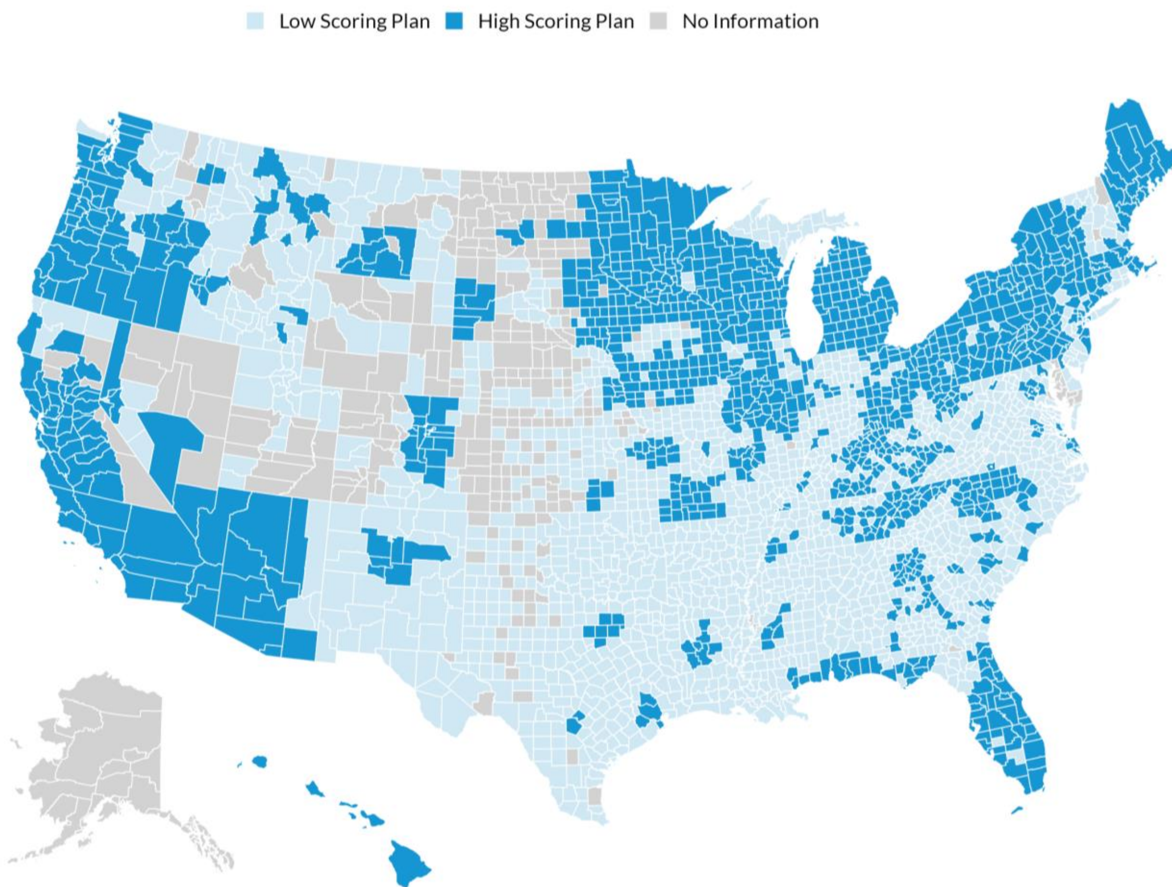
Source: Urban Institute analysis of Medicare Current Beneficiary Survey and Centers for Medicare & Medicaid Services Medicare Advantage Quality Star Ratings data, 2015–20.

Notes: FPL = federal poverty level. ^Denotes reference group. Estimates are weighted by enrollees ever enrolled in Medicare. Number of enrollees and contracts are unweighted. *Differences are statistically significant at the $p < 0.05$ level.

In 2015, beneficiaries in the Southeast and South-Central regions of the country were more likely to live in a county that did not have a high-scoring MA plan (figure 2). In these regions, Medicare beneficiaries are generally more likely to have lower incomes and be racial and ethnic minorities (Luo 2022). Beneficiaries who lived along the West Coast, in the Great Lakes region, New England, and some Mid-Atlantic areas were more likely to live in a county with at least one high-scoring plan.

FIGURE 2

Access to High-Scoring MA Plans, by County, 2015



URBAN INSTITUTE

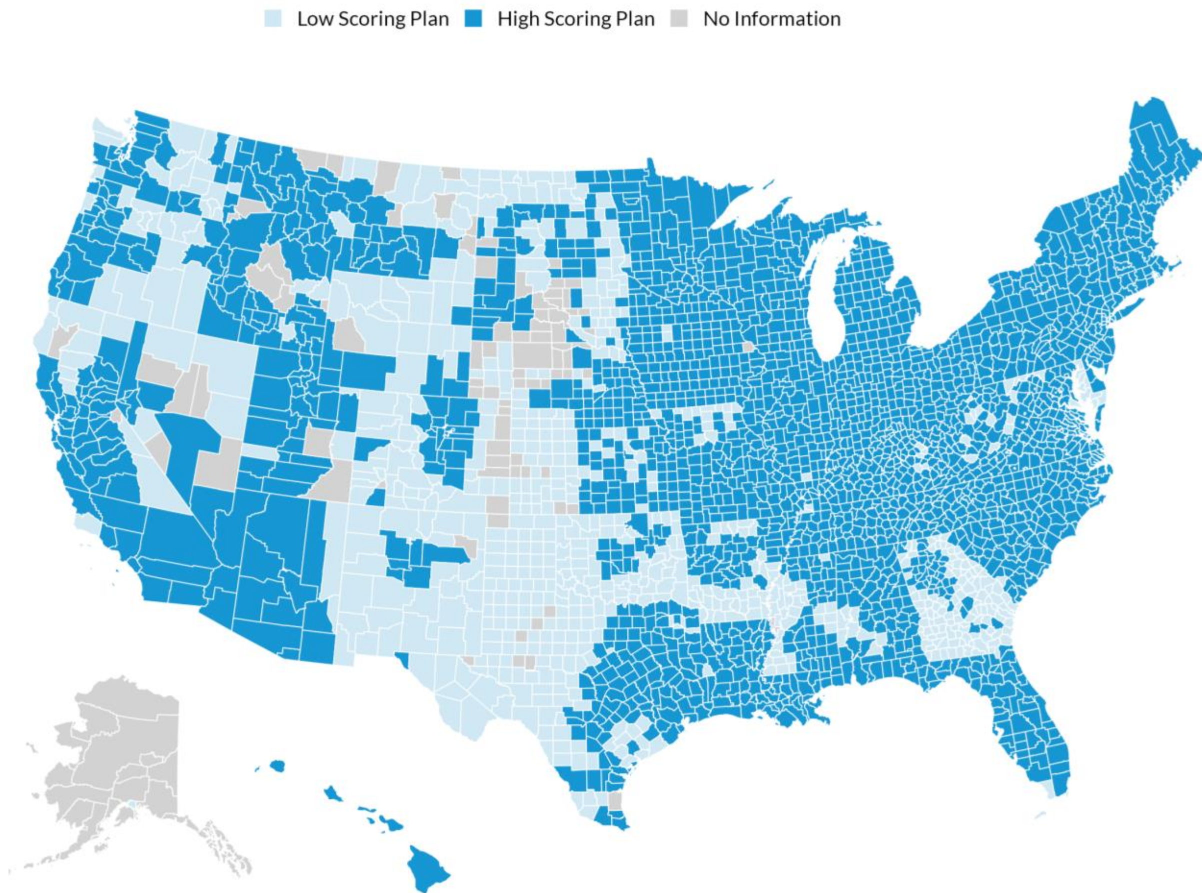
Source: Urban Institute analysis of Centers for Medicare & Medicaid Services Medicare Advantage (MA) contract/plan/state/county enrollment and MA Star Rating Data, 2015.

Note: Counties with at least one plan with 4 or more stars have a high-scoring plan. Counties without plans with 4 or more stars have no high-scoring plans. Counties with no information have no MA plans, or no MA plans receiving star ratings. This analysis excludes special needs and employer group health insurance plans to focus on availability of high-scoring plans that are open to all Medicare beneficiaries in the county.

In 2023, a larger number of counties had at least one high-scoring MA plan available (figure 3). Almost all counties along the East Coast, Great Lakes region, and Southern California/Arizona had at least one high-scoring MA plan available for beneficiaries. In much of Georgia, parts of the Pacific Northwest, and Central US, beneficiaries had no high-scoring MA plans available. Even though MA scores have increased overall, there are still pockets where beneficiaries cannot access a higher-scoring plan.

FIGURE 3

Access to High-Scoring MA Plans, 2023



Source: Urban Institute analysis of Centers for Medicare & Medicaid Services Medicare Advantage (MA) contract/plan/state/county enrollment and MA Star Rating Data, 2023.

Note: Counties with at least one plan with 4 or more stars have a high-scoring plan. Counties without plans with 4 or more stars have no high-scoring plans. Counties with no information have no MA plans, or no MA plans receiving star ratings. This analysis excludes special needs and employer group health insurance plans to better examine high-scoring plan choice and availability.

QBP Payments

In 2023, we find that Medicare spent $12.8 billion on QBP payments to plans, similar to other published estimates (Biniek, Damico, and Neuman 2023). This represents an over $9.8 billion increase since 2015 when Medicare spent $3.0 billion on QBP payments (table 3).

Spending per enrollee has also increased considerably. Overall, average QBP payments per enrollee increased between 2015 and 2023 (table 3) from $104 to $351, a 238 percent increase (not shown in table). Average QBP payments per enrollee decreased in only one state (Minnesota) between 2015 and 2023. Increases range from a $43 increase in Montana to a $499 increase in Arizona. In 2015, 16 states had average QBP payments per enrollee less than $100, and these states generally experienced a high

percent growth in QBP payments (percent increases not shown). An exception is Montana, with average QBP payments per enrollee growing 54 percent from $81 in 2015 to $124 in 2023. By 2023, average QBP payments per enrollee ranged from $91 in North Dakota to $621 in Arizona.

TABLE 3

Average QBP per Enrollee, US Total and by State, 2015 and 2023

	2015	2023	$ change
National			
Total QBP payments	$3.0 billion	$12.8 billion	$9.8 billion
QBP payment per enrollee	$104	$351	$248
State			
AK	179	488	309
AL	10	435	425
AR	20	234	215
AZ	122	621	499
CA	253	421	168
CO	422	514	91
CT	187	349	162
DC	44	375	331
DE	29	378	349
FL	201	480	278
GA	77	287	210
HI	186	501	315
IA	119	271	153
ID	168	415	246
IL	168	331	163
IN	66	283	218
KS	168	453	286
KY	122	285	163
LA	173	402	229
MA	175	376	201
MD	117	426	309
ME	149	296	147
MI	301	460	159
MN	340	304	-36
MO	220	411	191
MS	64	312	248
MT	81	124	43
NC	146	374	229
ND	10	91	81
NE	102	355	254
NH	121	341	220
NJ	58	369	311
NM	131	206	75
NV	158	457	299
NY	146	416	270
OH	213	485	272
OK	184	360	176
OR	285	543	258
PA	255	543	288
RI	286	582	296
SC	25	263	238
SD	29	102	73

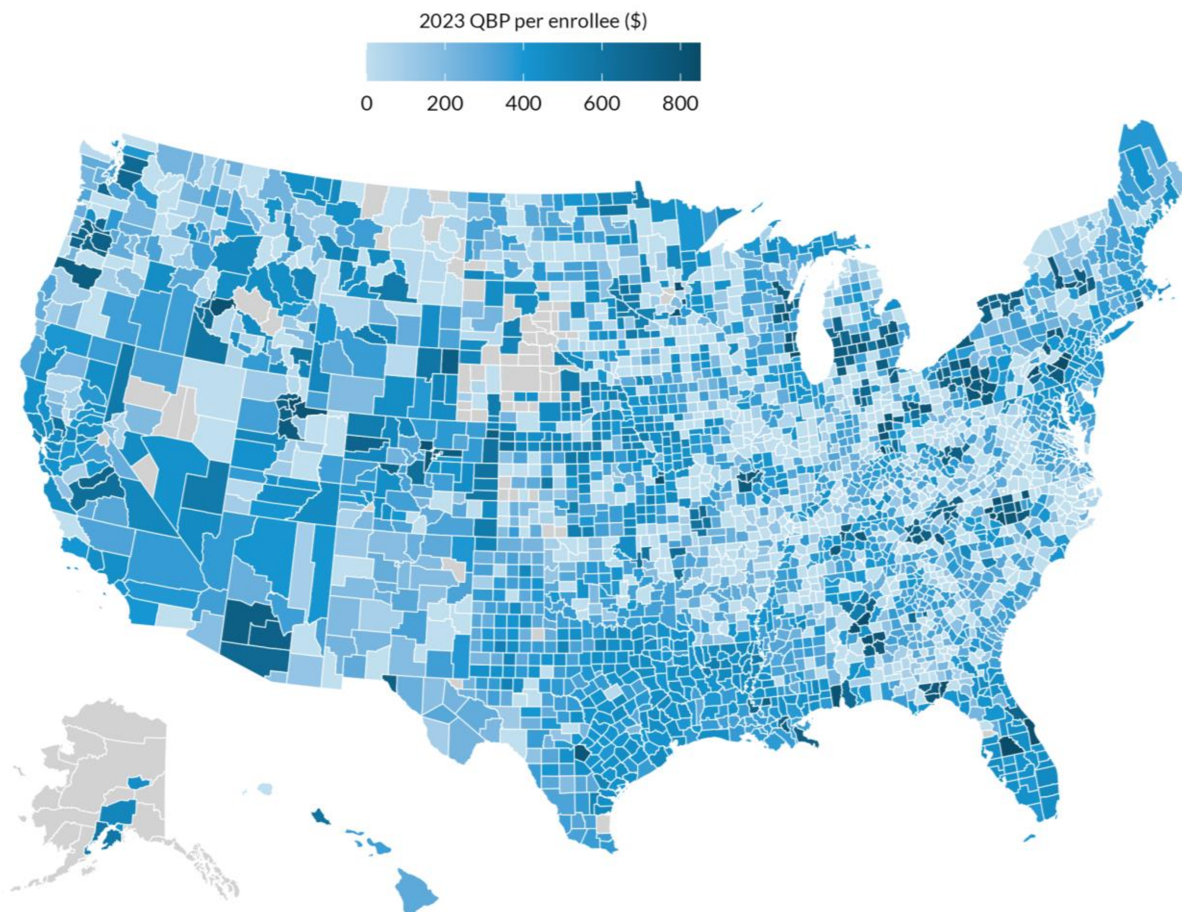
	2015	2023	$ change
TN	203	428	225
TX	66	446	380
UT	253	577	324
VA	73	257	184
VT	1	127	126
WA	175	464	288
WI	279	489	211
WV	134	300	166
WY	10	324	313

Source: Urban Institute analysis of Centers for Medicare & Medicaid Services Medicare Advantage contract/plan/state/county enrollment, Star Ratings, County and Regional Benchmarks, and Plan Crosswalk data, 2015 and 2023.
Note: QBP = quality bonus program. Average QBP payment per enrollee is weighted by state contract enrollment. Total national QBP payments are weighted by national contract enrollment.

Figure 4 shows that even within states, there is substantial variation by county in average 2023 QBP payments per enrollee. A few pockets of higher average QBPs exist in the Northeast, Southwest, California, Arizona, Florida, and Michigan. Generally, the Appalachian region of the country had comparatively lower average QBP payments per enrollee in 2023.

FIGURE 4

Average QBP Payments per MA Enrollee, by County, 2023



Source: Urban Institute analysis of Centers for Medicare & Medicaid Services Medicare Advantage (MA) contract/plan/state/county enrollment, Star Ratings, County and Regional Benchmarks, and Plan Crosswalk data, 2023.
Note: QBP = quality bonus program. Average QBP payments per enrollee are measured at the county level and weighted by county-contract enrollment. Counties with no plans with calculatable QBPs are gray.

Conclusion

In examining the relationship between beneficiary characteristics and access to higher-scoring MA plans, we find socioeconomic differences in beneficiaries with access to high-scoring versus low-scoring plans. Only a few quality measures in the star ratings system are adjusted for beneficiary characteristics, yet lower-quality plans have a larger percentage of disadvantaged populations. Quality bonus payments to these plans are lower, which means that the plans cannot offer the same benefit enhancements to enrollees like premium and cost-sharing reductions or expanded dental and vision coverage. Similarly, QBP payments are higher to plans that disproportionately enroll white, higher-

income, and healthier beneficiaries. These differences in QBP payments are not strongly associated with quality improvement but contribute to differences in plan benefits.

Further, our analysis finds that in many counties, no high-scoring MA plans are available for beneficiaries. To the extent that the star ratings reflect actual differences in how the MA plan coordinates and manages care for its enrollees, these lower QBP payments may be justified. However, if star ratings instead capture sociodemographic differences in enrollee populations associated with lower performance on quality measures, the lack of adjustment in the QBP methodology may exacerbate differences in health care access and quality for Medicare enrollees.

Between 2015 and 2023, average star ratings increased. The number of contracts with a star rating higher than 4.0 also increased, as well as the number of contracts receiving the highest 5-star rating. We refer to high- and low-scoring plans in this brief based on their star rating, but we note that the current star rating system is not a comprehensive measure of plan quality. In addition, we cannot determine whether the increase in star ratings represents a meaningful improvement in quality for Medicare beneficiaries—evidence suggests the QBP program has not improved plan quality. In essence, the increases in star ratings over time appear to have no relationship to quality improvement despite the substantial increase in spending. Berenson and Skopec (2024) suggest replacing the QBP and offer ideas on a revised structure for ensuring adequate performance and quality in MA.

The increases in star ratings we report could reflect methodological changes by CMS that resulted in higher star ratings for contracts or more widespread and effective efforts organizations use to maximize star ratings. For example, CMS adjusted the star rating methodology as part of the response to the COVID-19 pandemic, and star ratings were elevated as a result. The 2023 star ratings were lower than the 2022 ratings as the pandemic adjustments ended, but they still are higher than the 2015 levels. Despite its limitations as a measure of quality in MA, changes in star ratings have large financial implications for the Medicare program and the potential benefits available to MA beneficiaries.

Our investigation of changes in QBP payments and variations in QBP payments per enrollee confirms that QBP payments have increased rapidly in recent years. Quality bonus payments in the Medicare Advantage program increased in aggregate and per enrollee between 2015 and 2023. Nationwide, per enrollee QBPs increased from $104 to $351. Every state except Minnesota experienced an increase in QBPs per enrollee over that time. Enrollment in MA is projected to grow relative to traditional Medicare; continued growth in per enrollee QBPs coupled with increased enrollment will place additional financial pressure on the Medicare program with no clear improvement in quality.

Notes

[1] Our analysis includes special need plans, employee group welfare plans, local preferred provider organizations, regional preferred provider organizations, health maintenance organizations, point of service, and private fee-for-service plans.

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About the Authors

Adele Shartzer is a senior research associate in the Health Policy Center at the Urban Institute, where her work focuses on health coverage, access to care, and the health care delivery system. Recent work has focused on value-based payment in Medicare. Her research has been published in notable health policy journals. Before joining Urban, she worked as a program analyst in the Office of Health Policy in the Office of the Assistant Secretary of Planning and Evaluation at the US Department of Health and Human Services. Shartzer holds a bachelor's degree from the University of Virginia, an MPH from George Washington University, and a PhD in health services research from the Johns Hopkins Bloomberg School of Public Health.

Avani Pugazhendhi is a research analyst in the Health Policy Center. Her research focuses on disparities in patient safety, health impacts of climate change, and Medicare. Pugazhendhi holds a bachelor's degree in economics and a minor in environmental studies from Hamilton College.

Bowen Garrett is an economist and senior fellow in the Health Policy Center. His research focuses on health reform and health policy, including health insurance and labor markets, Medicare's prospective payment systems, and Medicare financing. He leads the development of the Urban Institute's Medicare policy simulation model (MCARE-SIM). Garrett received his PhD in economics from Columbia University in 1996 and was a postdoctoral research fellow in the Robert Wood Johnson Foundation's Scholars in Health Policy Research Program at the University of California, Berkeley, from 1996 to 1998.

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500 L'Enfant Plaza SW
Washington, DC 20024

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