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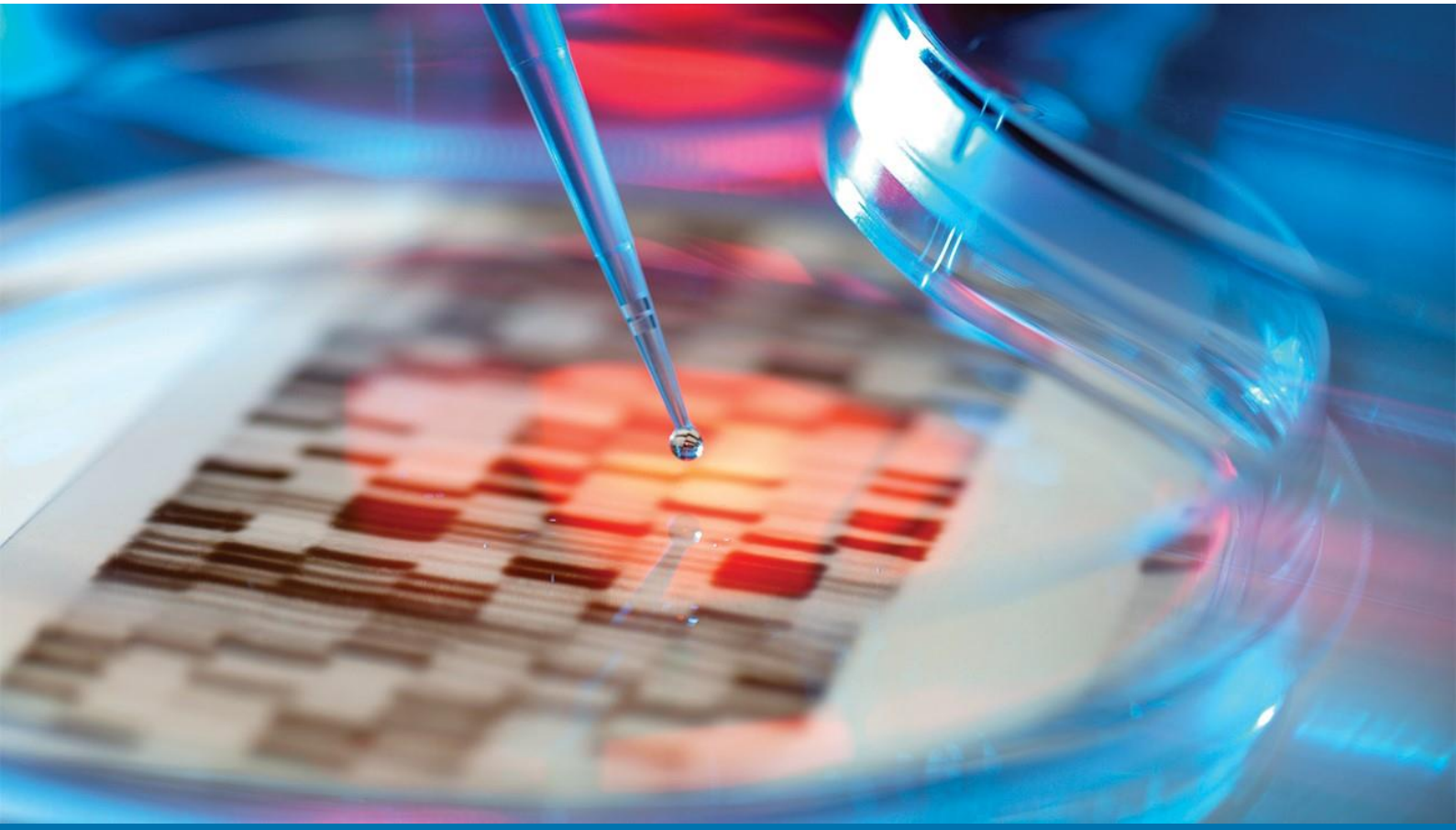

Evaluating Medicare Stars for cardiovascular disease patients

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Contents

Executive summary

Background: As Medicare enrollment continues to expand, and as the early effects of the Inflation Reduction Act (IRA) on access and affordability take shape, there is an opportunity for the Medicare Star Ratings program to play an important role in incentivizing health plan performance, guiding beneficiary choice, and supporting the aims of the IRA. Given that cardiovascular disease (CVD) remains the leading cause of death in the United States, particularly affecting the growing population of Medicare beneficiaries, there are questions as to whether the current design of the Star Ratings program sufficiently reflects the clinical realities and access needs of patients with CVD.

Approach: To assess the effectiveness of the Star Ratings program for CVD patients, we (1) undertook a review of current Star measures relevant to CVD care; (2) fielded a national survey of 150 Medicare beneficiaries with CVD; and (3) analyzed 5,249 Medicare Part D plans in terms of their coverage for high-use CVD medications. Together, these findings provide insight into the strengths and limitations of the current program and identify areas to improve the Stars program to better align with patient-centered priorities.

Key findings: Our research found that while several Star measures (e.g., blood pressure control, statin use) are highly relevant and informative for CVD patients' plan selection, performance across these measures remains low, with 2025 ratings falling well below the 4-star benchmark. Despite efforts to improve performance, such as triple-weighting blood pressure control, ratings have not improved, highlighting a potential gap in expected care quality.

The patient survey showed that while awareness of the Star Ratings program was low, those who were familiar with it found value in the program. Among respondents, 58% reported making decisions affected by access challenges, such as skipping doses of a medication. Respondents supported the inclusion of new measures in the Stars program, such as information on formulary coverage and frequency of prior authorization (PA).

The formulary analysis revealed minimal correlation between Star Ratings and access to high-use CVD drugs. Coverage, utilization management (e.g., PA), and tier placement were largely similar across high- and low-rated plans. These findings raise questions about whether the Stars program meaningfully incentivizes access to essential CVD medications.

Recommendations: Recognizing the limitations of the Star Ratings program, particularly low patient awareness, the absence of meaningful access-related measures, and the limited improvement in CVD-specific performance metrics, we consider policy recommendations that could strengthen the Stars program to better serve CVD patients.

1. Introduction

1.1 The Medicare Star Ratings program

The Medicare Star Ratings program was established in 2007 by the Centers for Medicare & Medicaid Services (CMS) to assess the quality of different Medicare Advantage Prescription Drug Plans (MA-PD) and Part D Prescription Drug Plans (PDP) using standardized performance metrics.[1] The program was designed to help beneficiaries make informed choices by offering a standardized framework for comparing plan quality.[2] CMS assesses plan quality by assigning ratings to plans in half-star increments from 1 to 5, with 1 star indicating poor performance and 5 stars representing excellent quality.[3] Importantly, CMS considers a rating of 4 stars or higher as the benchmark for "high performance." Plans at or above this threshold qualify for quality bonus payments and can use their rating as a competitive differentiator (e.g., in marketing efforts). This creates a positive incentive encouraging competition over quality. Higher-rated plans should be both more attractive to potential enrollees and eligible for increased CMS payments tied to quality performance measures, creating a strong incentive to improve the quality of the plan's services.[4] Improvements in a plan's overall rating typically lead to increases in enrollments and decreases in disenrollments.[5] After the introduction of quality bonus payments in MA-PD plans, a 1-star increase was associated with an increase of 11,337 enrollees in the subsequent year.[6] This financial incentive aims to align insurers and patient interests.[7]

Initially focused solely on Medicare Part D performance measures, the program has evolved considerably to include Part C (Medicare Advantage) measures, thereby incorporating broader aspects of plan performance.[8] MA-PD contracts are assessed on up to 40 Part C and Part D measures, while PDP contracts are rated on up to 12 Part D measures.[9] For each measure, CMS sets cut points that are used to establish the star rating. Some examples of quality measures are medication adherence, price accuracy, member complaints, and customer service.[10]

1.2 Cardiovascular disease in Medicare and the application of Stars Ratings

"Cardiovascular disease" refers to a group of disorders that affect the heart and blood vessels.[11] Common types include coronary artery disease, arrhythmia, deep vein thrombosis, and heart failure.[12] Risk factors such as high blood pressure and high cholesterol contribute to CVD onset and progression.[13] Individuals with CVD face significantly higher risks of morbidity and mortality compared to those without the condition. If left untreated, CVD can lead to serious and potentially life-threatening complications.

There are a number of reasons that the Stars program is particularly important for CVD:

- Given the **considerable clinical and economic burden of CVD**, it is essential that the Medicare Stars program performs effectively for this patient population. The program can play a pivotal role in incentivizing quality improvement, promoting preventive care, and encouraging care coordination across health plans. In Medicare, a significant proportion of beneficiaries are affected by CVD, with more than 40% of Medicare beneficiaries aged 65 years or older reporting at least one CVD condition.[14] The burden is especially high in beneficiaries aged 85 and older and disproportionately affects Black/African American and American Indian/Alaskan Native populations.[15]

- **Improving performance on CVD-related measures** could reduce avoidable hospitalizations and improve outcomes. CVD is responsible for a considerable burden on health care utilization and delivery in Medicare. Individuals with heart conditions experience substantially higher rates of inpatient admissions—nearly three times more than those without CVD—which has contributed to increased pressure on emergency departments.[16] The economic impact is also notable: Medicare beneficiaries with CVD incurred approximately twice the total annual health care costs compared to those without CVD ($18,000 vs. $9,000).[17] Out-of-pocket (OOP) expenses, including those for prescription medications, are also considerably higher for beneficiaries living with CVD.[18] CVD patients often face high rates of multimorbidity, including conditions such as diabetes, kidney disease, and hypertension, which increase clinical complexity and the need for integrated care. Polypharmacy (taking multiple drugs) is common, with patients frequently prescribed statins, antihypertensives, antithrombotics, and heart failure therapies. Ensuring appropriate use and adherence to these treatments is vital to prevent disease progression, reduce avoidable hospitalizations, and maintain patients' quality of life.

- Star ratings influence both **plan quality and beneficiary experience**, and barriers such as prior authorization, step therapy, and non-medical switching can have negative impacts. Evidence from a recent CVS Caremark formulary change highlights these risks in CVD: among patients who non-medically switched from stable anticoagulant therapy, seven percent experienced a heart attack and four percent suffered a stroke.[19] These findings, echoed by the American Geriatrics Society's Beers Criteria, highlight how minimizing treatment disruptions is crucial for maintaining stability and avoiding adverse outcomes among older adults with CVD.[20]

1.3 Current policy context

Each year, CMS evaluates plan performance to assign star ratings. These annual assessments are also used to update the cut points (i.e., the thresholds that determine how many stars a plan receives). This encourages plans to improve over time, as current performance influences future star ratings and the associated bonus payments.

In recent years, plan performance across both MA-PD and PDP contracts has fallen.i The average star rating for MA-PD plans fell from 4.37 in 2022 to 3.92 in 2025, while PDP plans dropped from 3.70 in 2022 to 3.06 in 2025.[21] Although this downward trend can be partially explained by the methodological changes highlighted above,ii the consistent erosion in ratings over this period raises concerns about the incentive structure and its ability to drive meaningful improvements in beneficiary experience and access.[22,23]

The need to maintain the quality of Medicare plans has become even greater since the passing of the 2022 Inflation Reduction Act (IRA). The implementation of the IRA's Part D benefit redesign provision

i It is important to note that recent methodological changes implemented by CMS, including the removal of COVID-19-related flexibilities and the adoption of new calculation methods, have led to recent rises in the cut point threshold. This needs to be accounted for in any comparison between years.

ii There have been significant legal developments in relation to these calculations, with a 2024 federal court ruling requiring CMS to recalculate ratings due to a statistical adjustment error, resulting in over $1 billion in additional bonus payments and prompting lawsuits from insurers.

was intended to lower OOP costs for Medicare beneficiaries. However, early evidence suggests that these reforms may be resulting in greater access barriers.[24,25]

- The IRA has significantly increased plan financial exposure, most notably by shifting more liability for high-cost drugs to Part D plans once patients enter the catastrophic phase. These heightened financial pressures are expected to lead to more aggressive formulary management and utilization controls, which may further exacerbate access challenges for beneficiaries.[26]

- Drug plans, particularly stand-alone PDPs, have exited the market, leaving people (especially those in rural areas) with fewer plans to choose from.[27] This is also relevant for beneficiaries in disadvantaged areas, including communities with a higher population of people of color and lower socioeconomic means, who often have had less access to high-rated plans.[28]

As plans adjust, many are turning to increased utilization management tools such as PA and increased patient cost-sharing as cost-containment strategies.[29] For CVD patients, who often manage multiple chronic conditions and depend on a complex regimen of medications, even small disruptions to access can lead to clinical consequences.

In this context, the Medicare Star Ratings program could play a role in supporting the aims of the IRA by improving accessibility to quality health care through ensuring access to innovative CVD therapies, reversing the trend in plan quality observed over the past three years (post-IRA implementation). This paper evaluates the current functioning of the Star Ratings program from the perspective of CVD patients and puts forward recommendations to improve it.

2. Overview of research approach

To determine how well the Stars program is performing and whether there is a need for policy intervention, we assessed how Medicare Star Ratings influence the health plan choices and experiences of patients with CVD. We employed a three-step research approach:

1. First, we conducted a targeted literature review to understand recent trends in Star rating measures and assessed which were most relevant for CVD patients.
2. Second, we worked with CVD-focused patient advocacy groups (StopAfib.org and Partnership to Advance Cardiovascular Health) to develop and field a survey of Medicare beneficiaries living with CVD.
3. Finally, we carried out a formulary analysis across a sample of MA-PD and stand-alone PDPs to evaluate access to commonly prescribed CVD medications. This analysis focused on the presence of utilization management tools such as PA.

2.1 Approach to assessing Star measures

CRA first conducted a targeted literature review to identify how the Medicare Star Ratings program and its component measures align with CVD care and treatment. The review drew on CMS documentation, such as technical notes, performance data, and rule-making summaries, alongside peer-reviewed studies focused on the Stars program. We also reviewed leading CVD clinical guidelines, such as those from the American College of Cardiology (ACC) and the American Heart Association (AHA).[30] Insights from this review were then used to inform an assessment of all Part C and Part D Star measures, evaluating their alignment with established CVD management guidelines

and their potential impact on prevention, diagnosis, and treatment. Measures were categorized as high, moderate, or low relevance based on the extent to which they could impact CVD outcomes.

We then assessed how ratings across the selected measures had changed over the past few years. This leveraged CMS's annual Star Ratings, which are published each October based on performance during the preceding measurement year (i.e., the 2025 ratings are based on 2024 performance). In 2025, this included approximately 600 Medicare Advantage and Part D contracts, encompassing over 4,000 individual plans.[31]

2.2 Approach to conducting patient survey

To better understand CVD patients' perspectives on the Medicare Star Ratings program, we conducted an online survey between March and April 2025. The survey captured responses from 150 Medicare beneficiaries who were responsible for choosing their plan, all of whom reported having at least one CVD condition (see Figure A1 in the appendix). Respondents represented a diverse range of racial and ethnic backgrounds, health statuses, and income levels. To ensure that the experiences of lower-income beneficiaries were adequately reflected, the sample included a quota of 50 respondents receiving Low-Income Subsidies (LIS). Participants reported a broad spectrum of medication use, and all had spent at least $100 out-of-pocket on prescription drugs in the past year. The survey explored patient perspectives across three key themes:

1. ***Familiarity with Medicare Star Ratings program***, including to what extent the patients had leveraged it, if at all, when selecting their plan, and how beneficial they viewed current CVD measures
2. ***Recent experiences accessing medicines***, such as whether the patients had any issues (e.g., delays) in the initiation of treatments their doctor had prescribed
3. ***Future plan selection,*** such as what types of measures or information would be more beneficial for CVD patients when selecting a drug plan

2.3 Approach to formulary analysis

We then carried out a formulary analysis to identify any differences in formulary exclusion of high-utilization and high-spend CVD drugs by high- and low-rated MA-PD and PDP plans.iii The restrictions on 10 drugs were examined and categorized (as a proxy for quality of care and medication access for CVD patients). This allowed us to test whether the star ratings of the plans were correlated with formulary coverage and utilization management for these CVD drugs.

Leveraging CMS's January 2025 Formulary Reference Files, we evaluated 387 formularies in total, comprising 347 MA-PD and 40 stand-alone PDP formularies, representing a total of 5,249 Medicare Part D plans. RXCUI codes were used to identify common dosing forms, allowing for consistent comparisons across plans for the basket of 10 CVD drugs. The analysis examined the presence of each drug on the plan's formulary as well as the use of utilization management tools such as PA and step therapy edits. To assess potential variation in access based on plan quality, we compared

iii The list of selected CVD drugs includes Brilinta, Eliquis, Entresto, Farxiga, Jardiance, Multaq, Praluent, Promacta, Repatha, and Xarelto. These drugs were selected because they represent the most widely used and highest-spend CVD drugs in Medicare. Data was taken from the CMS drug spending dashboard.

coverage patterns between plans with high Part D overall star ratings (defined as 4 stars and above) and those with low ratings (defined as 2.5 stars and below).

3. Evaluating the Medicare Stars program

3.1 CVD measures analysis – findings

Based on our assessment of Part C and Part D Star measures, the following were identified as having the highest relevance to CVD patients: controlling blood pressure, statin therapy for patients with CVD, medication adherence for hypertension, medication adherence for cholesterol, and statin use in persons with diabetes. Only controlling blood pressure is an outcome measure (i.e., evaluates the outcomes of care or treatment), while the others are process or adherence-based measures that assess whether patients are prescribed and consistently take recommended therapies.[32]

We then conducted an analysis to understand how ratings for these measures had changed over the past few years (see Table 1 below).

Table 1. Trends in CVD Star measures, 2022–2025

CVD Star Measures	Measure	Plan Type	Trends from 2022-2025 Star Ratings
Controlling Blood Pressure *(introduced in 2023)*	% of plan members with high BP who got treatment and were able to maintain a healthy pressure	MA Plans	↓ 3.5 → 3.0
Statin Therapy for Patients with Cardiovascular Disease	% of plan members with CVD who were dispensed ≥ 1 high or moderate-intensity statin medication	MA Plans	↓ 3.5 → 3.0
Medication Adherence for Hypertension (RAS Antagonists)	% of plan members with a Rx for a BP medicine who fill their Rx often enough to cover ≥ 80% of the time they are supposed to be taking the medicine	MA-PD	↓ 3.9 → 3.3
		PDP	↓ 3.5 → 2.9
Medication Adherence for Cholesterol (Statins)	% of plan members with a Rx for a statin who fill their Rx often enough to cover ≥ 80% of the time they are supposed to be taking the medicine	MA-PD	↓ 3.6 → 3.3
		PDP	↓ 3.6 → 2.9
Statin Use in Persons with Diabetes (SUPD)	% of plan members with diabetes who take the most effective cholesterol-lowering drugs (statins)	MA-PD	↓ 3.4 → 2.8
		PDP	↓ 3.3 → 2.7

Our analysis of the 2025 Star Ratings data found that the mean ratings for all the CVD-specific measures were below the 4-star benchmark,[iv] indicating significant gaps in coverage and quality of care for CVD patients.20 Most notably, medication adherence program metrics for hypertension and cholesterol and statin use in persons with diabetes for Part D were rated at 2.9, 2.9, and 2.7, respectively, by CMS in its 2025 Star Ratings data.[33]

The analysis also showed that efforts by CMS to improve performance across specific measures, such as applying triple-weighting to their rating (i.e., for controlling blood pressure), have not led to higher ratings. Ratings for this measure declined from 3.3 in 2024 to 3.0 in 2025, which is similar to decreases for measures that did not have triple-weighted ratings (i.e., statin therapy for patients with CVD). As there has been no change in methodology between these years, the decrease cannot be attributed to changes in the methodology used to calculate the rating.

[iv] As noted in the introduction, CMS considers a rating of 4 stars or higher as the benchmark for "high performance." Plans at or above this threshold qualify for quality bonus payments.

3.2 Patient survey – findings

The following section presents findings from the patient survey and provides insight into how CVD patients perceive the usefulness of existing Star Ratings measures, their recent experiences obtaining prescribed medicines, and the factors they consider most important when selecting a drug plan.

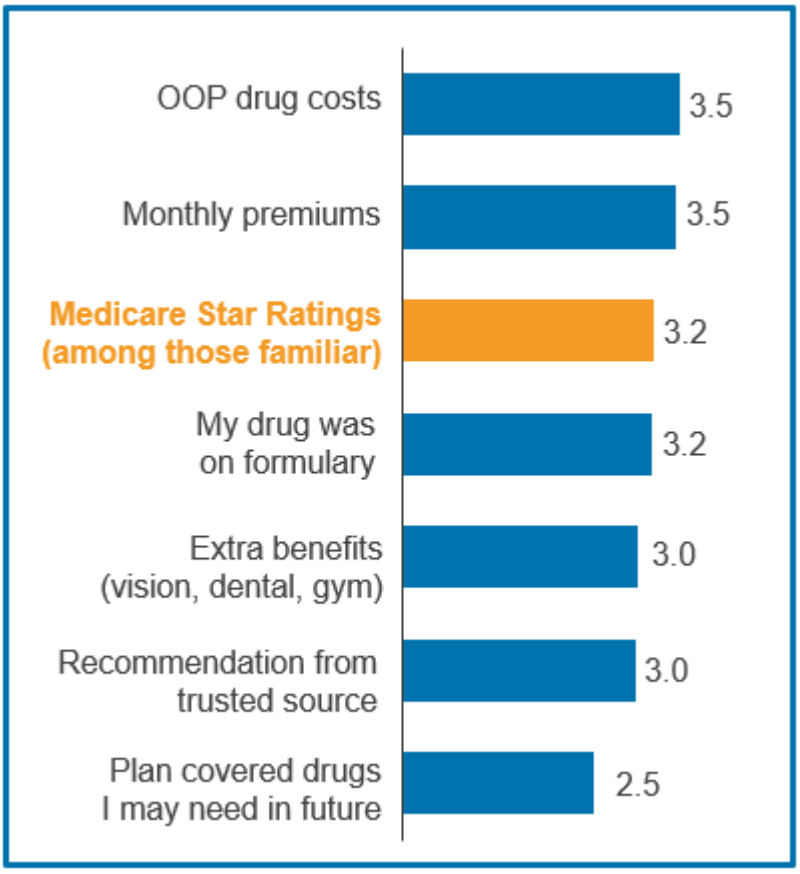
Question – Familiarity with Medicare Star Ratings program

- Only one in three respondents reported any familiarity with the Medicare Star Ratings program, indicating limited general awareness among CVD patients.

Question – Importance of factors when selecting current Medicare drug plan

- OOP drug costs and monthly premiums were ranked as the most important factors influencing selection of a Medicare drug plan (see Figure 1 below) by those familiar with the Stars program.
- Medicare Star Ratings (when segmenting for those who were familiar with the program) and the drug they were taking being on formulary were tied as the next most-important rating factors. When considered alongside the findings on familiarity of the Stars program, this suggests that for a considerable number of Medicare beneficiaries, low awareness of the Stars program may be limiting its utility in guiding plan selection.

Figure 1. Importance of factors when selecting current Medicare drug plan[34]



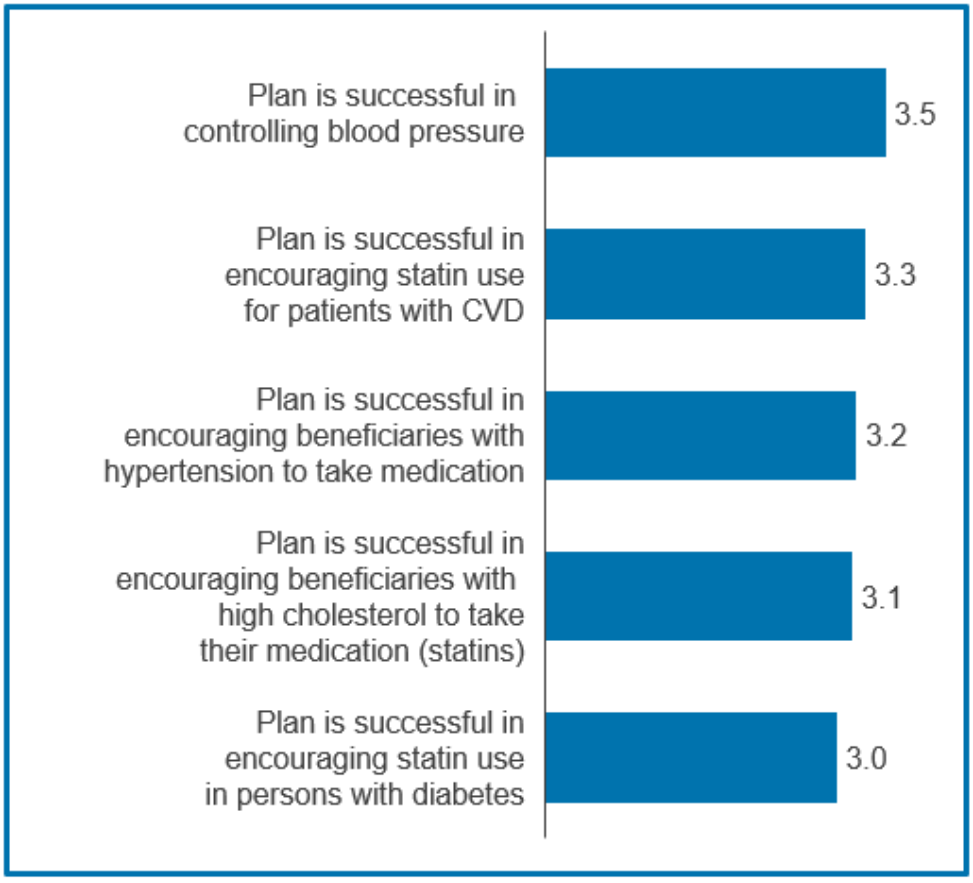
Question – How beneficial are current Star measures to inform plan selection?

The survey also looked to understand to what degree the current CVD-specific Star measures (as determined by our measures analysis) are beneficial for informing plan selection. Because familiarity with the Medicare Star Ratings program varies among beneficiaries, all respondents were asked to consider this question hypothetically, i.e., how useful such measures would be in guiding their plan choices if they were aware of them.

- The findings showed that the measure for controlled blood pressure (the only outcome-based measure) was ranked among the most important factors (Figure 2), comparable to financial considerations like monthly premiums and drug costs. Medication adherence measures, by contrast, were rated lower in importance.

- Subgroup analysis showed that urban respondents and adults under age 65 rated all Star measures between 3.3 and 3.6 on a 4-point scale, placing them on par with the top priorities in plan selection. These findings indicate that some CVD patients would place high value in Star measures (if they were aware of the program prior to plan selection).

Figure 2. How beneficial are current Star measures to inform plan selection?[35]



Question – Recent experiences accessing medicines and future plan selection

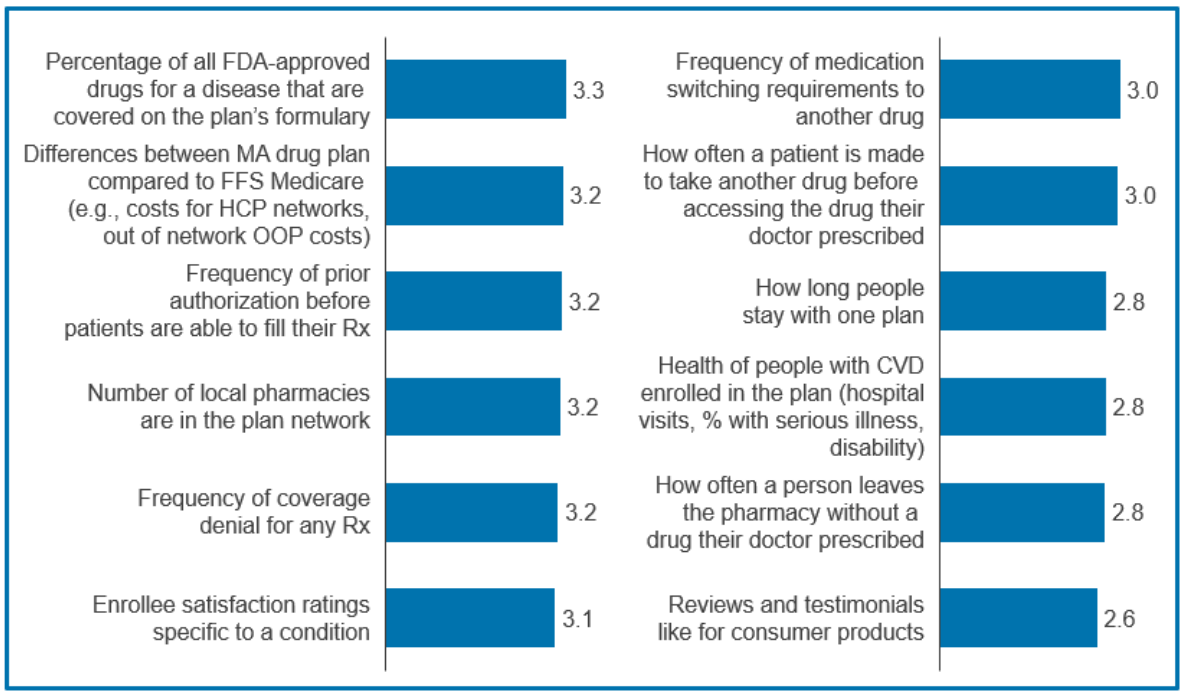
While the Stars program currently focuses on adherence and quality performance, it does not explicitly measure patients' ability to access prescribed treatments. However, given that this gap has become increasingly important in the context of the IRA, with early evidence suggesting that CVD beneficiaries may be experiencing greater access barriers, such barriers were investigated in the survey.[36,37] Our analysis looked to understand the extent of these challenges and whether they might justify consideration of access-related metrics within future iterations of the Stars program. Key findings from the survey include:

- 58% of respondents reported engaging in at least one behavior indicative of access challenges, such as skipping doses or paying OOP for uncovered medications.
- Notably, only 26% explicitly stated, when asked directly, that they had experienced access challenges. Patient groups suggested that many CVD patients may normalize these behaviors as routine aspects of managing their care.
- Access issues were more pronounced among beneficiaries receiving LIS. Beneficiaries receiving LIS were more likely than non-LIS respondents to skip doses or split pills (26% vs. 15%) and use over-the-counter alternatives (15% vs. 9%), though they were less likely to pay out-of-pocket for drugs not covered by their plan (13% vs. 34%).
- Respondents with the highest annual OOP spending ($2,000 or more) faced particularly severe challenges, including higher rates of skipped doses (30% vs. 10%) and paying cash for medications (57% vs. 19%) compared to those spending $100–$999.
- Meanwhile, respondents taking fewer medications (one to three drugs) reported fewer instances of skipped doses (5% vs. 17–24%) or leaving the pharmacy without their medication (11% vs. 28%–37%) but were more likely to turn to over-the-counter alternatives (16% vs. 8%–13%).

To understand what future changes could be beneficial to CVD patients, we proposed 12 hypothetical new measures (drawing on the literature review and feedback from patient group partners) and asked if they would be valuable in informing Medicare plan selection. Key findings include:

- A common theme across high-performing measures was the need to address concerns about real-world access, including (1) the percentage of all FDA-approved drugs for diseases that are covered on a plan's formulary; (2) differences in access and cost between Medicare Advantage drug plans and traditional fee-for-service (FFS) Medicare, such as provider network restrictions and out-of-network out-of-pocket costs; (3) the frequency at which PA is required before patients can fill their prescriptions; (4) the number of local pharmacies included in the plan's network; and (5) the frequency of prescription drug coverage denials (Figure 3).
- The measures considered most beneficial were more directly tied to patients' day-to-day access experiences than several current Star measures (e.g., use of statins), underscoring the potential for more meaningful alignment between patient priorities and quality measurement.

Figure 3. How beneficial would hypothetical measures be to plan selection?[38]



The survey findings highlight that Medicare beneficiaries with CVD have limited awareness of the Star Ratings program, with only one in three reporting familiarity. While those who knew about the program valued it in plan selection, most of them prioritized financial considerations when selecting plans. Many respondents, especially those with high OOP costs or receiving LIS, reported behaviors suggesting difficulty accessing medications. Looking forward, participants emphasized the need for future measures to better reflect real-world access concerns, such as formulary breadth, PA burdens, and pharmacy network coverage.

3.3 Formulary analysis – findings

The following section sets out the findings from the formulary analysis, assessing how access to commonly prescribed CVD medications varies across MA-PD and PDP plans. Across the analysis, the findings include:

- **Formulary coverage.** There were no statistically significant differences in coverage rates of CVD medications according to a plan's Star Rating, with similar rates across both high- and low-star plans. However, formulary inclusion of Praluent™, a PCSK9i, was limited across all plans, which aligned with experiences reported by patient groups.

- **Prior authorization.** Use of PA was similar across high- and low-rated Part D plans—in some cases, less common in lower-rated plans.

- **Tier placement.** While the proportion of CVD drugs placed on tier 3 or lower varied somewhat between high- and low-rated MA-PD plans, no consistent relationship emerged between plan quality and tier assignment.

In summary, the key findings from the analysis included limited evidence that formulary coverage, PA use, and formulary tier placements correspond to differences in Star Ratings. These findings support the potential role for access-related measures to be introduced into the Stars program to incentivize access-focused plan performance, especially for patients managing complex conditions like CVD.

4. Policy recommendations

Given low patient awareness of the Medicare Star Ratings program, as well as the potential interest from respondents in using ratings and in meaningful access-related measures, the patient survey suggests improvements are possible. This could potentially help reverse the worsening CVD-specific performance metrics, improving quality and aligning with IRA objectives. There is therefore an opportunity to strengthen the Stars program to better serve beneficiaries with CVD.

The following policy recommendations aim to better align the program with CVD patient priorities, incentivize improved care quality and access, and enhance the program's relevance in the context of CVD care and the goals of the IRA.

1. Introduce access-oriented measures

The current Stars program lacks indicators that meaningfully capture access challenges commonly faced by CVD patients, such as PA and coverage denials. CMS should consider incorporating new metrics that assess:

- The percentage of FDA-approved CVD drugs covered on a plan's formulary
- The frequency of PA requirements for innovative CVD drugs
- The rate of prescription drug coverage denials

2. Elevate the role of outcomes-based measures in CVD care

Currently, controlling blood pressure is the only outcomes-focused CVD measure in the Stars program. CMS could expand and prioritize outcomes-based quality metrics, such as improved cholesterol control or prevention of CVD-related hospitalizations. These indicators would more accurately reflect care quality and could be triple-weighted to encourage plan performance improvements.

3. Integrate CVD screening and prevention measures into Star Ratings

The Stars program lacks CVD-specific screening or risk assessment measures. Including metrics such as routine cholesterol screening, atherosclerotic cardiovascular disease risk scoring, or hypertension detection (as proposed in the ACC/AHA guidelines) would align the Stars program with evidence-based prevention strategies and encourage earlier intervention.

4. Enhance beneficiary education and awareness of star measures

Survey results show that low awareness is a key barrier to the effectiveness of the Stars program. CMS should fund member awareness and education campaigns, particularly for high-risk populations like those with CVD. In addition, CMS could consider requiring plans to educate beneficiaries about the Stars program; this could be supported by stakeholder engagement with organizations such as America's Health Insurance Plans.

5. Pilot patient-centered star enhancements via the CMMI

CMS could test an enhanced version of the Stars program tailored to chronic disease populations like CVD patients, through the Center for Medicare and Medicaid Innovation (CMMI). Pilots could evaluate the impact of including access-focused and outcome-based measures on CVD medication adherence, clinical outcomes, and access to care. This would allow CMS to refine and scale changes based on real-world performance.

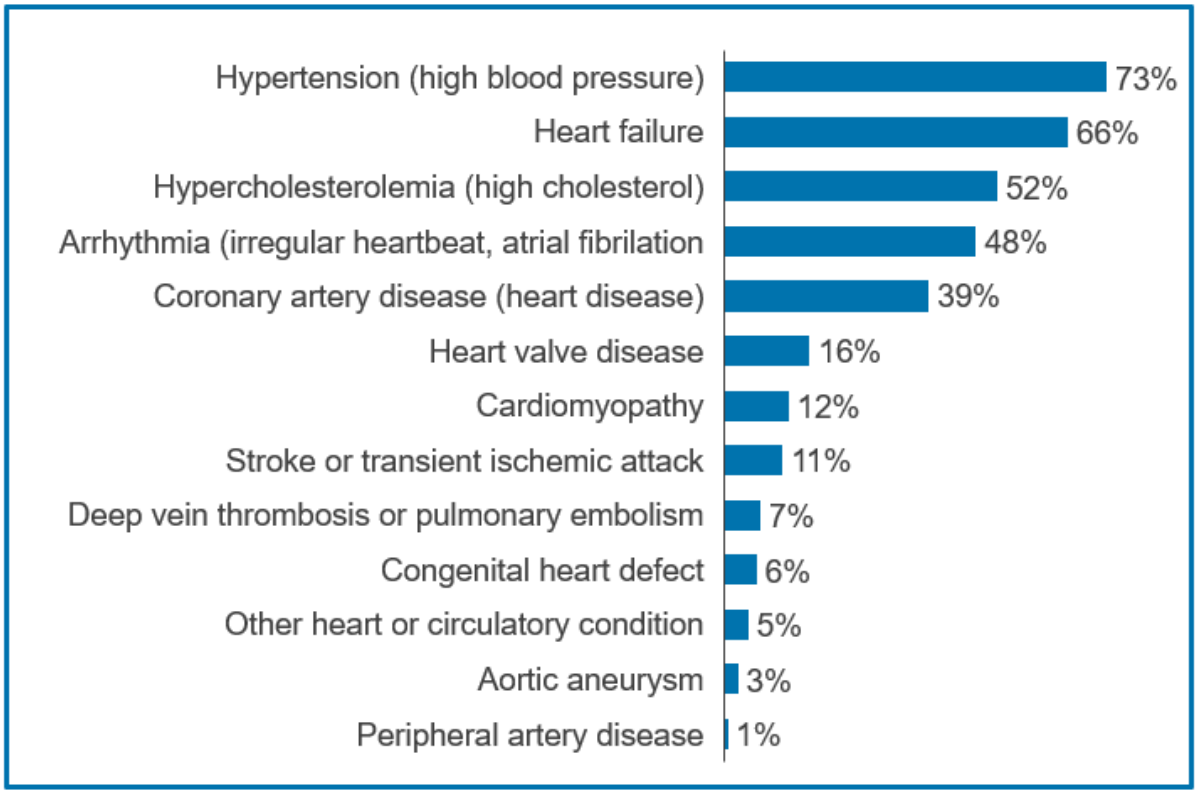
5. Conclusion

As the impact of the IRA's Medicare reform provisions begins to reshape the Medicare landscape, and as drug plans continue to exit the market or raise premiums, the role of Medicare Star Ratings could become more important. Our research highlights that despite the inclusion of several CVD measures, the Stars program currently falls short in promoting meaningful access or rewarding plans that meet the needs of CVD patients. Performance on CVD-specific metrics remains low. Beneficiary awareness of the program is limited, and even for those who are aware, Star Ratings do not meaningfully inform patients on formulary design and utilization management.

Strengthening the Stars program by incorporating access-focused and outcomes-based measures, enhancing patient awareness, and better reflecting real-world challenges faced by CVD patients will be essential to improving the Stars program. Without such reforms, Medicare plans may continue to rely on restrictive practices that undermine the full intent of the IRA and leave CVD patients behind.

Appendix

Figure A1. Frequency of CVD conditions among survey respondents



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[34] All respondents (150) provided an answer to the question "When selecting your current Medicare drug plan, how important, if at all, were the following factors?"

[35] All respondents (150) provided an answer to the question "The Star Ratings program currently includes several cardiovascular disease-specific measures for each plan. To what extent, if at all, do you consider these measures beneficial when making a decision about your Medicare drug plan?"

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[38] All respondents (150) provided an answer to the question "How beneficial, if at all, would the following information be when selecting your future Medicare drug plan?"