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WHITE PAPER

When Stars Realign: Understanding CMS's 2027 Proposed Rule

An Analysis of Proposed Star Rating Changes on Medicare Advantage Payments

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On November 25, 2025, the Centers for Medicare & Medicaid Services (CMS) issued[1] the Contract Year 2027 Medicare Advantage and Part D Proposed Rule (CMS-4212-P). The proposed rule calls for improving quality through a number of updates to Medicare Advantage (MA) and Part D (PD) Star Ratings quality measurements and streamlined enrollment processes. This white paper focuses on proposed changes to the MA and PD Star Ratings only.

Key components of the proposed Star Ratings changes include:

- **Not Implementing the Excellent Health Outcomes for All (EHO4all) Reward:** CMS will not implement the EHO4all reward (previously known as the Health Index Equity reward) in Star Rating Year (SY) 2027 and instead continue with the historical reward factor.
- **Removing 12 Measures:** Administrative and process-focused measures with high performance and little variation between contracts will be removed by the 2027 measurement year (SY 2029).

In this paper, Wakely provides an overview of all proposed changes to Star Ratings, along with an examination of the potential impact of changes to Overall Star Ratings and Quality Bonus Payments (QBPs)[2] impacting plan revenue. We also summarize changes outside of the proposed rule that will occur through SY 2029 and highlight several outstanding questions regarding these changes.

Although the removal of the EHO4all reward and continuation of the historical reward factor preserves plan revenue overall, the elimination of 12 administrative measures will reduce Overall Star Ratings. The impact of these changes will vary widely across Medicare Advantage Organizations (MAOs), but the majority will experience a reduction in QBPs due to lower Star Ratings.

[1] CMS Fact Sheet: Contract Year 2027 Medicare Advantage and Part D Proposed Rule. Available at: https://www.cms.gov/newsroom/fact-sheets/contract-year-2027-medicare-advantage-part-d-proposed-rule

[2] Appendix A contains more information on QBPs and how they affect plan revenue

Wakely's analysis of the 2027 proposed and finalized Star Ratings changes through SY 2029 highlights three key findings:

- **The cumulative effect of proposed and finalized Star Ratings changes is expected to materially lower market-wide performance and reduce QBPs**. Between SY 2026 and SY 2029, Wakely estimates that the enrollment-weighted market average Overall Star Rating will decline by approximately 0.25 Stars. These declines translate into fewer contracts qualifying for QBPs, resulting in a 1.4% decline in MA-PD payments across the market.
- **The removal of 12 administrative, process, and patient experience measures disproportionately affects high-performing organizations and drives increasing revenue pressure.** The eliminated measures meaningfully reduce Overall Star Ratings because many plans historically performed well on these measures. Wakely estimates that nearly all large MAOs—including all of the top 10 organizations—will experience declines in Overall Star Ratings and associated plan revenue if the proposed changes are finalized.
- **CMS's broader signals suggest continued structural change to the Star Ratings program, increasing uncertainty for future revenue tied to quality performance.** Beyond the specific proposed rule changes, CMS's Request for Information indicates ongoing interest in refining Star Ratings methodology, including potential adjustments to measure weighting, scoring thresholds, display periods, and the relationship between Star Ratings and QBPs. These signals suggest that plans should prepare for continued volatility and evolving incentives, reinforcing the importance of forward-looking Stars strategy and scenario planning.

Table 1 contains Wakely's calculation of enrollment-weighted market average Overall Star Ratings and enrollment in SY 2026 through SY 2029.[3] These figures were calculated using SY 2026 public contract-level Stars data, 2025 MA-PD enrollment files, and the 2026 Part C and D crosswalk file.

Note that the payment changes below are driven solely by Star Ratings and associated QBPs. Other upcoming changes, such as benchmark growth, risk adjustment changes, changes to plan designs and offerings, and regulatory changes implemented by CMS, have been excluded from these calculations.

[3] Note that each year's Star Ratings determine QBPs for the following year. For example, Star Ratings in SY 2026 determine QBPs for payment year (PY) 2027.

Table 1. Summary of the Proposed Rule Star Ratings Modeling[4]

Star Rating Year	Payment Year	Overall Star Rating	Annual Change to MA-PD Payments, PMPM	Annual Change to MA-PD Payments, %
2026	2027	3.99	$0.00	0.0%
2027	2028	3.90	-$4.30	-0.3%
2028	2029	3.88	-$4.17	-0.3%
2029	2030	3.74	-$11.68	-0.8%
Change SY 2026 to 2029		**-0.25**	**-$20.15**	**-1.4%**

STAR RATINGS IN THE 2027 PROPOSED RULE

Table 2 contains a summary of all announcements related to Star Ratings in the Contract Year 2027 MA-PD Proposed Rule.

Table 2. Proposed Rule Star Ratings Announcements

CMS Announcement	Description	Timing
Removing the EHO4all/HEI reward	CMS will no longer implement the EHO4all/HEI reward and will instead continue with the historical reward factor	SY 2027
Removing 12 Stars measures	Removes seven operational and administrative measures, three process measures, and two patient experience measures	SY 2028 (3 measures), SY 2029 (9 measures)

[4] Overall Star Rating weighted by November 2025 enrollment after applying 2026 Part C and D crosswalks and removing plans intended for termination in 2026.

CMS Announcement	Description	Timing
Adding Depression Screening and Follow-Up Part C measure	Captures the average percentage of MA plan members screened for clinical depression and, if screened positive, received follow-up care within 30 days. This is a process measure with a weight of 1.	SY 2029
Request for Information	Soliciting information to streamline and modify the Star Ratings methodology to further incentivize quality improvement. Feedback is due January 26, 2026.	N/A

REMOVING THE EHO4ALL REWARD

The EHO4all reward was initially proposed in the 2024 proposed rule to be added in SY 2027. At the same time, the historical reward factor was to be removed. In the 2027 proposed rule, CMS has proposed not to implement the EHO4all reward in SY 2027 and will continue to apply the historical reward factor instead.

The latest publicly available data, SY 2026 Star Ratings, contains the historical reward factor. Therefore, this proposal will have no impact because if it is adopted in the final rule, the reward factor will continue to be included in SY 2027 and future years.

REMOVING 12 STARS MEASURES

The Medicare Payment Advisory Commission (MedPAC),[5] a Star Ratings technical expert panel (TEP), and other interested parties have recommended that CMS adjust the measures in the Star Rating program. After taking this feedback into consideration, the proposed rule calls for removing 12 measures from the Star Rating program: seven measures focused on operational and administrative performance, three centered on process of care, and two related to patient experience of care. **Table 3** shows the measures proposed for removal.

[5] Replacing the Medicare Advantage quality bonus program – MedPAC.

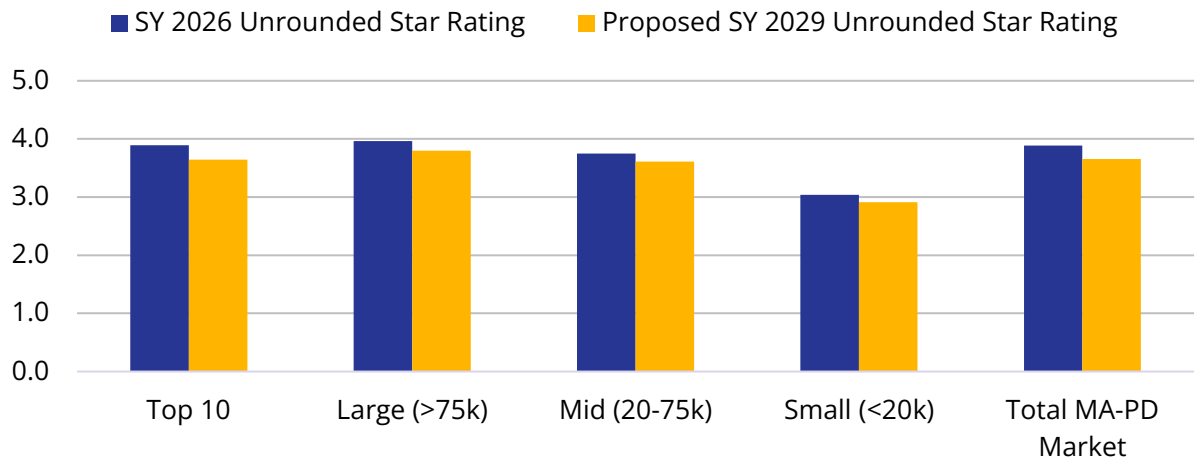
Table 3. Measures CMS Proposes to Remove from Star Ratings

Part C or D	Measure Name	Measure Focus	Year Proposed for Removal
C	Plan Makes Timely Decisions About Appeals	Operational/ Administrative	SY 2029
C	Reviewing Appeals Decisions	Operational/ Administrative	SY 2029
C	Special Needs Plan (SNP) Care Management	Process of Care	SY 2029
C	Call Center – Foreign Language Interpreter and TTY Availability	Operational/ Administrative	SY 2028
D	Call Center – Foreign Language Interpreter and TTY Availability	Operational/ Administrative	SY 2028
C and D	Complaints about the Health/Drug Plan	Operational/ Administrative	SY 2029
D	Medicare Plan Finder (MPF) Accuracy	Operational/ Administrative	SY 2029
C	Diabetes Care – Eye Exam	Process of Care	SY 2029
C	Statin Therapy for Patients with Cardiovascular Disease	Process of Care	SY 2028
C and D	Members Choosing to Leave the Plan	Operational/ Administrative	SY 2029
C	Customer Service	Patient Experience	SY 2029
C	Rating of Health Care Quality	Patient Experience	SY 2029

Wakely's analysis of the measures proposed for removal indicates a negative impact on Overall Star Ratings in SY 2028 and SY 2029, driving lower QBPs in PY 2029 and PY 2030, respectively.

Figure 1 below shows the weighted average measure-level Star Rating in SY 2026 compared against the weighted average after all 12 measures are removed in SY 2029. Of note, this chart incorporates the measure removals proposed for SY 2029 as well as other measure changes that are planned on or before SY 2029.

Figure 1. SY 2029 Measure Removal Impact on Unrounded Star Ratings,[6] by Parent Organization Size



The unrounded Star Ratings were calculated by using SY 2026 measure-level Star Ratings and then changing the measure weights to reflect the proposed rule and other finalized changes for implementation on or before SY 2029. Results indicate that removing all 12 measures by SY 2029 will lead to lower Star Ratings across MAOs of all sizes. Across the total MA-PD market, unrounded Star Ratings will drop from 3.73 to 3.58, a 4.2% decline.

Wakely also estimated the impact of removing 12 measures on QBPs and total plan revenue through 2030. As shown in **Table 4**, our analysis indicates that nine of the ten largest MAOs would experience a reduction in plan revenue if these proposed measure changes are finalized.

[6] Weighted averages use November 2025 enrollment and incorporate 2026 Part C and D crosswalks.

Table 4. Impact of Star Rating Changes on Top 10 MAOs, Applied to Payment Year 2027[7]

Parent Organization	Change in Plan Revenue
UnitedHealth Group, Inc.	-1.7%
Humana Inc.	-2.6%
CVS Health Corporation	-0.2%
Elevance Health, Inc.	-0.8%
Kaiser Foundation Health Plan, Inc.	-1.2%
Centene Corporation	-0.5%
Health Care Service Corporation	-0.6%
Blue Cross Blue Shield of Michigan Mutual Ins. Co.	-0.2%
Highmark Health	-1.0%
Healthfirst, Inc.	-1.3%
All Other MAOs	-0.7%
Total MA-PD Market	**-1.4%**

Overall, the results suggest a broad negative revenue impact across the MA market, with an estimated average reduction of 1.4% across all MAOs. Among the top 10 organizations, Humana is projected to experience the largest decline in plan revenue (-2.6%), reflecting its relatively high performance in the measures proposed for removal. In contrast, CVS Health (Aetna) has the smallest decline (-0.2%). These findings suggest that the proposed changes would have uneven effects across plans and could significantly affect revenue for those MAOs that have traditionally scored well on the measures slated for removal.

[7] Although CMS measures will be removed in SY 2029 and affect plan revenue in PY 2030, we have modeled these changes on SY 2026 Star Ratings data. For comparison purposes, these estimates evaluate PY 2027 plan revenue using: 1) the actual, published SY 2026 Star Ratings, and 2) the calculated SY 2026 Star Ratings after removing 12 measures as proposed.

For a detailed description of the methodology used to estimate plan revenue changes, see Appendix A.

ADDING DEPRESSION SCREENING AND FOLLOW-UP PART C MEASURE

The 2027 proposed rule also introduces a new depression screening measure to the Star Rating program in SY 2029. If adopted, it will be the first measure specific to behavioral health services in the Star Rating program.

At this time, no performance data for this measure is publicly available, making it difficult to assess how MAOs are likely to perform once it is incorporated into Star Ratings. The absence of display data creates uncertainty for plans as they evaluate potential impacts and consider operational readiness.

If adopted, the depression screening measure will first appear in display data for SY 2027 and SY 2028. The two years of display data provide plans with time to track performance and refine processes ahead of formal inclusion in the Star Rating program in SY 2029. The measure is a process measure and will therefore have a weight of 1, limiting its impact relative to other higher-weighted measures.

REQUEST FOR INFORMATION TO MODIFY THE STAR RATING METHODOLOGY

The proposed rule includes a broad Request for Information (RFI) seeking stakeholder input on potential future changes to the Star Ratings methodology. Through this RFI, CMS signals continued interest in refining the program to better align measure scoring, weighting, and incentives with care quality, equity, and beneficiary experience. The agency specifically notes concerns about measure volatility, the cumulative impact of recent methodological changes, and whether the current framework appropriately rewards meaningful improvements in care.

CMS also requests feedback on the pace of measure additions and removals, the appropriate length of display periods, and potential adjustments to scoring thresholds, cut points, and measure weights. These methodological elements directly affect year-over-year predictability and, in turn, Star Rating stability, which has material implications for MAO revenue, investment decisions, and long-term planning.

Notably, CMS raises the possibility of partially or fully separating Star Ratings from QBPs. This would represent a significant shift in how quality performance translates into plan revenue, potentially reducing the direct financial leverage of Star Ratings while increasing uncertainty about future bonus structures. For MAOs, this discussion underscores the potential for substantial changes in the magnitude and timing of Stars-related revenue in future years.

ADDITIONAL UPCOMING CHANGES OUTSIDE OF THE PROPOSED RULE

The following list contains measure removals, additions, and weight changes through SY 2029 that have already been finalized outside of the latest proposed rule.

Measures for Removal

1. Part C - Care for Older Adults – Pain Assessment (SY 2027)
2. Part C - Medication Reconciliation Post-Discharge (SY 2027)
3. Part D - MTM Program Completion Rate for CMR (SY 2027)

Measures for Addition

1. Part C - Care for Older Adults – Functional Status Assessment (SY 2027)
2. Part D - Concurrent Use of Opioids and Benzodiazepines (SY 2027)
3. Part D - Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (SY 2027)
4. Part D - Initiation and Engagement of Substance Use Disorder Treatment (SY 2028)
5. Part D - Initial Opioid Prescribing for Long Duration (SY 2028)

Measure Weight Changes

1. Part C - Improving or Maintaining Physical Health, increase from weight 1 to 3 (SY 2027)
2. Part C - Improving or Maintaining Mental Health, increase from weight 1 to 3 (SY 2027)
3. Part D - Medication Adherence for Diabetes Medications, decrease from weight 3 to 1 (SY 2028) then increase back to 3 (SY 2029)
4. Part D - Medication Adherence for Hypertension (RAS antagonists), decrease from weight of 3 to 1 (SY 2028) then increase back to 3 (SY 2029)
5. Part D - Medication Adherence for Cholesterol (Statins), decrease from weight of 3 to 1 (SY 2028), then back to 3 (SY 2029)

CONCLUSION AND RECOMMENDATIONS

CMS is proposing to change 2027 Star Ratings, with the stated goal of streamlining the Star Rating program and focusing on measures that have the greatest impact on quality and member experience. This simplification could reduce reporting burden for health plans but also raises the possibility that fluctuations in Star Ratings could occur as plans adjust to the new measure set.

MAOs and other stakeholders should carefully consider the implications of these changes. Plans, in particular, will need to evaluate how the removal of specific measures affects their quality improvement priorities.

CMS will release the final rule in 2026. If the proposed Star Rating changes are implemented in the final rule, plans should consider taking the following actions to prepare:

- Review the measures being removed and assess implications for quality improvement initiatives
- Adjust internal monitoring and reporting processes to focus on remaining measures
- Identify opportunities to strengthen performance on measures that remain, ensuring they reflect meaningful quality outcomes
- Prepare communications for internal and external stakeholders about expected Star Rating impacts
- Monitor post-implementation ratings to evaluate the effect of the measure changes and adjust strategies accordingly

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Founded in 1999, Wakely Consulting Group, an HMA Company, is known for its top-tier healthcare actuarial consulting services. With nine locations nationwide, Wakely boasts deep expertise in Medicare Advantage, Medicaid managed care, risk adjustment and rate setting, market analyses, forecasting, and strategy development. The firm's actuaries bring extensive experience across all sectors of the healthcare industry, collaborating with payers, providers, and government agencies.

APPENDIX A: REVENUE METHODOLOGY

Methodology Overview

Wakely used the published 2026[8] and modeled 2029 Overall Star Ratings to evaluate the revenue impact of the proposed Star Rating changes.

MA Spending Changes

This paper describes how changes in Overall Star Ratings were determined for all contracts based on the CMS Star Rating methodology. The last step in the analysis was to quantify the resulting financial impact of these changes. **Table A1** demonstrates the relationship between contract Star Ratings, QBP, and rebate percentages.

Table A1. Quality Bonus and Rebate Percentages, by Star Rating

Plan Rating	Bonus Payment	Quality Bonus Quartile-Adjusted Benchmark	Rebate Percentage
5.0 Stars	5.0%	105% of Benchmark	70%
4.5 Stars	5.0%	105% of Benchmark	70%
4.0 Stars	5.0%	105% of Benchmark	65%
3.5 Stars	0.0%	100% of Benchmark	65%
3.0 or Less Stars	0.0%	100% of Benchmark	50%
New Plans under New MAOs	3.5%	103.5% of Benchmark	65%
Low Enrollment Contracts	3.5%	103.5% of Benchmark	65%
Plans Not Reporting	0.0%	100% of Benchmark	50%

First, we excluded contracts that do not have MA payments tied to Overall Star Rating, including Prescription Drug Plan (PDP), Demo, 1876 Cost, and Medical Savings Account (MSA) contracts. We also excluded contracts without published CMS enrollment. CMS does not report enrollment for plans with less than 10 members in each county; therefore, we cannot estimate the MA spending impact on these contracts.

[8] https://www.cms.gov/medicare/health-drug-plans/part-c-d-performance-data

To quantify the MA spending impact of the Star Rating changes, first, individual county-level benchmarks for 2027[9] were determined for every contract at each 2026 through 2029 Star Rating (2027 through 2030 payment years). This involved using published March 2025 county-level enrollment and Wakely internal county benchmark projections based on the known quartile changes, ACA benchmark caps, qualifying double bonus counties, and current CMS benchmark projections.

The number and percent of enrollment in double bonus counties is from 2026 Rate Calculation Data. A bid estimate was derived for each Star Rating by applying an estimated bid-to-benchmark ratio to the contract-level benchmark. For individual plans, the average Part A/B per member, per month (PMPM) payment and average Medicare Advantage (MA) county benchmark rates are from 2023 Plan Payment Data (PPD) files, 2023 MA county benchmark rates, and published 2022 Medicare Advantage Star Ratings.

County-level payments and benchmarks are used. The bid-to-benchmark ratio is calculated as the average payment divided by the average benchmarks in the local market, where each benchmark reflects plan QBPs from the 2022 Star Ratings and the county-level average is weighted by enrollment. The bid-to-benchmark ratio was estimated using the first level of data that was available: PBP, county, state, product, with county, state and product data calculated by product/Special Needs Plan (SNP) type/Employer Group Wage Plan (EGWP). For EGWPs, the estimated 2028 county-level bid-to-benchmark ratio was assigned using CMS's quartile adjustment methodology. Using this established bid and benchmark, we determined the resulting MA revenue for all individual plans at each Star Rating. To develop a range around the MA revenue at each Star Rating level, the bid was varied between a constant PMPM rate and a constant bid-to-benchmark rate.

Because EGWPs do not submit a bid, the revenue for these plans was determined by the EGWP payment rate. The MA spending impact of a change in Star Rating, therefore, is based on the change in the payment rates based on Star Ratings.

[9] Contract level benchmarks for 2027 assumed a constant county level enrollment distribution from 2025.

Finally, the quantified impact on MA spending was multiplied by the estimated contract risk score. The v24 risk scores were pulled from the 2023 PPD files. Wakely calculated v24-to-v28 adjustment factors at the by plan-county level based on an internal data source. These adjustment factors were then applied to v24 risk scores at the plan-county level to calculate v28 risk scores for individual and EGWP plans. For plans that were unavailable in the 2023 PPD files, we used the first level of data that was available, matching on county, state, plan type, and product. Risk scores were applied to the contract based on their enrollment distribution at the county, product, and SNP-type level.

New Contracts Under an Existing Parent Organization

Contracts under an existing parent organization that were new in 2025 or later do not have their own 2026 Star Rating; instead, these contracts will receive 2027 MA payments based on the weighted average 2026 Star Rating of the parent organization. The weighted average 2026 Star Rating is calculated using enrollment from November 2025. For contracts that were too new to receive a 2026 Star Rating, we calculated the average parent organization Star Rating using November 2025 enrollment data.