Falling Star Rating trajectory: 2027 Proposed Rule implications

How the new changes delay the anticipated Star Rating declines

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The CMS 2027 Proposed Rule[1] includes significant changes to the Star Rating program, offering short-term relief to carriers by foregoing EHO4All while setting up substantial Star Rating and revenue reductions with proposed measure removals.

The 2027 Proposed Rule includes two major Star Ratings policy changes: (1) retaining the current reward factor rather than implementing the previously finalized Excellent Health Outcomes for All (EHO4All or Health Equity Index) reward and (2) retiring 12 existing measures. It also adds the "Depression Screening and Follow-Up" measure.[2]

In the Proposed Rule, CMS published financial projections relative to a regulatory baseline where EHO4All would be implemented in the 2028 payment year. While CMS's projections are appropriate for budget purposes, carriers may be more focused on how revenue would change relative to the latest known baseline, the 2026 Star Rating results that determine 2027 payments. Therefore, we created a new simulation modeling the impact of removing the proposed measures under the 2026 Star Rating methodology and reward factor. **Our simulation shows that the twelve proposed measure removals would likely lower Star Ratings and reduce revenues over time.**

Key highlights of this paper include:

- **CMS projection – Net measure and EHO4All removal impact:** CMS estimates that reversing EHO4All and adopting the measure changes increases MA payments by $13.18 billion over eight years, with most of the increase occurring in the first two years before the measure removals are fully implemented. However, CMS projected a revenue increase because its baseline includes the EHO4All rewards. This comparison also causes CMS's contract-level Star Rating simulations to appear more balanced than what Medicare Advantage Organizations (MAOs) should expect compared to the current Star Ratings.
- **Milliman simulation – Measure removals under current policy:** To isolate the impact on the 2026 Star Ratings under the current reward system and help MAOs understand the impact of the new proposed rule, we modeled the impact of removing the 12 proposed measures. Our simulation is not directly comparable with CMS's because CMS modeled a different policy scenario for budgetary purposes. Our simulation reflects current policy, where the historical reward factor remains in place and EHO4All was never implemented. Key highlights of our simulation include**:**
  - The national contract-weighted average Star Rating declines by approximately 0.15 Stars.
  - Approximately 158 contracts would drop by 0.5 Stars, and two contracts would decrease by a full Star. Five contracts lose their numeric rating entirely, including three that had earned 4.5 or 5.0 Stars. [3]
  - Forty-two contracts fall below the 4.0-Star Quality Bonus Payment (QBP) threshold, and eleven rise above it.[4]
  - The number of contracts below 3.5 Stars increases by 63.

1. CMS. (2025, November 28). Medicare program; Contract Year 2027 policy and technical changes to the Medicare Advantage program, Medicare Prescription Drug Benefit program, and Medicare Cost Plan program [Proposed rule]. HHS. https://public-inspection.federalregister.gov/2025-21456.pdf.
2. See the "Detailed summary of CMS proposed Star Rating changes" section for additional information about the proposed measure changes.
3. New/low enrollment contracts receive a 3.5% QBP compared to 5% for 4+ Stars or 0% for 3.5 Stars or lower.
4. Includes contracts shifting between new/low enrollment contracts and a numeric Star Ratings at or above 4.0 Stars.

CMS's Federal Budget impact estimate for the proposed Star Rating changes

As shown in Figure 1, CMS estimates that retaining the current reward factor and adopting the proposed Star Ratings measure changes would increase MA payments by $13.18 billion from 2028 through 2036.[5] Because CMS's projection is for budget purposes, CMS modeled this impact relative to a regulatory baseline that assumed the EHO4All reward system was fully implemented. Under this baseline, the projected increase in MA payments is driven largely by reversing the transition to EHO4All (and its associated savings). The upcoming measure changes in 2029 and 2030 are expected to offset much of the impact of keeping the current reward factor.

FIGURE 1: 2027 PROPOSED RULE, TABLE K3 (PAGE 366) [6]

NET IMPACTS ($ MILLIONS) PER YEAR TO THE MEDICARE TRUST FUND FOR STAR RATING UPDATES			
PAYMENT YEAR	**NET IMPACT STAR RATING UPDATES**	**% IMPACT TO PRIVATE HEALTH PLAN PAYMENTS**	**PROPOSED CHANGES IMPLEMENTED**
2027	$0	0.00%	None
2028	$5,020	0.80%	Replace EHO4All with current rewards
2029	$2,320	0.33%	Remove Call Centers and SPC7
2030	$780	0.10%	Remaining measure changes
2031–2036	$5,060	0.08%	None
Total	**$13,180**	**0.15%**	

As shown in Figure 1 above, in the 2027 Proposed Rule CMS projects that reversing the EHO4All implementation will increase 2028 MAO payments by $5.02 billion, roughly $4.3 billion higher than the originally projected savings of $670 million in the 2024 Final Rule.[8] This significant swing reflects the new Star Ratings landscape, where the existing reward system lifts more contracts to QBPs than previously anticipated. As a result, replacing it with EHO4All produces a much larger projected impact than earlier estimates suggested.

The CMS projected financial impact declines sharply in later years as the proposed measure changes take effect. CMS estimates a $2.7 billion revenue reduction in 2029 compared to 2028, when the Call Center (Part C and D) and Statin Therapy for Patients with Cardiovascular Disease (SPC) measures are removed.[9] By 2030, the remaining measure changes would be implemented, and the expected payment decreases by an additional $1.5 billion reduction relative to 2029. The lower revenue levels are generally maintained in the subsequent years. However, changes to Stars landscape may cause actual results to vary significantly, as we saw with the original EHO4All scenario.

Because the EHO4All rewards were never implemented, the most relevant comparison for MAOs is the year-over-year declines that CMS projects as measure removals are phased in. These declines represent the true financial impact under current policy and show how the proposed changes shift Star Rating-related revenue downward once the measure changes take effect.

CMS's analysis shows that the proposed policy changes mostly delay the revenue reductions that would have occurred under EHO4All rather than eliminate them. Carriers may see stable Star Rating-related payments in 2028 compared to 2027 and 2026 as CMS foregoes the reward system overhaul. However, significant revenue decreases are likely beginning in 2029 as the measure changes take effect.

5. CMS's projections were based on a simulation using 2025 Star Ratings data, with methodology adjustments to reflect the finalized 2026 rules, including changes to measure weights and CAHPS weighting. Savings/cost reductions for CMS also represent revenue reductions for MAOs/Medicare Advantage as a whole.

6. 2027 Proposed Rule, ibid

7. "Statin Therapy for Patients with Cardiovascular Disease" measure

8. Table 10: 2024 Final Rule: https://public-inspection.federalregister.gov/2023-07115.pdf.

9. See the "Detailed summary of CMS proposed Star Rating changes" section for additional information about the proposed measure changes.

2026 Star Rating – Impact of removing the proposed measures

CMS published contract-level Star Rating simulated impact results in the 2027 Proposed Rule as part of its financial projections. CMS modeled those changes using the 2025 Star Ratings and applied the 2026 methodology updates (weight changes and measure sets). Their simulation assumed the EHO4All reward had already been implemented and then measured the combined effect of removing both the EHO4All and the proposed measure changes.[10] This approach shows how the expected federal payments would change relative to their previously budgeted projections.

To help MAOs understand how their current 2026 Star Ratings may evolve under the proposed policy, we conducted a separate simulation using the 2026 Star Ratings and the current reward system. This approach isolates the impact of removing the proposed measures without including the hypothetical EHO4All implementation, which under the proposed rule would never occur. The simulation results reinforce CMS's financial projections by showing that Star Ratings are likely to decline meaningfully once the proposed measure removals take effect.

Figure 2 illustrates the simulated transition between the actual 2026 Star Ratings (shown horizontally) and the modeled 2026 Star Ratings with the proposed measure removals applied (shown vertically). This figure only includes MA-PD contracts that receive payments tied to Star Ratings.[11] The colors highlight the direction of change, where green indicates improvement and orange indicates a decline.

FIGURE 2: IMPACT OF MEASURE REMOVAL ON THE 2026 STAR RATINGS

MODELED STAR RATINGS – WITHOUT MEASURES	ACTUAL 2026 STAR RATINGS								
	2.0	2.5	3.0	3.5	4.0	4.5	5.0	NEW/LOW	TOTAL
1.5	1	1	0	0	0	0	0	0	2
2.0	1	2	0	0	0	0	0	0	3
2.5	0	18	22	0	0	0	0	1	41
3.0	0	0	88	63	0	0	0	0	151
3.5	0	0	0	99	38	1	0	0	138
4.0	0	0	0	9	72	28	0	1	110
4.5	0	0	0	1	6	42	4	0	53
5.0	0	0	0	0	0	0	13	0	13
New/low	0	0	1	1	0	2	1	199	204
Total	**2**	**21**	**111**	**173**	**116**	**73**	**18**	**201**	**715**

19	Star Rating and revenue increase	**134**	Star Rating and revenue decrease
0	Star Rating only increase	**30**	Star Rating only decrease

10. See the "Detailed summary of CMS proposed Star Rating changes" section for additional information about the proposed measure changes.

11. The simulation includes coordinated care plans (CCPs), private fee-for-service (PFFS), and regional CCP contracts. This analysis excludes Prescription Drug Plans (PDPs), 1876 Cost, medical savings accounts (MSAs), and dual demonstration contracts.

Removing the 12 proposed measures[12] creates a meaningful downward pressure across the Star Ratings, with only a few contracts improving. The national contract-weighted average would decrease by 0.15 Stars.[13] For context, CMS previously reported a similar decline in the enrollment-weighted Star Ratings compared with 2024,[14] with a revenue impact of −0.69%.[15] Therefore, the implied revenue impact from our simulation is consistent with CMS's financial projections, discussed in the *"CMS's Federal Budget impact estimate for the proposed Star Rating changes"* section, which indicate that the MAO's star rating related revenue would reduce by roughly 0.70% between Payment Year 2028 (0.80%) and 2030 (0.10%) when the measure changes are implemented.

There were significant shifts in calculated Star Ratings, some with important revenue and compliance implications:

- 158 contracts dropped by half a Star, and two contracts fell by a full Star
- 15 contracts gained a half Star, and one contract gained a full Star
- The number of 4.0+ Star contracts fell from 207 to 176, a net loss of 31
  - 39 contracts dropped from 4+ Stars to 3.5 or lower Stars
  - 10 contracts improved from 3.5 to 4+ Stars
  - Three contracts with numeric ratings of 4+ Stars changes to new/low status, and one new/low contract changes to a 4-Star rating
- The number of contracts below 3.5 stars increased from 134 to 197, which would impact their rebate revenue[16]
- Contracts below 3.0 stars increased from 23 to 46, doubling the population potentially subject to CMS compliance attention[17]

In our simulation, five contracts that had a numeric overall rating in the 2026 Star Ratings shifted to "Not enough data available" in the modeled scenario.[18] Three of these contracts had 4.5 or 5.0 Stars in the actual 2026 Star Ratings, reducing their QBP from 5% to 3.5%. The loss of a 5.0 Star Rating can also have marketing and enrollment implications. Additionally, one contract gained a 2.5-Star numeric rating and another a 4-Star rating in the modeled scenario after having "Not enough data available" status in the actual 2026 Star Ratings.

The new "Depression Screening and Follow-Up" measure was not included in this simulation. However, based on its weight, we anticipate only a minimal effect on overall Star Ratings once it is added.

The downward shifts observed in this simulation reflect the natural consequence of CMS's proposal to retire measures that have "topped out." CMS noted in the proposed rule that many of the measures being removed show consistently high performance, little variation across contracts, and in several cases small denominators that cause volatility rather than meaningful differentiation. As performance approaches the theoretical ceiling, these measures cease to significantly discriminate among plans and instead act as stabilizers in the rating distribution. Their removal, therefore, produces a downward adjustment in overall Star Ratings, not because quality is worsening, but because many of the measures MAOs are performing best on are being removed from the program.

MAOs will need to adapt by strengthening performance on the remaining measures, reevaluating internal performance buffers, and preparing for a Star Ratings environment where fewer measures carry greater weight and can result in greater Star Rating volatility.

12. See the "Detailed Summary of CMS Proposed Star Rating Changes" section for additional information about the proposed measure changes.
13. Contract-weighted national average (every contract counting equally). Excludes new/low enrollment contracts.
14. CMS. (2024, October 10). 2025 Medicare Advantage and Part D Star Ratings. https://www.cms.gov/newsroom/fact-sheets/2025-medicare-advantage-and-part-d-star-ratings.
15. CMS. (2025, January 10). Advance notice of methodological changes for Calendar Year (CY) 2026 for Medicare Advantage (MA) capitation rates and Part C and Part D payment policies. https://www.cms.gov/files/document/2026-advance-notice.pdf.
16. Contracts at three stars or lower have a 50% rebate instead of a 65% or 70% rebate. See The future is now: 2024 Star Ratings release, Figure 10 at https://www.milliman.com/en/insight/the-future-is-now-2024-star-ratings-release for an illustration of the financial impact of the reduction of rebate percentage.
17. Contracts can face penalties, such as marketing/enrollment restrictions or contract termination, if they remain below 3 Stars for three or more years.
18. Measure removals can affect whether some contracts retain enough information to receive a numeric rating.

Updated list of upcoming Star Rating methodology changes

Figure 3 outlines the updated list of potential upcoming changes to the methodology across the 2027 to 2029 Star Ratings cycles:

- Finalized changes are shown in black
- Proposed changes from the 2027 Proposed Rule are shown in red

FIGURE 3: PREVIOUSLY FINALIZED UPCOMING STAR RATING METHODOLOGY CHANGES

2027 STAR RATING	2028 STAR RATING	2029 STAR RATING
▪ Physical and mental health measures increase to a weight of 3 ▪ Part D patient safety measure updates ▪ Reversal of the implementation of EHO4All reward ▪ Keeping the current reward factor, which is tied to consistently high performance on the ratings ▪ Removal of Care for Older Adults – Pain Assessment	▪ Changes to the three medication adherence measures, including implementation of risk adjustment and removal of inpatient/SNF stay adjustment ▪ Removal of the Part C and D Call Center measures ▪ Removal of SPC	▪ Removal of the Appeals measures (2), SNP Care Management, Complaints about Plan (Part C and D), MPF Price Accuracy, Diabetes Care – Eye Exam, Members Choosing to Leave the Plan (Part C and D), Customer Service and Rating of Health Care Quality measures ▪ Addition of the Depression Screening and Follow-up measure

Detailed summary of CMS proposed Star Rating changes

Figure 4 provides additional details on the proposed measure removals, along with CMS's rationale for each. In general, CMS targeted measures for removal that have had consistently high performance with little room for differentiation across plans, are largely administrative or process-oriented, or overlap with other existing measures.[19]

FIGURE 4: MEASURES PROPOSED FOR REMOVAL FROM STAR RATINGS, STAR YEAR EFFECTIVE, AND CMS RATIONALE

MEASURE	EFFECTIVE STAR RATING YEAR	CMS RATIONALE FOR REMOVAL
Call Center – Foreign Language Interpreter & TTY Availability (Parts C & D)	2028 Star Ratings	Extremely high performance across plans, with little variation. Small sample sizes also lead to noise. CMS will continue to enforce call center requirements; related consumer experience is captured through CAHPS* survey questions.
Statin Therapy for Patients with Cardiovascular Disease	2028 Star Ratings	High performance and overlap with the Part D Statin Adherence outcome measure. NCQA** has also substantially revised this statin therapy process measure for the future. CMS will drop it from Star Ratings and instead monitor the updated version on the display page.
Plan makes timely decisions about appeals and reviewing appeals decisions	2029 Star Ratings	Very high and improving performance with minimal variation; some contracts have very small denominators, causing volatile scores. CMS will continue oversight of appeals timeliness and fairness outside of Star Ratings.
SNP Care Management	2029 Star Ratings	Administrative process measure with nearly universal high compliance. Little differentiation in performance and does not directly reflect enrollee outcomes.
Complaints about the Health/Drug Plan (Parts C & D)	2029 Star Ratings	Plan complaint rates have declined significantly over time and now show little variation. Nearly all contracts score at or near the maximum on this measure. CMS will keep using its complaint tracking outside of Star Ratings.
Medicare Plan Finder Price Accuracy	2029 Star Ratings	Limited variation and high scores make it a poor discriminator of quality. CMS will monitor plan pricing accuracy as a compliance matter.

19. One measure slated for removal, MPF Price Accuracy, saw a significant shift in cut points for the recently released 2026 Star Ratings. This shift appeared to be driven by the interaction of Tukey Outlier removal and the distribution of measure scores, with both the 25th and 75th percentile receiving measure scores of 99.

MEASURE	EFFECTIVE STAR RATING YEAR	CMS RATIONALE FOR REMOVAL
Diabetes Care – Eye Exam	2029 Star Ratings	Process measure for diabetic eye exams is being removed to streamline the diabetes measure set. Performance is high and multiple other diabetes care measures address similar outcomes.
Members Choosing to Leave the Plan (Part C & D)	2029 Star Ratings	Metric has limited actionable meaning for consumers without context of why members leave. Most contracts have low voluntary disenrollment and differences are not easily interpretable. Industry feedback suggested this measure might be more useful at parent-organization level with reasons included.
Customer Service and Rating of Health Care Quality	2029 Star Ratings	These patient experience measures show consistently high scores across plans, with relatively low variability compared to other CAHPS measures. CMS wants to emphasize experience areas with more room for improvement.

* CAHPS: Consumer Assessment of Healthcare Providers System
** NCQA: The National Committee for Quality Assurance

Along with the removals, CMS proposes adding the "Depression Screening and Follow-Up" measure to Star Ratings, noting that it would address the gaps in measures specific to behavioral health care, an area of emphasis in the broader Medicare "Universal Foundation" measure set. This measure assesses the percentage of enrolled patients screened for depression and whether flagged members received appropriate follow-up care. The measure would begin with the 2027 measurement year and first impact Star Ratings in 2029.

In the Proposed Rule, CMS also invites broader feedback on the future direction of Star Ratings. CMS is seeking comments on how to simplify the program, focus more directly on measures that improve quality, and shorten the time between developing a measure and using it in Star Ratings. CMS also asks for input through the Request for Information on Future Directions in Medicare Advantage, indicating that this proposal is only the first step in a longer effort to refine and potentially further narrow the measure set.

Comparison of 2026 Advance Notice vs. 2027 Proposed Rule

Although many of the Star Rating changes in the 2027 Proposed Rule were previewed in the 2026 Advance Notice,[20] several differences have emerged. The Advance Notice, released in early 2025, outlined a broader set of potential measure removals and additions. The Proposed Rule reflects a more targeted approach, with some measures added that were not previously flagged and others omitted that had been under consideration.

Measures not previewed in the 2026 Advance Notice but included in the 2027 Proposed Rule:

- SPC (Part C): Newly proposed for removal due to upcoming NCQA specification changes
- Diabetes Care – Eye Exam (Part C): Added to streamline overlapping diabetes measures and reduce redundancy
- Members Choosing to Leave the Plan (Parts C and D): Included based on industry concerns over interpretability at the contract level
- Customer Service (Part C) and Rating of Health Care Quality (Part C): CAHPS-based measures proposed for removal due to high performance and low variation across plans

Measures previewed in the 2026 Advance Notice but excluded from the 2027 Proposed Rule:

- MTM Program Completion Rate for CMR (Part D): Cited for possible removal, but retained for now
- Care for Older Adults – Medication Review and Functional Status Assessment (Part C): Previewed as candidates for retirement but not proposed for removal
- Care for Older Adults – Pain Assessment (Part C): Not addressed in the Proposed Rule, as it is already scheduled for retirement by NCQA in 2027

20. CMS. (2025, January 10). Op cit.

[i]**Measures previewed in the 2026 Advance Notice for addition but excluded from the 2027 Proposed Rule:**

- Adult Immunization Status (AIS, Part C): Expected to be added following prior CMS display page tracking, but not included in the proposal
- Social Need Screening and Intervention (SNSI, Part C): Flagged in the Advance Notice as part of CMS's equity strategy but omitted in the current rule

These changes reflect evolving priorities under the new administration and feedback received from plans and industry stakeholders. CMS continues to solicit input on how to simplify and refocus the Star Ratings program. Plans should closely monitor future rulemaking cycles and consider responding to CMS requests for comment to help shape the direction of quality measurement.

Conclusion

The 2027 Proposed Rule represents a structural realignment of the Star Ratings program. By removing a concentrated set of topped-out and low-variation measures, CMS is intentionally shrinking the measure set to focus on areas where meaningful performance differences remain.

Going forward, plans will depend on a smaller set of clinical and experience measures. Performance on these measures varies more across the market and is more sensitive to operational issues. This will make ratings less stable and more dependent on early performance patterns. Plans will need a clear understanding of where they stand relative to the rest of the market and which member groups and providers most influence their performance.

The next several Star Rating cycles will be shaped by a leaner measure set and faster changes in cut points. Plans that understand their true position in the national landscape and act early on emerging performance signals will be best positioned to manage this transition.

For more information about how these Star Rating changes may affect your organization, please contact your Milliman consultant.

Limitations and data reliance

This analysis is based on the 2027 Proposed Rule released on November 25, 2025. Our analysis could be subject to change based on the 2027 Final Rule expected to be released in April 2026.

We primarily relied on information and data provided by CMS, including publicly released membership data and projections for model impacts. We also relied on other information provided by additional sources, primarily relating to policy analysis. Throughout this analysis, Milliman relied on data and other information provided by publicly available data sources. Many of the simulations and projections in this paper were driven by Milliman's Star Rating Market Intelligence (SRMI), a Star Ratings solution built on 100% of Medicare Advantage and Part D market data. This product tracks actual emerging quality results across the entire market and forecasts cut points using the same contract-level performance that will ultimately determine future thresholds. SRMI provides plans with a clear view of where they stand against competitors, where they are most vulnerable under the smaller measure set, and where to target resources to optimize their Star Ratings performance.

The estimates included in this paper are not predictions of the future; they are estimates based on the assumptions and data analyzed at a point in time. If the underlying data or other listings are inaccurate or incomplete, then the results may also be inaccurate or incomplete. Milliman has not audited or verified this data and other information but has reviewed it for reasonableness.

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