ChatGPT Exec Summary of CMS' FY 2027 Contract Year 2027 Final Rule for Medicare Advantage (Part C), Part D, and Cost Plans

April 3, 2026

Here is a two-page, policy-focused synthesis of the Contract Year 2027 final rule for Medicare Advantage (Part C), Part D, and cost plans —with special emphasis on the Star Ratings program, because that is one of the most consequential pieces of this rule.

Executive takeaway

This is a broad MA/Part D final rule, but the policy story is concentrated in four areas.

First, CMS is reshaping the Star Ratings program by removing a sizable group of measures, preserving the Diabetes Care – Eye Exam measure after strong feedback, dropping the planned Health Equity Index reward, and keeping the historical reward factor instead. That is the biggest strategic change because it affects quality incentives, bonus eligibility pressure, and the relative importance of remaining measures.

Second, CMS is finalizing a set of Part D redesign codifications tied to the Inflation Reduction Act, including the new Part D benefit structure, termination of the old Coverage Gap Discount Program, and codification of the Manufacturer Discount Program. These changes are not newly invented by this rule, but this rule locks the operational framework more firmly into regulation.

Third, CMS is tightening oversight of supplemental benefits, especially SSBCI eligibility transparency and the use of debit cards for supplemental benefits. That matters because CMS is signaling continued concern about marketing, transparency, and program integrity in the MA benefit package.

Fourth, the rule is notable for what it does not do: CMS says it is not finalizing the proposal to establish a special enrollment period for provider terminations. That matters operationally for plans that were preparing for further enrollment-process changes.

1. Star Ratings: the most important policy section in the rule

What changed

CMS finalized a broad simplification of the Star Ratings program by removing 12 measures from the ratings over the next two cycles. The removals are intended to shift the program away from measures where performance is already very high or variation is limited, and to increase the relative weight of measures tied more directly to outcomes and patient experience. CMS

explicitly says reducing operational, administrative, and some process measures will increase the relative weight of the outcome measures in summary and overall ratings.

The measures CMS finalized for removal are:

For the 2029 Star Ratings:

- Plan Makes Timely Decisions about Appeals
- Reviewing Appeals Decisions
- Special Needs Plan Care Management
- Complaints about the Health/Drug Plan
- Medicare Plan Finder Price Accuracy
- Diabetes Care – Eye Exam was proposed for removal but ultimately retained
- Members Choosing to Leave the Plan
- Customer Service
- Rating of Health Care Quality

For the 2028 Star Ratings:

- Call Center – Foreign Language Interpreter and TTY Availability (Part C)
- Call Center – Foreign Language Interpreter and TTY Availability (Part D)
- Statin Therapy for Patients with Cardiovascular Disease (Part C)

The single biggest exception is that CMS did not remove Diabetes Care – Eye Exam. After commenters argued it captures a distinct and clinically important aspect of diabetes care, CMS agreed and kept it in Star Ratings. That is an important signal that CMS remains willing to reverse course when a measure is shown to represent a clinically meaningful domain rather than mere administrative duplication.

Why this matters

This changes the incentive map for MA and Part D contracts. If you remove measures where many plans score well, overall Star Ratings can become harder to sustain because there are fewer "easy" points. CMS itself says measure removals would generally be expected to decrease ratings, although that effect is partly offset by the separate decision to keep the historical reward factor and abandon the HEI reward.

Policy-wise, the main implication is that CMS is moving Star Ratings toward a smaller, more selective measure set. That can be attractive from an administrative-burden standpoint, but it also means plans will have less room to compensate for weakness in core clinical or member-experience performance. In other words, fewer measures means each remaining measure matters more.

What to be concerned about

The immediate concern is volatility. A smaller measure set can make ratings more sensitive to underperformance on any one remaining measure. Plans with uneven performance may see more rating instability, especially if they previously relied on high scores in administrative or topped-out measures to support overall ratings. That can affect quality bonus payments, rebate levels, marketability, and enrollment strategy. CMS estimates the net impact of the Star Ratings updates at $18.56 billion over 2027 through 2036, equal to about 0.21 percent of Medicare payments to private plans over that period, so these changes are financially meaningful even if they look technical on paper.

2. Star Ratings reward structure: HEI is out, historical reward factor stays

What changed

CMS finalized that it will not implement the Health Equity Index (HEI), also called the Excellent Health Outcomes for All reward, for the 2027 Star Ratings. Instead, CMS will continue using the historical reward factor. The HEI reward had been finalized previously and was supposed to begin with the 2027 Star Ratings using 2024 and 2025 measurement-year data, while the historical reward factor was supposed to come out at the same time. CMS is now reversing that course before implementation.

CMS explains that the HEI reward was intended to encourage improvement for beneficiaries who are dually eligible, receive the low-income subsidy, or qualify based on disability status, but CMS now prefers to continue a reward approach that encourages strong performance for all enrollees rather than a reward targeted to specific subpopulations. CMS also says keeping the existing historical reward factor avoids a one-year methodological disruption while the agency continues to consider broader simplification of Star Ratings.

Why this matters

This is one of the most important policy decisions in the rule. It tells you that CMS is, at least for now, pulling back from embedding a distinct health-equity reward into Star Ratings. That does not mean CMS is abandoning equity as a program goal; CMS explicitly says MA organizations remain responsible for equitable access and quality for all enrollees. But it does mean that plans should not assume the Star Ratings bonus structure will directly reward targeted improvement in low-income, dual-eligible, or disabled populations in the way HEI was designed to do.

What to be concerned about

The practical concern is that some plans likely made investments expecting the HEI reward to go live. CMS acknowledges those comments but states the change is not retroactive because it only affects future Star Ratings calculations beginning in 2027. For plans that serve higher-risk or more socially complex populations, this could be seen as a lost opportunity to better align ratings incentives with member mix. At the same time, plans that perform strongly across the board may benefit from keeping the historical reward factor, which rewards consistently high overall performance.

A related nuance that matters: CMS clarifies that the "historical" reward factor does not use old historical data; it uses the same most recent data used elsewhere in Star Ratings. "Historical" just distinguishes it from the newer HEI concept.

3. Star Ratings administration: more transparency, clearer rules, and important technical clarifications

What changed

CMS codified more detail about what plans receive during the Star Ratings preview periods. In the first preview, plans review methodology and posted numeric data for each measure in HPMS before display on Medicare Plan Finder. In the second preview, they review any updates plus preliminary measure, domain, summary, and overall ratings. CMS also codified the practice of providing sample data for one measure of each type during the second preview so sponsors can validate cut point calculations.

CMS also clarified the process for measure removals, making clear that CMS can either announce certain removals through the payment/risk-adjustment process in advance of the measurement period or propose and finalize them through rulemaking in advance of the measurement period.

Finally, CMS finalized a technical clarification for contract consolidations: when a consumed or surviving contract is missing a measure because there is not enough data to meet the technical specification, or for CAHPS due to reliability below 0.6, CMS treats that score as missing in the enrollment-weighted measure calculation, while certain missing scores caused by data integrity issues get a zero.

Why this matters

These changes are not as headline-grabbing as measure removals, but they are important for operations, disputes, and forecasting. More explicit preview-period data should help plans better identify errors before ratings are released. The consolidation clarification matters particularly for mergers and acquisitions because missing data treatment can materially affect enrollment-weighted scores. And the clarified measure-removal process reinforces that CMS wants the flexibility to keep simplifying the program.

4. Other major policy points in the rule outside Star Ratings

The rule also codifies the IRA-driven Part D redesign, including the new benefit phases, updated TrOOP policies, reinsurance updates, the sunsetting of the old Coverage Gap Discount Program, and the rules for the Manufacturer Discount Program that replaced it beginning January 1, 2025. These are operationally important and financially significant, but they are more a codification of statutory redesign than a fresh policy surprise in this rule.

CMS also finalized requirements for SSBCI transparency, including that MA plans must post their objective SSBCI eligibility criteria on public-facing websites, and finalized guardrails for

supplemental benefit debit cards, including real-time verification mechanisms and stronger disclosure expectations. These provisions matter because CMS continues to push plans to make supplemental benefits more transparent and less vulnerable to misuse or misleading marketing.

Bottom line

The most important policy issue in this rule is the re-engineering of Star Ratings. CMS is making the program smaller, more selective, and more focused on what it sees as meaningful clinical, outcome, and patient-experience performance. It is also backing away from the HEI reward and preserving the historical reward factor, which shifts incentives away from an explicit equity reward and back toward consistent overall excellence.

The immediate concerns are these: a smaller measure set can make ratings more volatile; preserving the historical reward factor may advantage contracts with already strong broad-based performance; and plans that expected HEI-driven upside will need to reset their quality strategy. The most durable strategic signal is that CMS is still in the middle of a broader effort to simplify and refocus Star Ratings, so this is probably not the last major restructuring.