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INSIGHTS

Contract Year 2027 Policy & Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, & Medicare Cost Plan Program Proposed Rule

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On November 25, 2025, the Centers for Medicare & Medicaid Services (CMS) released a proposed rule that would revise the Medicare Advantage (MA) Program, the Medicare Prescription Drug Benefit Program (Part D), and the Medicare Cost Plan Program for Contract Year 2027 (CY27). The CMS press release can be found here. A CMS fact sheet can be found here. The 60-day comment period under the Administrative Procedure Act (APA) for the CY27 MA/Part D Proposed Rule ends on January 26, 2026.

MA & PART D: UPDATES TO STAR RATINGS

The MA and Part D Star Ratings program evaluates plan performance on a 1-to-5-star scale across up to 43 measures for MA-PD contracts, 33 for MA-only, and 12 for Part D, covering categories like outcomes, intermediate outcomes, process, patient experience, and access. Ratings are based on CMS administrative data, enrollee surveys, and plan-submitted information. These ratings influence quality bonus payments (QBPs) for MA plans (up to 5-10% added to benchmarks for 4+ star plans), beneficiary rebates (50–70%), marketing rules, and the way consumers are presented plan options in the Medicare Plan Finder.

In keeping with the Trump administration's effort to deemphasize equity programs, the CY27 proposed rule would eliminate the Biden-era Excellent Health Outcomes for All reward (formerly the Health Equity Index or HEI). This reward – finalized in the 2023 final rule for implementation in CY27 – was intended to incentivize high measure-level performance among enrollees with specific social risk factors (SRFs), such as dual eligibility for Medicare and Medicaid, receipt of the low-income subsidy (LIS), or disability. For CY27, the Biden-era reward would have given plans an HEI score ranging from -1 to 1 based on a subset of measures, and those plans with positive HEI scores would have received a bonus added to their overall Star Rating (0.4 for the top third, 0.267 for the middle third, and 0.133 for the bottom third). As proposed, the CY27 rule would eliminate this construct while retaining the historical reward factor (which similarly rewards plans but emphasizes improvement efforts in clinical care, outcomes, and patient experience across the entire patient population).

Continuing the administration's deregulation theme, the CY27 proposed rule would also remove 12 measures starting from the 2027 measurement year. Removals would take effect for the 2028- or 2029-

Star Ratings, depending on the measure. The measures slated for removal under the CY27 proposed rule include:

- Plan Makes Timely Decisions about Appeals (Part C, 2029)
- Reviewing Appeals Decisions (Part C, 2029)
- SNP Care Management (Part C, 2029)
- Call Center – Foreign Language Interpreter and TTY Availability (Part C, 2028)
- Call Center – Foreign Language Interpreter and TTY Availability (Part D, 2028)
- Complaints about the Health/Drug Plan (Parts C and D, 2029)
- Medicare Plan Finder Price Accuracy (Part D, 2029)
- Diabetes Care – Eye Exam (Part C, 2029)
- Statin Therapy for Patients with Cardiovascular Disease (Part C, 2028)
- Members Choosing to Leave the Plan (Parts C and D, 2029)
- Customer Service (Part C, 2029)
- Rating of Health Care Quality (Part C, 2029)

If finalized, these changes would, in the aggregate, have the practical effect of increasing QBPs to plans. Simulations using 2025 data show 62% of contracts with unchanged ratings, 13% gaining 0.5 stars, 25% losing 0.5 stars, 5% gaining QBP eligibility, and 4% losing it. CMS estimates these shifts in Star Rating status would result in a $13.18 billion net increase in Medicare Trust Fund spending over the 2027–2036 window (0.15% of MA payments). CMS projects that much of that increase (~$7.3 billion) would occur in the CYs 28 and 29.

MA: OPERATIONAL REFORMS

Per President Trump's executive order (EO) #14192 ("Unleashing Prosperity through Deregulation"), the CY27 proposed rule includes several proposed reforms intended to reduce the regulatory burden on plans and, therefore, the marginal operational costs passed on to beneficiaries by those plans. Proposed changes include:

- Exempting account-based plans from creditable coverage disclosures: Currently, group health plans, including account-based arrangements such as Health Reimbursement Arrangements (HRAs), Flexible Spending Accounts (FSAs), and Health Savings Accounts (HSAs), must disclose their creditable prescription drug coverage status to CMS and Medicare-eligible individuals. CMS proposes amending this section to exclude these plans, as they do not directly offer drug coverage but only reimburse expenses. In practice, this would eliminate redundant paperwork for about 7,049 entities (mostly HR managers), saving approximately 585 hours and $90,266 annually.

- Rescinding mid-year notices for unused supplemental benefits: MA organizations must mail individualized mid-year notices by July 31 detailing unused supplemental benefits from the Evidence of Coverage. The proposal would rescind this requirement entirely. Practically, this reduces administrative burdens, yielding annual savings of $1.36 million in printing/mailing, plus $499,091 in one-time costs for system updates.

- Eliminating health disparities activities in MA quality improvement programs: Under § 422.152(a)(5), MA organizations must incorporate activities to reduce health disparities into their Quality Improvement (QI) programs. CMS proposes removing this requirement.

- Eliminating health equity requirements for MA Utilization Management (UM) Committees: Current rules at § 422.137(c)(5) require a health equity expert on UM Committees, and §§ 422.137(d)(6)–(7) mandates annual health equity analyses of prior authorizations. The proposal would rescind these provisions. In practice, this streamlines committee operations by saving about 6,040 hours and $814,000 annually in data aggregation and posting, enabling focus on core UM functions, but potentially reducing targeted equity reviews for vulnerable populations.

- Waiving the LI NET call center hours requirement: The Limited Income Newly Eligible Transition (LI NET) program currently requires toll-free call centers to be open from 8 a.m. to 8 p.m. in all regions. CMS proposes amending this requirement to limit hours to 8 a.m.–7 p.m. ET, Monday–Friday. This adjustment accounts for low call volumes and 24/7 pharmacy support, saving $800,000–$1 million annually in operational costs.

MA: SPECIAL ENROLLMENT PERIOD REFORMS

The MA program currently includes a Special Enrollment Period (SEP) for enrollees affected by a "significant" provider network change, such as terminations of providers or facilities, where significance is determined, case by case, by CMS and the MA organization based on factors like the scale of the termination. Affected enrollees – those assigned to, receiving care from, or who received care within the past three months from the terminated provider – can switch MA plans or disenroll to Original Medicare, but only if notified of eligibility. MA organizations must send termination notices, but these do not always include detailed SEP information, and separate notifications may be required for eligibility. CMS guidance (but not rules) requires that certain other SEPs, such as those for CMS sanctions, contract violations, or exceptional circumstances, receive CMS approval.

In the CY27 proposed rule, CMS proposes to modify the SEP for provider terminations by renaming it from "Significant Change in Provider Network" and eliminating the "significant" determination requirement, making eligibility automatic for affected enrollees upon any no-cause provider or facility termination. The SEP would begin in the month of eligibility notification and last for two additional calendar months, usable once per network change, with MA organizations assessing eligibility via beneficiary attestations rather than solely through 1-800-MEDICARE. Termination notices would be enhanced to include mandatory details on SEP eligibility, start/end dates, Annual Enrollment Period (AEP), MA Open Enrollment Period (MA-OEP), Medigap guaranteed issue rights, and impacts on employer/union coverage.

Separately, CMS proposes codifying the requirement for prior CMS approval of certain SEPs at §§ 422.66(g), 423.32(k), and 423.36(g), mandating that MA organizations obtain approval via CMS-operated mechanisms (e.g., 1-800-MEDICARE, Online Enrollment Center, or notices) before transmitting elections for specified SEPs like contract violations or sanctions.

MA: REQUESTS FOR INFORMATION (RFIS)

CMS includes several RFIs in the CY27 Proposed Rule to gather public input on enhancing the Medicare Advantage program, including:

- Dually Eligible Individual Enrollment Growth in C-SNPs and I-SNPs: CMS seeks comments on the significant growth in dually eligible individuals enrolling in chronic condition special needs plans (C-SNPs) and institutional special needs plans (I-SNPs) rather than dual eligible special needs plans (D-SNPs). Comments are sought on policy solutions such as requiring State Medicaid Agency Contracts for plans with high dually eligible concentrations (e.g., 60%+), enhancing care coordination requirements, applying D-SNP look-alike limitations, and strategies to encourage C-SNPs focused on mental health or substance use disorders.
- Future Directions in Medicare Advantage Risk Adjustment: CMS solicits input on modernizing the MA program through risk adjustment, including leveraging AI and alternative data sources for next-generation models, to promote data transparency, quality improvement, competition, taxpayer savings, and fraud reduction, potentially via programmatic changes or Innovation Center models.
- Future Directions in Medicare Advantage Star Ratings: CMS requests feedback on simplifying and streamlining the Star Ratings program, including reducing timelines from measure development to implementation and shortening the lag between measurement years and payment application to better incentivize quality improvements.
- Quality Bonus Payments in Medicare Advantage: CMS seeks information to refine the QBP structure and its impact on rebates, including options to shorten new-measure implementation timelines, delink bonuses from MA bids through an Innovation Center model, and broader strategies to encourage cost containment alongside enhanced care quality.

- Well-Being and Nutrition: CMS solicits input on tools and policies to improve overall health, happiness, and life satisfaction in MA, including emotional well-being, social connections, self-care, and nutrition strategies like promoting healthy eating, preventive care, and incentives for MA organizations to support long-term beneficiary nutritional habits.

- Marketing and Communications Oversight: CMS seeks comments on modernizing agent/broker regulations and marketing requirements, including redefining the Third-Party Marketing Organizations (TPMO) definition to segment by size, scope, or role; modifying the 5% translation threshold for materials; removing the requirement for CMS approval of Medicare card images in ads; revising testimonial standards for authenticity, substantiation, and disclosures; eliminating outbound enrollment verification and certain mailing statements; reducing call recording retention periods; and broader strategies for accountability, data-driven monitoring using AI, and preventing misleading practices.

- Other Medicare Advantage Program Areas: CMS solicits input on deregulation and simplification across various MA aspects, such as updating medical loss ratio calculations and reporting; streamlining network adequacy reviews, exceptions (including a new "pattern of care" exception), and access standards; enhancing oversight of supplemental benefits design and marketing; revising SNP Model of Care requirements; automating data sharing; and identifying burdensome reporting elements.

PART D: IMPLEMENTING CERTAIN PROVISIONS OF THE INFLATION REDUCTION ACT (IRA) OF 2022

The IRA significantly redesigned the Medicare Part D benefit to lower beneficiary costs, including eliminating the coverage gap phase, reducing the annual out-of-pocket (OOP) threshold starting at $2,000 (with annual indexing based on per capita Part D costs or CPI-U), and removing enrollee cost sharing in the catastrophic phase (setting it to $0 after the OOP threshold is met). It also terminated the Coverage Gap Discount Program (CGDP) and replaced it with the Manufacturer Discount Program (MDP), which requires manufacturers to provide discounts on applicable drugs (brand-name drugs under New Drug Application or Biologics License Application, excluding selected drugs under negotiation) in the initial coverage and catastrophic phases. The IRA granted CMS temporary authority to implement these changes through sub-regulatory program instructions and guidance through 2026. As part of the CY27 rule, CMS proposes to formally codify these reforms through rulemaking. A summary is below.

- CMS proposes to codify the termination of the CGDP for 2027. The CGDP (under which manufacturers provided 70% discounts on applicable drugs for non-LIS beneficiaries in the coverage gap) technically terminated on January 1, 2025, but continues to handle discounts and reconciliations for drugs dispensed before that date. If finalized, these changes would permanently sunset the program, ensuring that no new agreements or discounts apply after 2024.

- CMS proposes establishing a new Subpart AA to codify the MDP for 2027 and beyond, requiring manufacturers to enter agreements covering all labeler codes for applicable drugs, provide 10% discounts in the initial coverage phase and 20% in the catastrophic phase (calculated on negotiated price including dispensing fees, taxes, and units), with phase-ins for specified manufacturers (based on 2021 Part D spending ≥1% or 2.5% for LIS/non-LIS) and small manufacturers (one drug ≥80% of expenditures). Proposed additions include detailed rules on aggregation, acquisitions, terminations, audits, disputes, and civil penalties.
- CMS proposes codifying OOP changes for 2027 and beyond by revising § 423.100 to limit "coverage gap" definitions to 2006–2024, amending § 423.104(d)(4) for pre-2025 applicability, eliminating the initial coverage limit post-2024 (§ 423.104(d)(3)(iii)), setting the reduced OOP threshold at $2,000 for 2025 and indexing it annually (§ 423.104(d)(5)(iii)(G)–(H)), and confirming $0 cost sharing in the catastrophic phase (§ 423.104(d)(5)(i)).

We trust you found this summary useful. Please reach out to us with any questions.