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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 Final Rule

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On April 2, 2026, the Centers for Medicare & Medicaid Services (CMS) released a final rule that will revise the Medicare Advantage (MA) Program, the Medicare Prescription Drug Benefit Program (Part D), and the Medicare Cost Plan Program for Contract Year 2027 (PY27). A CMS fact sheet can be found here. The regulation is effective June 1, 2026, and will be applicable to MA and Part D coverage beginning January 1, 2027.

MA & PART D: UPDATES TO STAR RATINGS

The Medicare Advantage (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 final rule eliminates 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 PY 2027—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, or disability. For PY 2027, 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). CMS finalized this provision exactly as proposed, removing the HEI/Excellent Health Outcomes for All reward 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). The change applies beginning with the 2027 Star Ratings.

Continuing the administration's deregulation theme, the final rule removes 11 of the 12 measures that were proposed for removal, starting from the 2027 measurement year. Removals take effect for the 2028- or 2029-Star Ratings, depending on the measure. CMS finalized these 11 removals exactly as proposed, with the sole modification that it did not finalize the proposed removal of the Diabetes Care – Eye Exam (Part C) measure (which will remain in the Star Ratings program). The measures removed under the final rule are:

- 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)
- 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)

Additionally, CMS finalized two technical updates to the Star Ratings program. CMS is adding a new Part C Depression Screening and Follow-Up measure to address behavioral health gaps. The new measure begins with the 2027 measurement year and will first affect the 2029 Star Ratings. CMS also finalized a technical clarification (originally proposed in the CY 2026 rule) regarding contract consolidations. This clarification specifies how enrollment-weighted measure scores are calculated when a surviving or consumed contract lacks data for a particular measure due to the consolidation (changes applicable to the 2027 Star Ratings).

As finalized, these changes will, in the aggregate, have the practical effect of increasing QBPs to plans. Simulations using 2025 Star Ratings data (accounting for changes implemented in the 2026 Star Ratings) show 63% of contracts with no change in overall rating, 13% increasing by half a star, and 24% decreasing by half a star. Four percent of contracts would gain QBP eligibility, and three percent would lose QBP eligibility. The shifts in Star Rating status are projected to result in an $18.56 billion net increase in Medicare Trust Fund spending over the 2027–2036 window (0.21% of MA payments). This is higher than the $13.18 billion estimate that appeared in the proposed rule (the difference is attributable to retaining the Diabetes Care – Eye Exam measure). Much of that increase is still expected in PYs 2028 and 2029.

MA: OPERATIONAL REFORMS

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

- 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 finalized the amendment to exclude these plans, as they do not directly offer drug coverage but only reimburse expenses. In practice, this eliminates 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. CMS finalized the complete rescission of this requirement. Practically, this reduces administrative burdens, yielding annual savings of $1.36 million in printing/mailing, plus prevented one-time costs of approximately $499,000 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 finalized the removal of 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) mandate annual health equity analyses of prior authorizations. CMS finalized the rescission of 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.

- 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 finalized the amendment 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.

- Removing restrictions on the time and manner by which beneficiaries can have conversations with licensed agents and brokers: Current regulations impose specific timing restrictions on beneficiary outreach, including a 12-hour delay requirement between educational events and marketing events in the same location and a 48-hour waiting period between completion of a Scope of Appointment form and a personal marketing appointment. CMS finalized the removal of these timing restrictions (along with the related prohibition on collecting Scope of Appointment forms at educational events). This change provides greater flexibility for plans, agents, and beneficiaries while preserving core consumer protections.

MA: SUPPLEMENTAL BENEFITS AND SERIOUSLY ILL BENEFICIARY SUPPLEMENTAL COVERAGE ITEMS (SSBCI)

Continuing its focus on reducing regulatory burden while clarifying allowable supplemental benefits, CMS finalized several targeted reforms to supplemental benefits and SSBCI administration. CMS finalized these provisions largely as proposed (with only minor technical refinements):

- Cannabis clarification: CMS refined the regulatory language to state more precisely that cannabis products that are illegal under applicable State or Federal law are not allowable as SSBCI.
- Public posting of SSBCI eligibility criteria: CMS finalized the requirement that MA organizations publicly post their plan-developed objective eligibility criteria for SSBCI on their website to increase transparency for beneficiaries.
- Debit card rules for supplemental benefits: CMS codified and clarified requirements for administering supplemental benefits through debit cards, including real-time electronic verification at the point of sale and limiting cards to the specific plan year. CMS did not finalize the proposed prohibition on marketing the dollar value of supplemental benefits on the debit card itself.

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 PY 2027 proposed rule, CMS proposed 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.

CMS did not finalize these proposed modifications to the provider termination SEP. The existing "Significant Change in Provider Network" SEP remains unchanged. CMS acknowledged broad stakeholder interest in the topic but stated it will continue to consider the extent to which rulemaking may be appropriate in this area.

Separately, CMS proposed 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. CMS finalized this provision exactly as proposed. The final rule adds explicit language to the affected SEP provisions in §§ 422.62(b) and 423.38(c) and corresponding limitations in §§ 422.66(g), 423.32(k), and 423.36(g) to require CMS approval prior to use of these SEPs. This codifies longstanding policy and guidance without adding new burden.

MA: REQUESTS FOR INFORMATION (RFIS)

CMS includes several RFIs in the PY27 Proposed Rule to gather public input on enhancing the Medicare Advantage program. The Final Rule included the following commentary from CMS regarding stakeholder feedback and the agency's reaction to the responses...

- Dually Eligible Individual Enrollment Growth in C-SNPs and I-SNPs: CMS sought 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). Stakeholders expressed strong concerns about care fragmentation and recommended requiring State Medicaid Agency Contracts and D-SNP-like integration rules for plans with high dual enrollment. CMS will consider the feedback received for potential future rulemaking.

- Future Directions in Medicare Advantage Risk Adjustment: CMS solicited 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. Stakeholders supported greater data transparency and alignment with Original Medicare data, while stressing privacy protections. CMS will consider the feedback for possible future rulemaking or demonstration projects.

- Future Directions in Medicare Advantage Star Ratings: CMS requested 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. Stakeholders supported simplification but many opposed broad measure removals due to potential impacts on oversight of SNPs. CMS will consider the input for potential future rulemaking.
- Quality Bonus Payments in Medicare Advantage: CMS sought information to refine the Quality Bonus Payment structure and its impact on rebates, including options to shorten new-measure implementation timelines and delink bonuses from MA bids. Stakeholders provided input on refining the structure to better balance quality incentives with cost containment. CMS will consider these comments for future policy development.
- Well-Being and Nutrition: CMS solicited 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. Stakeholders offered ideas for expanding supplemental benefits related to food, housing, and social connections to support prevention and wellness. CMS will consider the feedback received for potential future rulemaking.
- Marketing and Communications Oversight: CMS sought comments on modernizing agent/broker regulations and marketing requirements, including redefining the TPMO definition, modifying translation thresholds, and revising testimonial standards. Stakeholders offered broad support for burden-reducing changes such as adjustments to disclaimers and retention periods. CMS will consider the feedback for potential future rulemaking.
- Other Medicare Advantage Program Areas: CMS solicited input on deregulation and simplification across various MA aspects, such as updating medical loss ratio calculations, streamlining network adequacy reviews, and revising SNP Model of Care requirements. Stakeholders expressed widespread support for further deregulation and streamlining to reduce administrative burden. CMS will consider the comments for future efforts to streamline the program.

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). The IRA granted CMS temporary authority to implement these changes through sub-regulatory program instructions and guidance through 2026. CMS finalized the codification of these reforms in the Contract Year 2027 final rule.

- CMS finalized the termination of the CGDP as proposed. 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. The final rule permanently sunsets the program.
- CMS finalized the establishment of a new Subpart AA to codify the MDP for 2027 and beyond largely as proposed. Manufacturers must enter agreements covering all labeler codes for applicable drugs and 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). The final rule includes detailed rules on aggregation, acquisitions, terminations, audits, disputes, and civil penalties, with only minor technical refinements from the proposal.
- CMS finalized the codification of OOP changes for 2027 and beyond exactly as proposed 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)).

In addition to the core IRA codifications described above, CMS finalized several related technical and operational updates to Part D program rules. These include clarifications to true-out-of-pocket (TrOOP) calculations, specialty-tier cost-sharing rules, reinsurance payment methodologies, and implementation details for the Selected Drug Subsidy. CMS finalized all these technical provisions exactly as proposed.

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