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What the 2027 Medicare Advantage Star ratings, availability changes mean for health systems

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What's Trending

The Centers for Medicare & Medicaid Services (CMS) released its 2027 Medicare Advantage (MA) Star ratings on October 8, a week ahead of Medicare's annual open enrollment period (AEP). After consistent years of Star rating decline beginning in 2022, Star ratings hit a low point in 2025—and 2026 ratings did not offer much improvement.

According to the [latest analysis by HealthScape Advisors](#), a Chartis Company, membership in higher-rated (4+ Star) plans has increased, but this is principally due to Humana's improved Star rating performance and the disproportionate impact of its large enrollment. Despite Humana's buoying effect, the enrollment-weighted Star rating for the entire MA market declined from 4.07 to 3.99 Stars.

The Star ratings release comes amid broader changes as MA plans balance affordability and benefits with financial sustainability. In HealthScape's January [survey of leaders responsible for MA](#) at more than 35 health plans, 93% of respondents reported their MA business was not profitable. Nearly 70% expected less generous benefit packages for 2027, up from 40% in the prior year's survey.

As it looks toward 2027 AEP, CMS projects average monthly MA plan premiums will fall from \$14.37 to \$12.00. But lower premiums do not necessarily mean lower overall costs for beneficiaries. Higher out-of-pocket maximums and drug deductibles, along with potential reductions in supplemental benefits, could leave some beneficiaries paying less in premiums but more when they access care, depending on coverage and care needs.

Insurers are also adjusting where and how they offer coverage. HealthScape's analysis of the recently released 2027 Landscape files show that United's exits will impact 615,000 members and Humana's exits will affect approximately 549,000 members. Aetna, Centene, and Blue Cross Blue Shield of Minnesota are also driving significant disruption through plan terminations and service area reductions (SARs).

For some beneficiaries, these changes mean fewer plan options. KFF found that the average beneficiary will have access to 28 MA prescription drug plans for general enrollment in 2027, down from 32 in 2026. However, availability varies considerably: 20% of beneficiaries have more than 40 options, while 1% have no MA prescription drug plans available for general enrollment.

Yet these changes do not represent a uniform withdrawal from MA. Some insurers are expanding health maintenance organization (HMO) offerings and Special Needs Plans for people with qualifying chronic conditions (C-SNPs). These developments suggest a more selective approach to growth, with insurers reassessing the markets, benefits, and provider relationships that can support financial sustainability and care delivery.

Why it Matters

For health systems, the most important question is how these national trends translate into changes for their patients, care delivery models, and financial arrangements in the markets they serve.

Broad availability of coverage does not guarantee affordable, continuous care. A study published in JAMA estimated that 2026 plan exits would require approximately 2.9 million beneficiaries (about 10% of enrollees in MA HMOs or MA PPOs) to change coverage. Rural beneficiaries were more likely to be affected.

Provider network changes add another consideration. Becker's has tracked 34 health systems with terminations of one or more MA contracts announced or effective in 2026. Providers often cite reimbursement and prior authorization concerns. These changes mean patients may need to reconsider coverage to maintain access to their providers, even when their existing health plan remains available.

The shift toward HMO offerings can also change how patients access care, given how HMOs generally place greater limits on routine out-of-network care and more often require primary care referrals for specialist services. Health systems will need to look beyond whether their hospitals remain in-network to assess whether patients can move reliably among primary care, specialty care, hospital, and post-acute services under the plans available in their markets.

Health systems should work with health plans to identify affected patients, particularly those currently undergoing treatment, and confirm coverage for ongoing care, medications, and referrals before coverage changes take effect. Transition planning should incorporate existing protections, including the minimum 90-day period during which a new MA coordinated care plan cannot require prior authorization for an active course of treatment.

Efforts to reduce administrative burden offer an opportunity for collaboration. In April, AHIP and the Blue Cross Blue Shield Association estimated that prior authorization requirements removed by insurers participating in voluntary multi-year commitments would eliminate approximately 11% of prior authorization requests (roughly 6.5 million), including a reduction of more than 15% in MA.

Similarly, CMS's electronic prior authorization and data-sharing requirements beginning in January 2027 are intended to improve information exchange and streamline authorization processes. Realizing those benefits will require coordinated implementation across health plans, electronic health record vendors, and health systems. They will also need a shared focus on reducing administrative burden and supporting timely access to care.

Changes to MA Star ratings methodologies provide another opportunity to strengthen these relationships. CMS is refocusing the Star ratings program on clinical care, outcomes, and patient experience while removing certain administrative measures. Nearly 90% of health plan leaders in HealthScape's recent survey anticipate increased collaboration with providers.

Aligning data sharing, care management responsibilities, and financial incentives around shared priorities such as preventive care, chronic condition management, and medication adherence could help health plans and providers improve outcomes and use resources more effectively.

Health systems should approach MA's next phase as a coordinated access, care delivery, and financial strategy. The goal should be payer-provider arrangements that preserve reliable care pathways and support better outcomes for patients and financial sustainability for both parties.

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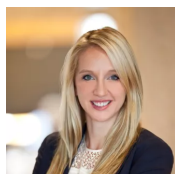
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