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Star Ratings in Retrograde: Decoding the 2025 Decline

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The 2025 Medicare Advantage Star Ratings release represents a continuing transformation for the quality program, requiring health plans to fundamentally reassess their strategies as they navigate this new landscape.

On October 10, 2024, the Centers for Medicare and Medicaid Services (CMS) released the 2025 Star Ratings for Medicare Advantage (MA) contracts, along with detailed measure and methodology files supporting these ratings.[1] This release contained significant Star Rating declines for many plans. This edition of our Star Rating series discusses the declining Star Ratings for Medicare Advantage Prescription Drug (MA-PD) contracts[2] and explores the factors contributing to the lower ratings and associated revenue implications.

Impact on members and drivers

- The member-weighted average Star Rating for MA-PD contracts has fallen to 3.92 in 2025 and the percentage of members in 5.0-Star contracts fell to 1.8%, the lowest point since the end of the Star Rating demonstration period in 2015.
- For the first time, the member-weighted average quality bonus payments (QBPs) for numerically rated contracts were below 3.5%, the payment level that new or low-enrollment contracts receive. This is led by narrowing performance gaps between large and small enrollment contracts.
- While 125 contracts serving 7.5 million beneficiaries improved by at least 0.5 stars, a much larger cohort – 206 contracts serving 16.1 million beneficiaries — experienced a reduction of at least 0.5 stars.[3] The largest eighteen contracts, with over 300,000 members each (44% of total MAPD membership), together saw 57% of Star Rating declines.
- Contracts with declining Star Ratings had a higher percentage (43%) of members with social risk factors (SRFs)[4] compared to improving contracts (30%).
- The contracts being consolidated have an SRF percentage of 66%, while the contracts they are merging into have an average SRF of 29%, which could improve their maximum rewards under the upcoming Health Equity Index (HEI) system. Ongoing Tukey Outlier removals in non-CAHPS measures contributed to the decline in Star Ratings.

Legal challenges

- Several large Medicare Advantage organizations (MAOs) have filed legal challenges against the 2025 Star Ratings, building on precedents set in the 2024 Star Rating litigation.[5] [6]
- This new wave of litigation by MAOs goes beyond CMS' methodology to also address the reliability and transparency of the Star Rating cut points, rounding, and the Call Center measures.

1. 2025 Star Ratings Fact Sheet is available at https://www.cms.gov/newsroom/fact-sheets/2025-medicare-advantage-and-part-d-star-ratings.
2. PDPs, dual demonstrations, National Program of All-Inclusive Care for the Elderly (PACE), 1833 Cost, and 1876 Cost contracts are not included in these estimates because their CMS revenue is not directly affected by changes to their Star Ratings.
3. July 2024 membership, available at https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-advantagepart-d-contract-and-enrollment-data.
4. Members with social risk factors (SRFs) include dual, low income and disabled populations.
5. See UnitedHealthcare Benefits of Texas, Inc. v. Centers for Medicare & Medicaid Services, No. 6:24-cv-00357 (E.D. Tex. filed Sept. 30, 2024), https://www.documentcloud.org/documents/25183840-unitedhealth_stars_complaint, Humana Inc. v. U.S. Department of Health and Human Services, No. 4:24-cv-01004 (N.D. Tex. filed Oct. 18, 2024), https://www.documentcloud.org/documents/25244688-humana_hhs_stars_complaint, Centene Corporation v. Becerra, No. 4:24-cv-01415 (E.D. Mo. filed Oct. 22, 2024), https://www.documentcloud.org/documents/25247476-centene_stars_complaint, Elevance et al v.Becerra No 4:24-cv-01064-P https://www.scribd.com/document/786902800/Elevance-Health-v-Becerra.
6. SCAN v, HHS. Retrieved November 3, 2024, from https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2023cv3910-33. Elevance v. HHS. Retrieved November 3, 2024, from https://www.scribd.com/document/696925680/Elevancev-hhs.

The 2025 Star Rating decline

The overall member-weighted average Star Rating for MA-PD contracts decreased from 4.07 in 2024 to 3.92 in 2025, representing the lowest MA-PD average Star Rating since 2015. For PDP contracts, the overall average Star Rating decreased from 3.34 to 3.06, marking the lowest average Star Rating for PDPs since 2014.

CONTRACT SHIFTS AND MARKET RESTRUCTURING

Contract-level analysis reveals broad deterioration in Star Ratings, with reductions significantly outnumbering increases. Figure 1 shows the transition between the 2024 and 2025 Star Ratings for the MA-PD contracts[7]. While 125 contracts achieved at least a 0.5 Star increase (112 of these contracts expect corresponding revenue increases for 2026PY), 206 contracts experienced a 0.5 Star or greater decrease (175 face revenue reductions).

This white paper references measure year (MY), Star Ratings year (SY), and payment year (PY). For example, a 2025 Star Rating (2025SY) influences the revenue in 2026 (2026PY) and is based on measure year 2023 (2023MY).

FIGURE 1: 2024 TO 2025 STAR RATING CHANGES BY CONTRACT[8]

2025 STAR RATINGS (2026 PAYMENT YEAR)	2024 STAR RATINGS (2025 PAYMENT YEAR)								
	2.0	2.5	3.0	3.5	4.0	4.5	5.0	NEW/ LOW ENR	DID NOT EXIST
2	0	1	0	0	0	0	0	0	0
2.5	1	1	9	5	0	0	0	7	0
3	0	12	56	31	8	4	0	12	0
3.5	0	6	33	69	36	11	0	11	0
4	0	0	5	15	39	37	9	10	0
4.5	0	0	1	3	29	27	21	4	0
5	0	0	0	0	0	0	7	0	0
NEW/LOW ENR	0	0	5	1	2	1	1	144	30
CONSOLIDATED	0	2	1	9	6	0	0	1	0
TERMINATED	3	10	16	8	2	1	0	30	0

112	**Star Rating and Revenue Increase**	**175**	**Star Rating and Revenue Decrease**
13	Star Rating Only Increase	31	Star Rating Only Decrease
13	Consolidated	70	Terminated

7. PDPs, dual demonstrations, National Program of All-Inclusive Care for the Elderly (PACE), 1833 Cost, and 1876 Cost contracts are not included in these estimates because their CMS revenue is not directly affected by changes to their Star Ratings.
8. Note slight differences in 2024 and 2025 contract counts by Star ratings due to CMS inclusion of 1876 Cost plans in their summaries: https://www.cms.gov/newsroom/fact-sheets/2025-medicare-advantage-and-part-d-star-ratings

The total number of rated contracts decreased by 24, reflecting significant market restructuring:

- **Newly rated:** 44 contracts moved from new/ low enrollment status to rated status, averaging 3.4 Stars
- **Dropped rating:** 10 previously rated contracts dropped to new/low enrollment status, having averaged 3.6 Stars
- **Consolidated:** 18 contracts were consolidated into existing contracts, averaging 3.5 Stars
- **Terminated:** 40 contracts were terminated, with an average rating of 3.0 Stars

This market restructuring has important implications for contracts in the future. The 68 departing contracts (through consolidation, termination, or transition to low enrollment status) showed notably weaker performance than new entrants. Among departing contracts, only 13 achieved four or more Stars, while 15 were rated at or below 2.5 Stars. The 44 newly rated contracts showed somewhat better performance, with 14 achieving 4+ Stars and 7 rating at or below 2.5 Stars.

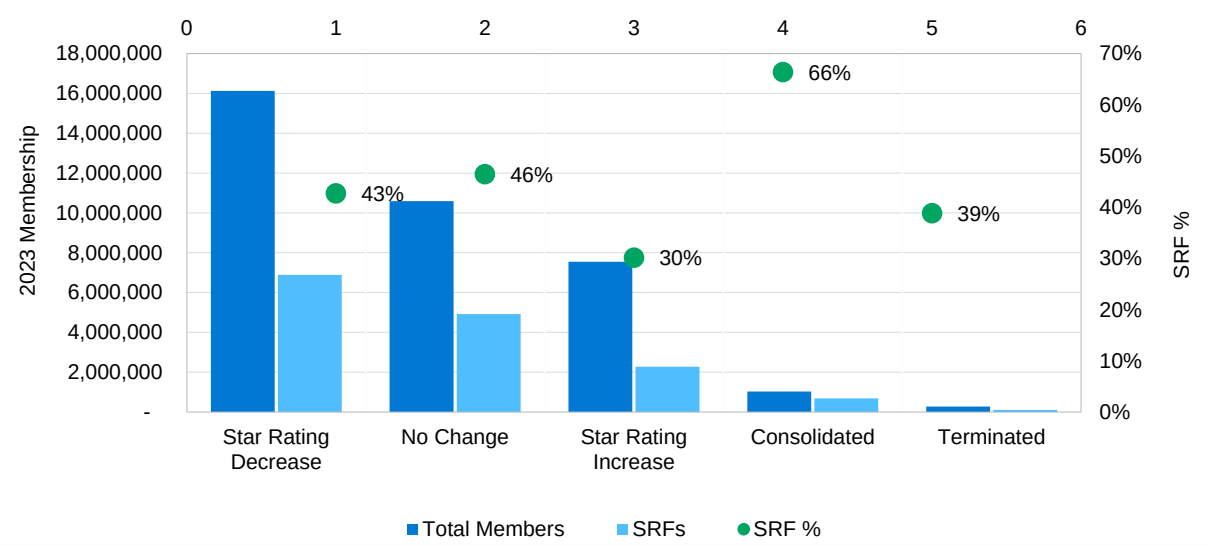
Looking ahead, this trend appears likely to continue. Only 30 new contracts joined the MA-PD market as new or low enrollment contracts, far below the 70 contract terminations and 19 consolidations. With fewer new entrants and limited contract growth into rated status, the market will likely continue consolidating. While the MA-PD market continues to grow in total membership and Medicare Advantage market share as a percentage of total Medicare eligibility[9], the shrinking number of contracts could create additional upward pressure on cut points and downward pressure on Star Ratings market-wide.

The impact of the reduced number of contracts extends beyond the members affected by these shifts. Cut points are determined based on contract-level measure distributions and are not member-weighted. Consequently, the removal of lower-performing contracts increases cut point thresholds, making it more challenging for remaining contracts to achieve higher ratings.

MEMBERSHIP IMPACT

Figure 2 summarizes the 2023 MAO members[10] included in this study across different Star Rating change categories between the 2024 and 2025 Star Ratings. This graph includes the total membership, SRF membership (see sidebar below), and the SRF percentages.

FIGURE 2: STAR RATING CHANGES 2024-2025: IMPACT ON 2023 MA MEMBERSHIP AND SRF POPULATION



9. Freed, M., Biniek, J.F., Damico, A., & Neuman, T. (August 8, 2024). Medicare Advantage in 2024: Enrollment Update and Key Trends. Kaiser Family Foundation. Retrieved November 3, 2024, from https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2024-enrollment-update-and-key-trends/.

10. 2023 Medicare Advantage enrollment based on the 2023 ResDAC enrollment databases for unique Medicare Advantage members.

Figure 2 demonstrates a continued decline in Star Ratings at the contract and membership levels previously observed in the 2024 Star Ratings.[11] Over 16 million members are in contracts experiencing a Star Rating decrease, significantly more than the total members in contracts with increases (7.5 million) or no change (10.5 million). Furthermore, there is a disproportionate impact on SRF members, as shown by higher SRF percentages in declining plans (43%) compared to improving plans (30%).

Based on the 2024 to 2025 plan crosswalk,[12] we observed some MAOs have started merging contracts with high SRF percentages (66%) into contracts with lower SRF percentages (average 29%).[13] This suggests MAOs may be positioning these contracts to qualify for rewards under the upcoming HEI system in the 2027 Star Ratings, as the new combined SRF percentage now allows those contracts to qualify for a reward (see sidebar).

Social Risk Factors (SRFs) identify Medicare members who are disabled, dual-eligible, or low-income. Monitoring them helps identify health equity disparities. Starting in SY2027/PY2028, plans can earn up to 0.4 in Star Rating rewards if their SRF percentage exceeds the median across contracts, 0.2 if above half the median, or zero if below.

This disproportionate Star Rating reductions for SRF populations could mean fewer resources available for quality improvement initiatives, member services, and supplemental benefits in plans serving vulnerable populations. While CMS' upcoming HEI reward system may boost Star Ratings for contracts with high SRF percentages, CMS' own analysis suggests limited positive impact. In the 2024 Final Rule, CMS analyzed how replacing the current reward system with HEI would have affected the 2021 Star Ratings (using 2018-2019 measurement data). The results showed minimal improvement: only 7 MA-PD contracts (1.7%) would have gained one-half Star, while 54 contracts (13.4%) would have lost one-half Star on their overall rating.[14]

REVENUE IMPLICATIONS

The 2025 Star Ratings mark an unprecedented decline in Quality Bonus Payments (QBPs), with the member-weighted average bonus falling below 3.5% for the first time in the program's history, as shown in Figure 3. This milestone is particularly significant as it places rated contracts below the automatic 3.5% bonus awarded to new and low-enrollment contracts. The contract-weighted average has declined even more sharply to 2.0%[15], suggesting a fundamental shift in the Medicare Advantage quality landscape.

11. Rogers, H.M., Smith, M., Nelson, P., & Yurkovic, M. (October 2023). The Future Is Now: 2024 Star Ratings Release. Milliman White Paper. Retrieved November 3, 2024, from https://www.milliman.com/en/insight/the-future-is-now-2024-star-ratings-release.

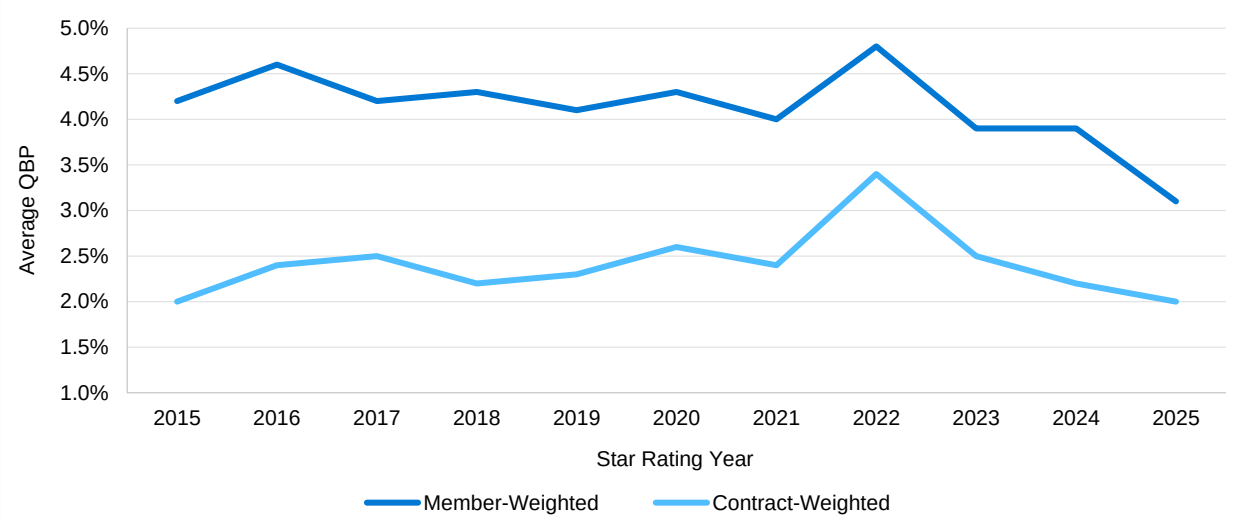
12. CMS. 2025 Part C&D Plan Crosswalk. Retrieved November 3, 2024, from https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/mcradvpartdenroldata/plan/2025-part-cd-plan-crosswalk.

13. We note that some states require Dual-Eligible Special Needs Plans (D-SNPs) to be in separate contracts; however, many states do not currently have this requirement, which then allows for this contract positioning.

14. CMS (2023). 2024 Final Rule, p 519. See https://public-inspection.federalregister.gov/2023-07115.pdf.

15. In this context, contract-weighted means that each contract gets the same weight as every other contract.

FIGURE 3: AVERAGE QUALITY BONUS PAYMENTS FOR RATED CONTRACTS: MEMBER-WEIGHTED VS CONTRACT-WEIGHTED



This decline reflects a material change in the historical relationship between contract size and performance. Traditionally, larger contracts maintained a consistent 1.5 to 2.0 percentage point advantage in QBPs over smaller contracts, leveraging their greater resources for quality improvements, sophisticated data analytics, and robust member engagement programs. However, this advantage appears to be eroding under new Star Rating methodologies that particularly impact high-performing contracts.

The impact of large contract performance on overall Star Ratings has been substantial. Among the 18 contracts with more than 300,000 members—representing 44% of total MAPD membership—the changes were material:

- Four contracts serving 4.3 million members dropped a full star
- Seven contracts serving 4.8 million members dropped half a star
- Four contracts serving 3.2 million members maintained their rating
- Three contracts serving 2.9 million members improved by half a Star

These changes among large contracts drove 57% of the total decline in member-weighted Star Ratings, highlighting how concentrated the impact has been among the industry's largest health plans.

Quality Bonus Payments (QBPs) provide a 5% benchmark rate increase for contracts rated 4.0+ Stars. New (with new parent org) or low enrollment contracts receive 3.5%, while contracts rated below 4.0 Stars receive no QBP. Actual bonus percentages vary by county. Double-bonus counties can see up to 10% difference between 3.5 and 4.0 Stars, while some counties capped at the pre-ACA benchmarks may see minimal or no difference.

Looking forward, the downward trend in Star Ratings and the reduction of the relative advantage that larger contracts have enjoyed, raise significant strategic questions for Medicare Advantage organizations. These strategic questions will become even more important with the upcoming implementation of the Health Equity Index (HEI), which will particularly impact contracts with lower proportion of SRF members. In this changing environment, where additional Star Rating declines are expected going forward[16] due to HEI and other methodology changes, it will become increasingly challenging for plans to reach a 4+ Star Rating and associated 5% bonus level.

16. Rogers, H.M., Smith, M., & Yurkovic, M. (November 2023). The Next Stage of Star Ratings Evolution: 2025 Proposed Rule and Beyond. Milliman White Paper. Retrieved November 3, 2024, from https://www.milliman.com/en/insight/the-next-stage-of-star-ratings-evolution-2025-proposed-rule-cms.

Some plans may consider maintaining smaller contracts to secure the automatic 3.5% bonus rather than risk evaluation under the full Star Rating system, though this strategy must be balanced against minimum enrollment requirements and the impact of less efficient economies of scale on administrative costs[17]. Others may re-evaluate their ability to achieve and maintain higher ratings in this new environment, which could lead to accelerated consolidation or reduced investments in quality improvement initiatives in the industry.

Legal Challenges

The Medicare Advantage Star Rating system faces unprecedented legal scrutiny, with challenges evolving from specific methodological disputes in 2024 to broader questions about system reliability and transparency in 2025. Multiple major insurers have filed lawsuits that could significantly impact both beneficiary choice and billions in quality bonus payments.[18]

THE FOUNDATION: THE 2024 STAR RATING LITIGATION

The initial wave of litigation in 2024 focused on CMS' methodological changes, particularly the introduction of Tukey Outlier removal for cut points and the application of 5% guardrails to hypothetical rather than actual prior-year cut points.[19] These changes dramatically reduced average ratings from 4.18 stars (2023) to 4.05 stars (2024), projecting approximately $1.0 billion in revenue reductions by 2025[20].

Both plaintiffs challenged this cut point methodology change in their 2023 lawsuits, with one of them also disputing the reliability of Call Center data. In June 2024, the courts ruled in favor of both plaintiffs regarding their challenges to the cut point methodology, ultimately resulting in CMS choosing to recalculate the 2024 Star Ratings for all contracts, and allowing all affected plans to resubmit their 2025 Medicare Advantage bids after the initial bid submission.

While the court rulings addressed the cut point issues directly, the Call Center dispute appears to have been settled privately with CMS, resulting in higher ratings for four MA contracts cited in the lawsuit. This settlement appears to have created an opening for other health plans to pursue similar challenges directly with CMS. After CMS released the recalculated 2024 Star Ratings on July 2, 2024, other health plans appear to have successfully appealed their Call Center data. CMS quietly updated the 2024 Star Ratings through July 25, 2024, revising only the Call Center measure results for select contracts that had appealed[21].

The Evolution: 2025 Star Rating challenges

The 2025 litigation expands beyond methodology challenges to address questions about data reliability and transparency in the Star Rating calculation process, again focused on the cut point calculations and the Call Center measure data.

One MAO reported that 60% of their calculation replication attempts produced different results from the 2025 Star Rating cut points, with variations up to 14 percentage point discrepancies[22]. CMS' own Technical Notes acknowledge it is not possible to replicate CMS' calculated cut points based on published information (see side bar) [23]. The lawsuit also challenged the availability of underlying data supporting the cut points.

17. According to the Medicare managed care manual, CMS has the authority to non-renew contracts that fall below minimum enrollment thresholds. Plans must generally maintain at least 5,000 members to avoid potential non-renewal, though they can submit justification to continue operating below this threshold. Additionally, non-SNP plans must maintain at least 500 members, while SNP plans must maintain at least 100 members, to avoid risk of termination. See CMS (2024). Medicare Managed Care Manual, Chapter 4 - Benefits and Beneficiary Protections. Retrieved November 3, 2024 from https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/mc86c04.pdf.

18. United v CMS, op cit. ; Humana v HHS, op cit.; Centene v Becerra, op cit.; Elevance v Becerra, op cit.

19. SCAN v, HHS, op cit; Elevance v. HHS, op cit

20. Rogers, H. M., Smith, M., & Yurkovic, M. (October 2023). Future of Medicare Star Ratings: The Reimagined CMS Bonus System. Milliman White Paper. Retrieved November 3, 2024, from https://www.milliman.com/en/insight/future-of-medicare-star-ratings-reimagined-cms-bonus-system.

21. CMS. Part C and D Performance Data. Retrieved November 3, 2024 from https://www.cms.gov/medicare/health-drug-plans/part-c-d-performance-data.

22. Humana v HHS, op cit.

23. CMS (October 3, 2024). Medicare 2025 Part C & D Star Ratings Technical Notes. CMS. Retrieved November 3, 2024 from https://www.cms.gov/files/document/2025-star-ratings-technical-notes.pdf.

Another lawsuit focuses on the availability of underlying data to support the cut points, the rounding methodology, case-mix adjustment, and CMS' randomization process. Multiple of the lawsuits also challenged specific calls made by CMS test callers that negatively affected their 2025 Star Rating Call Center measures, as well as concerns regarding the data collection and validation process to support those measures.[24]

According to the lawsuits, in the 2025 these organizations have seen dramatic effects including a decline in 4+ star plan enrollment from 94% to 25% and a $73 million revenue impact from a single disputed call. Another previous lawsuit had alleged a $190 million impact from a different disputed call[25]. With a perfect score now required for 5 stars on Call Center measures, even a single disputed call can have multi-million dollar impacts on plan revenues and enrollment.[26]

These lawsuits could have far-reaching implications to the industry. Outcomes could impact future Star Rating calculations in areas such as data collection, validation processes, and Call Center measurement methodologies. These lawsuits could also impact the final 2025 Star Ratings and the bidding process for 2026 bids this coming spring.

2025 Star Rating Technical Notes, page 22

It is not possible to replicate CMS's calculations exactly due to factors including, but not limited to: using published measure data from sources other than CMS's Star Rating program which use different rounding rules, and exclusion of some contracts' ratings from publicly-posted data (e.g., terminated contracts).

Closing remarks

The 2025 Star Ratings present significant challenges for many plans, driven by the new Tukey Outlier deletion process, shifts in the contracts large enough to get Star Ratings, and performance changes for many of the largest MA contracts. However, CMS' own projections suggest these changes may be just the beginning of a broader transformation in MA Star Ratings, with methodology changes that include:

- The implementation of Tukey Outlier removal effects in the 2024 Star Ratings (2025 PY)
- Measure reweighting starting with the 2026 Star Ratings (2027 PY), shifting focus toward clinical outcomes and away from patient experience measures
- Implementation of the Health Equity Index (HEI) reward system beginning with the 2027 Star Ratings (2028 PY), replacing the current reward system
- Unfinalized rule to expand "hold harmless" provision that will impact plans not continuously improving toward the 5.0 Star Rating threshold

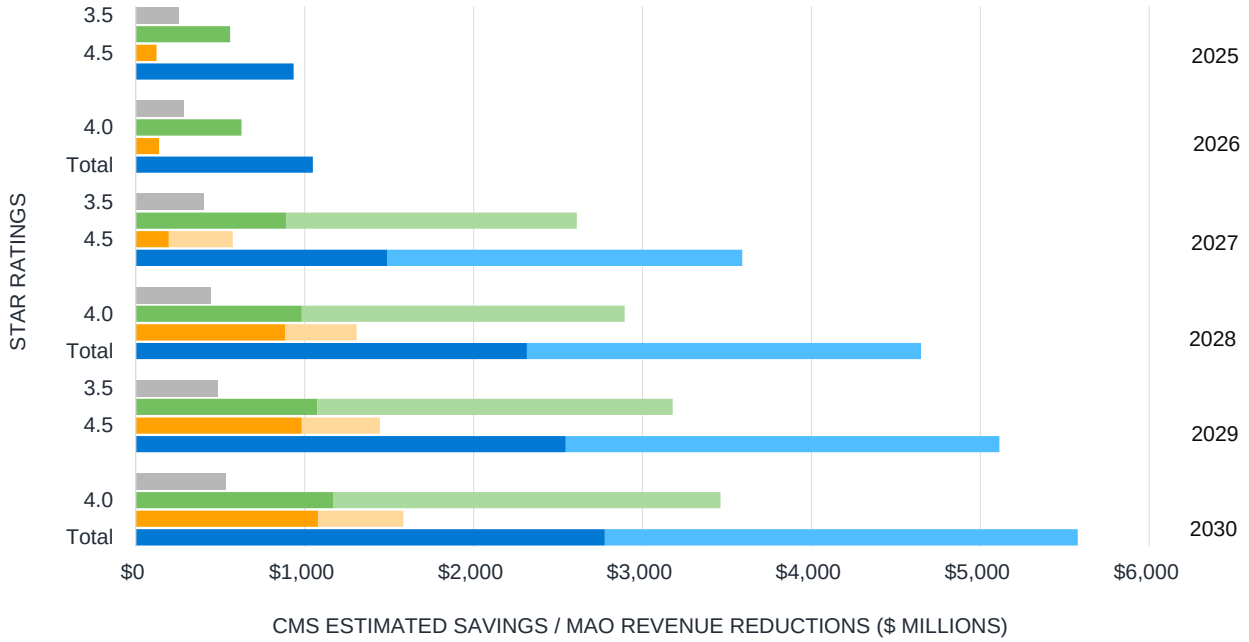
Figure 4 shows CMS' estimates of the savings (reductions in payments to MA-PD plans) from these methodological changes to the Star Ratings program, separated by year as well as by the previous Star Rating of individual contracts. Please note the lighter highlights on the bars from 2027 onward show CMS' estimates of the potential impact of changing Hold Harmless from a 4-Star to a 5-Star threshold.

24. Specific allegations included: technical failures being incorrectly attributed to plans rather than recognized as CMS software/connectivity issues; inconsistent application of disconnection policies across different plans; disputed accountability for telecommunications relay service (711 operator) performance, which plans argue they do not control; and CMS' "no callback" rule that counts dropped calls against plans even when they attempt to promptly reconnect, including in cases where the connection was dropped by the caller.

25. Humana v HHS, op cit.; Centene v Becerra, op cit.; Elevance v HHS, op cit.

26. The Call Center measure's national average fell to 3.97 stars in 2025, with the share of 5-star contracts falling from 64.7% to 22.0%. The Medicare Plan Finder Price Accuracy measure also now requires 100% performance for a five-Star rating, and has also seen a large drop in both national average Stars and the number of high-performing contracts.

FIGURE 4: CMS COST SAVINGS / MAO REVENUE REDUCTIONS ($ THOUSANDS) BY PAYMENT YEAR AND STAR RATING[27][28]



The magnitude of projected impacts makes clear that the Medicare Advantage industry has entered a transformative period in quality measurement and Star Ratings that will require sustained strategic adaptation. Health plans should proactively consider how to adjust processes to best prepare for these Star Rating changes, both immediate and future, and seek expert guidance on managing their Star Rating risks and investments effectively

Limitations and data reliance

We primarily relied on information and data provided by CMS, including both 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. 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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The views expressed in this research paper are made by the authors and do not represent the opinions of Milliman, Inc. Other Milliman consultants may hold alternative views and reach different conclusions from those shown.

27. CMS 2021 Final Rule, Tukey Outlier CMS Cost Savings, Table 12. See https://www.federalregister.gov/documents/2020/06/02/2020-11342/medicare-program-contract-year-2021-policy-and-technical-changes-to-the-medicare-advantage-program.

28. CMS 2024 Final rule, HEI Rewards, weight changes and hold harmless CMS cost savings, Table 1. See: https://public-inspection.federalregister.gov/2023-07115.pdf.

Qualifications

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Hayley Rogers and Matthew Smith are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses in this paper.

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