

**2025 National Conference on Special Needs Planning and
Special Needs Trusts**

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MEDICARE UPDATES

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I. Federal Update

A. Reconciliation Bill

On July 4, 2025, President Trump signed into law H.R. 1 – One Big Beautiful Bill Act (OBBA).¹ Narrowly passing Congress using the reconciliation process in the Senate (which requires a simple majority rather than 60 votes), the bill extends the 2017 tax cuts and funds other administration priorities. In order to offset some of the costs of these policies, the bill makes unprecedented and wide-ranging cuts to a number of safety-net programs, including over \$1 trillion in cuts to health programs, which will result in an estimated 10 million people losing insurance coverage, along with cuts to food assistance provided to low-income individuals through the federal SNAP program, among other changes.² With respect to health care, the bulk of cuts, which will be implemented over a number of years, are directed at the Medicaid program and aimed at reducing the number people covered. These changes include: new “community engagement” (work requirements) for certain individuals to maintain coverage; more frequent eligibility redeterminations; rescission of eligibility for certain groups of lawfully present immigrants (similar to the Medicare-specific provision described below); and reduced ability for states to raise additional Medicaid funds through provider taxes. There are also significant changes for Affordable Care Act marketplace enrollees, including non-renewal of financial assistance for qualifying individuals.

¹ Pub. Law No: 119-21.

² Congressional Budget Office (CBO), “Estimated Budgetary Effects of Public Law 119-21, to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, Relative to the Budget Enforcement Baseline for Consideration in the Senate” (July 21, 2025), available at: <https://www.cbo.gov/publication/61569>.

Many of the cuts to Medicaid will impact people who have both Medicare and Medicaid (dual eligibles). As outlined in joint publications by the Center for Medicare Advocacy, Justice in Aging, Medicare Rights Center and Community Catalyst,³

- One in five Medicare enrollees relies on Medicaid to help pay Medicare premiums and cost sharing
- Nearly 30% of Medicaid funding goes to people with Medicare
- Medicaid is the primary payer for 63% of nursing facility residents
- Without Medicaid, over 12 million Medicare enrollees would experience gaps in care that jeopardize their health and well-being.

There are also provisions of the OBBA that will directly impact Medicare beneficiaries, including:

- *Limiting eligibility and terminating coverage of certain lawfully present non-citizens* – Upon enactment, §71201 restricts Medicare eligibility to citizens or nationals of the U.S., lawful permanent residents (green card holders), certain Cuban/Haitian entrants and Compacts of Free Association (COFA) migrants (rescinding eligibility for all other lawfully present immigrants, including asylees, refugees, people granted withholding of removal, trafficking survivors, survivors of domestic violence, and individuals granted humanitarian parole for a period of at least 1 year). Not later than one year after enactment (July 4, 2026), the Commissioner of the Social Security Administration is directed to identify individuals with Medicare coverage who do not meet the new criteria,

³ Center for Medicare Advocacy, Justice in Aging, Medicare Rights Center and Community Catalyst, “A Cut to Medicaid is a Cut to Medicare” (March 2025) – Fact Sheet: <https://medicareadvocacy.org/wp-content/uploads/2025/03/A-Cut-to-Medicaid-is-a-Cut-to-Medicare-fact-sheet.pdf>; Issue Brief: <https://medicareadvocacy.org/wp-content/uploads/2025/03/A-Cut-to-Medicaid-is-a-Cut-to-Medicare-Issue-Brief.pdf>.

and notify such individuals “as soon as practicable after such identification and in a manner designed to ensure such individual’s comprehension of such notification” that their coverage will be terminated as of 18 months after enactment (approximately January 2027). Note: Undocumented individuals have never been eligible for Medicare coverage, but, until enactment of the OBBB, lawfully present individuals who meet the requisite work history requirements through SSA have been eligible for Medicare coverage.

- *Ending implementation of a rule streamlining eligibility and enrollment in Medicare Savings Programs (MSPs)* – §71101 prohibits the Secretary of Health & Human Services from implementing (for 9 years) certain provisions of the final rule published by CMS on September 21, 2023 (88 Fed. Reg. 65230), which was aimed at making it easier for Medicare beneficiaries to enroll in and qualify for MSPs, which can cover some Medicare premiums and costs for lower income beneficiaries. The Congressional Budget Office (CBO) estimates that this will save over \$66 billion over 10 years due to fewer people enrolling in MSPs; more than 1.3 million dually eligible individuals are expected to lose assistance through MSPs.
- *Prohibiting implementation of a final staffing rule for nursing facilities* - §71111 prohibits CMS from implementing a final rule issued in 2024 (89 Fed Reg 408706) which established national minimum staffing requirements for nursing facilities to promote quality care (note that provisions of this rule were vacated by a federal court, but the Trump Administration continues to defend the rule). Researchers at the University of

Pennsylvania have estimated that the staffing rule would save 13,000 residents' lives each year.⁴

- *Restricting the Medicare program's ability to negotiate the price of certain drugs* – the Inflation Reduction Act of 2022 (Pub. Law No: 117-169) gave the Secretary authority to negotiate the prices for certain high-cost drugs for Medicare beneficiaries, with negotiated prices first effective in 2026. Section 71203 of the OBBA carves out certain “orphan drugs” (medications developed to treat rare diseases) from Medicare drug price negotiation.

Finally, unless Congress acts, the bill threatens Medicare's sustainability by triggering massive future cuts to the program. Nearly \$500 billion in Medicare cuts would be required,⁵ with an estimated \$45 billion occurring as soon as fiscal year 2026.

B. Federal Agency Cuts & Reorganization

Since January 2025, there have been significant changes, including workforce reductions, at several agencies that could impact access to services for Medicare beneficiaries (and those approaching eligibility).⁶

⁴Letter (Jul. 8, 2024) from Rachel M. Werner, Professor, Health Care Management and Economics, Professor, Medicine, University of Pennsylvania, Norma B. Code, Director of Research, LDI, Professor, Medical Ethics and Health Policy, University of Pennsylvania, to Senator Elizabeth Warren, available at: https://www.warren.senate.gov/imo/media/doc/letter_from_researchers_to_sen_warren_070824.pdf. Also see, e.g., Center for Medicare Advocacy, *CMA Alert*: “Reconciliation Bill will Cause Nursing Home Residents to Suffer” (June 5, 2025), available at: <https://medicareadvocacy.org/bill-will-cause-nursing-home-residents-to-suffer/>.

⁵ See, e.g., Congressional Budget Office (CBO) “Potential Statutory Pay-As-You-Go Effects of a Bill to Provide Reconciliation Pursuant to H. Con. Res. 14, the One Big Beautiful Bill Act” (May 20, 2025), available at: <https://www.cbo.gov/publication/61423>.

⁶ See, e.g., KFF, “Which Federal Agencies Make Medicare Work and How Were They Affected by Recent Changes Made by the Trump Administration?” by Nancy Ochieng, Juliette Cubanski, and Tricia Neuman (June 4, 2025),

The **Social Security Administration** (SSA) handles eligibility, enrollment and premium payment for certain parts of Medicare, along with assistance with programs for low-income beneficiaries. Already at a 50-year staffing low, SSA has faced mass workforce reductions, policy changes that have led to overwhelmed field offices and telephone lines, crashing of SSA's website, and the dissolution of the agency's Office of Civil Rights and Equal Opportunity.⁷

The **Department of Health & Human Service** (HHS), which houses the **Centers for Medicare & Medicaid Services** (CMS) has terminated staff and announced a major reorganization, including the dismantling of the Administration of Community Living (ACL). HHS has eliminated half of its 10 regional offices, including those in Boston, Chicago, New York City, San Francisco, and Seattle. Staff cuts at HHS, when combined with recent staff departures, will lead to an estimated 25% reduction in the HHS workforce. According to *Politico*, staff cuts at CMS include 200 people from the Office of Program Operations and Local Engagement which "ensures Medicare health plans and providers are in compliance with CMS requirements and helps manage case work for Medicare Advantage and Affordable Care Act marketplace patients."⁸

According to an HHS statement,⁹ the reorganization includes the following change: "HHS will have a new Assistant Secretary for Enforcement to provide oversight of the Departmental

available at: <https://www.kff.org/medicare/issue-brief/which-federal-agencies-make-medicare-work-and-how-were-they-affected-by-recent-changes-made-by-the-trump-administration/>.

⁷ See, e.g., Center for Medicare Advocacy, *CMA Alert* "CMA Urges Court to Stop DOGE's Dismantling of Social Security" (April 10, 2025), available at: <https://medicareadvocacy.org/cma-urges-court-to-stop-doges-dismantling-of-social-security/>; also see, e.g., SSA, "Social Security Announces Workforce and Organization Plans" (Feb. 28, 2025), available at: <https://blog.ssa.gov/social-security-announces-workforce-and-organization-plans/#:~:text=Last%20Updated:%20April%2018%2C%202025,the%20agency%20by%20specific%20dates.>

⁸ *Politico*, "HHS Aftershocks" by Kelly Hooper and Chelsea Cirruzzo (March 28, 2025), available at: <https://www.politico.com/newsletters/politico-pulse/2025/03/28/hhs-aftershocks-00255723>.

⁹ HHS, "Fact Sheet: HHS' Transformation to Make America Health Again" (March 27, 2025), available at: <https://www.hhs.gov/press-room/hhs-restructuring-doge-fact-sheet.html>.

Appeals Board (DAB), Office of Medicare Hearings and Appeal (OMHA), and the Office for Civil Rights (OCR) to combat waste, fraud, and abuse.” It is unclear what impact this reorganization might have on the independence and decision-making of these agencies.

II. Medicare Advantage Updates

The Medicare Advantage program (MA, also known as “Part C”) – the private plan option in Medicare in addition to traditional Medicare (sometimes called “Original” or Fee-for-Service) – now covers more than half of all Medicare beneficiaries, and is growing. According to KFF, MA enrollment has more than doubled since 2010 and is projected to grow from 54% of the eligible population in 2025 to 64% by 2034.¹⁰

It is well established that MA plans are significantly overpaid relative to what traditional Medicare spends on a given beneficiary due to a variety of factors, including manipulation of the risk-adjusted payment system. According to the Medicare Payment Advisory Commission (MedPAC), “Medicare spends approximately 20 percent more for MA enrollees than it would spend if those beneficiaries were enrolled in [traditional] Medicare, a difference that translates into a projected \$84 billion in 2025.”¹¹ MedPAC notes: “the benefits from MA’s higher cost relative to [traditional Medicare] are subsidized by the taxpayers and beneficiaries who fund Medicare, increasing fiscal strain on the program. The Commission estimates that Part B

¹⁰ KFF, “Medicare Advantage in 2025: Enrollment Update and Key Trends” (July 2025), available at: <https://www.kff.org/medicare/medicare-advantage-enrollment-update-and-key-trends/>.

¹¹ Medicare Payment Advisory Commission (MedPAC), “Report to Congress: Medicare Payment Policy” (March 13, 2025), available at: <https://www.medpac.gov/document/march-2025-report-to-the-congress-medicare-payment-policy/>; also see accompanying Press Release at: https://www.medpac.gov/wp-content/uploads/2025/03/March_2025_MedPAC_Report_Press_Release_SEC.pdf.

premiums, paid by all Medicare beneficiaries, will be about \$13 billion higher in 2025 because of higher MA spending.”¹²

As outlined in a Center for Medicare Advocacy issue brief, during the Biden Administration modest, but important, progress was made in improving access to care for MA enrollees in areas such as oversight of prior authorization, network adequacy, marketing misconduct, and supplemental benefits.¹³ During the first Trump Administration, the Medicare Advantage program was favored over traditional Medicare, both in Medicare’s own materials and in policy.¹⁴ While the second Trump Administration is less than a year old, its approach to Medicare and Medicare Advantage is still taking shape. On the one hand, in its first significant MA policy updates, it increased MA payment without taking measures to account for rampant upcoding and failed to finalize some key consumer protections and plan oversight provisions in the final CY2026 Part C & D rule. On the other hand, there appears to be increased scrutiny of Medicare Advantage by the new administration. For example, CMS announced that it will be expanding its audit efforts regarding MA plan payment, and the Department of Justice (DOJ) has both maintained involvement in pre-existing MA-related suits and taken new actions against MA plans.

¹² *Id.*

¹³ Center for Medicare Advocacy, “Issue Brief: Medicare Advantage Oversight and Consumer Protections” (April 1, 2025), available at: <https://medicareadvocacy.org/issue-brief-medicare-advantage-oversight-and-consumer-protections/>.

¹⁴ See, e.g., Center for Medicare Advocacy “Special Report: MEDICARE & YOU 2022 – An Important First Step Towards Reversing Bias in Favor of Medicare Advantage” (September 20, 2021), available at: [Medicare’s own materials](#); also see Center for Medicare Advocacy, *CMA Alert* “Center for Medicare Advocacy Analysis of President’s Medicare Executive Order” (October 19, 2019), available at: <https://medicareadvocacy.org/alert-analysis-of-presidents-medicare-executive-order/>.

A. New Rules for 2026

On April 15, 2025, CMS issued a final rule: Medicare and Medicaid Programs; Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly.¹⁵ The final rule included, among other provisions, certain improvements to MA appeals in the hospital setting and other protections surrounding MA appeals, including:

- Ensuring that MA appeal rules apply to adverse decisions, regardless of whether the decision is made before, after, or during the receipt of services;
- Codifying requirements that plans give providers notice of a coverage decision and enrollees are notified when providers submit requests on behalf of beneficiaries; and
- Clarifying that an enrollee's liability to pay for services cannot be determined until an MA organization issues a decision, ensuring that an enrollee has the right to appeal MA plan coverage denials that affect their ongoing course of treatment.

The final rule also establishes guardrails for Medicare Advantage Special Supplemental Benefits for the Chronically Ill (SSBCI) by codifying a list of non-allowable examples (e.g., non-healthy food, alcohol, tobacco and life insurance).

Pursuant to a rule issued in 2024, starting in 2026, MA plans are required to issue a “Mid-Year Enrollee Notification of Unused Supplemental Benefits” annually, between June 30 and July 1 of the plan year, personalized to each enrollee including a list of any supplemental benefits not accessed by the individual during the first six months of the year.¹⁶ In a memo dated September

¹⁵ Contract Year 2026 Policy and Technical Changes, 90 Fed. Reg. 15792 (Apr. 15, 2025).

¹⁶ 89 Fed. Reg. 30448 (April 23, 2024), amending 42 C.F.R. §§422.111(l) and .2267(e)(42).

8, 2025, CMS announced that it is suspending enforcement of this rule for contract year 2026 “and beyond” while the agency “reconsiders regulatory requirements.”¹⁷

Note that a rule finalized in February 2024 aimed at improving the electronic exchange of information and prior authorization processes related to MA plans, Medicaid managed care plans, and plans offered through the federal exchanges included MA-related provisions that are first effective in 2026.¹⁸ Such provision require MA plans to:

- Issue organization determinations for items and services subject to prior authorization within 7 days of a request and within 14 days for items and services not subject to prior authorization (until 2026, the timeframe for all standard organization determinations was 14 days);
- Include a specific reason for denying a prior authorization request in notices sent to providers; and
- Publicly report prior authorization metrics, similar to the metrics that traditional Medicare already makes available.

In anticipation of the upcoming annual enrollment period (AEP), CMS made a number of changes to the **Medicare Plan Finder (MPF)**, the primary online tool that Medicare beneficiaries use to compare Medicare Advantage and Part D plans. These changes include a new filter that allows users to screen out MA Special Needs Plans (SNPs) from other types of MA plans,¹⁹ an expanded display of MA supplemental benefits,²⁰ and the posting of MA

¹⁷ CMS Memo: “Mid-Year Notice of Unused Supplemental Benefits; Delayed Enforcement of Requirements under 42 CFR §§ 422.111(l), and 422.2267(e)(42)” (Sept. 8, 2025).

¹⁸ Advancing Interoperability and Improving Prior Authorization Processes, 89 Fed. Reg. 8758 (Feb. 8, 2024).

¹⁹ See CMS Memo: “Medicare Plan Finder Enhancements for Contract Year 2026” (May 27, 2025), available at: <https://www.google.com/url?sa=t&source=web&rct=j&opi=89978449&url=https://granepbm.com/wp->

provider directory information for 2026.²¹ Note that for the MA provider directory information, CMS is using a third-party vendor for 2026 plan information, and has announced that there will be a Special Enrollment Period (SEP) for individuals who relied on inaccurate provider directory information when signing up for a plan through the Medicare Plan Finder.²² This SEP applies to enrollments effective in 2026 only. CMS also issued a final rule relating to MA provider directories that outline MA plan obligations which are generally applicable for the 2027 plan year.²³

B. Federal Oversight

i. CMS Action

As part of the annual process for determining payment rates to Medicare Advantage and Part D plans in the next calendar year, in January 2025 the outgoing Biden Administration issued an Advance Notice proposing MA payment rates for 2026.²⁴ On April 7, 2025, CMS issued the final Rate Announcement for CY2026²⁵ which, on the one hand, retained a phase-in of updates to the risk adjustment payment model that will make payments to MA plans more accurate, but, on the

[content/uploads/2025/05/CY2026_MPF_HPMS_updates_05272025_final.pdf&ved=2ahUKewjchqzv-caPAXUFFFFkFHZs3AqUQ-NANegQIKhAC&usg=AOvVaw2hZzEZqE09r5fT0YEPnOJo.](https://www.cms.gov/files/document/cy2026mpfenhancements08252025finalpdf.pdf)

²⁰ See CMS Memo: “Updates to the Contract Year 2026 Medicare Plan Finder and Medicare.gov” (Aug. 25, 2025), available at: <https://www.cms.gov/files/document/cy2026mpfenhancements08252025finalpdf.pdf>.

²¹ Id.

²² CMS Memo: “Special Election Period for Incorrect Medicare Plan Finder Medicare Advantage (MA) Provider Directory Information” (Sept. 12, 2025), available at: https://www.google.com/url?sa=t&source=web&rct=j&opi=89978449&url=https://portal.kingdomins.com/wp-content/uploads/2025/09/HPMS_MPF_Provider_Directory_SEP.pdf&ved=2ahUKewjaxef35vGPAXU9E1kFHWODDk8Q-NANegQIJBAC&usg=AOvVaw1lihhZt6MiVvXsj6yLQCVp.

²³ 90 Fed. Reg. 45140 (Sept. 19, 2025).

²⁴Centers for Medicare & Medicaid Services (CMS), “Calendar Year (CY) 2026 Advance Notice of Methodological Changes for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies (the CY 2026 Advance Notice)” – see Press Release (Jan. 10, 2025): <https://www.cms.gov/newsroom/press-releases/cms-releases-proposed-2026-payment-policy-updates-medicare-advantage-and-part-d-programs>.

²⁵ CMS, CY2026 Rate Announcement – see Press Release (April 7, 2025) at: <https://www.cms.gov/newsroom/press-releases/cms-finalizes-2026-payment-policy-updates-medicare-advantage-and-part-d-programs>.

other hand, increased payment by 5.06% from the proposed rate and did not use other means at CMS' disposal to rein in overpayments to MA plans.

On May 21, 2025, CMS announced that it will be expanding its audit efforts for MA plans. In a press release, CMS stated that "Beginning immediately, CMS will audit all eligible MA contracts for each payment year in all newly initiated audits and invest additional resources to expedite the completion of audits for payment years 2018 through 2024."²⁶ This effort builds on a Biden Administration rule from 2023 that finalized the structure of risk adjustment data validation, or RADV audits. Such audits are aimed at recouping improper payments to MA plans by, among other things, confirming diagnoses used for risk-adjusted payment are supported by medical records. Note that on September 25, 2025, Judge O'Connor of the Northern District of Texas vacated the 2023 CMS rule re: RADV audits on which CMS' effort were based.²⁷

ii. DOJ Action

Over the course of the new Administration, the federal Department of Justice (DOJ) has both maintained involvement in pre-existing Medicare Advantage-related suits and taken new actions against MA plans. For example, DOJ continues to: defend a challenge to the RADV auditing rule (described above, but recently vacated by the court);²⁸ defend a CMS rule aimed at making

²⁶ CMS, Press Release: "CMS Rolls Out Aggressive Strategy to Enhance and Accelerate Medicare Advantage Audits" (May 21, 2025), available at: <https://www.cms.gov/newsroom/press-releases/cms-rolls-out-aggressive-strategy-enhance-and-accelerate-medicare-advantage-audits>.

²⁷ See Order Granting Plaintiff's Motion to Dismiss, U.S. District Court, Northern District of Texas., Case 4:23-cv-00909-O (Sept. 25, 2025), available at: https://storage.courtlistener.com/recap/gov.uscourts.txnd.380836/gov.uscourts.txnd.380836.76.0_2.pdf.

²⁸ See, e.g., *STAT News*, "Trump, building on Biden policy, to speed up audits of Medicare Advantage insurers" by Bob Herman (May 21, 2025), available at: https://www.statnews.com/2025/05/21/cms-expands-medicare-advantage-radv-audits-used-to-spot-potential-fraud/?utm_source=topic_author_alerts&utm_medium=email&utm_campaign=alert_author-bob-herman.

agent/broker commissions and incentives more in line with beneficiary interests;²⁹ and maintain involvement in a suit that alleges UnitedHealth Group committed MA fraud by not eliminating unnecessary diagnosis codes of its members.³⁰ According to the *Wall Street Journal*, DOJ is also now investigating UnitedHealth Group for possible criminal Medicare fraud.³¹

In addition to these actions, on May 1, 2025 DOJ filed another Medicare Advantage-related suit, this time against several plan sponsors other than UnitedHealth. As described by *KFF Health News*:

Now a blockbuster lawsuit filed May 1 by the federal Department of Justice alleges that insurers Aetna, Elevance Health (formerly Anthem), and Humana paid “hundreds of millions of dollars in kickbacks” to large insurance brokerages — eHealth, GoHealth, and SelectQuote. The payments, made from 2016 to at least 2021, were incentives to steer patients into the insurer’s Medicare Advantage plans, the lawsuit alleges, while also discouraging enrollment of potentially more costly disabled beneficiaries.³²

²⁹ See, e.g., Center for Medicare Advocacy, “Issue Brief: Marketing Medicare Advantage and Part D Plans: Regulation and Recent Legal Challenges” (March 27, 2025), available at: <https://medicareadvocacy.org/cma-issue-brief-marketing-medicare-advantage-and-part-d-plans-regulation-and-recent-legal-challenges/>.

³⁰ See, e.g., *STAT News*, “House Democrats urge judge to advance UnitedHealth Medicare fraud case to trial” by Bob Herman (May 16, 2025), available at: https://www.statnews.com/2025/05/16/unitedhealth-house-democrats-urge-judge-to-advance-medicare-fraud-case/?utm_campaign=stat_plus_today&utm_medium=email&_hsenc=p2ANqtz-4TrUji8G3I8k6diQlnGBPWLwf5aWVz6U5pmkh1JoJhlun8ip_D9MNNpbb1my9Q6Zr5VD7r02NDCOOpreMHHgNbw9DEnzgPRST9HgTRQMPHmXN3A&_hsmi=361902073&utm_content=361902073&utm_source=hs_email.

³¹ *Wall Street Journal*, “UnitedHealth Group Is Under Criminal Investigation for Possible Medicare Fraud” by Christopher Weaver and Anna Wilde Mathews (May 15, 2025), available at: <https://www.wsj.com/us-news/unitedhealth-medicare-fraud-investigation-df80667f>.

³² *KFF Health News*, “Trump’s DOJ Accuses Medicare Advantage Insurers of Paying ‘Kickbacks’ for Primo Customers” by Julie Appleby (May 19, 2025) available at: <https://kffhealthnews.org/news/article/the-week-in-brief-medicare-advantage-insurance-trump-doj-insurance-brokers/>.

III. Part D Updates

A. Inflation Reduction Act (IRA) Provisions

On August 16, 2022, President Biden signed into law the Inflation Reduction Act of 2022 (IRA).³³ Among other things, the IRA makes a number of changes to the Part D prescription drug benefit that will be phased in over several years, including.

- Caps beneficiary out-of-pocket costs in 2024 (at around \$3,500), and lowers that cap to \$2,000 in 2025 (\$2,100 in 2026); also allows spreading of costs over the course of the year (2025);
- Eliminated cost-sharing for vaccines covered under Part D (effective 2023);
- Imposed a \$35 cap on covered insulin (2023);
- Expands eligibility for the Part D Low-Income Subsidy (LIS, or “Extra Help”) (2024) – those currently eligible for the partial subsidy are now eligible for the full subsidy (full LIS up to 150% of the Federal Poverty Level (FPL) with higher resource limits);
- For the first time, the Secretary of Health & Human Services (HHS) will be able to negotiate the prices for certain high-cost drugs for Medicare beneficiaries, effective 2026; and
- Other measures that limit the growth in the cost of drugs and Part D premiums.³⁴

Starting in 2025, a provision of the IRA gives Medicare beneficiaries the option to pay out-of-pocket costs in monthly payments spread out over the year instead of having to pay high upfront

³³ Public Law 117-169 (Aug. 16, 2022).

³⁴ See, generally, KKF (formerly Kaiser Family Foundation) website at: <https://www.kff.org/medicare/>, including this summary document of the relevant IRA provisions: <https://www.kff.org/medicare/issue-brief/explaining-the-prescription-drug-provisions-in-the-inflation-reduction-act/>; also see Department of Health & Human Services website at: <https://www.hhs.gov/inflation-reduction-act/index.html>.

costs at once or over a short period of time. This option is called the Medicare Prescription Payment Plan (aka “M3P” or “smoothing”).³⁵ See, generally, CMS webpage on the [Medicare Prescription Payment Plan](#).

B. Premium Stabilization Demonstration

Among other things, the IRA made significant changes to Part D’s standard benefit design, which shift additional costs to Part D plan sponsors while reducing beneficiary out-of-pocket expenses. Out of concern about how these shifting costs could impact plan sponsors’ offerings, including premiums that they charge, in July 2024 CMS announced a voluntary Part D Premium Stabilization Demonstration “designed to test whether additional policy changes stabilize year-over-year changes in premiums for participating standalone PDPs, leading to more predictable options for beneficiaries during the initial implementation of the Inflation Reduction Act of 2022’s (IRA’s) benefit improvements [...]”³⁶ This demonstration limited premium increases for participating Part D plan sponsors to no more than \$35 a month for 2025.

On July 28, 2025, CMS issued a memorandum³⁷ announcing that the Part D Premium Stabilization Demonstration will continue for another year for CY 2026, but will be scaled back. The monthly premium subsidy to plan sponsors will be reduced from \$15 to \$10, and the limit on the monthly PDP premium increase will increase from \$35 in 2025 up to \$50 in

³⁵ See, generally, CMS webpage at: <https://www.cms.gov/inflation-reduction-act-and-medicare/part-d-improvements/medicare-prescription-payment-plan>.

³⁶ CMS, Memorandum: “Annual Release of Part D National Average Monthly Bid Amount and Other Part C & D Bid Information” (July 29, 2024), available at: <https://www.cms.gov/files/document/july-29-2024-parts-c-d-announcement.pdf>.

³⁷ CMS Memo:

“Annual Release of Part D National Average Bid Monthly Bid Amount and Other Part C & D Bid Information” (July 28, 2025), available at: <http://www.cms.gov/files/document/july-28-2025-parts-c-d-announcement.pdf>.

2026. The component of the demonstration that further mitigated costs to plan sponsors relating to risk corridors is being eliminated.

As noted by KFF³⁸ after CMS' announcement about a scaled back demo for 2026, "In announcing these changes, CMS states that it is 'facilitating the [Part D] program's return to operating under regular market conditions.' Increasingly, however, these regular conditions appear unfavorable to the ongoing stability of the stand-alone prescription drug plan market, further tilting the playing field for coverage towards Medicare Advantage."

C. Miscellaneous Updates

Note that most regulatory efforts and legislative proposals to streamline prior authorization tend to exclude prescription drugs. On September 2, 2025, HHS announced that it had issued a final rule³⁹ that "ensures that health care providers using certified health IT systems are able to submit prior authorizations electronically, select drugs consistent with a patient's insurance coverage, and exchange electronic prescription information with pharmacies and insurance plans" effective Oct. 1, 2025.

³⁸ KFF *Quick Take*: "The Trump Administration is Reducing Enhanced Support for the Part D Stand-Alone Drug Plan Market" by Juliette Cubanski (July 28, 2025), available at: <https://www.kff.org/quick-take/the-trump-administration-is-reducing-enhanced-support-for-the-part-d-stand-alone-drug-plan-market/>.

³⁹ See Dept Health & Human Services (HHS) Press Release: "Americans to Gain New Access to Real-Time Prescription Drug Price Information" (Sept. 2, 2025), available at: <https://www.hhs.gov/press-room/hhs-prescription-drug-price-transparency-rule.html>. The final rule is at 90 Fed. Reg. 36536 (Aug. 4, 2025).

IV. New Observation Status Appeals Process

A. Overview

On October 4, 2024, CMS issued a rule implementing the Court's order in the nationwide class action, *Alexander v. Azar*, 613 F. Supp. 3d 339 (D. Conn. 2020), *aff'd sub nom. Barrows v. Becerra*, 24 F.4th 116 (2d Cir. 2022).⁴⁰ In March 2020, the U.S. District Court in Hartford, Connecticut issued a decision concluding that Medicare beneficiaries whose hospital classification is changed from inpatient to outpatient receiving observation services have the right to appeal that decision to Medicare and a chance to receive certain types of coverage, or to receive reimbursement for certain noncovered services resulting from that change. Although the actual hospital services received are typically indistinguishable to beneficiaries under either classification, the distinction between designation as an inpatient (Part A coverage) versus outpatient (Part B coverage) can and has resulted in devastating financial consequences for Medicare beneficiaries. For example, many Medicare beneficiaries who were reclassified as outpatient have had to either pay thousands of dollars out of pocket for required skilled nursing facility (SNF) care or forgo it altogether.

The Center for Medicare Advocacy, Justice in Aging, and *pro bono* partner Wilson Sonsini Goodrich & Rosati represented the plaintiffs in this lengthy litigation. See the Center for Medicare Advocacy's Frequently Asked Questions webpage for more information about the case and outpatient observation status.⁴¹

⁴⁰ 89 Fed. Reg. 83240 (Oct. 4, 2024).

⁴¹ Center for Medicare Advocacy website at:

<https://link.edgepilot.com/s/092767ca/Jwg95muhu0qkp9o7qV9smQ?u=https://medicareadvocacy.org/frequently-asked-questions-about-the-observation-status-court-decision/>

As discussed below, the regulations address two types of appeals: retrospective and prospective. The retrospective appeals are for class members who were denied the right to appeal in the past. Prospective appeals are available on an ongoing basis for eligible beneficiaries who are still in the hospital.

B. Retrospective Appeals (42 C.F.R. §§405.931 – .938)

Retrospective appeals have been operational since January 1, 2025. Retrospective appeals are for class members who did not have an appeals process available at the time of their hospitalizations, covering hospitalizations that occurred between January 1, 2009 and February 13, 2025.

As outlined in the our [Retrospective Appeals Flowchart](#), to file a retrospective appeal, you must be a Medicare enrollee who:

- Was admitted as a hospital inpatient on or after January 1, 2009.
- Was enrolled in Original Medicare at the time of the hospital stay.
- While in the hospital, was changed from inpatient to outpatient receiving observation services.
- Received either a Medicare Summary Notice and/or a Medicare Outpatient Observation Notice (MOON) showing that the observation services were not covered under Medicare Part A; and **EITHER:**
 - Was not enrolled in Medicare Part B at the time of the hospitalization; **OR**
 - Stayed at the hospital for 3 or more consecutive days but was designated as an inpatient for less than 3 days. You also need to have been admitted to a nursing facility within 30 days of discharge from the hospital.

See the Flowchart and other resources linked below for additional information.

C. Prospective Appeals (42 C.F.R. §§405.1210 – .1212)

Prospective appeals became operational on February 14, 2025. Covering hospitalizations starting on or after February 14, 2025, prospective appeals are for individuals who are in the hospital and wish to appeal their reclassification from inpatient to observation. Such appeals are available on an expedited basis as well as under the standard appeals timeframe for those who do not appeal before leaving the hospital.

As outlined in our [Prospective Appeals Flowchart](#), to file a prospective appeal, you must be a:

- A person enrolled in Traditional Medicare (not Medicare Advantage) who is admitted as an inpatient, but later reclassified as an “outpatient receiving observation services”; and was EITHER:
 - Not enrolled in Part B coverage at the time of hospitalization; OR
 - In the hospital for 3 or more consecutive days (not including the date of discharge) but classified as an inpatient for fewer than 3 days.

D. Resources

See Center for Medicare Advocacy website at: <https://medicareadvocacy.org/observation-status-appeal-resources/> which includes the following resources:

- [Frequently Asked Questions](#) about the “Observation Status” Court Decision
- [Recorded Webinar](#) (Jan. 22, 2025) on Observation Status Appeals
- [Retrospective Appeals Flowchart](#)
- [Prospective Appeals Flowchart](#)

- [Request for Retrospective Appeal of Medicare Part A Coverage](#) – to request a retrospective appeal.
- [Medicare Change of Status Notice](#) – to be issued by hospitals to patients eligible to submit prospective appeals.
- [Instructions from the Centers for Medicare & Medicaid Services \(CMS\) on Patient Status Appeals](#).
- [Appointment of Representative form](#) – to appoint someone to act on your behalf for a Medicare appeal.
- CMS booklet on [Medicare Appeals](#).
- [NAELA News Article on Observation Status Appeals](#)

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