

Medicare Updates

2025 National Conference on Special Needs Planning and Special Needs Trusts

Stetson Law

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Center for Medicare Advocacy

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About the Center for Medicare Advocacy

The Center for Medicare Advocacy is a non-profit, non-partisan law organization founded in 1986 that works to advance health equity, access to comprehensive Medicare, and quality health care. Based in Connecticut and Washington DC with additional attorneys in California, Maryland, Massachusetts, and Wisconsin.

- Attorneys, advocates, communication and technical experts
- Education, legal analysis, writing, assistance, and advocacy
- Systemic Change - Policy and Litigation
 - Based on our experience with the problems of real people
- Medicare coverage and appeals expertise
- Medicare/Medicaid Third Party Liability Projects

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Agenda

- I. Federal Updates
 - H.R.1 – Reconciliation Bill
 - Agency Cuts/Reorganization
- II. Medicare Advantage Updates
 - New Rules for 2026
 - Federal Oversight
- III. Part D Updates
 - Inflation Reduction Act of 2022
 - Part D Premium Stabilization Demonstration
- IV. New Observation Status Appeals

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Federal Updates

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H.R. 1 – “One Big Beautiful Bill” Act (OBBA)

- Cuts over \$1 trillion from health programs (over 10 years), resulting in estimated 10 million people losing health insurance coverage (+ 4 million if ACA subsidies are not renewed by the end of this year)
- **Medicaid** (including more than 12 million dual eligibles)
 - Work requirements (Jan. 2027) - Adults 19 to 64
 - More frequent eligibility checks (Jan. 2027) – every 6 months
 - Immigration restrictions (eligibility for many lawfully-present immigrants ends Oct. 2026)
 - Reduced state funding options – limitations on provider taxes
 - States will have to make tough choices re: reduced Medicaid spending

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H.R. 1 and Medicare

• New Restrictions on Lawfully Present Immigrants

- Starting immediately, **only** the following groups can newly enroll in Medicare:
 - U.S. citizens,
 - Lawful permanent residents (green card holders),
 - Cuban and Haitian family reunification program entrants, and,
 - Individuals from certain Pacific Island nations with special agreements with the U.S. (“COFA” migrants).
- Medicare eligibility is **eliminated** for all other lawfully present immigrants, regardless of how long they have worked or paid into the system. Including:
 - Refugees and people granted asylum,
 - People with Temporary Protected Status,
 - Survivors of human trafficking,
 - Survivors of domestic violence, and,
 - Individuals granted humanitarian parole.

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H.R. 1 and Medicare (cont'd)

- **Eligibility Restrictions** (cont'd)
 - By July 2026, SSA is directed to identify individuals who do not meet the new criteria 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 (January 2027)
- **Blocking Improvements to Medicare Savings Programs (MSPs)**
 - Prohibits implementation (for 9 years) a 2023 final rule aimed at streamlining MSP enrollment (see next slide)
- **Blocking Nursing Home Staffing Standards**
 - Prohibits implementation of a 2024 rule establishing minimum staffing ratios
- **Limiting Drug Price Negotiation**
 - Expands carve-outs for certain orphan drugs from negotiation

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Medicare Savings Programs (MSPs)

- **Medicare Savings Programs (MSPs)** are Medicaid programs that assist low-income Medicare beneficiaries with Medicare costs, administered by state Medicaid agencies:
 - **Qualified Medicare Beneficiary (QMB)** covers Part A premiums for individuals without free Part A; Part B premiums; and cost-sharing including co-payments, co-insurance, and deductibles
 - **Specified Low-Income Medicare Beneficiary (SLMB)** covers Part B premiums
 - **Qualified Individual (QI)** covers Part B premiums
- Barriers to enrollment: previously no link between enrollment in other federal programs with the MSPs, even though high likelihood individuals in those programs would be eligible for MSPs; burdensome documentation requirements for enrollment;
- CMS finalized a rule (Sept. 21, 2023) that targeted barriers to enrollment and designed to increase enrollment in MSPs for eligible beneficiaries
- **H.R. 1 stops implementation of improvements to MSPs** (not already implemented) in the final rule

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Agency Cuts and Reorganization

- **HHS Fact Sheet** (3/27): agency reorganization includes: “HHS will have a new Assistant Secretary for Enforcement to provide oversight of the Departmental Appeals Board (DAB), Office of Medicare Hearings and Appeal (OMHA), and the Office for Civil Rights (OCR) to combat waste, fraud, and abuse.”
- **KFF** (June 2025) cuts include eliminating half of 10 Regional Offices, cuts to Office of Program Operations and Local Engagement (helps with casework); Administration for Community Living (ACL) dissolved
- **Social Security** – plans to reduce workforce by 12%, eliminate 6 of 10 Regional Offices
 - See [CMA Alert](#) (9/11/25) re: recent changes re: SSA procedures

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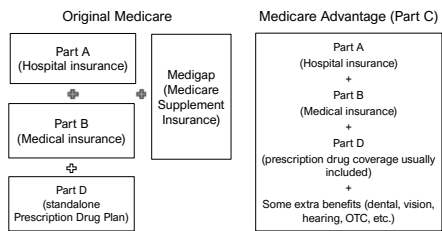
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Medicare Advantage Updates

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Reminder: Two Paths to Medicare



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Potential Medicare Advantage Tradeoffs for Beneficiaries

Potential Advantages

- One stop shopping – no need for Medigap or separate Part D plan
- Lower premiums than Medigap; most pay no premium other than Part B
- Plans typically offer additional benefits (like dental)
- Plans have an out-of-pocket limit for benefits covered under Parts A and B
- Potential for better coordinated care

Source: KFF

Potential Disadvantages

- Limited provider network
- Potential for higher out-of-pocket costs for certain services
- More utilization review than traditional Medicare
- No choice of separate drug plan to reduce drug costs
- Limited ability to switch back to traditional Medicare with Medigap

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Final Rules for 2026

- CMS Final Rule for CY 2026 90 Fed Reg 15792 (April 15, 2025) included some **MA appeal changes**, 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.

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Final Rules for 2026

- **MA Supplemental Benefits for the Chronically Ill (SSBCI)**
 - A final rule issued in 2025 establishes guardrails for SSBCI benefits by codifying a list of non-allowable examples (e.g., non-healthy food, alcohol, tobacco and life insurance). 90 Fed. Reg. 15,792 (April 15, 2025).
 - 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. 89 Fed. Reg. 30448 (April 23, 2024), amending 42 C.F.R. §§422.111(i) and .2267(e)(42).
 - **NOTE:** CMS has delayed implementation of this rule re: mid-year notices for 2026 "and beyond"

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Final Rules for 2026

- **CMS Final Rule re: Interoperability** (MA, Medicaid, ACA) 89 Fed Reg 8758 (Feb. 8, 2024) included MA-related provisions first effective in 2026, including:
 - For items and services subject to prior authorization, MA plans must issue an organization determination (coverage decision) within 7 days (currently 14 days; expedited decisions remain 72 hours)
 - Include specific reasons for denying a prior authorization request in notices sent to providers
 - Publicly report certain prior authorization metrics
 - By January 2027, MA plans will be required to have "application programming interface" (API) in place for prior authorizations, separate patient and provider API

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Regulatory Action

- CMS **increased payment to MA plans** for CY 2026 by 5.06% from proposal issued by outgoing Biden Administration
- In May 2025, CMS announced **expanded audit efforts for MA plans** re: collecting past overpayments (note: on Sept. 25, 2025, a federal judge in Texas vacated the 2023 rule that served as basis for these increased audits – will HHS appeal this ruling?)
- **Department of Justice** – has maintained involvement in suits against MA plans re: collecting overpayments and defending audits, and brought new suit against several MA plan sponsors alleging illegal kickbacks to insurance brokerages to steer individuals towards MA plans
- On Aug. 18, 2025, a federal judge in Texas vacated key provisions of rule designed to align agent/broker compensation with beneficiary needs – will HHS appeal this ruling?

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Part D Updates

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Inflation Reduction Act of 2022 (IRA)

- Allows Medicare to **negotiate with drug manufacturers** for the price of some Part D and Part B drugs (starting in 2026)
- **Caps beneficiary out-of-pocket Part D drugs costs at \$2,000** per year (starting in 2025 – also allows spreading of costs over course of the year); in 2024, the 5% coinsurance for Part D catastrophic coverage was eliminated) – cap will be \$2,100 in 2026
- Imposes **checks on the annual rise in costs of drugs and Part D premiums** (limitations on drug prices starting in 2023, and limitations on Part D premiums starting in 2024)
- **Limits monthly out-of-pocket copays for insulin to \$35** (starting in 2023)
- **Eliminates cost-sharing for adult vaccines** covered under Part D (2023)
- **Expands access to the Part D low-income subsidy** ("Extra Help") (starting in 2024) – full LIS up to 150% FPL with higher resource limits

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Standard Part D Benefit - 2026

Coverage Phase	Beneficiary Costs
Annual Deductible	\$615
Initial Coverage Limit	25% of costs up to \$2,100 (including deductible)
Catastrophic Coverage	\$0

- Note that non-standard plans (enhanced plans) can reduce or eliminate the deductible and/or cost-sharing for covered Part D drugs

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Part D Premium Stabilization Demo

- IRA of 2022 included out-of-pocket cap for Part D drugs and other consumer protections, also shifted additional costs to Part D plans
 - Part D Premium Stabilization Demo, introduced in 2024 for the 2025 plan year, is being scaled back for 2026
 - 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 2026.
 - The component of the demonstration that further mitigated costs to plan sponsors relating to risk corridors is being eliminated.

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Observation Status Appeals

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New Observation Status Appeals Process

- Hospital observation status can impact eligibility for SNF care, can impact people with no Part B coverage
 - Medicare requires a 3-day inpatient hospital stay as a prerequisite for SNF coverage – observation ≠ inpatient
- CMS issued a final rule in Oct. 2024 implementing court's decision in *Alexander v. Azar*
- Medicare beneficiaries whose hospital classification is changed from inpatient to outpatient receiving observation status have a right to appeal that decision
- Retrospective and Prospective appeals available

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Observation Status Appeals (cont'd)

- **Retrospective Appeals** – effective Jan. 1, 2025
 - For class members with hospitalizations between Jan. 1, 2009 and Feb. 13, 2025
- **Prospective Appeals** – effective Feb. 14, 2025
 - For individuals who wish to appeal their reclassification from inpatient to observation
 - Expedited appeals; also standard appeals available for those who don't appeal before leaving the hospital
 - For information on who qualifies as class members, FAQs and more, visit CMA's [Observation Appeals Resource Page](#); Final Rule, October 15, 2024: [89 Fed. Reg. 83240 \(Oct. 15, 2024\)](#).

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Questions and Discussion

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