

Medicare Updates

2026 National Conference on Special Needs Planning and Special Needs Trusts

Stetson Law

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Presented by
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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, Georgia, Maryland, and Wisconsin.

- Attorneys, advocates, a nurse, 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 Overview
 - Implementation of H.R.1 Immigration Provisions
- II. Medicare Advantage and Part D Updates
 - New Rules for 2027
 - Part D Updates
- III. Miscellaneous Updates
 - Skilled Nursing Facility (SNF) Oversight
 - Improper Coverage Changes by SNFs
 - Improper Classification of Observation Status Appeals by Contractors

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H.R. 1 and Medicare

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H.R. 1 and Medicare

- **New Restrictions on Lawfully Present Immigrants**
 - (See below)
- **Blocking Improvements to Medicare Savings Programs (MSPs)**
 - Prohibits implementation (for 9 years) a 2023 final rule aimed at streamlining MSP enrollment
 - CBO: will save \$66 billion over 10 years due to 1.3 million fewer people enrolled in MSPs
 - States can still address some MSP challenges
- **Blocking Nursing Home Staffing Standards**
 - Prohibits implementation of a 2024 rule establishing minimum staffing ratios (CMS since rescinded rule)
- **Limiting Drug Price Negotiation**
 - Expands carve-outs for certain orphan drugs from negotiation
 - CBO estimates this will cost \$8.8 billion over 10 years

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H.R.1 Amended the Social Security Act – New Section 1899C (42 U.S.C. §1395mmm) Limits Medicare Eligibility To:

☐ U.S. Citizens and Nationals

Eligible Non-Citizens:

- ☐ Lawful Permanent Residents (LPR) = Green Card holders
- ☐ Cuban-Haitian Entrant (CHE) grantees
- ☐ Compact of Free Association (COFA) migrants – from Federated States of Micronesia, Republic of the Marshall Islands, and the Republic of Palau

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Lawfully Present Non-Citizens Who Are No Longer Eligible for Medicare

- ☐ Refugees
- ☐ Asylees
- ☐ Individuals with Temporary Protected Status
- ☐ Humanitarian Parolees
- ☐ Survivors of Human Trafficking and Domestic Violence
- ☐ Persons Granted Withholding of Removal

NOTE: Persons in these categories may still be eligible for Title II benefits

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CMS Issued a Proposed Rule Implementing HR1 Immigration Provisions

- On July 16, 2026, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that includes provisions implementing new Section 1899C of the Social Security Act (section 71201 of H.R.1) at 91 Federal Register 43842 (July 16, 2026) (CMS-1848-P). Comments are due Sept 14.
– See CMA [Explainer](#) (Aug. 2026)
- *Note that the provisions of this rule as described below are in proposed form and may be changed prior to being finalized before January 2027.*

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Proposed Disenrollment Processes

Separate processes for:

“Grace Period” Population – Persons identified by SSA as being ineligible under the new restrictions between July 4, 2025 and the end of December 2026.

“Outside of the Grace Period” Population – Everyone else, including persons who SSA overlooked, or improperly enrolled, or whose immigration status changed during the grace period, or someone who one day enrolls in Medicare but then later loses their eligible status.

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Grace Period Population Disenrollment Process (Proposed)

SSA must provide:

- ☐ **Preliminary Notice** – “as soon as practicable” informing them that SSA records show they do not meet 1899C criteria and their entitlement to or enrollment in Medicare will be terminated in January 2027 if they cannot provide evidence proving eligibility. It instructs them to contact SSA if they believe the information is incorrect.
- ☐ **Termination Notice** – towards end of December 2026. This serves as a formal “initial determination” of ineligibility and that enrollment will be **terminated effective February 1, 2027**. It must inform of appeals rights pursuant to SSA regulations governing reconsiderations at 20 CFR. part 404, subpart J.

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Outside of Grace Period Population Disenrollment Process (Proposed)

SSA must provide:

- ☐ **Termination Notice** – explaining that per available data they do not satisfy 1899 criteria and their Medicare enrollment will be terminated at the end of the month following the month in which the notice is dated.
- ☐ SSA will not terminate anyone prior to notification
- ☐ Notice will include information about appeal rights

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Disenrollment From Medicare Advantage (MA) & Part D

- ☐ CMS proposes to create a separate involuntary disenrollment process that will be *prospective* and effective the first day of calendar month following the last month of entitlement to Part A or B.
- ☐ CMS would process disenrollments automatically (through internal MARx system) when SSA provides updated eligibility and entitlement records.
- ☐ CMS would notify the plan of disenrollment (through MARx).
- ☐ Plans would have the *option* to (but not be required to) provide notice to the beneficiary of disenrollment, since SSA will already be notifying the beneficiary that they lost Part A and B entitlement.

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Special Enrollment Period (SEP) for Those Who Gain or Regain Eligibility

- ☐ Would apply to individual who was terminated from Medicare, or who initially does not meet, but later meets the 1899C requirements.
- ☐ SEP would begin the month in which the individual "upon contacting the SSA, provides sufficient documentation to establish eligibility" and end 6 months later
- ☐ **For premium-free Part A**, CMS proposes **retroactive entitlement for up to 6 months**, but not earlier than first month in which individual met all the eligibility requirements.
- ☐ **For premium Part A and B**, CMS proposes a uniform **prospective-only effective date**, beginning with first day of month following month of enrollment.

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Special Enrollment Period (SEP) for MA and Part D

- ☐ **SEP to enroll in Medicare Advantage** would become available the month the person establishes entitlement to Part A and is enrolled in Part B, and last for 2 more months.
- ☐ **SEP to enroll in Part D** would last for 2 months after either the individual's Part A or Part B entitlement date, whichever is earlier. The SEP would end based on the earlier of the two entitlement dates.
- ☐ Enrollments in MA and Part D in would be effective the first day of the calendar month following the month in which election is made.

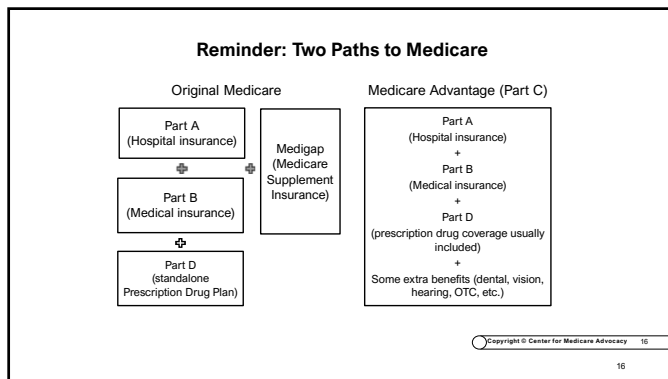
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Medicare Advantage and Part D Updates

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Potential Medicare Advantage Tradeoffs for Beneficiaries

Source: KFF

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

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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Medicare Advantage Updates

- On April 2, 2026, CMS issued the Medicare Advantage and Part D final rule for 2027
 - Center for Medicare Advocacy's full comments on the proposed rule – raised concerns about the roll-back of important consumer protections ...

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New Medicare Advantage and Part D Rules for 2027

Special Enrollment Period (SEP) re: Medicare Advantage Provider Terminations

- CMS did not finalize the CMS proposal to expand current SEP rights to change MA plans following provider terminations
- CMS stated: "In this final rule, CMS is not finalizing the proposal to establish a special enrollment period for provider terminations and are not addressing comments received on this proposal"

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New MA and Part D Rules for 2027

MA Supplemental Benefits

- Rescind Mid-Year Supplemental Benefits Notice –CMS first delayed, then rescinded, the proposal to require MA plans to issue mid-year personalized notices to plan enrollees that would include details about unused benefits
- Administration of Supplemental Benefits Through Debit Cards –CMS did not finalize a proposed prohibition on marketing the dollar value of supplemental benefits
- Special Supplemental Benefits for the Chronically Ill (SSBCI) – CMS did include a requirement for MA plans to post their objective SSBCI eligibility requirements on their public-facing website

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New MA and Part D Rules for 2027

Updating Third-Party Marketing Organizations (TPMO) Disclaimer Requirements

- CMS finalized their proposal that TPMOs no longer need to reference State Health Insurance Assistance Programs (SHIPs) in their disclaimers
- CMS: "for the TPMO disclaimer, 1-800-MEDICARE is a better option to assist beneficiaries with health care choices"

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New MA and Part D Rules for 2027

Removing Rules on Time and Manner of Beneficiary Outreach

- Marketing Events Following Educational Events in Same Location
- Timing of Personal Marketing Appointment After Scope of Appointment (SOA) Form Completion
 - No more 48-hour cooling off period
- Scope of Appointment (SOA) Forms at Educational Events

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New MA and Part D Rules for 2027

Star Ratings Changes

- CMS finalized significant changes to the Star Ratings measures, including removing 11 measures focusing on administrative processes on which CMS has indicated that plans perform similarly including:
 - how plans respond to appeals of claims denials
 - measuring why members chose to leave their plans
 - providing access to foreign language interpreters and Deaf communication access

Rescission of various measures aimed at addressing health disparities and improving health equity, including the requirement for MA quality improvement programs to include activities that reduce health disparities

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GLP-1 Coverage

- Medicare law excludes coverage of drugs solely for weight loss BUT in recent years has allowed Part D coverage for qualifying medical conditions
- GLP-1 Bridge Demo – July 1, 2026 – December 31, 2027
 - Allows coverage for people using drug solely for weight loss
 - Available to eligible beneficiaries in Part D plans (but pre-authorization requests go to Medicare contractor)
 - \$50 copay, Part D deductible, TrOOP, LIS don't apply

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End of Part D Demo

- End of Part D Premium Stabilization Demonstration for Stand-Alone Part D plans (PDPs)
 - Inflation Reduction Act of 2022 (IRA) Part D changes (including out-of-pocket cap, rx price negotiation) shifted additional costs on to Part D plan sponsors, leading many to increase premiums
 - Demo started 2025 plan year to offset increased PDP premiums – see [CMA Alert \(8/6/26\)](#)
 - CMS told *WSJ* around 75% of PDP enrollees will see their premium costs increase next year (around 30% will have an increase of less than \$10 per month, and 45% will have increases "largely in the \$11 to \$20 range a month")

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Part D Landscape

- Number of stand-alone Part D plans (PDPs) has shrunk in last several years
 - Average beneficiary's choice dropped from 30 in 2021, to 14 in 2025 to 11 in 2026 (average number of MA-PDs increased from 27 to 32 between 2021 and 2026)
 - At the same time, PDP premiums have increased
- KFF "[How Medicare Advantage Rebates Disadvantage Medicare's Stand-Alone Drug Plan Market](#)" (June 2026)
 - "A continuation of recent trends in the Part D market—fewer PDPs coupled with higher average premiums for PDPs than MA-PDs—could diminish the ability of Medicare beneficiaries in traditional Medicare to find PDPs at a comparatively affordable price, especially for those with modest incomes, which could make enrollment in Medicare Advantage more likely."

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MA Landscape

- MA plans are scaling back in 2027...
- [STAT News](#) (Oct. 1, 2026):
 - MA "insurers are raising out-of-pocket costs for enrollees, drastically cutting money for dental work and other benefits, and eliminating plans that have broad networks of hospitals and doctors"
 - In 2026, MA enrollment is highly concentrated among plans owned by a small number of parent organizations, with UnitedHealth Group leading the market, and, together with Humana, accounting for nearly half (46%) of all Medicare Advantage enrollees nationwide (the same as in 2025, and consistent with the pattern in prior years) – see KFF

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Miscellaneous Updates

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New Risk-Based Surveys for Nursing Facilities

- Citing lack of any increase in the federal survey budget since 2015 and 20% increase in complaints about nursing homes, CMS announced implementation of risk-based survey (RBS) for "higher quality facilities to undergo a more focused survey protocol requiring less onsite time and a smaller survey team," beginning Sep. 8, 2026.
- Advocates are concerned that RBS reduces and streamlines survey requirements, places residents at a heightened risk of harm and undermines accountability.

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SNF Issues

- **Beneficiary Choice**
 - Reports of SNFs enrolling people without consent in Institutional-Special Needs Plans (I-SNPs) with which facilities have contracts/affiliations
 - Reports of SNFs disenrolling people without consent from MA plans they had selected to original/traditional Medicare, which pays higher reimbursement rates and does not require prior authorization
 - This practice is illegal

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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*
- Effective 2025, Medicare beneficiaries whose hospital classification is changed from inpatient to outpatient receiving observation status have a right to appeal that decision
- Prospective appeals available (deadline for retrospective appeals has passed)
 - Handled by QIOs – Acentra or Commence Health

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Observation Status Appeals Misclassified

- CMA has encountered and heard additional reports of Medicare contractors misclassifying observation status appeals as hospital discharge appeals
 - Hospital required to issue a Medicare Change of Status Notice (MCSN)
 - Reports that if such notice is not issued, QIO is not processing appeal as an observation status appeal, rather they are treated as hospital discharge appeals
 - Beneficiaries still has an appeal right even if hospital does not issue notice

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Q&A

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