Rapid-Fire Medicare Changes
What Advocates Should Know

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The Medicare Trust Fund

Medicare Trust Fund

- Monies held by the U.S. Treasury:
  - Receives taxes and premiums
  - Pays costs of medical and health services for elderly and disabled Americans
- Two separate funds:
  - Hospital Insurance Trust Fund
  - Supplemental Medical Insurance (SMI) Trust Fund

Medicare Trust Fund

What Is at Risk: Hospital Insurance Fund

- Only Part A, hospital insurance, is at risk
- Inpatient hospitalization, skilled nursing facility care, hospice, and home health care
- Financed primarily through 2.9% payroll tax

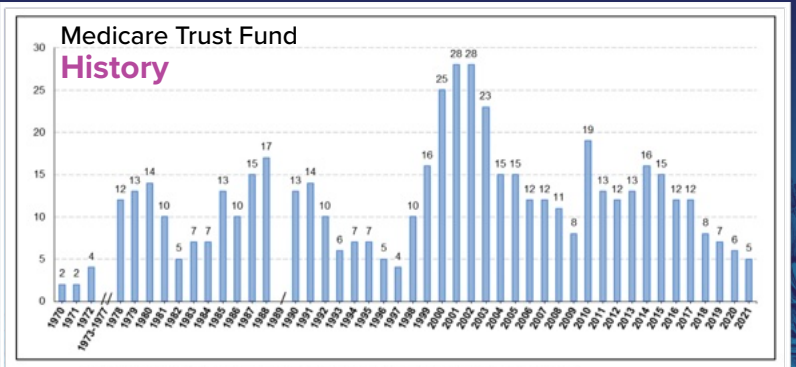
Medicare Trust Fund

What Is not at Risk: SMI

- Part B, medical insurance, and Part D, drug coverage, are financed through general revenues, premiums
- IRMAA adds to the Part B and Part D revenues
- Medicare Advantage (Part C) funds come from Trust Fund, general revenue, and premiums
- Medigap policies funded through beneficiary premiums

Medicare Trust Fund

History



Sources: Intermediate projections of various Medicare Trustees Reports, 1970-2021.

Congressional Research Service, "Medicare: Insolvency Projections," October 25, 2021
Health Affairs, "The Coming Crisis For The Medicare Trust Fund," December 15, 2020

Medicare Trust Fund

Recent Forecasts

KFF, "FAQs on Medicare Financing and Trust Fund Solvency," May 29, 2024

Medicare Trust Fund

What is Insolvency?

- Insolvency is not bankruptcy, Medicare won't go broke
- However, Medicare will be unable to pay all current expenses (pay providers in full):
  - Federal statute prohibits CMS from paying in excess of funds in the trust
  - Estimates are Medicare would pay 89%
- Could hospitals turn to patients? There are no provisions that govern this situation

Medicare Trust Fund

Factors Contributing to Insolvency

- Demographics: 4.1 million retiring through 2027
- Fewer employees paying payroll taxes
- Rising medical care utilization and costs
- Tax cuts and senior deductions that reduce incoming revenue
- Higher-than-expected costs for Medicare Advantage plans ($76B in overpayments this year)

Medicare Trust Fund

What Is Potential Impact on Beneficiaries?

- Inpatient hospitalizations may be declining:
  - Elimination of inpatient-only procedures list (2028)
  - Trend toward increased ambulatory surgery
  - Providers would determine when inpatient admission justified
- Skilled nursing facility stays may not happen:
  - Require a three-day inpatient admission
  - Medicare Advantage prior authorization, 12% denial rate

Medicare Trust Fund

What Is Potential Impact on Beneficiaries?

- Home health services:
  - Utilization has declined in recent years
  - Payment disincentives, quality incentives, Medicare Advantage payment inadequacy, workforce shortages (to name a few)
  - New fraud investigations
- Nationwide moratorium on new home health, hospice enrollments

Medicare Trust Fund

Fixes

- ***In your dreams***: Implode the entire system and start over
- The following require Congressional involvement:
  - Using funds from general revenue to pay for Part A
  - Raising Medicare eligibility age
  - Decreasing/modifying benefits
  - Increasing payroll taxes

Medicare Trust Fund

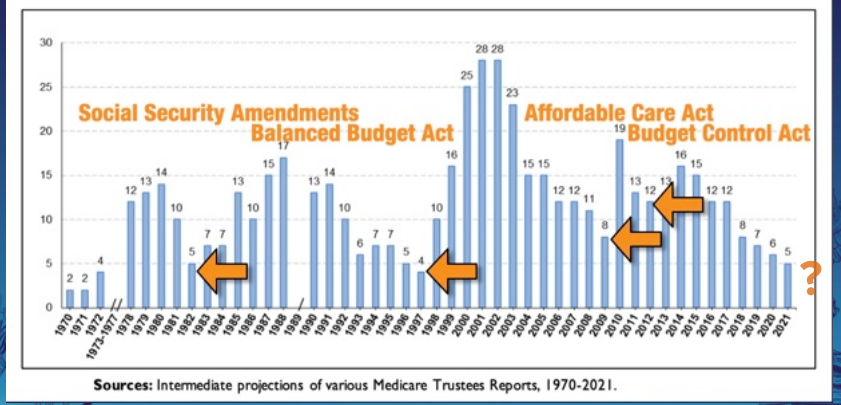
Fixes

- Reducing Medicare expenditures: Probably unlikely, given demographics
- Recouping Medicare Advantage overpayments:
  - Identified big dollar amounts
  - However, CMS ran into snafus mainly because of methodology
- Stopping Medicare Advantage overpayments: Common sense and doable but not being done

Medicare Trust Fund

Should We Worry?

- This is not the first time the Trust Fund has been in danger but is has never been insolvent
- Policymakers took action to:
  - Increase revenues and deficit spending
  - Reduce expenditures
  - Modify benefits



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Medicare Trust Fund

Should We Worry?

- Fixes would likely take an act of Congress
- 119th Congress has passed just 102 bills (Typical term averages 350-400)
- Social Security Trust Fund presents more concern:
  - Projected depletion end of 2032
  - Will be able to pay only 78% of benefits (22% cut)

Medicare Trust Fund

Advice for Worried Clients

- Design a retirement plan to address healthcare costs
- Use your power as a citizen

Medicare GLP-1 Bridge

History

The BALANCE Model

- Better Approaches to Lifestyle and Nutrition for Comprehensive hEalth
  - Proposed in December 2025
  - Five-year demonstration model to increase access to GLP-1 drugs, circumvent statute
  - Included a bridge until December 2026 to allow program to gain traction
- Drug plans did not buy in so model delayed and revised bridge model introduced

Demonstration

Medicare GLP-1 Bridge

- Began July 1, 2026, will go until December 31, 2027
- Three drugs, Wegovy, Foundry, Zepbound (KwikPen):
  - Available for $50, does not apply to Part D deductible or cap (model outside Part D)
  - Low-income subsidy does not apply
- Any prescribing physician (not on excluded list)
- Prescriptions handled by central processor Humana
- Pharmacy networks not an issue

Medicare GLP-1 Bridge

Eligible Participants

- Must be 18 years or older and enrolled in Part D drug coverage
- Participate in lifestyle modifications:
  - Manufacturers must demonstrate program meets requirements (no details available yet)
  - Providers must attest that participate is engaged in program but will not have to document

Medicare GLP-1 Bridge

Other Important Points

- Clinical eligibility criteria:
  - BMI 35 or greater
  - BMI 30 or greater with uncontrolled hypertension, CKD Stage 3a or higher, diastolic heart failure
  - BMI 27 or greater with pre-diabetes, previous MI or stroke, or symptomatic peripheral artery disease
- Claim is first denied, then pharmacist must send prior authorization form to physician

Medicare GLP-1 Bridge

Non-Eligible Participants

- Do not meet the BMI criteria
- Would qualify under Part D criteria:
  - Risk for MI or stroke in obese individuals
  - Diagnosis of sleep apnea, Type 2 diabetes
- Irrelevant that no drug plan covers Wegovy or Zepbound

Medicare GLP-1 Bridge

Going Forward

- Response:
  - Walgreens, CVS have filled over 100,000 prescriptions each
  - More than 600,000 beneficiaries have signed up in the first two months (Dr. Oz)
- What happens on January 1, 2028?
  - Only a demonstration
  - “Coverage cliff”

Wegovy: Part D or the GLP-1 Bridge?

- Part D negotiated drug:
  - Plans must cover for cardiovascular risk, as of 2027
  - 30-day supply, negotiated price $274
- GLP-1 Bridge:
  - BMI, supporting diagnoses, lifestyle modifications
  - 30-day supply, $50
- One, the other, or neither?

End of Part D Premium Subsidies

Another Demonstration

Voluntary Part D Premium Stabilization

- Inflation Reduction Act $2,000 cap:
  - Reduce out-of-pocket costs for over one million
  - Shift costs to Part D plans, creating disruptive enrollment shifts in the Part D market
- Beginning with 2025 standalone plans:
  - Greater government risk
  - A $15 reduction to the base beneficiary premium
  - A $35 limit on plan premium increases

Voluntary Part D Premium Stabilization

- Demonstration extended in 2026, $50 increase
- In July, CMS announced the end of the subsidies:
  - Market has stabilized
  - 2027 premiums will increase by no more than $20 for most
- The announcement generated widespread themes

Part D Premium Subsidies Ending, Part D Is Going Away

Shop for a Lower-priced Plan

- Watch for Annual Notice of Changes (mid-September)
- Check out available plans during Open Enrollment Period, October 15-December 7:
  - All drugs listed in plan's formulary
  - Pharmacies in-network
  - Coverage rules (prior authorization, step therapy)
- If making a change, avoid push for Medicare Advantage

Part D Premium Subsidies Ending, Switch to Advantage

Medicare Advantage Costs

- Lower plan premiums: Average about $8
- Out-of-pocket costs:
  - In-network maximum – $9,250
  - In/out-of-network combined – $13,900
  - Averages – $5,421 and $9,825

Part D Premium Subsidies Ending, Switch to Advantage

Medicare Advantage Drug Costs

- In the past, Advantage plans have had lower drug costs than standalone Part D plans
- However, that is changing:
  - More plans charge the full deductible ($700 in 2027)
  - Tier 4 coinsurance has replaced a copayment
  - Formularies are becoming more restrictive

Medicare Advantage Turmoil

Supplemental Benefits

Medicare Advantage

Supplemental Benefits

- In late 1990s, plans were allowed to offer non-Medicare did not cover with “savings generated from managed care efficiencies”
- Two types:
  - Prevent, cure or diminish a disease
  - Improve functioning, lessen the impact of symptoms and reduce hospital or ER visits

Medicare Advantage

Supplemental Benefits

- Enticement to enroll in a plan
  - 83% consider them important
  - 25% say benefits were reason for enrolling
- In 2026, $2,660 per beneficiary in rebate payments (supplemental benefits, Part D costs)

Medicare Advantage Supplemental Benefits

What Are You Getting?

- Good luck trying to figure all this out through the Medicare Plan Finder and plan’s Evidence of Coverage
  - Very long list, identifying coverage, cost, and limits
  - Plans do not use same terminology as CMS

Medicare Advantage Supplemental Benefits

What Are You Getting?

- Good luck trying to figure all this out through the Medicare Plan Finder and plan’s Evidence of Coverage
  - Very long list, identifying coverage, cost, and limits
  - Plans do not use same terminology as CMS
- Many plans offer a monthly/quarterly dollar amount to use on selected benefits; members may not get as much as they thought they were getting

Six New Supplemental Benefits in 2026

- Wigs for hair loss related to chemotherapy
- Weight management programs
- Home-based palliative care
- Readmission prevention
- Post-discharge in-home medication reconciliation
- Adult day health services

New Supplemental Benefits Availability

- Review of 190 plans (HMO, PPO, SNP) in three ZIP codes
- Findings:
  - 26 plans cover wigs, $500 benefit limit
  - 15 SNPs cover weight management (obesity screening, related services)
  - Not one plan covers the remaining four benefits

Medicare Advantage Supplemental Benefits

Mid-Year Notification About Unused Benefits

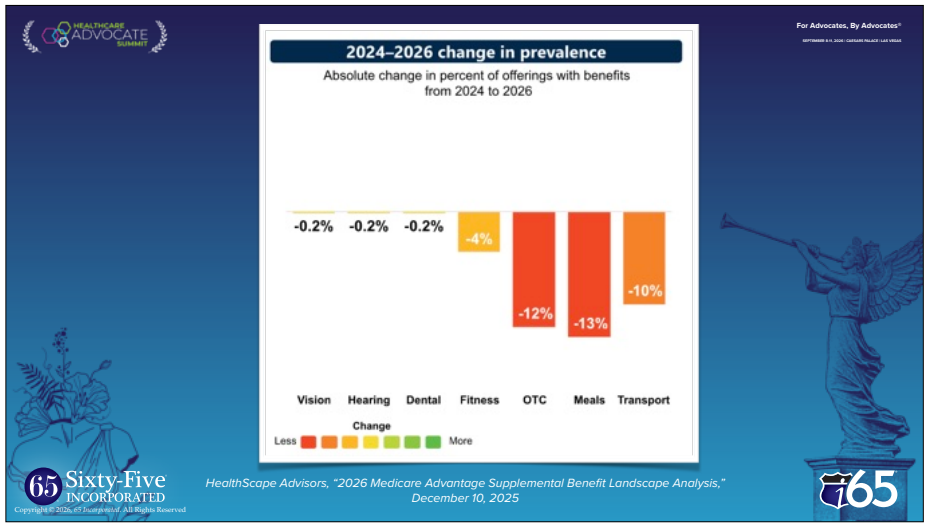
- 10% used grocery; less than half dental, vision, gym; 30% report never using any benefits
- Notification of unused benefits was to start in July:
  - Benefits not used during first half of year
  - Scope, details, cost, networks, how to access
- However, CMS delayed that:
  - Not enough time to provide technical guidance
  - Plans could provide notice voluntarily

Medicare Advantage Supplemental Benefits

Looking Ahead

- Dental, vision, hearing (core benefits):
  - Maximum benefit amounts decreasing
  - Comprehensive services more limited
- Benefits continue to contract:
  - Most acute degradation in non-core benefits
  - OTC, meals, transportation benefits, others offered by fewer plans

HealthScape Advisors, "Medicare Advantage health plan outlook for 2027; Annual survey of health plan executives," February 26, 2026



HealthScape Advisors, "2026 Medicare Advantage Supplemental Benefit Landscape Analysis," December 10, 2025

Medicare Advantage Turmoil
Provider Directories

Network Directory
New Rules

- In September 2025, CMS updated directory rules
- Changes to improve transparency, decisions:
  - Supply standardized data for Plan Finder inclusion
  - Update for changes within 30 days
  - Attest to accuracy (accepting patients, location, specialties) at least once a year
- SEP until end of 2026 if someone chose plan based on wrong information, enrolled through MPF

Network Directory
2025 Open Enrollment Test Run Finding

- 55% of providers inactive/shouldn't be listed
- "Ghost providers" (possibly to meet network adequacy standards)
- Location, phone number, other errors
- Doctors don't accept the plan, even though listed

Network Directory

Coming to a Plan Near You in 2028

- REAL (Requiring Enhanced and Accurate Lists) Providers Act
- Components:
  - 90-day provider data verification
  - Identify unverified providers in directory
  - Five-day, non-network removal (online and print)
  - Annual provider directory accuracy analysis, reports
  - Public provider data accuracy scores

Medicare Advantage Turmoil

Networks

Medicare Advantage Turmoil

Plans Leaving the Market

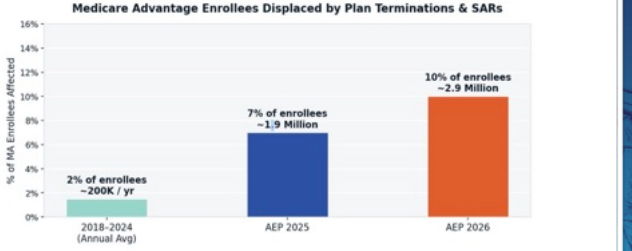
- Happening in 2027:
  - Humana exiting markets that cover 600,000 members
  - Molina dropping MA-PD plans in 20 states
  - Clear Spring leaving Medicare Advantage entirely
  - UHC dropping plans in 32 counties in 12 states
  - Not enough room for all the others
- Concern: Plans not paying commissions

Medicare Advantage Turmoil

Health Systems Dropping Plans

- Health systems that cut or narrowed contracts:
  - 32 in 2024; 40 in 2025; 26 so far this year
  - Of note, Mayo Clinic, Scripps Health, Johns Hopkins
- Reasons:
  - Prior authorization delays and denials
  - Delayed, inadequate payment

State of the Medicare Market



Medicare Market Insights, August 27, 2026

Medicare Advantage Turmoil
Prior Authorization

Prior Authorization
Medicare Advantage Situation

- 99%+ of members in plans with authorization
- 93% of physicians report delay in necessary care
- 82% of patients abandon care RNs spend **467 hours/ year**, at the cost of almost $35,000 (CMS)
- Physicians complete **39 requests per week**
- Almost **53 million** requests filed in 2024:
  - Up from 50 million in 2019
  - Average of two per member

CMS Final Rule, December 13, 2022; KFF, January 28, 2026; AMA Press Release, February 24, 2025

Prior Authorization
Medicare Advantage Situation

- Over **4.1 million requests were fully or partially denied** in 2024 (up from 3.2 million 2023):
  - Just 11.5% of denials were appealed
  - Of those, 81% were fully or partially overturned (denial not appropriate in first place)
- Reform measures:
  - CMS Final Rule for Prior Authorization
  - Industry pledge

KFF, January 28, 2026

CMS Final Rule

Provisions Effective January 1, 2026

- Adopt standard digital systems for faster submissions
- Respond to standard request in seven days and expedited determination within 72 hours
- Include a specific reason for denial in clear language
- Report metrics publicly:
  - Only 7.3% denials appealed with 53% overturned
  - Inconsistent reporting methodologies, difficulty accessing metrics

CMS Final Rule

Provider Response to 2026 Updates

- Positive reaction to mandatory response windows
- Over 90% are happy to retire the fax machine (electronic submission)
- Publicly reported metrics can help figure out what plans need and guide documentation
- But still early in the process

Prior Authorization

2025 Industry Pledge to Fix Broken System

- Standardize electronic prior authorization
- Honor existing approvals in plan changes
- Enhance communication, transparency
- Expand real-time response to requests
- Reduce scope of claims subject to authorization
- Continue (?) review of denials by medical professionals
- Basically a rehash of the 2018 pledge

Prior Authorization

2026 Progress on Industry Pledge

- Industry side, April 2026 AHIP and BCBSA survey:
  - Major insurers have cut 11% of prior authorizations
  - 6.5 million fewer requests (12%)
  - No data to back up the findings
- Provider side, May 2026 AMA report:
  - Only 33% of physicians believe voluntary pledge will make meaningful difference
  - 70% doubtful that denials are supervised by licensed clinician

Healthcare Dive Brief, April 7, 2026; AHIP News, April 24, 2026; AMA Press Release, May 13, 2026

CMS Rule, Industry Pledge

Issues That Still Need Attention

- Reasons for denials or services involved
- The use of AI, algorithms, human involvement
- Post-service denials
- Complicated, lengthy appeals process: 72 hours for expedited, 30 days for standard

Prior Authorization

Inquiring Minds Want to Know

- Will this correct plans' history of denying requests for high-cost, post-acute care?
  - Denial rate – 65% LTCHs, 54% IPR, 12% SNF
  - All other services – 8%
  - Three largest insurers have highest denial rates
- Will denials actually be valid?
  - 67% of denials overturned on appeal
  - 18% SNF denials appealed, 95% overturned

KFF July 6, 2026, and Office of Inspector General, June 8, 2026.

CMS Proposed Rule

Prior Authorization for Drugs

- CMS Interoperability Standards and Prior Authorization for Drugs
- Beginning October 1, 2027:
  - Electronic prior authorization process
  - Shorter decision times
  - Specific, actionable reason for denial
  - Public reporting of approvals, denials, and processing times

Medicare Advantage Turmoil

What Many Who Switched Wished They Had Known

Just switch to Medicare Advantage

Medicare Advantage Trial Period

- Those electing Medicare Advantage must give up their Medicare supplement plan (Medigap policy)
- There is a 12-month trial period for the first time enrolling in plan after dropping Original Medicare:
  - Buy back the same supplement, if available
  - If not, get any supplement, except Plan M or Plan N

Medicare Advantage

After the Trial Period Ends

Those who live in 47 states will likely have to pass medical underwriting to get a supplement

The WISeR Model
(Wasteful and Inappropriate Service Reduction)

Prior Authorization

WISeR Model for Original Medicare

- January 1, 2026, in six states (AZ, NJ, OH, OK, TX, WA); two three-year periods
- Voluntary participation
- 17 service codes accounting for 25% of total healthcare spending:
  - Unnecessary, inappropriate service or with little clinical benefit
  - Increased incidence of fraud

WISeR

2026 Update

- Model started January 15, 2026
- 13 services (removed deep brain stimulation, percutaneous lumbar decompression)
- Report from one state:
  - 62% initial approval, 84% with follow-up submission
  - Some technical glitches, portal and communication problems
- Nothing has crossed *65 Incorporated's* radar

WISeR

Congressional Challenges

- In May, GAO determined WISeR constitutes a rule because it prescribes new Medicare requirements:
  - As a rule, it must be submitted to Congress before it can take effect
  - If not submitted, it can be stopped in its tracks
- In June, Democrats introduced a resolution to repeal WISeR

WISeR

An Attempt to Fix a Big Problem

- Trying to rein in prior authorization:
  - Defined criteria (NCDs, LCDs)
  - Standardized processes
  - A sane use of artificial intelligence (can't ignore it)
  - Affirmations or non-affirmations (not denials)
  - Resubmissions (multiple) (not appeals)
- Six years to get it right but it may not survive that long

Part D Negotiated Drugs

Medicare Drug Price Negotiation Program

- Help lower Medicare spending on prescription drugs by requiring the federal government to negotiate the price of some high-cost drugs
- Improve coverage of drugs: Law requires all Part D plans to cover each drugs (all dosages and forms)
- Save beneficiaries $1.5 billion out of pocket costs

2026 List of Negotiated Drugs

Eliquis	Entresto
Jardiance	Xarelto
Januvia	Farxiga
Enbrel	Imbruvica
Stelara	NovoLog / Flash

Part D Negotiated Drugs

Early Findings: 2026 Survey

- 46% paid more for at least one negotiated drug
- 48% reported drugs not available at pharmacy
- 40% unaware of IRA protections ($2,100 cap, Medicare Prescription Payment Plan)
- 89% did not change drug plans
- 33% had drug denied by plan

DLA Piper, "Medicare Part D beneficiary survey: 2026 affordability and access considerations for IRA-selected drugs," August 14, 2026

Part D Negotiated Drugs

Looking Ahead to 2027

- 15 drugs with estimated discounts of 38% - 85% off the list price
- About 5.3 million beneficiaries use these 15 medications
- Projected savings over $680 million in out-of-pocket expenses
- Considerable debate about the impact of provisions in H.R. 1

2027

Wegovy: Part D or the GLP-1 Bridge?

- Part D negotiated drug:
  - Plans must cover for cardiovascular risk
  - 30-day supply, negotiated price $274
- GLP-1 Bridge:
  - BMI, supporting diagnoses, lifestyle modifications
  - 30-day supply, $50
  - Ending December 31, 2027
- One, the other, or neither?

A Few Quick Points

Substance Access Beneficiary Engagement Incentive

Hemp Products

- ACO organizations can consult on, provide eligible hemp products ($500) to improve symptom control
  - Optional incentive program that integrates into existing models, aligns with executive order
  - Effective April 1, 2026
- This is not an FDA-approved product
- Cornbread Hemp is the exclusive provider

Beneficiary Points

CMS ACCESS Model

- Advancing Chronic Care with Effective, Scalable Solutions, effective July 5, 2026
- Original Medicare beneficiaries with chronic conditions
- Virtual visits, lifestyle coaching, connected and/or wearable devices, apps, medication management, behavioral health support
- Part B coverage, no more than $13 monthly copayment

Provider Concerns

CMS ACCESS Model

- Medical director for program
- Fast Healthcare Interoperability Resources (FHIR)-based API Integration
- Coordination, active patient engagement
- Payments based on outcomes, not activities
- Payment rates lower than expected, leading to questions whether this is worth the work

Provider Concerns

FDA Approval of Rasonque (Daraxonrasib)

- First targeted RAS therapy for metastatic pancreatic cancer
- Median overall survival was 13.2 months (6.7 months for patients receiving standard chemotherapy)
- Wholesale list price for 30-day supply, $39,800
- Pundits expect Part D to cover it