

CMS Caves to Medicare Advantage Industry

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Increases Payment and Rolls Back Consumer Protections

In recent days, the Centers for Medicare & Medicaid Services (CMS) has issued policy – a Rate Notice and a final rule, both for 2027 – that significantly favor the Medicare Advantage (MA) industry, at the expense of both Medicare program finances and consumer protections.

The recent announcement about MA payment, which backtracks from a proposal to both give a smaller raise in rates and more accurately determine risk-adjusted payment, along with the recent rule relating to various MA issues are discussed below.

MA Payment – Final Rate Notice for 2027

The Medicare Payment Advisory Commission (MedPAC), an independent congressional agency established to advise Congress on issues affecting the Medicare program, has long warned about overpayments to Medicare Advantage (MA) plans. Most recently, in its March 2026 [Report to Congress](#), the agency noted that for 2026, MA payments are projected to be \$76 billion – or 14% more – above what spending would be in traditional Medicare for the same beneficiaries. According to MedPAC, as outlined in a [press release](#), this is largely due to two factors: 1) favorable selection of beneficiaries into MA plans – the tendency of beneficiaries with lower spending to enroll in MA; and 2) coding intensity – the tendency for MA plans to record more diagnoses codes for their enrollees, which increases risk adjusted payment to plans.

As part of the annual process to set payment rates for MA and Part D plans, on January 26, 2026, CMS issued an [Advanced Notice](#) that included proposed payment rates for MA and Part D plans for 2027. The proposed payment increase to MA plans was .09%, much smaller than the industry was expecting. The Advance Notice also included proposed changes to risk adjustment policy aimed at more accurately paying plans, along with a proposal to exclude diagnoses submitted on unlinked chart reviews, which CMA supported (see [CMA Alert](#) (Feb. 26, 2026)).

On April 6, 2026, CMS released the final [Rate Notice](#) for 2027 with an increase of approximately 2.5% – over \$13 billion – in additional payments to MA plans, a significant increase from the proposed rate. CMS also announced that the agency would not

implement the updated risk adjustment formula. While proceeding with the proposal to exclude diagnosis information from unlinked chart reviews from risk score calculations, CMS will allow an exception for beneficiaries who switch from one MA organization to another.

With respect to the higher increase in payment, an article in *Inside Health Policy* titled “[CMS Finalizes Nearly 2.5% Pay Bump For Medicare Advantage Plans](#)” by Dorothy Mills-Gregg and Amy Lotven (April 6, 2026) notes that:

MA stakeholders last month [called on the Trump administration](#) to prove its stated support for the program by finalizing a higher pay rate and warned that MA cuts could be a major factor in the mid-terms if seniors see fewer choices and benefits during Medicare’s open enrollment period, which kicks off about a month before the election [emphasis in original].

Similarly, a *PoliticoPulse* [post](#) (April 8, 2026) noted that:

The jump in the pay rate from the proposal to the final rule comes after an extensive lobbying campaign from insurers, who argued the initial bump of less than 1 percent didn’t keep pace with rising medical cost trends among seniors and would force the private plans to cut benefits and raise premiums. After CMS posted the final rule Monday afternoon, major Medicare Advantage insurers’ stocks soared.

With respect to abandoning the risk adjustment payment reform, a recent *STAT News* article titled “[Health insurers score major win with higher 2027 Medicare Advantage rates](#)” by Bob Herman (April 6, 2026) states that “the Trump administration scrapped a proposal that would have used more updated data in the payment process, ensuring that Medicare Advantage insurers retain billions of dollars.”

Herman explains that the current risk adjustment system relies on data from 2018 but the Trump administration “proposed using newer data to help determine” individuals’ risk scores, “but after intense industry pushback over the past two months, they are dropping the proposal indefinitely.”

In another more recent *STAT News* [article](#), Herman states that “the final regulation was almost exactly what plans wanted. A STAT review of lobbying letters shows the largest Medicare Advantage insurers and lobbying groups specifically pressured the Trump administration not to move forward with its risk adjustment proposal.”

Final Part C & D Rule for CY2027

CMS issues annual updated rules to the Medicare Advantage (Part C) and Part D programs for the following calendar year, first in proposed form, with opportunity for public comment, followed by a final rule. In November 2025, CMS issued a proposed Part C & D rule for

CY2027. See *CMA Alert* “[CMA Comments to Proposed CY 2027 Rule re: Medicare Advantage and Part D](#)” (Jan. 29, 2026); for the Center for Medicare Advocacy’s full comments on the proposed rule, see [here](#).

On April 2, 2026, CMS issued a final rule for 2027. The final rule was published in the Federal Register on April 6, 2026, and can be found [here](#) (91 Fed. Reg. 17384 (April 6, 2026)). CMS also released related press releases on April 2, 2026, available [here](#) and [here](#).

Summary of Selected Provisions of Final Rule

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

One of the only new consumer protections proposed by CMS was to expand current SEP rights to change MA plans following provider terminations, but CMS did not finalize it. Without further explanation, 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” (p. 17387).

2. MA Supplemental Benefits

CMS finalized a number of changes relating to supplemental benefits offered by MA plans, including:

- Rescind Mid-Year Supplemental Benefits Notice – due to concerns with underutilization of supplemental benefits, in 2024 CMS proposed to require MA plans to issue mid-year personalized notices to plan enrollees that would include details about unused benefits. CMS first suspended, and now rescinds this requirement.
- Administration of Supplemental Benefits Through Debit Cards – MA plans using debit cards to administer supplemental benefits must electronically link cards to plan-covered items and services through a real-time point-of-sale verification mechanism. Further, card use is limited to a specific plan year. CMS is not finalizing a proposed prohibition on marketing the dollar value of supplemental benefits
- Special Supplemental Benefits for the Chronically Ill (SSBCI) – CMS is codifying a requirement for MA plans to post their objective SSBCI eligibility requirements on their public-facing website.

3. Updating Third-Party Marketing Organizations (TPMO) Disclaimer Requirements – Removal of Reference to SHIPs

CMS finalized their proposal that TPMOs no longer need to reference State Health Insurance Assistance Programs (SHIPs) in their disclaimers. CMS provides no additional justification for this change beyond the thin reasoning in the proposed rule, which, as we noted in our [comments](#), completely ignored a number of relevant issues. These include : 1) ongoing marketing misconduct and financial incentives of agents and brokers, including the

fact that TPMOs don't have to sell all available plans in a given area; and 2) the value of SHIPs and their unbiased counseling compared to both agents/brokers and the shortcomings of 1-800-MEDICARE. As we noted in our comments to the proposed rule, "Should CMS proceed with this proposal, it would signal a clear capitulation to the insurance industry and a regrettable rollback of an important consumer protection."

4. Removing Rules on Time and Manner of Beneficiary Outreach

CMS finalized a number of changes to rules that restricted agent/broker activities; CMS characterized these changes in the above-referenced press release as being "designed to improve the enrollment decision-making process by creating a more convenient, beneficiary-friendly outreach experience and to reduce the burden on beneficiaries, plans, and agents/brokers." To the contrary, as discussed at length in our [comments](#) to the proposed rule, these changes are far more advantageous to insurers, agents and brokers and remove important consumer protections meant to address marketing misconduct.

- Marketing Events Following Educational Events in Same Location – the Medicare statute requires "educational" vs. "marketing" events to be distinct. CMS has now removed the previous 12-hour delay requirement between educational and marketing events. Agents/brokers can now hold such events back-to-back, increasing the risk that individuals merely seeking information will be subject to high-pressure sales tactics. In response to concerns about marketing abuses raised in the comments, and in contrast to previous statements, the agency implausibly asserts that "CMS believes that such instances of plan marketing violations and negative beneficiary enrollment experiences that commenters describe are rare, as CMS does not often receive reports or complaints in this area" (p. 17453).
- Timing of Personal Marketing Appointment After Scope of Appointment (SOA) Form Completion (p. 17454) – CMS eliminates the 48-hour waiting period between collection of an SOA form and a subsequent marketing appointment ("cooling off" period). Among CMS' provided rationale is that "[t]here is often a built-in layer of added protection from any potential undue pressure, as evidenced by the tendency for vulnerable beneficiaries to have other people help them with plan options and making decisions" which does not account for individuals who do not have other people to help them.
- Scope of Appointment (SOA) Forms at Educational Events (p. 17459) – CMS has lifted the prohibition on collecting SOAs at educational events, which contradicts the agency's own prior rationale for reinstating this prohibition, including that educational events are "meant to provide generic information about the different options, rather than to persuade beneficiaries to enroll in any type of plan" (see, e.g., 2024 proposed rule).

5. 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, and providing access to foreign language interpreters and Deaf communication access. CMS did add a new MA depression screening and measure to address behavioral health gaps, to be reflected in the 2029 star ratings.

As noted in a recent article published by *Healthcare Dive* titled “[CMS finalizes Medicare Advantage star ratings overhaul, sending billions of dollars more to insurers](#)” by Rebecca Pifer Parduhn (April 3, 2026), CMS’ overhaul of the MA star ratings system is “expected to significantly boost insurers’ ratings — and the reimbursement that’s attached.” The article notes that such “changes are expected to cost taxpayers more than \$18 billion over the next decade, according to an analysis in the final rule.”

6. Rescission of various measures aimed at addressing health disparities and improving health equity

As noted in the *Healthcare Dive* article referenced above, “[t]he final rule also undoes key health equity changes to the MA program enacted by the Biden administration, as the Trump administration continues to target diversity, equity and inclusion initiatives.”

CMS’ press release announcing changes in the final rule state that the agency “is finalizing several changes to remove duplicative and burdensome regulatory requirements that have limited beneficiary choice, hindered innovation and increased costs: [including ...]

- Eliminating the requirement for MA quality improvement programs to include activities that reduce health disparities. [... and]
- Eliminating health equity requirements for MA Utilization Management Committees, including requiring a health equity expert member, conducting annual health equity analyses, and publicly posting these analyses.”

Conclusion

Despite tough talk about reining in Medicare Advantage payment and boosting oversight of plans, CMS has bowed to industry pressure and is backtracking on even modest adjustments to overpayments and is making it easier for plans and those who sell them to improperly target and influence beneficiaries through unbridled marketing.

As aptly summarized in a *STAT News* article titled “[Trump promised to clamp down on health insurers. His policies are enriching them](#)” by Bob Herman (April 9, 2026):

President Trump and his health leaders have repeatedly directed their ire toward health insurance companies, painting them as fat cats that need to be reined in.

But almost every major decision Trump officials have made since reclaiming the White House has benefitted insurers and their bottom lines.

The Medicare Advantage program needs more oversight, not less, and policy decisions should be driven by what is best for Medicare beneficiaries and the Medicare program, not the interests of insurance companies, their shareholders and those who sell their products.

April 9, 2026 – D. Lipschutz