What's New for Medicare in 2026?

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In 2026, there will be changes to Medicare prescription drug costs, Medicare eligibility for noncitizens, telehealth coverage, Special Enrollment Period opportunities, and Parts A, B, and D Medicare costs. There will also be a limited demonstration project on prior authorization.

Drug price negotiation

The Inflation Reduction Act (IRA) of 2022 created the ability for Medicare to negotiate prices for the most expensive drugs the program covers. The first set of negotiated drug prices, which will go into effect in 2026, is estimated to save $1.5 billion in annual out-of-pocket costs for Medicare beneficiaries while saving the Medicare program $6 billion per year. The negotiated prices are a minimum of 38% off the 2023 list price.

Drugs selected for negotiation must be brand-name drugs that don't have competition and must be among those that drive the highest Medicare spending. These are the 10 drugs for 2026:

- Eliquis
- Jardiance
- Xarelto
- Januvia
- Farxiga
- Entresto
- Enbrel
- Imbruvica
- Stelara
- NovoLog

These medications treat serious chronic illnesses like cancer, diabetes, blood clots, heart failure, autoimmune conditions, and chronic kidney disease.

All eligible Medicare beneficiaries will have access to these prices and new drugs will be added to the negotiated list each year. The next set of negotiated prices, for 15 additional drugs including popular diabetes drugs like Ozempic, will go into effect in 2027.

Note that Medicare is negotiating the total price for the drug, not the amount beneficiaries pay as a copay or coinsurance. It is likely, but not guaranteed, that beneficiaries will see savings, but the amount will depend on the structure of their specific Part D plan.

Medicare eligibility for noncitizens

Due to the One Big Beautiful Bill Act (OBBBA), there are new eligibility restrictions for lawfully present immigrants. Before the OBBBA, noncitizens with legal immigration statuses were eligible for Medicare if they:

- Qualified to receive Social Security retirement benefits, Social Security Disability Insurance, or Railroad Retirement Benefits
- OR were lawful residents age 65 and older and lived continuously in the United States for five years

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OBBBA made Medicare eligibility changes for some immigrants. Eligibility for Social Security retirement benefits, Social Security Disability Insurance, or Railroad Retirement Benefits is no longer sufficient for Medicare eligibility without consideration of immigration status.

There is no change for (meaning these groups will maintain their Medicare eligibility):

- Lawful permanent residents (green card holders)
- Certain immigrants from Cuba or Haiti
- Certain immigrants from the Compact of Free Association (COFA) states

All other immigrants with qualifying Social Security quarters, including refugees, asylees, and victims of abuse or trafficking, will lose Medicare coverage. The Congressional Budget Office estimates that this affects 100,000 individuals nationally.

This change is effective immediately for people not yet enrolled. Those who are already enrolled will be disenrolled within 18 months of passage (by January 4, 2027). The Social Security Administration is required to identify current beneficiaries who will be disenrolled.

Telehealth

Before the COVID-19 public health emergency (PHE), Medicare telehealth coverage was limited. For example, telehealth services were:

- Generally only covered in rural areas, and beneficiaries would still have to go to a specific "originating site" (often a different medical office or clinic) to receive the telehealth
- Generally only covered if provided via interactive, two-way audio and video technology
- Limited to certain providers, such as physicians and nurse practitioners

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During the PHE, telehealth coverage was temporarily expanded to include more flexibilities and allow more people to receive care from their homes. These flexibilities have been extended through January 30, 2026.

Through January 30, 2026, telehealth services are:

- Covered for all beneficiaries in any geographic area, at home in addition to health care settings
- Sometimes delivered using audio only
- Provided by any health care professional who is eligible to bill Medicare

After January 30, 2026, most telehealth services will again be more limited unless Congress acts. For now, only some of the broader telehealth coverage has been made permanent.

After January 30, 2026, telehealth services will likely be:

- Still available regardless of geographic area for certain types of care
    - For example: Behavioral/mental health care, monthly End-Stage Renal Disease (ESRD) visits for home dialysis, diabetes self-management training, and Medicare nutrition therapy
- Still able to be delivered using audio-only communication platforms for behavioral/mental health care
- Subject to pre-PHE restrictions for other types of care

Temporary Special Enrollment Period (SEP)

There is a new, temporary SEP for Incorrect Medicare Plan Finder Medicare Advantage (MA) Provider Directory Information. In fall 2025, the Medicare Plan Finder incorporated provider directory information to help beneficiaries when comparing MA plans. This new, temporary SEP is for any beneficiary who relied on inaccurate provider directory information during the first year of the Medicare Plan Finder provider directory and, within three months of the effective date of that coverage, discovered that the directory information was inaccurate and their preferred provider is not in the plan's network.

Medicare will grant an SEP to beneficiaries who:

- Used the Medicare Plan Finder provider directory information to select an MA plan
- Enrolled in that plan through Medicare Plan Finder
- And, within three months of the effective date of the plan, realized that their preferred provider is not in the plan's network

To use this SEP, a beneficiary will need to call 1-800-MEDICARE (633-4227) so that a Medicare

representative can confirm that the enrollment happened directly through Medicare Plan Finder and then make the requested enrollment change. Beneficiaries can choose to enroll in a different Medicare Advantage plan or switch to Original Medicare with or without a Part D plan. The requested change will be effective the first day of the following month, not retroactively.

This SEP is temporary and only for beneficiaries with Medicare Advantage plan effective dates of January 1, 2026, through December 1, 2026.

Limited demonstration project: Original Medicare and prior authorization

There is no change to Medicare coverage or payment policy for 2026, and for the most part, Original Medicare services will not be subject to new prior authorization in 2026. However, there is a Centers for Medicare & Medicaid Services (CMS) demonstration program that will test prior authorization for certain services only and in certain states only.

The Wasteful and Inappropriate Service Reduction (WISeR) Model plans to introduce new prior authorization for some Medicare services. It aims to use technologies like artificial intelligence and machine learning, along with clinician review, to review the medical necessity of Medicare services identified by the administration as being frequently inappropriately provided, dangerous, or both. The WISeR Model begins on January 1, 2026, and runs

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for six years, through December 31, 2031. The model runs in the following states: New Jersey, Ohio, Oklahoma, Texas, Arizona, and Washington. The model only applies to select items and services for the initial year of implementation (subject to change):

- Stimulator services
  - Electrical nerve stimulators
  - Sacral nerve stimulation for urinary incontinence
  - Phrenic nerve stimulator
  - Deep brain stimulation for essential tremor and Parkinson's disease
  - Vagus nerve stimulation
- Induced lesions of nerve tracts
- Epidural steroid injections for pain management
- Percutaneous vertebral augmentation (PVA) for vertebral compression fracture (VCF)
- Cervical fusion
- Arthroscopic lavage and arthroscopic debridement for the osteoarthritic knee
- Hypoglossal nerve stimulation for obstructive sleep apnea
- Incontinence control devices
- Diagnosis and treatment of impotence
- Percutaneous image-guided lumbar decompression for lumbar spinal stenosis
- Skin and tissue substitutes
  - Application of bioengineered skin substitutes to lower extremity chronic non-healing wounds
  - Wound application of cellular and/or tissue-based products (CTPs), lower extremities

Medicare Part A, Part B, and Part D costs in 2026

In November, CMS announced the following changes to Medicare costs in the coming year:

Original Medicare Part A (hospital insurance)

- Premium for those with 40+ working quarters: $0/month
- Premium for those with between 30 and 39 working quarters: $311/month
- Premium for those with fewer than 30 working quarters: $565/month
- Benefit period deductible: $1,736
- Hospital daily coinsurance for days 61 to 90: $434/day
- Hospital daily coinsurance for 60 lifetime reserve days: $868/day
- Skilled nursing facility (SNF) daily coinsurance for days 21 to 100: $217/day

Original Medicare Part B (medical insurance)

- Premium: $202.90/month
  - All beneficiaries are responsible for the Part B premium, even if they are enrolled in an MA plan.
- Annual deductible: $283

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Medicare Part D (prescription drug benefit)

- National base premium: $38.99/month
- Annual deductible: No more than $615
- Catastrophic coverage phase: Begins after $2,100 in out-of-pocket costs for covered Part D drugs

MA plans may charge a premium in addition to the Part B premium and can have different cost sharing than Original Medicare.

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