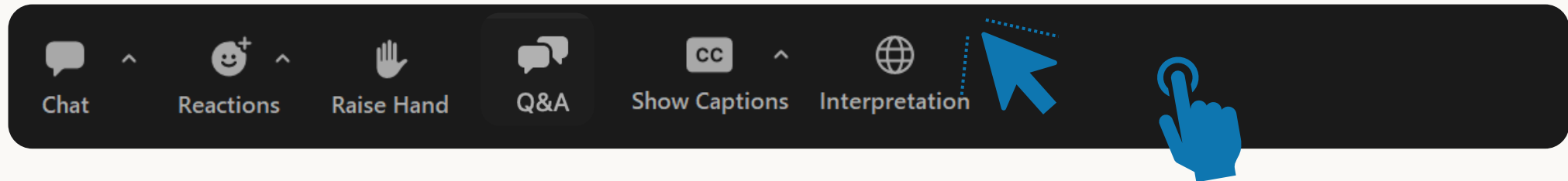


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and respectful tone.*



**SHIP**

State Health Insurance  
Assistance Program

# What's New for Medicare in 2024

**Emily Whicheloe**, Medicare Rights Center Director of Education  
**Shea Corti**, Medicare Rights Center Coordinator of Education

January 4, 2024, 2:00 P.M. E.T.



# Welcome



**SHIP**

State Health Insurance  
Assistance Program  
Navigating Medicare



**SMP**

Senior Medicare Patrol  
Preventing Medicare Fraud



national council  
on aging

# Today's Speakers

## **Medicare Rights Center**

- **Emily Whicheloe**, Director of Education
- **Shea Corti**, Coordinator of Education



# Agenda

- Understand changes to Extra Help and the Part D catastrophic coverage phase
- Review telehealth flexibilities
- Become familiar with the Postal Service Health Benefits program
- Advise beneficiaries on opportunities to change coverage in 2024



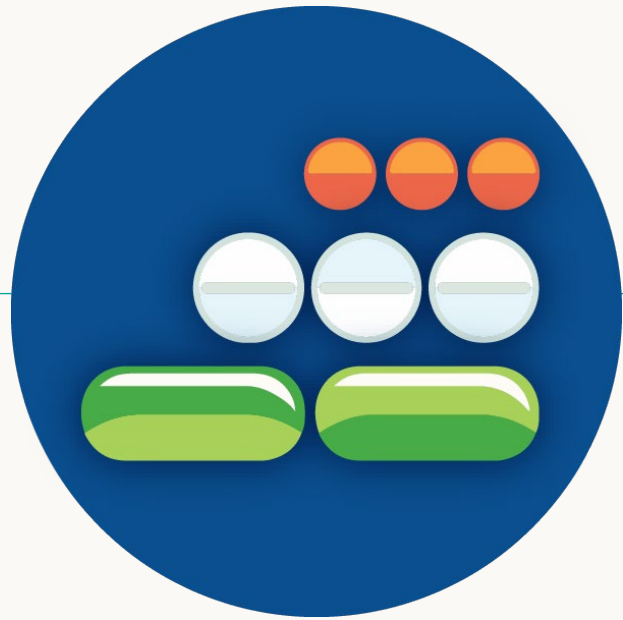
# Changes to Extra Help



# Extra Help

- Medicare drug cost assistance program administered by Social Security
- Also known as Low-Income Subsidy (LIS)
- Before 2024, Extra Help had two levels
  - Partial Extra Help: 135% - 150% federal poverty level (FPL)
  - Full Extra Help: Up to 135% FPL

# Extra Help



## 2024 changes

- In 2024, income eligibility for full Extra Help will be expanded to 150% FPL
  - Limit was previously 135% FPL
- Partial Extra Help will be eliminated
  - Anyone previously eligible for partial Extra Help will be entitled to the full benefit

# Full Extra Help eligibility in 2024

|               | Single        | Couple        |
|---------------|---------------|---------------|
| Income limits | \$1,843/month | \$2,485/month |
| Asset limits  | \$17,220      | \$34,360      |

**Reminder:** Until 2024 FPL is released, eligibility is based on 2023 income limits

# Extra Help costs in 2024

- **\$0 premium** in benchmark plans
- **\$0 deductible**
- **Copayments:** \$4.50 for generics and \$11.20 for brand names
  - For those with Medicaid and income below 100% FPL, copays are \$1.55 and \$4.60
  - Those who are institutionalized and/or who receive home and community-based services do not have prescription drug copays
- **No copay after reaching \$8,000 in out-of-pocket drug costs**

# Changes to Catastrophic Coverage

# Phases of Part D coverage

- During calendar year, beneficiary pays different amounts for covered drugs
- Four coverage phases
  - Deductible period
  - Initial coverage period
  - Coverage gap (or donut hole)
  - Catastrophic coverage

# Coverage gap

- Beneficiary enters coverage gap (also known as the donut hole) after they and their plan together have paid \$5,030 in drug costs
  - The donut hole closed for all drugs in 2020
  - In the past, individuals were responsible for a higher percentage of the cost of their drugs
- **Beneficiary's costs**
  - 25% of cost of covered drugs
- Extra Help beneficiaries do not have coverage gap

# Catastrophic coverage

- Beneficiary enters catastrophic coverage after spending \$8,000 out of pocket in 2024
- Out-of-pocket costs include:
  - Deductible
  - What beneficiary paid during initial coverage period
  - Almost the full cost of brand-name drugs (including the manufacturer's discount) purchased during the coverage gap
  - Amounts paid by others, including family members, most charities, and other persons on beneficiary's behalf
  - Amounts paid by State Pharmaceutical Assistance Programs (SPAPs), AIDS Drug Assistance Programs, and the Indian Health Service



# Catastrophic coverage costs



- Beneficiary's costs in 2023
  - 5% coinsurance, or copay of \$4.15 for generics and \$10.35 for brand-name drugs, whichever was greater
- Starting in **2024**, this 5% coinsurance is eliminated, and beneficiaries will have **\$0 cost-sharing**

In **2025**, annual out-of-pocket Part D costs will be capped at \$2,000

# Upcoming changes

# Drug price negotiation



- From **2026 onward**, the federal government will be required to negotiate prices for certain high-cost drugs
  - 2026: 10 Part D drugs
  - 2027: 15 Part D drugs
  - 2028: 15 Part B and Part D drugs
  - 2029: 20 Part B and Part D drugs

# Drugs for 2026

- Centers for Medicare & Medicaid Services (CMS) announced the first 10 Medicare Part D drugs that will be subject to negotiation under the Inflation Reduction Act (IRA)
- Price negotiations began between CMS and drug manufacturers in 2023
- CMS will publish final prices in fall 2024, and they will take effect in 2026

# Drugs for 2026

- In 2023, CMS announced the first 10 Medicare Part D drugs that will be subject to negotiation under the IRA

| Drug Name  | Commonly Treated Conditions  |
|--|--|
| Eliquis  | Prevention and treatment of blood clots  |
| Jardiance  | Diabetes; Heart failure  |
| Xarelto  | Prevention and treatment of blood clots; Reduction of risk for patients with coronary or peripheral artery disease |
| Januvia  | Diabetes   |
| Farxiga  | Diabetes; Heart failure; Chronic kidney disease  |
| Entresto   | Heart failure  |
| Enbrel   | Rheumatoid arthritis; Psoriasis; Psoriatic arthritis   |
| Imbruvica  | Blood cancers  |
| Stelara  | Psoriasis; Psoriatic arthritis; Crohn's disease; Ulcerative colitis  |
| Fiasp; Fiasp FlexTouch; Fiasp PenFill; NovoLog; NovoLog FlexPen; NovoLog PenFill | Diabetes   |

# Telehealth

# What is telehealth?



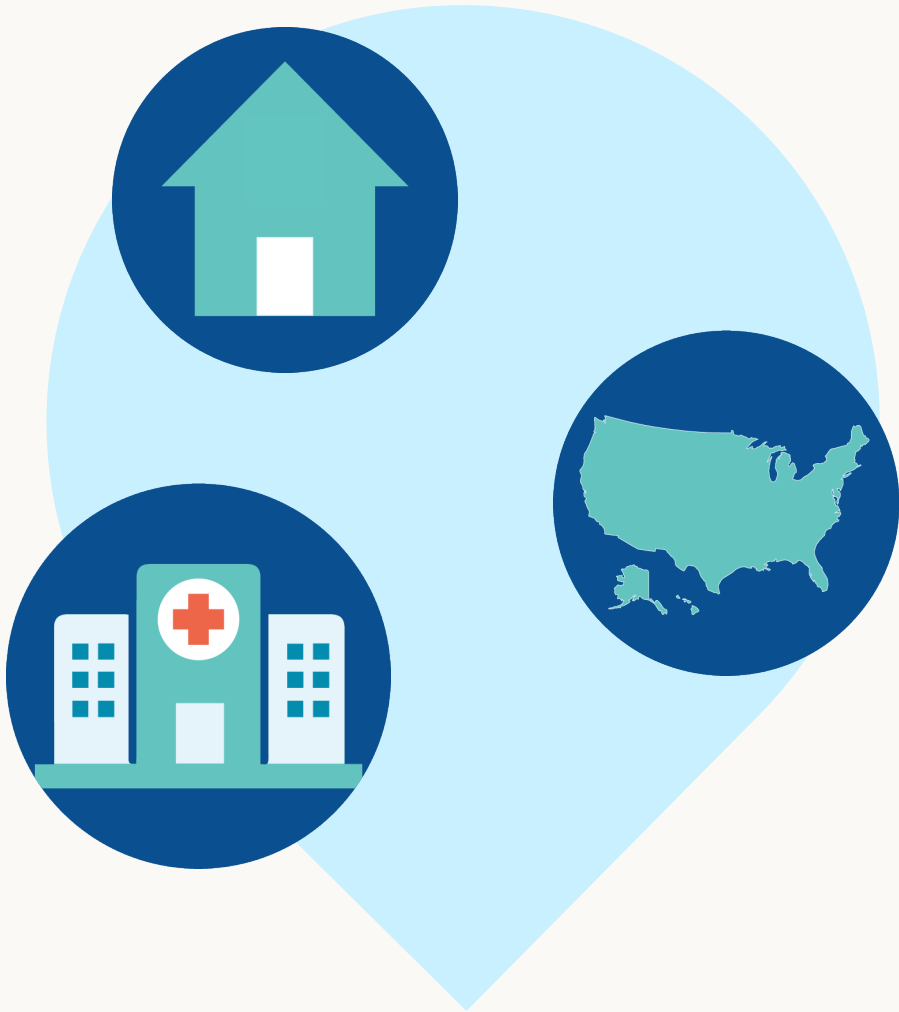
- Certain services that an individual receives from a health care provider outside of an in-person office visit
- A telehealth service is a full visit with a provider using telephone or video technology that allows for **both audio and video communication**
- Original Medicare expanded the list of covered telehealth services during the public health emergency (PHE)

# Locations

- Before the PHE, Original Medicare Part B covered telehealth in limited situations
- Beneficiaries could generally only access telehealth if they **lived in a rural area** and traveled from their home to a local medical facility to receive the services
- They had to be at an “**originating site**” in an eligible geographic area
  - Rural health professional shortage areas (HPSA)
  - Counties not classified as a metropolitan statistical area (MSA)



# Locations during PHE



- During the PHE, telehealth services were covered for all beneficiaries in **any geographic area**
- They could receive these **services at home** in addition to health care settings

# Technology requirements

- Before the PHE, Original Medicare required that telehealth visits be conducted with **interactive, two-way audio and video technology**
  - Must allow for real-time communication between the practitioner and the beneficiary at the originating site
- Only exception: federal telemedicine demonstration programs in Alaska and Hawaii
  - Beneficiaries could send medical information to a practitioner to review later without real-time interaction

# Technology requirements during PHE



- Beneficiaries were generally still required to use an interactive audio and video system that allowed for real-time communication with the provider
- Limited telehealth services could be delivered using **audio only**, via audio-only telephone or a smartphone without video
  - Counseling and therapy provided by an opioid treatment program
  - Behavioral health care services
  - Patient evaluation and management



# Practitioners

- During the PHE, **any health care professional that was eligible to bill Medicare** for professional services could provide and bill for telehealth services
- Included professionals who previously could not receive payment for Medicare telehealth services
  - Physical therapists
  - Occupational therapists
  - Speech language pathologists



# Costs

- Cost-sharing for telehealth did not change during the PHE
  - Original Medicare: Part B deductible and Part B 20% coinsurance
  - Medicare Advantage: Cost varied by plan
- Providers could choose to reduce or waive cost-sharing for telehealth visits
  - Providers usually cannot routinely waive cost-sharing, but the Department of Health and Human Services (HHS) provided this flexibility

# Telehealth after the PHE

- PHE-related telehealth flexibilities have been extended through **December 31, 2024**
  - Medicare beneficiaries can access telehealth in any geographic area, at home and in health care settings
  - Some limited telehealth services can be provided with audio only
  - All eligible Medicare providers can provide and bill for telehealth services
- After December 31, 2024, coverage for telehealth benefits may be more limited
  - Future changes will be determined by Congress and CMS

# **Access to Mental Health Care Services**



# Provider enrollment

- Providers must sign up to bill Medicare for services they provide to Medicare beneficiaries
- Three categories of providers:
  - Participating
  - Non-participating
  - Opt-out



# Types of providers

| Participating provider  | Non-participating provider   | Opt-out provider  |
|---|--|---|
| Accepts Medicare  | Accepts Medicare   | Does not accept Medicare  |
| Takes assignment –accepts Medicare’s approved amount for services as full payment | Does not agree to take assignment in all cases                                   | Signed an agreement to be excluded from the Medicare program  |
| Beneficiary pays 20% coinsurance for Medicare-covered Part B services             | Can bill up to 15% more than Medicare’s approved amount for the cost of services | Can charge whatever they want — must provide a private contract describing their charges and confirming that beneficiary understands they are responsible for the full cost of care |

# New in 2024

- Licensed Mental Health Counselors and Licensed Marriage and Family Therapists can enroll for the first time in Medicare and bill Part B directly for their services
- Intensive outpatient program (IOP) services can be billed and covered by Medicare in hospital outpatient departments, community mental health centers, RHCs, and FQHCs
  - IOP services may also be covered in OTPs for the treatment of opioid use disorder
- New CMS policies for Medicare Advantage Plans
  - Extend network adequacy requirements to mental health professionals, including Clinical Psychologists and Licensed Clinical Social Workers
  - Specify that emergency behavioral health services should not be subject to prior authorization

# **Postal Service Health Benefits (PSHB)**

# Postal Service Health Benefits (PSHB)

- The Office of Personnel Management (OPM), in conjunction with the Postal Service, will implement a new Postal Service Health Benefits (PSHB) Program
- PSHB is a separate program within the Federal Employees Health Benefits (FEHB) Program
- Coverage under the PSHB Program will be effective January 1, 2025

# Current Postal Service benefits

- Postal Service employees, retirees, and eligible family members currently participate in the FEHB Program
- Their FEHB enrollment will continue for the 2024 plan year

# Federal Employees Health Benefits (FEHB)

- FEHB is always primary during active employment
- Medicare is primary for retirees who enroll in Part B
  - FEHB is secondary and may cover Medicare cost-sharing
- FEHB pays primary for retirees who do not enroll in Part B
  - Some individuals choose to enroll in Part A because it is premium-free, but turn down Part B because of the monthly premium
  - If individual wants to enroll in Part B later, they may face the Part B premium penalty and coverage gaps



# PSHB enrollment

- Eligible Postal Service employees and retirees must enroll in a PSHB plan during the PSHB Program Open Season period: November 11, 2024 to December 9, 2024
- Those currently enrolled in FEHB plans who do not actively enroll in a new PSHB plan during Open Season in 2024 will be automatically enrolled in a PSHB plan
- PSHB plan options and premium information will be available in fall 2024

# PSHB and Part B

- PSHB Program requires certain retirees to enroll in Medicare Part B to continue PSHB coverage
- Retirees as of January 1, 2025 who did not enroll in Part B:
  - NOT required to enroll in Part B to continue coverage in PSHB
- Retirees as of January 1, 2025 who are already enrolled in Part B as of that date:
  - Required to remain enrolled in Part B to continue coverage in PSHB



# PSHB and Part B enrollment

- Retirees entitled to Part A as of January 1, 2024 who did not enroll in Part B may be able to participate in a Special Enrollment Period (SEP) for Part B that starts on April 1, 2024
  - Those who enroll during this SEP will not owe a late enrollment penalty
  - Eligibility letters will be sent to retirees and eligible family members in early 2024
- Those who retire between October 31, 2024 and December 31, 2024, and are entitled to Medicare Part A, will have the option to enroll in Part B using the Part B SEP for job-based insurance

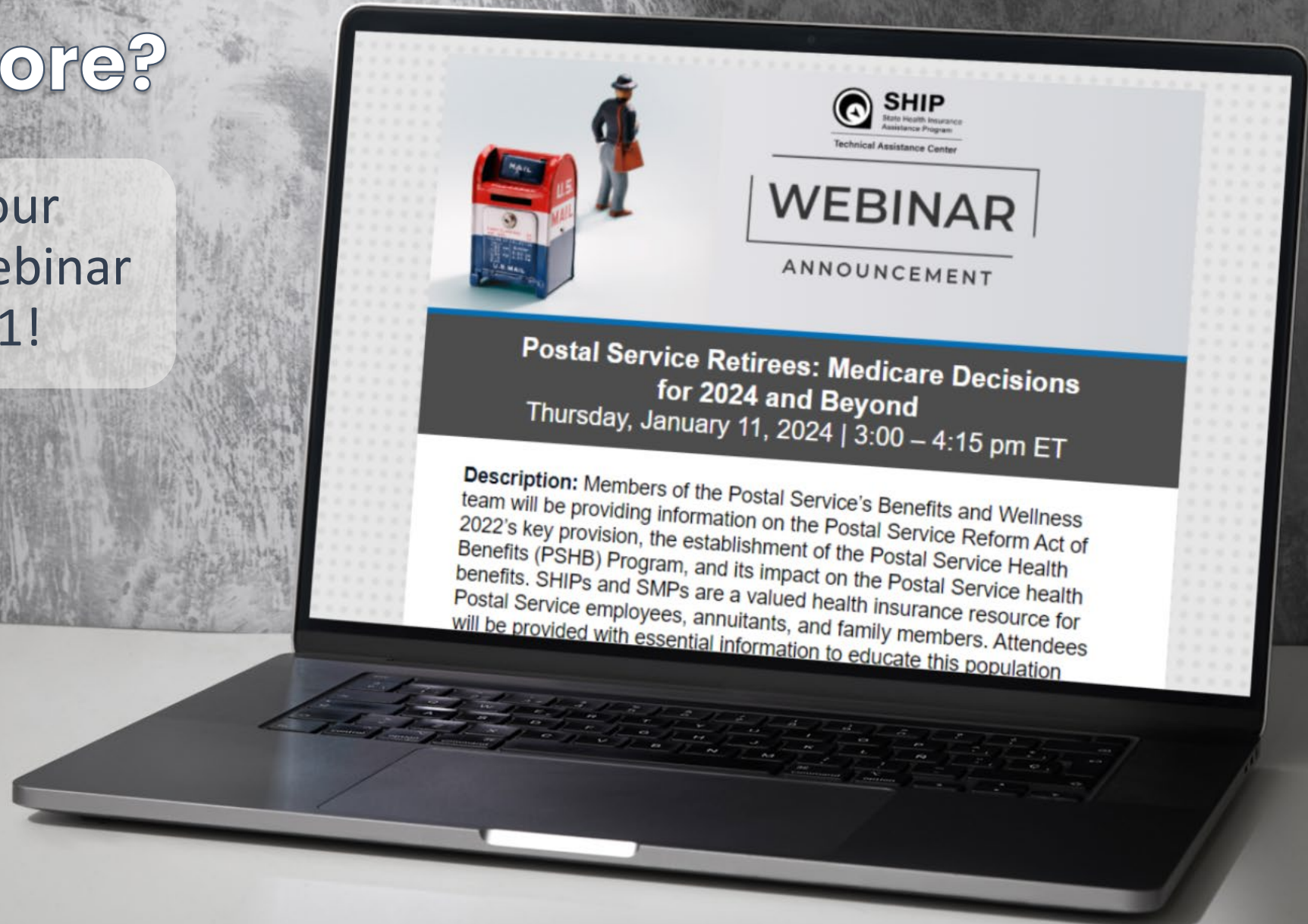
# PSHB for future retirees

- Individuals who become retirees after January 1, 2025 will be required to enroll in Part B once they are Medicare-eligible to continue participating in PSHB
- Exceptions to the Part B enrollment requirement
  - Individual was an active Postal Service employee as of January 1, 2025, and was at least 64 years old as of that date; or
  - Individual demonstrates that they reside outside the United States and its territories; or
  - Individual is enrolled in health care benefits provided by the Department of Veterans Affairs; or
  - Individual is eligible for health services provided by the Indian Health Service



# Want to learn more?

Register for our upcoming webinar on January 11!



# Annual Reminders

# Medicare Advantage Open Enrollment Period (MA OEP)



- **January 1 through March 31 each year**
- Beneficiaries enrolled in Medicare Advantage Plans may make one change:
  - Switch between MA Plans
  - Or, switch to Original Medicare with or without Part D
- Change is effective first of the following month

# Part D and MA Plan Special Enrollment Periods

- CMS can grant an SEP on case-by-case basis for those who have experienced exceptional circumstances related to MA or Part D plan enrollment
- Situations may include:
  - Beneficiary's enrollment in a plan was based on misleading or incorrect information provided by plan representative or SHIP counselor
  - Beneficiary was enrolled in a plan without their knowledge or consent
- Contact 1-800-MEDICARE to use SEP
  - Beneficiary generally does not need to provide evidence beyond their own statement about what happened, but keeping track of who they spoke to and when can help



# Transition fills

- One-time 30-day supply of a drug someone currently takes
- Available to:
  - A person whose new plan doesn't cover a drug, or has restrictions
  - A person whose current plan no longer covers a drug in 2024, or has drug restrictions
- Generally, must be used within the first 90 days of the plan year
- Within 3 days of using transition fill, plan must send notice explaining that after transition fill the drug will not be covered or will be covered with restrictions

# Exception requests

- Formal, written request to a Part D plan asking that it pay for a drug that is not on its formulary or asking it to lower the price of a drug
- At the beginning of the year, exception requests may be expiring
- Beneficiaries should ask their doctor to write a letter of support explaining:
  - Why they need the drug
  - How other medications to treat the same condition are dangerous or less effective
- If an exception request is denied, beneficiaries can file an appeal



# Medicare Costs in 2024

# Part A costs

| Part A                                     |   |
|--|---|
| Part A premium                             | \$0/month for those with 10+ years (40 quarters) of work history<br>\$278/month for those with 7.5-10 years (30-39 quarters) of work history<br>\$505/month for those with fewer than 7.5 years (30 quarters) of work history |
| Hospital deductible                        | \$1,632 each benefit period   |
| Hospital coinsurance                       | \$408/day for days 61-90 each benefit period<br>\$816/day for days 91-150 (non-renewable lifetime reserve days)   |
| Skilled nursing facility (SNF) coinsurance | \$204/day for days 21-100 each benefit period   |

# Part B and Part D costs

## Part B

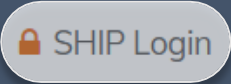
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| Annual deductible        | \$240    |
| Standard monthly premium | \$174.70 |

## Part D

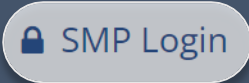
|                        |  |
|------------------------|--|
| Base premium           | \$34.70                                  |
| Maximum deductible     | \$545                                    |
| Initial coverage limit | \$5,030                                  |
| Coverage gap           | 25% cost of generic and brand-name drugs |
| Catastrophic coverage  | \$8,000                                  |

# Webinar Resources in the Libraries



1. Login at  [www.shiphelp.org](http://www.shiphelp.org)
2. Go to the Resource Library
3. Search for keyword “what’s new.”



1. Login at  [smpresource.org](http://smpresource.org)
2. Search for keyword “**what’s** new”.



1. Resources will be emailed to NCOA’s MIPPA listserv.

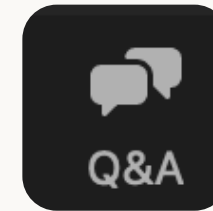
# Questions?

- Thank you for participating in today's webinar!
- Today's presentation is available for download in the Zoom chat.
- If you have questions later,

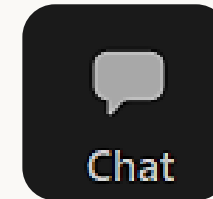
 [medicarehelp@shiptacenter.org](mailto:medicarehelp@shiptacenter.org)

 [info@smpresource.org](mailto:info@smpresource.org)

 [centerforbenefits@ncoa.org](mailto:centerforbenefits@ncoa.org)



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