2023 Changes to Medicare

This fact sheet provides an overview of the changes to Original Medicare enrollment, Medicare Advantage, and Part D plans that will impact Medicare beneficiaries beginning January 1, 2023.

Please be advised that this fact sheet is based on current Centers for Medicare & Medicaid Services (CMS) guidance, which is subject to additional rule revisions. NCOA will update this fact sheet in accordance with revised or new regulations. Please contact ann.kayrish@ncoa.org with any updates or questions.

Changes to Parts A & B Enrollment

Beginning in 2023, Part B coverage will begin earlier for individuals first signing up for Medicare.

Individuals have a seven-month Initial Enrollment Period (IEP) window upon turning age 65 to first join Medicare. Those who sign up in the last two months of that window will have their coverage begin the first day of the month following the month of enrollment. This change only applies to people who become eligible for Medicare on January 1, 2023, and after.

Individuals who use the Medicare General Enrollment Period (GEP, running January 1 through March 31 each year) also will have an earlier start date for coverage. Beginning in January 2023, the Consolidated Appropriations Act (CAA) changes the effective date for enrollment into Medicare Parts A and B in the GEP from July 1 to the month following the month of enrollment.

Beneficiary concerns: The CAA did not amend the Part D Special Enrollment Period (SEP) associated with the GEP. Therefore, clients using the GEP may still have a delay in Part D enrollment, and associated late penalties. NCOA continues to monitor this issue with CMS.

Currently (through 2022), individuals enrolling in Medicare during the last two months of their IEP would wait 2-3 months after enrollment for coverage to begin. Those using the GEP would have coverage starting July 1.

Several new Special Enrollment Periods (SEPs) will provide relief to those who missed a Medicare enrollment period due to exceptional circumstances.

A CMS final rule issued in October 2022 expands Medicare SEPs to advance health equity and provide relief for individuals facing unique circumstances that affect their ability to first enroll in Medicare during their IEP. Starting in 2023, people who qualify for a Part B exceptional circumstances SEP can enroll without having to wait for the GEP and without being subject to a Part B late enrollment penalty. These new SEPs are applicable to:

- Persons impacted by a disaster or government-declared emergency
- Those whose employer or health plan materially misrepresented information related to timely enrollment in Medicare Part B
- Individuals leaving incarceration
- Those whose Medicaid coverage was terminated after the COVID-19 PHE ends or on or after January 1, 2023 (whichever is earlier)

The SEP for formerly incarcerated individuals to enroll in Medicare following their release from a correctional facility runs for 12 months post-release and allows qualifying individuals to choose between retroactive coverage going back to their release date (not to exceed six months and for which premium payments would be owed) or coverage beginning the month after they enroll. The SEP would not offer relief to individuals released from a correctional facility more than 12 months ago.

Beneficiary concerns: Beneficiaries may not be familiar with the new exceptional circumstances SEPs and the ability to enroll into Medicare Part A and B without waiting for a GEP and be subject to a late enrollment penalty.

Previously, special enrollment into Parts A & B was limited to those losing health coverage through active employment (self/spouse).

Changes to Medicare Part D

Medicare beneficiaries will see a cap on insulin costs under Part D.

The Inflation Reduction Act (IRA) of 2022 contains several provisions aimed at limiting rising drug prices. Beginning January 1, 2023, all Medicare plan copayments for each insulin product (listed on the plan's formulary) will be capped at $35 for a month supply. An insulin product refers to one of the following:

- A product that contains insulin
- A combination of products that contains more than one type of insulin
- A combination of products that contains both insulin and a non-insulin drug or biological product

A "covered insulin product" falls into one of three categories:

- Insulin products included on the plan's formulary
- Products treated as on formulary due to a coverage determination or appeal
- Products covered as a "transition fill"

Beneficiary concerns: The maximum $35 cap applies for a 30-day supply of each insulin product purchased during all phases of the Part D benefit If a client obtains one short-acting, one intermediate-acting, and one long-acting insulin product during the month then three separate maximum $35 copays apply. Only the $35 (or less) cost-sharing for a month's supply of each insulin product counts toward true out-of-pocket costs. NCOA continues to seek clarification from CMS as to whether a plan's quantity limits can restrict the amount of insulin a beneficiary can receive under the $35 cap/30-day supply provision. Because of the timing of the passage of legislation, Medicare Plan Finder does not reflect the insulin cost cap when running a plan comparison.

In 2022, only Medicare plans participating in the Senior Savings Model offered a $35 cap on insulin products, during the deductible, initial coverage and coverage gap portion of the Part D drug benefit.

A new exceptional circumstances SEP is available to those who wish to change Part D plans due to insulin coverage issues.

In recognition that the Medicare Plan Finder does not currently reflect the $35 insulin cap for the 2023 plan year, CMS has created a Special Enrollment Period for individuals who take insulin and wish to change Part D plans. Anyone interested in using the insulin in exceptional circumstance SEP should contact 1-800-MEDICARE beginning December 8, 2022. This SEP will allow an individual who uses a covered insulin product to add, drop, or change their Part D coverage beginning on December 8th, 2022, and ending on December 31, 2023.

Beneficiary concerns: Beneficiaries may be confused by insulin cost as displayed on Plan Finder and likely unfamiliar with the one-time SEP. Additionally, beneficiaries may be dismayed to learn that they must call 1-800-MEDICARE to take advantage of this SEP.

Drug rebates and first 10 drugs to be selected for negotiation

Starting January 1, 2023, the IRA will require drug manufacturers to pay rebates to Medicare if they increase list prices for drugs paid for under Medicare Part B or Part D faster than the rate of inflation. Manufacturers will have to pay Medicare the above-inflation amount. Parts B and D drugs subject to rebates are those with annual costs per individual ≥$100. Part B does not, however, apply the rebate rule to COVID-19, flu, hepatitis B, and pneumococcal vaccines.

Manufacturers that fail to pay the rebate will be subject to civil monetary penalties. The rebates are modeled after those employed by Medicaid, so CMS already has significant experience operationalizing these types of rebates.

Beneficiary concerns: The rebates are designed to discourage drug manufacturers from increasing drug prices faster than inflation, which should help reduce drug plan premiums and out-of-pocket costs for Medicare beneficiaries

On a related note: Beginning in 2026, the IRA will also allow Medicare to negotiate the price for 10 Part D drugs. This marks the first time Medicare will be authorized to negotiate drug prices with manufacturers. Part B negotiated prices will not be effective until 2028.

CMS is expected to publish by September 1,2023 the list of the first 10 Part D drugs that prices will be subject to price negotiation in 2026.

New Part B benefit for kidney transplant recipients allows Part B for life (to cover immunosuppressants)

Beginning January 1, 2023, Medicare will cover the cost of immunosuppressive drugs for individuals who receive a kidney transplant and are no longer eligible for End Stage Renal Disease (ESRD) Medicare Parts A and B. The new benefit ensures that the loss of Medicare A and B eligibility does not result in a loss of access to essential drugs when alternative insurance is not available. Eligible individuals can apply for the benefit beginning October 1, 2022. More information on the Part B-ID benefit and the application process can be found at the link provided.

Beneficiary concerns: The monthly premium for the Part B-ID benefit is $97.10 in 2023 and the annual deductible is $226. Once the deductible is met, beneficiaries will pay 20% of the Medicare-approved amount for immunosuppressive drugs. To sign up for the Part B-IB benefit, beneficiaries should call Social Security at 1-877-465-0355. This is a special phone number just for this program. TTY users can call the general line at 1-800-325-0778.

Currently, beneficiaries eligible for Medicare coverage based solely on an ESRD diagnosis lose Medicare coverage 36 months following a transplant.

Vaccines covered under Part D (and Medicare Advantage plans with prescription drug coverage) will be available with no cost-sharing.

Starting January 1, 2023, adult vaccines recommended by the Advisory Committee on Immunization Practices will be available with no deductible and no cost-sharing to people with Medicare prescription drug coverage. These vaccines include:

- Shingles vaccine
- TDAP (tetanus, diphtheria, and pertussis) booster

Other vaccines (pneumococcal, influenza, COVID-19, and, under certain circumstances, hepatitis B vaccines) are covered under Part B with no cost-sharing.

Beneficiary concerns: The elimination of the copayment for Part D vaccines removes a barrier to this Medicare-covered preventive benefit, making it accessible to more beneficiaries.

Currently, beneficiaries may be subject to a copayment for some Medicare Part D covered vaccines.

Expanded coverage of medically necessary dental care and colorectal cancer screening

Beginning in 2023, traditional Medicare will expand its coverage of "medically necessary" oral and dental treatment that is directly related to Medicare-covered primary procedures or services that cannot proceed, would be delayed, or would be otherwise negatively compromised but for resolution of an oral disease or condition. For the oral health service to be covered under traditional Medicare, it must occur prior to, be inextricably related and integral to the Medicare-covered organ transplant surgery, cardiac valve replacement, and valvuloplasty procedures. Medically necessary oral and dental treatment directly related to head and neck cancer treatments will be added in 2024.

Wishing to provide greater clarity, CMS codified for the first time the following previously covered oral health services, which will provide greater legal guarantees for beneficiaries: 1) oral examinations relating to renal transplantation; 2) dental splits for covered treatment of certain medical conditions; 3) the extraction of teeth prior to radiation treatment of neoplastic disease; 4) the reduction of jaw fractures; and 5) the coverage for the wiring of teeth related to covered medical services.

Also beginning in January, Medicare will expand coverage of colorectal cancer screening services to those 45 years and older. Also, CMS will cover a complete colorectal screening if a

previous, non-invasive stool test returns a positive result. Cost-sharing will not apply to the initial stool test or the subsequent colonoscopy.

Beneficiary concerns: Beneficiaries should work with their Medicare provider to ensure that the services and screenings they are seeking are included under Medicare's expanded benefit provisions.

Coverage of certain audiology services without a prerequisite family physician referral

Beginning in 2023, Medicare will cover a visit to an audiologist without a referral from a physician if the hearing loss or balance issue has been there for 12 or more months. For these qualifying patients, Medicare will cover the audiology visit once every 12 or more months. The services this change will apply to are: 1) prescribing, fitting, or adjusting hearing aids; 2) receiving hearing aids; and 3) any hearing assessment unrelated to symptoms of disequilibrium. Regarding the latter service's scope, CMS believes a physician needs to first evaluate any patient that is experiencing disequilibrium.

Beneficiary concerns: Beneficiaries are reminded that Original Medicare does not cover hearing aids or exams for fitting hearing aids.

Currently, Medicare covers audiologic evaluations when ordered by physician, nurse practitioner or physician's assistant to inform the physician's diagnosis and medical treatment of hearing deficit and/or related medical problems.

Resources

CMS, FAQ: Reduced Drug Prices, Enhanced Medicare Benefits Under the Inflation Reduction Act Frequently Asked Questions (FAQs): https://www.cms.gov/files/document/10522-external-faqs-about-inflation-reduction-act.pdf

National Kidney Foundation, FAQ. Expanded Medicare Coverage of Immunosuppressive Drugs for Kidney Transplant Recipients: https://www.kidney.org/atoz/content/faq-expanded-medicare-coverage-immunosuppressive-drugs-kidney-transplant-recipients

CMS, news release. Calendar Year (CY) 2023 Medicare Physician Fee Schedule Final Rule: https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2023-medicare-physician-fee-schedule-final-rule

Kaiser Family Foundation: https://www.kff.org/medicare/issue-brief/explaining-the-prescription-drug-provisions-in-the-inflation-reduction-act

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