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Reactions

Raise Hand

Q&A

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Interpretation

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- **Chat:** Watch for information and resources from the event hosts. Chat technical issues to all panelists.
- **Reactions:** Click the button to react to the presentation. Click the arrow to change reaction intensity or hide reactions shared by others.
- **Raise Hand:** All participants' lines are muted during today's webinar. During the Q&A session, raise your hand if you want the host to unmute you.
- **Q&A:** During the Q&A session, send questions for panelists.
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Questions?

Q&A

Use **Q&A** for subject-matter questions.

Chat

Use **Chat** for technical support or resource questions.

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Reminder

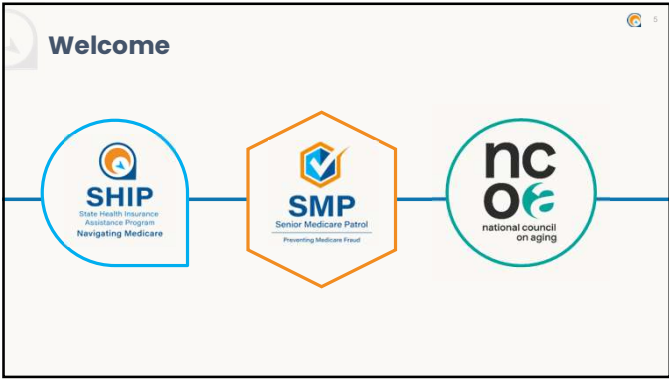
Please speak clearly and avoid using inappropriate language. Maintain a polite and respectful tone.

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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



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Changes to Extra Help

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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

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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

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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

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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

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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


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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


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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

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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

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Upcoming changes


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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

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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

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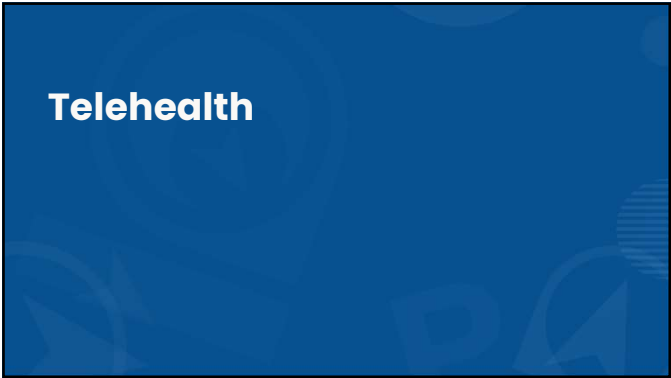


Drugs for 2026

- 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
Faniga	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

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A circular icon with a blue background. Inside, a white silhouette of a doctor in a white coat with a stethoscope is shown on a computer monitor. A small green square with a white plus sign is in the top right corner of the monitor.

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)

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A circular icon with a blue background. Inside, a white location pin is shown on a map. A small green square with a white plus sign is in the top right corner of the map.




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)

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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

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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

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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

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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

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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

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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

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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

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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

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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



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Postal Service Health Benefits (PSHB)

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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



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Current Postal Service benefits


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

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Federal Employees Health Benefits (FEHB)

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- 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

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PSHB enrollment

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- 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

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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




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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




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PSHB for future retirees

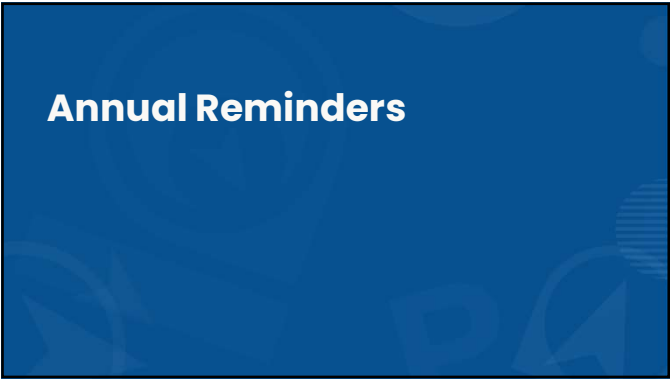
- Individuals who become retirees after January 1, 2025 will be required to enroll in Part B once they are Medicare-eligible to continue participating in PSHB
- Exceptions to the Part B enrollment requirement
 - Individual was an active Postal Service employee as of January 1, 2025, and was at least 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




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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

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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


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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


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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

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Medicare Costs in 2024

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Part A costs

Part A	
Part A premium	\$0/month for those with 10+ years (40 quarters) of work history \$278/month for those with 7.5-10 years (30-39 quarters) of work history \$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 \$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


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Part B and Part D costs


Part B	
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


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
Webinar Resources in the Libraries






1. Login at  www.shiphelp.org
2. Go to the Resource Library
3. Search for keyword "what's new."




1. Login at  smpresource.org
2. Search for keyword "what's new."






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


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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,

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Use **Q&A** for subject-matter questions.



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