Medicare in 2024:

Promises vs. REALITY

Diane J. Omdahl, RN, MS

Promises vs. REALITY

Medicare Advantage

- Marketing
- Prior authorization and final rule
- Physicians and networks
- Supplemental benefits

Promises vs. REALITY

Inflation Reduction Initiatives

- Inflation rebates
- Drug price negotiation
- $2,000 Part D drug plan cap
- Medicare Prescription Payment Program
- Part D Premium Stabilization
- Part D Premium Stabilization Demonstration
- $2,000 cap and employer drug coverage

Promises vs. REALITY

Medicare Advantage Marketing

Open Enrollment 2022
643,852 commercials
9,500 per day
92% focused on extra benefits
21,024 did not identify the sponsoring organization

In 2023, the rules changed
Ads must now be approved
CMS rejected over 1,000 ads in eight months —
300 right before the Open Enrollment Period

Commercials now:
Cannot use a Medicare-like card
Must include insurer name and plans they sell

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Promises vs. REALITY

Prior Authorization

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Medicare Advantage plans use various medical management and care coordination tools to ensure beneficiaries receive the most clinically appropriate and cost-effective care. A commonly used tool is prior authorization, in which the beneficiary's health care provider works with the health plan to make certain a treatment or service is the best option for the needs of the individual patient. It works to guarantee the most appropriate option available is used and that it will be covered by the health plan. Prior authorization promotes better, smarter health care delivery and protects seniors from unnecessary services and unexpected medical bills when deployed appropriately.

Prior Authorization Benefits Patients

Various Medicare Advantage plans' websites

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REALITY

Prior Authorization Nightmare

- 99% of members in plans with authorization
- 91% of physicians say authorization has negative impact on patients, "overused, costly, inefficient, delays care"
- RNs spend **467 hours/year**, at cost of almost $35,000
- More than **46 million** prior authorization requests filed in 2022
- Over **3.4 million requests were fully or partially denied**:
  - Just 10% of denials were appealed
  - 83% of appeals resulted in fully or partially overturning denial
  - If no authorization, member pays the bill

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REALITY

You don't need to get a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers, you may want to ask for a pre-visit coverage decision to confirm that the services you are getting are covered and are medically necessary.

This is important because: **without a pre-visit coverage decision, if we later determine that the services are not covered or were not medically necessary, we may deny coverage and you will be responsible for the entire cost.**

From the Evidence of Coverage for PPO plans

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OUR CLIENTS' STORIES

MEET ELIZABETH

After successful knee replacement surgery, Elizabeth learned that the procedure had not been authorized by her insurance company.

She is being billed $62,000.

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Promise

CMS

CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F)

March 26, 2024

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CMS Final Prior Authorization Rule

- Applies to Medicare Advantage, not commercial insurers
- Effective January 1, 2026, deadline for decision:
  - Seven days for standard request
  - 72 hours for expedited determination
- Denial must include a specific reason
- Three new and one updated application programming interfaces (API) by January 2027:
  - Patient, provider access, payer-to-payer, prior authorization
  - Facilitate data sharing
  - Prior authorization rules, requirements

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OUR CLIENTS' STORIES

MEET HENRY

He was hospitalized for five weeks. His physicians wanted either an SNF or inpatient rehab stay. His plan denied both (not medically necessary) and approved two skilled nursing home health visits a week.

Henry's daughter has no idea what to do. His first home health visit was on the fifth day.

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OUR CLIENTS' STORIES

MEET HENRY

The family's appeals to the QIO and QIC were denied.

Do they live with the current plan or pay privately for a rehab stay and appeal to the ALJ ?

That decision can take 90 days.

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Inquiring Minds Want to Know:

Will this rule fix the prior authorization nightmare?

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The Final Rule deals with processes.

The CMS Final Rule aims to reduce provider burden related to prior authorization processes and improve patients' access to timely care.

CMS has finalized a new final rule that aims to shorten prior authorization timelines and streamline processes to remove barriers to patient care.

Provider groups, including the American Medical Association …, said the final rule will help streamline prior authorization processes.

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One big insurer's prior authorization efforts.

"To help reduce the administrative burden on health care professionals and their staff, starting Sept. 1, 2023, we'll begin a two-phased approach to **eliminate the prior authorization requirement** for many procedure codes."

CPT/HCPC Code	Description
E1620	BLOOD PUMP FOR HEMODIALYSIS REPLACEMENT
E1625	WATER SOFTENING SYSTEM FOR HEMODIALYSIS
DURABLE MEDICAL EQUIPMENT (CONT.)	
CPT/HCPC Code	Description
E1630	RECIPROCATING PERITONEAL DIALYSIS SYSTEM
E1632	WEARABLE ARTIFICIAL KIDNEY EACH
E1634	PERITONEAL DIALYSIS CLAMPS EACH
E1635	COMPACT TRAVEL HEMODIALYZER SYSTEM
E1636	SORBENT CARTRIDGES FOR HEMODIALYSIS PER 10
E1637	HEMOSTATS EACH
E1639	SCALE EACH
E1699	DIALYSIS EQUIPMENT NOT OTHERWISE SPECIFIED
E1812	DYN KNEE EXT/FLEX DEVC W/ACTV RESISTANCE CONTROL
E2310	PWR WC ACSS ELEC CNCT BETWN WC CNTRLLER&ONE PWR
E2311	PWR WC ACSS ELEC CNCT BETWN WC CNTRLLER&TWO/MORE
E2321	PWR WC ACSS HND CNTRL REMOT JOYSTCK NO PRPRTNL
E2609	CUSTOM FABRICATED WHEELCHAIR SEAT CUSHION SIZE
E2617	CSTM FAB WC BACK CUSHN ANY SZ ANY MOUNT HARDWARE
K0020	FIXED ADJUSTABLE HEIGHT ARMREST PAIR
K0037	HIGH MOUNT FLIP-UP FOOTREST EACH
K0039	LEG STRAP H STYLE EACH
K0044	FOOTREST UPPER HANGER BRACKET REPL ONLY EACH
K0046	ELEVATING LEGREST LWR EXTENSN TUBE REPL ONLY EA
K0047	ELEVATING LEGREST UPR HANGER BRACKT REPL ONLY EA
K0050	RATCHET ASSEMBLY REPLACEMENT ONLY
K0051	CAM RLS ASSEM FOOTREST/LEGREST REPL ONLY EACH
K0056	SEAT HT<17/>TO/>21 IN LTWT/ULTRALTWT WHLCHAIR
K0065	SPOKE PROTECTORS EACH
K0072	FRONT C ASSEMBLY COMPL SEMIPNEU TIRE REPL ONLY E
K0073	CASTER PIN LOCK EACH
K0098	DRIVE BELT FOR POWER WHEELCHAIR REPLACEMNT ONLY
K0105	IV HANGER EACH
K0609	REPL ELEC W/AUTO EXT DEFIB GARMNT TYPE ONLY EA
K0743	SUCTION PUMP HOME MODEL PORTABLE FOR USE WOUNDS


FEDERAL REGISTER
Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, Merit-Based Incentive Payment System (MIPS) Eligible Clinicians, and Eligible Hospitals and Critical Access Hospitals in the Medicare Promoting Interoperability Program

The rule is all about processes:

Clarify criteria
Streamline process (three APIs)
Evaluate policies

It does not tackle decisions (outcomes):

The rule "does not address how decisions are made (using AI, statistical methods, algorithms).
"But decisions involving AI or other algorithmic systems must still comply with requirements."

OUR CLIENTS' STORIES

Henry's plan complied with the rule provision.
Timing: It issued the denial decision within 72 hours.
Reason: Services were not medically necessary.

It's doubtful the final rule would have helped Henry.

Promises vs. REALITY

Physicians and Networks

Promise

Access to specialists, non-VA hospitals and walk-in care locations near you

REALITY

Required Text: "Out-of-network/non-contracted providers are under no obligation to treat <Plan> members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost- sharing that applies to out-of-network services."

Medicare Communications and Marketing Guidelines (MCMG): Disclaimers

Promise

Medicare Advantage organizations … must maintain a network of appropriate providers that is sufficient to provide adequate access to covered services to meet the needs of the population served.

CMS.gov Network Adequacy

REALITY

Financial Management

17 health systems dropping Medicare Advantage plans | 2024

Health Systems Dropping Medicare Advantage Plans

- Reasons cited for dropping Advantage include:
  - Nonproductive negotiations
  - Slow processing of claims
  - Delayed reimbursement
  - Prior authorization denial rate (one system reported 22% for Advantage compared to 1% for traditional Medicare)
- Thousands of patients left in the lurch

REALITY

'Starting from ground zero again': Scripps to cut 32k Medicare Advantage plan patients in San Diego

Medicare Advantage Network Changes

- Plans are allowed to change networks at any time, must provide a 30-day written notice

OUR CLIENTS' STORIES

MEET SONDRA

She had to have open heart surgery. After working with the plan for over two months, she finally found a heart surgeon in-network and got authorization from the plan.
One month before her surgery, she received a notice that the surgeon would no longer be in-network.

Sondra had to start the process all over.

Medicare Advantage Network Changes

- Plans are allowed to change networks at any time, must provide a 30-day written notice
- If CMS determines that the network change is significant, there is a two-month SEP:
  - CMS notifies enrollees
  - They can choose another Advantage plan or return to Part A and Part B
  - However, a Medicare supplement is not guaranteed

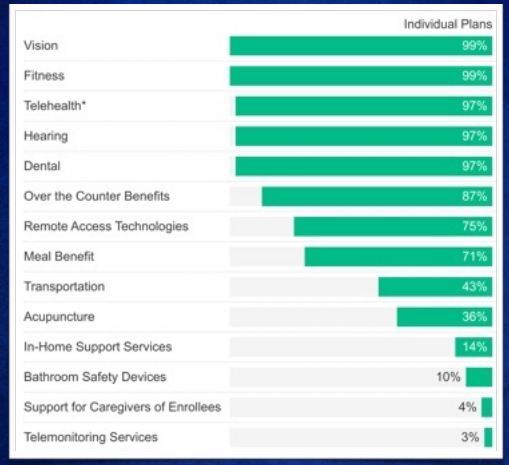
REALITY

Generally, networks only matter when there are health issues of concern. In those situations, getting a Medigap policy may not be possible.

Promises vs. REALITY

Medicare Advantage Supplemental Benefits

Promise



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Medicare Advantage Supplemental Benefits

- New beneficiaries drawn to Medicare Advantage because of the extra benefits
- "New supplemental benefits tailored to their specific needs" (CMS 2019):
  - "Primary purpose … daily maintenance of health"
  - "Improving or maintaining the health or overall function"
- Plans have received $335 billion in rebates over 10 years; one use is to pay for benefits

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Mid-Year Enrollee Notification of Unused Supplemental Benefits

- CMS is concerned about low utilization of benefits:
  - Beneficiaries may be unaware of the benefits or how to use them
  - Plans should use rebates for specified purposes, not marketing
- Between June 30 and July 31, plans must send a personalized notice
- Notice must contain:
  - Benefits not utilized during first six months of the year
  - Details on eligibility criteria and overview of limitations
  - Instructions on how to access benefits and related provider networks
  - A toll-free customer service number for questions

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Fewer Supplemental Benefits in 2025?

- Plans are not making as much money as in past years:
  - Humana cut its earnings-per-share projections for 2024 and 2025, citing unprecedented cost surges
  - Centene products "will be a little less attractive"
- Health insurers' shares fell between 6% and 12% after the final 2025 payment rates were announced:
  - Not a cut (increase of about 3.7%)
  - Just not as much as plans would like
  - But plans are still being overpaid, more than $75 billion in 2025

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REALITY

OUR CLIENTS' STORIES

MEET RICHARD

He elected Medicare Advantage for the gym membership. That saved him over $200 a month.
Then, he was in an car crash and now is trying to get approval for the six weeks of rehabilitation in a skilled nursing facility his physician ordered.

"What good is a gym membership if I can't get rehab?"

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Promises vs. REALITY

Inflation Rebates

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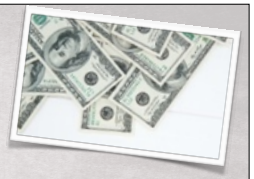
Inflation Rebates



- Drug companies must pay rebates to Medicare if raising prices faster than inflation

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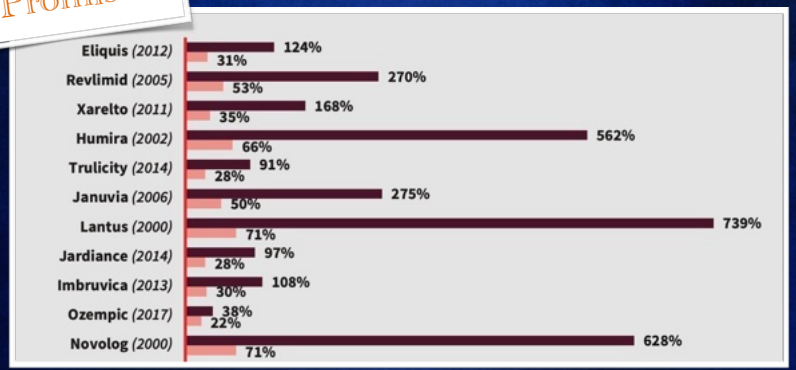
Promise



AARP Public Policy Institute analysis of 2021 data from the CMS' Medicare Part D Spending by Drug Dashboard and Medi-Span Price Rx Pro
Top line: Lifetime list price actual change, bottom line: Lifetime general inflation

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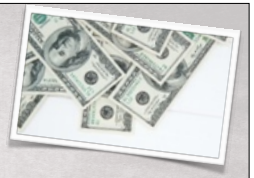
Inflation Rebates



- Drug companies must pay rebates to Medicare if raising prices faster than inflation
- Rebates will go into the Medicare Trust Fund
- Beneficiaries may may or may not see cost reduction for Part D drugs
- Part B drugs coinsurance is being adjusted:
  - Original Medicare beneficiaries with a Medigap policy likely will not see savings (Medigap covers the Part B coinsurance)
  - Those with Original Medicare (Part A and Part B only) or Advantage plan may see a reduction from standard 20% coinsurance

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HCPCS Code	Short Description	Inflation-Adjusted Coinsurance Percentage (Normally 20.000%)
J0287	Abelcet	19.790%
J9042	Adcetris	19.172%
J8655	Akynzeo	18.035%
J7504	Atgam	15.373%
J0898	Argatroban (Auromedics)	7.418%
J3145	Aveed	19.266%
J0558	Bicillin C-R	16.010%
J0561	Bicillin L-A	16.342%
J9039	Blincyto	19.633%
J9046	Bortezomib (Dr. Reddy's)[1]	9.293%
J9048	Bortezomib (Fresenius Kabi)	9.293%
J0703	Cefepime (B. Braun) [2]	8.381%
J0701	Cefepime (Baxter)	7.832%
J2850	Chirhostim	19.477%
J0584	Crysvita	19.448%

CMS Inflation Rebates website

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Promises vs. REALITY

Drug Price Negotiation

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Medicare Drug Price Negotiation Will Lower Prices by Thousands of Dollars per Month

A new analysis estimates prices for 30-day supplies of the first 10 Medicare Part D drugs undergoing price negotiations, with monthly reductions as high as $6,500 for some drugs.

Drug Price Negotiation

- Medicare can negotiate directly on Part B and Part D drugs
- First round:
  - Negotiated prices scheduled to take effect in January 2026
  - Ten drugs among the highest annual Part D spending and/or utilization
  - Significantly lower the amount Medicare spends for the drugs
  - Expected to save U.S. government $164 billion over 10 years:

Drug Name	Participating Drug Company	Commonly Treated Conditions	Agreed to Negotiated Price for 30-day Supply for CY 2026	List Price for 30-day Supply, CY 2023
Januvia	Merck Sharp Dohme	Diabetes	$113.00	$527.00
Fiasp; Fiasp FlexTouch; Fiasp PenFill; NovoLog; NovoLog FlexPen; NovoLog PenFill	Novo Nordisk Inc	Diabetes	$119.00	$495.00
Farxiga	AstraZeneca AB	Diabetes; Heart failure; Chronic kidney disease	$178.50	$556.00
Enbrel	Immunex Corporation	Rheumatoid arthritis; Psoriasis; Psoriatic arthritis	$2,355.00	$7,106.00
Jardiance	Boehringer Ingelheim	Diabetes; Heart failure; Chronic kidney disease	$197.00	$573.00
Stelara	Janssen Biotech, Inc.	Psoriasis; Psoriatic arthritis; Crohn's disease; Ulcerative colitis	$4,695.00	$13,836.00
Xarelto	Janssen Pharms	Prevention and treatment of blood clots; Reduction of risk for patients with coronary or peripheral artery disease	$197.00	$517.00
Eliquis	Bristol Myers Squibb	Prevention and treatment of blood clots	$231.00	$521.00
Entresto	Novartis Pharms Corp	Heart failure	$295.00	$628.00
Imbruvica	Pharmacyclics LLC	Blood cancers	$9,319.00	$14,934.00

CMS Fact Sheet, Medicare Drug Price Negotiation Program, August 15, 2024

REALITY

Impact on Beneficiaries

- May not see any savings:
  - Drugs going off patent
  - Competition between similar branded medications
  - Insulin capped at $35
- Plans won't be required to cover similar drugs so some could lose access to ones they now take
- Could prevent companies from maintaining pricing power over a treatment
- Part B negotiation starts in 2028; experts say that could have a more significant impact

Promises vs. REALITY

$2,000 Part D Drug Plan Cap

Promise

The Inflation Reduction Act's redesign of Medicare Part D is projected to reduce enrollee out-of-pocket spending by about $7.4 billion annually among more than 18.7 million enrollees.

HHS Press Release, August 16, 2023

The Medicare Part D Donut Hole

- Officially, the Coverage Gap because drug plans do not cover costs
- In 2006, drug plan members paid full cost for drugs
- Discounts began in 2012 – 50% for brand-name, 14% for generics
- In 2020, donut hole closed:
  - However, drugs were not free
  - Members paid a straight 25% of retail cost
- Once exiting the donut hole, beneficiaries entered Catastrophic Coverage with a 5% coinsurance and no out-of-pocket limit

The $2,000 Cap

- This year, the IRA eliminated the 5% coinsurance
- As of January 1, 2025, the cap will apply:
  - Automatically to anyone with Part D coverage; drug plan members do not have to do anything
  - Only to covered medications, those that are included in a plan's formulary
- It does not apply to Part B drugs
- The cap will be indexed annually for inflation

2024 Elimination of Coinsurance:
1.5 million enrollees (4%) will save about $3,100
Drug plans will pay $4.65 billion in costs

2025 IRA initiatives:
18.7 million enrollees (36%) will save more than $18.7 million
Drug plans will pick up 60-65% of costs

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Take a Lesson from
Elimination of 5% Catastrophic Coverage Coinsurance

- Once reaching threshold in 2024 (about $3,300 out-of-pocket):
  - Drug plan members pay nothing
  - Plans pick up the costs
- Drug plans responded by:
  - Raising premiums (coming next)
  - Increasing copayments for Tier 1, Tier 2 by $1-$9) (6%)
  - Changing Tier 3 copayments to coinsurance (32%)
  - Increasing coinsurance for Tier 4, Tier 5 (29%)

Review of 65 drug plans in three ZIP codes

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REALITY

Change copayment to coinsurance

Eliquis: retail cost $594
$47 copayment became a **25% coinsurance**

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REALITY

Increase coinsurance

Humira: retail cost $7,300
25% coinsurance became a **29% coinsurance**

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How Plans May Respond to the $2,000 Cap

- Change copayments to coinsurance
- Increase copayments, coinsurance
- Add more restrictions (prior authorization, step therapy)
- Drop drugs from plan formularies

Promise

For the first time, beginning in 2025,
the Inflation Reduction Act requires all Medicare Part D plans
to offer enrollees the option to
pay out-of-pocket prescription drug costs in the form of
capped monthly payments instead of all at once at the pharmacy.

CMS Medicare Prescription Payment Plan website

Medicare Prescription Payment Plan (MPPP)

- Those who reach the 2025 cap likely will face $2,000 all at once
- This program is similar to an installment payment plan:
  - Previously referred to as the "OOP Smoothing Program"
  - The drug plan member can pay off the amount in consecutive payments over time, instead of all at once
- Plans must identify and notify those:
  - Who incurred $2,000 in costs between January 1 and September 30, 2024
  - Will incur those costs going forward (hit a trigger point)

REALITY

Medicare Prescription Payment Plan (MPPP)

- MPPP can help those on fixed incomes, others
- Drug plan or pharmacy must issue the Medicare Prescription Payment Plan Likely to Benefit Notice:
  - However, pharmacies are not obligated to educate on MPPP
  - Plans are responsible for that
- Plan is optional, drug plan members must enroll:
  - During the Open Enrollment Period
  - At any time during the plan year when hitting trigger point
- Big question: Will they?

Consider Managing Your Monthly Drug Costs with the Medicare Prescription Payment Plan

You might benefit from participating in the Medicare Prescription Payment Plan because you have high drug costs.

What's the Medicare Prescription Payment Plan?

The Medicare Prescription Payment Plan is a new payment option that works with your current drug coverage to help you manage your out-of-pocket Medicare Part D drug costs by spreading them across the calendar year (January – December). Starting in 2025, anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage Plan with drug coverage) can use this payment option for drugs covered by Part D. **All plans offer this payment option and participation is voluntary.**

If you select this payment option, each month you'll continue to pay your plan premium (if you have one), and you'll get a bill from your health or drug plan to pay for your prescription drugs (instead of paying the pharmacy). There's no cost to participate in the Medicare Prescription Payment Plan, and you won't pay any interest or fees on the amount you owe, even if your payment is late.

Will this payment option help me?

It depends on your situation. If you have high out-of-pocket drug costs earlier in the calendar year, this payment option spreads out what you'll pay each month across the calendar year (Jan – Dec), so you don't have to pay out-of-pocket costs to the pharmacy. **This payment option might help you manage your monthly expenses, but it doesn't save you money or lower your drug costs.** Visit Medicare.gov/basics/costs/help/drug-costs to learn about programs that can help lower your drug costs.

How will my costs work?

The prescription drug law caps your out-of-pocket costs at $2,000 in 2025. This means you'll never pay more than $2,000 in out-of-pocket drug costs in 2025. **This is true for everyone with Medicare drug coverage, even if you don't join the Medicare Prescription Payment Plan.**

When you fill a prescription for a drug covered by Part D, you won't pay your pharmacy (including mail-order and specialty pharmacies). Instead, you'll get a bill each month from your health or drug plan. Your monthly bill is based on what you would have paid for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year.

Even though you won't pay for your drugs at the pharmacy, you're still responsible for the costs. If you want to know what your drug will cost before you take it home, call your plan or ask the pharmacist.

Note: Your payments might change every month, so you might not know what your exact bill will be ahead of time. Future payments might increase when you fill a new prescription (or refill an existing prescription) because as new out-of-pocket drug costs get added to your monthly payment, there are fewer months left in the year to spread out your remaining payments.

How do I know if this payment option might not be the best choice for me?

This payment option might not be the best choice for you if:

- Your yearly drug costs are low.
- Your drug costs are the same each month.

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Promises vs. REALITY

Part D Premium Stabilization

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Promise

CMS Projects 2024 Medicare Part D Premiums Will Fall by 1.8%

The projected decrease in Medicare Part D premiums reflects premium stabilization and improved Part D benefits, both tied to the Inflation Reduction Act.

CMS Releases 2024 Projected Medicare Part D Premium and Bid Information, July 31, 2023

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REALITY

What Really Happened

- No big premiums increases for Medicare Advantage plans; these plans can use rebates to reduce premiums
- On the other hand, **59 of 65 stand-alone Part D plans increased premiums from 2%-84%**
- The base beneficiary or average total premium is not what beneficiaries pay; there is **no cap or limit on the monthly premiums**
- CMS observed more variation in the stand-alone plan bids, creating "disruptive enrollment shifts" (beneficiaries switching because of premium increases)

65 Incorporated review of 65 plans in three ZIP codes

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Promises vs. **REALITY**

Part D Premium Stabilization Demonstration

Voluntary Part D Premium Stabilization Demonstration

- CMS will:
  - Apply a uniform reduction of $15 to the base premium
  - Impose a year-over-year increase limit of $35
  - Provide greater government risk sharing for potential plan losses
- Bottom line: Pay attention to premiums during Open Enrollment

Promises vs. **REALITY**

$2,000 Cap and Employer Drug Coverage

The $2,000 Cap and Employer Drug Coverage

- IRA initiatives may make it difficult for employer plans to prove creditable coverage (pay at least as much as a Part D drug plan)
- If continuing with non-creditable coverage for 63 days or longer:
  - Late enrollment penalty applies
  - 1% of national base premium (36.78 cents in 2025) for every month without creditable coverage
  - Example – One year adds $4.40/month
  - Penalty changes every year, follow for Part D life
- Sponsors of drug coverage must provide notice to Medicare-eligible employees every October

Important Notice from [Insert Name of Entity] About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with [Insert Name of Entity] and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **[Insert Name of Entity] has determined that the prescription drug coverage offered by the [Insert Name of Plan] is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

CMS Creditable Coverage Model Notice Letters website

OUR CLIENTS' STORIES

Did you get a creditable prescription drug determination notice?

Yes, I get one every year, just like every other employee. It tells me that I have health insurance and don't have to worry.

She is talking about the Certificate of Creditable Coverage.

REALITY

What to Do about Employer Coverage

- Get a notice about the status of 2025 coverage
- If creditable, no need for action
- If not, conduct cost/benefit analysis:
  - Costs – Part D plan premium, Part D IRMAA, loss of Health Savings Account
  - Benefits – $2,000 cap, $35 insulin, no cost sharing for Part D vaccines, Prescription Payment Program
- Options:
  - Enroll in Part A (if necessary) and a Part D drug plan, or
  - Live with penalty

Notices Medicare Beneficiaries Will Receive

- Prior authorization standard and expedited determination notices
- Notice from Medicare Advantage plans about network changes
- Notice from CMS about significant network changes
- Mid-Year Enrollee Notification of Unused Supplemental Benefits
- Medicare Prescription Payment Plan Likely to Benefit Notice
- Creditable prescription drug determination notice

REALITY

Medicare in 2024 and Beyond

- The environment:
  - Changes and notices will keep coming
  - Beneficiaries may experience dizziness, anxiety, and migraines
- Two important tips:
  - Open the mail
  - Pay attention to changes during the Open Enrollment Period, October 15-December 7

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Promise

If you don't pay attention during the OEP, you will pay in $$$ AND COVERAGE.

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Medicare in 2024:

Promises vs. REALITY

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