City of Seattle
Mayor's Council on African American Elders (MCAAE)
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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

CMS NTP NATIONAL TRAINING PROGRAM

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Agenda

- Medicare Overview
- Medicare Enrollment
- Medicare Advantage Updates
- Medicaid & Children's Health Insurance Program (CHIP)
- Inflation Reduction Act (IRA)
- Medicaid Renewals
- Questions & Resources

Medicare Overview

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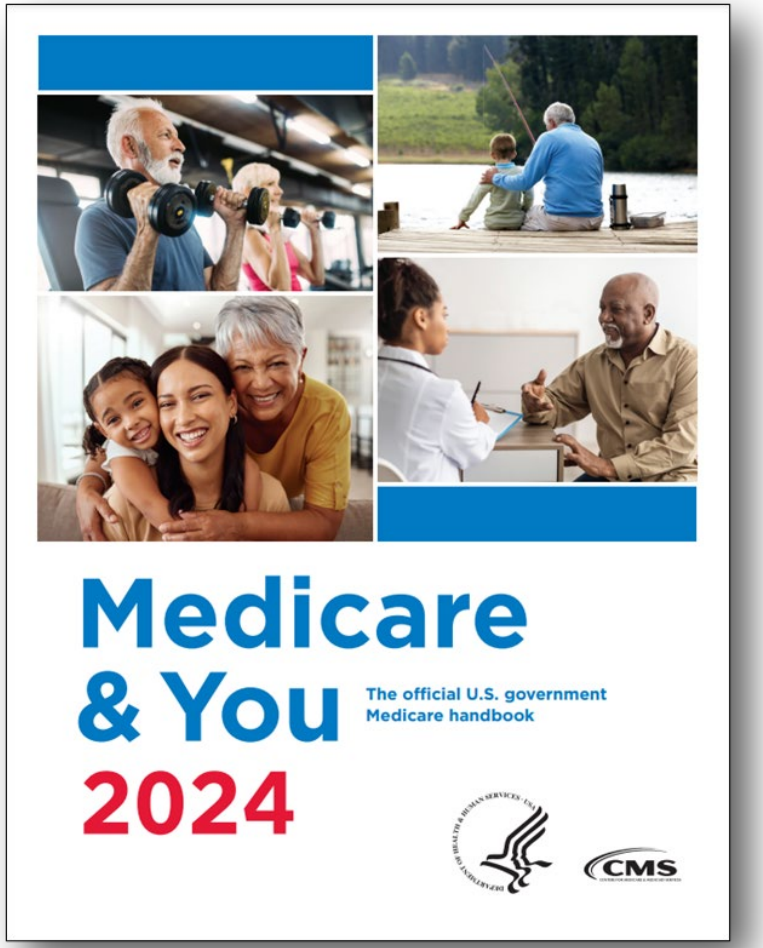
What is Medicare?

- Health insurance for people
  - 65 and older
  - Under 65 with certain disabilities
    - Amyotrophic Lateral Sclerosis (ALS), also called Lou Gehrig's disease without a waiting period
  - Any age with End-Stage Renal Disease (ESRD)

NOTE: To get Medicare you must be a U.S. citizen or lawfully present in the U.S. Must reside in the U.S. for 5 continuous years.



Medicare Options

Original Medicare

- ☑ Part A 
- ☑ Part B 

You can add:

- ☐ Part D 

You can also add:

- ☐ Supplemental coverage 

  This includes Medicare Supplement Insurance (Medigap). Or, you can use coverage from a former employer or union, or Medicaid.

Medicare Advantage (Part C)

- ☑ Part A 
- ☑ Part B 

Most plans include:

- ☑ Part D 
- ☑ Extra benefits

Some plans also include:

- ☐ Lower out-of-pocket costs

Original Medicare

- Fee for Service Payment
- Part A – Hospital insurance (inpatient hospital services, skilled nursing facility for 100 days)
  - Funding comes from the Medicare Trust Fund (that deduction out of your paycheck no premium for most beneficiaries)
- Part B – Medical insurance (clinic services, physical therapy, medical devices, lab tests/imaging, some drugs (mostly infused drugs like chemotherapy)
  - Funds come from participant's monthly premiums & tax revenue
  - FQHCs and Rural Health Clinics are paid out of Part A funds, but Part B rules apply to copay/deductible
- Part D – Drug Coverage
  - Funds come from participant's monthly premiums & tax revenue
  - Private insurance plans, issuers bid

Medicare Advantage

- A Medicare Advantage (MA) Plan (like a Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO)) is another way to get your Medicare coverage (sometimes called “Part C” or “MA Plans”)
- Offered by Medicare-approved private companies that must follow rules set by Medicare
- If you join an MA Plan, you’ll still have Medicare but you’ll get your Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) services from the MA Plan, not Original Medicare
    - You’ll need to use health care providers who participate in the plan’s network (some plans offer out-of-network coverage)

Part D Considerations

- Look at the estimated total costs to you, including premium, deductible, and cost sharing
- Review the formulary to see if it covers your drugs
- Check to see if the plan has restrictions like prior authorization, step therapy, quantity limits
- See if your pharmacy is in the plan's preferred network or if mail order is available
- Check star ratings to see how the plan is rated
- Understand how the plan works with other coverage you may have

Medicare Enrollment

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Enrolling in Medicare

If you receive Social Security Administration (SSA) retirement or disability benefits or Railroad Retirement Benefits (RRB), you'll be automatically enrolled four (4) months before you turn 65.

- Otherwise, to enroll in Medicare through Social Security:
  - Visit socialsecurity.gov, or
  - Call 1-800-772-1213; TTY: 1-800-325-0778
    - ❖ Make an appointment to visit your local office
    - ❖ To find your local office, visit secure.ssa.gov/ICON/main.jsp
- If retired from a railroad, enroll through the RRB office
  - Call your local RRB office at 1-877-772-5772

Enrollment Periods

Initial Enrollment Period (IEP)

- When you turn 65 (up to 3 months before or after)
- In your 25th month of SSDI (automatic)

General Enrollment Period (GEP)

- If you've missed your IEP
- January 1 to March 31
  - *Coverage begins the 1st day of the following month*

Special Enrollment Period (SEP) *(If you qualify)*

- e.g. when you lose employer-based health coverage
- Turned 65 while living overseas – now returned to the U.S.

Why Enrolling on Time is Important

If people with Medicare don't enroll on time…

- Costs could be higher (late enrollment penalties) or they could pay more for a Medicare Supplement Insurance (Medigap) policy

  - **Premium Part A** late enrollment penalty lasts 2X the number of years a person with Medicare could have had Part A but didn't
  - **Part B** and **Part D** late enrollment penalties last a lifetime

- Coverage might be affected, like having a gap in coverage or a waiting period for a pre-existing condition (Medigap)

- They might not be able to buy a Medigap policy or may have to pay more

Changing your Medicare Choices

- You may change between Original Medicare and Medicare Advantage, or change your drug plan:
  - Yearly Open Enrollment Period (OEP) from Oct 15 to Dec 7
  - Medicare Advantage OEP
  - 5-star Enrollment Period
  - Special Election Periods

Circumstances for Other Medicare Special Enrollment Periods (SEPs)

- You move out of your plan's service area
- You have Medicaid and Medicare
  - Once per calendar quarter during first 9 months each year
- Your plan leaves the Medicare Program or reduces its service area
- You leave or lose employer or union coverage
- You enter, live at, or leave a long-term care facility (like a nursing home)
- You lose your Extra Help status
- You're sent a retroactive notice of Medicare entitlement
- Other exceptional circumstances

Medigap Policies

- Are sold by **private insurance companies**
- Fills **gaps in Original Medicare** coverage, like copayments, coinsurance, and deductibles
- Each **standardized** Medigap policy under the same plan letter:
  - Must offer the same basic benefits, no matter who sells it
  - May vary in costs
- Another type of Medigap policy called Medicare SELECT is available in some states
- Plans are different in Minnesota, Massachusetts, and Wisconsin

Decision: Do I Need a Medigap Policy?

It only works with Original Medicare, right?	Yes.
What if I have other supplemental coverage, like from an employer?	You might not need Medigap.
Can I afford Medicare deductibles and copayments?	Weigh this against how much the monthly Medigap premium costs.
What does the monthly Medigap premium cost?	It can vary.

Medicare Advantage Updates

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Network Adequacy & Behavioral Health

- CMS evaluates Medicare Advantage (MA) plan networks for adequacy. Beginning January 1, 2024, MA plan networks must include and will be evaluated for
  - Clinical psychologists
  - Licensed clinical social workers
- CMS also finalized wait time standards for behavioral health and primary care services and more specific notice requirements from plans to patients when these providers are dropped from their networks
- In addition, CMS is requiring most types of Medicare Advantage Plans to include behavioral health services in care coordination programs, ensuring that behavioral health care is a core part of person-centered care planning

Agents & Brokers Oversight Plan

- MA organizations must establish and implement an oversight plan that monitors agent and broker activities, identifies non-compliance with CMS requirements, and reports non-compliance to CMS
- TPMOs must verbally convey the information required in the disclaimer (the names of the MA organizations and Part D sponsors with which they contract) within the first minute of a sales call when speaking to a person with Medicare

Medicaid & Children's Health Insurance Program (CHIP)

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Medicaid/CHIP Background

- Medicaid and CHIP are jointly administered by federal and state agencies to provide health coverage to over 91 million Americans, including children, pregnant women, parents, seniors, and individuals with disabilities.
- Medicaid is authorized by Title XIX and CHIP is authorized by Title XXI of the Social Security Act. All states, the District of Columbia, and the U.S. territories have Medicaid and CHIP programs to provide health coverage for low-income people.
- Federal law requires coverage of certain mandatory benefits and allows states to choose some other optional benefits
- Once a person becomes eligible for Medicaid or CHIP, they have access to all medically necessary services the state offers in its state plan.
- Delivery systems for these services are either fee-for-service or managed care

Medicaid Eligibility

- In general, to qualify for Medicaid in a state, you must:
  - Reside in that state
  - Belong to an eligibility group
  - Meet certain financial and non-financial requirements
- Eligibility groups specified in the federal Medicaid law include:
  - Limited income parents and caretaker relatives
  - Qualified Pregnant woman
  - Children
  - Age 65 or over
  - Blind
  - Individuals with disabilities
  - Individuals getting Supplemental Security Income (SSI)

How Are Medicare & Medicaid Different?

Medicare

- National program that's the same in every state
- The federal government (CMS) administers
- Eligibility factors include age, disability, or an End-Stage Renal Disease (ESRD) diagnosis
- Nation's primary payer of inpatient hospital services for the elderly and people with ESRD

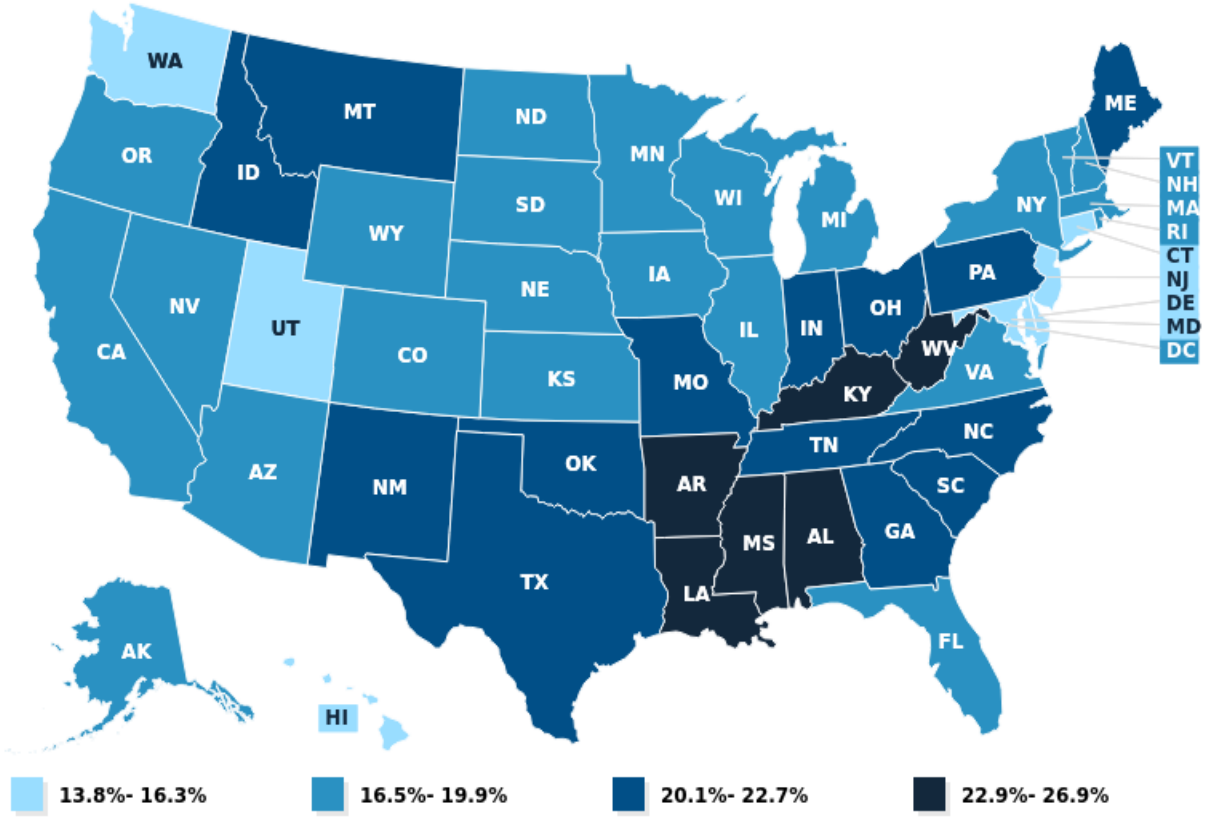
Medicaid

- Statewide programs that vary between states
- State governments administer within federal rules (federal/state partnership)
- Eligibility factors include limited income and resources and other non-financial requirements
- Nation's primary public payer of mental health and long-term care services; covers 42% of all births

Medicare - Medicaid Enrollees: “Dual Eligibles”

- 12.3 million people nationally
- People with Medicare who get full Medicaid benefits (full dual) and people with Medicare who get help with Medicare costs (partial dual)
- Medicare Savings Programs help pay Medicare premiums and sometimes out-of-pocket costs
- For dual eligible people with full Medicaid, Medicare pays first and Medicaid pays second for care that both Medicare and Medicaid cover

Distribution of Medicare Beneficiaries Living with Income under the Poverty Level



In 2021,13% of Medicare beneficiaries (7.5 million) are living under the poverty line, and another 19% (another 11 million) are living just above it

Kaiser Family Foundation's State Health Facts Distribution of Medicare Beneficiaries by Federal Poverty Level

Medicare Savings Programs Offer Significant Benefits

The MSPs promote access to health care and free up individuals' limited income for food, housing & other necessities.

MSP Eligibility Group°	Benefit	Financial Eligibility 2023 (single/couple)*	Enrollees June 2022
Qualified Medicare Beneficiary (QMB)	Part A & B premiums, deductibles, cost-sharing	Monthly Income: 100% FPL **$1,133/$1,525**** Resources: **$9,090/$13,630**	**8.1m**
Specified Low Income Beneficiary (SLMB)	Part B premium	Monthly Income: 101 to 120% FPL **$1,478/$1,992**** Resources: **$9,090/$13,630**	**1.4m**
Qualifying Individual (QI)	Part B premium	Monthly Income: 121 to 135% FPL **$1,660/$2,239**** Resources: **$9,090/$13,630**	**0.6m**

* Some states have effectively expanded MSP financial eligibility beyond the limits listed here. Check with your Medicaid agency for eligibility in your state.

** Includes a $20 standard income disregard. Limits slightly higher in Alaska and Hawaii.

° A fourth MSP, the Qualified Disabled Working Individual (QDWI) group, pays the Part A premium for individuals under 65 with limited incomes and resources who are otherwise ineligible for Medicaid, have a qualifying disability, and have lost premium-free Part A coverage after returning to work.

Inflation Reduction Act (IRA)

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Inflation Reduction Act (IRA) CMS Provisions

- Places a $35 monthly out-of-pocket cap on Medicare-covered insulins
- Makes ACIP-recommended vaccines free under Medicare Part D prescription drug coverage
- Temporarily increases Medicare payment for qualifying biosimilars to encourage use
- Requires manufacturers to pay rebates to Medicare if their price increases for certain drugs exceed inflation
- Makes Medicare Part D prescription drug coverage more affordable

Inflation Reduction Act CMS Provisions (continued)

- 2024: People with very high prescription drug costs will no longer pay once they reach the “catastrophic phase”
- 2024: Full low-income subsidy expanded for people with low incomes, lowering premiums and out-of-pocket costs for their prescription drug coverage
- 2025: All people with Medicare Part D will have a $2,000 annual out-of-pocket cap on their drug costs
- Allows Medicare to negotiate the price of certain high-cost, brand name prescription drugs

Insulin & Medicare Coverage

The cost of a month's supply of each covered insulin product is currently capped at $35, and you don't have to pay a deductible for insulin

- People enrolled in a Medicare prescription drug plan won't pay more than $35 for a month's supply of each insulin covered by their Medicare prescription drug plan and dispensed at a pharmacy or through a mail-order pharmacy. Also, Part D deductibles no longer apply to the covered insulin product
- Insulin (delivered through a durable medical equipment pump) covered by Part B and Medicare Advantage Plans
- If you get a 60- or 90-day supply of insulin, your costs can't be more than $35 for each month's supply of each covered insulin

The Medicare Drug Price Negotiation Program (1 of 3)

- Medicare will be able to negotiate (and re-negotiate) drug prices of certain high expenditure Medicare drugs with drug manufacturers
- For the drug companies of selected drugs that elect to participate in the Negotiation Program, the maximum fair prices that are negotiated will apply beginning in 2026

The Medicare Drug Price Negotiation Program (2 of 3)

- For the first year of the Negotiation Program, CMS selected 10 high expenditure, single source drugs for negotiation on August 29, 2023
- CMS will select up to an additional 15 drugs for negotiation for 2027, up to an additional 15 drugs (including drugs covered under Part B) for 2028, and up to an additional 20 drugs for 2029 and subsequent years

The Medicare Drug Price Negotiation Program (3 of 3)

The negotiated maximum fair prices for the first 10 drugs will apply beginning in 2026.

- **June 30, 2023** – CMS issued its revised guidance for the Negotiation Program for initial price applicability year 2026 and issued the revised data collection process and invited public comments on the data and information the federal government will collect for consideration when negotiating the maximum fair prices. This information collection request is open for public input for 30 days.
- **July 3, 2023** – The deadline for drug companies to submit a request for a drug to qualify for the small biotech drug exception.
- **September 1, 2023** – Deadline for CMS to publish the list of up to 10 drugs selected for negotiation for 2026.
- **October 1, 2023** – Deadline for participating drug companies that manufacture the drugs selected for the Negotiation Program for 2026 to sign agreements to participate in the Negotiation Program.
- **October 2, 2023** – Deadline for drug companies that manufacture the drugs selected for the Negotiation Program for 2026 and that have signed an agreement to participate in the Negotiation Program to submit manufacturer-specific data to CMS for consideration in the negotiation of a maximum fair price. In addition, this is the deadline for the public to submit data on therapeutic alternatives to the selected drugs, data related to unmet medical need, and data on impacts to specific populations.

Expansion of Extra Help

- Beginning January 1, 2024, nearly 300,000 low-income people with Medicare currently enrolled in the Extra Help program will be newly eligible for expanded benefits including no deductible, no premiums and fixed, lowered copayments for certain medications. An additional 3 million people could benefit from the Extra Help program now but aren't currently enrolled
- Expands eligibility for the full low-income subsidy (LIS) benefit (also known as "Extra Help") to individuals with limited resources and incomes up to 150% of the federal poverty level
- People with Medicare who are currently enrolled in partial Extra Help will automatically be converted to full Extra Help; they won't need to take any action

Medicaid Renewals

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Steps to Take if You've Lost Medicaid Coverage

1. **Review the notice from your state to see why you lost Medicaid coverage**
   - If the state ended your coverage because they didn't have the necessary information to complete your renewal, you can contact your state to provide the missing information. Find your state's contact information at Medicaid.gov/renewals.
   - If the state ended your coverage because they determined you're no longer eligible, you'll need to find another option for health coverage.
2. **Appeal the decision or re-apply for Medicaid**
   - If you think you're still eligible for Medicaid and the state wrongly ended your coverage, you can ask the state for a second review and appeal the decision.
   - If there is a change in your situation (like a change in income), you can reapply for Medicaid at any time. Visit Medicaid.gov to find out how you can contact your state to re-apply.

Steps to Take if You've Lost Medicaid Coverage (continued)

3. **Look at other health coverage options and find the one that is best for you**
   - **The Health Insurance Marketplace** – HealthCare.gov
     - Most people can find a plan for $10 or less per month with financial help.
     - People can qualify for savings on a health plan that lowers the monthly cost.
     - All plans cover doctor visits, prescription drugs, emergency care, and more.
     - You may qualify for a Special Enrollment Period (SEP)
   - **Medicare** – Medicare.gov
     - You may qualify for an SEP to enroll in Medicare without paying a penalty if you missed your initial enrollment period.
   - **Employer-sponsored coverage** – check with your employer
     - You can enroll in an employer plan outside of open enrollment if you recently lost Medicaid or CHIP.

Questions and Resources

- “Medicare & You 2024” book
- Medicare: 1-800-Medicare (1-800-633-4227)
  - Can answer questions on coverage, benefits and provide assistance in comparing and signing up for Medicare health and drug plans
  - Customer service reps available 24/7 (except Thanksgiving/Christmas Day)
- Social Security: 1-800-772-1213 7A-7P (Central) M-F, to sign up for Medicare or Extra Help
- Medicare.gov, benefits/coverage info and can compare plans
- Funded by federal gov’t, SHIBA counselors provide free, unbiased Medicare advice
  - Washington SHIBA: http://www.insurance.wa.gov/about-oic/what-we-do/advocate-for-consumers/shiba/ & Telephone Number: (800) 562-6900

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Activity Name and link:

- Mayor's Council of African American Elders (MCAAE)
- https://recon.my.salesforce-sites.com/act/Evaluation