MMW Webinar
Medicare Policy Updates
January 23, 2019

Webinar Logistics:
• Audio: Listen through your computer speakers or call in using a telephone. To get call-in information, click “telephone” under “audio”.
• Because there will be a large number of people on the call, all lines will be muted to ensure good audio quality.
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AgeOptions Webinar:
Medicare Policy Updates

January 23, 2019

PRESENTED BY:

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Connecting Older Adults with Community-based Resources and Options

The Area Agency on Aging of Suburban Cook County, since 1974
AgeOptions’ MMW work is supported by grants from local and regional foundations:

- The Retirement Research Foundation
- The Chicago Community Trust
- The Russell & Josephine Kott Memorial Charitable Trust
Who We Are: MMW Leadership

- AgeOptions
  - Area Agency on Aging (AAA) for suburban Cook County
- Smart Policy Works (SPW)
  - Policy and advocacy organization
- Progress Center for Independent Living
  - Cross-disability, non-residential – suburban Cook County
What We Do

• Gather and create practical, accessible information and materials
• Educate Medicare consumers, service providers and policymakers
• Problem solving – individual and systemic
• Provide training and technical support for professionals and volunteers
• Advocate for consumer focused laws and policies
• Target underserved groups
What We’ll Cover Today -

• Medicare Costs in 2019
• Medicare Part D & Coverage of Opioids
• Changes in Extra Help Special Enrollment Period
• New Medicare Cards
• MediGap Plans Changes
• Medicare Advantage Plan Changes
Medicare Costs in 2019
Part A Hospital Costs - 2019

• **Hospital Deductible** = $1,364 for first day (For each 60-day benefit period)

• **Daily Copayment for days 1-60** = $0

• **Daily Copayment for days 61-90** = $341 per day

• **Daily copayment for days 91-150** = $682 per day (These are lifetime reserve days)
Part A Skilled Nursing Facility Costs in 2019

- Days 1-20 = $0
- Days 21-100 = $170.50 per day
- Over 100 days, you pay all

Part A Premium in 2019

- Less than 30 Credits = $437/month
- Between 30-39 Credits = $240/month
Part B Costs in 2019

- **Monthly Medicare Part B Premium**
  - $135.50 per month for most beneficiaries
  - There is a 2.8% increase in Social Security benefits, covering the increase in premium for *most* Medicare beneficiaries
  - About 3.5% of beneficiaries who were previously subject to the “hold harmless” provision will pay less, because the 2019 Social Security increase will not cover their increased Part B premium

- **Annual Deductible - $185**
Part B Costs in 2019

Monthly premium for beneficiaries with higher incomes-

- Beneficiaries with annual income of more than $85,000 (single) or $170,000 (married and joint filing) will pay the standard Part B premium of $135.50 plus the income related premium amount each month

- This higher premium is a sliding scale up to $460.50
Part D Donut Hole Closing Sooner

• The Bipartisan Budget Act of 2018 closes the Medicare Part D donut hole one year sooner - in 2019 instead of 2020

• Beginning in 2019, beneficiary cost sharing for covered brand name drugs during the donut hole will be no more than 25%
  – The new law requires drug manufacturers to provide increased discounts during the donut hole (70% manufacturer and 5% from the plan)

• In 2019, beneficiaries will pay 37% for generic drugs in the coverage gap

• Beginning in 2020, beneficiaries will pay no more than 25% for covered brand name and generic drugs in the coverage gap

### 2019 Medicare Part D Costs

<table>
<thead>
<tr>
<th></th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Monthly premium</strong></td>
<td>Varies by plan</td>
<td>Varies by plan</td>
</tr>
<tr>
<td><strong>Yearly deductible</strong></td>
<td>$0 - $405</td>
<td>$0 - $415</td>
</tr>
<tr>
<td><strong>Initial Coverage Limit (ICL)</strong></td>
<td>Until $3,750 (count what the beneficiary and the plan pays for formulary drugs)</td>
<td>Until $3,820</td>
</tr>
<tr>
<td></td>
<td>• The beneficiary pays a co-pay or co-insurance for each prescription and the Part D plan pays the rest</td>
<td></td>
</tr>
<tr>
<td><strong>Donut hole (Coverage Gap)</strong></td>
<td>• Begins once the beneficiary’s covered drug expenses reach $3,750</td>
<td>• Begins when covered drug expenses reach $3,820</td>
</tr>
<tr>
<td></td>
<td>• 65% discount on brand name drugs</td>
<td>• 75% discount on brand name drugs (beneficiary coinsurance is no more than 25%)</td>
</tr>
<tr>
<td></td>
<td>• 56% discount on generics</td>
<td>• 63% discount on generics (beneficiary coinsurance is 37%)</td>
</tr>
<tr>
<td><strong>True Out-of-Pocket Threshold (TrOOP)</strong></td>
<td>TrOOP = $5,000 Beneficiaries in catastrophic coverage pay no more than 5% or $3.35/$8.35 for generics/brand names – whichever amount is greater</td>
<td>TrOOP = $5,100 Beneficiaries in catastrophic coverage pay no more than 5% or $3.40/$8.50 for generics/brand names – whichever amount is greater</td>
</tr>
<tr>
<td></td>
<td>• TrOOP may include costs paid not only by the beneficiary, but also manufacturer discounts, a charity program, or the Extra Help program</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Once TrOOP is met, the beneficiary enters <strong>Catastrophic Coverage</strong> and pays less for formulary drugs for the remainder of the calendar year</td>
<td></td>
</tr>
</tbody>
</table>
Higher Part B and Part D Premiums for Higher Income Beneficiaries

• IRMAA = Income Related Monthly Adjustment Amount
• Beneficiaries with higher incomes ($85,000 single or $170,000 for a couple) have to pay higher Part B and Part D monthly premiums
  – Based on income submitted to the IRS
• Extra IRMAA amount paid separately and directly to Medicare
  – Additional premium amounts will be deducted from beneficiary's SSA or RRB benefits, or Medicare will bill directly
• Beginning in 2019, beneficiaries with modified adjusted gross incomes of $500,000 or more ($750,000 or more for a couple) will pay an additional IRMAA for their Medicare Part B and Part D premiums
  – Increases costs from 80% to 85%
  – Provision of the Bipartisan Budget Act
2019 Medicare Part D IRMAA

2019 Medicare Part D Income-Related Monthly Adjustment Amounts (IRMAA) based on 2017 tax returns

<table>
<thead>
<tr>
<th>Beneficiaries who file individual tax returns with income:</th>
<th>Beneficiaries who file joint tax returns with income:</th>
<th>Applicable Percentage</th>
<th>Part D income-related monthly adjustment amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than or equal to $85,000</td>
<td>Less than or equal to $170,000</td>
<td>N/A</td>
<td>$0.00</td>
</tr>
<tr>
<td>Greater than $85,000 and less than or equal to $107,000</td>
<td>Greater than $170,000 and less than or equal to $214,000</td>
<td>35%</td>
<td>$12.40</td>
</tr>
<tr>
<td>Greater than $107,000 and less than or equal to $133,500</td>
<td>Greater than $214,000 and less than or equal to $267,000</td>
<td>50%</td>
<td>$31.90</td>
</tr>
<tr>
<td>Greater than $133,500 and less than or equal to $160,000</td>
<td>Greater than $267,000 and less than or equal to $320,000</td>
<td>65%</td>
<td>$51.40</td>
</tr>
<tr>
<td>Greater than $160,000 and less than $500,000</td>
<td>Greater than $320,000 and less than $750,000</td>
<td>80%</td>
<td>$70.90</td>
</tr>
<tr>
<td>Greater than or equal to $500,000</td>
<td>Greater than or equal to $750,000</td>
<td>85%</td>
<td>$77.40</td>
</tr>
</tbody>
</table>

Source: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/PartDandMABenchmarks2019.pdf
### 2019 Medicare Part B IRMAA

#### 2019 Medicare Part B IRMAA Amounts based on 2017 tax returns

<table>
<thead>
<tr>
<th>Individuals</th>
<th>Couples</th>
<th>Monthly premium in 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equal to or below $85,000</td>
<td>Equal to or below $170,000</td>
<td>$135.50</td>
</tr>
<tr>
<td>$85,001 - $107,000</td>
<td>$170,001 – $214,000</td>
<td>$189.60</td>
</tr>
<tr>
<td>$107,001 – $133,500</td>
<td>$214,001 – $267,000</td>
<td>$270.90</td>
</tr>
<tr>
<td>$133,501 – $160,000</td>
<td>$267,001 – $320,000</td>
<td>$352.20</td>
</tr>
<tr>
<td>$160,001 – $499,999</td>
<td>$320,001 – $749,999</td>
<td>$433.40</td>
</tr>
<tr>
<td>$500,000 and above</td>
<td>$750,000 and above</td>
<td>$460.50</td>
</tr>
</tbody>
</table>
Medicare Part D & Coverage of Opioids
Medicare Part D & Opioids - “At Risk” Beneficiaries

• Beginning in 2019, CMS will allow Medicare Part D plans to voluntarily implement drug management programs for beneficiaries who are at high risk of abusing or misusing frequently abused drugs (opioids and benzodiazepines)
  – Comprehensive Addiction and Recovery Act (CARA) of 2016

• Plans may limit at risk beneficiaries to selected prescribers and pharmacies to access frequently abused drugs-called “Lock-in”
  – Plans can impose these limitations only if the plan engages in case management services with the prescribers and beneficiaries
  – A notice to the beneficiary is required before limiting access to frequently abused drugs with the opportunity for beneficiaries to select their prescriber and pharmacy preferences

• Some beneficiaries are exempt
  – Exceptions include beneficiaries with cancer related pain, residents of LTC facilities, and beneficiaries receiving hospice care
Medicare Part D & Opioids-
“Opioid Naive Patients”

- Plans will limit initial opioid prescription fills for treatment of acute pain to no more than a 7 day supply

- If a beneficiary reaches an established morphine milligram equivalent (MME) per day, a pharmacist must consult with the prescriber before filling the Rx
  - This consultation may delay prescription fill

- CMS FAQ:
Changes to Extra Help Special Enrollment Period
Change in Extra Help Special Enrollment Period (SEP)

• Beginning January 1, 2019, beneficiaries with Extra Help/LIS will no longer have a continuous SEP to enroll, disenroll or change plans at any time during the year

• LIS beneficiaries, including dual-eligibles, will be limited to using their LIS SEP to once per calendar quarter for the first nine months of the year (January to March, April to June, and July to September)
  – LIS SEP will not be available the last quarter of the year. The Medicare Annual Enrollment Period (Oct 15 - Dec 7) can be used to make plan changes in quarter 4 with a plan effective date of January 1
  – Plan changes using the LIS SEP will still continue to take effect the first of the month following the month of the enrollment request
  – SEP is considered “used” in the month enrollment request is made and not the plan effective date

• Change in LIS SEP does not apply to MMAI enrollees
  – If an individual is enrolled in MMAI, they can change plans or disenroll at any time of the year- up to once per month.

SEP for Gain, Loss, or Change in Dual-Eligible or LIS Status

- Effective January 1, 2019, Medicare beneficiaries who have a change in LIS or dual-eligible status are eligible to receive a one-time SEP
  - SEP is for beneficiaries who gain, lose or have a change in LIS or Medicaid status
  - Eligible for a one-time opportunity to make a plan election within three months of the change or notification of the change – whichever is later
  - plan change using this SEP is effective the first day of the month following the month of enrollment

Medicare Part D & Opioids

• Beneficiaries with the Low-Income Subsidy (LIS) who are identified and notified as being at-risk for opioid abuse cannot use their LIS special enrollment period (SEP) to change plans
  – Will be notified by their plan of the LIS SEP limitation

• LIS SEP limitation lasts
  – as long as the individual is enrolled in the plan;
  – once an “at-risk” determination is successfully appealed; or
  – “at-risk” status expires or terminated by the plan (reassessed at the 12-month period)

• At-risk beneficiaries are still be able to use the Medicare Annual Enrollment Period or other SEPs to change plans

Sources:
https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/RxUtilization.html
The Medicare Card

Current Medicare Card

MEDICARE HEALTH INSURANCE
1-800-MEDICARE (1-800-633-4227)

NAME OF BENEFICIARY
JANE DOE
MEDICARE CLAIM NUMBER
000-00-0000-A
SEX
FEMALE
IS ENTITLED TO
HOSPITAL (PART A) 07-01-1986
MEDICAL (PART B) 07-01-1986
EFFECTIVE DATE

SIGN HERE
Jane Doe

New Medicare Card

MEDICARE HEALTH INSURANCE

John L Smith
Name/Nombre

MEDICARE Number/Número de Medicare
1EG4-TE5-MK72

Coverage starts/Cobertura empieza
Part A 03-03-2016
Part B 03-03-2016
New Medicare Cards

• Card mailings complete nationwide!
  – Individuals enrolled in Medicare Advantage plans will also receive new Medicare cards, but will continue using their MA plan card to receive benefits

• MACRA law of 2015 required CMS to remove Social Security numbers from Medicare cards and replace them with new cards that have a Medicare Beneficiary Identifier (MBI)

• The MBI is unique and randomly assigned to each beneficiary and does not contain any personally identifiable information
  – MBI consists of 11 characters (only numbers and uppercase letters)
  – Beneficiaries should begin using their new cards right away, but providers will have a transition period through December 2019 to use either number
  – Beginning January 2020, the old Medicare number can no longer be used
New Medicare Cards

• Medicare beneficiaries in Illinois who did not receive their new card, can…
  
  – Sign in to MyMedicare.gov to get their number or print their official card
  
  – Call 1-800-Medicare to find out if there is an issue such as an incorrect mailing address

• Beneficiaries should be cautious of scammers and continue protect their new Medicare numbers!
New Medicare Card Resources

• Check the status of your new card using Medicare’s official website:  [https://www.medicare.gov/newcard](https://www.medicare.gov/newcard)

  – Created by the Illinois SMP as an informational resource for consumers (available in English and Spanish)

• “10 Things to Know About Your New Medicare Card” tip sheet created by CMS:  [https://www.medicare.gov/Pubs/pdf/12018-10-Things-To-Know-About-New-Medicare-Card.pdf](https://www.medicare.gov/Pubs/pdf/12018-10-Things-To-Know-About-New-Medicare-Card.pdf)
DMEPOS Competitive Bidding-on hold in 2019

• Starting January 1, 2019, there will be a temporary gap in the DMEPOS Competitive Bidding Program that CMS expects will last until December 31, 2020

• During the gap, any Medicare enrolled DMEPOS supplier may furnish DMEPOS items and services to people with Medicare

• In most cases, beneficiaries will not need to change DMEPOS suppliers

• Beneficiaries should beware of aggressive marketing by suppliers

• CMS Fact Sheet for partners:

• CMS Consumer Fact Sheet:
MediGap Changes
New Medigap Changes Coming in 2020

• Medigap insurance companies will NOT be allowed to market or sell plans C and F to people newly eligible for Medicare on or after January 1, 2020
  – MACRA Act, Section 401

• Currently, plans C and F are the only plans that cover the Part B deductible

• Beneficiaries eligible for Medicare prior to January 1, 2020, will still be able to purchase a plan C or plan F after January 1, 2020 (including high deductible plan F)

• Beneficiaries who currently own a Plan C or Plan F will be allowed to keep their plans after January 1, 2020 if they choose

• Plan options D & G offer similar covered services as C & F except…
  – Plans D & G do not offer coverage of the Part B deductible
## Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2020

This chart shows the benefits included in each of the standard Medicare supplement plans. Some plans may not be available. Only applicants first eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

Note: A ✓ means 100% of the benefit is paid.

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Plans Available to All Applicants</th>
<th>Medicare first eligible before 2020 only</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td>Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Medicare Part B coinsurance or Copayment</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Blood (first three pints)</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Part A hospice care coinsurance or copayment</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Skilled nursing facility coinsurance</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Medicare Part A deductible</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Medicare Part B deductible</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Medicare Part B excess charges</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Foreign travel emergency (up to plan limits)</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Out-of-pocket limit in [2016]²</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

¹ Plans F and G also have a high deductible option which require first paying a plan deductible of [≥2,180] before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

² Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

³ Plan N pays 100% of the Part B coinsurance, except for a co-payment of up to $20 for some office visits and up to a $50 co-payment for emergency room visits that do not result in an inpatient admission.

Source: https://www.naic.org/documents/committees_b_senior_issues_exposure_medigap_plans_sold_after_200101.pdf
Medicare Advantage Plan Changes
Medicare Advantage
Open Enrollment Period

• Beginning in 2019, a new Medicare Advantage (MA) Open Enrollment and Disenrollment Period is now available
  – January 1st – March 31st of every year
  – Section 17005 of the 21st Century Cures Act

• A beneficiary enrolled in a MA plan will be able to make a one-time change to another MA plan or return to Original Medicare and enroll in a stand alone prescription drug plan (PDP)

• Changes made during this period take effect the first of the month following the month you enroll

• Marketing to MA enrollees during the MAP OEP is prohibited

• Beneficiaries can also continue to use the Medicare Annual Enrollment Period (October 15 - December 7) to enroll in, switch or disenroll from MA plans for the following calendar year

• The Medicare Advantage Disenrollment Period will no longer be offered (previously from Jan 1 – Feb 14 of each year)
Reminder of Other Enrollment Periods for Medicare Beneficiaries

- **Initial Enrollment Period (IEP)**
  - When an individual first becomes eligible for Medicare (3-1-3 rule)

- **General Enrollment Period** (January 1-March 31)
  - If you miss your IEP or SEP, you can sign up for Medicare Parts A & B
  - Medicare coverage would begin on July 1 of the same year

- **Medicare Annual Enrollment Period** (October 15-December 7)
  - Any Medicare beneficiary can enroll, disenroll or switch Medicare Part D or Medicare Advantage plans for the following calendar year

- **Special Enrollment Period (SEP)**
  - Special opportunity to switch or enroll in a plan outside of your IEP and the AEP
  - Various SEPs that depend on circumstance
  - For a list of Medicare Part D & Medicare Advantage SEPs, visit https://www.medicareinteractive.org/pdf/SEP-Chart.pdf
Medicare Advantage Plans to Expand Supplemental Benefits in 2019

- Medicare Advantage (MA) plans are now allowed to include additional supplemental benefits not covered under Original Medicare as long as the new benefits increase an individual’s health or quality of life.

- The Bipartisan Budget Act of 2018 reinterprets the definition of “primarily health related benefits“ under MA plans so as to include items or services that are used to:
  - diagnose, prevent, or treat an illness or injury,
  - compensate for physical impairments, improve the functional/psychological impact of injuries or health conditions, or
  - reduce avoidable emergency and healthcare utilization.

- For example, MA plans may begin to offer supplemental benefits that include transportation, assistive devices, home & bathroom safety modifications, over-the-counter drugs, adult day services, in-home support services.

To see if plan offers new “Targeted” supplemental benefits, click “Health & Drug Benefit” tab in Medicare.gov PlanFinder & scroll to “Benefit Highlights”

<table>
<thead>
<tr>
<th>Benefits Highlights</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly health plan premium</td>
<td>$46.10</td>
</tr>
<tr>
<td>Health plan deductible</td>
<td>$0</td>
</tr>
<tr>
<td>Other health plan deductibles?</td>
<td>In-Network: No</td>
</tr>
<tr>
<td>Maximum out-of-pocket enrollee responsibility (does not include prescription drugs)</td>
<td>$10,000 In and Out-of-network $6,700 In-network</td>
</tr>
<tr>
<td>Optional supplemental benefits [?]</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional benefits and/or reduced cost-sharing for enrollees with certain health conditions?</td>
<td>In-Network: No</td>
</tr>
<tr>
<td>Inpatient hospital coverage</td>
<td></td>
</tr>
</tbody>
</table>
MA Plans and Expanded Benefits for Enrollees with Chronic Conditions

• Beginning in 2020, MA plans have the option to improve care and health outcomes by offering expanded benefits to enrollees with certain chronic conditions
  – Bipartisan Budget Act with provisions of the Chronic Care Act
  – May include benefits that are not “primarily health related” and in addition to any supplemental benefits made available to all MA plan enrollees, with the expectation of maintaining or improving an enrollee’s health

• Bipartisan Budget Act also expands the Medicare Value-Based Insurance Design (VBID) model to all states by 2020
  – Specifically for enrollees with chronic conditions
  – Allows MA plans to offer reduced cost sharing and additional benefits to encourage enrollees to use “high value” services

Medicare Advantage Supplemental Benefits - Review

1. **Standard** - Offered to all enrollees, such as dental, vision & hearing benefits

2. **Targeted** - Available to qualifying enrollees being treated for certain health conditions (New in 2019)

3. **Chronic** - Offered to chronically ill enrollees (New in 2020)

**Plans must explain in Evidence of Coverage (EOC)**

Source:
Medicare Advantage and End-Stage Renal Disease (ESRD)

• 21st Century Cures Act – Section 17006

• Currently, individuals with End-Stage Renal Disease (ESRD) are prohibited from enrolling in MA Plans except in certain situations

• Beginning in 2021, beneficiaries with ESRD will have the option to enroll in an MA Plan

• Coverage for kidney transplants will be carved out of the MA plan and reimbursed under Medicare Part A and Part B
Medicare Advantage and Step Therapy for Part B Drugs

• Beginning January 1, 2019, MA plans will have the option of applying step therapy to Part B medications
  – Plans will only be allowed to apply step therapy to new Part B prescriptions or physician administered Part B drugs
  – Step therapy cannot be applied to ongoing Part B drug treatment
  – If step therapy is applied to a drug, the plan must offer care drug management care coordination services
  – Members can request an exception and have the right to appeal

• Plans must disclose Part B step therapy requirements in their ANOCs and EOC materials

• MA plans will still be required to cover all medically necessary Part B drugs

Questions & Answers
Since 1974, AgeOptions has established a national reputation for meeting the needs, wants and expectations of older adults in suburban Cook County. We are recognized as a leader in developing and helping to deliver innovative community-based resources and options to the evolving, diverse communities we serve.

Thank You!

Alicia Donegan, Health Care Choices Coordinator
alicia.donegan@ageoptions.org
(708)383-0258

To download MMW Materials, see our calendar of events and join the MMW email list, visit:
http://www.ageoptions.org/services-and-programs_makemedicarework.html

AgeOptions
1048 Lake Street, Suite 300
Oak Park, IL 60301-1102
phone (708)383-0258
fax (708)524-0870
(800)699-9043
ageoptions.org