MASTERING MEDICARE

Learn your A, B and Ds with CEs

Sixty-Five INCORPORATED i65

MEET YOUR PRESENTERS

Diane Omdahl, RN, MS

- Co-Founders of a 65 Incorporated® and the i65® Medicare Guidance Software, i65.com, 65incorporated.com
- Professional Medicare educators who **DO NOT SELL INSURANCE**
- Combined six decades of helping business and consumers make sense of Medicare *(Conducted over a thousand Medicare consultations and have done hundreds of speaking engagements)*
- Regularly featured in national news media
- Diane released the book, *"Medicare For You,"* in 2023. *(An Amazon Best Seller!)*

Melinda Caughill, CSA

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Learning Objectives:

- Name the two Medicare Open Enrollment Periods (OEP).
- List three reasons why reviewing coverage during the OEP is critically important for Medicare beneficiaries.
- Define two tenants of the Inflation Reduction Act (IRA) that can have an impact on Medicare drug coverage and costs.
- Identify two differences between living with the Original Medicare Path and the Medicare Advantage Path.
- Identify four points to know about long-term care.

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CHAPTER ONE:

Step Six: Review Your Coverage Annually

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STEP SIX:

Review Your Coverage **Annually**.

Annual Open Enrollment Period (OEP)

- October 15 - December 7
  - New plans take effect January 1
- Also called the Annual Enrollment Period (AEP)

Medicare Advantage Open Enrollment Period (MA OEP)

- January 1 - March 31
  - New plans take effect the first day of the next month

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Open Enrollment Period: **Basics**

- If you have **Original Medicare**:
  - Drop it to enroll in a Medicare Advantage plan
  - Change or drop Part D plans
  - Join a Part D drug plan or Medicare Advantage plan

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Open Enrollment Period: **Basics**

- If you have **Medicare Advantage (MA)**:
  - Change to a different MA plan *with* or *without* drug coverage
  - Drop Medicare Advantage for Original Medicare (Parts A and B) with or without a Part D drug plan
    - ➡ Adding a Medigap policy could require underwriting depending on your state and specific situation

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Medicare Advantage Open Enrollment Period: **Basics**

- **Only** for people enrolled in a Medicare Advantage
  - Drop MA plan, *with* or *without* drug coverage, to go to Original Medicare with the option of getting a Part D drug plan
    - ➡ Getting a Medigap can require underwriting
  - Change MA plans to another MA plan *with* or *without* drug coverage
- Plan members can make only one change in a calendar year
  - Choose between using the MA OEP or the OEP

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I'm happy with my plan. Why do I need to review it?

Those awful drug companies keep gouging seniors!

It's much more likely she didn't review the coming changes to her Medicare coverage.

Open Enrollment Period:

Plans can change almost everything about the plan

- Premiums
- Deductibles
- Out-of-pocket copays
- Spending limits
- Pharmacy networks
- Provider networks
- Restrictions (prior authorization, step therapy)

… All while keeping the same plan name!

Open Enrollment Period:
Annual Notice of Changes (ANOC)

- Plans must set ANOC to all members by October 1
  - ANOCs must use a template created by the government
- **Changes in Part D drug coverage:**
  - Formulary, drug tiers, pharmacies, coverage rules
  - Costs (premium, deductible, cost-sharing)
- **Changes in Medicare Advantage plan:**
  - Drug changes
  - Network physicians, coverage rules
  - Costs (premium, cost-sharing, maximum limit)

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The government's template

[MA-PD PPO (and ISNPs and CSNPs) models] [2024 ANOC model]

[Insert 2024 plan name] ([insert plan type]) offered by [insert MAO name] [insert DBA names in parentheses, as applicable, after listing required MAO names]

Annual Notice of Changes for 2024

[Optional: insert member name] [Optional: insert member address]

You are currently enrolled as a member of *[insert 2023 plan name]*. Next year, there will be changes to the plan's costs and benefits. ***Please see page 5 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at *[insert URL]*. *[Insert as applicable:* You can also review the attached OR enclosed OR separately mailed *Evidence of Coverage* to see if other benefit or cost changes affect you.*]* You may also call Member Services to ask us to mail you an *Evidence of Coverage*.)

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. **ASK:** Which changes apply to you
   - ☐ Check the changes to our benefits and costs to see if they affect you.
     - Review the changes to Medical care costs (doctor, hospital).
     - *[Insert if offering Part D]* Review the changes to our drug coverage, including authorization requirements and costs.
     - Think about how much you will spend on premiums, deductibles, and cost sharing.
   - ☐ Check the changes in the 2024 "Drug List" to make sure the drugs you currently take

An insurance company's version

Cigna True Choice Medicare (PPO) offered by Cigna Healthcare

ANNUAL NOTICE OF CHANGES FOR 2024

You are currently enrolled as a member of Cigna True Choice Medicare (PPO). Next year, there will be changes to the plan's costs and benefits. ***Please see page 4 for a Summary of Important Costs, including Premium.*** This document tells about the changes to your plan. To get more information about costs, benefits or rules please review the *Evidence of Coverage*, located on our website at www.cignamedicare.com. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.
- Review the changes to Medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including authorization requirements and costs.
- Think about how much you will spend on premiums, deductibles, and cost sharing.

☐ Check the changes in the 2024 "Drug List" to make sure the drugs you currently take are still covered.

☐ Check to see if your primary care doctors, specialists, hospitals, and other providers, including pharmacies will be in our network next year.

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

☐ Check coverage and costs of plans in your area. Use the Medicare Plan Finder at www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2024* handbook.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

OUR CLIENTS' STORIES

MEET CHARLES

In January, he received a big surprise. His premium had jumped from $9.60 to $69.70. The insurer consolidated plans and eliminated his. The ANOC informed him that, unless he made a change, he would be enrolled automatically in the new plan with the higher premium.

$721 lost to higher premiums for no reason.

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2024 is the MOST IMPORTANT Open Enrollment Period in Medicare's history.

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INFLATION REDUCTION ACT

The Inflation Reduction Act requires that Medicare Part D *(through a stand-alone Part D plan or through Medicare Advantage)* implement **a $2,000 out-of-pocket spending limit** beginning in 2025.

WARNING!

THIS MAY NOT BE GOOD FOR SOME MEDICARE BENEFICIARIES.

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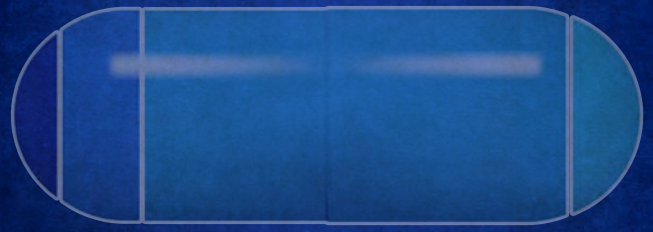
In 2023, Medicare Part D had **four payment stages**.

Stage 1: Deductible
Stage 2: Initial Coverage
Stage 3: Coverage Gap
Stage 4: Catastrophic Coverage



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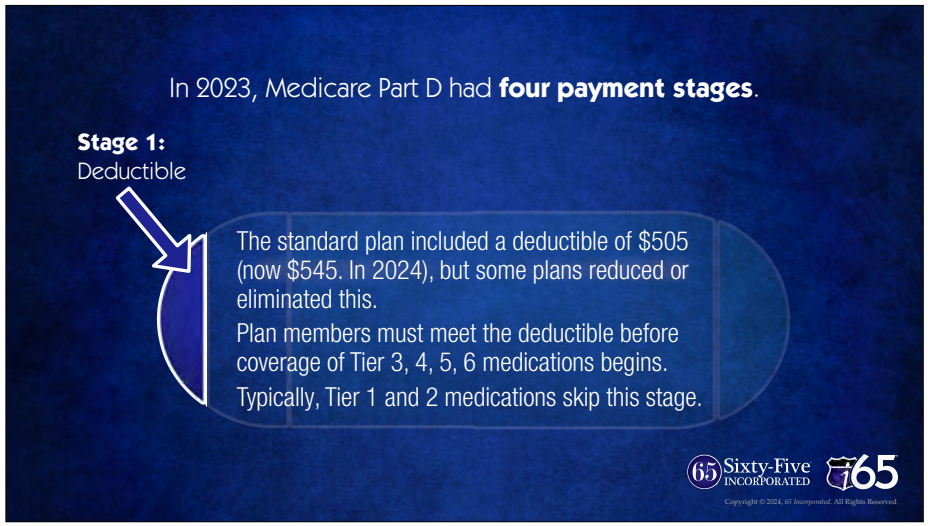

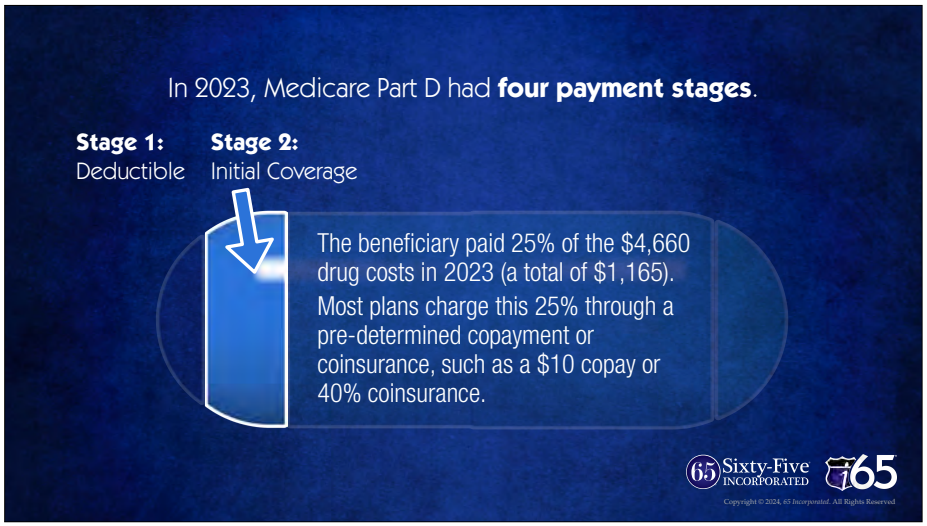

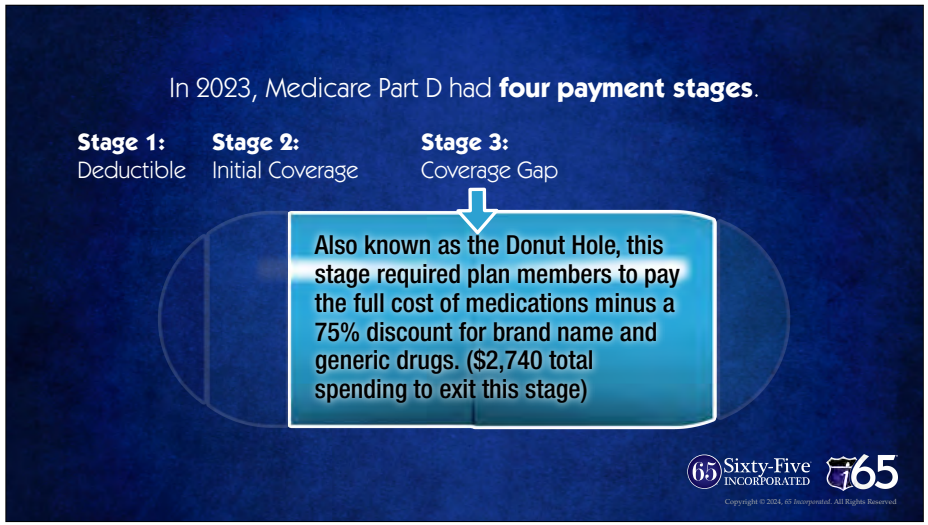

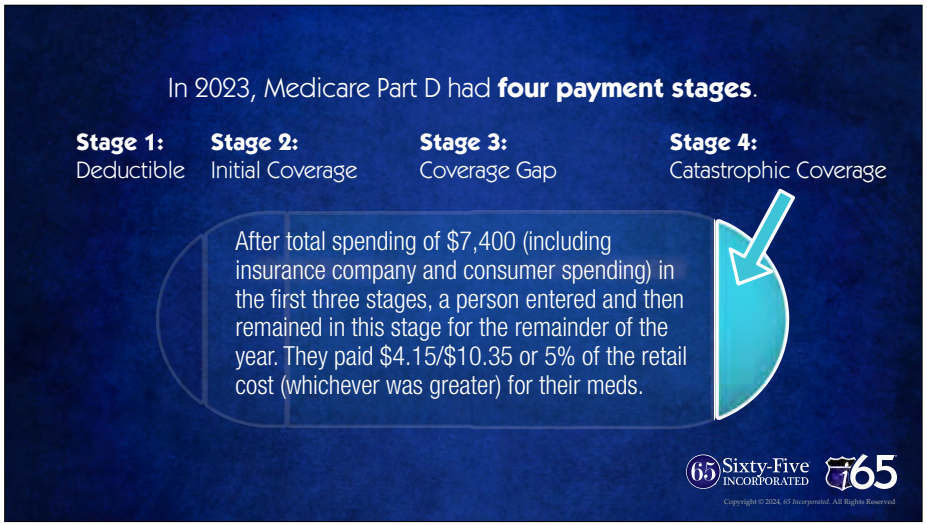

In 2024, Medicare Part D has **three payment stages.**

The Catastrophic Coverage phase gap is gone.

Stage 1: Deductible
Stage 2: Initial Coverage
Stage 3: Coverage Gap
Stage 4: Catastrophic Coverage

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In 2025, Medicare Part D will have **two payment stages.**

The Coverage Gap will also go away.

Stage 1: Deductible
Stage 2: Initial Coverage
Stage 3: Coverage Gap

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In 2025, Medicare Part D will have **two payment stages.**

The Coverage Gap will also go away.

Stage 1: Deductible
Stage 2: Initial Coverage

This essentially caps Part D costs at $2,000 per year… *but that doesn't magically make medications free.*

So, who will pick up those costs?

No!

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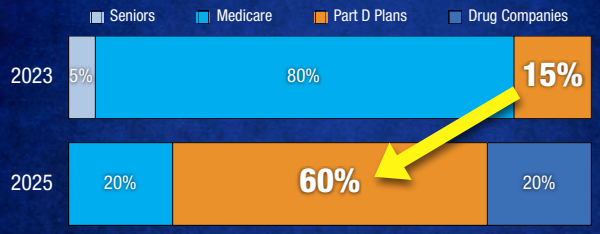
Who pays for the medication costs?



Do you think Part D insurance companies will take a

$4.65 BILLION dollar hit?

https://www.kff.org/medicare/issue-brief/changes-to-medicare-part-d-in-2024-and-2025-under-the-inflation-reduction-act-and-how-enrollees-will-benefit/

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How Part D insurance companies pass on these costs:

- **Plan premiums increase overall**
  - In review of three zip codes, Part D plan premiums increased an average of 23% in 2024
- **Increased cost sharing for all**
  - Higher co-pays ($0 to $3, $5 to $10, etc.)
  - Co-pays change to coinsurances
    - Flat amounts change to a percentage of total cost
    - **Example:** Eliquis (Retail price: $550)
      - ➡ With a Copay: $47 refill cost
      - ➡ With a Coinsurance of 25%: $137.50 refill cost

And most importantly…

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How Part D insurance companies pass on these costs:

- **Dropping medications from the plan.**

People will pay **FULL RETAIL PRICE** for medications not covered by their Part D drug plans.

The $2,000 limit ONLY applies when medications are covered by the plan.

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"Part D plan formularies includes at least 2 drugs in the most commonly prescribed categories and classes."

Medicare.gov, https://www.medicare.gov/drug-coverage-part-d/what-medicare-part-d-drug-plans-cover

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"Part D plan formularies includes at least 2 drugs in the most commonly prescribed categories and classes."

Medicare.gov, https://www.medicare.gov/drug-coverage-part-d/what-medicare-part-d-drug-plans-cover

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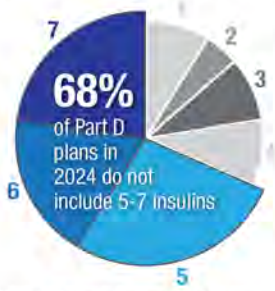
An analysis of non-covered insulins in 2024 Part D drug plans within a specific ZIP code



According to an analysis by *65 Incorporated*, 68% of 2024 Part D drug plans in a ZIP code with 22 plans available do not cover 5 to 7 common insulins.

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The study looked at the coverage of 10 insulins prescribed for 65 Incorporated *clients.*

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In 2023, the cancer drug, Tagrisso, was covered by **16 out of 22** Part D plans.

In 2024, this drug was covered by just **2 out of 22** Part D plans.

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The retail cost of Tagrisso: **$32,000 per month.**

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Exceptions to the MA OEP and the OEP:

Living in a Skilled Nursing Facility

- If moving into or out of a nursing home or other institution, a person can switch Medicare Advantage or drug plans at that time
- If living in a facility, a person can switch Medicare Advantage or drug plans once per month
- If a person leaves a facility, they can change Medicare Advantage or drug plans once a month for two months after moving out
- ***Getting or changing Medigap policies can still require underwriting***

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Exceptions to the MA OEP and the OEP:
5-Star Special Enrollment Period

- 5-star Medicare Advantageplans provide higher-quality coverage
- If one is available:
  - Can switch into it anytime from December 8-November 30
  - Can also choose one during the OEP
- Finding a 5-star plan can be a challenge:
  - Two 5-star Part D drug plans in 2024, down from 10 in 2022
  - 31 Medicare Advantage plans in 2024 with 5-star rating, down from 57 in 2023 and 74 in 2022

Where to get help:

✓ Medicare.gov Plan Finder tool
- If you can order products at Amazon.com, you can use the Plan Finder

✓ Medicare insurance agents
- No cost to clients, but will often only compare plans they sell
- Agents make very little money helping clients change Part D plans ($50)

✓ Local Pharmacies
- No cost, but will only show drug costs using their pharmacy

✓ State Health Insurance Programs (SHIPs)
- Services provided by volunteers
- Skills and services available vary greatly by location

✓ Financial Advisors/Fee-for-service Advisors
- Fiduciary services, but you must pay a fee or already be an existing client

CHAPTER TWO (NOT COMPLETED DURING SESSION THREE):

The **General Enrollment Period**

The General Enrollment Period (GEP)

- The "Oops, you missed your chance" time
- Did not enroll during IEP:
  - No coverage
  - Coverage other than an EGHP based on current employment
  - Did not qualify for premium-free Part A and no employer coverage
- Did not enroll during Part B SEP: COBRA, retiree, FEHB retiree, any non-EGHP coverage

GEP Basics

- Those who qualify for premium-free Part A can enroll online at any time or do it during the GEP
- Those who need Part B must wait for GEP, January 1-March 31 every year
- How to enroll:
  - Online for Part A and Part B
  - Submit CMS-40B form to local Social Security office for Part B only
- Coverage begins (supposedly) on first day of month after enrolling

GEP Basics

- After enrolling in Part B, there is opportunity to enroll in additional coverage but there may be a gap in coverage
- Penalties can apply:
  - Part B, medical insurance, after one year (12 months) that enrollment is delayed
  - Part D, prescription drug coverage, after 63 days without creditable coverage
  - Premium Part A, hospital insurance, after one year

CHAPTER:

Living with Medicare

Designate a **Medicare Authorized Representative**

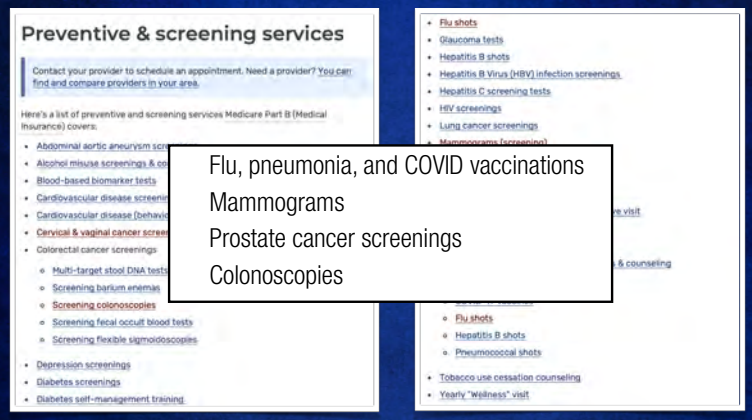
- Medicare requires a person's written permission to use or provide personal medical information for any purpose not defined in the Medicare & You handbook's privacy notice
- Complete "1-800-MEDICARE Authorization to Disclose Personal Health Information:"
  - Identify representative, type of information to share
  - Mail in form or submit through medicare.gov account
  - Update as needed

Authorize
Medicare Plan Representatives

- Part D and Medicare Advantage plans and Medigap policies have authorization forms
- Provide authority to speak to plan about claims, coverage, more
- Check the plan's member information or contact customer service

Preventive Services

- Affordable Care Act eliminated cost-sharing and expanded benefits



Flu, pneumonia, and COVID vaccinations
Mammograms
Prostate cancer screenings
Colonoscopies

www.medicare.gov/coverage/preventive-screening-services

Preventive Services

- Affordable Care Act eliminated cost-sharing and expanded benefits
- Screening test:
  - Checks for medical issue before signs, symptoms
  - No cost
- Diagnostic test:
  - Recent medical history or condition that needs attention
  - Deductible, copayment

Initial Preventive Physical Exam: **Welcome to Medicare Visit**

- Within first year of Part B enrollment
- Not a physical exam at all:
  - Height, weight, blood pressure, BMI, vision text
  - Review risk for depression, level of safety
  - Discussion about creating advance directives
  - A written plan for screenings, shots, preventive services
- If doctor addresses any medical issues, deductible and copayment can apply

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Initial Preventive Physical Exam

The initial preventive physical exam (IPPE), also known as the "Welcome to Medicare" preventive visit, promotes good health through disease prevention and detection. We pay for 1 IPPE per lifetime if it's provided within the first 12 months after the patient's Part B coverage starts.

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Annual Medicare Wellness Visit

- Personalized prevention plan to help you stay healthy
- Not a physical exam or medical visit:
  - Height, weight, blood pressure
  - A review of medical, family history
  - A review of current prescriptions
  - Screening for depression, cognitive issues
  - Advance care planning
- Medicare Advantage home visits
- If doctor addresses any medical issues, not a free visit

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Medicare Paths

- Original Medicare Path:
  - Part A, hospital insurance, and Part B, medical insurance
  - A Medigap policy (Medicare supplement insurance)
  - Part D, prescription drug plan
- Medicare Advantage Path: Medicare Advantage plan with prescription drug coverage (MA-PD plan)

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Medicare-covered Services:
Medicare Advantage

- Plans must provide Part A and Part B services
- One exception: Hospice services
- A few plans waive the three-day inpatient stay for SNF stays
- Also have authority to provide:
  - Medically necessary services beyond what Medicare covers, such as acupuncture, chiropractic service, telehealth
  - Non-covered services (dental, vision, gym, OTC drugs, daily maintenance)

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Cost-sharing

- Everyone must pay Part B premiums
- Original Medicare Path:
  - Part D and Medigap policy generally have monthly premiums
  - Deductibles, copayments, coinsurance
- Medicare Advantage Path:
  - Most plans have no premium
  - May or may not have deductible
  - Hospitalization – per-day copayment or per-stay charge
  - Outpatient – per-visit copayment or coinsurance

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Cost-sharing:
Out-of-pocket Maximum Limit

- Original Medicare:
  - No maximum limit
  - Not a factor for those who have a Medigap policy
- Medicare Advantage:
  - Once limit is reached, plan pays remainder of costs for year
  - Limit excludes premiums, drugs, noncovered services
  - In-network maximum $8,850, out-of-network $13,300
  - Plans can set lower limits

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Coverage Rules:
Networks

- Original Medicare Path:
  - No networks
  - See any provider who accepts assignment (Physician Compare database www.medicare.gov/care-compare)
- Networks staple of Medicare Advantage plans
- Health maintenance organization (HMO) plan:
  - Covers nonemergency care in network
  - Plan can require a referral

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Coverage Rules:
Referrals

- Original Medicare Path:
  - No referral requirements
  - Health systems may have their own requirements
- Medicare Advantage HMO plans can require referrals
- Medicare Advantage PPO plans:
  - Give members the ability to choose physicians
  - However, physicians have no obligation to see members if no contract with the plan

Coverage Rules:
Prior Authorization

- Advanced plan approval: Evidence-based medical management tools to ensure optimal care, prevent overuse, misuse
- Medicare Advantage Path:
  - Many or more services
  - If no authorization, member pays the bill

Coverage Rules:
Prior Authorization and PPO Plan

- Can require prior authorization for in-network care but not for out-of-network services
- Evidence of Coverage recommends pre-visit determination

"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."

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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Medicare Advantage and Part D Drug Plans
Evidence of Coverage (EOC)

- A document that describes in detail:
  - Services or drugs covered by the plan
  - Benefits
  - Costs
  - Coverage rules and limits
- Get EOC from plan or find one on the plan's website

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Finding a Medicare Advantage plan's Evidence of Coverage

Network Health Medicare Advantage Plans

(PPO)

Plan type: Medicare Advantage (without drug coverage)

Plan website | Non-members: Members:

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Finding a Medicare Advantage Plan's Evidence of Coverage

General Plan Information

- Enrollment Form (PDF)
- Evidence of Coverage (PDF)
- Summary of Benefits (PDF)
- Star Ratings (PDF)
- Benefit Highlights
- Annual Notice of Changes (ANOC) (PDF)[5]

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- Medically necessary dental services, as covered by Original Medicare

Prior authorization requirements may apply.

CHAPTER THREE:

Medicare in 2024: Prior Authorization Rule

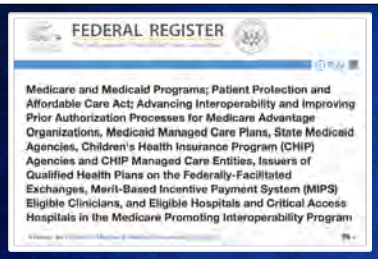
Prior Authorization Nightmare

- 99% of members in plans that require authorization
- More than 35 million prior authorization requests in 2021
- 91% of physicians say authorization has negative impact on patients
- Over 2 million prior authorization requests were fully or partially denied
- Just 11% of denials were appealed
- 82% percent of appeals resulted in fully or partially overturning the initial denial

Prior authorization is a health plan cost-control process that requires providers to qualify for payment by obtaining approval before performing a service. It is overused, costly, inefficient, opaque and responsible for patient care delays.

American Medical Association

CMS Final Prior Authorization Rule



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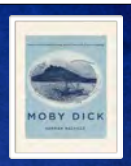


209,640 words

Which one would you rather read?

84,799 words

85,141 words

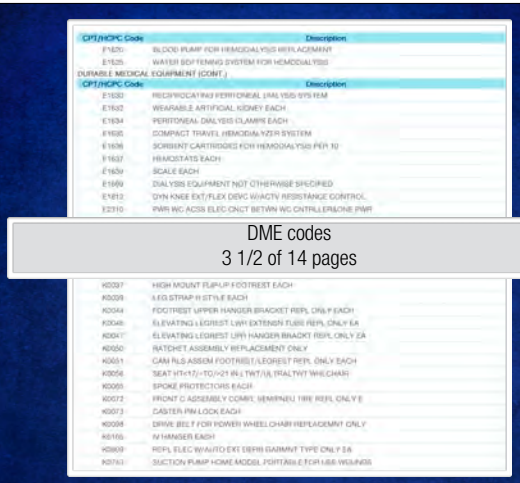
CMS Final Prior Authorization Rule

- Effective January 1, 2026:
  - Seven days for standard request
  - 72 hours for expedited determination
- Denial must include 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

Prior authorization reduction equals nearly 20 percent of overall volume

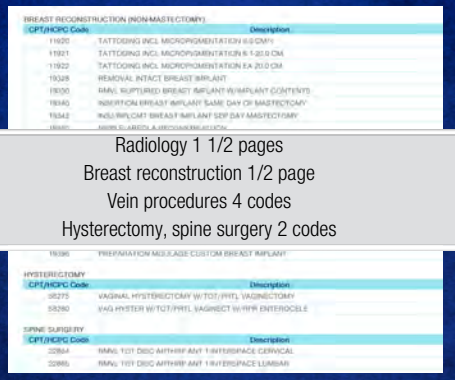
Volume of Procedures
or
Volume of Codes?

"To help … health care pro… …ot. 1, 2023, w… …eliminate the prior authorization requirement for many procedure codes."



DME codes
3 1/2 of 14 pages

Orthotics/prosthetic codes
7 1/2 pages



Radiology 1 1/2 pages
Breast reconstruction 1/2 page
Vein procedures 4 codes
Hysterectomy, spine surgery 2 codes

Original Medicare Path:
Prior Authorization

- Subject to authorization:
  - Power mobility devices, wheelchairs
  - Oxygen systems
  - Prosthetic parts
  - Hospital beds, mattresses
  - Procedures that could be considered cosmetic
- Eventually, prior authorization procedures, timeframes will apply to Original Medicare situations

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CHAPTER FOUR:

Medicare in 2024: Medicare Advantage Marketing

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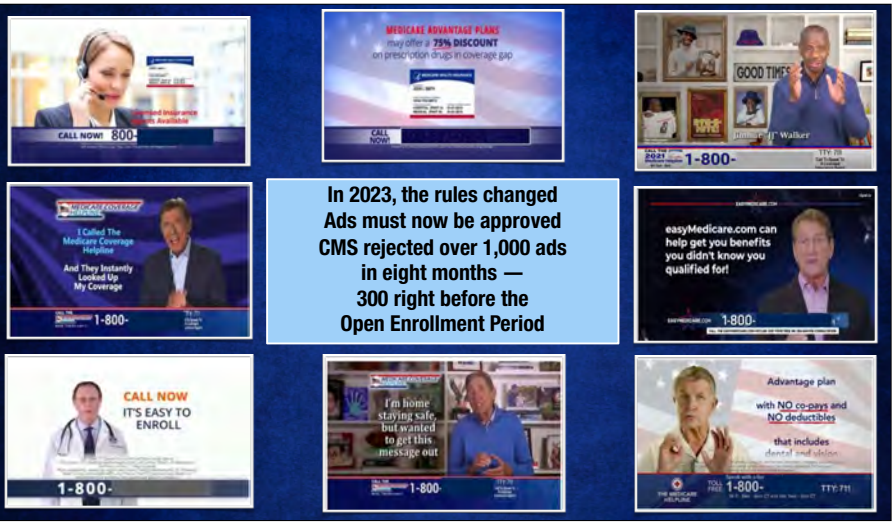
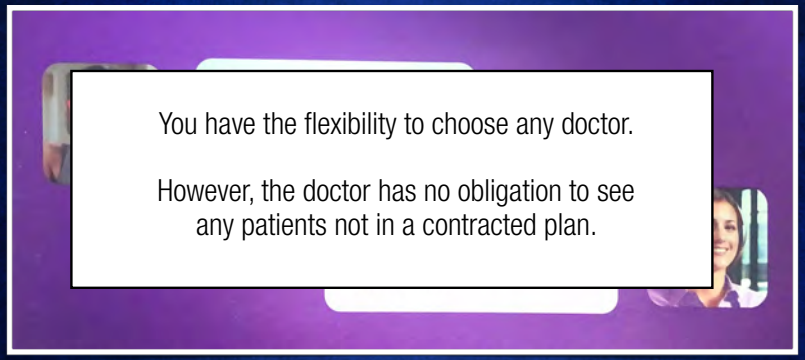
Open Enrollment 2022
643,852 commercials
9,500 per day
92% focused on extra benefits
21,024 did not identify the sponsoring organization



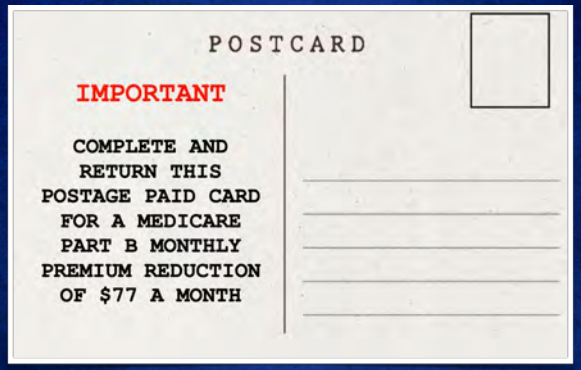
In 2023, the rules changed
Ads must now be approved
CMS rejected over 1,000 ads in eight months —
300 right before the Open Enrollment Period

Commercials now must:
Not use a Medicare-like card
Include insurer name and plans they sell

Marketing a PPO Plan



Marketing the Part B Premium Reduction



CHAPTER FIVE:

Medicare in 2024: The Inflation Reduction Act (IRA)

IRA: Medicare Vaccinations

- Part B vaccines:
  - Have never had a copayment
  - Pneumonia, flu, COVID, injury or exposure
  - Can get at physician's office or network pharmacy
- Part D vaccines:
  - As of 2024, not subject to deductible, no copayment
  - Shingrix, RSV, DTaP, Hepatitis B (not high risk)
  - Should get at a network pharmacy

IRA: Insulin

- Covered insulin (injectable, via pump) capped at $35
- Every plan determines which insulins it will cover
- Ten of 22 national drug plans are covering few insulins this year than they did in 2023
- Levemir in U.S. being discontinued by manufacturer because of "decreasing patient coverage"

Part D Premium Stabilization

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.

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IRA:
Part D Premium Stabilization

- IRA caps premium growth at 6%, average premiums would decrease 1.8% but that didn't happen:
  - One plan in each ZIP lowered premiums on average 16.5%
  - 59 plans increased increased premiums from 2%-84%
  - Los Angeles plans increasing on average 27%, from $4.50-$69.10 to $18.60-116
- 2025 prediction: Premiums will increase in response to the $2,000 cap

Review of 65 plans in three ZIP codes

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IRA Part D Premium Stabilization:
A Matter of Semantics

- Base beneficiary premium (starting point for premium calculation) capped at 6%
- Average total premium (likely average of premiums) decreased by 1.8%
- However, other considerations, calculations come into play:
  - The base beneficiary or average total premium is not what beneficiaries pay
  - There is no cap or limit on the monthly premiums

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IRA:
Inflation Rebates

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

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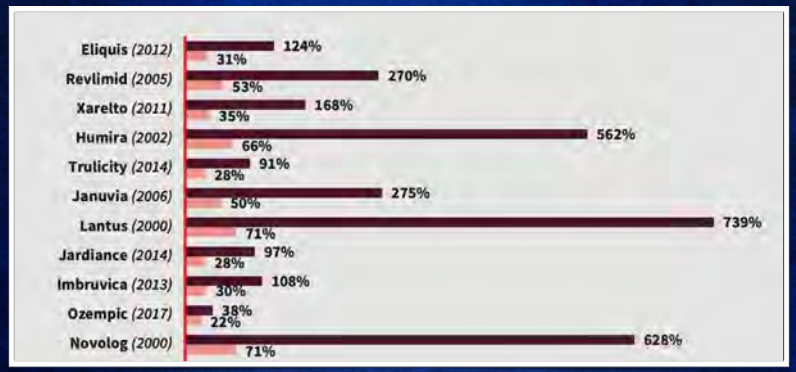

AARP Public Policy Institute analysis of 2021 data from the CMS' Medicare Part D Spending by Drug Dashboard and Medi-Span Price Rx Pro
Top line: Lifetime list price actual change, bottom line: Lifetime general inflation

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IRA:
Inflation Rebates

- Drug companies must pay rebates to Medicare if raising prices faster than inflation:
  - Rebates will go into the Medicare Trust Fund
  - Goal is to discourage drug companies from raising prices too fast
- Drug plan members may or may not see any cost reduction for drugs
- Part B drugs coinsurance is being adjusted

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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)[1]	8.381%
J0701	Cefepime (Baxter)	7.832%
J2850	Chirhostim	19.477%
J0584	Crysvita	19.448%

Footnote

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IRA:
Drug Price Negotiation

- Medicare can negotiate directly on Part B and Part D drugs
- Expected to save U.S. government $164 billion over 10 years
  - May or may not mean lower prices (Novolog capped at $35)
  - Price reductions on some and more limited price growth on others
- Plans won't be required to cover similar drugs; some could lose access to ones they now take

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Drug Name	Commonly Treated Conditions	Total Part D Gross Covered Prescription Drug Costs from June 2022-May 2023	Number of Medicare Part D Enrollees Who Used the Drug from June 2022-May 2023
Eliquis	Prevention and treatment of blood clots	$16,482,621,000	3,706,000
Jardiance	Diabetes; Heart failure	$7,057,707,000	1,573,000
Xarelto	Prevention and treatment of blood clots; Reduction of risk for patients	$6,031,393,000	1,337,000
Januvia			869,000
Farxiga			799,000
Entresto			587,000
Enbrel	Rheumatoid arthritis; Psoriasis; Psoriatic arthritis	$2,791,105,000	48,000
Imbruvica	Blood cancers	$2,663,560,000	20,000
Stelara	Psoriasis; Psoriatic arthritis; Crohn's disease; Ulcerative colitis	$2,638,929,000	22,000
Fiasp; Fiasp FlexTouch; Fiasp PenFill; NovoLog; NovoLog FlexPen; NovoLog PenFill	Diabetes	$2,576,586,000	777,000

10 Part D drugs in 2026
Total cost over $5 billion

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CHAPTER SIX:

Long-term Care

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REMEMBER THIS FROM SESSION ONE?

Myth 3: **Medicare covers long-term care.**

72% The percentage of pre-retirees who believe Medicare will cover long-term care costs in retirement.

Nationwide Health Care Costs in Retirement Survey, October 2023

MAKING THESE EVEN WORSE IS THIS...

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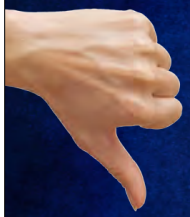

Fewer than

10% Believe they are very aware of the costs of long-term care.

Arctos Foundation/HCG Secure 2022 Long-term Care Perceptions and Preparation: A Middle-income Market Study, January 2022

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2023 Costs of Care

- Adult daycare $24,700
- Homemaker $68,600
- Assisted living facility $64,200
- Homecare aide $75,500
- Skilled nursing facility $104,000-$116,800

2023 Genworth Cost of Care Survey

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Long-term Care Planning

- One in 10 have long-term care insurance
- Four of 10 have financial plans, wills, trusts, and healthcare directives in place

2023 Genworth Cost of Care Survey

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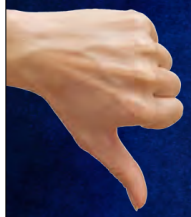

50%

Of survey respondents are not prepared to cover these costs.

Arctos Foundation/HCG Secure 2022 Long-term Care Perceptions and Preparation: A Middle-income Market Study, January 2022

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LTC Levels of Care with Costs

- Adult daycare $24,700
- Homecare aide, personal care worker $75,500
- Assisted living facility $64,200
- Nursing home $104,000-$116,800

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Adult Day Care

- For those with physical or cognitive disabilities who may need more supervision and service
- Clients receive:
  - Professional supervision
  - Social activities, exercise, meals and snacks
  - Medication management, physical and/or occupational
- Beneficial for caregivers' well-being
- Payer sources: some Medicare Advantage plans, Medicaid, state program, private pay (including LTC insurance, annuities, etc.)

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Medicare Coverage: Home Health Care

- Not really long-term care
- Must be considered homebound:
  - Illness, injury restricts ability to leave home, infrequent absences
  - Choosing to stay home is not homebound
- Medicare-covered if need for skilled nursing or therapy
- Intermittent care:
  - Visit-basis
  - Daily for limited period of time with predictable end date
- Part A or Part B service, no cost-sharing

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Medicare Coverage: Home Health Aide Services

- Must be receiving skilled nursing or therapy services and be considered homebound
- Home health aide services:
  - Personal care, facilitate treatment, maintain health
  - Provided by aides that meet training, competency requirements
  - Visit basis, less than eight hours a day for duration of skilled services

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A home health visit: As long as necessary to complete assigned duties, based on the patient's plan of care.

- Part-time or intermittent skilled nursing (SN) and home health aide services – These services can be furnished any number of days per week as long as they are furnished (combined) less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours per week)

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No Medicare Coverage:
Homecare Aide Services

- Provided by a personal care agency:
  - Generally not Medicare-certified, maybe state-licensed
  - Requirements for training, supervision, vary from state to state
- Duties:
  - Personal care, light housekeeping, meals, errands
  - Respite care, companionship
- Payer sources: some Medicare Advantage plans, Medicaid, state program, private pay (including LTC insurance, annuities, etc.)

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Medicare Advantage Coverage:
Homecare Aide and LTC Services

- Services from an in-network agency:
  - May be able to choose only one
  - More common in HMO plans
- Daily maintenance benefits:
  - Homecare aides, meals, rides to medical appointments
  - Prior authorization and limits
- Benefits likely to change over time

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A homecare nurse had been seeing an 85-year-old patient for four years, visiting once a month to several times a week.

Their son switched them to Medicare Advantage. The plan authorized four visits for the nurse to teach the 89-year old husband. Within one month, they were both in a facility.

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Medicare Coverage:
Nursing Homes

- Medicare-certified skilled nursing facility (SNF):
  - Three-day inpatient hospital stay for condition that will be treated in SNF
  - Part A covers first 20 days, $204 copayment for days 21-100
- Must need skilled care:
  - RNs or therapists must provide or supervise on daily basis (5-7 days per week)
  - Response or improvement
- Average length of Medicare stay around 27 days

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Medicare Advantage Coverage:
Nursing Homes

- In-network, Medicare-certified SNF
- A few plans waive the three-day hospital stay
- Same skilled care criteria
- Prior authorization requirement
- Several reports that stays are shorter than average Original Medicare stay

No Medicare Coverage:
Nursing Homes and Facilities

- Community-based residential facility (CBRF), assisted living facility (ALF), memory care, nursing home
- Stay does not meet Medicare coverage criteria:
  - No three-day hospital admission
  - No need for or response to skilled care 5-7 days per week
  - Need for greater level of personal care, assistance with mobility, behavior supervision
- Medicaid, state program, private pay (including LTC insurance, annuities, etc.)

Continuing Care Retirement Communities (CCRC)

- Life-care plan, contract with resident:
  - Over 1,900 communities
  - Independent, assisted living, memory care, skilled nursing
  - Same coverage rules apply
- Many accept Medicare, which will pay for covered services
- Problem with Medicare Advantage:
  - Facility not in the plan's network
  - If so, residents must move out if needing SNF care or pay for services (Medicare wouldn't work)

Long-term Care Realities

- Your plan:
  - You are never too young to start planning
  - Work with trusted advisors
  - Update the plan for life events
  - Do not assume automatically that your family will play a role
- Your role as a caregiver:
  - Never make the "no nursing home" promise
  - Have a "take care of yourself, too" plan

Long-term Care Bottom Line

- Medicare does not cover long-term care
- Medicare Advantage LTC coverage is limited and can change
- Don't wait until Medicare age to start planning

CHAPTER SEVEN:

The trouble with COBRA

Timing of Medicare With COBRA

- Many employers now offer retirement packages featuring "paid COBRA coverage" as a benefit
- Many HR professionals do not understand how this benefits works with Medicare rules, putting retirees in danger

Timing of Medicare With COBRA

- In order to have full medical coverage, one must enroll in Medicare Parts A and B for coverage to begin immediately after employment ends.
  - *"When a person is eligible for Medicare A and B, this plan will pay as the Secondary Plan to Medicare Part A and B* ***regardless if the person is actually enrolled in Medicare Part A and/or Part B*** *and regardless if the person seeks care at a Medicare Provider or not for Medicare covered services."*
    Copy from a standard Summary of Benefits

Timing of Medicare With COBRA

- If turning 65 or older than 65 years of age, the person will have a Guaranteed Issue Right to purchase a Medigap policy for the first six months after enrolling in Medicare Part B.
- After six months, the person will need to go through medical underwriting in order to get a Medigap policy.
  - This means, depending on health, that person may not qualify for a Medigap policy *(NY, CT, MA excluded)*

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Timing of Medicare With COBRA

- You will have a Guaranteed Issue Right (GIR) again IF your coverage drops you from the plan. **This ONLY applies when you are dropped from the coverage; *it does not apply* if you drop the coverage.**
- If you remain on COBRA until it ends at 18 months, you will be dropped from the plan. Then, you will have a GIR again.
- If you drop COBRA coverage voluntarily at 12 months when the company stops paying for COBRA, you will not have a GIR. (NY, MA, CT excluded)

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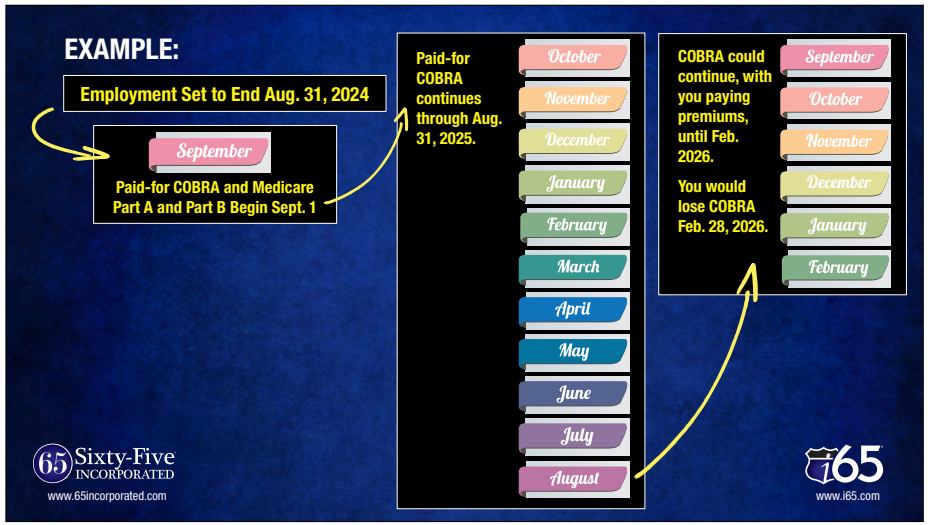

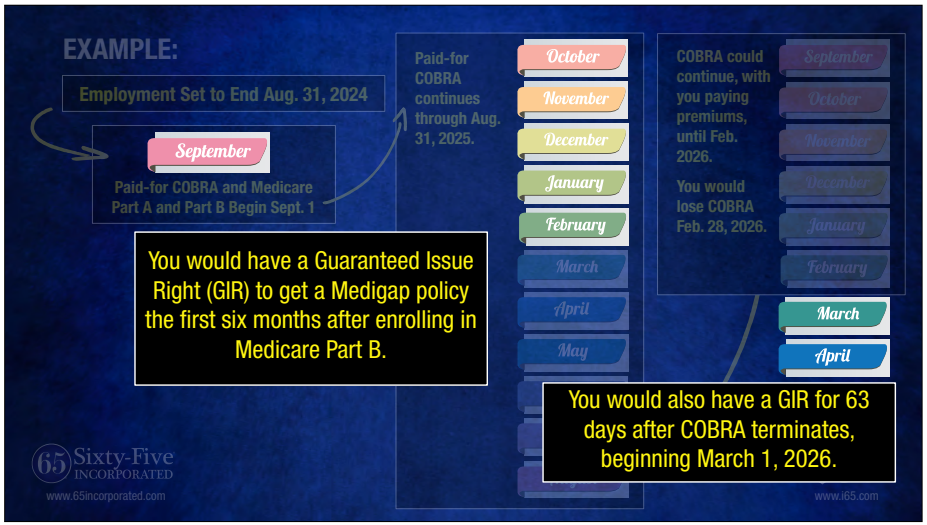

EXAMPLE:

Employment Set to End Aug. 31, 2024

September

Paid-for COBRA and Medicare

Paid-for COBRA continues through Aug. 31, 2025.

October
November
December
January
February
March
April
May
June
July
August

COBRA could continue, with you paying premiums, until Feb. 2026.

You would lose COBRA Feb. 28, 2026.

September
October
November
December
January
February

If you wanted to move to Medicare and get a Medigap policy in any of these months, you would have to go through medical underwriting. ***Depending on your health, you might NOT get a Medigap policy.***

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EXAMPLE:

Employment Set to End Aug. 31, 2024

September

Paid-for COBRA continues through Aug. 31, 2024.

October
November
December
January
February
March
April
May
June
July
August

COBRA could continue, with you paying premiums, until Feb. 2026.

Enroll in Medicare fully for coverage to begin no later than March 1

BOTTOM LINE:

To maximize a paid-COBRA benefit but still be able to get a Medigap policy, do 6 months of paid COBRA. Enroll in a Medigap policy & Part D drug plan during the 4th-5th month of COBRA for that coverage to begin of the first day of the 7th month.

You would forgo the additional 6 months of paid COBRA coverage.

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OUR CLIENTS' STORIES

MEET COMPANY XYZ

After consulting with an insurance agent, the company put together a retirement package that effectively left their retirees 65 years of age and older without functional health insurance for the duration of "paid coverage," plus they'd face a late enrollment penalty for life.

Uncovered medical liabilities of millions?

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CHAPTER EIGHT:

Understanding the business side of Medicare insurance sales

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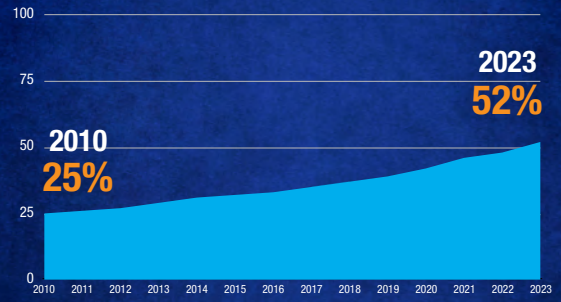
Percentage of Medicare Beneficiaries Choosing Medicare Advantage



https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-enrollment-update-and-key-trends/

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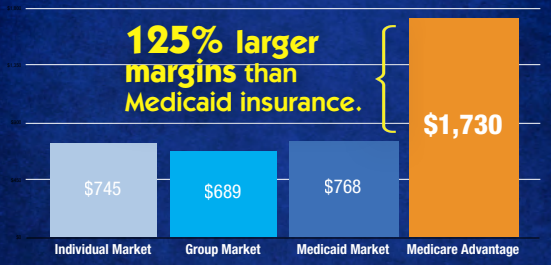
Gross Margins Per Enrollee, By Type of Insurance



https://www.kff.org/medicare/press-release/medicare-advantage-insurers-report-much-higher-gross-margins-per-enrollee-than-insurers-in-other-markets/

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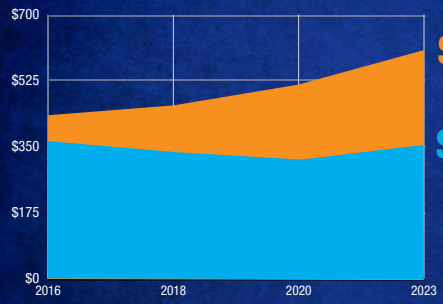
Insurance Agent Commissions By Type of Coverage (2023)



$601
$360
Agents make 40% more selling Medicare Advantage

Medicare Advantage Commission
Medigap Commission

https://www.ritterim.com/blog/2023-maximum-broker-commissions-for-medicare-advantage-medicare-part-d/
https://s3.documentcloud.org/documents/23131242/mac-22-level-6-street.pdf

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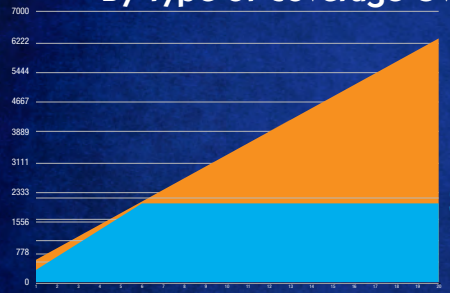
Insurance Agent Commissions By Type of Coverage Over 20 Years



$6,320
$2,053
After 6 years, agents stop receiving commissions on Medigap policies.

Total MAPD Commission
Total Medigap Commission

https://www.ritterim.com/blog/2023-maximum-broker-commissions-for-medicare-advantage-medicare-part-d/
https://s3.documentcloud.org/documents/23131242/mac-22-level-6-street.pdf

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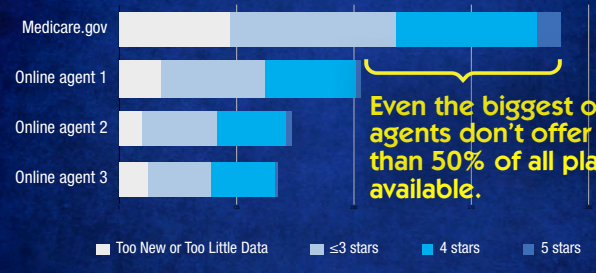
Agents do not have to sell all policies available in a market



Commonwealthfund.org, "How Agents Influence Medicare Beneficiaries' Plan Choice"

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Tips to Qualify an Insurance Agent:

1. Do you sell Medicare Advantage, Part D and Medigap policies?
2. What is your sales ratio of Medicare Advantage v. Medigap policies?
3. How many companies are you allowed to sell?
4. Pay attention during the sales conversation.
   - Does the agent prioritize discussions about low monthly premiums and extra free benefits? **(Not good.)**
   - Does the agent talk about today only, stating that you can always change your coverage later on? **(Not good.)**
   - Does the agent talk about networks, prior authorization and Guaranteed Issue Right? **(Good!)**

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