

Medicare in 2023: Changes Affecting Low-Income Beneficiaries Webinar Q&A

Access webinar recording at: <https://connect.ncoa.org/products/medicare-in-2023-changes-affecting-low-income-beneficiaries>

Medicare costs

Can you please provide the link to the additional information about how Medicare out-of-pocket (MOOP) costs will be calculated? With regard to MOOP what is secondary coverage?

A final rule issued earlier this year from the Centers for Medicare & Medicaid Services (CMS) specified that the MOOP limit in an MA plan (after which the plan pays 100% of costs for Part A and Part B services) must be calculated based on the accrual of all cost-sharing in the plan benefit, regardless of whether that cost-sharing is paid by the beneficiary, Medicaid, other secondary insurance (employer or commercial insurance), or remains unpaid (including cost-sharing that remains unpaid because of State limits on the amounts paid for Medicare cost-sharing and dually eligible individuals' exemption from Medicare cost-sharing).

Learn more at: <https://www.federalregister.gov/documents/2022/05/09/2022-09375/medicare-program-contract-year-2023-policy-and-technical-changes-to-the-medicare-advantage-and>

Does your chart about Part D also apply to MA plans?

There are slight differences in the calculations for Part D and MA plan deductibles, out-of-pocket costs, etc. See <https://www.ncoa.org/article/medicare-part-d-cost-sharing-chart> for a description of Part D coverage and costs and <https://www.ncoa.org/article/what-are-the-costs-of-medicare-advantage-part-c> for an outline of costs in MA plans.

Any early indication that the FPL limits will go up significantly in 2023?

Federal poverty guidelines are typically released in mid-January. It is unclear at this point whether they will increase significantly, though the Feds do factor inflation into their calculations, which has been especially high in 2022.

Landscape of plans

What are the criteria used in the star system? What is the difference between a 3-star and a 4-star plan, for example?

The star rating system was developed by CMS to measure MA and Part D plans against customer satisfaction, plan performance, drug safety and pricing, and (for MA plans) services to

help members stay healthy and receive recommended tests and treatments for chronic conditions. Learn more at: <https://www.medicareinteractive.org/get-answers/medicare-health-coverage-options/changing-medicare-coverage/how-to-compare-plans-using-the-medicare-star-rating-system>.

Dual-Special Needs Plans (D-SNPs)

How can you tell when a plan is a D-SNP “look-alike” plan?

It isn't always easy to identify a D-SNP look-alike plan. These plans market themselves to people with Medicare & Medicaid and often include supplemental benefits that may appeal to duals, but have cost-sharing associated with those benefits. D-SNP look-alikes usually have a premium for Part D and a high Part D deductible (often the maximum). Actual D-SNPs will be identified as such in the Medicare Plan Finder. Justice in Aging offers this more in-depth primer on D-SNP look-alikes: <https://www.justiceinaging.org/wp-content/uploads/2019/07/D-SNP-Look-Alikes-A-Primer.pdf>.

D-SNP look-alikes—do they last all during 2023 or end during 2023? If so, when?

D-SNP look-alike plans are defined as general enrollment plans (i.e., not D-SNPs) whose enrollment is comprised of at least 80% dual eligibles. For the 2023 plan year, anyone enrolled in a D-SNP look-alike that meets this definition in a state which has existing D-SNPs or Medicare-Medicaid plans (integrated care plans) will be transitioned over to those plans.

It's important to note, however, that Chronic Special Needs Plans (C-SNPs), which often enroll a large dual population, do not fall under the D-SNP look-alike rule and are thus not subject to the D-SNP integration requirements. Additionally, there may be plans that continue to operate as D-SNP look-alikes but keep enrollment below the 80% threshold; Medicare advocacy groups continue to urge CMS to revisit this threshold.

Is it still true that only FIDE D-SNPs have a unified appeals and grievance process?

Fully Integrated Dual Eligible (FIDE) and Highly Integrated Dual Eligible (HIDE) SNPs with exclusively aligned enrollment can have integrated appeals and grievances. The [Integrated Care Resource Center](#) defines exclusively aligned enrollment as occurring when state policy limits the D-SNP's membership such that every enrollee in the D-SNP receives their Medicaid benefits from the D-SNP, or from an affiliated Medicaid managed care plan offered by the same parent company.

So, importantly, not every HIDE & FIDE SNP will have integrated grievances and appeals.

Medicare Subsidy Programs (MSP/LIS)

Is there a list of states that plan on increasing the MSP limits? I'm in TN and I'm concerned about how the SSA increase and Part B decrease will affect those on the borderline limits.

NCOA updates our chart of states' guidelines for MSPs each year following release of the Federal poverty guidelines (see: <https://www.ncoa.org/article/medicare-savings-programs-eligibility-coverage>). As of this date, we are aware of California and New York taking steps in 2023 to expand eligibility for these programs.

Note that many states retain the previous year's MSP eligibility guidelines until March/April 1, when they adjust to reflect the new Federal poverty guidelines. As noted above, the FPLs account for inflation, so there is a possibility they will rise as well. Check with your state Medicaid agency to find out when the guidelines for the new year apply in your state.

If someone is turning 65 in January, Medicare effective date 1/1, how soon can they fill out the MSP and Extra Help applications? Do they have to wait until they are actually active on Medicare or can they do it ahead to try and keep from having to pay Part B premium from the get go?

Typically, once someone has their Medicare number, they can go ahead and apply for the Medicare subsidies up to one month in advance of their Medicare coverage effectiveness date. Administrative processes in some states make advanced enrollment very difficult.

Can a person on Social Security Disability Insurance (SSDI) and under age 65 enroll in a MA plan and also have LIS?

An individual under age 65 who qualifies for Medicare after receiving SSDI for 24 months is eligible to enroll in a Medicare Advantage plan. That person can also receive LIS/Extra Help so long as their plan is an MA plan with prescription drug coverage. The LIS benefit may reduce some or all of the plan's premium (if there is one) that goes toward the prescription drug benefit. However, the person still may be fully responsible for the portion of the plan premium that goes toward medical and hospital benefits.

Where does Social Security obtain income and asset information? How is income defined for LIS and MSP? Adjusted gross from tax returns? Does depreciation on investment real estate count or added back?

The Medicare subsidies count income as anything an individual receives in cash or in kind that can be used to meet his or her needs for food or shelter, including earned and unearned income. The Social Security Program and Operations Manual outlines the rules around counting income for LIS at: <https://secure.ssa.gov/apps10/poms.nsf/lnx/0603000000>; the POMS also outlines how assets such as investments are counted. States may have more flexible rules

around counting income and assets for MSPs; check with your state's Medicaid manual for details.

In making LIS determinations, the Social Security Administration (SSA) verifies application information against data available from other government sources, though this is incomplete and does not always reflect a full accounting of an applicant's assets.

Medicare Enrollment and Special Enrollment Periods (SEPs)

How will CMS determine if a client is eligible (an insulin user) to use the Insulin exceptional circumstances SEP?

This SEP is available for individuals that use covered insulin products to add, drop, or change their Part D coverage beginning on December 8th, 2022, and ending on December 31, 2023

While it is unclear if the 1-800-Medicare representative will be reviewing beneficiary medical information prior to facilitating a change in plans, representatives can confirm that insulin is on the beneficiary's drug list as they help beneficiaries compare plans on Medicare Plan Finder.

A client signs up for A and B during the General Enrollment Period (GEP); will the client need to wait until April to sign up for Part D, with Part D coverage beginning on July 1?

Beginning in January 2023, the Consolidated Appropriations Act (CAA) changes the effective date for enrollment into Medicare Parts A and B in the GEP from July 1 to the month following the month of enrollment. The CAA, however, did not amend the Part D SEP associated with the GEP. The federal regulation that applies to the Part D SEP for the GEP [42 CFR 423.38\(c\)\(16\)](#) remains unchanged and is provided below:

The individual is not entitled to premium free Part A and enrolls in Part B during the General Enrollment Period for Part B (January through March) for an effective date of July 1st is eligible to request enrollment in a Part D plan that begins April 1st and ends June 30th, with a Part D plan enrollment effective date of July 1st.

So, the existing Part D regulation stands, and the Part D SEP associated with a GEP enrollment has an effective date of July 1.

CMS is aware of the issue but does not have any updates to share currently.

If a person turns 65 in October 2022 and signs up for Part B in December 2022 when does Part B begin, January 2023 or March 2023?

The changes made by the 2021 Consolidated Appropriations Act only apply to people who become eligible for Medicare on January 1, 2023, and after. If a person turns 65 in October 2022 and signs up for Part B in December 2022, Part B coverage would begin in March 2023, the first day of the third month following Part B enrollment.

Will the new SEP for incarcerated individuals help an individual released from prison 10 years ago and missed his IEP and is currently facing a huge late enrollment penalty?

Starting in 2023, people who qualify for a Part B exceptional circumstances SEP can enroll without having to wait for the GEP and without being subject to a Part B [late enrollment penalty](#). The SEP for formerly incarcerated individuals to enroll in Medicare following their release from a correctional facility runs for 12 months post-release and allows qualifying individuals to choose between retroactive coverage going back to their release date (not to exceed six months and for which premium payments would be owed) or coverage beginning the month after they enroll.

The SEP would not offer relief to individuals released from a correctional facility more than 12 months ago.

Regarding the exceptional circumstances SEP, do you have any sense if CMS will add living overseas to the list of exceptional circumstances?

While CMS does allow for an [SEP for international volunteers](#), CMS has given no sign that it will extend the exceptional circumstances SEP to include individuals that are returning to the United States after living overseas.

Insulin & drug pricing

Please explain what is considered an insulin product under the Inflation Reduction Act (IRA) and are combination medicines eligible for the \$35 cap?

Beginning January 1, 2023, copayments for each insulin product (listed on the Medicare plan's formulary) will be capped at \$35 for a month supply. An insulin product refers to one of the following:

- a product that contains insulin
- a combination of products that contains more than one type of insulin
- a combination of products that contains both insulin and a non-insulin drug or biological product

A "covered insulin product" falls into one of three categories:

- insulin products included on the plan's formulary
- products treated as on formulary due to a coverage determination or appeal
- products covered as a "transition fill"

When you say the insulin cap is \$35/month per insulin product, does that mean per vial of insulin or per type of insulin? For example, if a client uses two vials of Humalog per month is the cap \$35 or two times \$35?

The \$35 cap applies for a [30-day supply of each insulin product purchased](#). If a client obtains one short acting, one intermediate acting, and one long-acting insulin product during the month then three separate maximum \$35 copays apply.

Regarding Insulin: Unclear guidance regarding whether insulin costs covered by the plan will count toward entering coverage gap.

Only the \$35 (or less) cost-sharing for a month's supply of each insulin product counts toward true out-of-pocket costs.

Is the insulin exceptional circumstances SEP only accessible by calling 1-800-Medicare?

To date, CMS is directing anyone interested in using the insulin exceptional circumstance SEP to contact 1-800-Medicare beginning December 8, 2022. This SEP will allow an individual who uses a covered insulin product to add, drop, or change their Part D coverage beginning on December 8th, 2022, and ending on December 31, 2023. A person with Medicare who takes insulin may use this SEP one time during this period. NCOA will notify the network if the protocol changes.

Can drug prices rise unchecked from pharmacies and/or insurance companies (while manufacturers have to hold to inflation)?

The Inflation Reduction Act contains [several provisions](#) aimed at limiting soaring drug prices. In 2023, this includes the insulin cap under Part D and a requirement for drug companies to pay rebates to Medicare if the prices of their medications rise faster than inflation for Medicare beneficiaries. Beginning in 2024, Part D plans will effectively cap out-of-pocket costs by eliminating the 5% coinsurance above the catastrophic coverage threshold. And in 2026, the Federal government will begin to negotiate for some drugs under Part B and Part D that have the highest spending.

Medicare Marketing

Are SHIBA/SHIP volunteers considered Third Party Marketing Organization (TPMOs)?

No. State Health Insurance Assistance Programs (SHIPs) are Federally funded to provide unbiased, local, one-to-one counseling to people with Medicare and their families and caregivers. Because SHIP staff and volunteers are strictly prohibited from marketing insurance, they are not considered TPMOs.

Is the TPMO disclaimer required at events?

No. Since the language of the [final rule](#) does not clearly require such a disclosure during a marketing event, CMS does not require it.

Is it true that insurance brokers make \$600 for selling an Advantage plan? And then a "retention fee" if the beneficiary stays in the plan?

Companies that contract with Medicare to provide health care coverage or prescription drugs typically use agents/brokers to sell their Medicare plans to Medicare beneficiaries. Below is a link to a file showing the amounts that companies pay independent agents/brokers to sell their Medicare drug and health plans. Generally, agents/brokers receive an initial payment in the first year of the policy and half as much for years two (2) and beyond if the member stays enrolled in the plan or makes a "like plan type" enrollment change.

<https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/AgentBroker>

Who will be enforcing the Plan/TPMO new rules?

CMS is monitoring the "chain of enrollment," which includes the distribution of marketing materials, lead generating, sales talks, and the enrollment process to ensure all activities are completed in accordance with applicable requirements. CMS is working with other federal agencies determine the appropriateness of the content of certain advertisements.

CMS has told plans it will begin policing marketing materials more closely. Starting the next open enrollment, Medicare will review and approve television advertisements before they air to make sure spokespersons accurately describe the plans' benefits. Attached are copies of CMS [October 8, 2022 bulletin](#) and [October 19, 2022 bulletin](#) which describe CMS increased monitoring of Medicare Advantage plans

I have gone to some of the TPMO sites and read the disclaimers. They are so small they are nearly impossible to read. Are there any provisions for font size or how the written disclaimer needs to be shown?

There isn't a particular [required](#) font size. The final rule says the disclaimer must be prominently displayed.