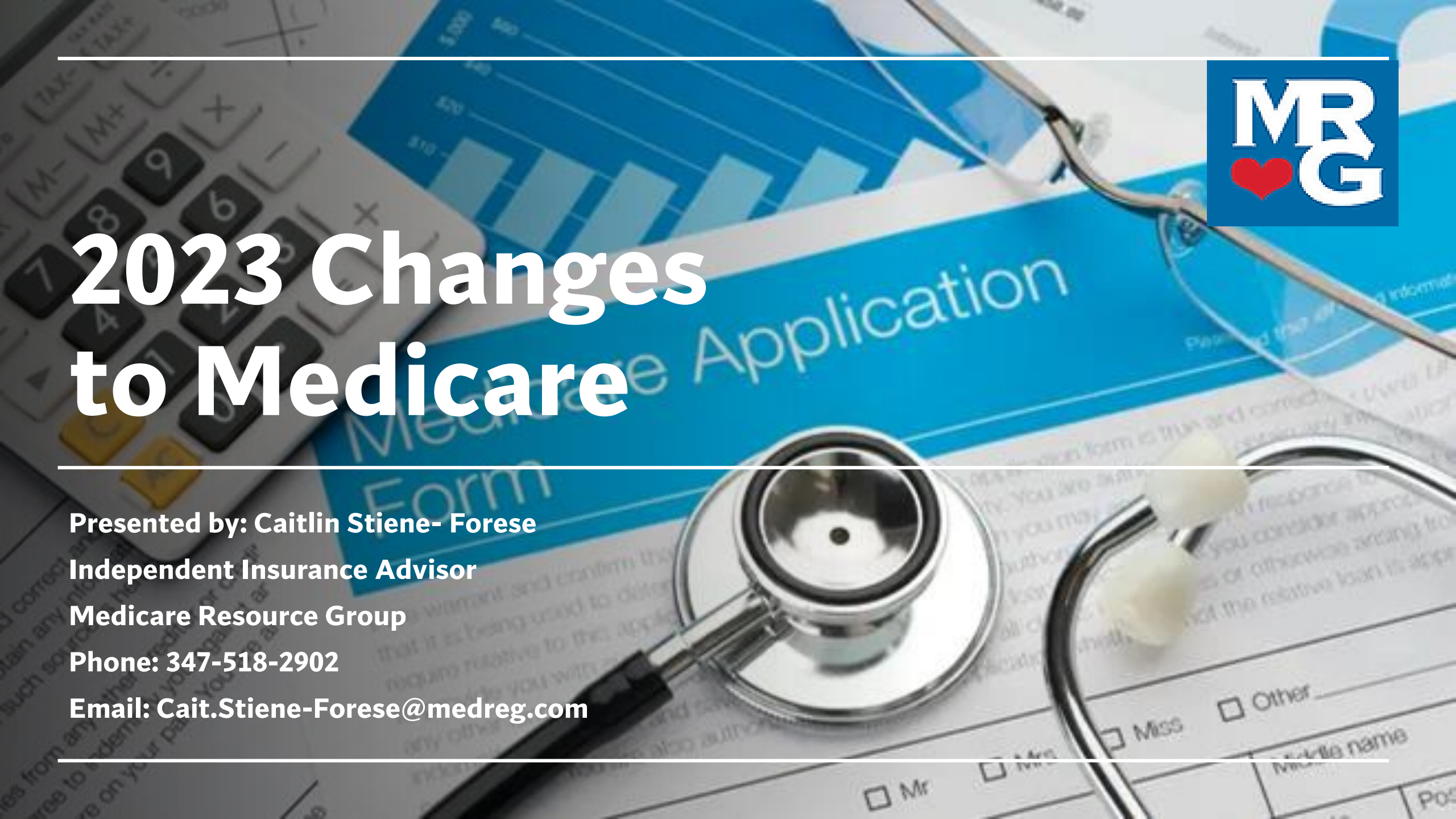

2023 Changes to Medicare

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In this presentation we will Discuss:

* The Inflation Reduction Act

* The New York Landmark Budget Act. Expansion of Medicaid

- NY EPIC and how the program can be used to get out of a plan that is no longer compatible with your medications.
- NY Laws that protect Seniors on Medicare
- Low Income Subsidy Part D
- 2023 Medicare Premiums and Amounts
- Pros and Cons of Medicare Supplement and Medicare Advantage

The Inflation reduction Act of 2022 or IRA is a United States Federal Law which aims to:

Require drug manufacturers to pay a rebate to the Federal government if prices for single source drugs and biologicals covered under Part B and nearly all covered drugs under Part D increase faster than the rate of inflation. This inflation rebate took effect in 2022 with the rebate payments required beginning 2023.

*These actions are expected to lower beneficiaries out of pocket spending on prescription drug costs. The goal is to cap out of pocket spending. For 2024 this inflation reduction act will aim to cap out of pocket Part D spending to $3,250, and a hard cap of $2,000 on out-of-pocket spending for Part D medications by 2025.

*Starting January 1st, 2023, if you get a 60- or 90-day supply of insulin, your costs cannot be more than 35$ for each month supply of covered insulin. You can find out more at www.kff.org or Medicare.gov about the IRA.

The NY Landmark Budget Act

Changes in NY States Medicare and Medicare Savings Program.
The 2022 Medicaid Income limits are $934 per individual in monthly income and $1,367 per couple in monthly income.

For 2023 These limits are expected to be increased and are expected to increase to $1,563 for an individual and $2,106 for a couple. The new budget also increases the permitted resource limit for Medicaid applicants. Currently, to be eligible for Medicaid an individual's resources could not exceed $16,800 and a couple's resources could not exceed $24,600. Under the new law for 2023, an individual may be able to keep $28,134 and a couple $37,908. This income and asset limit could allow New Yorkers to qualify for Medicaid if they are 65+ years old, blind or disabled.

As you can see the income amount being projected for Community Medicaid could allow more people to qualify. Community Medicaid is what provides Long Term Care to seniors, and it can also provide cost sharing assistance to Part A/B Medical bills.

Now that you know what Community Medicaid is-

We need to talk about the Medicare Savings Program. The Medicare savings Program is also administered by Medicaid, however, if you fall into one of the MSP categories, you are not eligible for LTC (community Medicaid) But, you may be eligible for Part B premium assistance and medical and hospital cost sharing if you are approved for the MSP (Partial Medicaid)

Now, Lets go into the different levels of the Medicare savings Program.

The Medicare Savings Program Income levels:

QMB: (Qualified Medicare Beneficiary) People who are 65+ are expected to qualify for QMB with the same income limit as those qualifying for community Medicaid. QMB's have a higher resource limit then those who qualify for community Medicaid. The LBA aims to get rid of the resource limits for QMB's and QI's.

QMB: the state helps pay for a recipients Medicare Part B premium as well as any medical cost sharing expenses. A Medical provider is forbidden from balance billing a QMB recipient.

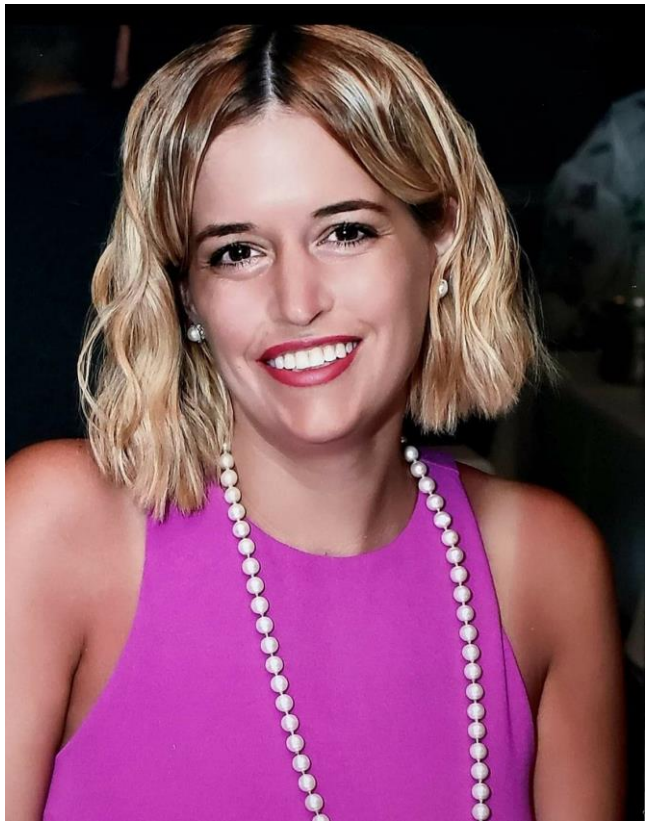
These limits are based on the federal poverty level and will formally be announced in January.

To find out more: Medicareinteractive.org and medicarerights.org

SLMB is going away for 2023: All recipients who are SLMB **(Specified Low-income Medicare Beneficiary**) are projected to move to QMB. SLMB is a MSP level where the recipient gets their Part B premium paid for by the state and sometimes can receive cost sharing assistance for medical bills. SLMB's could be balance billed by providers legally. This is going away in 2023.

QI: (Qualified Individual) The State pays for the recipients Part B premium only. However, the recipient will be responsible for all medical and hospital cost sharing expenses. These recipients will be balance billed. **Projected 2023 Income limits for QI:** Individual: $2,107 Couples: $2,839.

The numbers will be finalized in January, but these are the current projections based on the FPL. I will provide the finalized numbers in January so RSS members can see if they qualify. Keep your eye out in January!



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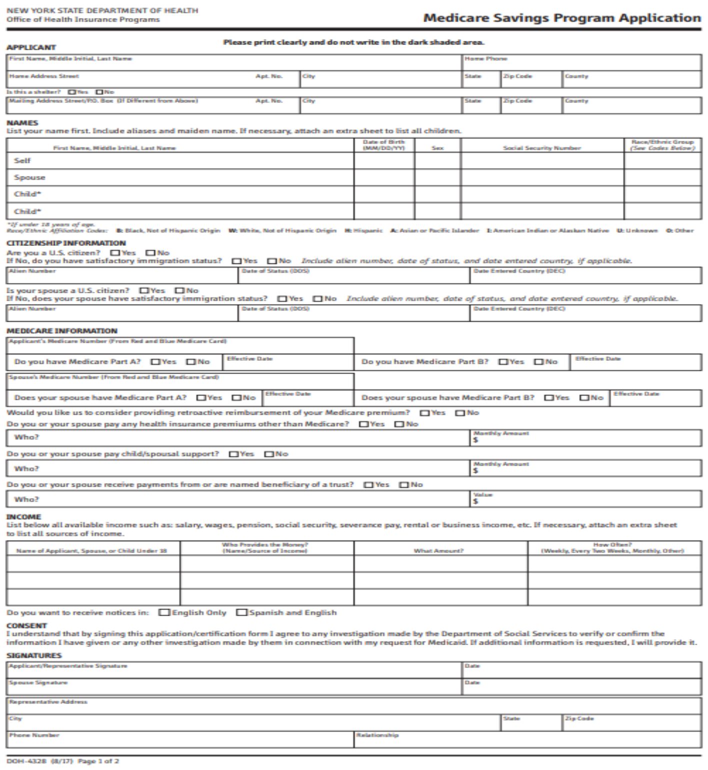
Short Application: MSP

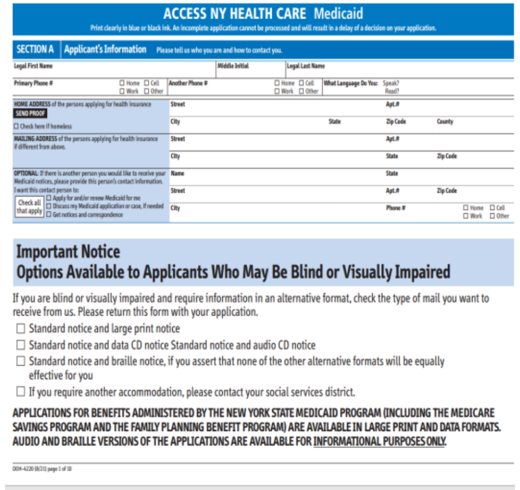


NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

Medicare Savings Program Application

Please print clearly and do not write in the dark shaded area.

The Long Application: Medicaid



ACCESS NY HEALTH CARE Medicaid

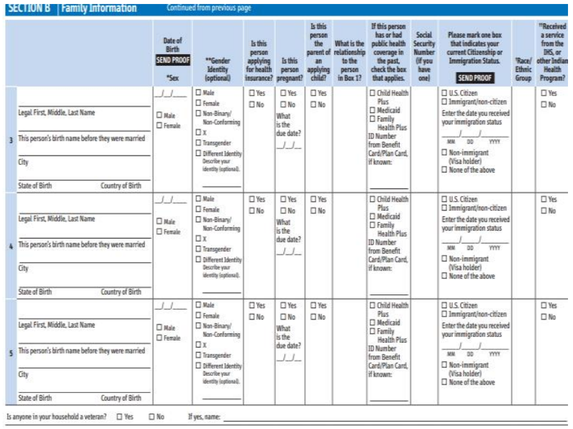
SECTION A Applicant's Information

Important Notice
Options Available to Applicants Who May Be Blind or Visually Impaired

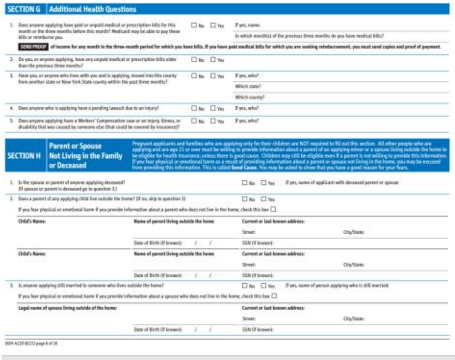
If you are blind or visually impaired and require information in an alternative format, check the type of mail you want to receive from us. Please return this form with your application.

- Standard notice and large print notice
- Standard notice and data CD notice Standard notice and audio CD notice
- Standard notice and braille notice, if you assert that none of the other alternative formats will be equally effective for you
- If you require another accommodation, please contact your social services district.

APPLICATIONS FOR BENEFITS ADMINISTERED BY THE NEW YORK STATE MEDICAID PROGRAM (INCLUDING THE MEDICARE SAVINGS PROGRAM AND THE FAMILY PLANNING BENEFIT PROGRAM) ARE AVAILABLE IN LARGE PRINT AND DATA FORMATS. AUDIO AND BRAILLE VERSIONS OF THE APPLICATIONS ARE AVAILABLE FOR INFORMATIONAL PURPOSES ONLY.

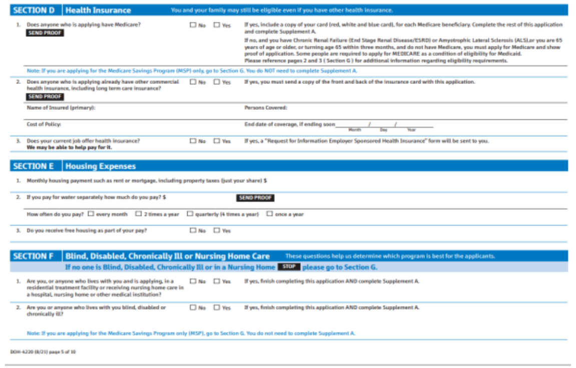


SECTION B Family Information



SECTION G Additional Health Questions

SECTION H Parent or Spouse Not Living in the Family or Deceased



SECTION D Health Insurance

SECTION E Housing Expenses

SECTION F Blind, Disabled, Chronically Ill or Nursing Home Care

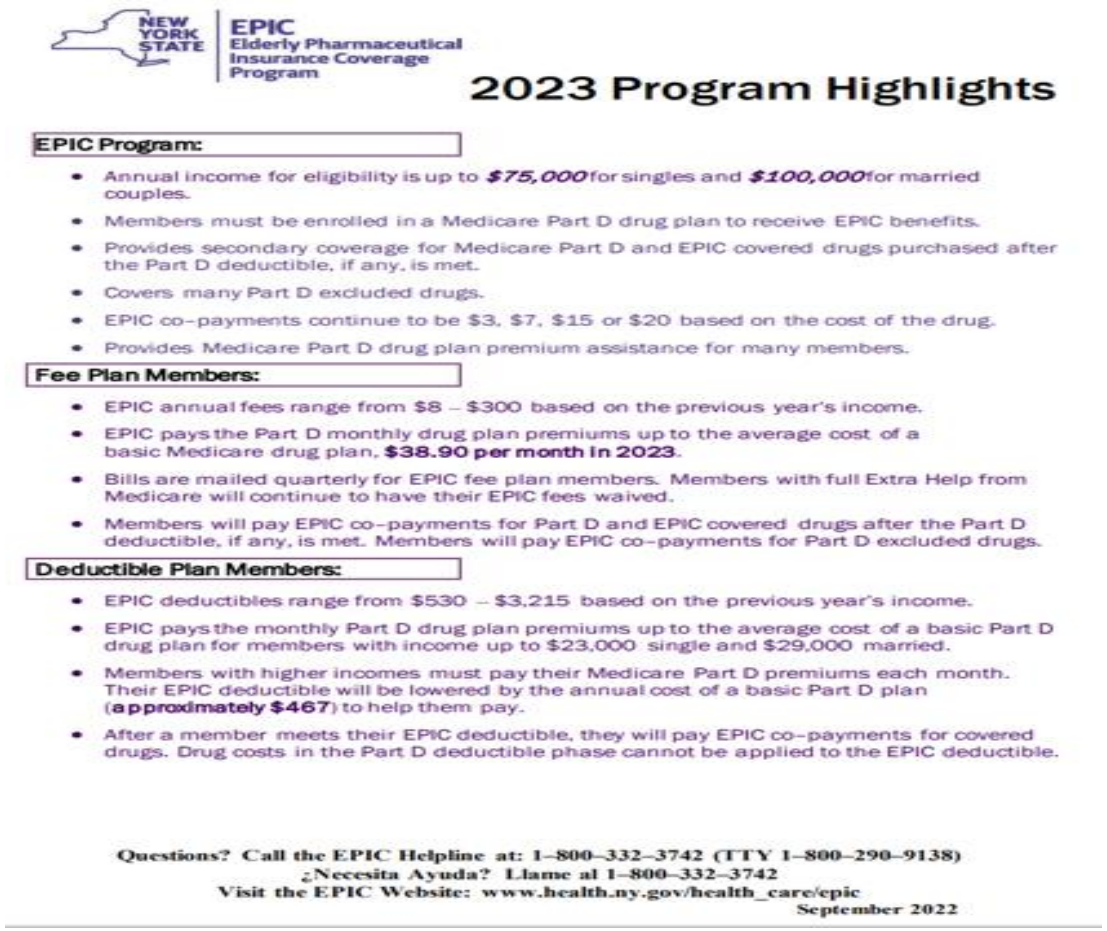
Now that you know the difference between Community Medicaid and the MSP: Lets get into LIS also known as **Low Income Subsidy:**

Low Income Subsidy is a federal program administered by social security and it can help drastically reduce outpatient prescription copayments as well as reduce Part D premiums if your plan has one. Most Medicare Advantage plans have the Part D built in, known as MAPD's. **LIS does not** offer medical cost sharing it is for outpatient prescription help only.

For 2022, the LIS Income Limit for full extra help is currently $1,719 in monthly income per individual and $ 2,309 for couples. An individual's assets cannot exceed $8,400 and a couple's assets cannot exceed $12,600.

For 2023, the asset limits for individual are $9,090 and for couples $13,360. Monthly income limits will be released in early 2023 according to CMS.gov

Not everyone will qualify for LIS, but many will qualify for NYEPIC.



NEW YORK STATE | EPIC Elderly Pharmaceutical Insurance Coverage Program

2023 Program Highlights

EPIC Program:

- Annual income for eligibility is up to ***$75,000*** for singles and ***$100,000*** for married couples.
- Members must be enrolled in a Medicare Part D drug plan to receive EPIC benefits.
- Provides secondary coverage for Medicare Part D and EPIC covered drugs purchased after the Part D deductible, if any, is met.
- Covers many Part D excluded drugs.
- EPIC co-payments continue to be $3, $7, $15 or $20 based on the cost of the drug.
- Provides Medicare Part D drug plan premium assistance for many members.

Fee Plan Members:

- EPIC annual fees range from $8 – $300 based on the previous year's income.
- EPIC pays the Part D monthly drug plan premiums up to the average cost of a basic Medicare drug plan, **$38.90 per month in 2023**.
- Bills are mailed quarterly for EPIC fee plan members. Members with full Extra Help from Medicare will continue to have their EPIC fees waived.
- Members will pay EPIC co-payments for Part D and EPIC covered drugs after the Part D deductible, if any, is met. Members will pay EPIC co-payments for Part D excluded drugs.

Deductible Plan Members:

- EPIC deductibles range from $530 – $3,215 based on the previous year's income.
- EPIC pays the monthly Part D drug plan premiums up to the average cost of a basic Part D drug plan for members with income up to $23,000 single and $29,000 married.
- Members with higher incomes must pay their Medicare Part D premiums each month. Their EPIC deductible will be lowered by the annual cost of a basic Part D plan (**approximately $467**) to help them pay.
- After a member meets their EPIC deductible, they will pay EPIC co-payments for covered drugs. Drug costs in the Part D deductible phase cannot be applied to the EPIC deductible.

Questions? Call the EPIC Helpline at: 1-800-332-3742 (TTY 1-800-290-9138)
¿Necesita Ayuda? Llame al 1-800-332-3742
Visit the EPIC Website: www.health.ny.gov/health_care/epic
September 2022

***NY EPIC can help with prescription drug plan costs.**

***NY EPIC also allows individuals to make a one-time plan change to their part D drug plan or MA-PD plan one time a year.**

***If you have NYEPIC You are allowed a yearly one -time Special Election Period (SEP) per calendar year when on NYEPIC, it can be used at anytime, but only once per calendar year.**

***Even if you do not take drugs currently, NYEPIC is good to have incase you do get prescribed a costly medication that doesn't work with your current plan.**

NY has more protection laws for Medicare beneficiaries than any other state in the US!

What are some of the protection laws? First, NY is a **MOM** state. NY has **M**edicare **O**vercharge **M**easure laws. If you see a provider that accepts Medicare, but is not on Medicare assignment, the provider is only allowed to bill a 5% excess charge. Most states it is a 15% excess charge.

NY is one of the very few states that is a guaranteed issue state for Medicare supplement (Medi Gap) policies. That means that regardless of age or health status, a beneficiary can sign up for a Medicare supplement policy with no health questions asked.

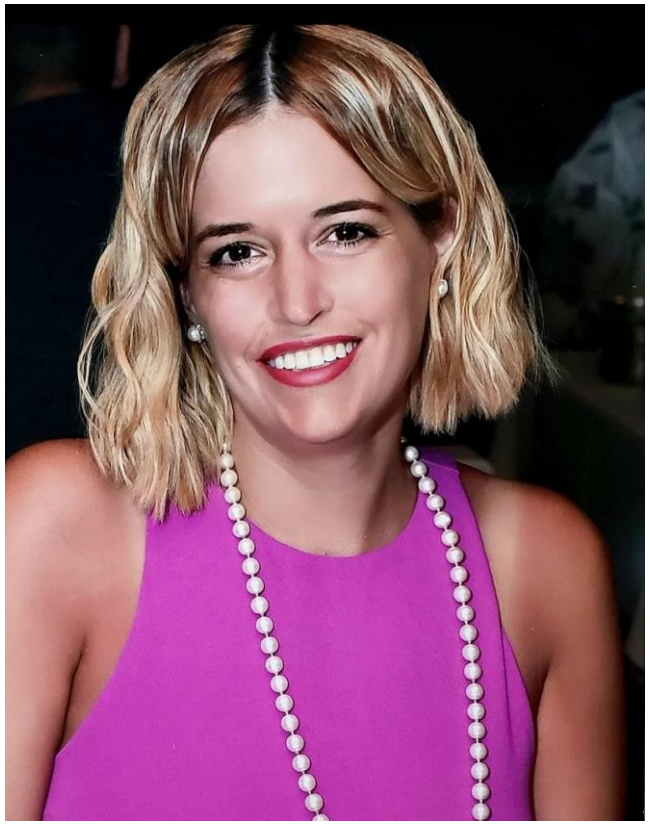
Most states do medical underwriting when it comes to Medicare Supplement policies. Most people who become new to Medicare have a 6-month window to sign up for a Medicare Supplement policy with no health questions asked..

This is true for most states, but not for NY. The only limitation NY has when it comes to Medicare Supplement (Medigap) policies is you could incur a 6-month waiting period for a pre-existing condition. However, if you did not have a 63- day lapse in coverage, the waiting period is waived.

How the 6-Month Waiting Period Works in NY

1. An individual decides to switch their Medicare Advantage plan to a Medigap Policy with a Part D plan. (**Waiting period is waived)**
2. An individual decides to change their Medicare supplement policy to another Medicare supplement policy. **(Waiting period is waived)**
3. An individual is on a retiree plan from their former employer, and they want to switch to a Medicare Supplement policy. **(Waiting period is waived)**
4. An Individual with Original Medicare only, wants to add a Medicare supplement policy. They will be able to purchase the policy**. (6 month waiting period will be enforced)** Having a Stand-Alone Part D plan with Original Medicare will not waive the waiting period!
5. If you are new to Medicare and did not have insurance prior to turning 65, the waiting period is waived, so long as you are in your 6- month open enrollment window, which starts the day of your Medicare Part B effective date.

This information can be found on www.dfs.ny.gov



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THE MEDICARE AMOUNTS FOR 2023

*For 2023, the standard Part B premium will be 164.90. Most people pay the standard premium. Individual income must be $97k or less, couples must be $194k or less in order to pay the standard.

*If your income is higher than $97k for individual and 194k for couple, you will be subject to IRMAA (**I**ncome **R**elated **M**onthly **A**djustment **A**mount)

**Individuals collecting social security will receive an 8.7% increase on their monthly SS check.

The Medicare amounts can be found on CMS.gov

Individual	Couples	IRMAA	Total
Less than or equal to $97,000	Less than or equal to $194,000	$0.00	$164.90
Greater than $97,000 and less than or equal to $123,000	Greater than $194,000 and less than or equal to $246,000	$65.90	$230.80
Greater than $123,000 and less than or equal to $153,000	Greater than $246,000 and less than or equal to $306,000	$164.80	$329.70
Greater than $153,000 and less than or equal to $183,000	Greater than $306,000 and less than or equal to $366,000	$263.70	$428.60

****People who are higher income also must pay Part D IRMAA in addition to Part B IRMAA****

Reminder: If you are under the income amounts of $97k for individual, and $194k for couples, you will not be subject to the Part D or B IRMAA amounts. Your only responsibility is the standard part B monthly premium which for 2023 is $164.90

All the information provided can be found on CMS.gov

Individual	Couples	D IRMAA
Greater than $97,000 and less than or equal to $123,000	Greater than $194,000 and less than or equal to $246,000	12.20
Greater than $123,000 and less than or equal to $153,000	Greater than $246,000 and less than or equal to $306,000	31.50
Greater than $153,000 and less than or equal to $183,000	Greater than $306,000 and less than or equal to $366,000	50.70
Greater than $183,000 and less than $500,000	Greater than $366,000 and less than $750,000	70.00
Greater than or equal to $500,000	Greater than or equal to $750,000	76.40

If you just have Original Medicare Only, these costs will apply to you. 2023 Medicare costs under Part A/B.

Medicare Cost Comparison, Year-Over-Year		
	2022	2023
Part A Premium	$499	$506
Part A Deductible	$1,556	$1,600
Part A Daily Co-Pay: Days 61-90	$389	$400
Part A Daily Co-Pay: Days 91-150	$778	$800
Part A Skilled Nursing Co-Pay	$194.50	$200
Part B Premium	$170.10	$164.90
Part B Deductible	$233	$226
Part B Co-Insurance	20%	20%

Skilled Nursing: 0$ per day. Days 1-20. $194.50 per day, days 21-100.

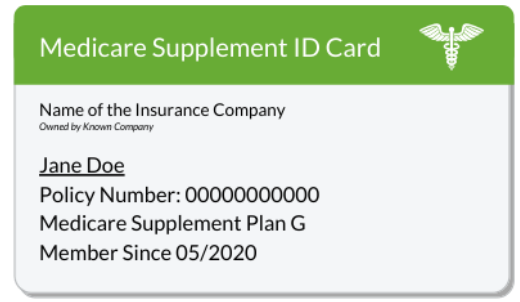
There is no-cap on your out-of- pocket expenses if you just have original Medicare Only.

As Comprehensive as Original Medicare is, there are gaps. An Individual may choose a Medicare Supplement Policy to " Supplement" or fill in those gaps that Original Medicare doesn't cover. **(Plan C and F cannot be purchased for those who turned 65 starting 1/1/2020 or those who have a Medicare Start date of 1/1/2020) Those who turned 65 prior to 1/1/2020 or had a Medicare Part A start date before 1/1/2020 can still purchase Plan C or Plan F) You must have Medicare Part A+B in order to purchase a medi-gap plan.**

Medigap Benefits	Medigap Plans									
	A	B	C	D	F	G	K	L	M	N
Part A Coinsurance + 365 additional lifetime reserve days	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Part B co-insurance	Yes	Yes	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes
1st 3 pints of blood	Yes	Yes	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes
Part A hospice care insurance	Yes	Yes	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes
Skilled nursing facility care co-insurance	No	No	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes
Part A deductible	No	Yes	Yes	Yes	Yes	Yes	50%	75%	50%	Yes
Part B deductible	No	No	Yes	No	Yes	No	No	No	No	No
Part B excess charge	No	No	No	No	Yes	Yes	No	No	No	No
Foreign travel exchange	No	No	80%	80%	80%	80%	No	No	80%	80%
Out-of-pocket limit (2022)	N/A	N/A	N/A	N/A	N/A	N/A	$6,220	$3,110	N/A	N/A

How a Medicare Supplement Policy works:

Medicare Part A/B is your primary insurance, the supplement is only there to follow your Medicare. You must show two cards when going to the DR. You will have a third card for your outpatient prescription drug plan.



There is no network, if the provider accepts Original Medicare, they must accept the supplement plan. The provider bills Medicare, and Medicare sends the remaining balance to the supplement plan. You must always carry all 3 cards with you.

Pros of a Medicare Supplement Policy

1.You have nationwide access to providers. Approximately 96% of providers nationwide accept Medicare. NO NETWORKS

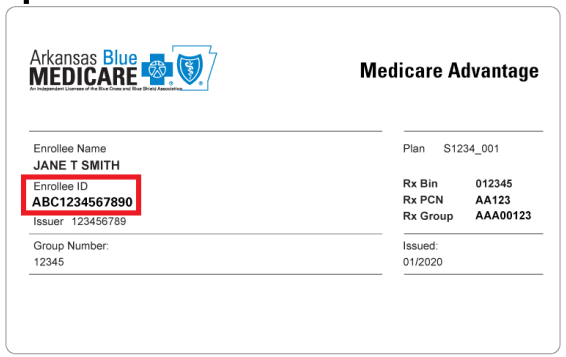
2. You have predictable out of pocket expenses

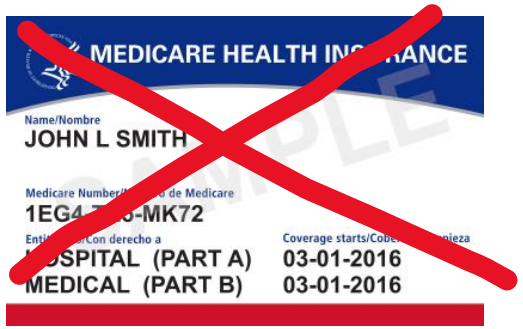
3. Your DR has the final say in managing your healthcare under OM. If the DR deems it medically necessary, Medicare will cover it without requiring a prior authorization. Under certain conditions OM may require a prior authorization.

The Cons of Medicare Supplement Plans

1. Since NY is a guaranteed issue state for Medicare Supplement Plans, the premiums are higher than states that do Medical underwriting. An **Individual will have 3 premiums they must pay monthly. 1. Part B premium 2. Supplement Premium 3. Drug plan premium.**
2. Medicare Supplement plans do not offer any ancillary benefits such as dental, vision or hearing. If an individual wants ancillary benefits, they will need to purchase a stand-alone dental, vision or hearing plan, resulting in additional monthly premiums.
3. Whether you use your supplement policy or not, you are required to pay the premium.
4. Supplement premiums can increase each year, this in turn over time can make these policies costly for an individual on a fixed income.

Medicare Advantage: You are still part of the Medicare program; however, your red white and blue card will not work as you now have a private insurance company managing your healthcare. The DR sends the bill to the private insurance company, **NOT MEDICARE**.





On a Medicare Advantage Plan, you use 1 card for everything, Most Medicare Advantage plans will have the drug coverage built in. You must have both Medicare Part A+B. **You still need to pay your Part B premium.**

Pros of a Medicare Advantage Plan:

1. Most Medicare Advantage plans have a low premium or a 0$ premium
2. You are capped on your out-of-pocket expenses on a Medicare Advantage plan. Pay as you go. You will have copayments on your Medicare Advantage Plan. Most Medicare Advantage Plans have a yearly **M**aximum **O**ut **O**f **P**ocket of $7,550 for 2022 for in network services. This is not a deductible. Every copayment you pay or coinsurance gets counted towards the MOOP, in the event you reach the MOOP, the plan pays the remainder of your medical costs for the year. The MOOP restarts again come the new calendar year.

- **Many Medicare Advantage plans will include extra ancillary benefits such as dental, vision and hearing for no additional premium or a small additional premium.**

Benefit Structure of a Medicare Advantage Plan:

ABC Medicare Advantage Plan HMO- 0$ Monthly Premium MOOP: $7,550 for in network services
Primary Care Doctor: 0$ Medical Deductible: 0$
Specialist visit: 40$
Inpatient hospital: 450$ copayment per day, days 1-5, 0$ per day, day 6 and beyond.
Outpatient hospital surgical services: 395$ copay
Ambulatory surgical services: 300$ copay
Hospital Observation Services: 395$ copay per stay
Outpatient X-Rays: 50$ copayment **Lab Services**: 0$ **Preventative Services:** 0$
MRI's and Ct-scans: 275$ copay **Chemotherapy and Part B drugs:** 20%
Emergency Room: 90$ copay
Ambulance: **Ground or Air:** 300$ copay
Gym membership included. **Dental benefit:** Plan pays up to 2k in dental **Hearing Aides:** Plans pays up to 750$ per ear at select hearing providers. **Vision:** Plan pays up to 150$ each year towards eyeglasses and contacts
Part D: Yes: Tier 1: 0$ Tier 2: 6$ Tier 3: 45$ Tier 4: 35% Tier 5: 25% (drugs that are Tier 3-5 have a 300$ Part D deductible) **You must pay your Part B premium.**

CONS OF A MEDICARE ADVANTAGE PLAN

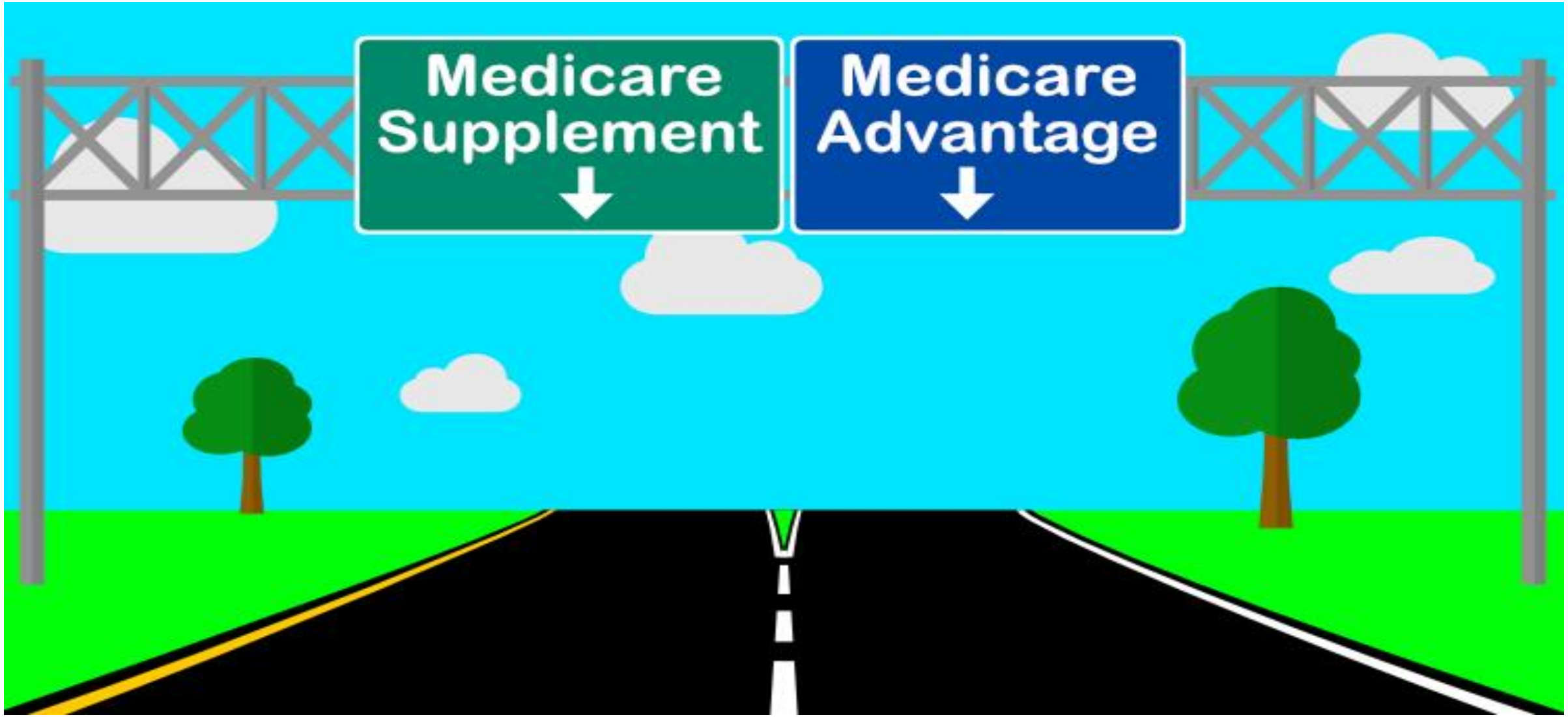
You must use a network of providers, on a traditional HMO, you can only go out of network in an emergency if you are outside the service area. you must remain in the network in order to receive medical services. **NETWORK LIMITATONS**

Because you pay as you go, in the event your health changes, out of pocket costs can start to pile up if you are seeing several providers per month.

For Example: Outpatient Cancer treatments and Dialysis will typically cost 20% on most Medicare Advantage Plans, in this scenario, the individual will most likely reach their MOOP. This can be costly if the individual is on a fixed income. Even though the cost is capped, hitting the MOOP can be stressful for those on a fixed income that do not qualify for any type of assistance. **The MOOP restarts each calendar year.**

Medicare Advantage Plans in general require prior authorizations. DR's may need to submit more medical documentation in order to get certain elective treatments approved. The plans DR's review the documentation and may approve an alternative treatment instead of what your DR ordered. **Plan has the final say over your healthcare, not your DR.**

Medicare 2022	Medicare Advantage	Medicare Supplement
Coverage	Local or regional network	Nationwide
Doctors	Out of network doctors may not be covered or cost more	Any doctor or hospital
Referrals	HMO (yes) PPO (no)	No referrals
Medical Underwriting	All health condition accepted including ESRD	No underwriting if you apply during initial open enrollment
Copays	Fixed copay each doctor visit or medical service	No copays on all Medigap Plans except plans K, L, and N.
Co-insurance	No	No Medigap co-insurance costs except for plans K, L and N.
Plan Premiums	Lower	Higher
Prescription Drugs	Most HMO and PPO plans include drug coverage	You must add Medicare Part D
Max Out-of-Pocket Limit	Up to $7,550	Medigap Plan K $6,220 and Plan L $3,310


Medicare
Supplement
Medicare
Advantage

2023 Standard Part D Phase

DEDUCTIBLE	INITIAL COVERAGE	COVERAGE GAP (DONUT HOLE)	CATASTROPHIC
You will pay... **up to $505** $505 is the maximum Part D Prescription Drug deductible A deductible is the amount you owe before the insurance carrier helps	**You will pay...** **A copay ($) or coinsurance (%), based on the drug's tier** Once **YOUR** out-of-pocket copays **PLUS** the amount the plan pays on your behalf for your prescriptions reach **$4,660**... ...you enter the Coverage Gap (Donut Hole), where you may pay a higher cost	**You will pay...** **25% of the cost of generic and brand name drugs...** ...until your **True Out-of-Pocket (TrOOP)*** costs reach **$7,400**	**You will pay the rest of the calendar year (the greater of)...** **5% coinsurance** **$4.15 for generic drugs** **$10.35 for all other drugs** **Note:** Part D does not have a cap or max out-of-pocket limit. If you reach the Catastrophic phase, you're always paying something the rest of the year.

If you are on an expensive Medication, these are some of the creative ways you can save:

1. **Your Medication may have a manufacturer program. Many manufacturer programs accept Medicare Part D recipients. You will need to meet the programs requirements in order to qualify. Some programs will have an income limit, other programs may require you to spend a certain amount each year on all your medications before they grant approval. If you are approved, the medication will be delivered to your DR's office for you to pick up. Ask your pharmacist if there are any manufacturer programs available. Call the manufacturer program to see how you can qualify. DON'T ASSUME YOU DON'T QUALIFY BASED ON THE WEBSITE Information, CALL THE PROGRAM TO FIND OUT MORE.**

2. Use a GoodRX or drug discount card: Believe it or not, sometimes a medication can be cheaper if you don't run it through the insurance. GoodRX can have better prices for certain medications than what you'd pay on your drug plan. YOU CANNOT USE A DRUG DISCOUNT CARD together with your Part D plan, you can only use on or the other. Ask your pharmacist if it would be cheaper to run it through the insurance or a discount card, each month the prices can fluctuate, ask every time you refill if there are any discounts.

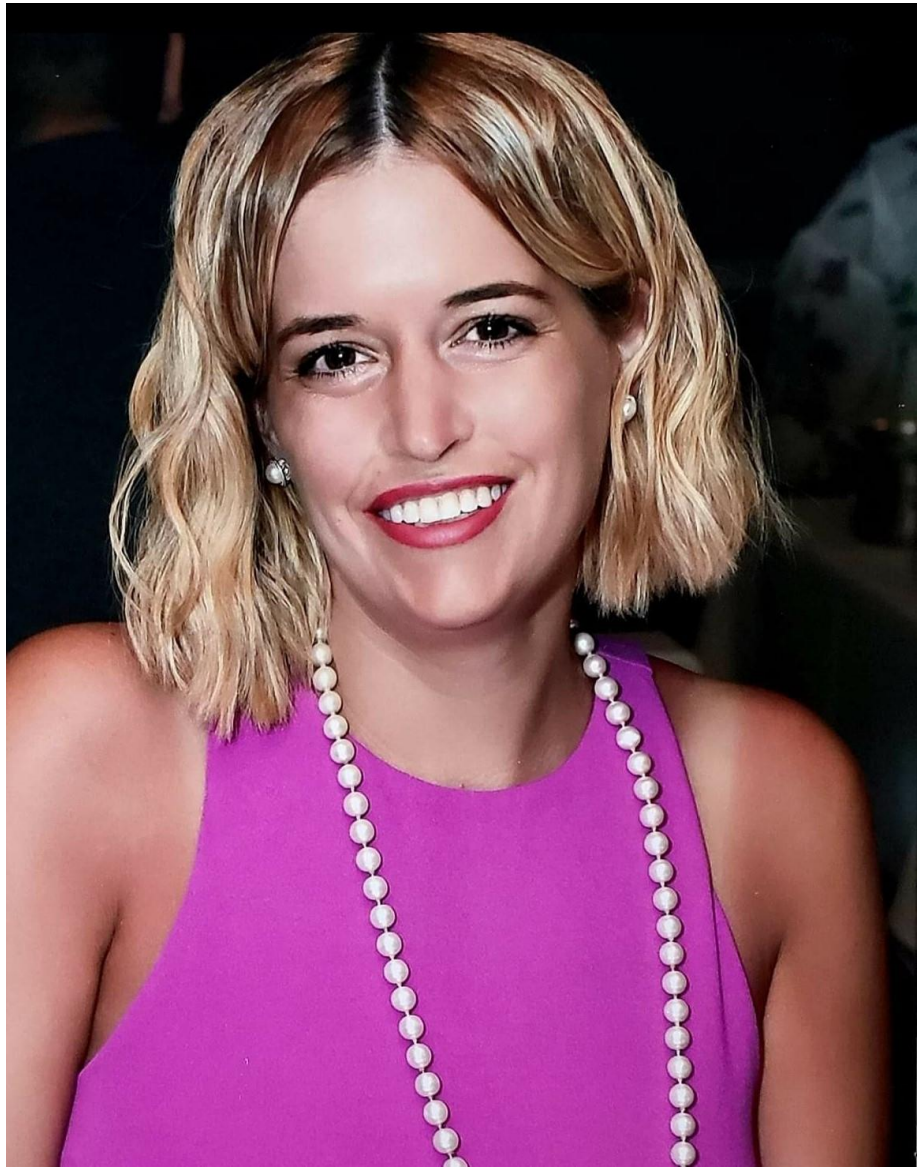
3. You have the right under Medicare Part D to ask your plan to make an exception. If you google your drug plan company name and the phrase" Request for Medicare Prescription Drug Determination Form" Your plans form will come up at the top of the search results. Print the form, bring the form to your DR that prescribes the medication and ask the DR to state why it is Medically necessary for you to take this medication.

You will then check the box where it says tiering reduction. The DR will then fax the form directly to the plan. It will take about 2-3 weeks for the plan to decide. There is no guarantee you will get the cost of the medication reduced, but having a DR sign the form gives you a fighting chance at getting that exception approved. If the plan denies it, appeal it, and try again.

4. There could be a generic that is just as effective as the brand name drug but is less expensive. For example: Lipitor costs $393 for a 30-day supply, Atorvastatin on average (generic for Lipitor) cost $6 for a 30 -day supply. DO NOT try the generic until you have consulted with your pharmacist and healthcare provider.

5. Each insurance company has their preferred pharmacies they prefer working with. This is known as an in-network pharmacy. If you use a non preferred pharmacy, you could be paying higher cost share for your medications.

6. There are pharmacies that are 340B pharmacies. 340B is a program that requires pharmaceutical manufacturers participating in Medicaid to sell outpatient drugs at discounted prices to healthcare organizations that care for patients in vulnerable communities. You do not need to qualify for Medicaid in order to use these pharmacies. You will need to find out which pharmacy is a 340B pharmacy and find out the protocol's you need to take in order to gain access to the program. The process is a bit complicated, but once approved, the individual can save a lot of money by using a 340b pharmacy. Large hospital systems tend to participate in the 340b program. You will need to consult with your provider to see if they participate with the 340b program as it does require a different prescription.



I help seniors find the most suitable plan for their financial and healthcare needs.

I hope you found this presentation helpful. Feel free to contact me below at-

Cait.Stiene-Forese@medreg.com or call 347-518-2902 if you have any questions or need to review your current coverage.

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