MedicareUpdate
The latest news and information for Medicare participants
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Spring 2024 | Issue 15

Centers for Medicare & Medicaid Services Finalizes Rule Relating to Medicare Advantage Prior Authorization

The Centers for Medicare & Medicaid Services (CMS) recently finalized the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F). The rule sets requirements for Medicare Advantage (MA) organizations, and some others, to improve the electronic exchange of health information and prior authorization processes for medical items and services. Together, these policies will improve prior authorization processes and reduce the burden on patients, providers, and payers, resulting in approximately $15 billion of estimated savings over ten years.

Prior authorization is a tool intended to control spending and promote cost-effective care. One of the criticisms over the years against Medicare Advantage plans, and a large impetus for this action by CMS, has been that some insurance companies use prior authorization requirements and rejections to reduce their claims exposure and thereby reduce their overall costs.

In a survey conducted by KFF Health News, 25% of adults whose insurance problems included prior authorization issues said their health status declined as a direct result of problems they had with their insurance; 33% said access to needed care was delayed or denied; and more than 35% said it resulted in higher out-of-pocket costs.

The survey found that 16% of all insured adults in 2023 experienced prior authorization problems; and consumers with certain characteristics are more likely to encounter such problems:

- Mental health conditions — 26% of people who sought treatment for or took prescription medication for a mental health condition experienced prior authorization problems.
- Diabetes — 23% of insured adults who sought treatment or took prescription medication for diabetes experienced prior authorization problems.
- Prescription drugs — 19% of adults who currently take at least one prescription medication experienced prior authorization problems.

“When a doctor says a patient needs a procedure, it is essential that it happens in a timely manner,” said U.S. Secretary of Health and Human Services Xavier Becerra. “Too many Americans are left in limbo, waiting for approval from their insurance company.”

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While prior authorization can help ensure medical care is necessary and appropriate, it can sometimes be an obstacle to necessary patient care when providers must navigate complex and varying payer requirements or face long waits for prior authorization decisions. This final rule establishes requirements for certain payers to streamline the prior authorization process and complements the Medicare Advantage requirements finalized in the Contract Year (CY) 2024 MA and Part D final rule, which add continuity of care requirements and reduce disruptions for beneficiaries. Beginning primarily in 2026, impacted payers will be required to send prior authorization decisions within 72 hours for expedited (i.e., urgent) requests and seven calendar days for standard (i.e., non-urgent) requests for medical items and services. For some payers, this new time frame for standard requests cuts current decision time frames in half. The rule also requires all impacted payers to include a specific reason for denying a prior authorization request, which will help facilitate resubmission of the request or an appeal when needed. Finally, impacted payers will be required to publicly report prior authorization metrics.

If you happen to incur a prior authorization rejection, make sure you appeal the rejection. Of those individuals who challenge an insurance company's rejection the vast majority win on appeal. Unfortunately, only about 11% of the individuals receiving a rejection ever appeal that rejection.

How Many Physicians Have Opted Out of the Medicare Program?

A common question asked about Medicare is, "What percentage of providers participate in Medicare?" In 2024, 65 million adults in the U.S., nearly 20% of the population, are covered by Medicare. And 10,000 Americans are turning 65 every day, which will drive those numbers up even higher. Physicians are not required to participate in Medicare, but the vast majority do because Medicare is a major source of revenue for providers. Let's look at the question from the opposite viewpoint. How many providers are opting out of Medicare? In 2023, based on data published by CMS:

- 1% of non-pediatric physicians formally opted-out of the Medicare program, with the share varying somewhat by specialty type, with the highest being psychiatrists at 7.7%.
- Among active physicians:
  - 40% of psychiatrists do not participate with Medicare.
  - 21% of family medicine physicians do not participate with Medicare.
  - 12.6% of internal medicine physicians do not participate with Medicare.
  - 6% of obstetrics/gynecology physicians do not participate with Medicare.

Overall, very few physicians are choosing to opt out of Medicare. For many physicians, older adults with Medicare coverage account for a relatively large share of their patient population and revenues. For these physicians, the loss of revenue resulting from opting out of Medicare would be substantial, notwithstanding the difference in payment rates between Medicare and private insurance. Other factors, such as physician-level characteristics (such as years of practice and age), and patient-level factors (such as average income of individuals in an area) may also play a role in physician decision-making.

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Big Changes in Part D Plans and Coverage Anticipated for 2025

Medicare insurance companies are scrambling to adjust to planned changes in the Part D cost sharing structure that will take effect Jan. 1, 2025. These changes are a direct result of the passage of the Inflation Reduction Act (IRA) in 2022. Sponsors of these Part D plans are preparing for the biggest changes in the Part D program's 18 year history. Plans will be looking to mitigate their drug costs.

Beginning on Jan. 1, 2025, the IRA eliminates the "donut hole," caps Medicare beneficiaries' out-of-pocket costs for prescriptions at $2,000 annually, and forces plans to pay for 60% of drug costs in the catastrophic coverage stage (triggered when costs exceed $2,000). Plans paid 15% of the cost in 2023 and are paying 20% in 2024.

We will not know until October what the 2025 Part D plans will look like, how their formularies and cost-share structures might change, or how much the plan premiums will increase. We do recognize that insurance companies will not be able to absorb these substantial cost increases without taking dramatic actions. No doubt, those on Medicare Part D plans are going to be sharing in those increased costs.

Make sure you reach out to Member Insurance Solutions in September to request the Scope of Appointment form (SOA)and prescription medication form so that we can conduct a Part D plan review during Medicare's 2024 Annual Election Period which will officially kick-off on Oct. 15. We are bracing for big changes in plans for 2025 and will need time to analyze member's medications and plan options due to the anticipated heavy volume of requests we will encounter. Email steve@mdaifg.com, or call 800-860-2272, ext. 450.

Diabetes Weight Loss Drugs

The Daily Insurance Report published that the use of GPL-1s, primarily for weight loss, is becoming more prevalent among Americans, with a significant portion of the population suffering from type 2 diabetes and obesity. Demand for these drugs is surging, leading to an alarming increase in spending on these medications.

Becker's Hospital Review recently reported that Ozempic and Mounjaro have become even pricier. They are among 775 brand name medications with higher prices in 2024 compared to 2023. Ozempic increased by 3.5% to nearly $970 for a 30-day supply and Mounjaro increased by 4.5% to nearly $1,070 for a 30-day supply.

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If you are covered by a Medicare Part D prescription plan or a Medicare Advantage plan with prescription coverage, be aware that the plans will not cover these medications simply for weight loss purposes. The patient must have been diagnosed with diabetes for the medications to be covered. Even then the copays on these medications can be very costly and your plan may require prior authorization or step therapy before they will approve the medication. Check your plan's drug formulary to see what tier the medication falls into and whether there are requirements. You should also check with your pharmacy to see what your copays might be and whether the pharmacy has challenges trying to get these medications in stock.

Need A Refresher On Medicare Basics?

Member Insurance Solutions will be offering Medicare educational seminars between June and September. If you need a refresher; simply have questions; or have a family member, employee, or friend turning 65 this year be sure to register or share these dates.

Available dates are:

- June 14, 1–3:30 p.m., LIVE at MDA Headquarters.
- Aug. 23, 1–3:30 p.m., LIVE at MDA Headquarters.
- Sept. 13, 1–3:30 p.m., Zoom, special 2024 Medicare Annual Election Period (AEP) presentation.

To register, please contact Steve Fulger at Member Insurance Solutions by emailing steve@mdaifg.com or calling 877-906-9924, ext. 450.

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