Inflation Reduction Act

A Series by:

Real World Health Care

2024

The Inflation Reduction Act of 2022 contained several provisions to lower out-of-pocket drug costs for people with Medicare.

Inflation Reduction Act is a recently published series of articles that answers key questions Medicare beneficiaries may have about how the act will affect them.

Brought to you by:

HealthWell Foundation®
When health insurance is not enough.®

https://www.healthwellfoundation.org/RealWorldHealthCare

Contents

Prescription Drug Provisions in the Inflation Reduction Act: What You Need to Know

According to the Centers for Medicare & Medicaid Services, the Inflation Reduction Act, signed by President Biden in August 2022, provides financial relief for millions of people with Medicare by improving access to affordable treatments and strengthening the Medicare Program for the long term. In the first year since the Act was signed, nearly 15 million people saved an average of $800 per year on their health insurance premiums, and the nation's uninsured rate reached an historic low.

Improvements to Medicare Part D under the Act mean that people with Medicare will benefit from lower prescription drug costs. Benefits introduced in 2023 include a $35/month cap per covered insulin prescription, providing certainty and critical cost savings for seniors who, in some cases, were paying as much as $400 for a month's supply of insulin. The Act also provided for access to recommended adult vaccines without cost-sharing, saving $70 on average for these vaccines.

Additional changes to the Medicare Part D benefit design will roll out in 2024 and 2025, including a new cap on Part D out-of-pocket prescription drug costs that took effect in January 2024, which will save thousands of dollars for people who take high-cost drugs.

To help *Real World Health Care* subscribers understand how these changes will impact them, we talked with Charles E. (Chuck) Collins Jr., MS, MBA, president, Healthcare Stakeholder Solutions, a consultancy focused on health care delivery disparities across multiple therapeutic areas. He describes why 2024 is a watershed year for Medicare beneficiaries and provides insights to help beneficiaries navigate changes to their plan in 2024 and beyond.

By sharing this conversation, *Real World Health Care* hopes to bring a bit of clarity to a complicated policy change. We will share additional insights throughout the year.

Helpful Terms

Real World Health Care: Health insurance is full of buzzwords and jargon that can be difficult to understand. What are a handful of key terms and definitions that Medicare beneficiaries should start to become familiar with as they navigate the changes to their plans in 2024 and beyond?

Chuck Collins: Here are a few basic concepts that will help beneficiaries understand the difference among plans:

- Annual Deductible: This is the amount you must pay before your health plan or drug plan begins to pay its share of your medical or covered drug expenses.
- Coinsurance: The percentage of costs of a covered health care service you pay (20% in Medicare Part B, for example) after you've paid your deductible.

Chuck Collins

- Copayment: A fixed amount ($20, for example) you pay for a covered health care service after you've paid your deductible.
- Formulary: A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. Also called a drug list.
- Initial Coverage Phase: In this phase, you and the prescription drug plan are splitting (generally 25%/75%) the cost of your drugs. You are paying either a fixed amount, or a percentage of the retail costs. That amount is based on which formulary tier the drug falls into. You remain in the cost-sharing phase until your annual prescription drug costs (retail costs, not what you have paid out of pocket) hit the coverage gap threshold.
- Smoothing: Starting in 2025, the law requires Part D sponsors to provide all Part D enrollees the option to pay their out-of-pocket prescription drug costs in monthly installments.

Selecting a Medicare Plan Can Be a Daunting Task

RWHC: As we enter 2024, most Medicare enrollees have already selected their plan for the year. How did the provisions of the Inflation Reduction Act impact their selection process?

CC: Besides the premium price increases for Medicare Part D plans, the Inflation Reduction Act provision changes for 2024 had minimal impact on the plan selection process. However, for 2025, I believe the process of picking a Part D plan will become more time-consuming and cumbersome as we approach the new overhauled Part D benefit design and smoothing option election.

Regardless of the new Inflation Reduction Act provisions, Medicare beneficiaries have a daunting task with the annual plan selection process in general. In 2024, on average, a Medicare beneficiary has approximately 60 plan choices between Part D prescription drug plans (PDPs) and Medicare Advantage drug plans (MA-PDs). In some states, Medicare beneficiaries have up to 80 plan options to choose from, which can be overwhelming.

No More Catastrophic Coverage Phase

RWHC: What will be most surprising to Medicare beneficiaries as they start to access their Part D benefits this year?

CC: The most surprising positive change for Medicare beneficiaries will be the elimination of the catastrophic coverage phase in the Part D benefit. For the first time in the history of this benefit design, there is now a cap on out-of-pocket expenses.

So, what is the impact? Prior to the Inflation Reduction Act's passage and through 2023, once a Medicare beneficiary satisfied the coverage gap phase (approximately $3,100 in out-of-pocket costs), the beneficiary was responsible for 5% of the cost of their branded drug with no maximum out-of-pocket cap. As an example, if a Medicare beneficiary was taking a specialty medication for, let's say psoriatic arthritis, and the monthly cost of that drug was $8,000, the beneficiary would be responsible for 5% of the cost of the drug in the catastrophic coverage phase, which would be $400 a month. Under a standard benefit design in 2023 with an $8,000 a month drug, applying the standard $505 deductible, the Medicare beneficiary would hit the catastrophic coverage phase in February and would have paid approximately $7,400 by the end of the calendar year.

Eliminating the catastrophic coverage phase for the Medicare beneficiary in 2024 is a huge deal. To clarify, the catastrophic coverage phase still exists, but the extra 5% the Medicare beneficiary would have paid ($7,400 – $3,100 = $4,300) is now being absorbed by the health plan in 2024.

RWHC: What should Medicare beneficiaries know about the cap on out-of-pocket costs and the point at which they satisfy their coverage gap requirement?

CC: In 2024, the Medicare beneficiary can expect an out-of-pocket cost to be approximately $3,250, due to the $600 increase in the catastrophic coverage phase threshold from 2023. The 2024 catastrophic coverage phase threshold amount, which is $8,000, includes what a Medicare Part D enrollee spends out-of-pocket (this generally includes the deductible, 25% cost of the drug in the initial coverage phase and the 25% cost of the drug in the coverage gap phase) plus the value of the manufacturer price brand discount (70%) in the coverage gap phase, formerly also known as the doughnut hole phase. As stated earlier, in 2024, the catastrophic coverage phase for the Medicare beneficiary has been eliminated.

Relief for Everyone

RWHC: Will the lowered cap on out-of-pocket drug costs be offset somewhat by higher Part D premium costs? Will beneficiaries see real relief, especially those in PDPs versus MA-PDs?

CC: The impact on the cap on out-of-pocket costs far outweighs the increase in Part D premiums. The Medicare Part D base beneficiary premium is $34.70. However, Medicare Part D plan premiums do vary across plans and can be higher or lower than the base beneficiary premium. The average national PDP monthly premium for 2024 is $48, up from $40 in 2023, a 21% increase. In addition, PDP monthly premiums are, on average, 5 times higher than their MA-PD counterparts. As a side note, the Inflation Reduction Act has a Part D premium stabilization provision starting in 2024, through which the Medicare Part D base beneficiary premium is capped at a 6% annual growth rate.

For 2024, Medicare beneficiaries that have a PDP benefit can expect higher cost sharing for brand drugs than for generics. The use of coinsurance, instead of copayment, will increase as well as coinsurance percentages across the board. However, with the elimination of the catastrophic coverage phase, all beneficiaries are now capped on out-of-pocket costs, which provides relief for everyone.

References

1. The White House, August 16, 2023. https://www.whitehouse.gov/briefing-room/statements-releases/2023/08/16/fact-sheet-one-year-in-president-bidens-inflation-reduction-act-is-driving-historic-climate-action-and-investing-in-america-to-create-good-paying-jobs-and-reduce-costs/
2. Explaining the Prescription Drug Provisions in the Inflation Reduction Act. Accessed December 19, 2023. https://www.kff.org/medicare/issue-brief/explaining-the-prescription-drug-provisions-in-the-inflation-reduction-act/
3. Healthcare.gov Glossary. Accessed December 28, 2023. https://www.healthcare.gov/glossary/

New Guidance Designed to Help Medicare Beneficiaries Manage Prescription Drug Costs

Source: Centers for Medicare & Medicaid Services

Continuing the ongoing implementation of President Biden's prescription drug pricing law, the Inflation Reduction Act of 2022, the Centers for Medicare & Medicaid Services (CMS) last week released the final part one guidance for the new Medicare Prescription Payment Plan. The guidance helps ensure that Medicare Part D plan sponsors can successfully implement the Medicare Prescription Payment Plan and effectively build the necessary infrastructure to provide a seamless experience for people enrolled in a Medicare Part D prescription drug plan who elect to participate in this program.

The drug law is already helping reduce the burden of high upfront out-of-pocket prescription drug costs for seniors and people with disabilities with Medicare, including by capping out-of-pocket costs for a month's supply of each covered insulin product at $35 under Medicare, and making Advisory Committee on Immunization Practices (ACIP)-recommended vaccines available at no cost for people with Medicare prescription drug coverage. The Medicare Prescription Payment Plan, which begins in 2025, will give people with Medicare prescription drug coverage (Medicare Part D) the option to pay out-of-pocket costs in monthly payments spread out over the year rather than requiring they pay in full at the pharmacy counter each time they fill a prescription.

"No one should have to choose between paying for medicine or putting food on the table. Thanks to President Biden's lower cost prescription drug law, the Inflation Reduction Act, fewer seniors and people with disabilities are making this difficult decision," said Health and Human Services Secretary Xavier Becerra. "For people who get their prescriptions through Medicare Part D and face high costs early in the year, we are easing the burden by allowing payments to be spread out over time. HHS will continue tackling high health care costs on all fronts so that every American can benefit from access to life-saving medicines."

"The guidance is an important step in helping certain people with Medicare prescription drug coverage who have high upfront drug costs to spread out their cost sharing over the year," said CMS Administrator Chiquita Brooks-LaSure. "CMS remains committed to implementing the historic Inflation Reduction Act in order to help people with Medicare lower costs and access the prescriptions they need."

The final part one guidance — which considered public comments received in response to the draft part one guidance released on August 21, 2023 — focuses on outlining the necessary operational requirements for Medicare Part D plan sponsors as they prepare for the new program. The guidance addresses topics such as identifying Medicare Part D enrollees likely to benefit from the program, the opt-in process for Part D enrollees, program participant protections, and the data collection needed to evaluate the program.

The final part one guidance requires Part D sponsors to notify a pharmacy to provide information on the program for anyone who meets a $600 out-of-pocket threshold based on a single prescription at the point-of-sale. This required notification is in addition to the communications that will be provided to people with Medicare Part D before and during the coverage year, as is outlined in the draft part two guidance for the program published on

February 15, 2024. This multi-prong approach will help ensure that those most likely to benefit from the program get the information they need to determine whether to participate in the Medicare Prescription Payment Plan, while reducing the risk of identifying Part D enrollees for whom this program may not be as helpful. The guidance also finalizes the requirement that Part D sponsors must process election requests within 24 hours during the plan year.

"People in Medicare who face very high out-of-pocket costs at the start of the year will be relieved to hear that the drug pricing law will make those costs more manageable with the arrival of the Medicare Prescription Payment Plan," said Meena Seshamani, MD, PhD, CMS Deputy Administrator and Director of the Center for Medicare. "This part one guidance will ensure a seamless experience for people with Medicare by setting clear expectations for plans to create a uniform experience for people who opt into the program."

The guidance is accompanied by the release of an Information Collection Request (ICR) for the Medicare Prescription Payment Plan, which includes model materials for Medicare Part D plan sponsors to use when communicating to Part D enrollees about the program. CMS is seeking feedback on the materials through the ICR public comment process. The comment period is open for 60 days, and comments must be received by April 29, 2024 to be considered. In addition, the draft part two guidance for the program is open for comment until March 16, 2024.

The Medicare Prescription Payment Plan complements the Inflation Reduction Act's other provisions that lower prescription drug and health care costs. The pieces of the law work together to lower drug costs and make them more manageable for people in Medicare.

- As of January 1, 2024, people enrolled in Medicare Part D who have very high drug costs will, for the first time, no longer have to pay cost sharing for their prescription drugs in the catastrophic phase of the program.
- Starting in 2025, all individuals with Medicare Part D will have their out-of-pocket prescription drug costs capped at $2,000.
- On January 1, 2024, the law also expanded eligibility for full benefits under the Low-Income Subsidy program (LIS or "Extra Help") under Medicare Part D. Nearly 300,000 people with low and modest incomes currently enrolled in LIS are now benefiting from the program's expansion including lowering drug costs such as no deductible, no premiums, and fixed, lowered copayments for certain medications. An additional 3 million people could benefit from the Extra Help program now who are not currently enrolled.
- The law also ensures people with Medicare Part D and people with Part B who receive insulin delivered through a pump pay no more than $35 for a month's supply of each covered insulin product.
- It also provides coverage without patient cost sharing of recommended vaccines for people who have Medicare Part D.

What Medicare Beneficiaries Need to Know About Hepatitis B Vaccines

As of January 2023, all Medicare-covered vaccines are available for free to Medicare beneficiaries. This means beneficiaries are not responsible for any cost-sharing, such as copayment, coinsurance, or deductibles for covered vaccines.

One vaccine covered under the Medicare rule is the hepatitis B vaccine. Hepatitis B is a vaccine-preventable liver infection caused by the hepatitis B virus. It is spread when blood, semen, or other body fluids from a person infected with the virus enters the body of someone who is not infected. The CDC recommends that adults aged 60 or older with risk factors for hepatitis B should receive a hepatitis B vaccination.

To help Medicare beneficiaries better understand the importance of hepatitis B vaccination, *Real World Health Care* reached out to Michaela Jackson, MPH MS, Program Director, Prevention Policy, Hepatitis B Foundation for insights.

Hepatitis B: Who is At Risk?

Real World Health Care: Who is most at risk for hepatitis B, and how can having the disease impact their lives?

Michaela Jackson: Hepatitis B is a global threat to public health with significant impacts on a person's life. There are nearly 300 million people living with chronic hepatitis B worldwide, and up to 2.4 million of those individuals live in the United States. Although there is no cure, there are highly effective treatments.

Michaela Jackson

All adults are at some degree of risk for hepatitis B because of how easily it can be transmitted and its lack of identifiable symptoms. However, certain groups are at an increased risk of hepatitis B infection. Here in the U.S., hepatitis B disproportionately impacts Asian Americans, Pacific Islanders, and African Immigrant communities. We have also seen an increase in hepatitis B cases in states heavily impacted by the opioid epidemic. Certain occupations, such as health care workers and emergency responders, and people with certain health conditions, such as diabetes or dialysis patients, are also at a higher risk of contracting hepatitis B.

People living with hepatitis B face an increased risk of developing serious liver complications, such as cirrhosis, liver failure, or even liver cancer. If left untreated, one in four individuals will die prematurely from hepatitis B-related liver complications.

Hepatitis B Myths vs. Facts

RWHC: What are some of the biggest misconceptions people have about hepatitis B?

MJ: Two of the biggest misconceptions about hepatitis B are that it can be spread through casual contact and that hepatitis B only infects certain individuals. As a blood-borne disease, hepatitis B is spread through direct contact with infected blood. It cannot be transmitted through hugging, holding hands, or sharing meals with someone who is living with hepatitis B. The virus is also not airborne, so it cannot be spread through sneezing or coughing. Oftentimes, people living with hepatitis B face stigma and isolation because of this misconception, so it is very important to address this!

It is also a common misconception that hepatitis B only impacts people who participate in certain behaviors, such as injecting drugs or getting tattoos. This is a stigmatizing viewpoint that misleads individuals into thinking that they don't need to get tested or vaccinated for hepatitis B, and thus leaves individuals vulnerable to new infections. The truth is that nearly 40 percent of new acute hepatitis B cases have no risk factor information. Additionally, more than 60 percent of people living with hepatitis B are unaware of their infection. Although certain groups have a higher chance of contracting the virus, hepatitis B can impact anyone – regardless of obvious risk factors.

Hepatitis B Vaccines: Essential for Disease Prevention

RWHC: Why are vaccines such an important part of the prevention equation for hepatitis B?

MJ: Vaccines are essential to preventing hepatitis B for so many reasons! To start, preventing hepatitis B means preventing primary liver cancer. Hepatitis B is the world's leading cause of liver disease and liver cancer, with over 60 percent of global liver cancer cases attributed to the virus. A person living with chronic hepatitis B has a 25-40 percent lifetime risk of developing liver cancer if left unmanaged. By getting vaccinated against hepatitis B, you are significantly reducing this risk. The vaccine also prevents hepatitis delta – the most severe form of viral hepatitis that can only occur in people who are already living with hepatitis B. Hepatitis delta carries a liver cancer risk of up to 70 percent.

Hepatitis B can also be spread from mother to child during the birthing process – this is the most common way hepatitis B is transmitted globally. And – nine out of ten babies who are born with hepatitis B will develop a chronic infection. Vaccination not only protects you, but also your family and your loved ones.

The Hepatitis B Vaccine is Safe and Effective

RWHC: What should people know about getting vaccinated for hepatitis B?

MJ: The hepatitis B vaccine is safe, effective, and free under most health insurance plans. Most adults are shocked to learn that they are not vaccinated against hepatitis B. Universal infant vaccination was only recommended beginning in 1991, so most people born before 1991 never received their hepatitis B vaccination. If you are unsure about your vaccination status, the best thing to do is check your immunization records and speak with your doctor.

People should also know that the hepatitis B vaccine provides a lifetime of protection against the hepatitis B virus – no boosters necessary after you complete the series! Getting vaccinated is a quick and simple way to prevent serious consequences.

Inflation Reduction Act Coverage for Hepatitis B Vaccines

RWHC: How has the Inflation Reduction Act, which includes provisions for Medicare to cover vaccines at no cost for beneficiaries, helped to increase uptake for hepatitis B vaccines?

MJ: For a two- or three-dose vaccine, paying out-of-pocket per dose adds up quickly. Prior to the Inflation Reduction Act (IRA), we often received calls from individuals on Medicare who wanted to get vaccinated, were considered at-risk for infection, and simply could not afford to pay for it.

We are hopeful that the IRA, coupled with updated adult hepatitis B vaccination recommendations from the CDC, will help increase hepatitis B vaccinations amongst people who are on Medicare. As a now-routine immunization, hepatitis B vaccination is gaining more awareness than before. Data shows hepatitis B outbreaks still occur in long-term care facilities, and we also continue to see slight national upticks occur amongst people aged 60 and older. There is a clear need for hepatitis B vaccination amongst the Medicare population, and now they have one less barrier to accessing the vaccine.

Hepatitis B Foundation Takes a Comprehensive Approach to Vaccinations

RWHC: How is the Hepatitis B Foundation working to raise awareness for the importance of getting vaccinated and driving vaccination rates?

MJ: Increasing vaccination rates involves many different stakeholders, which makes it critical to take a comprehensive approach to this endeavor. Each year, we educate policymakers and communities on the importance of hepatitis B vaccination during key awareness days and months, such as National Adult Hepatitis B Vaccination Awareness Day (April 30th), Hepatitis Awareness Month (May) and Immunization Awareness Month (August).

The Foundation also works closely with providers to identify systemic barriers to increasing hepatitis B vaccination, and to create resources, like this vaccine handout, that aid their current hepatitis B vaccination efforts.

In addition to working with providers, we collaborate with people who are living with or have been impacted by hepatitis B. Our national storytelling campaign, #justB, highlights the powerful experiences of those affected by hepatitis B to raise awareness and encourage people to get tested and vaccinated. Stories like Sura's, whose brother passed away from a fulminant hepatitis B infection, and DeWayne's, who was diagnosed with hepatitis B after he had a blood transfusion as a child, speak to the importance of vaccination.

Our national coalition, Hep B United, is integral to our efforts. With almost 60 organizations across 27 states in the U.S., the coalition is a powerful partner in spreading education about hepatitis B and encouraging people to get screened and vaccinated. The coalition includes many community-based organizations and federally qualified health centers that actively immunize individuals as well as raising awareness. It truly is a team effort to increase vaccination rates!

Medicare Part D Enrollment: What You Need to Know

Medicare Open Enrollment began yesterday and runs through December 7, 2024. During open enrollment, you can review your current health insurance coverage and make changes to your health insurance and other benefits. Changes you make during open enrollment may affect your coverage starting January 1, 2025.

To help *Real World Health Care* subscribers understand how the Inflation Reduction Act's recent changes to Medicare Part D will impact them, we spoke with Charles E. (Chuck) Collins Jr., MS, MBA, president, Healthcare Stakeholder Solutions, a consultancy focused on health care delivery disparities across multiple therapeutic areas. He described some of the biggest changes enrollees will see and the options they have for paying for prescription medicines.

Shifting Drug Costs

Chuck Collins

Real World Health Care: How will the Medicare enrollment process change for 2025?

Chuck Collins: The Inflation Reduction Act (IRA) drastically changed the Medicare Part D benefit design by shifting more drug costs from the Medicare beneficiary (the patient) and the federal government to health plans and pharmaceutical manufacturers. For the first time, **Medicare Part D beneficiaries will have a maximum out-of-pocket cap of $2,000**, whether they take one drug, five drugs, or even more. That means a Medicare Part D beneficiary will not pay more than $2,000 for their drugs in 2025.

This new benefit design has two phases: an initial deductible phase up to $590 (though not all plans have a deductible) and an initial coverage phase in which the beneficiary pays 25% of the retail cost of the drug until the $2,000 cap is satisfied.[1]

The IRA also caps Part D premiums at an annual growth rate of 6%. For 2025, the base beneficiary Part D premium is $36.78 a month, a 6% increase from 2024. However, the monthly amount that Part D enrollees pay for individual Part D plans is typically different from the base beneficiary premium. That means actual monthly premiums paid by Part D enrollees will vary considerably, ranging from $0 to $100 or more depending on their plan.[2]

Medicare Advantage Plans

RWHC: Medicare enrollees have the option of purchasing a Medicare Advantage plan. How do Medicare Advantage plans differ from traditional Medicare plans in terms of prescription drug coverage and premiums?

CC: About 53 million of the 67 million Medicare beneficiaries are enrolled in Medicare Part D plans in 2024. Of those, 57% are enrolled in MAPDs (Medicare Advantage Prescription Drug Plan) and 43% are enrolled in stand-alone PDPs (Original Medicare Part D Prescription Drug Plan).[2]

Medicare Advantage plans receive an additional amount of money from the government (Medicare) above their estimated cost of providing Medicare-covered services (Part A and Part B) for an enrollee. Because of this additional payment, over 75% of MAPD enrollees have minimal or zero-dollar premiums.[3] However, MAPDs can use cost-containment measures such as prior authorizations to restrict beneficiary choices. Medicare Advantage plans typically cover additional benefits such as dental, vision, and wellness services, which are not part of original Part A or Part B coverage.

For services covered under Parts A and B, federal regulation requires Medicare Advantage plans to provide an out-of-pocket limit. In contrast, traditional Medicare (Parts A and B) do not have an out-of-pocket limit for covered services. In 2024, the out-of-pocket limit for Medicare Advantage plans may not exceed $8,850 for in-network services and $13,300 for in-network and out-of-network services combined.[3] These out-of-pocket limits apply to Part A and B services only, and do not apply to Part D spending. In 2025, MAPD plans will have the same $2,000 drug cap as Part D stand-alone PDPs.

New Medicare Prescription Payment Plan

RWHC: What is the Medicare Prescription Payment Plan, and how can Medicare enrollees know if they should opt in to this new program?

CC: In 2025, the Medicare Prescription Payment Plan (MPPP) – also known as "smoothing" – will be offered to Medicare Part D beneficiaries by their health plans to assist in lowering monthly Part D drug costs, by enabling the enrollee to spread their out-of-pocket costs across the year. **This payment plan is completely voluntary**. The beneficiary may opt in to the MPPP during open enrollment season, or in any month during the plan year, by completing an election request form. Conversely, a beneficiary may opt out at any time.

Part D sponsors (Medicare plans) must notify prospective Part D beneficiaries of the option to enroll in the MPPP using promotional materials during open enrollment, or whenever a person enrolls in Medicare Part D throughout the year.

Part D sponsors also must have a mechanism to notify a pharmacy when a Part D beneficiary incurs covered Part D drug out-of-pocket costs that make it likely for the beneficiary to benefit from participating in the program. A $600, single-prescription threshold will be used to identify beneficiaries likely to benefit.[4]

RWHC: If enrollees decide to opt in to the MPPP, what will they need to do? How will this work when they visit the pharmacy?

CC: Part D beneficiaries who opt in to the MPPP will pay $0 at the point of service (at a retail pharmacy or specialty pharmacy) for a covered Part D drug instead of the out-of-pocket cost share they would normally pay when filling a prescription. MPPP enrollees will receive a bill from the Part D health plan for their incurred out-of-pocket costs, whether for one drug, five drugs or more. This bill will be in a monthly amount that cannot exceed the applicable maximum monthly cap.

To stay compliant with the MPPP, Part D beneficiaries will need to pay their monthly bill within the due date. It's important to note that a Part D beneficiary can be involuntarily removed from the MPPP for lack of payment.

References

1. Explaining the prescription drug provisions in the Inflation Reduction Act. Accessed October 13, 2024. https://www.kff.org/medicare/issue-brief/explaining-the-prescription-drug-provisions-in-the-inflation-reduction-act
2. A Current Snapshot of the Medicare Part D Prescription Drug Benefit. Accessed October 13, 2024. https://www.kff.org/medicare/issue-brief/a-current-snapshot-of-the-medicare-part-d-prescription-drug-benefit/#:~:text=The%202025%20Part%20D%20base,in%20the%20Inflation%20Reduction%20Act
3. Medicare Advantage in 2024: Premiums, Out-of-Pocket Limits, Supplemental Benefits, and Prior Authorization. Accessed October 13, 2024. https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2024-premiums-out-of-pocket-limits-supplemental-benefits-and-prior-authorization/
4. Medicare Prescription Payment Plan: Final part one guidance on select topics, implementation of section 1860D-2 of the social security act for 2025, and response to relevant comments. Memorandum from Meena Seshamani, MD, PhD. February 29, 2024. Accessed October 13, 2024. https://www.cms.gov/files/document/medicare-prescription-payment-plan-final-part-one-guidance.pdf

Have a Grant with HealthWell? How to Decide if the Medicare Prescription Payment Plan is Right for You

The prescription drug law that went into effect in January 2023 was designed to help save money for people with Medicare. One of the law's provisions – effective January 1, 2025 – caps yearly Part D out-of-pocket prescription drug costs at $2,000, a significant savings for millions of Americans.

The law also provides an option for Medicare beneficiaries to pay their out-of-pocket drug costs in monthly amounts over the plan year. This new payment option, the Medicare Prescription Payment Plan (MPPP, sometimes referred to as "smoothing"), will be offered by all Medicare drug plans and Medicare health plans with drug coverage (such as a Medicare Advantage plan with drug coverage).

Beneficiary participation in the MPPP is voluntary and there is no cost to participate. If beneficiaries select this payment plan option, they will continue to pay their plan premium (if they have one) and will receive a monthly bill from their health or drug plan to pay for their prescription drugs, instead of paying at the pharmacy. Beneficiaries may opt in to and out of the MPPP at any time by notifying their Medicare plan.

Impact of MPPP on Charitable Grant Recipients

Fred Larbi

Charitable Patient Assistance Programs (CPAPs) like the HealthWell Foundation have been anticipating the MPPP's rollout for two years and are working to educate grant recipients about the program to help them determine whether opting in to the MPPP is right for them. We asked HealthWell's Chief Operations Officer, Fred Larbi, to share some insights.

Larbi stressed that while the MPPP may change the logistics of how HealthWell grant recipients pay for their medications, the HealthWell grant process remains the same. Patients must meet the Foundation's long-established eligibility criteria:

- They must have a diagnosis for a disease covered under a HealthWell Disease Fund.
- They must have some form of health insurance (i.e., Medicare).
- Their medication must be listed under the Disease Fund associated with the grant.
- Their income must fall within HealthWell's guidelines.
- They must be receiving treatment in the United States.

Things to Consider before Opting in to MPPP

Larbi encouraged Medicare beneficiaries to consider several variables when deciding whether to opt in to the MPPP.

"The MPPP may be a good option for beneficiaries who incur high prescription costs earlier in the year, those who have difficulties paying for their prescriptions all at once, and those who take multiple medications," he said. "However, for Medicare beneficiaries who have a grant with a CPAP like HealthWell, the benefit may not be as great because the grant will immediately cover the cost of their medications. They would not have to be billed by their health plan, pay that bill, submit a claim to the CPAP, and then wait to be reimbursed by their grant."

Larbi reiterated that because Medicare beneficiaries can opt out of the MPPP at any time, those who sign up for the program early in the year and then are awarded a CPAP grant later in the year can opt out of MPPP to accommodate their new situation.

Medicare beneficiaries eligible for Medicare's Extra Help program (for those with household incomes of 150% of the federal poverty level or below) are another group that may not benefit from opting in to the MPPP according to Larbi. That is because enrolling in this program provides beneficiaries with a more advantageous out-of-pocket responsibility than the MPPP.

"If someone is eligible for Extra Help, they should enroll in that first because it negates the need to enter the MPPP," he said.

How MPPP Works at the Pharmacy

The new $2,000/year cap on prescription drugs will be applied at the pharmacy automatically. Medicare beneficiaries will not need to do anything to receive the benefit if they are enrolled in a Part D plan. (Some plans may apply an even lower cap.)

For those enrolled in the MPPP, the prescription drug law requires pharmacies to notify beneficiaries about the MPPP if they have out-of-pocket drug costs of $600 or more a year, although Medicare does not provide a mechanism to opt in to the program directly at the pharmacy.

Larbi offered advice for those with grants from HealthWell:

- Ask the pharmacy how much their copay and out-of-pocket costs are for each transaction.
- Check that the pharmacy has HealthWell's BIN and PCN numbers (the information the pharmacy needs to bill the CPAP for the covered medication).
- Request that the pharmacy bill HealthWell in the secondary position instead of the MPPP if they have opted in to the program.

"Make sure the pharmacy knows that you have a grant and ask them to use that grant before using the MPPP option," he stressed.

Additional MPPP Resources

HealthWell's Contact Center representatives are available, Monday through Friday from 9am to 5pm to help answer grant recipient questions about the MPPP. Reach them at 800-675-8416. The HealthWell website also has links to related resources.

In addition, the official Medicare website offers several resources for patients, caregivers, and others interested in learning more about the Medicare Prescription Payment Plan:

- What the prescription drug law means for Medicare beneficiaries: https://www.medicare.gov/about-us/prescription-drug-law
- Things to know before opting in to the MPPP: https://www.medicare.gov/prescription-payment-plan/before-payment-option
- Examples of how the MPPP works in different situations: https://www.medicare.gov/prescription-payment-plan/examples
- An interactive Q&A designed to help patients decide if the MPPP will help them: https://www.medicare.gov/prescription-payment-plan/will-this-help-me
- What to know about using the MPPP: https://www.medicare.gov/prescription-payment-plan/using-payment-option