ANNUAL NOTICE OF CHANGE *(ANOC)*

parrott Benefit Group

Agenda

- What is ANOC?
- What is the Inflation Reduction Act: How Does It Affect Medicare?
- What Changes Could I See In My Medicare Part D or MedAdvantage Plans?
- Final Tips & Take-Aways

WHAT IS THE ANNUAL NOTICE OF CHANGE?

ANOC

The Annual Notice Of Change (ANOC) is a document listing the changes in a plans coverage, service area or cost that will go into effect the following January.

ALL Medicare plans are required to send this to plan members by September 30 or 15 days prior to the start of the Medicare Annual Election Period (October 15th – December 7th)

This information will come from your Insurance Carrier from your stand-alone Part D plan; if you have Original Medicare and a Medicare Supplement.

Or if you have a Medicare Advantage plan that includes Part D coverage.

A pamphlet/brochure of about 15-30 pages with details of any changes to your health plan and prescription coverage for the upcoming new plan year.

The Federal Government requires the ANOC to have a standard format that includes:

- A table of contents
- Side by side comparison of benefits for the current year and upcoming year
- Side by side comparison of cost for the current year and upcoming year.
- Information about the changes in covered medication.

***Annual Notice of Changes* for 2016**
Table of Contents

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1 – Changes to the Monthly Premium

[Plans may add a row to this table to display changes in premiums for optional supplemental benefits.]

[Plans that include a Part B premium reduction benefit may insert a row to describe the change in the benefit.]

Cost	2015 (this year)	2016 (next year)
Monthly premium *[Plans that include a Part B premium reduction benefit may modify this row to describe the change in the benefit.]* (You must also continue to pay your Medicare Part B premium.)	*[Insert 2015 premium amount]*	*[Insert 2016 premium amount]*
Monthly plan premium *[Plans with no optional supplemental benefits delete the following.]* (See Section *[edit section number as needed]* 2.1 for details.)	*[Insert 2015 premium amount]*	*[Insert 2016 premium amount]*
[Plans with no deductible may delete this row.] **Deductible**	*[Insert 2015 deductible amount]*	*[Insert 2016 deductible amount]*

The Inflation Reduction Act (IRA)

The Inflation Reduction Act was a roughly $1 trillion bipartisan Bill passed in August 2021.

The IRA authorizes funds for federal-aid for highways, transit, highspeed internet, broadband access, clean drinking water and other infrastructure needs; as well as HUMAN INFRASTRUCTURE and closing the DONUT HOLE for prescriptions.

This Bill is being paid in part through changes in several changes to healthcare polices:

- The amount of subsidies that insurance carriers received for your enrollment in their plan
- Delaying the Medicare Part D rebate rule for another three years
- Reducing Medicare payment amounts to providers

IRA UPDATES AFFECTING PRESCRIPTION DRUG COVERAGE (PART D)

The Part D (prescription drug coverage) updates started in 2023 with a $35 cap on monthly insulin copays and will create further consumer savings in 2025 that continue into 2026 and beyond. Here are the three main ways changes will happen:

Part D Benefit Redesign	Drug Price Negotiating	Drug Price Inflation Limits
This updates Part D cost sharing for members, created an insulin copay cap in 2023 and expands eligibility for LIS (Extra Help) subsidies to 150% of the federal poverty line.	The federal Medicare program will work to lower prices for drugs with high consumer costs.	This limits Medicare drug price increases to the level of inflation.

. Part D Plan Benefits: The Standard Benefit Plan for 2025 (Illustrated)

Medicare Module 3 – Part D Standard Benefit Enrollee Cost Sharing

Catastrophic Coverage Enrollee pays $0
$2000 (out-of-pocket threshold)
Initial Coverage Enrollee Pays 25% of prescription drug costs
$590 (deductible)
Deductible Enrollee pays 100%

Additional Part D Changes for 2025

Medicare Part D members may choose to pay monthly payments over the plan year to smooth out monthly costs.

Maximum annual out-of-pocket cost capped at $2,000

- After reaching your deductible, you pay your 25% cost-sharing. When you reach $2,000 out of pocket, you pay $0 for prescription drugs for the rest of the year.
- Excludes drugs covered by Part B

No more "donut hole" coverage gap phase

- Now there is only the deductible, initial coverage phase and catastrophic (after you reach maximum out of pocket)

Spread out your prescription drug costs over the year

- This can smooth your costs, helping you to budget
- Example: You have one prescription that costs $300 every three months. You now have the option to pay $100 per month — the same $1,200 over a year.

What You Should Look for in Your ANOC

Plans often change their costs, deductibles and benefits annually.

Medicare Advantage plans are often the plans where you end up with different coverage, even if you kept the same policy.

- Medications: Are the medication you take covered by your plan? Check what tier they're in and what the copays are to make sure your medications are still affordable.
- Pharmacies: Is your regular pharmacy in your plan's network? If not, are there in-network pharmacies near you or mail-order options that suit your needs?
- Costs: How will any changes affect your out-of-pocket costs, such as your deductible, copays, and coinsurance?
- Providers: If your ANOC is for a Medicare Advantage plan, are your preferred doctors, specialists, and hospitals in your network in the coming year? You have certain rights and protections regarding your health care providers.

- If you have seen your PCP or behavioral health provider in the last three years and leaves your network, the MA plan will send you notification and assign you to a new PCP, which you can later change by calling your plans Customer Service.
- If your Specialist leaves your MA plan, you will receive a written notification, and your MA plan will assist you in selecting a new qualified IN-Network provider.
- If you are undergoing medical treatment or therapies with your current provider, you have the right to request your MA plan work with you to ensure that medically necessary treatment or therapies you are receiving continues.
- If you find out your doctor or specialist is leaving your plan, you should contact your MA plan so they can help you in finding a new provider.
- If you feel your MA plan has not furnished you with a qualified provider to replace your previous provider or your care is not being appropriately managed, you have the right to file a quality of care complaint or grievance to your MA plan.

Medicare requires the MA plans provide you with uninterrupted access to qualified doctors and specialists. MA plans are required to notify you in writing if your providers leave their network.

You should pay particular attention to the Summary of your plans benefit for the new year. Plans can ADD or DROP medications from their list of covered medications. The plan may add prescription deductibles. The plan may change the tier that medications fall under. The plan may change the tiers cost. You want to pay particular attention to your out of pocket for your covered medications, higher tiered medications will cost you more.

Make sure to weigh the costs and benefits of MAPD plans compared to standalone Part D plans.

Changes to the list of Covered Medications (formulary) and Pharmacy Network (applies to Stand-Alone Part D and MA Plans with Pharmacy Benefits)

RECAP OF 2025 IRA MEDICARE CHANGES

The IRA changes to Medicare Part D have benefits for many Medicare enrollees, adding value by:

- ✓ Capping out-of-pocket drug spending at $2,000 per year
- ✓ Removing the coverage gap “donut hole”
- ✓ Smoothing the cost of prescription drugs over the year

Final Tips & Takeaways

Plans often change their cost and benefits annually, so you can end up with different coverage, even if you kept the same policy. So is important you review your ANOC and consider making a change if:

- Have new health needs that aren't covered by your plan
- No longer need a particular benefit that costs you more
- Need prescription medications that are not covered or are not affordable under your plan
- Have a plan that's no longer affordable
- Have a plan that has changed or removed benefits that you need

THANK YOU

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