The Infinitus Group

MEDICARE - GROUP - INDIVIDUAL - P&C

Monthly Newsletter www.theinfinitusgroup.com

We're Halfway There - Medicare!

We're now in the middle of the Medicare Open Enrollment season, a critical period running from October 15 through December 7 each year. This is the window when Medicare beneficiaries can make changes to their health coverage, such as switching from Original Medicare to Medicare Advantage, changing Medicare Advantage plans, or adjusting their Part D prescription drug coverage. Given the complexities of these options, it can be a confusing time for many, and beneficiaries often need help navigating the choices to ensure they get the best coverage for their needs.

The Infinitus Group is here to provide guidance during this busy season. We understand that Medicare decisions can impact healthcare access, costs, and overall well-being, making it crucial to have accurate, reliable information. Our team is equipped to help answer your questions, from understanding the differences between Medicare plans to finding providers and managing prescriptions under each type of plan. The Infinitus Group focus is on empowering Medicare beneficiaries to make informed choices based on their health needs, budget, and other personal priorities.

As the deadline approaches, it's important to review any changes to Medicare plans and coverage rules that may have occurred since last year. With The Infinitus Group by your side, you can feel confident in understanding these updates and selecting the plan that best fits your requirements. Don't hesitate to reach out for assistance—we're here to provide support, reduce confusion, and help you get the coverage you deserve. Whether you need a quick answer or in-depth assistance, The Infinitus Group is committed to making this Open Enrollment season smooth and stress-free.

INSIDE THIS EDITION

956-352-9550
facebook
www.theinfinitusgroup.com
info@theinfinitusgroup.com

Ten Things to Watch for 2025 ACA Open Enrollment

1. Unsubsidized premiums are increasing modestly, but most enrollees won't pay that. Premiums for benchmark silver plans, which are the basis for subsidy calculations, are increasing by 4% on average, while lowest-cost bronze premiums are up by 5%. Premium increases are steepest in Vermont, Alaska, and North Dakota, where unsubsidized monthly costs are growing by 10% or more. Meanwhile, low-cost plan premiums are falling in 9 states, including by double digits in Louisiana. (State-level data are here.) A Peterson-KFF Health System Tracker analysis found that rising hospital costs and increased use of GLP-1 drugs are among factors contributing to higher premiums. On average nationally, a 40-year-old's benchmark silver premium would be $497 per month without a subsidy. However, the vast majority (92%) of Marketplace shoppers receive a subsidy, and with enhanced subsidies most of them can find a plan with a premium of less than $10 per month. Because these subsidies cap monthly payments at a share of an enrollee's income, the vast majority of Marketplace enrollees will not have to pay a premium increase.

2. This could be the last year of enhanced subsidies. Enhanced subsidies under the Inflation Reduction Act (IRA) are set to expire at the end of 2025. Initially introduced in the American Rescue Plan Act, these subsidies increased premium support for existing enrollees and expanded eligibility to those earning above 400% of the poverty level. These subsidies, which have driven the record-high enrollment in Marketplaces, will remain in place for the duration of 2025, but would require an act of Congress to extend them in 2026 or beyond. If these enhanced subsidies expire, the original ACA subsidies will remain in place but premium payments (net of subsidies) are expected to double or more in a number of states in 2026.

3. Marketplace shoppers will have more choice of insurers. On average, across states, 9.6 insurers are participating on the ACA Marketplaces, which is higher than in any prior year (state data are here). In 2025, 97% of Healthcare.gov enrollees will have 3 or more ACA insurers, up from 78% of enrollees in 2021. Several insurers are entering into new states in 2025. For example, UnitedHealth Group is expanding into 4 new states and 119 additional counties in 13 of the 26 states where they already participate. Centene (Ambetter) also announced it is expanding into 60 new counties across 10 states. With ACA Marketplace signups reaching record highs and strong financial performance for participating insurers, the ACA Marketplaces have become a more appealing market than they had been in 2018, when insurer participation was at a low point.

4. Open enrollment is from November 1, 2024 to January 15, 2025 in most states. In accordance with new federal rules encouraging states to standardize their open enrollment periods, the 2025 open enrollment period will now begin on November 1, 2024 in all states except Idaho, where open enrollment began October 15. Open enrollment will end on January 15, 2025 in most states, except Idaho (December 16, 2024), Massachusetts (January 23), California, New Jersey, New York, Rhode Island, and DC (all January 31).

5. New states are transitioning to a State Based Marketplace. Georgia will be transitioning to a State Based Marketplace for the 2025 plan year. This will bring the total number of state-based marketplaces to 20. Illinois is scheduled to transition into a state-based marketplace for the 2026 plan year and will stop using the federal platform in November 2025. For now, Illinois residents should continue to use Healthcare.gov.

6. The federal government is taking new actions to combat fraud. The federal government has received numerous complaints from consumers who have been the victims of fraud, where insurance brokers have signed them or switched their plans without their consent. The federal government has taken enforcement actions to combat this fraud (including suspending certain brokers) and has applied Healthcare.gov standards on web brokers and direct enrollment entities to State-Based Marketplaces.

7. Changes to short-term plans are taking effect. The Biden Administration is reversing the Trump Administration's expansion of short-term health insurance plans that are not ACA-compliant and can discriminate against people with pre-existing conditions. The new rules require that short-term plans be limited to 4 months total, and must now come with a consumer notice in all online and written marketing, enrollment application and other materials stating that the coverage "is NOT comprehensive health coverage." Short-term plans are not sold on the ACA Marketplaces, but some consumers have reported feeling misled into believing they were buying comprehensive plans. A similar disclaimer notice must be included in materials for fixed indemnity policies sold to consumers off Marketplace. These are plans that pay a specific amount if someone is sick or hospitalized. Like short-term plans, fixed indemnity plans do not have to meet most of the ACA's consumer protections. Written and online information must now say that this fixed indemnity coverage "is NOT health insurance." While a recent lawsuit challenges the new notice for fixed indemnity plans, as of now it is still required.

8. Special enrollment opportunities are changing. HealthCare.gov enrollees with incomes up to 150% of poverty will continue to have a year-round special enrollment opportunity, though this is optional for state-based marketplaces. However, the "Medicaid Unwinding" special enrollment period is ending November 30, 2024. In addition, starting in 2025, all consumers who choose an ACA Marketplace plan during a special enrollment period (whether a federal or state-based marketplace) will have their coverage begin on the first day of the month following their plan selection. (In the past, in some state-based Marketplaces, if a consumer chose a health plan during a special enrollment period after the 15th of the month, coverage began on the first day of the second month.)

9. Deferred Action for Childhood Arrivals (DACA) recipients will be allowed to sign up for subsidized coverage through the Marketplace in 2025. A new Biden-Harris administration rule finalized earlier this year expands eligibility for DACA recipients by redefining "lawfully present." Starting November 1, 2024, DACA recipients will be allowed to sign up for coverage through the Marketplace or through the Basic Health Program. They will have access to premium tax credits and cost sharing reductions, even if their income is below 100% FPL. There will be a 60-day special enrollment period starting on November 1, 2024 that allows newly eligible DACA recipients to sign up for coverage. Consumers who enroll during November 2024 can have their new Marketplace coverage begin as early as December 1, 2024. While there is pending litigation, DACA recipients can still enroll.

10. Network adequacy rules must be met. Starting in 2025, federal Marketplace plans will be required to meet maximum appointment wait-time standards (e.g., no more than a 10-business day wait for a behavioral health appointment, a 15-business day wait for routine primary care appointments, and 30 business days for non-urgent specialty care appointments). These plans are expected to have a "secret shopper" survey conducted starting in 2025 to test whether in-network providers are meeting these appointment wait times for new patients seeking primary and behavioral health care.

Total Health Discount Plans
Now Available With The Infinitus Group
Family Monthly Rate: **$29.95**
Benefits Available To Anyone - No SSN Needed

With **The Infinitus Groups** *Total Healh Discount Plan*, you know have access to benefits that covers dental, vision, hearing, lab services, wellness, fitness, a 24-hour nurse line, diabetic testing supplies, a shopping network, telemedicine, and teledentistry offers a multitude of benefits that can significantly enhance your overall health and well-being.

Such plans provide substantial savings on a wide range of healthcare services, making essential care more affordable and accessible. With discounts on dental and vision care, you can maintain regular check-ups and treatments, preventing minor issues from becoming major health problems.

Hearing services and lab testing discounts ensure that you can monitor and manage your health effectively, while wellness and fitness benefits promote a healthier lifestyle through access to resources like gym memberships and wellness programs.

Additionally, the inclusion of a 24-hour nurse line and telemedicine services provides convenient, round-the-clock access to professional medical advice and consultations, reducing the need for unnecessary in-person visits and offering peace of mind.

Diabetic testing supplies and a shopping network ensure that you have access to essential health products at lower prices, supporting chronic condition management.

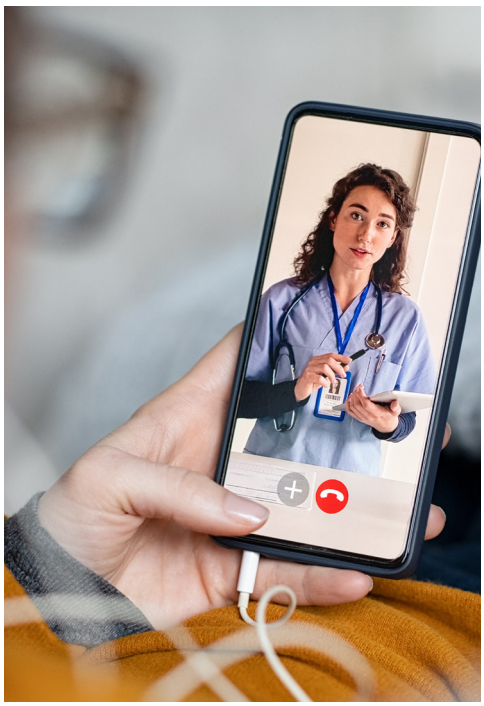
The convenience of teledentistry services allows for remote dental consultations, saving time and providing prompt advice for dental concerns.

Overall, such a comprehensive discount plan not only helps you save money but also supports proactive health management, contributing to a higher quality of life.

Benefits Include:

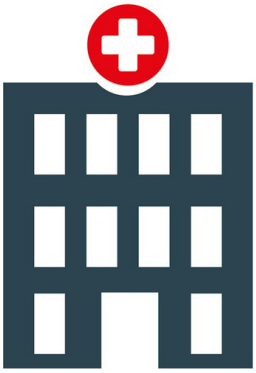
- **Dental - Up To 60% Savings**
- **Vision - VSP Exclusive Savings**
- **Vision Correction Surgery**
- **Teledentistry**
- **DialCare Telemedicine**
- **Lab Services**
- **Alternative Health & Wellness / Fitness**
- **24-Hour Nurse Line**
- **Diabetic Testing Supplies**
- **Medical Information**
- **Prescription Discounts**
- **Hearing Care**
- **Shopping Network**

Watch our video regarding our Discount Benefit Plan.



THIS PLAN IS NOT INSURANCE
AND PROVIDED BY AN INDEPENDENT CARRIER

Medicare Plans May Be Ailing



As Medicare Open Enrollment progresses, seniors in North Texas have more than 60 Medicare Advantage plans to consider. While the popularity of these private insurance plans grows, with more Medicare-eligible Americans choosing them each year, hospital advocates are voicing concerns about the impact on patient care and provider finances. "Many of the providers are struggling with Medicare Advantage," stated Stephen Love, president and CEO of the Dallas-Fort Worth Hospital Council. Love emphasized that these private plans are causing considerable concern among providers due to delayed payments, denied claims, and increased administrative burdens.

Medicare Advantage, offered by private insurers like UnitedHealthcare and Humana, is an alternative to traditional Medicare, attracting seniors with lower premiums and extra benefits like dental and fitness services. Enrollment in these plans has more than doubled in the past decade, reaching 33 million participants in 2023, or 54% of eligible beneficiaries, according to KFF Health News. Texas is ahead of the national average, with 58% of eligible residents enrolled in Medicare Advantage. Health experts suggest that further privatization under President-elect Donald Trump's upcoming term could amplify current issues, as plans for expanding Medicare Advantage have been championed by conservative groups and supported in Trump's previous term.

Providers nationwide report challenges with Medicare Advantage plans due to claim denials, pre-authorization requirements, and delayed payments, all of which can delay care and create financial stress for hospitals. Some Texas hospitals, such as Memorial Hermann Health System in Houston, have stopped accepting certain Medicare Advantage plans, citing a lack of trust and transparency with insurers. The Texas Hospital Association has been raising concerns about these plans for years, with spokesperson Carrie Williams noting that delays and denials are putting a strain on both patients and hospitals. The U.S. Department of Health and Human Services has reported that some Medicare Advantage plans have denied necessary care, while the National Association of Insurance Commissioners has warned that these issues may lead to patient harm if not addressed by federal regulators.

CANCER

Learn more at: https://youtu.be/i7cwoKLryIQ

Buying a cancer insurance plan can offer several important benefits, particularly for those concerned about the financial impact of a cancer diagnosis. Here are key reasons why people opt for a cancer insurance plan:

Supplemental Coverage: While traditional health insurance may cover the medical costs of cancer treatment, there are often gaps, such as deductibles, copayments, and uncovered services (e.g., experimental treatments). Cancer insurance helps fill these gaps.

Non-Medical Expenses: Cancer insurance can provide funds for non-medical costs, such as travel for treatment, lodging, childcare, and even household bills that may become difficult to manage during long treatments or hospital stays.

Income Replacement: Cancer treatment often leads to time off work, and in severe cases, it can result in extended leaves of absence. A cancer insurance plan can help replace lost income so that financial stability is maintained during treatment and recovery.

Focus on Recovery: Having financial security can reduce the stress of managing healthcare costs, allowing patients and their families to focus more on recovery and less on finances.

Affordable Premiums: Cancer insurance policies can be relatively affordable compared to comprehensive health insurance plans, making it a cost-effective way to protect against the financial burden of a cancer diagnosis.

Customization: Many cancer insurance plans are customizable, allowing policyholders to choose specific coverage options that fit their needs, such as coverage for specific cancer types, treatments, or stages of the disease.

Family History or High Risk: Individuals with a family history of cancer or those who are at higher risk due to lifestyle factors may find cancer insurance particularly valuable as a way to mitigate the potential financial risks.

Lump-Sum Payments: Some cancer insurance policies offer lump-sum payouts upon diagnosis, providing immediate financial relief that can be used in any way the policyholder sees fit, from paying medical bills to covering day-to-day living expenses.

Having cancer insurance adds a layer of financial protection in the event of a cancer diagnosis, complementing existing health coverage and providing peace of mind.

THE INFINITUS GROUP

Lump Sum Cancer Coverage

- AGES 18 - 99
- ENTRY AGE FREEZE
- AGES 41 - 69 PAY AGE 40 RATES
- UP TO $75,000 OF COVERAGE

Benefits Paid Upon Diagnoses

5-Year Lookback

Unisex Rates

Customizable Coverage

Guaranteed Renewable

SCAN ME

www.theinfinitusgroup.com

ADDITIONAL RIDERS AVAILABLE

- $500 Second Opinion
- Travel Rider
- Wellness Rider
- Skin Cancer Rider
- Heart-Stroke Benefit
- Benefit Builder Rider
- Specified Disease Rider
- Additional Occurence Rider
- Cancer Hospitalization Rider
- Cancer Radiation & Chemotherapy Rider

956-352-9550
877-308-3801 TTY; 711

www.theinfinitusgroup.com
Quotes@theinfinitusgroup.com

2025 Medicare Part D Annual Limits

Starting in 2025, Medicare Part D will implement an annual limit, capping out-of-pocket prescription drug costs at $2,000. In subsequent years, this limit will be adjusted based on inflation. However, this cap does not apply to out-of-pocket expenses for Part B drugs, which are administered by healthcare providers in outpatient settings, such as doctor's offices. Examples of Part B drugs include some cancer treatments and injectable medications.

This change will primarily benefit people with Part D coverage who have high prescription drug costs and do not qualify for the Extra Help program. For instance, someone whose drug expenses typically reach the catastrophic threshold could save approximately $1,300 in 2025 compared to their 2024 spending.

As of January 1, 2025, all Medicare prescription drug plans, including Medicare Advantage plans with prescription drug coverage, must offer patients the option to pay their out-of-pocket costs in monthly installments, with a set limit. Patients will need to enroll in this "smoothing" option, as monthly payment plans will not be automatic.

Impact on Insurance Coverage

These changes will not affect current Medicare enrollment and should not influence decisions during the open enrollment period. During open enrollment, individuals are encouraged to select plans that best match their prescription and medical needs.
The reforms apply to all Part D plans, Medicare Advantage (Part C) plans with prescription drug coverage, and Medicare HMO plans that offer drug coverage. However, they do not apply to supplemental insurance, Medigap plans, or Red, White, and Blue insurance that covers Medicare Parts A and B.

Medicare Reforms Overview:

Medicare Reforms Apply To

- All Part D plans
- Medicare Part C (Medicare Advantage) with prescription coverage
- Medicare HMO plans with prescription coverage

Medicare Reforms Do Not Apply To

- Supplemental Insurance
- Medigap Plans
- Red, White, and Blue Insurance (Parts A&B)

No Impact on Medication Choices

PROUD MEMBERS OF:

2025 Medicare Part D Annual Limits

These Medicare reforms, including the Part D cap and smoothing option, apply to all medications covered by Medicare, including those on specialty tiers. No medications are excluded, so you will not need to switch drugs to benefit from these changes. Whether you take brand-name or generic drugs, the reforms apply equally.

The choice of medication remains between you and your healthcare provider. During the open enrollment period, it is recommended that you review any updates to your current plan regarding the medications you take and carefully assess the drug coverage, copays, and coinsurance of any new plan.

Out-of-Pocket Prescription Drug Costs After Reforms

In 2024, after paying the initial deductible, Medicare enrollees will pay 25% of their drug costs, with a cap of around $3,300, and will no longer be required to pay 5% of drug costs in the catastrophic phase.

In 2025, after the initial deductible, enrollees will still pay 25% of drug costs, but their total annual out-of-pocket expenses will be capped at $2,000. Cost-sharing in the catastrophic phase will be reduced in 2024 and completely eliminated by 2025.

Patients will continue to pay copays at the pharmacy until they reach the $2,000 Part D cap in 2025.

You don't have to be great to start, but you have to start to be great.

-Zig Ziglar

HOLLIS ROBERSON SCHOLARSHIP
FOR ENHANCED PROFESSIONAL DEVELOPMENT

Call for Details
956-352-9550 x 110

Hollis Roberson, CLU, FMLI, RHU was truly a Texas legend whose accomplishments would fill many volumes. He worked tirelessly in the insurance industry for 34 years. His work with the Texas Association of Health Underwriters (Now the National Association of Benefits and Insurance Professionals-Texas) is memorialized in the awarding of the top honor of NABIP-TX - The Hollis Roberson Award. Because of Hollis' support of all forms of professional development, the Hollis Roberson Scholarship for Enhanced Professional Development was established to help the National Association of Benefits and Insurance Professionals-Texas members who have earned NABIP's Designations or Certifications. The scholarship goal is for the recipient to continue in the health insurance industry, ensuring the future of the industry.

Selection will be made without regard to the applicant's race, color, ethnic origin, religious belief, gender, marital status or physical handicap, in accordance with Title IX of the Education Amendments, and with Section 504 of the Rehabilitation Act 011973.

Submission of completed application and all documentation required under the guidelines below should be sent to Hollis Roberson Scholarship, NABIP-TX Honorees Corporation, 312 North Avenue East, Suite 5, Cranford, NJ 07016.

- **Applicant must be a member of NABIP and NABIP-TX**
- **Scholarship will be in the form of a reimbursement for the cost of taking a NABIP certification course, at an amount of 50% of course cost, to a maximum of $200 per course. There is a lifetime maximum of 3 scholarships per member for Certifications. Passing each course is required.**
- **A second Scholarship can be received in addition to the three above in the amount of $500 for achieving the designation of Registered Employee Benefits Consultant (REBC) from NABIP.**
- **Eligibility year will be based on calendar year. Completed application(s) must be received by March 31st of the following year. I.E., scholarship applied for time period 01-01-2024 through 12-31-2024 must be received by 3-31-2025.**
- **One application per course is required. All applications must include receipt of payment and proof of passage of the Certification course. For REBC, receipt for cost and proof of earning the designation from NABIP must be included. Passage of Course and/or Earning Designation date must be within the time period allotted for both Certifications and Designation.**

Application

Name: _____ Signature: _____ Date: _____

Address:_____

Telephone: _____ Email: _____

Local Chapter: _____

NABIP Certification or Designation Applying for:

Please attach receipt of payment and proof of passage. Proof of passage must include date of completion for Certifications and date of earning for Designations.