Medicare Advantage

Basic SHIP Counselor Training
Acknowledgement

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Medicare Advantage Overview
Objective

Build on your Knowledge of Medicare Advantage:

- Medicare Advantage Overview
- Rights, Protections, & Appeals
- Medicare Communications & Marketing Guidelines

Practice talking about Medicare Advantage
Medicare Advantage

Availability and basic benefits
Medicare Advantage aka Medicare Part C

☑ Part A
☑ Part B

Most plans include:
☑ Part D
☑ Some extra benefits
Medicare Advantage (MA) Eligibility

- Must be enrolled in Part A and B
  - Enrollment into a Medicare Advantage plan does not cause disenrollment from Original Medicare
  - Original Medicare is dormant
- Must reside in the region in which the plan is operating
  - Must receive all Medicare covered services from the plan
How Medicare Advantage works

Still in Medicare with all rights and protections, and

• Must provide all Medicare Part A and Part B covered services
• May offer Medicare Part D
• May offer supplemental benefits
• Can charge different out-of-pocket costs
• Have a yearly limit on out-of-pocket costs
  • Maximum Out Of Pocket (MOOP)
• Plans cannot charge more than Original Medicare for certain services, e.g., chemotherapy, dialysis, and skilled nursing facility care
Medicare Advantage in Wisconsin

• Plans available in all 72 counties
  • 14 MA plan sponsors
  • 103 individual plans

• Not all plans are in all counties
  • Certain types of plans are only available in certain counties

• If a plan is available in more than one county
  • The plan may have a different provider network
  • Beneficiaries need to contact the plan with their new address if moving from county to county

Counselor Note: Good practice to have a list of the plans available in your county
Medicare Advantage Supplemental Benefits

May include:
• Fitness
• Vision
• Dental
• Hearing Aids
• Food and Meals
• Transportation
• Flex Spending Cards/Money
• Coverage of Part B premium
Questions?
Types of Medicare Advantage Plans
Types of MA plans

- Medicare Advantage Plans
  - Health Maintenance Organization (HMO) Plan
  - Preferred Provider Organization (PPO) Plan
  - Private Fee-for-Service (PFFS) Plan
  - Special Needs Plan (SNP)
  - Medicare Medical Savings Account (MSA) Plan
Medicare Health Maintenance Organization (HMO) Plans

Can I get my health care from any doctor, other health care provider, or hospital?  
Generally, must use network providers.

Are prescription drugs covered?  
Yes, if the plan bundles Part D.

Do I need to choose a primary care doctor?  
In most cases, yes.

Do I need a referral to see a specialist?  
In most cases, yes.

What else do I need to know about this type of plan?  
Check with the plan about its provider network, the plan’s rules, and more.
### Medicare Preferred Provider Organization (PPO) Plans

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can I get my health care from any doctor, other health care provider, or hospital?</td>
<td>Yes, but out of network may be a higher cost</td>
</tr>
<tr>
<td>Are prescription drugs covered?</td>
<td>Yes, if the plan bundles Part D</td>
</tr>
<tr>
<td>Do I need to choose a primary care doctor?</td>
<td>No.</td>
</tr>
<tr>
<td>Do I need a referral to see a specialist?</td>
<td>No, in most cases.</td>
</tr>
<tr>
<td>What else do I need to know about this type of plan?</td>
<td>Check with the plan about the provider network, the plan’s rules, and more.</td>
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Medicare Special Needs Plans (SNPs)

- Can I get my health care from any doctor, other health care provider, or hospital?
  - Some SNPs cover services out-of-network and some don’t.

- Are prescription drugs covered?
  - Yes.

- Do I need to choose a primary care doctor?
  - Generally, yes.

- Do I need a referral to see a specialist?
  - Yes, in most cases.
Medicare Special Needs Plans (SNPs) (continued)

• What else is there to know about this type of plan?

• Three types of SNPs
  • C-SNP – Chronic disease
  • D-SNP – Dual eligible,
    • Enrolled in Full Medicaid or MSP
    • Som plans may be QMB-only
  • I-SNP – Institutional
    • Nursing home or home and community based services (HCBS)

• A SNP provides benefits targeted to its members’ special needs, including care coordination services
Medicare Private Fee-for-Service (PFFS) Plans

Can I get my health care from any doctor, other health care provider, or hospital?

You can go to any Medicare-approved doctor, other health care provider, or hospital that accepts the plan’s payment terms and agrees to treat you.

Are prescription drugs covered?

Sometimes.

Do I need to choose a primary care doctor?

No.

Do I need a referral to see a specialist?

No.
Medicare Private Fee-for-Service (PFFS) Plans (continued)

What else is there to know about this type of plan?

- Some PFFS Plans contract with a network of providers
- Out-of-network doctors, hospitals, and other providers may decide not to treat
- In a medical emergency, doctors, hospitals, and other providers must treat you.
Can I get my health care from any doctor, other health care provider, or hospital?
Yes.

Are prescription drugs covered?
No.

Do I need to choose a primary care doctor?
No.

Do I need a referral to see a specialist?
No.
What else is there to know about this type of plan?

- The plan deposits money into a special savings account. The amount of the deposit varies by plan.
- Beneficiary can not deposit their own money into the account.
- Money left in the account at the end of the year remains there (rolls over) and may be used for health care costs. The plan will add any new deposits to the amount left over for the next year.
  - No premium
  - Some plans may cover extra benefits, like dental, vision, and hearing. There may be a premium for that coverage.
  - Check each MSA for details
Questions?
Medicare Advantage Costs

What beneficiaries pay with a Medicare Advantage plan
What Are Medicare Advantage Plan Costs?

Out-of-pocket costs in a Medicare Advantage Plan vary depending on:

- Premiums
- Deductibles
- Copayments or coinsurance
- The health care services you get
- Yearly out-of-pocket costs
- Extra benefits/premium
- Whether you have Medicaid
Medicare Advantage Premiums

• Continue to pay Part B premium

• Can have two separate premiums
  • Medical
  • Drug

• Can pay premium in different ways
  • Automatic transaction through bank
  • Social security deduction
  • Monthly statements through mail

• Beneficiaries can be disenrolled for failure to pay the premium
  • May not be able to re enroll in the plan or any other plan, even if back premiums are paid.
Copayment and Coinsurance

• Depending on the plan and service
  • Copay for doctor visits
  • Copay for ER or hospitalization
  • Copay or coinsurance for diagnostic testing
  • Copay or coinsurance for Part B medications

• Maximum Out Of Pocket (MOOP)
  • The amount that the plan has set that the plan members must pay out of pocket
  • Varies plan to plan, but no more than the yearly maximum set by CMS

• When MOOP is met member pays zero for all covered services
  • Does not include Part D premium or prescription costs
If enrolled in a Special Needs Medicare Advantage Plan all beneficiaries will need to be enrolled in Medicaid.

a. True
b. False
c. Maybe

**Countdown timer:** Answer the question before the bar disappears!
Check Your Knowledge

If enrolled in a Medicare Advantage Plan beneficiaries will continue to pay a monthly Part B premium.

a. True
b. False

Countdown timer: Answer the question before the bar disappears!
Questions?
Enrollment

Opportunities to join or change to a different Medicare Advantage plan
When You Can Join or Switch a MA Plan

You can only join or switch Medicare Advantage Plans during 4 periods:

1. **Initial Enrollment Period (IEP)**
   - Begins 3 months immediately before entitlement to both Part A and Part B, and ends on the day before eligibility to Part A and Part B begins, or the last day of the Part B IEP, whichever is later.
   - **Coverage begins** the 1st day of the month of entitlement to both Part A and Part B, or the first of the month following the month the enrollment request was made (if after entitlement).

2. **Open Enrollment Period (OEP)**
   - October 15–December 7 each year.
   - **Coverage begins** on January 1.
When You Can Join or Switch a MA Plan (continued)

You can only join or switch Medicare Advantage Plans during 4 periods:

3. Medicare Advantage Open Enrollment Period (MAOEP)
   Change Medicare Advantage Plans or disenroll and return to Original Medicare during the:
   - **Annual Medicare Advantage OEP** (January 1–March 31 each year)—if already enrolled in a Medicare Advantage Plan, or
   - **Newly Eligible Medicare Advantage OEP** (first 3 months of entitlement to Medicare Part A and Part B)—if enrolled during the first 3 months of becoming eligible

4. Special Enrollment Period (SEP)
   - In certain circumstances only
   - **Coverage begins** the 1st day of the month after the month the plan receives the enrollment request
Medicare Advantage Disenrollment

Locked into plan for the plan year unless eligible for a SEP

- Voluntary Disenrollment – can always disenroll if plan not effective
  - MAOEP
  - OEP
  - SEP for certain circumstances, e.g., admitted to Nursing Home

- Involuntary Disenrollment
  - Moved and did not contact the plan within 12 month timeframe
  - Failure to pay premiums
Change of Address

• Move intrastate - Wisconsin
  • Move from county to county
    • Check if plan is available in new county of residence
    • If yes, file change of address with plan
    • Check on providers and pharmacy network

• Move interstate – contiguous 48, Alaska, Hawaii
  • Temporary move – can potentially stay in plan
    • Can have up to 12 months to tell plan that the move is permanent
    • Will be disenrolled if plan not notified
  • Permanent move – can potentially stay in plan if available in area
    • Notify plan
    • Will be disenrolled if plan not notified of move
Check Your Knowledge

It is December 23, and Mrs. Smith realizes she was impulsive and enrolled in a Medicare Advantage plan she saw on TV during the OEP because she could get money for OTC medications. Now she wants to disenroll. Can she go back to Original Medicare and her Part D plan?

a. Yes

b. No
Questions?
Activity

Medicare Advantage or Original Medicare
#1: MA or Original Medicare?

Can use any health care provider who accepts Medicare
#2: MA or Original Medicare?

**MEDICARE ADVANTAGE**

May include extra benefits like vision, hearing, and dental services
#3: MA or Original Medicare?

Covers both Medicare Part A and Medicare Part B services
#4: MA or Original Medicare?

There is no limit to how much you pay out-of-pocket each year.
#5: MA or Original Medicare?

MEDICARE ADVANTAGE

Usually includes drug coverage
#6: MA or Original Medicare?

Run by private insurance companies approved by Medicare

MEDICARE ADVANTAGE
#7: MA or Original Medicare?

Can buy a Medigap plan to help with out-of-pocket costs
#8: MA or Original Medicare?

May need a referral to see a specialist
#9: MA or Original Medicare?

Can only get care in the U.S.

BOTH
#10: MA or Original Medicare?

BOTH

Must consider the total costs (premium, deductible, coinsurance, copayment) and healthcare needs.
Break

To help you track when we’ll resume, each bar takes 1 minute to disappear from the slide…
Rights, Protections, & Appeals
All people with Medicare have guaranteed rights to:

- Get needed health care services
- Get easy-to-understand information
- Have personal medical information kept private
Rights in Medicare Health Plans

All people with Medicare have guaranteed rights to:

- Choose health care **providers** within the plan
- Get a **treatment plan** from the doctor
- Know how doctors are **paid**
- Request an **appeal** to resolve differences with your plan
- File a **complaint** (called a grievance)
- Get a **coverage decision** (or organization determination) or coverage information in writing from the plan
- Maintain **privacy** of personal health information
Appeals in Medicare Advantage & Other Health Plans

Plan must put in writing how to appeal if it:
- Will not pay for a service
- Does not allow a service
- Stops or reduces course of treatment

File an appeal
- Call or write the plan
- Plan may charge a fee for a copy of a file and to mail it

Can ask for expedited (fast) decision
Plan decides within 72 hours
## Medicare Advantage (Part C) Appeals Process

<table>
<thead>
<tr>
<th>60 days to file</th>
<th>5th Level of Appeal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal District Court</td>
<td>AIC ≥ $1,760**</td>
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<tr>
<td>NOTE: The time to file starts when the previous decision or determination is received.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>60 days to file</th>
<th>4th Level of Appeal</th>
</tr>
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<tbody>
<tr>
<td>Medicare Appeals Council</td>
<td>No statutory time limit for processing</td>
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</tbody>
</table>

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<thead>
<tr>
<th>60 days to file</th>
<th>3rd Level of Appeal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office of Medicare Hearings and Appeals (OMHA)</td>
<td>ALJ Hearing; AIC ≥ $180**</td>
</tr>
<tr>
<td>No statutory time limit for processing</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>60 days to file</th>
<th>2nd Level of Appeal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Plan Reconsideration</td>
<td>Pre-Service: Decision issued in 30 days; Payment: Decision issued in 60 days; Part B Drug: Decision issued in 7 days</td>
</tr>
<tr>
<td>Automatic forwarding to IRE if plan reconsideration upholds denial</td>
<td></td>
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</tbody>
</table>

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<thead>
<tr>
<th>60 days to file</th>
<th>1st Level of Appeal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Service: Decision issued in 14 days; Payment: Decision issued in 60 days; Part B Drug: Decision issued within 72 hours</td>
<td></td>
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<table>
<thead>
<tr>
<th>60 days to file</th>
<th>Organization Determination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Service: Decision issued within 72 hours; Part B Drug: Decision issued within 24 hours</td>
<td></td>
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</tbody>
</table>

### STANDARD PROCESS*

*Plans must process 95% of all clean claims from out of network providers within 30 days. All other claims must be processed within 60 days.

**The AIC requirement for an ALJ hearing and Federal District Court is adjusted annually in accordance with the medical care component of the consumer price index. The chart reflects the amounts for calendar year 2022.
Questions?
Medicare Advantage Communications & Marketing Guidelines
Communication & Marketing Materials

The Centers for Medicare & Medicaid Services (CMS):

- Requires review and approval of certain materials
  - Annual Notice of Change
  - Plan communications to members, e.g., letters
- Creates standardized and model marketing materials
- Creates model communications materials, like provider and pharmacy directories

Counselor Note: Medicare health and drug plans must use standardized communication and marketing materials approved by CMS.
Explanation of Benefits (EOB)

• Plan members must receive notice of what claims were paid
  • Can be received monthly or when a claim is submitted
• Must receive notice of MOOP total paid by plan and member
  • Give amount paid toward MOOP
  • Give amount still needed to meet MOOP
• Must receive notice of Part D prescription total paid by plan and member
  • Give amount paid toward the initial coverage level
  • Give amount paid toward True Out Of Pocket(TROOP)
  • Give information on when reach catastrophic level and copay amount
Plan Annual Notice of Change

• Every Medicare Advantage plan member gets an *Annual Notice of Change* letter from their plan by September 30\textsuperscript{th}
  • Explains changes for the coming year

• Plan could have same name but different costs, formulary, and rules
  • Different set of plans available every year
  • Plans change their list of covered drugs and cost structure.
  • Plans can add prior authorization requirements or quantity limits
  • Plans can change drug tiers for particular drugs

**Counselor Note:**
Even if individual is happy with the current plan, they should always revisit during the annual Open Enrollment Period (OEP).
Marketing Reminders

- Marketing for the upcoming plan year may not occur before October 1

- When referencing a plan’s star rating from CMS in marketing materials:
  - Individual measures must be marketed/communicated with the plan’s overall performance rating
  - Plans with a low-performing star rating status must include it in marketing materials and explain what it means
Nominal Gift Reminders

Plans can offer nominal gifts to potential enrollees for marketing purposes:

• Per individual item/service: $15 or less
• Maximum aggregate of all gifts, per person, per year: $75
• Given regardless of enrollment and without discrimination
• May not be in the form of cash or other monetary rebates
Unsolicited Enrollee Contact

Allowed unsolicited marketing activities include:

- Conventional mail or other print media
- Email (must have an opt-out function)

Prohibited unsolicited marketing activities:

- Door-to-door solicitation
- Approach in common areas
- Telephonic solicitation
Cross-Selling Prohibition

Prohibited during any Medicare Advantage Plan or Medicare drug coverage sales activity or presentation

Can not market non-health-related products, like:
- Annuities
- Life insurance
- Other products

Allowed on inbound calls per the request of the person with Medicare
Scope of Appointment Reminders

- Form or recorded call must specify product type to be discussed
- Required for all one-on-one appointments regardless of venue
- May only market health-related products
Promotional Activity Reminders

• Prospective enrollees may **not** be given meals or have meals subsidized at sales/marketing events

• Refreshments and light snacks may be given

• Items given can’t be reasonably considered a meal and/or multiple items can not be “bundled” and given as if a meal
Educational Events

Before
Must be advertised as educational

During
Plan may set up a marketing appointment, and distribute business cards and contact information
Event must not include marketing or sales activities or distribution of marketing materials or enrollment forms

After
Plan may conduct marketing/sales event in the same general location
Marketing/Sales Events

- Health and drug plans:
  - Must submit talking points and presentations to CMS prior to use including those to be used by agents/brokers
  - Can not require attendees to provide contact information as a prerequisite for attending an event
- Sign in sheets must clearly be labeled as optional
- Health screenings or other activities that may be perceived as, or used for, “cherry picking” are not permitted
- Contact information provided for raffles or drawings may only be used for that purpose
Licensure, Appointment, & Termination of Agents and Brokers

All Medicare Advantage Plan and drug plan agents/brokers or other marketing representatives must:

- Comply with state-licensure and appointment laws
- Be appointed by the plan, if required by the state

Plans must report:

- Termination of agents/brokers, and the reasons for termination, to state(s) if required
- For-cause terminations to CMS Account Manager, by email or letter
Agent/Broker Training & Testing

All agents/brokers must:

- Be trained and tested annually by plans on:
  - Medicare rules and regulations
  - Plan details specific to plan products sold
- Pass the test with a score of 85% or higher before marketing products
Check Your Knowledge

Who’s responsible for training and testing agents/brokers about Medicare and proper marketing of Medicare products?

a. Insurance associations
b. Medicare health and drug plans
c. The Centers for Medicare & Medicaid Services (CMS)
d. State Department of Insurance

Countdown timer: Answer the question before the bar disappears!

15
Questions?
Counseling Skills

Referrals and expectations
When to Refer

• “Basic-level” SHIP counselors should be able to:
  • Describe Medicare Advantage and use the plan finder
  • Explain and assist with enrollment
  • Recognize when assistance is needed with coverage of prescriptions and/or needed uncovered medical services
  • Recognize when an individual may qualify for financial help.

**NOTE:** Refer a client to a [benefit specialist](#) or a helpline for further assistance with Medicare Advantage and/or Part D unique coverage questions or appeals.
How to determine with what your client needs help

Sample questions:

1. When did your Medicare start?
2. When did your MA plan start?
3. Did you lose employer health coverage?
4. Do you have VA, Tricare or any other health care coverage?
5. Are you eligible for Medicaid?
6. Why was your medication/service not covered?
7. Do you have paperwork?
Practice Scenario
Medicare Advantage Scenario

Mrs. Perry, 92 years old, has seen quite a few commercials on television about Medicare Advantage. She called the number on TV and asked would she be able to get extra benefits. The person on the phone talked about a lot of things and asked her if she wanted to enroll. Mrs. Perry says she told him she really didn’t understand all the jargon and would think about it after she spoke to her daughter. Now she has received a letter and a bill that she will be enrolled in DEF Medicare effective May 1. Today is April 29.

What do you say and do for Mrs. Perry?
Questions?