Medicare Advantage

Basic SHIP Counselor Training

SHIP
State Health Insurance Assistance Program

disabilityrights WISCONSIN

Acknowledgement

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SHIP

State Health Insurance Assistance Program

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 maintain Original Medicare and pay all premiums
- Must reside in the service area in which the plan is operating
  - In Wisconsin, each county is considered a service area

Counselor Note: As with original Medicare, there are no couples. Each beneficiary must join a plan individually.

How Medicare Advantage works

Still in Medicare with all rights and protections

- 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)
- Cannot charge more than Original Medicare for certain services, e.g., chemotherapy, dialysis, and skilled nursing facility care

Medicare Advantage in Wisconsin

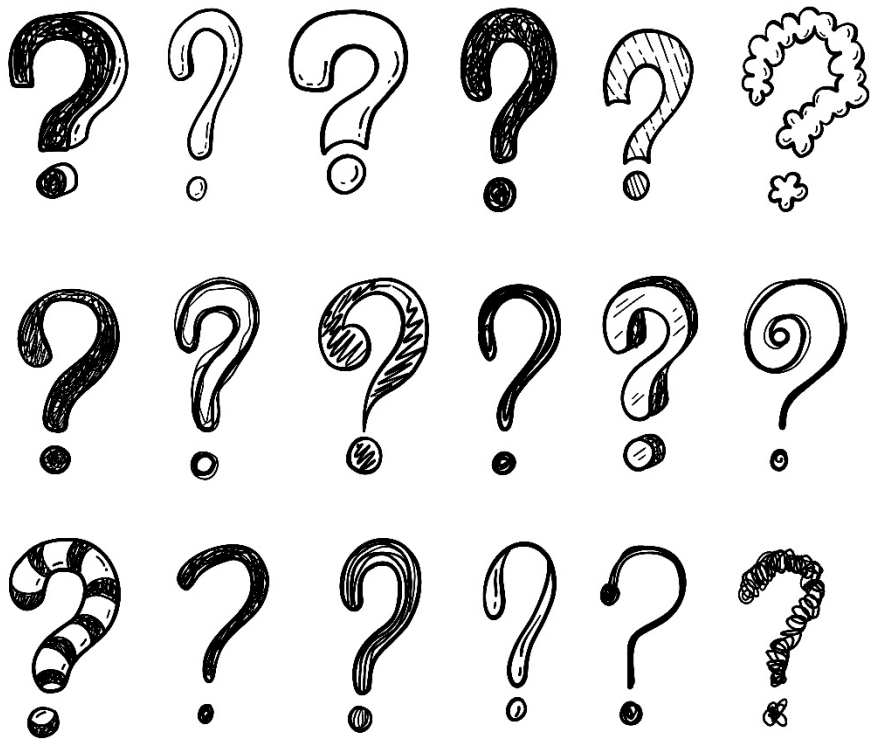
- Plans are available in all 72 counties
  - 15 MA plan sponsors
  - 103 individual plans
- Not all plans are in all counties
  - Certain types of plans are only available in certain counties
- If a plan is available in more than one county
  - The plan may have a different provider network
  - Beneficiaries need to contact the plan with their new address if moving from county to county

Counselor Note: It is considered good practice to have a list of the plans available in your county

Medicare Advantage Supplemental Benefits

May include:

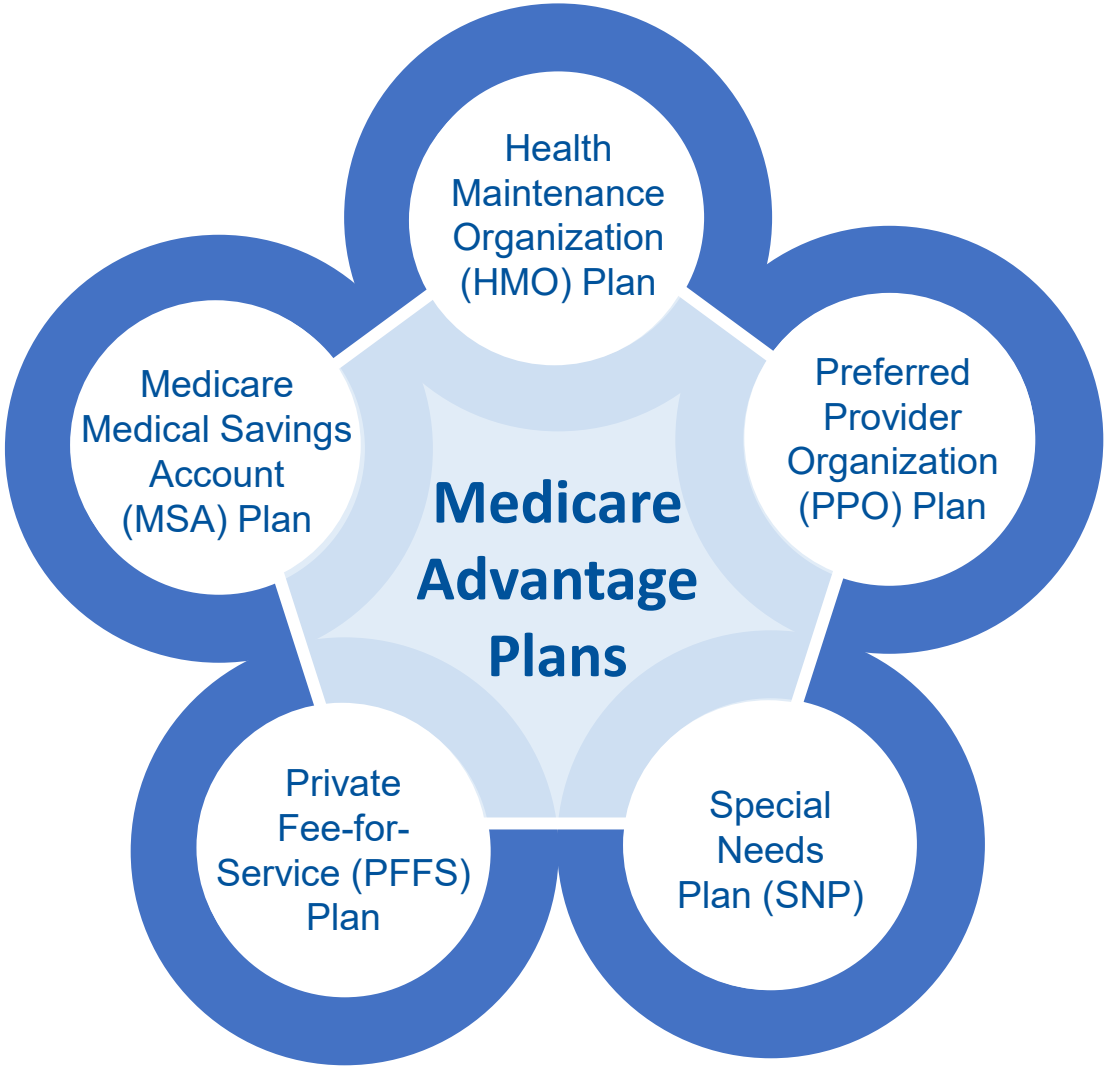
- Fitness
- Vision
- Dental
- Hearing Aids
- Food and Meals
- Transportation
- Flex Spending Cards/Money
- Coverage of Part B premium



Questions?

Types of Medicare Advantage Plans

Types of MA plans



Medicare 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

Can I get my health care from any doctor, other health care provider, or hospital?	Yes, but out of network may be a higher cost
Are prescription drugs covered?	Yes, if the plan bundles Part D
Do I need to choose a primary care doctor?	No.
Do I need a referral to see a specialist?	No, in most cases.
What else do I need to know about this type of plan?	Check with the plan about the provider network, the plan's rules, and more.

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.

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
      - Cardiovascular Disorders, Chronic Heart Failure and Diabetes
    - 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 Medical Savings Account (MSA) Plans

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.

Medicare Medical Savings Account (MSA) Plans (continued)

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

- The plan deposits money into a special savings account at a bank of the plan's choice.
  - 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, e.g.,dental, vision, and hearing and charge a premium for that coverage.
  - Check each MSA for details

Check Your Knowledge

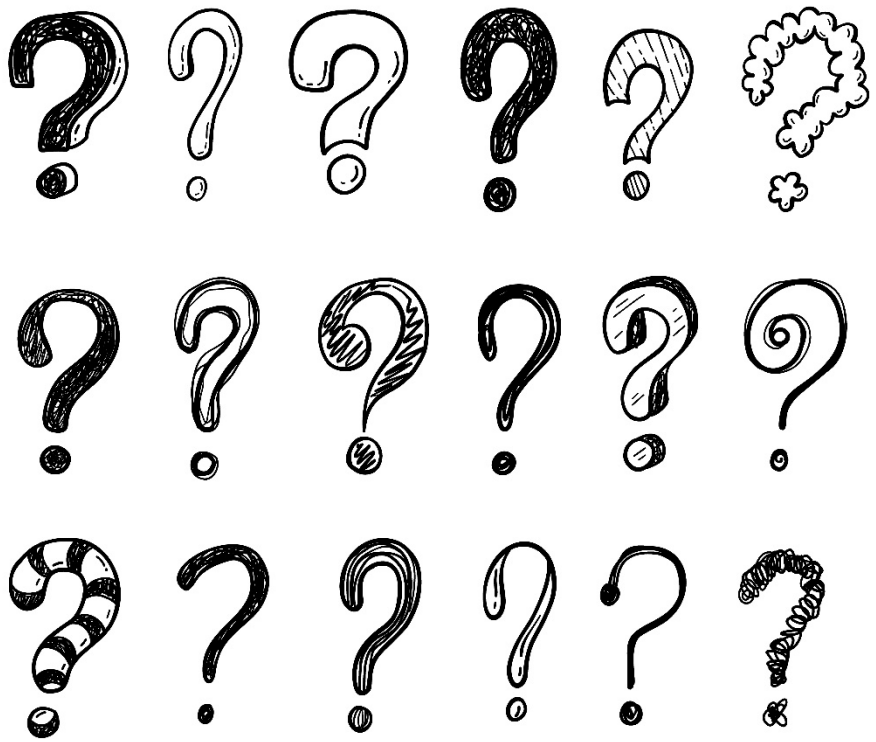
If enrolled in a Special Needs Medicare Advantage Plan all beneficiaries will need to be enrolled in Medicaid.

a. **True**

b. **False**

c. **Maybe**

Countdown timer: Answer the question before the bar disappears!

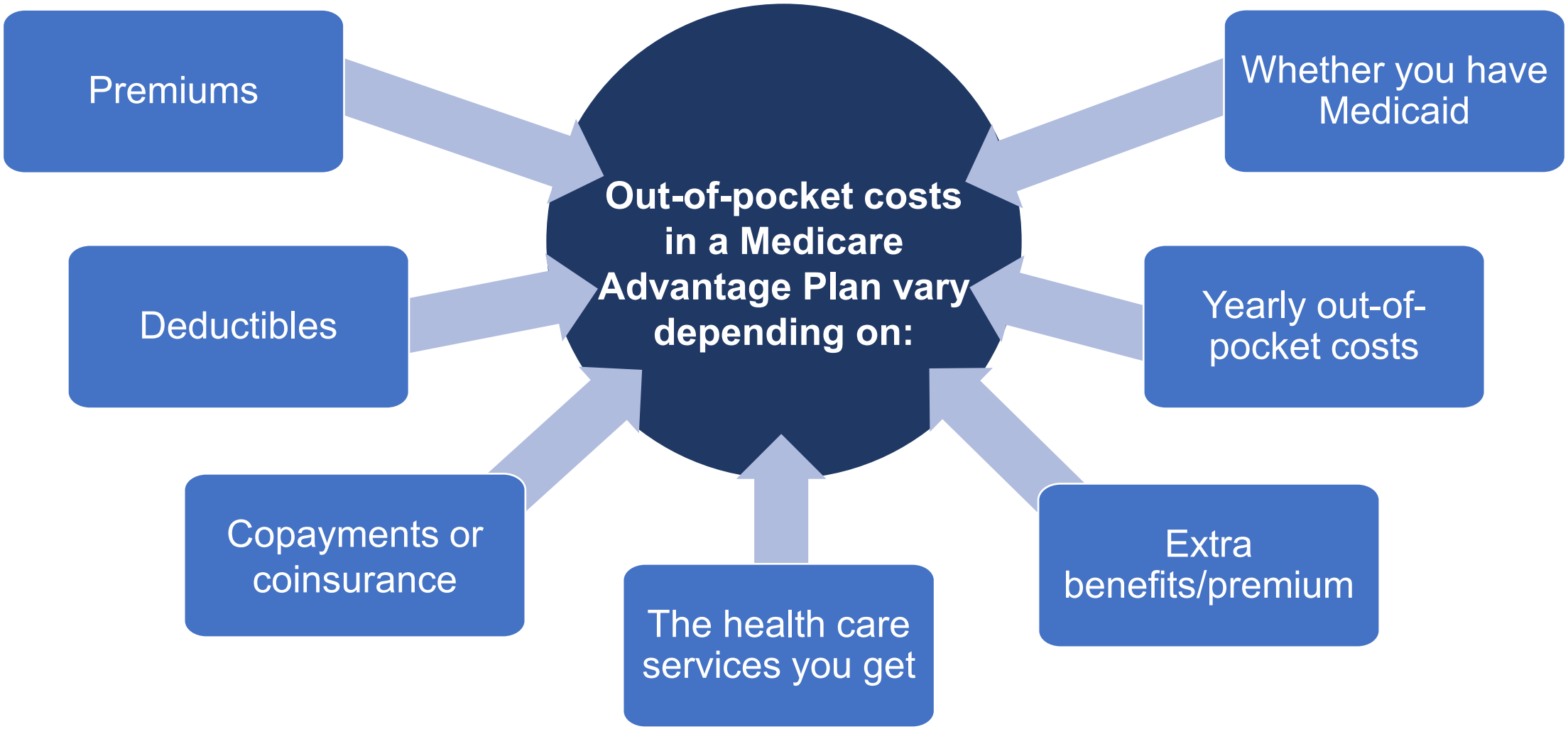


Questions?

Medicare Advantage Costs

What beneficiaries pay with a Medicare Advantage plan

What Are Medicare Advantage Plan Costs?



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 even if back premiums are paid.

Copayment and Coinsurance

- Depends on the plan and service received
  - 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
    - Can be up to $10,000
- When MOOP is met member pays zero for all covered services
  - Does not include Part D premium or prescription costs

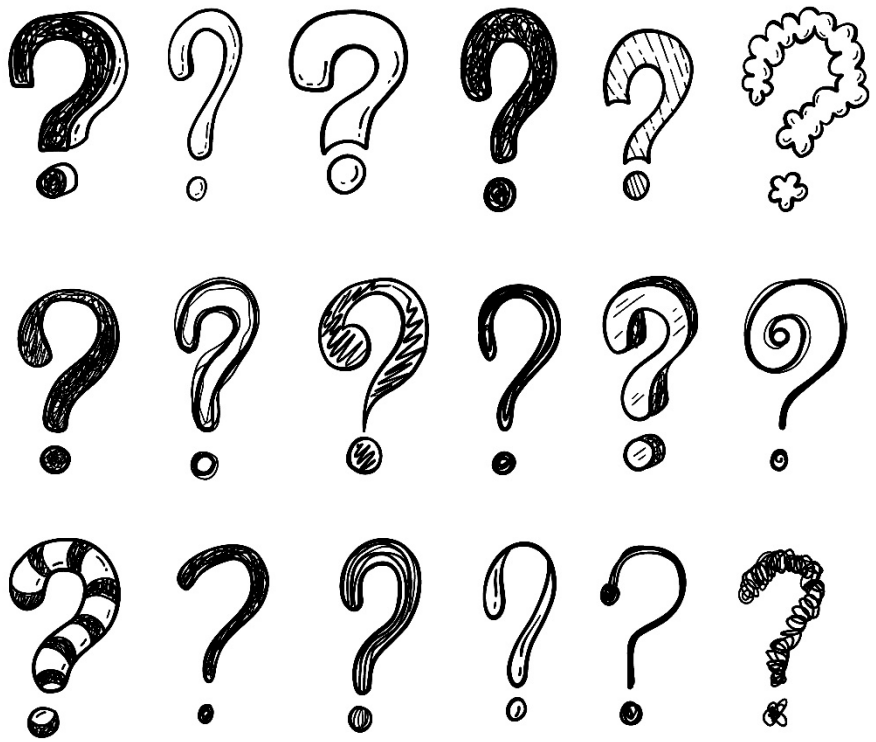
Check Your Knowledge

If enrolled in a Medicare Advantage Plan beneficiaries will continue to pay their 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/discharged from Nursing Home
- Involuntary Disenrollment
  - Moved and did not contact the plan within 12 month timeframe
  - Failure to pay premiums

Change of Address

- Move intrastate
  - 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 provider and pharmacy networks

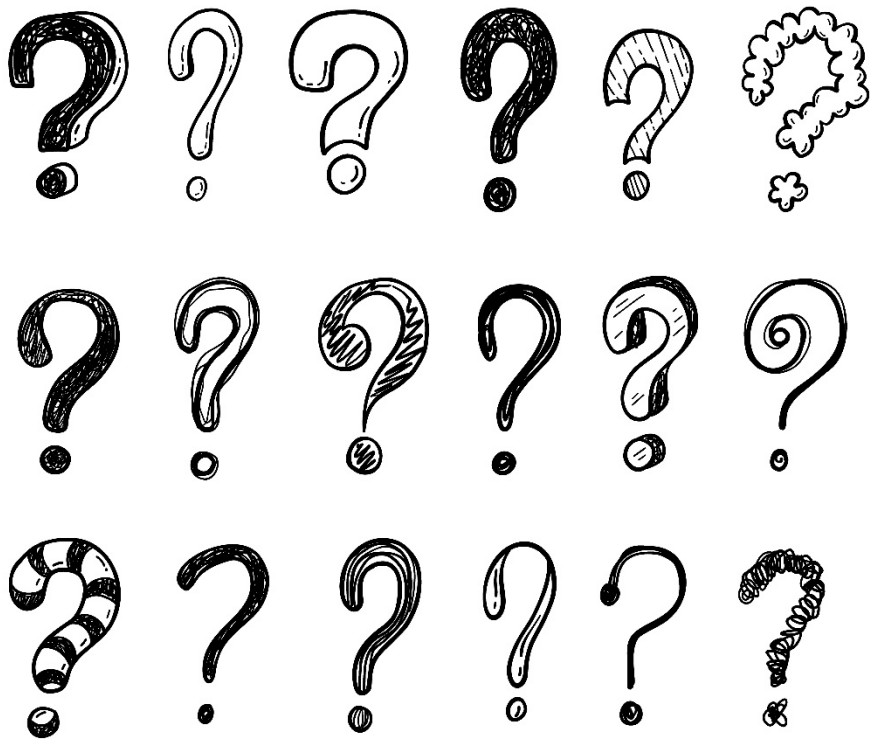
- Move interstate – contiguous 48, Alaska, Hawaii
  - Temporary move – can potentially stay in plan
    - Can have up to 12 months to tell plan that the move is permanent
    - Will be disenrolled if plan not notified
    - Temporary out of service area for an unusual circumstance
  - Permanent move – 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 because she found out her doctor is not in network. Can she go back to Original Medicare and her Part D plan?

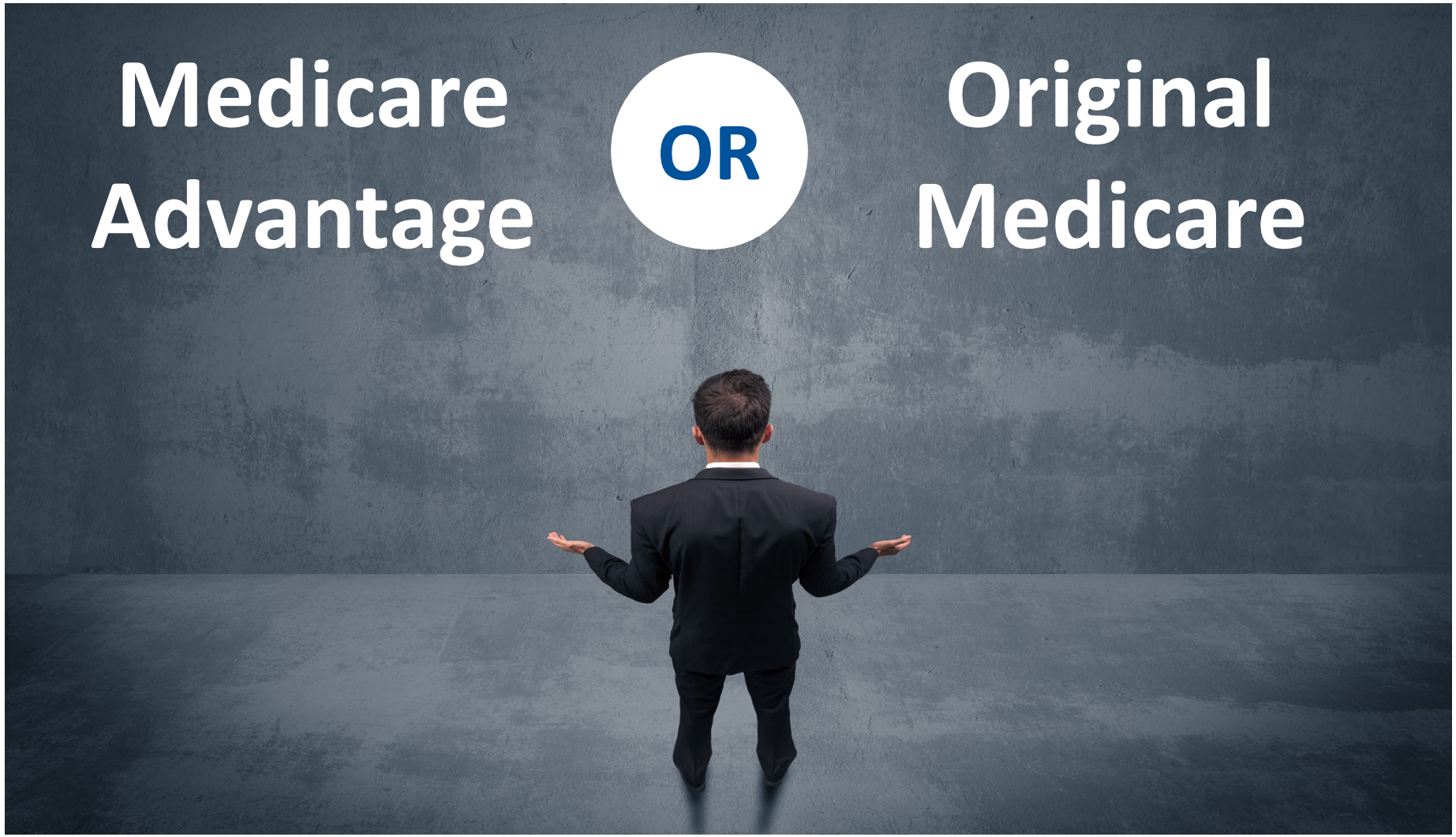
a. Yes

b. No



Questions?

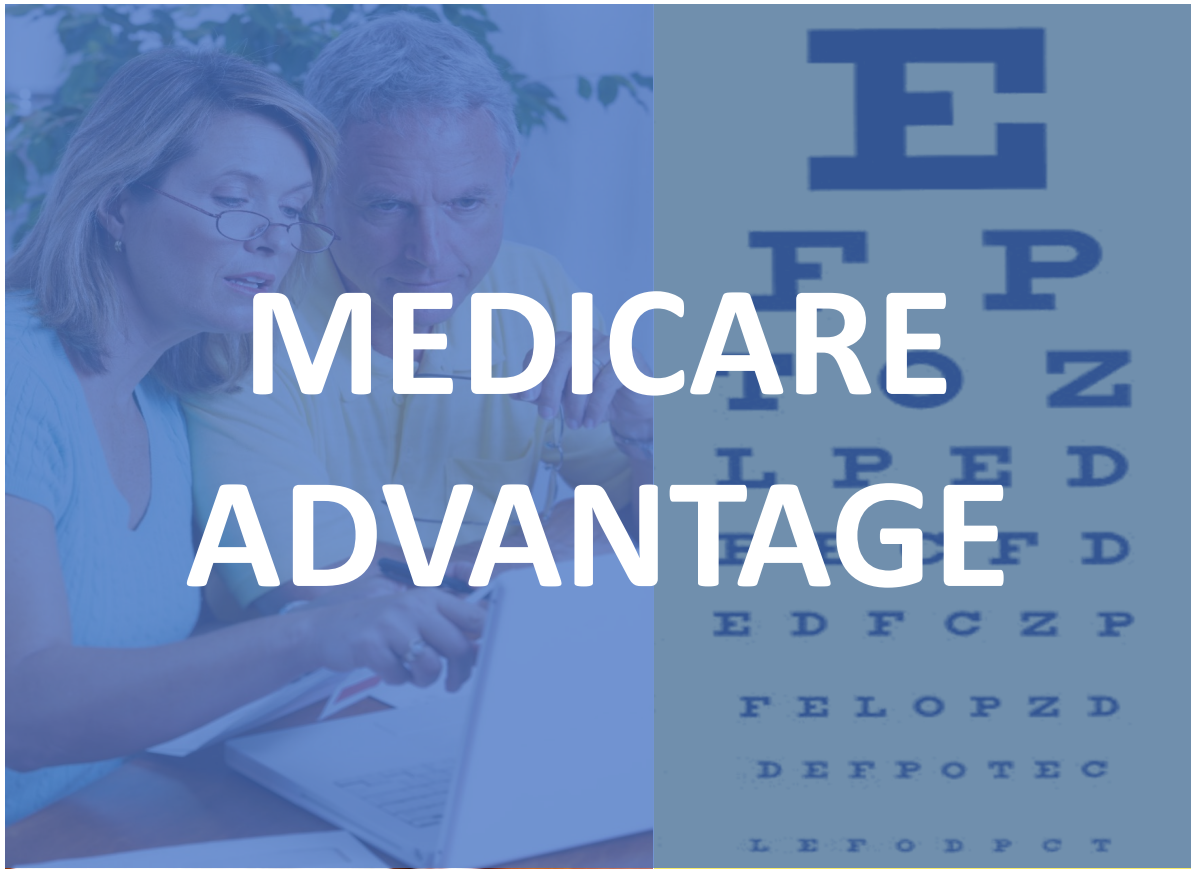
Activity



#1: MA or Original Medicare?

Can use any health care provider who accepts Medicare

#2: MA or Original Medicare?



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

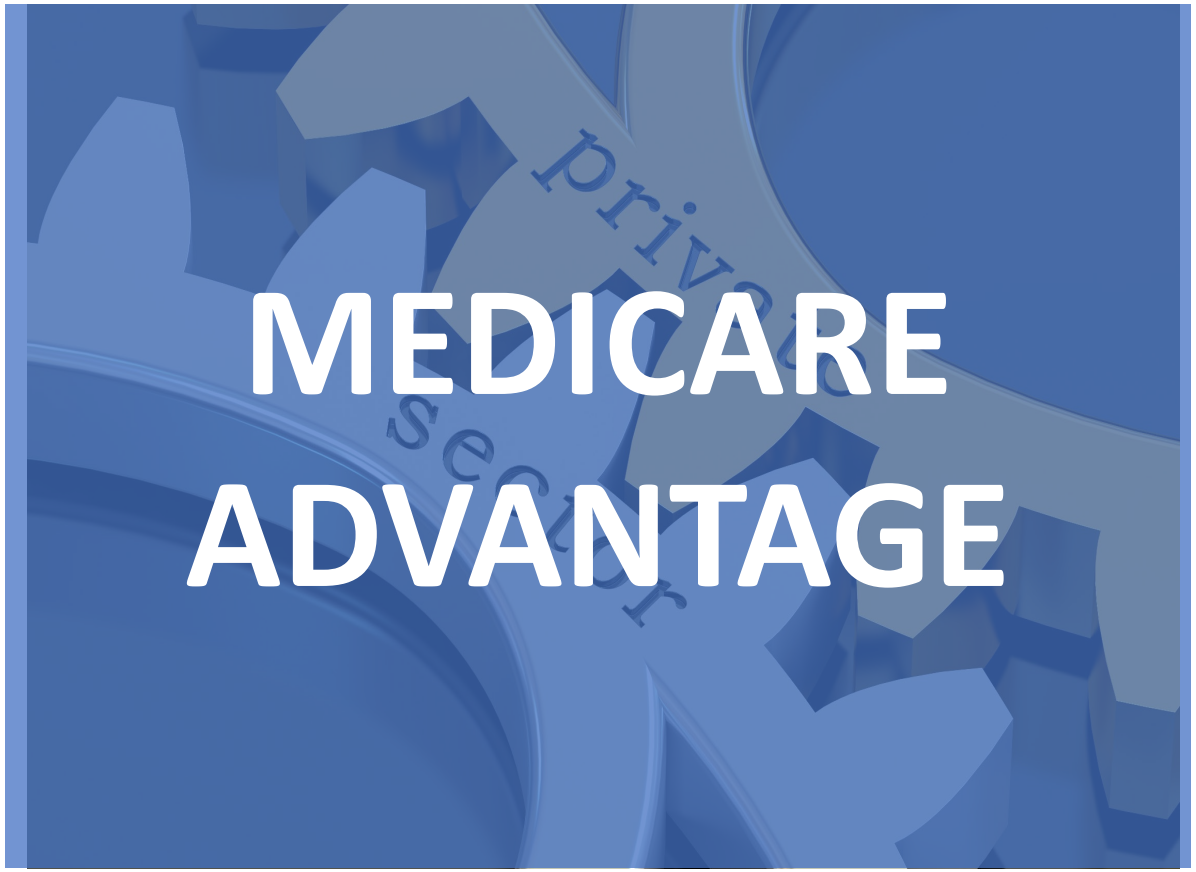
#4: MA or Original Medicare?

There is no limit to how much you pay out-of-pocket each year

#5: MA or Original Medicare?

Usually includes drug coverage

#6: MA or Original Medicare?



Run by private insurance companies contracted with and approved by Medicare

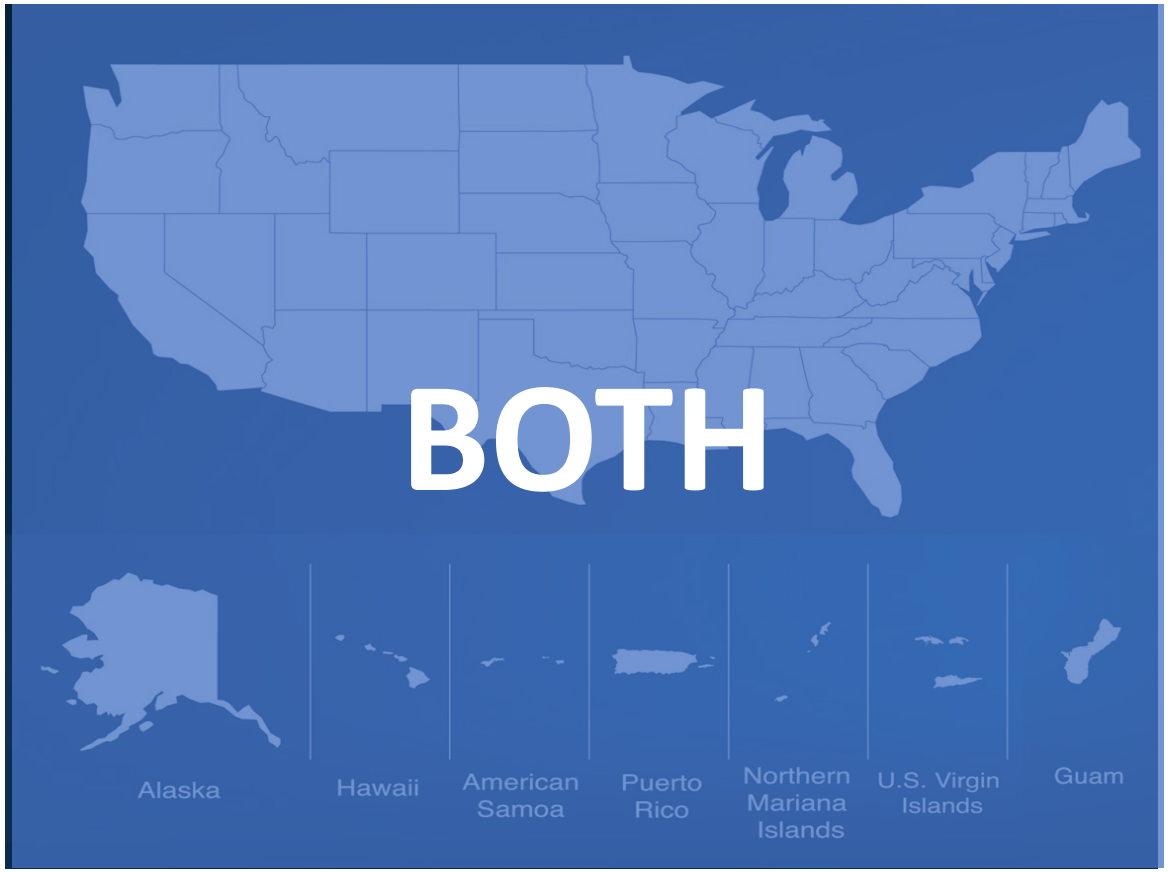
#7: MA or Original Medicare?

Can buy a Medigap plan to help with out-of-pocket costs

#8: MA or Original Medicare?

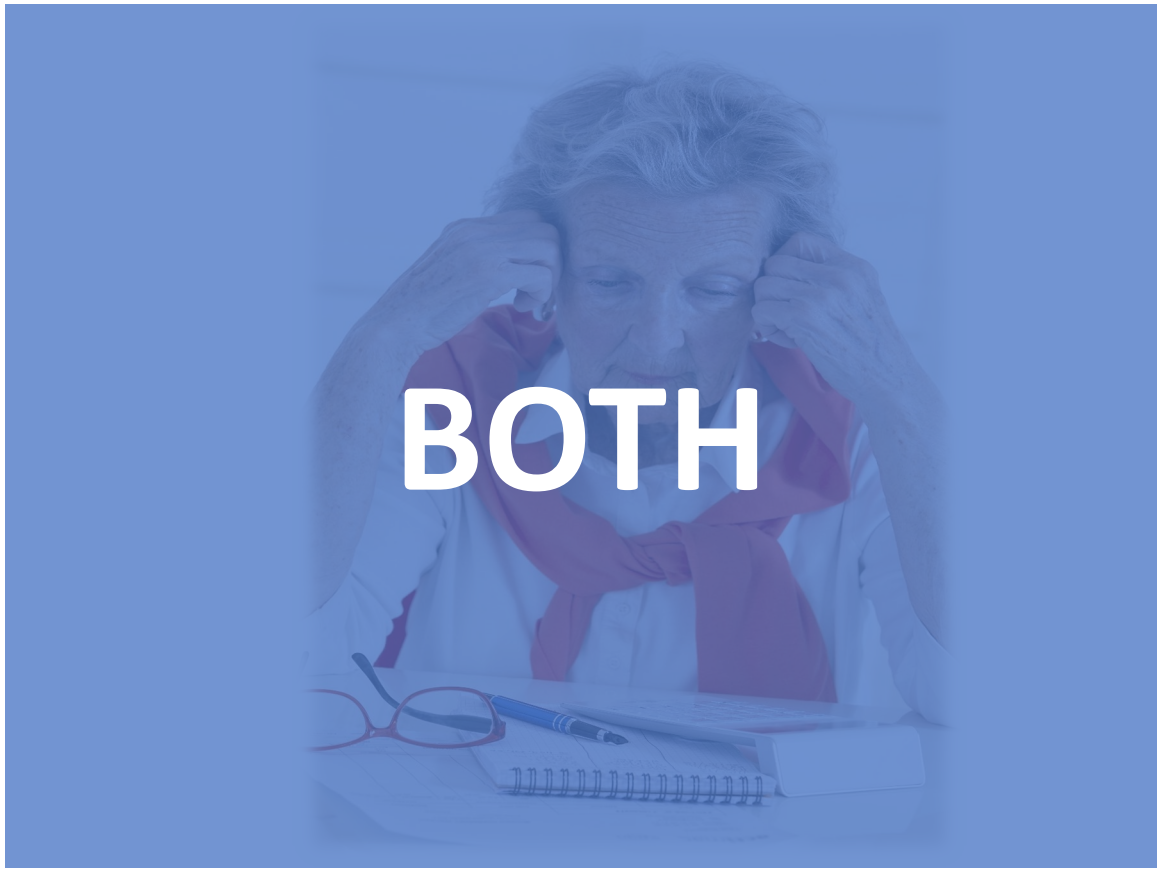
May need a referral to see a specialist

#9: MA or Original Medicare?



Can only get care in the U.S.

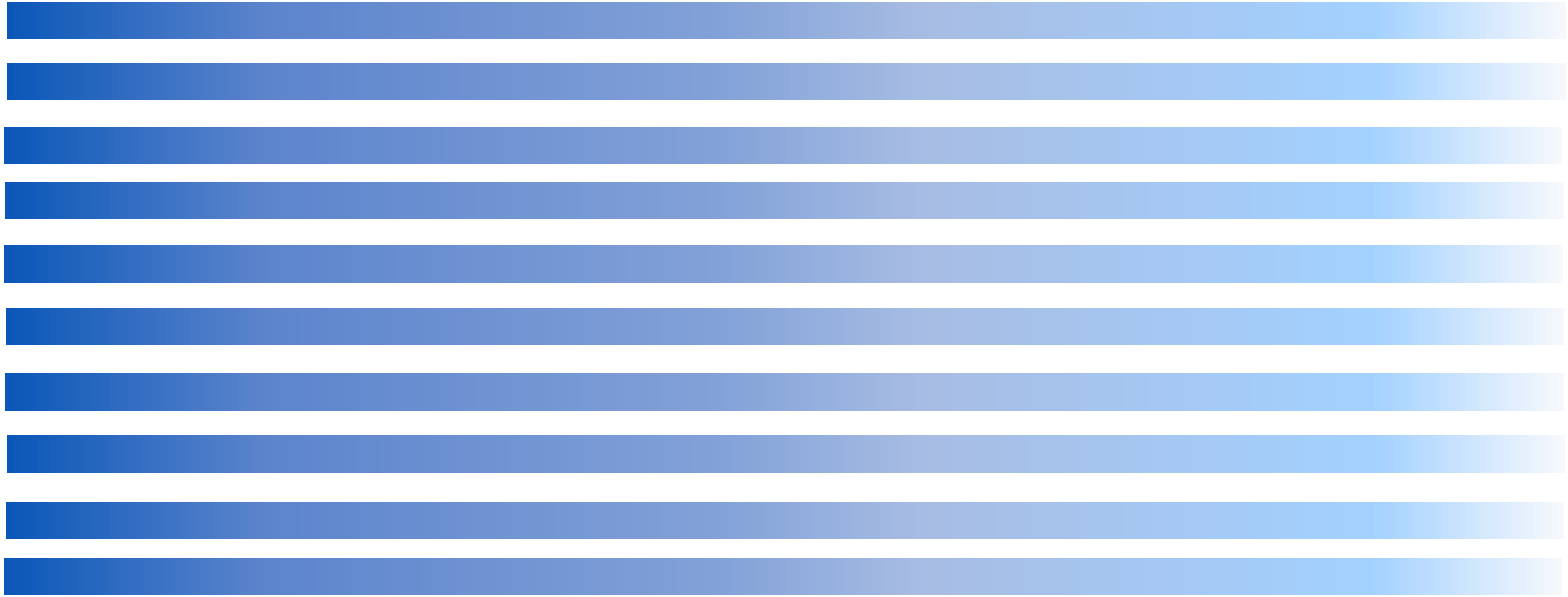
#10: MA or Original Medicare?



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

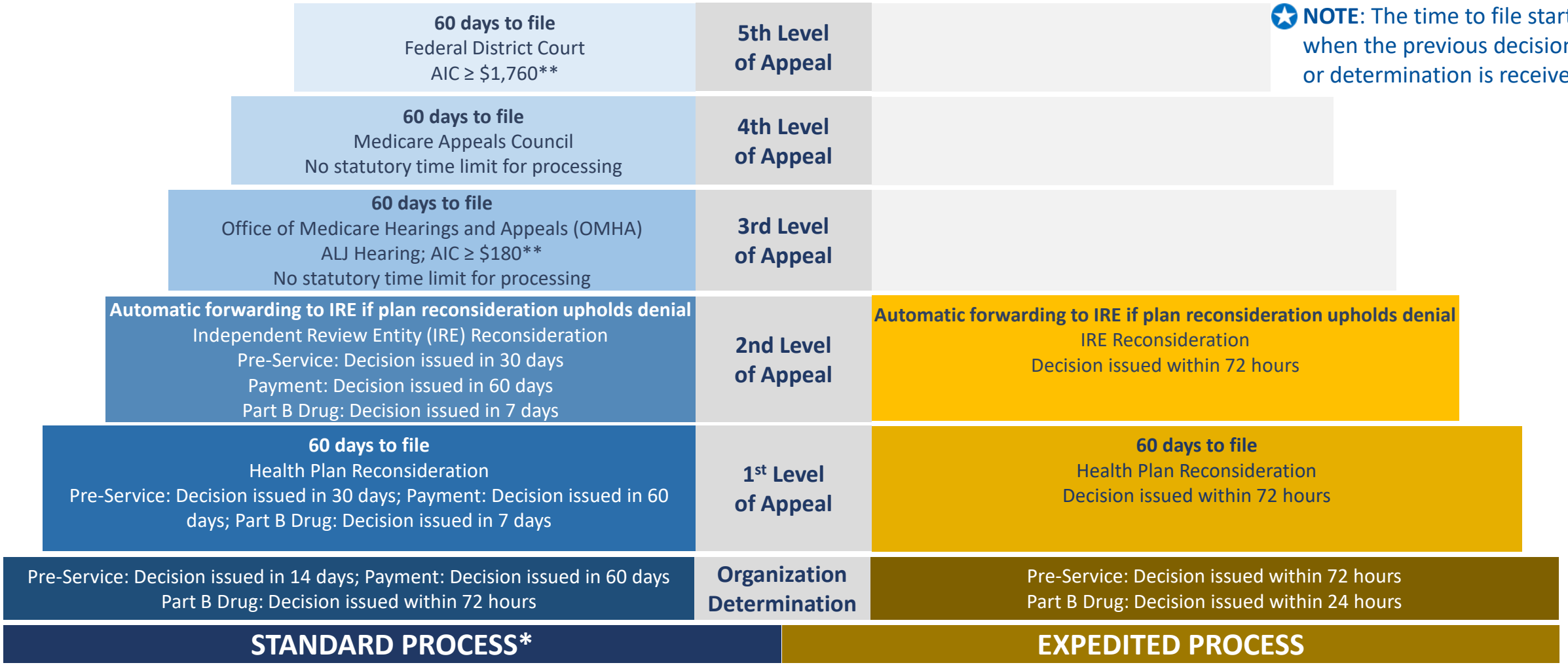
File an appeal

- 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

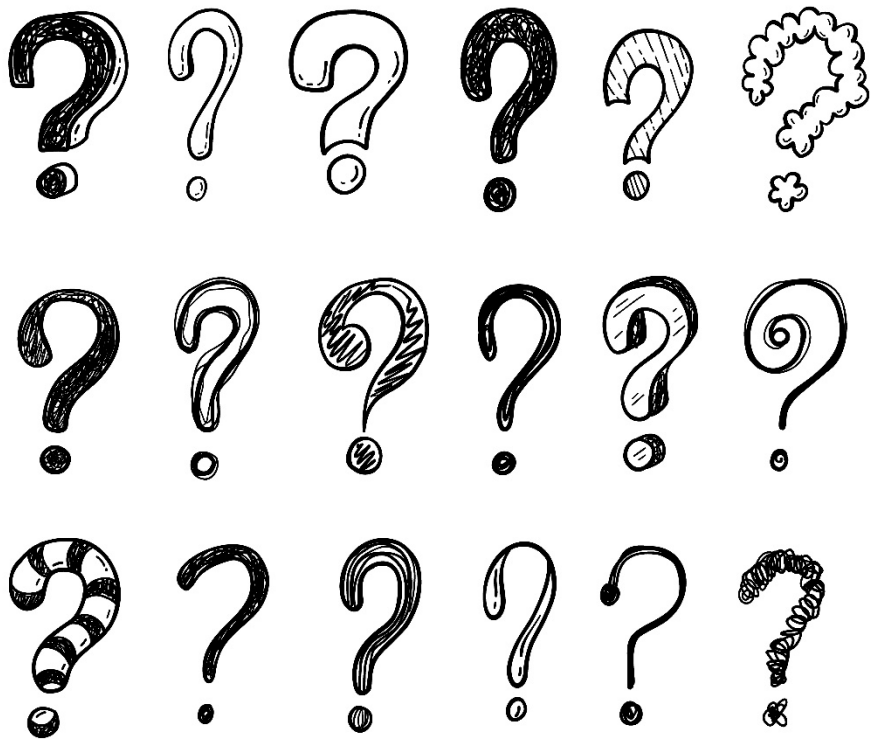
Medicare Advantage (Part C) Appeals Process



NOTE: The time to file starts when the previous decision or determination is received.

*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 intial coverage level
  - Give amount paid toward True Out Of Pocket(TROOP)
  - Give information on when reach catastrophic level

Plan Annual Notice of Change

- Every Medicare Advantage plan member gets an *Annual Notice of Change* letter from their plan by September 30th
  - 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 cost structure.
  - Plans can add prior authorization requirements
  - Plans can change drug tiers for particular drugs, costs, etc.

Counselor Note:

Even if individual is happy with their current plan, they should always revisit during the annual Open Enrollment Period (OEP).

Marketing

- 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 Gifts

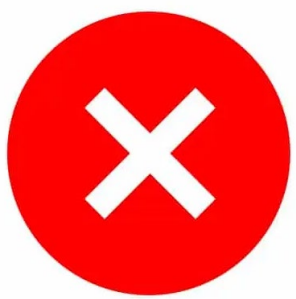
Plans can offer nominal gifts to potential enrollees for marketing purposes

- 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)

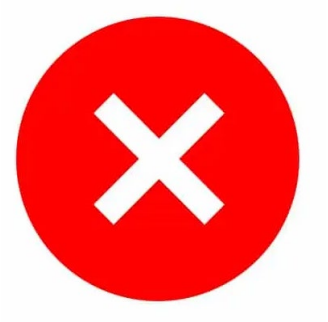


Prohibited unsolicited marketing activities:

- 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

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

- 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

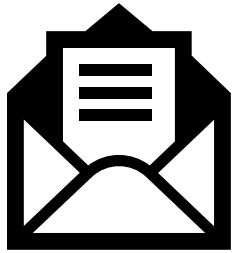
Marketing/Sales Events

- 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



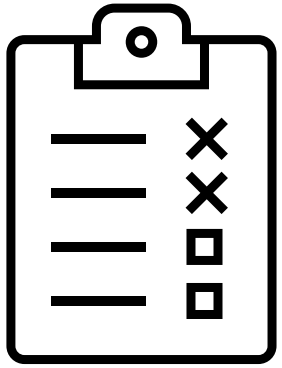
Plans must report:

- 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?

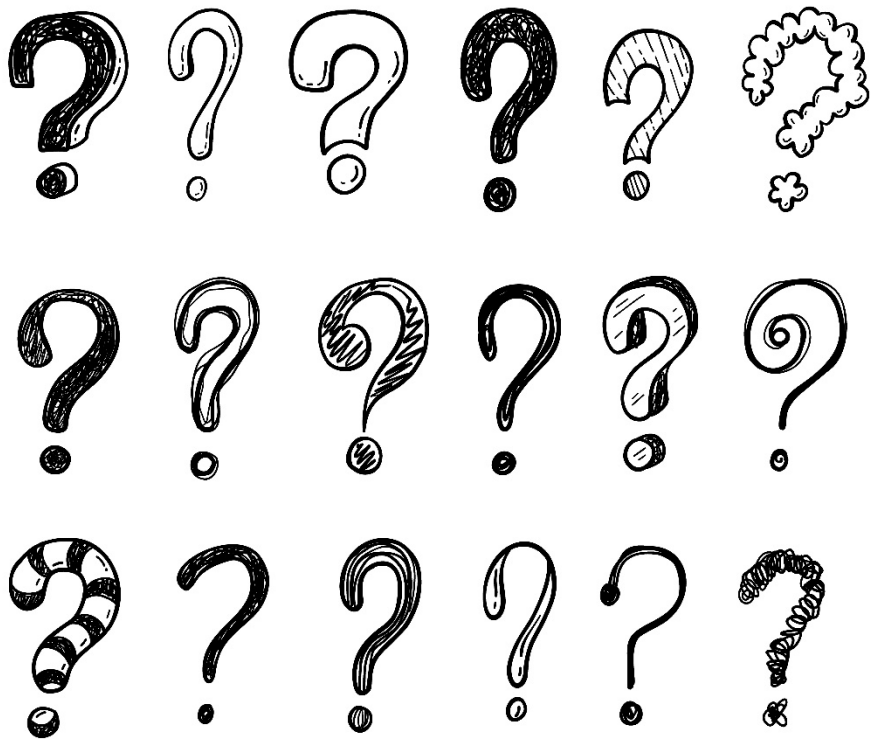
a. Insurance associations

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!



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 what help your client needs

Sample questions:

1. When did your Medicare start?
2. What is your MA plan start and when did it 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 if she would 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 and owes a premium. Today is April 29.

What do you say and do for Mrs. Perry?

Contacts

Questions are encouraged! You can go to the following SHIP counselors for help:

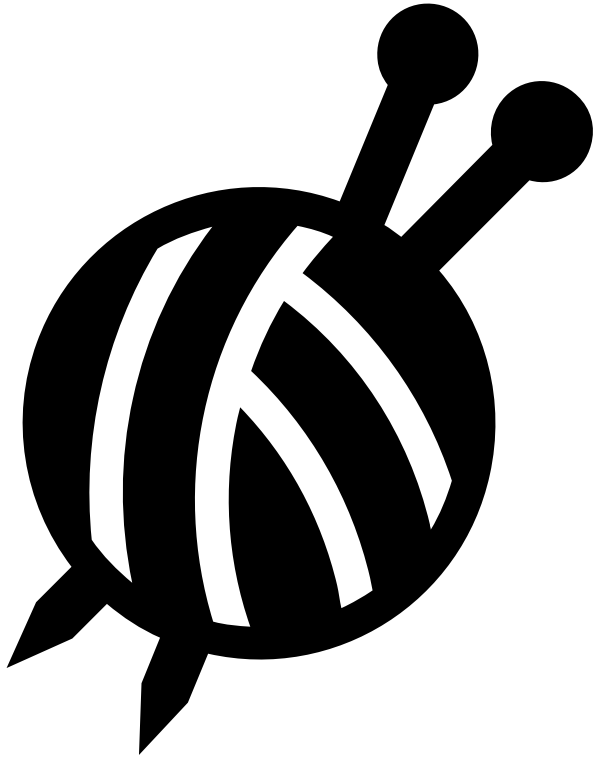
- **Your local SHIP supervisor**
- **The Board on Aging and Long Term Care**
  - Medigap Helpline: 1-800-242-1060
  - BOALTCMedigap@wisconsin.gov
  - Medigap Part D and Prescription Drug Helpline: 1-855-677-2783
  - BOALTCRXHelpline@wisconsin.gov
- **Disability Rights Wisconsin**
  Medicare Part D Helpline:
  - 1-800-926-4862
  - medd@drwi.org

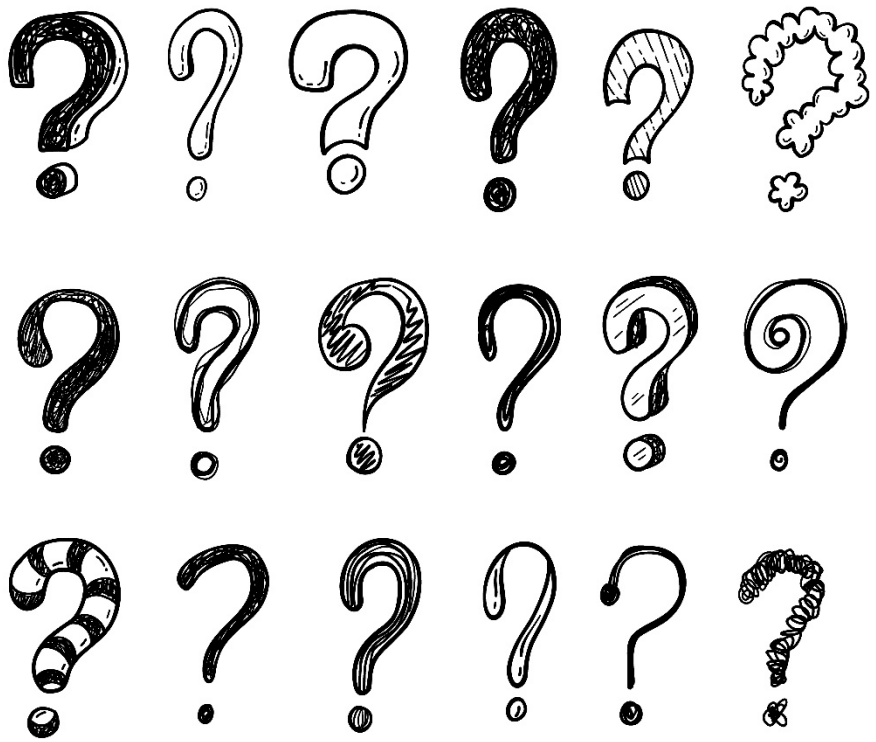
Request CEU/CEH

- Complete the Zoom survey following this training to request a CEU/CEH certificate
- You must attend live trainings to be eligible to receive a certificate.
  - Attendance will be verified using Zoom attendance reports
- The CEU/CEH is being provided through University of Wisconsin-Stevens Point, an accredited university. The continuing education certificate may cover several professions from social workers, counselors, educators, etc. The training attendee can submit the CEH certificate to their area of practice for approval.

Please send CEU/CEH questions to Pamela Watson, MIPPA grant program coordinator,
pamela.watson@dhs.wisconsin.gov

Ginger Rogers
Medicare Part D Program Coordinator
Disability Rights Wisconsin
6737 W. Washington Suite 3230
Milwaukee, WI 53214
ginger.rogers@drwi.org
414-773-4646





Questions?