Overview
Medicare Program Basics

Part 1

Version 12
June 18, 2018

Terms and Conditions

This training program is protected under United States Copyright laws, 17 U.S.C.A. §101, et seq. and international treaties. Except as provided below, the training program may not be reproduced (in whole or in part) in hard paper copy, electronically, or posted on any web site or intranet without the prior written consent of AHIP. Any AHIP member company in good standing sponsoring a Medicare Advantage or Part D plan may reproduce the training program for the limited purpose of providing training and education to the company's own employees and contractors on the subject matter contained in the training program. Employees or contractors participating in such training may not further reproduce (in whole or in part) the training program. No changes of any kind may be made to the training program and any reproduction must include AHIP's copyright notice. This limited license is terminable at will by AHIP.

The training program is intended to provide guidance only in identifying factors for consideration in the basic rules and regulations governing coverage, eligibility, marketing, and enrollment for Medicare, Medicare supplement insurance, Medicare health plans, and Part D prescription drug plans and is not intended as legal advice. While all reasonable efforts have been made to ensure the accuracy of the information contained in this document, AHIP shall not be liable for reliance by any individual upon the contents of the training program.

Learning Objectives

- After reviewing "Part 1: Medicare Program Basics" you will be able to explain:
  - The different ways to get Medicare;
  - Entitlement to Original Medicare;
  - Medicare premiums;
  - Eligibility for Medicare Advantage and prescription drug plans;
  - Help for beneficiaries with limited income;
  - Original Medicare benefits;
  - Combining Original Medicare and Part D; and
  - Medigap coverage.

Training Roadmap: Part 1

- ☐ Medicare Program Basics and Ways to Get Medicare
- ☐ New Medicare Identification Cards
- ☐ Medicare Entitlement, Premiums & Eligibility
- ☐ Help for Individuals with Limited Income
- ☐ Original Medicare Benefits
- ☐ Original Medicare and Part D
- ☐ Medigap Coverage

Medicare Program Basics

- Medicare is a health benefits program for U.S. citizens or permanent residents who meet certain work history requirements:
  - Age 65 or older
  - Under age 65 with certain disabilities
    - All who get disability benefits from Social Security or certain disability benefits from the Railroad Retirement Board for 24 months.
    - Individuals with Amyotrophic Lateral Sclerosis (ALS), often referred to as Lou Gehrig's Disease
  - Individuals with end-stage renal disease (ESRD)

- History – Medicare was signed into law in 1965. A brief history of Medicare is available at http://www.cms.gov/History/

- Medicare is administered by the Centers for Medicare & Medicaid Services, an agency of the U.S. Department of Health and Human Services

New Medicare Identification Cards

- Every Medicare beneficiary receives a Medicare identification card.
- During the next year, Medicare will stop using Social Security numbers for identification. For beneficiaries who already have their Medicare identification card with their Social Security number, Medicare will mail them new cards with Medicare ID numbers. Mailing will begin in April 2018 and be completed by April 2019.
- The change is intended to protect beneficiaries from identity theft.
- After they receive them, beneficiaries need to bring their new cards whenever they get care.
- Beneficiaries should also destroy their old cards after they receive their new cards.

Medicare Law -- Title XVIII of the Social Security Act (Parts A, B, C, D, & E)

- Medicare statutes are found under Title XVIII of the Social Security Act: "Health Insurance for the Aged and Disabled."

- Title XVIII is split by topic into several subsections:
  - Part A – Hospital
  - Part B – Medical
  - Part C – Medicare health plans, which must cover Part A and Part B benefits
  - Part D – Prescription drug coverage
  - Part E – Miscellaneous Provisions, including Medigap coverage

Overview of Different Ways to Get Medicare

- ☐ Original Medicare (Part A and Part B)
- ☐ Medicare Advantage Plans (Medicare Part C, with or without Part D)
- ☐ Medicare Cost Plans
- ☐ PACE Plans
- ☐ Medicare-Medicaid Plans
- ☐ Medicare Prescription Drug Plans (Medicare Part D)
- ☐ Medigap

Overview of Different Ways to Get Medicare - Examples

- Mr. Jones has Original Medicare. He has purchased a Medigap plan to cover some of the Medicare cost sharing and a stand-alone prescription drug plan to cover his drugs.
- Mrs. Hernandez has purchased a Medicare Advantage plan that includes Part D coverage to cover her Medicare benefits, drugs benefits and some of the Medicare cost sharing.
- Mr. Watanabe receives both Medicare and Medicaid benefits. He has enrolled in a single Medicare-Medicaid plan that furnishes both Medicare and Medicaid services for him.
- Ms. Krauss has purchased a Medicare Advantage plan without Part D coverage because she has a generous drug plan that is offered by her former employer.

Different Ways to Get Medicare: Original Medicare

- Original Medicare (has two Parts – Part A and Part B)
  - Part A – Hospital, skilled nursing facility, hospice, and home health services
  - Part B – Professional services such as those provided by a doctor or non-physician professional, outpatient care, clinical lab services and other medical services

Different Ways to Get Medicare, continued: Medicare Advantage Plans-Part C

- Part C - Medicare Advantage Plans (Medicare Advantage plans must cover all Part A and Part B services)
  - Health Maintenance Organizations (HMOs) (some plans also include Part D)
  - Preferred Provider Organizations (PPOs) (some plans also include Part D)
  - Private Fee-for-Service Plans (PFFS) (some PFFS plans may offer Part D, however PFFS plans are not obligated to offer Part D)
  - Special Needs Plans (SNPs) (all plans include Part D)
  - Medical Savings Account Plans (MSAs) (do not include Part D)
  - Employer or Union Group Plans

Note: See "Part 2, Medicare Health Plans," for more information.

Part C Medicare Health Plans

- All Medicare Advantage (MA) plans must:
  - Cover all Part A and Part B benefits;
  - Provide plan cost-sharing actuarially equivalent to cost sharing under Medicare Parts A and B, but may be different for specific services; and
  - Include an annual maximum out-of-pocket (MOOP) limit on total enrollee cost sharing (deductibles, coinsurance, and copayments) for Part A and Part B services
    - Original Medicare does not have such a cap.
  - Cover the following services even when provided by non-network providers:
    - emergency services;
    - out-of-area (and in limited circumstances, in-area) urgently needed services; and
    - out-of-area renal dialysis.

Part C Medicare Health Plans, continued

Extra Benefits–Medicare health plans also may cover extra benefits not covered by Original Medicare, such as:

- Vision Services
- Hearing Aids
- Routine Dental Services and/or Dentures
- Routine Transportation to Medical Appointments
- Chiropractic Services
- Annual Physical Exams*
- In Home Safety Assessments and fall prevention devices
- Worldwide Urgently Needed and Emergency Services.
- Over the Counter Drugs

* An annual physical is different from the annual wellness visit covered under Medicare, which does not include a physical exam.

Different Ways to Get Medicare, continued

- Other types of Medicare Health Plans:
  - Medicare Cost Plans (some also include Part D)
  - PACE Plans (includes Part D)
  - Medicare-Medicaid Plans (includes Part D)

Different Ways to Get Medicare, continued: Medicare Cost Plans

Medicare Cost Plans are a type of Medicare health plan that are not Medicare Advantage Plans. They are only available in certain areas of the country.

- Individuals can enroll even if they have Part B and not Part A.
- If enrollees who have both Part A and Part B and go to a non-network provider, the services are covered under Original Medicare. In these cases, enrollees pay Part A and Part B coinsurance and deductibles.
- Individuals can join anytime the plan is accepting new members.
- Enrollees can leave anytime and return to Original Medicare.
- Enrollees can get prescription drug coverage from the plan (if offered) or join a Medicare Prescription Drug Plan (Part D).

Different Ways to Get Medicare, continued: PACE Plans

Programs for All-Inclusive Care for the Elderly (PACE) is a Medicare and Medicaid program offered in many states that allows people who otherwise need a nursing home level of care to remain in the community. To qualify an individual must meet these conditions:

- Be age 55 or older,
- Live in the service area of a PACE organization,
- Be certified by the state as needing a nursing home level of care, and
- At the time the individual joins, he or she is able to live safely in the community with the help of PACE services.

Different Ways to Get Medicare, continued : Medicare-Medicaid Plans

- Medicare-Medicaid Plans serve individuals eligible for both Medicare and Medicaid.
- The individuals are sometimes referred to as dual-eligibles.
- Medicare-Medicaid Plans include Part D Prescription Drug coverage.

Different Ways to Get Medicare, continued: Part D

- Part D – Prescription Drug Coverage
  - Stand-alone Prescription Drug Plan (PDP) or
  - Coverage under a Medicare health plan

Example: Mr. Ing decides to obtain stand-alone Part D coverage to use with his Original Medicare instead of enrolling in a Medicare Advantage plan that offers Part D coverage. If Mr. Ing decides to enroll in a Medicare Advantage HMO plan, he can only receive Part D coverage from the Medicare Advantage plan.

Note: See "Part 3, Medicare Part D Prescription Drug Coverage," for more information.

Medigap (Medicare Supplement Insurance)

- Medigap insurance:
  - Is sold by private insurance companies to fill "gaps" in Original Medicare coverage;
  - Works only with Original Medicare;
  - Covers all, or a portion, of Part A and Part B cost sharing (coinsurance, copayments, or deductibles) for beneficiaries in Original Medicare.
    - Does not cover Medicare benefits, but works in tandem with Original Medicare coverage.

- Some Medigap policies cover benefits not covered by Part A or Part B of Original Medicare, such as extra days of coverage for inpatient hospital care or foreign travel emergency care.

Note: See section titled "Medigap Coverage" for more information on Medigap.

Entitlement to Original Medicare, Premiums, & Eligibility

Medicare Entitlement – Part A

- Most individuals get Part A coverage without having to pay a Part A premium. This is because they or a spouse paid Medicare taxes while working for a specified duration of time. This duration is generally 40 quarters (10 years).

- For those individuals who do not automatically qualify for premium-free Part A coverage, the monthly Part A premium in 2018 is up to $422 depending on an individual's duration of Medicare-covered employment.

Medicare Entitlement – Parts A and B

- At Age 65
  - Individuals who are already getting benefits from Social Security or the Railroad Retirement Board (RRB) will automatically get Part A and Part B starting the first day of the month they turn 65. These individuals are also given the opportunity to refuse Part B coverage.
  - Individuals who are not getting benefits from Social Security or the Railroad Retirement Board (RRB) may sign up for Parts A and B during their initial enrollment period, which begins 3 months before their 65th birthday, includes the month they turn 65 and ends 3 months after.

Medicare Entitlement – Parts A and B, continued

- Individuals with disabilities who are under age 65 are automatically enrolled in Parts A and B the month after they have received Social Security or Railroad Retirement disability benefits for 24 months. They also are given an opportunity to refuse Part B coverage. [Note: Disabled individuals who live in Puerto Rico automatically get Part A after 24 months but need to sign up for Part B if they want it.]

- Individuals with ALS (Amyotrophic Lateral Sclerosis, also called Lou Gehrig's disease) get Part A and Part B automatically the month their Social Security disability benefits begin.

- Individuals with end-stage renal disease (ESRD) may sign up for Medicare at any time. However, the date on which their Medicare coverage begins usually on the fourth month after dialysis treatments begin, but may be earlier if certain conditions are met.

Enrollment in Part B After the Initial Entitlement Period

- Individuals who do not enroll in Part B when first eligible can enroll during a General Enrollment Period each year from January 1 – March 31.
  - Part B coverage begins on July 1 of the year they enroll.

- Individuals who have group health plan coverage based on their own current employment or the employment of a spouse may enroll in Part B anytime while covered under the group health plan or during a special enrollment period that occurs during the 8-month period immediately following the last month of the group coverage.

Medicare Premiums for Part B

Beneficiaries enrolled in Part B must pay a monthly premium.

- In 2018, the standard monthly premium for Part B is $134 (or higher depending income). However, some people who get Social Security benefits pay less than this amount.
- Those who pay the standard monthly premium or higher include individuals who:
  - enroll in Part B for the first time in 2018;
  - don't get Social Security benefits;
  - are directly billed for Part B premiums (e.g. do not have it taken out of their Social Security check);
  - have Medicare and Medicaid, and Medicaid pays the premiums (the state will pay the premium); or
  - have a modified adjusted gross income on their IRS tax return from 2 years ago above a certain amount.

Medicare Premiums for Part B, continued

- Individuals who pay their Part B premium through their monthly Social Security benefit pay less ($130 on average).
- Individuals with income over $85,000, or filing jointly with incomes over $170,000, pay more, up to $428.60 a month in 2018 based on the income related monthly adjustment amount (IRMAA).

Individual tax return	Joint tax return	2018 Part B premium
< $85,000	<$170,000	$134
>$85,000 to $107,000	>$170,000 to $214,000	$187.50
>$107,000 to $160,000	>$214,000 to $320,000	$267.90
>$160,000 to $214,000	>$320,000 to $428,000	$348.30
>$214,000	>$428,000	$428.60

Medicare Premiums for Part B, continued

- Part B premiums may be deducted from Social Security checks, Railroad Retirement checks or Office of Personnel Management (civil service annuity) checks.
- Employers may pay monthly Part B premiums on behalf of retirees.

Medicare Premiums for Part B, continued

- For individuals who do not enroll in Part B when first eligible, the Part B premium is increased 10% for each full 12-month period the beneficiary could have had Part B but, did not enroll. This is known as a "late enrollment penalty."

- Exception: Individuals who have group health plan coverage based on their own current employment or the employment of a spouse are not subject to the premium increase if they enroll in Part B anytime while covered under the group health plan or during the special enrollment period that occurs during the 8-month period immediately following the last month of the group coverage.

Medicare Premiums for Part B, continued

Example: Ms. Stein retires from her job when she is 69. She did not previously enroll in Part B because she had employer group coverage. Her last month of group coverage is February. She has until October to enroll in Medicare Part B without incurring a late enrollment penalty.

Example: Mr. O'Hare, who is 70 and does not have Part B, is retired, but he has health coverage through his wife's current employer. If Mr. O'Hare decides to get Part B now he can do so without incurring a late enrollment penalty.

Medicare Eligibility – Part C/Part D

- Part C Medicare Advantage Health Plan
  - Individuals who are entitled to benefits under Part A and enrolled under Part B are eligible to enroll in a Medicare Advantage plan.
- Part D Prescription Drug Benefits
  - Individuals who are entitled to benefits under Part A and/or enrolled under Part B are eligible for Part D prescription drug benefits.

Example: Ms. Gray did not have the required work history to automatically get Part A without a premium. She has chosen not to enroll in Part A, but has enrolled in Part B. Ms. Gray is not eligible to enroll in a Medicare Advantage plan but she can get Part D.

Help for Individuals with Limited Income

Help for Individuals with Limited Income/ Resources–Apply to State Medicaid Office

- Beneficiaries with limited income and resources should be encouraged to apply to their State Medicaid office to determine eligibility for various (Federal or State) programs.

- Beneficiaries may qualify for help to pay the Medicare Part A (if any) and Part B premium, the Part A and Part B deductibles and cost sharing, and/or some Part D prescription drug costs.

- Tell them to call or visit their Medicaid office, and ask for information on Medicare Savings Programs. To get the phone number for the state, visit Medicare.gov/contacts or call 1-800-MEDICARE (1-800-633-4227), and say “Medicaid.”

Help for Individuals with Limited Income/ Resources–Apply to State Medicaid Office, continued

- Beneficiaries may qualify for these programs by applying to the State Medicaid office.
  - Medicaid: help with health care costs.
  - Medicare Savings Program: help paying for the Medicare Part B premium and, in some cases, deductibles and coinsurance.
  - Part D low-income subsidy: help paying for prescription drug coverage. The State Medicaid office will check eligibility for this and other programs such as the Medicare Savings Program. Persons interested in Part D help only may call the Social Security Administration (SSA) at 1-800-772-1213 or apply online at www.ssa.gov/prescriptionhelp.
  - Persons who do not qualify for the Part D low-income subsidy but are of limited means may qualify for help in paying Part D drug costs through a State's Pharmaceutical Assistance Program.
  - Supplemental Security Income (SSI) benefits: help with cash for basic needs. You also may apply through SSA.

Original Medicare Benefits

Medicare Part A Benefits

- Part A helps cover medically necessary inpatient care in hospitals. In 2018, for each benefit period (as defined by Medicare) in a year, beneficiaries pay:

  - $1,340 deductible and no coinsurance for a stay of up to 60 days
  - $335 coinsurance per day for days 61-90 of a hospital stay
  - $670 coinsurance per "lifetime reserve day" after day 90 each benefit period (up to 60 days over a beneficiary's lifetime)
  - All costs for each inpatient day beyond 150 days

Medicare Part A Benefits, continued

- Part A also helps cover:
  - Blood
  - Hospice care
  - Home health care
  - Skilled nursing and rehabilitative care only after a three day hospital stay, up to 100 days in a benefit period (as defined by Medicare). In 2018, beneficiaries pay $167.50 coinsurance for days 21-100 each benefit period. (Medicare Advantage Plans may waive the prior three day hospital stay requirement.)
  - Inpatient psychiatric care (up to 190 lifetime days)
- Part A does not cover custodial or long-term care
- Cost-sharing may differ for enrollees of Medicare health plans.

Medicare Part B Benefits

- Part B generally covers:
  - medically necessary physician and other health care professional services;
  - outpatient hospital;
  - clinical lab and diagnostic tests, therapies, mental health care;
  - medical equipment; and
  - medications and supplies provided incident to a physician's service.
- Beneficiaries pay a deductible each year ($183 in 2018), and after the deductible is satisfied, 20% coinsurance on most Part B covered services.
- Cost-sharing may differ for enrollees of Medicare health plans.

Medicare Part B Benefits - Preventive Services and Screenings (1 of 4)

- Beneficiaries covered under Original Medicare and Medicare Advantage plans will have no cost-sharing for most preventive services.

- Preventive Services include:
  - One-time "Welcome to Medicare" preventive visit
  - Annual wellness visit after 12 mos. enrolled in Part B and annually thereafter
  - Immunizations – pneumococcal, hepatitis B, annual flu shot (shingles shots are covered under Part D, not Part B)
  - Abdominal aortic aneurysm screening – one time, with referral
  - Alcohol misuse screening – every 12 months for certain individuals
  - Bone mass measurement – every 24 months for certain conditions or meets certain criteria

Medicare Part B Benefits – Preventive Services and Screenings (2 of 4)

- Cardiovascular screening blood tests – every five years for all persons
- Colorectal cancer screening – five different tests, vary in frequency
- Depression Screening – every 12 months
- Diabetes screenings – up to two per year for those with risk factors
- Diabetes self-management training – for persons with diabetes
- Glaucoma testing – once per year for those at high risk
- Hepatitis C test – once, if certain conditions are met. For certain people at high risk Medicare also covers yearly repeat.

Medicare Part B Benefits - Preventive Services and Screenings (3 of 4)

- HIV Screening – every 12 months if certain conditions are met.
- Intensive Behavioral Therapy for Cardiovascular Disease – one face-to-face visit annually in a primary care setting
- Lung Cancer screening – every 12 months if certain conditions are met.
- Mammogram (Breast Cancer Screening) – annual screening for most women
- Medical nutrition therapy – for those with diabetes/kidney disease or kidney transplant
- Obesity Screening and counseling – for certain individuals
- Pap test and pelvic examination – every 24 mos. for all women; every 12 mos. for those at high risk

Medicare Part B Benefits - Preventive Services and Screenings (4 of 4)

- Prostate cancer screening – every 12 mos. for men over age 50
- Screening for Sexually Transmitted Infections (STIs) and High Intensity Behavioral Counseling to Prevent STIs – for certain individuals
- Smoking and tobacco-use cessation counseling – for any illness related to tobacco use

☐ Note that beneficiaries may have cost sharing if they receive non-preventive services during an appointment for preventive services. For example, if they receive diagnostic lab tests during their annual wellness visit.

Other Part B Items and Services, Part 1 of 2

- ☐ Ambulance services
- ☐ Ambulatory surgical center fees
- ☐ Blood
- ☐ Cardiac rehabilitation–for certain situations
- ☐ Chiropractic services–for limited situations
- ☐ Chronic care management services
- ☐ Clinical research studies–some costs of certain care in approved studies
- ☐ Defibrillator (implantable automatic)
- ☐ Diabetic supplies
- ☐ Durable medical equipment–restricted to certain suppliers in some areas
- ☐ Emergency room services
- ☐ Eyeglasses after cataract surgery–limits apply

Other Part B Items and Services, Part 2 of 2

- ☐ Foot exams and treatment for certain diabetics
- ☐ Hearing and balance exams (no hearing aids) if needed for medical treatment
- ☐ Home health services in certain situations
- ☐ Kidney dialysis and disease education–certain situations
- ☐ Mental health care (outpatient)–limits apply
- ☐ Occupational and physical therapy–limits apply
- ☐ Prosthetic/Orthotic items
- ☐ Pulmonary rehabilitation for COPD
- ☐ Second surgical opinions
- ☐ Speech-language pathology services
- ☐ Telehealth services in some rural areas
- ☐ Tests like X-rays, MRIs, CT scans
- ☐ Transplant physician services and drugs

Not Covered by Medicare Part A & B

- ☐ Acupuncture
- ☐ Routine dental care/dentures
- ☐ Cosmetic surgery
- ☐ Custodial care
- ☐ Health care while traveling outside the US–exceptions apply
- ☐ Hearing aids
- ☐ Orthopedic shoes (with limited exceptions)
- ☐ Outpatient prescription drugs (this is covered under Part D)
- ☐ Routine foot care
- ☐ Routine eye care and eyeglasses
- ☐ Some screening tests and labs
- ☐ Vaccines, except as previously listed (those not covered under Part B are covered under Part D)
- ☐ Syringes and insulin unless used with an insulin pump (this is covered under Part D)

For example, Medicare does not cover routine screening tests for thyroid dysfunction or eye examinations for purposes of prescribing eyeglasses. However, Medicare may pay for eye exams that are part of the diabetes services benefit, a glaucoma test, or for macular degeneration.

Original Medicare and Part D

Original Medicare and Part D Prescription Drug Coverage

- A beneficiary in Original Medicare may receive Part D prescription drug coverage through a stand-alone prescription drug plan (PDP).
- A beneficiary may also leave Original Medicare and receive drug coverage through a Medicare Advantage health plan (MA-PD) or sometimes through a Medicare Advantage (MA) plan and a separate PDP.
- Generally, with the exception of those dually eligible for Medicare and Medicaid, Medicare beneficiaries must actively select a Part D plan.
- In selecting a Part D plan, beneficiaries should consider expected premiums and cost sharing, formulary, and network pharmacies among other factors.

Original Medicare and Part D Prescription Drug Coverage, continued

- Annual Election Period - is October 15 to December 7

- Cost - Beneficiaries who enroll in Part D typically pay a monthly premium, annual deductible and per-prescription cost-sharing.
  - Extra help is available for low-income beneficiaries.
  - Beneficiaries with income above $85,000 (individual) or $170,000 (couple) pay an income-related monthly adjustment amount (IRMAA) in addition to the Part D premium.

- Penalty for late enrollment:
  - There is a permanent premium penalty of 1% of the national standard premium for every month that a beneficiary could have had Part D coverage, or equivalent creditable coverage and choses not to enroll. There is no penalty for individuals who qualify for low-income assistance or for individuals who join a Part D plan within 63 days of losing creditable coverage.

For More Information about Medicare

- ☐ Centers for Medicare & Medicaid Services (technical information) www.cms.gov

- ☐ Medicare (beneficiary audience) www.medicare.gov

- ☐ **Medicare & You Handbook** https://www.medicare.gov/pubs/pdf/10050-Medicare-and-You.pdf

- ☐ **Your Medicare Benefits** https://www.medicare.gov/Pubs/pdf/10116-Your-Medicare-Benefits.pdf

Note: Original Fee-for-Service (FFS) Medicare is also referred to as Original Medicare or the Original Medicare Plan

Medigap Coverage

Further Information on Medigap (Medicare Supplement Insurance)

- Medigap is health insurance sold by private insurance companies to fill gaps in Original Medicare coverage.
- Medigap helps pay all, or a portion, of Part A and Part B coinsurance, copayments, and/or deductibles when Original Medicare determines that a benefit is medically necessary.
- Some Medigap plans also cover benefits not covered by Original Medicare, such as foreign travel.
- Medigap policies are available in standardized benefit plans, identified by certain letters between A and N (different plans are offered in Massachusetts, Minnesota, and Wisconsin).
- Turning age 65 and signing up for Part B triggers a six-month Medigap open enrollment period when Medigap plans must be issued, regardless of any pre-existing conditions, called a guaranteed issue right. In limited circumstances, leaving a Medicare Advantage plan will trigger a guarantee issue opportunity. Some states have guarantee issue for Medicare beneficiaries under age 65.

Medigap Coverage

Most Medigap plans pay for some or all of the following costs:

Part A

- ☐ Part A Coinsurance and Hospital Benefits
- ☐ Part A Deductible
- ☐ Coverage for 365 Additional Hospital Days when Medicare coverage ends
- ☐ Hospice Care Coinsurance or Copayment
- ☐ Skilled Nursing Facility Care Coinsurance

Part B

- ☐ Part B Coinsurance or Copayment
- ☐ Part B Deductible
- ☐ Part B Excess Charges
- ☐ Blood (First 3 pints) (also under part A)

Other

- ☐ Foreign Travel Emergency not covered by Medicare
- ☐ Non-Medicare-covered Preventive Services

Beneficiaries in Original Medicare with Medigap Drug Coverage

- Medigap plans H, I, and J offer non-Medicare drug coverage. These plans could no longer be sold as of January 1, 2006. However, some beneficiaries may have decided to keep their H, I, or J policy with the drug coverage they had before January 1, 2006.
- Individuals who are enrolled in Medigap plans may only obtain Medicare drug coverage (Part D) through a stand-alone prescription drug plan.
- To enroll in Part D, individuals who have Medigap plans H, I or J may:
  - Keep their Medigap coverage with the drug portion of the coverage removed and enroll in a Part D PDP plan; OR
  - Drop their Medigap coverage and enroll in a MA-PD or other health plan with a PDP.

Note: See also Part 3, "Medicare Part D Prescription Drug Coverage."

Beneficiaries in Original Medicare with Medigap Drug Coverage, continued

- If the Medigap coverage was not "creditable coverage" (i.e., covered at least as much as Part D), an individual dropping Medigap coverage and enrolling in Part D will have to pay a late enrollment penalty unless they qualify for 'Extra Help."

Example: Mr. Green purchased Medigap policy J in 2005 and has remained continuously enrolled. Under policy J, after a deductible of $250.00 is met, 50% of prescription drug charges are covered up to a maximum amount of $3,000.00 yearly. The Medigap plan determined that the coverage is not creditable. Thus, if Mr. Green wishes to enroll in Part D, he will incur a late enrollment penalty unless he qualifies for extra help.

Beneficiaries in Original Medicare with Medigap Drug Coverage, continued

- Non-Medicare insurers (including Medigap plans) are required to notify beneficiaries annually whether or not the prescription drug coverage they have is creditable (coverage that expects to pay, on average, at least as much as Medicare's standard Part D coverage expects to pay).

- All beneficiaries who do not maintain creditable coverage must pay a Part D late enrollment penalty if they wish to enroll in Part D.

- Beneficiaries who are informed that their non-Medicare drug coverage is no longer creditable will have a special enrollment period to enroll in a Part D plan without the obligation to pay a Part D late enrollment penalty.

Medigap is NOT

- Medigap is NOT a Medicare Advantage health plan or other Medicare health plan.
- Medigap supplements Original Medicare benefits only.
- In addition,
  - A Medigap plan cannot be used with a Medicare Advantage health plan.
  - It is illegal to sell a Medigap plan to someone already in a Medicare Advantage health plan.

Medigap is NOT, continued

- Types of coverage that are NOT Medigap policies
  - Medicare Part A or Part B
  - Medicare Advantage Plans (Part C), such as an HMO, PPO, PFFS, SNP, or MSA
  - Medicare Cost Plans
  - Medicare Prescription Drug Plans (Part D)
  - Medicaid
  - Employer or union plans
  - TRICARE
  - Veterans' Administration (VA) benefits
  - Long-term care insurance policies
  - Indian Health Service, Tribal and Urban plans

Changes in Medigap

- Plans E, H, I, and J are no longer sold, but beneficiaries with those plans may keep them.
- New policies effective on or after June 1, 2010, will cover Hospice Part A coinsurance or copayment. (Plan K will cover 50%, and Plan L will cover 75% of these costs.)
- Plans D and G bought on or after June 1, 2010 have different benefits than D or G plans bought before June 1, 2010, but benefits won't change for beneficiaries who had these policies before June 1, 2010.
- All plans pay 100% of the Part B coinsurance except:
  - Plans K and L pay a portion of Part B coinsurance until beneficiaries reach their out of pocket limit (in 2018, $5,240 for K and $2,620 for L). Then they pay 100%.
  - Plan N requires beneficiaries make copayments for office and emergency room visits.

Medigap Plans

Medigap Benefits	A	B	C	D	F[1]	G	K[4]	L[4]	M	N
Part A Coinsurance and Hospital Benefits	X[2]	X	X	X	X	X	X	X	X	X
Part B Coinsurance or Copayment	X	X	X	X	X	X	50%	75%	X	X[3]
Blood (First 3 pints)	X	X	X	X	X	X	50%	75%	X	X
Part A Hospice Care Coinsurance/ Copayment	X	X	X	X	X	X	50%	75%	X	X
Skilled Nursing Facility Care Coinsurance			X	X	X	X	50%	75%	X	X

1. Plan F also offers a high-deductible plan. In 2018, a policyholder pays $2,240 before the Medigap policy pays anything.
2. "X" indicates that coverage is 100% of the Medicare allowable amount. A percentage number indicates the proportion of the Medicare allowable amount covered.
3. Plan N has a copayment of up to $20 for physician office visits and up to $50 for emergency room visits (waived in certain circumstances).
4. Plans K and L pay 100% after out-of-pocket limit is reached. In 2018 the out-of-pocket limits for Plan K and Plan L are $5,240 and $2,620, respectively.

Medigap Plans

Medigap Benefits	A	B	C	D	F[1]	G	K[4]	L[4]	M	N
Medicare Part A Deductible		X	X	X	X	X	50%	75%	50%	X
Medicare Part B Deductible			X		X					
Medicare Part B Excess Charges					X	X				
Foreign Travel Emergency (up to plan limits)[3]			80%	80%	80%	80%			80%	80%

1. Plan F also offers a high-deductible plan. In 2018, a policyholder pays $2,240 before the Medigap policy pays anything.
2 ."X" indicates that coverage is up to 100% of the Medicare allowable amount. A percentage number indicates the proportion of the Medicare allowable amount covered, except for foreign travel.
3. The foreign travel benefit pays 80% of charges after a $250 deductible, up to a $50,000 lifetime maximum.
4. Plans K and L pay 100% after out-of-pocket limit is reached. In 2018 the out-of-pocket limits for Plan K and Plan L are $5,240 and $2,620, respectively.

Medigap Plans – Case Study

Ms. Smith wishes to buy a Medigap plan. She explained that she wishes to get a plan with a lower premium and doesn't mind paying more when she uses services, up to a limit. The agent correctly directed her to choose between Plans K and L to meet her needs.

Changes coming to Medigap

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) will make changes to Medigap plans effective 2020. Specifically, for individuals newly eligible to Medicare, the Part B deductible cannot be covered. Therefore, Plans C and F will no longer be an option for newly eligible individuals starting January 1, 2020. However, individuals who already have Plans C and F will be able to keep their current versions of the plans and individuals eligible for Medicare prior to January 1, 2020, can purchase the current version of Plans C and F on or after January 1, 2020.

For More Information about Medigap

- Centers for Medicare & Medicaid Services: http://www.cms.gov/Medigap/

- 2017 Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare: https://www.medicare.gov/Pubs/pdf/02110-Medicare-Medigap.guide.pdf

Medicare Health Plans

Part 2

Version 12
June 18, 2018

Terms and Conditions

- This training program is protected under United States Copyright laws, 17 U.S.C.A. §101, et seq. and international treaties. Except as provided below, the training program may not be reproduced (in whole or in part) in hard paper copy, electronically, or posted on any web site or intranet without the prior written consent of AHIP. Any AHIP member company in good standing sponsoring a Medicare Advantage or Part D plan may reproduce the training program for the limited purpose of providing training and education to the company's own employees and contractors on the subject matter contained in the training program. Employees or contractors participating in such training may not further reproduce (in whole or in part) the training program. No changes of any kind may be made to the training program and any reproduction must include AHIP's copyright notice. This limited license is terminable at will by AHIP.

- The training program is intended to provide guidance only in identifying factors for consideration in the basic rules and regulations governing coverage, eligibility, marketing, and enrollment for Medicare, Medicare supplement insurance, Medicare health plans, and Part D prescription drug plans and is not intended as legal advice. While all reasonable efforts have been made to ensure the accuracy of the information contained in this document, AHIP shall not be liable for reliance by any individual upon the contents of the training program.

Learning Objectives

- After reviewing "Part 2: Medicare Health Plans" you will be able to:
  - Explain what types of Medicare health plans are available
  - Explain who is eligible for the different types of plans
  - Understand the role of Special Needs Plans (SNPs) in delivering care
  - Describe features of different Medicare health plan types
  - Describe key issues for beneficiaries eligible for both Medicare and Medicaid
  - Explain how Medicare health plans work with prescription drug plans

Training Roadmap: Part 2

- ☐ Medicare Health Plans
  - Medicare Advantage Plan Types
    - Coordinated Care Plans
    - Private-Fee-for-Service Plans
    - Medical Savings Account Plans
  - Other Plan Types
- ☐ Dual Eligible Beneficiaries
- ☐ Medicare Advantage Plans and Prescription Drugs

Medicare Advantage Plans

- Under the Medicare Advantage (MA) program, private companies offer health plans that cover all Medicare Part A and Part B benefits.
  - Many also cover Part D prescription drug benefits (MA-PD plans).
  - All MA plans offer a maximum out-of-pocket limit.
  - Many MA plans also offer extra benefits that Medicare does not cover.

- The types of Medicare Advantage (MA) plans are:
  - Coordinated Care Plans. These plans have a network of preferred providers and include:
    - Health Maintenance Organizations (HMOs), some have a point-of-service (POS) benefit
    - Preferred Provider Organizations (PPOs), local and regional;
  - Private Fee-for-Service (PFFS) Plans; and
  - Medical Savings Account (MSA) Plans.

Medicare Advantage Plans, continued

- Certain Medicare Advantage plans can restrict enrollment eligibility to:
  - Individuals with special needs (such plans are known as special needs plans (SNPs)
  - Employees and/or retirees and their dependents (such plans are known as employer group waiver plans (EGWPs) or Employer/Union plans)

For example, a SNP can restrict enrollment eligibility to individuals diagnosed with certain chronic conditions. An EGWP can limit eligibility to retirees of the sponsoring employer and their dependents.

Other Medicare Health Plans

- In addition to Medicare Advantage Plans, there are other types of Medicare health plans, including:
  - Medicare Cost Plans;
  - Programs of All-Inclusive Care for the Elderly (PACE) plans;
  - Medicare-Medicaid Plans (MMPs); and
  - Other Demonstration Plans
    - Other Medicare health plan demonstrations include state-specific demonstrations such as the Minnesota Senior Health Care Options (MSHO) program.

Medicare Advantage Eligibility

- To be eligible to enroll in a Medicare Advantage plan:
  - A beneficiary must be entitled to Part A and enrolled in Part B.
  - The beneficiary must live in the MA plan's service area.
- A beneficiary must generally continue to pay his/her Part B premium.
- The beneficiary may also need to pay an MA plan premium.
- As noted later, additional restrictions apply to MA MSA plans.

Medicare Advantage Eligibility, continued

- MA plans must enroll any eligible beneficiary who applies regardless of health status, except that:
  - Generally, beneficiaries are not eligible if they have end-stage renal disease (ESRD) unless:
    - the beneficiary was enrolled in a health plan offered by the same organization that offers the MA plan (in the same state) before becoming eligible for Medicare;
    - the MA plan is a special needs plan for persons with ESRD;
    - The MA plan is an employer group waiver plan that enrolls individuals with ESRD;
    - The beneficiary developed ESRD after being enrolled in the plan; or
    - The beneficiary was enrolled in a MA plan and their enrollment was terminated due to the plan's termination, non-renewal, or service area reduction.

Medicare Advantage Eligibility, continued: SNPs

- Special Needs Plans (SNPs) must limit new enrollments to beneficiaries who meet specified plan eligibility criteria (e.g., beneficiaries who are dual eligible, have specified chronic conditions (which may include ESRD), or reside in institutions or live in the community, but require an institutional level of care.)

- There are three overall types of Special Needs Plans (SNPs):
  - Chronic
  - Dual eligible
  - Institutional

Medicare Advantage Eligibility, continued: SNP Description

- Chronic condition SNPs (C-SNPs) are SNPs that restrict enrollment to special needs individuals with specific severe or disabling conditions.

- Dual eligible SNPs (D-SNPs) enroll beneficiaries who are entitled to both Medicare and medical assistance from a State plan under Medicaid.

- Institutional SNPs (I-SNPs) are SNPs that restrict enrollment to MA eligible individuals who, for 90 days or longer, have had or are expected to need the level of services provided in a long-term care (LTC) skilled nursing facility, a LTC nursing facility (NF), a SNF/NF, an intermediate care facility for the mentally retarded (ICF/MR), or an inpatient psychiatric facility.

Medicare Advantage Eligibility, continued

- Individuals receiving hospice benefits prior to completing an enrollment request, may not enroll in an MSA plan.

- Employer group waiver plans (EGWPs) or Employer/Union plans may only enroll Medicare beneficiaries who are members of an employer/union-sponsored group health plan.
  - A beneficiary's enrollment in an EGWP must be based on receiving "employment-based" health coverage from an employer/union group health plan sponsor.
  - Coverage obtained through a professional or other type of group association would not make a beneficiary eligible for an EGWP, except to the extent that the coverage obtained through the association can properly be characterized as "employment-based" group health plan coverage.

Medicare Advantage Eligibility, continued

Example: Ms. Clark was enrolled in ABC health plan through her employer when she developed ESRD. She subsequently became eligible for Medicare as her primary coverage. Ms. Clark may enroll in an MA plan offered by ABC health plan, but she may not enroll in an MA plan offered by any other organization unless it is a special needs plan for individuals with ESRD or it is an MA employer group waiver plan offered by her employer.

MA Plan Types
Coordinated Care Plans

MA Plan Types
Coordinated Care Plans – HMOs

- HMO enrollees must generally use doctors and hospitals within the plan's network to receive covered services.
  - Emergency and urgently needed services received outside of the plan network are covered.
  - When the enrollee is temporarily absent from the plan's service area, dialysis services are covered.
  - In most other cases, if enrollees get care out-of-network without prior approval from the plan, they will have to pay for it themselves.

- HMOs must have a maximum limit on member out-of-pocket costs of not greater than $6,700 per year and many plans have lower limits.

MA Plan Types
Coordinated Care Plans – HMOs, continued

- HMO enrollees may need to select a primary care doctor and may need a referral for specialty care.
- If an HMO enrollee needs a type of specialist who is not in the plan's network, the plan will arrange for care outside of the network.
- Some HMOs offer a Point of Service (POS) Option that allows enrollees to go to non-plan doctors and hospitals generally without receiving prior approval for certain services.
  - Unlike a PPO, an HMO-POS plan may limit the services available out of network or may put a dollar cap on the amount of out-of-network coverage.
  - Cost sharing is generally higher than for services obtained from network providers.

MA Plan Types
Coordinated Care Plans – PPOs

- PPO enrollees generally may get care from any provider in the U.S. who accepts Medicare.
- PPO enrollees do not need a referral to see an out-of-network provider, but may be encouraged to contact the plan to be sure the service is medically necessary and will be covered.
- PPO enrollees generally pay higher cost sharing amounts if they see a provider who/that is not part of the PPO's network.
- PPOs must have a maximum limit on member out-of-pocket costs for network providers of not greater than $6,700 per year and an aggregate limit on network and non-network costs of $10,000.
- Regional PPOs are PPOs that serve an entire region, made up of one or more states.

MA Plan Types
Coordinated Care Plans – SNPs

- Special Needs Plans, as mentioned before, limit enrollments to certain beneficiaries. SNPs are the only plan type that can limit enrollment based on health care status or eligibility for Medicaid. Types of SNPs include:
  - Dual Eligible SNPs – serve beneficiaries eligible for both Medicare and Medicaid (dual eligibles);
  - Chronic Care SNPs – serve beneficiaries with certain severe or disabling chronic conditions, such as diabetes, chronic heart failure or cancer; and
  - Institutional SNPs – serve beneficiaries who, for 90 days or longer, have had or are expected to need an institutional level of care. They may also, or alternatively serve beneficiaries living in the community, but requiring an institutional level of care, such as residents of assisted living facilities.

- All SNPs provide Part D prescription drug coverage.

MA Plan Types
Private Fee-for-Service (PFFS) Plans

MA Plan Types
Private Fee-for-Service (PFFS) Plans

- Individuals enrolled in PFFS plans may receive covered services from any provider in the U.S. who is eligible to provide Medicare services and agrees to accept the plan's terms and conditions of payment.
- Some PFFS plans contract with network providers. If the PFFS plan has a network, enrollees may pay more if they see out-of-network providers.
- Except for emergencies, enrollees must inform providers before receiving services that they are PFFS plan members so the non-network providers can decide whether to accept the plan's terms and conditions.
- Non-network providers that accept Original Medicare may choose not to accept PFFS plan enrollees.

MA Plan Types
Private Fee-for-Service Plans, continued

- Individuals enrolled in a PFFS plan receive their Medicare benefits through the plan.
- PFFS is ***not*** the same as Original Medicare.
- PFFS is ***not*** a Medicare supplement, Medigap, or a Medicare Select policy.

Example:
Mr. Young is enrolled in a PFFS plan. He wants to continue seeing his current doctor, however his doctor does not contract with any Medicare Advantage plans. Mr. Young should check with his doctor to see if he is willing to accept his PFFS plan's terms and conditions.

MA Plan Types
Private Fee-for-Service Plans, continued

- Providers are not permitted to charge the enrollee more than the cost sharing specified in the PFFS plan's terms and conditions of payment.
  - Cost sharing may include balance billing up to 15% of the Medicare rate only if allowed in the plan's terms and conditions of payment.

- PFFS plans must have a maximum limit on member out-of-pocket costs for network and non-network providers of not greater than $6,700 per year.

- PFFS plans may choose to offer Part D benefits but are not required to do so.

MA Plan Types
Medicare Savings Account Plans

MA Plan Types
Medical Savings Account (MSA) Plans

- A Medicare MSA is a high deductible health plan combined with a savings account for health care expenses. Medicare makes a contribution to the beneficiary's savings account.
- MSA enrollees pay for health care expenses from the savings account and then out-of-pocket until the annual deductible is met, after which the plan pays 100% for covered services.
  - The maximum deductible for MSA plans in 2018 is $11,980 and $12,650 in 2019.
- MSAs cover Part A and Part B benefits.
- MSAs do NOT cover, Part D Medicare prescription drug benefits.
  - MSA Members must enroll in a stand-alone PDP if they want prescription drug benefits.
- Enrollees pay their Part B premium and any premium for supplemental benefits.

MA Plan Types: MSA Plans, continued

- Enrollees may receive covered services from any Medicare approved provider in the U.S.
- MSAs may not have a network or may have a full or partial network of providers.
- All non-network providers must accept the same amount that Original Medicare would pay them as payment in full.
- MSA plans must cover-the preventive services that have no cost sharing before the enrollee has met the deductible. However, enrollees may have to pay for services obtained while getting the preventive services. For example, they may have to pay for non-preventive lab tests ordered when they receive their annual wellness visit.

MA Plan Types: MSA Plans, continued

The following individuals MAY NOT enroll in an MSA:

- An individual who receives health benefits that cover all or part of the annual deductible under the MA MSA plan. Examples include, but are not limited to, primary health care coverage other than Medicare, Medicare hospice, certain supplemental insurance policies, and retirement health benefits.
- An individual who is enrolled in a Federal Employee Health Benefit plan, or is eligible for health care benefits through the Veteran's Administration.
- Dual eligibles entitled to coverage of Medicare cost-sharing under Medicaid.
- An individual who cannot provide assurances that he or she will reside in the United States for at least 183 days during the year for which the election is effective.
- An individual who has already elected hospice.

Medicare Advantage Employer/Union Plans

Employer/Union Plans

- Employers and unions may offer their retirees and their dependents:
  - Medicare Advantage individual or group plans provided by a plan sponsor.
  - A Medicare Advantage plan through a direct contract with CMS.
- Employers with less than 20 employees may be able to offer Medicare Advantage plans to active employees and their dependents.
- Beneficiaries should check with their employer or union group benefits administrator before changing plans to avoid losing coverage they want to keep.

Other Medicare Health Plan Types Cost Plans and PACE Plans

Cost Plans

- Medicare 1876 Cost Plans
  - May offer Part D prescription drug coverage as an optional benefit.
  - May offer other optional supplemental benefits.
  - Are available only in certain areas in the United States.
  - Cost plan enrollees can choose to receive Medicare-covered services:
    - Under the plan's benefits by going to plan network providers
      - Plan cost sharing applies
    - Under Original Medicare by going to non-network providers
      - Original Medicare cost sharing applies

Cost Plans, continued

- Eligibility:
  - Individuals with Part A and Part B or
  - Individuals with only Part B may enroll. Enrollees with Part B only will not have Part A coverage under the plan unless they purchase it. The plan may adjust the enrollee premium for individuals with Part B only.

- Premiums:
  - Enrollees must pay their Part B premiums and any plan premium.

Cost Plans, continued

- An individual may be enrolled in a cost plan and a PDP.
  - This applies regardless of whether the cost plan offers Part D as an optional supplemental benefit.

- Cost plans generally have longer open enrollment periods than MA plans.
  - Most cost plans are open for enrollment all year. However, if an individual is disenrolling from an MA plan or PDP they must have a valid Part C or Part D disenrollment opportunity.
  - Cost plans that are transitioning to an MA contracts will have limitations on the individuals who may enroll in the cost plan during its last cost contract year. These limitations will not apply for enrollments that become effective January 1st of the last year.

Cost Plans, continued

- During the 2018 annual election period for enrollment beginning in 2019, special rules may apply to cost plans that are changing to a Medicare Advantage contract.
  - Individuals enrolled in the cost plan may be "deemed" to enroll in the organization's new Medicare Advantage plan if they do not make another election.
  - Cost plan that are transitioning will provide notice to their members that includes their options and an explanation of the deeming process.

PACE Plans

- Programs of All-Inclusive Care for the Elderly (PACE)
  - A Medicare plan for frail, elderly beneficiaries living in the community
  - Available in limited areas of the United States
  - Include comprehensive medical and social service delivery systems using an interdisciplinary team approach in an adult day health center, supplemented by in-home and referral services

PACE Plans, continued

- Eligibility for PACE: Participants must be
  - age 55 or older;
  - reside in the PACE organization's service area;
  - be certified as eligible for nursing home care by their state; and
  - be able to live safely in a community setting at the time of enrollment.

Medicare-Medicaid Plans (MMPs)

- Medicare-Medicaid Plans (MMPs):
  - Are established under demonstration authority
  - Are available only in limited parts of the United States.
  - Only certain individuals eligible for both Medicare and Medicaid may enroll
    - Eligibility varies by state
  - Integrate Medicare and Medicaid benefits
    - In some states, may offer additional benefits
  - Include Part D benefits
  - Are NOT Medicare Advantage plans

Medicare Advantage Plans and Dual Eligible Beneficiaries

MA Plans and Dual Eligible Beneficiaries

- Beneficiaries who qualify for both Medicare and Medicaid are considered “dual eligible” individuals.

- Issues that are important to dual eligible beneficiaries considering MA enrollment include:
  - Whether the beneficiary is eligible for medical benefits under Medicaid. Medicaid may provide additional benefits, but Medicaid will only pay if the services are furnished by Medicaid participating providers.
  - Whether the beneficiary will need help to find providers who accept both Medicare and Medicaid.
  - Whether a single Medicare-Medicaid plan that combines Medicare and Medicaid benefits is available to the beneficiary.

MA Plans and Dual Eligible Beneficiaries, continued

There are seven different categories of dual eligible beneficiaries to be considered:

- **QMB (only)** (Qualified Medicare Beneficiary)
- **QMB Plus**
- **SLMB (only)** (Specified Low-Income Medicare Beneficiary)
- **SLMB Plus**
- **QI** (Qualifying Individual)
- **FBDE** (Full Benefit Dual Eligible)
- **QDWI** (Qualified Disabled & Working Individual)

MA Plans and Dual Eligible Beneficiaries, continued

- Categories of dual eligible beneficiaries and costs paid by Medicaid:
  - **QMB (only)** (Qualified Medicare Beneficiary) – Medicaid pays Medicare Part A and Part B premiums; cost sharing for Part A & Part B benefits.
  - **QMB Plus** – Medicaid pays Medicare Part A & Part B premiums; cost sharing for Part A & Part B benefits; Full Medicaid benefits.
  - **SLMB (only)** (Specified Low-Income Medicare Beneficiary) – Medicaid pays Medicare Part B premium.
  - **SLMB Plus** – Medicaid pays Medicare Part B premium; Full Medicaid benefits. **QI** (Qualifying Individual) – Medicaid pays Medicare Part B premium.
  - **Other FBDE** (Full Benefit Dual Eligible) – Medicaid pays Medicare Part B premium; Full Medicaid benefits.
  - **QDWI** (Qualified Disabled & Working Individual) – Medicaid pays Medicare Part A premium.

MA Plans and Dual Eligible Beneficiaries, continued

- When a dual eligible individual enrolls in any MA plan, if the individual has coverage for Part A and B cost sharing, they will not have to pay more than the cost sharing that would apply under Medicaid.

- Dual eligible beneficiaries may enroll in any type of MA plan except an MA MSA.

- Some MA plans, known as **dual eligible Special Needs Plans (D-SNPs)**, are tailored to dual eligible individuals, depending on the category (see prior slides) to which they belong.

Case Study

- Mr. Henley is a Qualified Medicare Beneficiary (QMB). He enrolls in a Medicare Advantage PPO. Mr. Henley sees an out-of-network doctor to receive a Medicare covered service. The normal cost sharing is 30 percent. The doctor may only collect from Mr. Henley the minimal cost sharing allowable under the Medicaid program.

Medicare Advantage and Prescription Drugs

MA & Prescription Drugs

- An organization offering coordinated care MA plans must offer at least one MA plan with prescription drug coverage (known as an MA-PD plan) in every service area.
- MA PFFS plans have the option of offering prescription drug coverage but are not required to do so.
- MA MSA plans are prohibited from offering prescription drug coverage. If an MSA member wants prescription drug coverage, the member must enroll in a stand-alone PDP.
- Outpatient prescription drug benefits offered by MA plans must meet Part D program requirements.

MA & Prescription Drugs, continued

- If a beneficiary enrolls in an MA plan that includes Part D prescription drug coverage (MA-PD plan), the beneficiary can only receive Part D drug coverage through that plan.

- If a beneficiary enrolls in an MA plan that is an HMO or PPO plan that does not include Part D coverage, the beneficiary cannot join a stand-alone Prescription Drug Plan (PDP).
  - Enrollees in certain Employer/Union retiree group plans may have different options.

MA & Prescription Drugs, continued

- If a beneficiary enrolls in a PFFS plan that does not include Medicare prescription drug coverage, or in a MSA plan, he or she can join a stand-alone Medicare Prescription Drug Plan.

- Beneficiaries enrolled in a Medicare Cost Plan can join a stand-alone Medicare Prescription Drug Plan if the Cost Plan does not offer Part D coverage or if the Cost Plan does offer Part D coverage but the beneficiary chooses not to enroll in it.

MA & Prescription Drugs, continued

Examples:

Mr. Page is enrolled in a MA PPO. He did not choose Part D coverage through the PPO. Now he wishes to enroll in a stand-alone PDP. Mr. Page cannot enroll in a PDP because he can only get Part D coverage through his PPO.

Ms. Smith is enrolled in a PDP. She wishes to enroll in an MA MSA plan. Ms. Smith can remain enrolled in her PDP because MSA plans do not offer Part D coverage.

Sources of Additional Information

- General information for organizations currently offering Medicare Advantage plans, or those planning to do so in the future http://www.cms.gov/HealthPlansGenInfo/

- Medicare & You Handbook
  https://www.medicare.gov/medicare-and-you/medicare-and-you.html

- Detailed information on Medicare Advantage plan requirements, enrollment and eligibility
  https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326.html?DLPage=2&DLEntries=10&DLSort=0&DLSortDir=ascending

Medicare Part D Prescription Drug Coverage

Part 3

Version 12

June 18, 2018

Terms and Conditions

- This training program is protected under United States Copyright laws, 17 U.S.C.A. §101, et seq. and international treaties. Except as provided below, the training program may not be reproduced (in whole or in part) in hard paper copy, electronically, or posted on any web site or intranet without the prior written consent of AHIP. Any AHIP member company in good standing sponsoring a Medicare Advantage or Part D plan may reproduce the training program for the limited purpose of providing training and education to the company's own employees and contractors on the subject matter contained in the training program. Employees or contractors participating in such training may not further reproduce (in whole or in part) the training program. No changes of any kind may be made to the training program and any reproduction must include AHIP's copyright notice. This limited license is terminable at will by AHIP.

- The training program is intended to provide guidance only in identifying factors for consideration in the basic rules and regulations governing coverage, eligibility, marketing, and enrollment for Medicare, Medicare supplement insurance, Medicare health plans, and Part D prescription drug plans and is not intended as legal advice. While all reasonable efforts have been made to ensure the accuracy of the information contained in this document, AHIP shall not be liable for reliance by any individual upon the contents of the training program.

Learning Objectives

- After reviewing "Part 3 - Medicare Part D Prescription Drug Coverage" you will be able to explain:
  - What Part D plans are;
  - Who is eligible to enroll in a Part D plan;
  - Part D standard and alternate benefits;
  - Part D management tools, covered drugs, and formulary requirements;
  - Part D True Out-of-Pocket (TrOOP) costs and help for beneficiaries with limited income;
  - Late enrollment penalties and premiums; and
  - How Part D works with other coverage.

Training Roadmap: Part 3

- ☐ Medicare Part D Basics
- ☐ Part D Standard and Alternative Benefits
- ☐ Part D Premiums and Late Enrollment Penalties
- ☐ Part D Management Tools
  - Covered Drugs
  - Formulary Requirements
- ☐ Part D Enrollee Costs and Assistance Programs
- ☐ Part D and Other Coverage

Medicare Part D
Prescription Drug Program Basics

- Coverage of Medicare Part D benefits is provided only through private companies. There is no fee-for-service Part D benefit.
  - Medicare pays a share of the program costs.
- The types of Part D plans are:
  - Stand-alone Prescription Drug Plans (PDP)
  - Medicare Advantage-Prescription Drug (MA-PD) Plans:
    - MA health plans that also cover Part D prescription drugs.
  - Cost-PD Plans
    - Medicare cost plans that cover Part D prescription drugs as an optional supplemental benefit.
- Part D coverage is also included under Medicare-Medicaid Plans, PACE plans, and may be included under other Medicare health plan demonstrations.

Medicare Part D
Prescription Drug Program Basics, continued

Only beneficiaries enrolled in Original Medicare, an MA MSA, a PFFS plan or a Cost plan may enroll in a standalone PDP to receive Part D benefits.

- ☐ Beneficiaries enrolled in a MA HMO or PPO may only obtain Part D benefits through their plan (Employer group plan enrollees may have additional choices.)
- ☐ Beneficiaries enrolled in a MA MSA may only obtain Part D benefits through a standalone PDP.
- ☐ Beneficiaries enrolled in a Cost plan or MA PFFS plan may obtain Part D benefits through their plan (if offered) or through a standalone PDP.
- ☐ Beneficiaries enrolled in a Medicare-Medicaid plan may only receive Part D benefits through that plan.
- ☐ PACE plan may only receive Part D benefits through that plan.

Medicare Part D
Prescription Drug Program Basics - Examples

Mr. Hendrix wishes to enroll in one of ABC's PFFS plans. ABC offers PFFS plan options with Part D and without Part D. If Ms. Griffin chooses a plan without Part D, she may enroll in a standalone PDP.

Mr. Page has Original Medicare and a standalone PDP. During the Annual Election Period, he wishes to enroll in an MA PPO. If Mr. Page chooses an MA PPO, he may no longer get his Part D benefits through a PDP and must choose an MA PDP with Part D benefits if he wishes to maintain prescription drug coverage.

Medicare Part D Eligibility

- Individuals entitled to Part A and/or enrolled under Part B are eligible to enroll in Part D plans.
- The beneficiary must live in the plan's service area.
  - Part D plan coverage is provided through network pharmacies in the Part D plan's service area, except that PFFS plans are not required to use a pharmacy network but may choose to have one.
- Part D plans must enroll any eligible beneficiary who applies regardless of health status except in limited circumstances in the case of MA-PD plans under MA program rules (e.g., certain beneficiaries with ESRD or those who do not meet the eligibility criteria of a chronic care SNP).

Medicare Part D Eligibility: Examples

- Example 1: Mr. Bradley is age 65, still working, and eligible for Medicare. Mr. Bradly does not enroll in Part B since he has similar coverage through his employer's plan. He is interested in Medicare Part D because he believes he can obtain coverage that better meets his needs. Mr. Bradley is eligible to enroll in Part D since he is entitled to Part A.

- Example 2: Mr. Singh is single, still working, and recently turned age 65. He has not contributed into the Social Security or Medicare programs for a sufficient number of quarters to be eligible for Part A for free. He would have to pay a premium for Part A coverage and has decided not to do so. He is eligible for Part B and has enrolled in that program. He would also like to enroll in Part D. Mr. Singh can enroll in Part D since he has opted to enroll in Part B even though he is not entitled to Part A.

Part D Standard and Alternative Benefits

Part D Plan Benefits Standard

- Part D plans must cover at least the Part D standard benefit or its actuarial equivalent.
- For 2019, the standard benefit requires the beneficiary to pay:
  - $415 deductible
  - 25% of prescription drug costs between $415 and $3,820 = $851.25
  - Part of the costs in the "Coverage Gap" - After total spending on drugs by the beneficiary, by certain subsidy programs and by the plan reaches $3,820 the beneficiary pays for 37% of generic drug costs and 25% of brand name drug undiscounted costs (drug manufacturers provide a 70% discount on brand name drugs).
    - The Bipartisan Budget Act of 2018 moved up the date for closing the so-called donut hole for brand name drugs to 2019. For 2019 and every year after, the beneficiary cost sharing for brand name drugs after the initial coverage limit is 25% -- the same as after the deductible and before the initial coverage limit. In 2020, the beneficiary cost sharing for generic drugs will also be 25%.

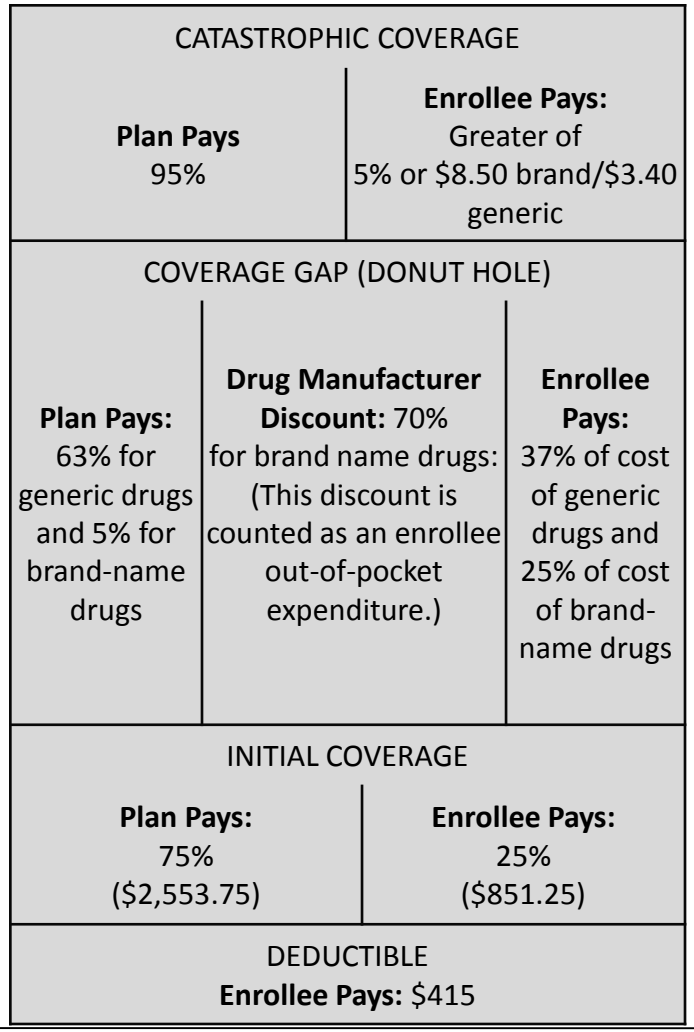
Part D Plan Benefits Standard, continued

- Nominal costs under catastrophic coverage: Once beneficiary expenditures (including drug manufacturer discounts) reach a total of $5,100, the beneficiary is through the coverage gap and reaches catastrophic coverage. On any future prescriptions the beneficiary pays either a co-pay of $3.40 for generic drugs or $8.50 for brand name drugs or a co-insurance of 5%, whichever is greater.

Part D Plan Benefits: The Standard Benefit Plan for 2019 (Updated Annually)

Total Drug Expenditures

(includes enrollee payment, plan payment & manufacturer discount)



$8,139.54 (varies depending on mix of brand-name and generic drugs)

$3,820

$415

$0

Enrollee Out-of-Pocket Cost

$5,100 - Annual out-of-pocket threshold

$1,266.25 - Initial Coverage Limit

$415 - Deductible

$0

Example 1 – Beneficiary Expenditures Standard Benefit Plan

Ms. Baker has Part D coverage that follows the standard benefit plan.

Ms. Baker takes several maintenance drugs that are covered under her plan. In a year, the total cost of drugs taken by Ms. Baker is $2400. Ms. Baker pays $911.25. ($2400 (total drug cost) –$415 (deductible) = $1,985 x .25 (initial coverage cost sharing percentage) = $496.25 + $415 (deductible) = $911.25)

Example 2 – Beneficiary Expenditures Standard Benefit Plan

Mr. Davis has Part D coverage that follows the standard benefit plan.

Mr. Davis takes a number of drugs that are covered under his plan. All of his drugs are generic. In a year, the total cost of drugs taken by Mr. Davis is $4500. Mr. Davis pays $1,517.85. ($4500 – $3,820 (initial drug coverage limit) = $680 x .37 (coverage gap generic cost sharing percentage) = $251.60+ $415 (deductible) + $851.25 (initial coverage cost sharing amount) = $1,517.85)

Part D Plan Benefits Alternative

- Part D plan benefits frequently differ from the standard benefit under specific Medicare rules.
- In all cases the value of Part D benefits must be at least the same as the standard coverage.
- Some Part D plans may also include enhanced coverage for an additional monthly premium.

Example – Alternative Benefit Plan

Mr. Bingham takes 5 prescription drugs. Three are generic and 2 are brand name. He is enrolled in a PDP with $0 deductible and a $56 per month premium. His copayment for generic drugs is $20 and for brand name is $47. Mr. Bingham's annual drug cost is $1,848. (3 generic drugs = $60/mo.) + (2 brand name drugs = $94/mo.) x 12 months = $1848. In addition, Mr. Bingham will pay $672 in premiums per year ($56 x 12 months).

Part D Pharmacy Networks

- Enrollees may fill prescriptions for covered drugs at network pharmacies that contract with plans.
  - Network pharmacies include retail pharmacies and may also include mail order pharmacies. Part D plans may designate preferred pharmacies that offer lower levels of cost-sharing than apply at non-preferred pharmacies.

- Under certain circumstances, enrollees may fill prescriptions for covered drugs at non-network pharmacies, but likely at higher cost to enrollees. For example:
  - If the enrollee has an illness or loses a drug while traveling outside the service area
  - If there are circumstances resulting in limited access to a drug through in-network pharmacies

Part D Premiums and Late Enrollment Penalties

Part D Premiums

- Part D plans generally charge a premium.
  - Typically, a higher premium means lower out-of-pocket costs for the plan.

- Part D enrollees have three options for paying their Part D premium.
  - (1) Automatic electronic monthly mechanism, such as withdrawal from their checking or savings bank account or automatic deduction from their credit or debit card;
  - (2) Direct monthly billing from the plan; or
  - (3) Automatic deduction from their monthly Social Security Administration (SSA) benefit check.
    - Typically it takes 2-3 months for SSA withholding to begin or end.
    - When withholding begins, it will be for the 2-3 months of premiums owed.
    - If a beneficiary is considering this option, he/she should call the plan first.

- Generally the beneficiary must stay with the premium payment option for the entire year.

Part D Late Enrollment Penalty

- Beneficiaries generally have to pay a premium penalty to join a Part D plan if:
  - They do not have creditable coverage and do not enroll when first eligible for Part D.
  - There has been a period of at least 63 continuous days following a beneficiary's initial enrollment period for Part D during which the beneficiary did not have either Part D or creditable coverage.

- Creditable coverage is prescription drug coverage that expects to pay, on average, at least as much as Medicare's standard Part D coverage expects to pay.

- The penalty will be 1% of the national average beneficiary premium for each month the beneficiary did not have Part D or creditable coverage.

Late Enrollment Penalty, continued

- In general, the penalty is in effect as long as the beneficiary has Medicare prescription drug coverage.
- Beneficiaries who qualify for the low-income subsidy are not subject to the late enrollment penalty.

Late Enrollment Penalty Examples

- Mr. Russell first became eligible for Part D on January 1, 2016. He did not sign up and has not had creditable drug coverage. Mr. Russell wishes to obtain drug coverage during the Annual Election Period to be effective on January 1, 2019. He is not LIS eligible. Mr. Russell will have to pay a penalty of 36% of the national average beneficiary premium for every month that he stays covered under Part D.

- Mr. Smith lost his creditable drug coverage that his employer provided when he retired. Mr. Smith signed up for Part D with an effective date of 60 days after he lost his coverage. Mr. Smith will not be subject to a late enrollment penalty.

Part D Drug Management Tools

Covered Drugs and Formulary Requirements

Covered Part D Drugs

- By law, Part D plans are permitted to cover any prescription drugs and biologicals that: must be covered by states that provide Medicaid prescription drug benefits

- Biologics are made from a variety of natural sources (human, animal or microorganism). Unlike most drugs, they are not chemically synthesized. Biologics can be composed of sugars, proteins, or nucleic acids or complex combinations of these substances, or may be living entities such as cells and tissues. Examples of biologics include
  - vaccines
  - allergenic extracts, which are used for both diagnosis and treatment (for example, allergy shots)
  - gene therapies
  - cellular therapies

Covered Part D Drugs, continued

- Many Part D plans do not cover all of these drugs because in some cases several similar drugs are available to treat the same medical condition.

- Part D plans include the drugs they will cover on formularies that are developed by pharmacists, doctors, and other experts.

- Part D plan formularies must include:
  - At least two drugs in each therapeutic category
  - Generic and brand-name drugs.

Part D Drug Management Tools

- Part D plans commonly use a variety of prescription drug benefit management tools, including:
  - A formulary: A list of drugs covered by the plan
  - Cost sharing tiers: Drugs may be grouped together by amount of cost sharing. Many plans group drugs into 3 or 4 tiers with lower tiers costing less than higher tiers, for example:
    - Tier 1: Generic drugs
    - Tier 2: Preferred brand-name drugs
    - Tier 3: Non-preferred brand-name drugs
    - Tier 4: High-cost drugs

Part D Drug Management Tools, continued

- Step therapy: One or more similar lower cost drugs must be tried before other more costly drugs are tried, if necessary.
- Prior authorization: Requires the doctor to contact the plan before the plan will cover these prescriptions. The doctor must show the plan that the drug is medically necessary for it to be covered.
- Substitution: Part D sponsors may substitute generic drugs for brand name drugs if the generic drugs have the same or lower cost sharing and certain conditions are met.
- Comprehensive Addiction and Recovery Act (CARA) programs: Plans may impose certain limitations to manage utilization for beneficiaries who are at risk of misusing or abusing frequently abused drugs.

Step Therapy Example

Step therapy is a requirement to try other medications first before a more costly drug is covered. The plan wants to determine that less expensive options do not work. Here's an example of step therapy:

- The beneficiary tries an over-the-counter medication for an allergy, but it does not provide relief from the symptoms.
- The doctor prescribes a low cost prescription allergy drug but it still does not provide relief.
- The doctor prescribes a third medication that is expensive but works well. The plan required that in order for this prescription to be covered, the beneficiary must first try the lower cost drugs.

Comprehensive Addiction and Recovery Act (CARA) programs

- Part D sponsors may adopt programs for beneficiaries who are at risk of misusing or abusing frequently abused drugs. Under such programs, sponsors identify at risk individuals by using criteria that includes the number of opioid prescriptions a beneficiary has and the number of prescribers who have written those prescriptions.

- Tools that plans may use to manage risk include:
  - Locking the beneficiary into one pharmacy
  - Locking the beneficiary into one prescriber

- Lock-in may apply to both opioids and benzodiazepines

- Certain beneficiaries are exempt from these programs and all beneficiaries have appeal rights related to the lock-in provisions.

Medicare Part D Medication Therapy Management: An Introduction

- All Medicare Part D sponsors are required to have a Medication Therapy Management (MTM) program with the exception of MA Private Fee for Service (MA-PFFS) and PACE organizations. Their MTM programs must be designed:
  - to ensure that covered Part D drugs prescribed to a targeted beneficiaries are appropriately used; and
  - to reduce the risk of adverse events, including drug interactions.

Medicare Part D Medication MTM Requirements

- MTM program elements include:
  - Comprehensive reviews of medications used on an annual basis;
  - Quarterly medication reviews;
  - Identification of medication related problems;
  - Prescriber and beneficiary interventions to promote coordinated care; and
  - Standardized action plans and summaries.

Medicare Part D Eligible MTM Beneficiaries

- To be eligible for the program, a beneficiary must:
  - have multiple chronic diseases – for example diabetes, hypertension, and asthma;
  - be taking multiple Part D drugs, and
  - be likely to incur drug costs of a specified amount (equal to or greater than $4,044 for 2019).

- Information about specific criteria is available from each Part D plan and is available on the plan's website.

- Enrollment in a Sponsor's MTM program must be done using an opt-out method. That is, a beneficiary that meets the plans targeting criteria for its MTM program would be automatically enrolled unless he/she declines enrollment.

Drugs Excluded from Part D Coverage

- By law, Part D plans are not permitted to include the following under their Part D covered benefits:
  - Drugs for weight loss or gain, fertility, cosmetic purposes, symptomatic relief of cough and colds
  - Vitamins
  - Medical foods formulated to be consumed or administered enterally under the supervision of a physician that are not regulated as drugs under section 505 of the Federal Food, Drug, and Cosmetic Act.
  - Erectile dysfunction drugs (when used for sexual dysfunction)
  - Non-prescription drugs
  - Some off label use drugs
  - Part B covered drugs

- Part D plans are permitted to offer supplemental benefits that cover certain drugs not covered under Part D, such as erectile dysfunction drugs.

Mid-year Formulary Changes

- Formulary changes must generally be approved by CMS
- Part D plans cannot make any formulary changes during the first 60 days of the contract year, unless it is in response to a drug's removal from the market.
- After March 1st, Part D plans may make some limited mid-year formulary.

Transition Requirements

- Enrollees initially enrolling in Part D, those switching plans, and current enrollees affected by formulary changes must receive coverage of a single one month fill of their non-formulary drugs during the first 90 days after their enrollment, the plan switch, or the formulary change.

Transition Requirement, continued

- To the extent that a current enrollee in a long term care setting is outside his or her 90-day transition period, the sponsor must still provide a one month supply of nonformulary Part D drugs while an exception or prior authorization request is being processed.

- During the transition period:
  - The Part D plan does not apply prior authorization or step therapy rules.
  - The enrollee and his/her physician can request an exception to the Part D plan's formulary to continue coverage of the non-formulary drug or can transition to a formulary drug.

Requesting Exceptions for Drugs

- Enrollees have the right to request a formulary exception either for coverage of non-formulary drugs or for coverage of formulary drugs at a less costly formulary tier.
- If a doctor thinks an enrollee needs a drug that is not on the formulary, the enrollee or the doctor can apply for a formulary exception.
- A standard form is available on Part D plan websites for enrollees to request a coverage determination, including a formulary exception.

Requesting Coverage Determinations and Appealing Decisions

- Plan Sponsors must provide access via a secure website or secure e-mail address on the website for enrollees to quickly request a coverage determination or appeal a decision.
  - Enrollees may appeal coverage determinations, decisions on exceptions requests concerning tiering or formularies.

- Plan Sponsors must also require network pharmacies to provide enrollees with a printed notice with the plan's toll-free number and website for requesting a coverage determination.

Part D Enrollee Costs and Assistance Programs

Part D Enrollee Costs: "True Out-of-Pocket" Costs (TrOOP)

- Part D True Out-of-Pocket costs or "TrOOP" are out-of-pocket costs enrollees incur that count towards the annual out-of-pocket threshold to move into catastrophic coverage.
  - TrOOP is calculated on an annual basis.
  - Generally, includes enrollee payments for Part D prescription drugs, including:
    - The annual deductible, cost-sharing above the deductible and up to the initial coverage limit, and above the initial coverage limit up to the annual out-of-pocket threshold.
  - After the initial coverage period, a drug manufacturer's discount for brand name drugs counts toward the true out-of-pocket costs.
  - Generally drugs must be on the plan's formulary and purchased at a plan's participating network pharmacy.
  - Amounts paid or borne by the AIDS Drug Assistance Program and the Indian Health Service also count toward TrOOP.

Part D Enrollee Costs: "True Out-of-Pocket" Costs (TrOOP), continued

- Some costs do not count toward the Part D true out-of-pocket (TrOOP) cost total including:
  - Costs for drugs not on a Part D plan's formulary, unless the beneficiary receives an exception under which the plan covers the drug;
  - Costs for over-the-counter (OTC) and other non-Part D drugs;
  - Costs for covered Part D drugs obtained out-of-network (unless the plan's out-of-network policy applies);
  - Costs paid for or reimbursed to an enrollee by insurance, a group health plan, most government-funded health programs (such as Medicaid), or another third party;
  - Costs for drugs purchased outside the United States.

Part D Enrollee Costs: "True Out-of-Pocket" Costs (TrOOP), continued: Examples

- Mr. Reynolds takes blood pressure medication. He requested a formulary exception, which was denied by his plan. He decided to continue taking the non-formulary prescription and pay for it out-of-pocket. The amounts Mr. Reynolds pays for the drug do not count toward his deductible or other out-of-pocket costs.

- To address her acid reflux, Ms. Lopez has been taking a formulary drug and an over-the-counter medication. Only the amount Ms. Lopez pays for the formulary drug counts toward Ms. Lopez's out-of-pocket costs.

Help for Individuals with Limited Income and Limited Resources

- If a beneficiary has limited income and resources, he/she may qualify for the low-income subsidy (LIS) to cover all or part of the Part D plan premium and cost-sharing. In 2018, to qualify for the LIS:
  - Beneficiary income may not exceed 150% of the Federal Poverty Level (FPL). The 150% FPL varies geographically as follows:
    - 48 states $18,210 (individual)/$24,690 (couple) in 2018.
    - Alaska $22,770 (individual)/$30,870 (couple) in 2018.
    - Hawaii $20,940 (individual)/$28,395 (couple) in 2018.
  - Beneficiaries resources may not exceed $14,100(individual)/$28,150 (couple).

Encourage Individuals with Limited Income/ Resources to Apply to the State Medicaid Office

- Beneficiaries with limited income and resources should be encouraged to apply for the low income subsidy (LIS) – also called extra help – through the State Medicaid office or the Social Security Administration (SSA). Beneficiaries may apply at any time.
  - If beneficiaries apply to the State Medicaid office for Part D help, the State Medicaid office also will check for eligibility for other low-income assistance programs.
  - Or call SSA at 1-800-772-1213 or apply online at: www.socialsecurity.gov/prescriptionhelp to apply for help with Part D costs.

- After SSA or the State approves an application for extra help, it is effective the first day of the month in which the individual applied.

Individuals with Limited Income – Full Low Income Subsidy

- Individuals qualifying for a low income subsidy (LIS) or a partial LIS have lower cost sharing.

- For 2019 individuals qualifying for full LIS (income less than 135% of the Federal Poverty Level and resources below the applicable threshold) have $0 deductible and cost sharing of:
  - Maximum cost sharing up to the out-of-pocket threshold of:
    - $3.40 for generic drugs
    - $8.50 for other drugs
  - No cost sharing after the out-of-pocket threshold.

Individuals with Limited Income – Partial Low Income Subsidy

- For 2019 individuals qualifying for Partial LIS (income less than 150% of the Federal Poverty Level and resources below the applicable threshold) have $83 deductible and maximum cost sharing of:
  - 15% up to the maximum out-of-pocket threshold
  - Maximum cost sharing after the out-of-pocket threshold of:
    - $3.40 for generic drugs
    - $8.50 for other drugs

Other Help For Low-Income – Pharmaceutical Assistance Programs

- Some pharmaceutical manufacturers operate programs that assist low income individuals in obtaining drugs at reduced or no costs.

- Some states have assistance programs designed specifically for their residents.
  - Some programs are “qualified” State Pharmaceutical Assistance Programs or SPAPs that count towards TrOOP and some do not count towards TrOOP.
  - Becoming familiar with your state’s programs may help a beneficiary address cost-sharing for prescriptions.

Assistance Programs – What Counts toward TrOOP?

- Enrollees may receive assistance for Part D costs, but costs paid by many assistance programs do not count toward TrOOP cost.
  - Included entities – costs do count towards TrOOP for:
    - Qualified State Pharmaceutical Assistance Programs (SPAPs), most charities, non-government and Indian Health Service funded tribal coverage, AIDS Drug Assistance Programs, health savings accounts, flexible spending accounts, and medical savings accounts.
  - Excluded entities – costs do not count towards TrOOP for:
    - Medicaid, State Children's Health Insurance Program (CHIP), Federally Qualified Health Centers, Rural Health Clinics, Patient Assistance Programs (PAPs) outside the Part D benefit, TRICARE, Federal Employees Health Benefits Program (FEHBP), Black Lung Funds, and health reimbursement arrangements.

Part D and Other Coverage

Employer/Union Coverage of Drugs

- Employer or Union Coverage: Employers/unions will notify their employees of whether their prescription drug coverage is "creditable" (coverage that, on average, equals at least as much as Medicare's standard Part D coverage expects to pay) via an annual statement.
  - If coverage is creditable and the beneficiary keeps it, he/she will not incur a premium penalty if he/she later loses or drops the employer coverage and joins a Part D plan.
  - If coverage is not creditable, the beneficiary will need to enroll in Medicare Part D during his/her initial eligibility period to avoid the late enrollment penalty.

- If a beneficiary has creditable drug coverage through TriCare, the VA, or the FEHBP, he/she can compare that coverage with available Part D plans to decide whether to enroll in Part D.

Employer Coverage of Drugs, continued

- The beneficiary should check with the employer or union benefits administrator before making any change.
  - If a beneficiary drops employer/union prescription drug coverage, he/she may not be able to get it back and also may lose health coverage.

- If the beneficiary retires or otherwise loses employer/union creditable coverage and joins a Medicare Part D plan or otherwise obtains creditable drug coverage within 63 days, there will not be a late enrollment penalty.

Employer/Union Coverage of Drugs: Example~~s~~

Mr. Diamond has employer group coverage that is creditable. During his initial Part D eligibility period, he decided not to enroll because he was happy with his drug coverage. However, a year later, Mr. Diamond loses him employer group coverage. If Mr. Diamond enrolls in a Part D plan before he has a 63 day break in coverage, he will not have to pay a late enrollment premium penalty.

Medicaid Drug Coverage

- When a Medicaid beneficiary becomes eligible for Medicare, then Medicare, instead of Medicaid, covers the Part D drugs once the beneficiary is enrolled in a Part D plan.
- If Medicaid beneficiaries don't choose a plan,-Medicare will select one for them.
- Medicaid beneficiaries can change Part D plans throughout the year.

For Additional Information

- Medicare's site on Part D prescription drug coverage for beneficiaries.
  - http://www.medicare.gov/part-d/index.html
- Medicare's information site on Part D prescription drug coverage which includes plan premium information
  - www.cms.gov/PrescriptionDrugCovGenIn/
- Medicare & You Handbook
  - https://www.medicare.gov/medicare-and-you/medicare-and-you.html

Marketing Medicare Advantage and Part D Plans

Part 4

Version 11

June 19, 2017

Terms and Conditions

- This training program is protected under United States Copyright laws, 17 U.S.C.A. §101, et seq. and international treaties. Except as provided below, the training program may not be reproduced (in whole or in part) in hard paper copy, electronically, or posted on any web site or intranet without the prior written consent of AHIP. Any AHIP member company in good standing sponsoring a Medicare Advantage or Part D plan may reproduce the training program for the limited purpose of providing training and education to the company's own employees and contractors on the subject matter contained in the training program. Employees or contractors participating in such training may not further reproduce (in whole or in part) the training program. No changes of any kind may be made to the training program and any reproduction must include AHIP's copyright notice. This limited license is terminable at will by AHIP.

- The training program is intended to provide guidance only in identifying factors for consideration in the basic rules and regulations governing coverage, eligibility, marketing, and enrollment for Medicare, Medicare supplement insurance, Medicare health plans, and Part D prescription drug plans and is not intended as legal advice. While all reasonable efforts have been made to ensure the accuracy of the information contained in this document, AHIP shall not be liable for reliance by any individual upon the contents of the training program.

Learning Objectives

- After reviewing "Part 4: Marketing Medicare Advantage and Part D Plans" you will be able to explain:
  - What activities constitute marketing;
  - The special rules for marketing Medicare health plans;
  - Required disclosures and rules for making marketing appointments;
  - Prohibited marketing practices;
  - Permitted promotional and marketing activities;
  - The difference between educational and marketing events;
  - Rules regarding agent compensation; and
  - Plan and CMS oversight and enforcement of the marketing rules.

Training Roadmap: Part 4

- Key terms and general background information
- Discussion of marketing activities in:
  - Marketing and sales events
  - Personal appointments
  - Telephone marketing
  - Other marketing (mail, multimedia, and email)
- Required and prohibited marketing practices
- Distinct issues
  - Promotional activities
  - Marketing in a health care setting
  - Marketing to employer/union groups
  - Educational events
  - Rules regarding agent compensation
  - Oversight and enforcement or the marketing requirements, including CMS concerns.

What is Marketing?

- CMS defines marketing as steering, or attempting to steer, a potential enrollee toward a plan or limited number of plans, or promoting a plan or a number of plans.
- "Assisting in enrollment" and "education" do not constitute marketing.

What are Marketing Activities?

- Examples of marketing activities include:
  - Conducting a formal event where a presentation is provided to Medicare beneficiaries where the intent is to steer them toward a plan or limited set of plans;
  - Conducting an informal event where health plan brochures and pre-enrollment materials are distributed;
  - Meeting with a Medicare beneficiary to encourage him or her to remain enrolled in his or her current Medicare plan;
  - Passing out plan specific information and agent business cards at a health fair; and
  - Accepting enrollment forms and performing enrollment at marketing/sales events.

What are Marketing Activities – Case Study

- Agent Travis calls her client, Mr. Watson, during the annual open enrollment period to see if he has any questions regarding his current plan. She lets him know that his current plan will continue to have a rich benefit package for a reasonable premium and seems suited for his needs. By encouraging Mr. Watson to remain enrolled in his current plan, Agent Travis is engaging in marketing activities.

What are Marketing Materials?

- Marketing materials include any MA, MA-PD, section 1876 cost, or PDP plan or plan sponsor informational materials targeted to Medicare beneficiaries which:
  - Promote the plan sponsor or any plan offered by the plan sponsor;
  - Inform Medicare beneficiaries that they may enroll, or remain enrolled in a plan offered by the plan sponsor;
  - Explain the benefits of enrollment or rules that apply to enrollees; or
  - Explain how Medicare services are covered under the plan, including conditions that apply to such coverage.

What are Examples of Marketing Materials?

- Examples of marketing materials include:
  - General audience materials such as brochures, direct mail, newspapers, magazines, television, radio, billboards, yellow pages or the Internet.
  - Marketing representative scripts or outlines for telemarketing, enrollment or other presentations.
  - Presentation materials such as slides and charts.
  - Promotional materials such as brochures or leaflets, including materials for circulation by physicians, other providers, or third parties.
  - Enrollee communications including rules; agreements; handbooks; contractual changes; changes in providers, premiums, or benefits; plan procedures; and wallet card instructions to enrollees.
  - Social media (e.g., Facebook, Twitter, YouTube, etc.) posts that meet the definition of marketing materials, specifically those that contain plan-specific benefits, premiums, cost-sharing, or Star Ratings.

Medicare Marketing Rules

- Medicare marketing rules apply to the following types of Medicare health plans and Part D plans:
  - Medicare Advantage (MA) only plans,
  - Medicare Advantage Prescription Drug (MA-PD) plans,
  - Prescription Drug Plans (PDPs), and
  - 1876 Cost plans.
  - Medicare-Medicaid Plans(MMPs).
    - For MMPs, marketing requirements may be modified by the state specific requirements. Each state in which MMPs are offered has state-specific marketing guidelines and CMS approved model documents. Those guidelines and documents can be accessed at: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html

Medicare Marketing Rules: Plan Marketing Representatives

- Plans are responsible for ensuring compliance with Medicare rules by their marketing representatives.
- Plan marketing representatives include:
  - individuals employed by a plan and
  - individuals or entities under contract to the plan through a direct or downstream contract
    - This would include brokers and agents (contracting directly with the plan or through an agency or other entity), third party marketing organizations (TMOs) such as a field marketing organizations (FMOs), general agents (GAs), or other marketing contractors).

Plan Marketing Representatives – Case Study

Agent Armstrong is an independent agent under contract with MarketCo, a third party marketing organization. MarketCo has a contract with BestChoice health plan, a Medicare Advantage organization, to offer marketing services through its contracted agents and agencies. Agent Armstrong returns calls to individuals who call MarketCo in response to its mailers promoting BestChoice health plan. Agent Armstrong is a marketing representative of BestChoice. Thus, he is obligated to comply with all marketing requirements, including those regarding using only approved call scripts.

Medicare Marketing Rules: Materials and Practices

- CMS reviews plan marketing materials to ensure they:
  - Comply with the requirements related to required or prohibited language,
  - Are not misleading, and
  - Do not make material misrepresentations.
- Generally, only CMS-approved materials and scripts can be used to market Medicare health plans and Part D plans.
  - All materials, scripts, and marketing practices that plan marketing representatives use must comply with Medicare rules.
  - Materials developed for use with employer/union group members are not subject to CMS prior review and approval.
  - No person may use the words “Medicare,” “Centers for Medicare & Medicaid Services,” “Department of Health and Human Services,” or “Health and Human Services” or their symbols in a manner that would convey the false impression that the business or product is approved, endorsed or authorized by Medicare or any other government organization.

Medicare Marketing Rules: Marketing Representatives – State Licensure

- Plan sponsors must contract with or employ as marketing representatives only individuals who are licensed by the state to conduct marketing activities in that state, and whom the plan has informed the state it has appointed, consistent with the appointment process provided for under State law**.**
  - Plans must comply with state requests for information about the performance of a licensed agent or broker as part of a state investigation into the individual's conduct.
  - Plans must report to States termination of agents or brokers including the reasons for the termination, if State law requires that the reasons be reported.
  - Upon discovery, Plans must report to States incidences of submission of applications by unlicensed agents or brokers and terminate their relationships with those individuals.

Marketing Representatives – State Licensure Case Study

Agent King is employed by an agency under contract with HealthMax health plan, a Medicare Advantage organization that offers plans in multiple states. The agency maintains a website marketing the Medicare Advantage plans with which it has contracts. Agent King follows up with individuals who request more information about HealthMax via the agency's website and tries to persuade them to enroll in HealthMax. Agent King is a marketing representative of HealthMax. Thus, he must be licensed and appointed in every state in which beneficiaries to whom he markets HealthMax are located. He may not submit enrollment applications or receive commissions for enrollees residing in states in which he is not licensed and appointed.

Medicare Marketing Rules: Marketing Representatives Training

- All employed and contracted representatives marketing MA and Part D plans must complete training each year on Medicare rules and regulations and on details specific to the plan products they sell.
  - They also must pass a written test each year that demonstrates thorough familiarity with both the Medicare program and the products they are selling. Agents/brokers marketing only employer/union group plans are not required to be tested. However, plans may choose to require testing.
  - Marketing representatives of MA and Part D plans must provide plan sponsors with documentation of completed training and testing (as applicable).
- Plans must provide training to marketing representatives on how to detect, correct, and prevent fraud, waste, and abuse.

Marketing and Unsolicited Contacts

- Marketing representatives are prohibited from making unsolicited contact with beneficiaries, including through:
  - Door-to-door solicitation, including leaving leaflets, flyers or door hangers at a residence or on someone's car;
  - Approaching beneficiaries in common areas such as parking lots, hallways, lobbies, or sidewalks; or
  - Telephonic solicitation, including leaving voicemail messages.
- The prohibition on marketing through unsolicited contacts does not extend to mail and other print media such as advertisements and direct mail that meets other CMS requirements.
- The prohibition does not extent to electronic contact.
- Leads may be generated through mailings, websites, advertising, and public sales events.

Unsolicited Contacts

- Marketing representatives may not accept an appointment to sell an MA or Part D product that resulted from an unsolicited contact, regardless of who made the contact even if the call started based on a non-MA or non-PDP product.
- Marketing representatives may leave business cards with beneficiaries for distribution to friends they are referring, but in all cases, a referred beneficiary must directly initiate contact with the plan or marketing representative.
- Enrollees who are voluntarily disenrolling may not be contacted for sales purposes or be asked to consent to sales contacts.

Unsolicited Contacts, continued

- Marketing representatives may:
  - Place outbound calls to existing enrollees to conduct normal business related to enrollment in the plan, including calls to enrollees who have been involuntarily disenrolled to resolve eligibility issues.
  - Call former enrollees after disenrollment to conduct disenrollment surveys for quality improvement purposes.
  - With advance approval from CMS, call low-income subsidy eligible enrollees that a plan is prospectively losing due to reassignment to encourage them to remain in their current plan.
  - Call their current enrollees to discuss/inform them about general plan information such as Annual Enrollment Period dates, availability of flu shots, upcoming plan changes, educational events and other important plan information.

Unsolicited Contacts, continued

Marketing representatives may:

- Contact individuals enrolled in one of the MA organization's commercial products when the individual is aging into Medicare,
- Contact the MA organization's Medicaid plan enrollees to discuss Medicare products, and
- Contact the MA organization's Medigap enrollees regarding MA, PDP, or cost plan options.
- Return calls or messages from individuals who initiate contact and request information.
- Initiate electronic contact. However, those communications must provide an opt-out process to no longer receive electronic communications. E-mails must include "Marketing" in the beginning of the subject line.

Unsolicited Contacts, continued

- Marketing representatives may:
  - Call beneficiaries who have expressly given permission for that specific contact, for example by filling out a business reply card, sending an e-mail requesting to be contacted or asking a plan customer service representative to have an agent contact them. Such permission is considered to be short-term, event-specific and not open ended.
  - Call a beneficiary who the marketing representative enrolled in a plan while the beneficiary is an enrollee of that organization.
  - Call beneficiaries to confirm an appointment that has already been agreed to by a beneficiary. This may also be done by third parties.
  - Market using mailings, websites, advertising and public sales events. Note that websites and other materials that reference specific MA/Part D products must be submitted to CMS through the plan sponsor for review and approval.

Marketing at Marketing and Sales Events

Medicare Marketing Rules: Marketing or Sales Events

- Marketing/sales events are events designed to steer potential enrollees toward a plan or limited set of plans.
  - Educational events are events designed to inform potential enrollees about MA, Part D, or other Medicare programs, but do not steer or attempt to steer individuals toward a specific plan or limited number of plans. (See slides titled "Educational Events" for more information.)
- There are two main types of marketing/sales events:
  - Formal events typically structured in an audience/presenter style with an agent providing specific plan information, via a presentation on the products being offered; and
  - Informal events, usually less structured for people passing by a table or kiosk manned by a sales agent or Sponsor representative who can discuss the merits of the plan sponsor's products.
- Personal/Individual marketing appointments also must follow marketing rules.
- Plans/Part D Sponsors must keep accurate records of all marketing/sales and educational events, and CMS reserves the right to request event information at any time.

Medicare Marketing Rules: Marketing or Sales Events, continued

- Advertisements and invitations (in any form of media) that are used to invite beneficiaries to attend a group session with the possibility of enrolling those individuals must include the following two statements on advertising and explanatory materials:
  - "A sales person will be present with information and applications."
  - "For accommodation of persons with special needs at sales meetings call <insert phone and TTY number>."

Medicare Marketing Rules: Marketing or Sales Events, continued

- At marketing/sales events agents may:
  - Discuss plan specific information such as premiums and benefits;
  - Discuss the merits of a plan;
  - Distribute and collect enrollment applications; and
  - Distribute plan-specific advertisements, explanatory information, and general information about Medicare.
- If enrollment applications are distributed, all required enrollment materials must be provided.

Medicare Marketing Rules: Marketing or Sales Events, continued

- At marketing/sales events agents may not:
  - Require beneficiaries to provide contact information as a prerequisite for attending the event.
    - This includes requiring an email address or other contact information as a condition to RSVP for an event online or through the mail.
    - Plans must indicate on sign-up sheets that completion of contact information is optional.
  - Conduct health screenings or other like activities that could give the impression of "cherry picking."
  - Use personal contact information obtained to notify individuals of raffle or drawing winnings for any other purpose.

Marketing at Individual Appointments

Medicare Marketing Rules
Individual Marketing Appointments

- Personal/Individual marketing appointments are defined by the intimacy of the appointments' location or format and typically take place in person at the beneficiary's home or a venue such as a library or coffee shop or via telephone call.
- All individual appointments
  - Are considered sales/marketing events;
  - Must meet sales/marketing event requirements;
  - Must follow scope of appointment requirements (See following slides).

Medicare Marketing Rules
Individual Marketing Appointments , continued

- During individual appointments, marketing representatives may:
  - Distribute plan materials such as an enrollment kit or marketing materials.
  - Provide educational information.
  - Provide and collect enrollment forms.
- During individual appointments, marketing representatives may not:
  - Discuss plan options that were not agreed to in the Scope of Appointment.
  - Market non-health care related products.
  - Ask for referrals.
- Solicit/accept an enrollment request for a January 1st effective date prior to the start of the Annual Election Period on October 15 unless the beneficiary is entitled to another enrollment period (for example, an initial enrollment period or special enrollment period).

Required Practices: Scope of Appointment

- Marketing representatives must:
  - Market only health care related products during any MA or Part D sales activity or presentation. Such products include Medicare health plans, Medigap plans and dental plans, but not accident-only plans.
  - Prior to any marketing appointment (48 hours in advance if practicable), clearly identify the types of product(s) that will be discussed, obtain agreement from the beneficiary and document that agreement.
    - Types of products include, for example, MA, PDP, Cost plans, and Medicare-Medicaid plans.
    - Documentation for appointments may be in writing, in the form of a signed agreement by the beneficiary, or a recorded oral agreement. Any technology (e.g., conference calls, fax machines, designated recording line, pre-paid envelopes, and email) can be used to document the scope of appointment.
    - For appointments made over the phone, documentation is generally a recording of the call. However, if the agent does not have a recording mechanism, the agent must obtain a written agreement signed by the beneficiary or authorized representative.

Required Practices: Scope of Appointment, continued

- A plan sponsor or agent may not agree to the scope on behalf of the beneficiary.
- Any business reply cards (BRCs) to be used for documenting a beneficiary's scope of appointment, agreement to be contacted, confirmation of attendance to a sales/marketing event, or request for additional information must be submitted to CMS for approval. The BRC should include a statement informing the beneficiary that a sales person may call as a result of their returning a BRC.

Scope of Appointment: Documentation

- Plans/Part D Sponsors are expected to include the following when documenting the SOA:
  - Product type (e.g. MA, PDP) that the beneficiary has agreed to discuss during the appointment,
  - Date of appointment,
  - Beneficiary contact information (e.g. name, address, telephone number),
  - Written or verbal documentation of beneficiary or appointed/authorized representative agreement,
  - Method of contact (e.g. walk-in),
  - Agent information (e.g. name and contact information) and signature,
  - A statement that beneficiaries are not obligated to enroll in a plan; their current or future Medicare enrollment status will not be impacted and clearly explain that the beneficiary is not automatically enrolled in the plan(s) discussed, and
- If the SOA was not documented 48 hours prior to the appointment, include an explanation why.

Required Practices: Marketing Activities

- During an appointment, marketing representatives may only discuss the products indicated in the scope of appointment.
- Exception: If during an individual appointment a beneficiary expresses interest in another product type, not covered in the pre-appointment scope of appointment, the marketing representative must document a second scope of appointment that includes the new product type, and then may then discuss the additional product during the same appointment.

Required Practices: Marketing Activities, continued

- Sales presentations open to the public do not require documentation of prior beneficiary agreement to the scope of the presentation.
  - A beneficiary may sign a scope of appointment form at a marketing presentation for a follow-up appointment.
- When a beneficiary unexpectedly initiates contact, for example, by unexpectedly walking into a marketing representative's office, or attending a sales appointment properly set up for another individual, the marketing representative should document their agreement to the scope of the appointment, note that the beneficiary was a "walk-in," and may then present the appropriate information.
- Records of beneficiary agreement to the scope of an appointment must be retained for ten (10) years.

Telephone Marketing

Marketing and Telephonic Contact

- Prohibited telephonic activities include:
  - Bait-and-switch strategies such as making unsolicited outbound calls to beneficiaries about other business or another topic as a means of generating leads for Medicare plans.
  - Unsolicited calls to beneficiaries based on referrals (e.g. from friends, relatives, neighbors, or companies that collect, buy, or sell contact information). Marketing representatives may provide their contact information (e.g., business cards) to friends and others who wish to make referrals, so that the referred beneficiary can contact the agent directly.
  - Calls for marketing purposes to enrollees in the process of voluntarily disenrolling or former enrollees who have disenrolled from the Medicare plan;
  - Calls or visits to beneficiaries who attended a sales event, unless the beneficiary gave explicit permission (which must be documented) for the call or visit; and
  - Calls to confirm receipt of mailed information.

Outbound Calls

- Outbound call scripts must:
  - Be submitted verbatim for CMS review and approval (bullets or talking points are not acceptable);
  - Include a privacy statement clarifying that the beneficiary is not required to provide any health-related information to the plan's representative unless it will be used to determine enrollment eligibility, such as ESRD status or qualifications for Special Needs Plans (SNPs); and
  - Clarify that failure to provide information will not affect the beneficiary's membership in the plan, but that Medicaid status or presence of a condition status will be needed to confirm eligibility for a dual eligible or chronic care SNP, respectively.

Outbound Calls, continued

- If during the course of an outbound call by a Medigap issuer, a beneficiary requests information on a MA or PDP product, the agent must document a scope of appointment by obtaining either written or recorded oral agreement before discussing MA or PDP products.
- Third parties may not make unsolicited MA, MMP, cost plan or PDP marketing calls to potential enrollees (other than to current plan enrollees, if the third party is contracted by the plan), for example:
  - Third parties may not make unsolicited calls to provide a “benefits compare” meeting and provide those contacts to plans for ultimate use as an MA, MMP, cost plan or PDP appointment.
  - Third parties may not set up an appointment to discuss Medigap policies and use the appointment to discuss MA, MMP, cost plan or PDP products unless the third party complies with CMS’ scope of appointment guidance.
- Third parties cannot gather contact information through a website to use for marketing unless the beneficiary requests to be contacted by a plan representative.

Marketing to Establish a New Relationship vs. to Current Clients

- CMS distinguishes between telephonic contact with a beneficiary to establish a new relationship and contact where a business relationship already exists with the marketing representative.
- When contacting a beneficiary by telephone to establish a new relationship when the beneficiary has given permission for the contact (e.g., by filling out a business reply card or sending an e-mail to the plan requesting such contact), a consent for future contact must be limited in scope, short-term, and event-specific, not open-ended.
- If an agent is contacting a current client or a plan is contacting current plan enrollees, consent for each specific contact is not required to discuss normal plan business.

Other Marketing: General Audience and E-mail

General Audience Marketing

- General audience marketing includes direct mail, newspapers, magazines, television, radio, yellow pages and the Internet
- Rules regarding unsolicited contacts do not apply to the marketing of these materials
- All of these materials are subject to CMS approval and content requirements:
  - Exception: Agents/Brokers may generate and use materials that are “generic in nature,” without prior submission, but such materials must not discuss content specific to plan benefits; discuss plan cost-sharing; or include the plan name.

Use of E-mails and Social Media to Market

- A Plan/Part D Sponsor may initiate separate electronic contact. Plans/Part D Sponsors must provide an opt-out process to no longer receive electronic communications.
- Plans/marketing representatives may purchase Internet pop-up or banner ads. However, the content of those ads will need to be reviewed and approved by CMS if they are plan-specific and meet the definition of marketing materials.

Use of E-mails and Social Media to Market, continued

- Plans/Part D Sponsors must submit to CMS social media (e.g., Facebook, Twitter, YouTube, LinkedIn, Scan Code, or QR Code) posts that meet the definition of marketing materials, specifically those that contain plan-specific benefits, premiums, cost-sharing, or Star Ratings.
- Social media posts are subject to marketing requirements, such as those related to testimonials. Generally disclaimers are not required unless a communication written for social media has the potential to be disseminated via other mediums, such as you-tube.
- Plans/Part D Sponsors must not include content on social/electronic media that discusses plan-specific benefits, premiums, cost-sharing, or Star Ratings for products offered in the next contract year prior to October 1.

Required and Prohibited Marketing Practices: Required Practices

Required Practices: Marketing Activities

- Marketing representatives must:
  - Provide to prospective enrollees only CMS-approved plan-specific marketing materials or CMS marketing materials.
  - Use only CMS-approved plan marketing scripts and presentations.
  - If gifts or prizes are offered, state clearly that there is no obligation to enroll.
  - Provide accurate, state-specific information if Medicare-Medicaid plans (MMPs) are discussed.
  - Refer beneficiaries to their State Medicaid Agency if they have questions about passive enrollment into an MMP.

Required Practices: Marketing & Non-Health Activities

- Plans/Part D Sponsors must obtain authorization from an enrollee prior to using or disclosing the enrollee's protected health information to market non-health related items or services such as accident-only policies, life insurance policies or annuities.
- Plans/Part D Sponsors must also obtain authorization from an enrollee prior to using or disclosing the enrollee's protected health information to contact him/her for purposes unrelated to plan benefits administration or CMS contract execution, such as the following:
  - Discussing volunteer or community activities.
  - Explaining pending State or Federal legislation.
  - Soliciting participation in grassroots advocacy, organizations and information about such advocacy.

Required Practices: Marketing & Non-Health Activities, continued

Authorizations must contain HIPAA required content.

- Plan Sponsors may send written requests to obtain the beneficiary's authorization. The beneficiary must sign and return the request before the plan can send non-plan related materials.
- Authorization may also be obtained by directing a beneficiary to a website to provide consent.
- Authorization can be provided in person at marketing events, health fairs, or other public venues.
- Authorization can be provided over the telephone, provided the authorization is recorded. The call must be a beneficiary-initiated inbound telephone call and scripts for such calls must comply with all CMS guidance.
- Authorization can be provided via an email to the plan, provided that the authorization includes an electronic signature.

Required Practices: Marketing & Non-Health Activities, continued

- The request for authorization may not:
  - Include non-plan or non-health related content,
  - Be included in the same mailing as information on non-health related issues, unless the Plan/Part D Sponsor has previously received prior authorization to send that particular non-health related information to that enrollee.
- For example, a request for authorization to send information about life insurance should not include a statement such as "Make sure your spouse's future is secure, with a life insurance policy from us," and/or should not be sent with documents that include details about the life insurance policy.
- A request for authorization to send information about legislative advocacy should not state "Congress is threatening your Medicare benefits by the introduction of HR 2."

Required Practices:
Required Materials with an Enrollment Form

- When a beneficiary is provided with enrollment instructions/form, he/she must also receive:
  - Plan ratings information (See slides titled "Plan Ratings")
  - Summary of Benefits; and
- When a beneficiary enrolls in a plan online, the plan sponsor must make these materials available electronically, (e.g., via website links) to the potential enrollee prior to the completion and submission of the enrollment request.

Required Practices:

Required Materials at the Time of Enrollment and Thereafter

- Plans must provide the following materials to new enrollees at the time of enrollment and to renewing enrollees annually:
  - Annual Notice of Change/Evidence of Coverage (ANOC/EOC) or EOC as applicable
  - Comprehensive or abridged formulary. The formulary may be provided in hard copy or the plan may provide a distinct and separate notice (in hard copy), describing where the enrollee can find it online and how the enrollee can request a hard copy.(Part D sponsors only)
  - Provider directory (does not apply to PDPs)
  - Either the pharmacy directory in hard copy or a distinct and separate notice (in hard copy), describing where the enrollee can find the pharmacy directories online and how the enrollee can request a hard copy. (Part D sponsors only)
  - Membership ID Card
- The materials must be provided within 10 days of confirmation of enrollment or by the last day of the month prior to the effective date, whichever is later.

Required Practices: Plan Ratings

- CMS releases star ratings that allow beneficiaries to compare MA plans and Part D plans. These ratings include topics such as getting appointments and care quickly, improving or maintaining health, how members rate the plan, and customer service.
- Beneficiaries who have access to the Internet may obtain plan rating information at http://www.medicare.gov.
  - Click the “Find Health & Drug Plans” button on the left.

Required Practices: Plan Ratings, continued

- Plan sponsors must provide the plan's overall performance ratings to beneficiaries in the standard Plan Ratings information document. The document must be provided with any enrollment form and/or Summary of Benefits and must also be available on plan sponsors' websites.
- The Star Ratings information document must also be prominently posted on plan websites.
- New Plans/Part D Sponsors that do not have any Star Ratings information are not required to provide Star Ratings information until next contract year.
- CMS generally issues plan ratings in October of each year, and plan sponsors must update their ratings within 21 calendar days of the release. Plan sponsors cannot display or release their Star Ratings until CMS releases them on Medicare Plan Finder.
- Plan sponsors must include the following statement on all materials referencing Plan Ratings information:
  - "Plan performance Star Ratings are assessed each year and may change from one year to the next."

Required Practices: Plan Ratings, continued

- Plan sponsors and their marketing representatives may only reference or mention a plan's rating on an individual measure in conjunction with the plan's overall (summary) performance rating. The overall rating must be given at least the same prominence.
- Plan sponsors and their marketing representatives may not use the plan's star ratings in a manner that misleads beneficiaries into enrolling in plans based on inaccurate information.
- Plans'/Part D Sponsors' written or graphical reference to a contract's overall Star Rating must make it clear that the rating is "___out of five (5) stars."
- Plans/Part D Sponsors with one or more contracts that do not have the same overall rating across contracts must not create or disseminate materials in a way that implies that all of their contracts achieved the same rating.

Required Practices: Plan Ratings, continued

- Plan sponsors and their marketing representatives may not:
  - Use a plan's star rating in an individual category or measure to imply a higher overall plan rating than is actually the case.
    - For example, a plan which received a 5-star rating in customer service promotes itself as "rated 5-stars by our enrollees," when its overall plan rating is actually only 4 - stars.
  - Use references to the poor performance rating of a beneficiary's plan in marketing. The option for beneficiaries in poor performing plans to request a special enrollment period does not create an opportunity for marketing.
  - Continue to use an old star rating after 21 days from the release of a new star rating.

Required Practices: Plan Ratings, continued

- Plans/Part D Sponsors are not permitted to display or release their Star Ratings information until CMS releases the Star Ratings on Medicare Plan Finder.
- Plans/Part D Sponsors must clearly identify which contract year their Star Ratings references. For example, a Plan/Part D Sponsor cannot reference the Star Rating that was achieved based on prior contract year data, when the marketing materials are for the upcoming benefit year.
- Plan sponsors with an overall 5-star rating may market and enroll beneficiaries year-round under a special election period (SEP).
  - If a plan sponsor with an overall 5-star rating is assessed a lower rating for the upcoming year, the sponsor must stop marketing under the SEP by November 30 of the current year.

Required Practices: Plan Ratings, continued

- Plan sponsors with a rating below 3 stars for three consecutive years receive a low performer icon (LPI).
  - CMS notifies enrollees in these plans that if they do not make a change during the Annual Election Period, they have a one-time chance to switch to a plan with 3 stars or more by calling 1-800-MEDICARE.
- Plan sponsors with an LPI:
  - Cannot mention their star ratings without also noting their LPI status.
  - Must state that its LPI status means that it received a 2.5-star or below summary rating in either Part C and/or Part D for the last three years.
  - Cannot dispute the validity or importance of the LPI in outreach materials.
  - Cannot encourage beneficiaries to enroll by telling the beneficiary that he or she can disenroll during a special election period.

Required Practices: PFFS Marketing Activities

- PFFS materials for potential enrollees, including presentations, must include the following disclaimer:
  - "A Private Fee-for-Service plan is not a Medicare supplement plan. Providers who do not contract with our plan are not required to see you except in an emergency."

Required Practices: MSA materials and disclaimers

MSA materials targeting potential enrollees must include the following disclaimers:

- "MSA Plans combine a high deductible Medicare Advantage Plan and a trust or custodial savings account (as defined and/or approved by the IRS). The plan deposits money from Medicare into the account. You can use this money to pay for your health care costs, but only Medicare-covered expenses count toward your deductible. The amount deposited is usually less than your deductible amount, so you generally have to pay out-of-pocket before your coverage begins."
- "Medicare MSA Plans don't cover prescription drugs. If you join a Medicare MSA Plan, you can also join any separate Medicare Prescription Drug Plan."

Required Practices: MSA material disclaimers, continued

- "There are additional restrictions to join an MSA plan, and enrollment is generally for a full calendar year unless you meet certain exceptions. Those who disenroll during the calendar year will owe a portion of the account deposit back to the plan. Contact the plan at [insert customer service and TTY] for additional information."

Required and Prohibited Marketing Practices: Prohibited Practices

Prohibited Practices: Marketing Activities

- Marketing representatives must NOT:
  - Market any non-health care related products (such as annuities and life insurance) during any MA or Part D sales activity or any other marketing activity for existing enrollees. This is considered cross-selling.
    - Plans may sell non-health related products on inbound calls only when a beneficiary requests information on other non-health products.
  - Use or disclose the enrollee's protected health information for marketing purposes, including sending any non-plan or non-health related information or otherwise contacting him/her for purposes unrelated to plan benefits administration or CMS contract execution, without first obtaining HIPAA required authorization from the enrollee.
  - Return uninvited to an earlier "no show" appointment.

Prohibited Practices: Marketing Activities, continued

- Marketing representatives must NOT:
  - Require potential enrollees to interact with a licensed agent in order to obtain plan materials or to enroll in a plan if the enrollee is not asking for advice or counseling.
  - Require a face-to-face appointment to provide plan information or enroll the beneficiary.
  - Use a Medicare beneficiary to endorse a plan unless the beneficiary is a current enrollee of the plan.
  - Solicit enrollment applications prior to the start of the annual election period on October 15.
  - Create their own plan specific marketing materials.
  - Charge beneficiaries marketing or administrative fees.

Prohibited Practices: Marketing Activities, continued

- Marketing representatives must NOT:
  - Encourage individuals to enroll based on their health status unless the plan is a special needs plan that focuses on the beneficiary's particular condition;
  - Conduct health screening or other activities that could give an impression of "cherry picking."
  - Use the term "free" to describe a zero dollar premium.
  - Use the term "free" in conjunction with any reduction in premiums, deductibles or cost share, including Part B premium buy-down, low-income subsidy or dual eligibility.
  - With regard to MSAs
    - Imply that the MSA plan operates as a supplement to Medicare.
    - Use the term "network" to describe a list of the MSA plan's contracted preferred providers.

Prohibited Practices: Marketing Activities, continued

- Marketing representatives must NOT engage in aggressive marketing, which includes prohibited marketing practices that have a high likelihood of misleading beneficiaries and causing harm, such as:
  - High pressure sales tactics and scare tactics. This would include activities such as pressuring a hesitant beneficiary to make a decision in a very short period of time or discouraging a beneficiary from consulting with a family member before enrolling;
  - Bait and switch strategies such as making unsolicited outbound calls to beneficiaries about other lines of business as a means of generating leads for Medicare plans; and
  - Engaging in activities that could mislead or confuse beneficiaries, such as claiming that a PFFS plan is the same as Original Medicare or a Medigap plan.

Prohibited Practices: Marketing Activities, continued

High pressure sales example:

Agent Cooper receives a lead from the Agency's website. Ms. Ford has provided through the website her contact information and agreed to have an agent call her. Agent Cooper calls and finds that Ms. Ford is generally happy with Original Medicare and her retiree plan that pays secondary. Agent Cooper tells her that she could go bankrupt if she remains Original Medicare and that she needs to sign up for a Medicare Advantage plan in the next week or will be locked out and risk financial ruin. He counsels Ms. Ford that she doesn't need to talk to her daughter about it first and says he will come by right away to help her sign up. Agent Cooper has engaged in prohibited high pressure sales activities.

Prohibited Practices: Marketing Activities , continued

- Marketing representatives must NOT:
  - Provide false or misleading information about the plan, including benefits, provider rules, and all other plan information.
  - Make disparaging remarks about Medicare-Medicaid Plans (MMPs). Marketing representatives need to be very careful in conveying any negative points about MMP programs unless they are clearly accurate.
  - Claim that Medicare, CMS, or any government agency endorses or recommends the plan.
  - Lead beneficiaries to believe that the broker or agent works for Medicare, CMS or any government agency.
  - Use any materials or make any presentations that imply PFFS plans function as Medicare supplement plans or use terms such as “Medicare Supplement replacement.”

Prohibited Practices: Marketing Activities, continued

- Marketing representatives must NOT:
  - Assert that their plan is the “best” plan.
  - Make explicit comparisons between their plan benefits and those of other named plans, unless they have written concurrence from all plan sponsors being compared.
  - Reference a non-CMS award or survey unless the sponsor or representative notified CMS in advance, note that the award was not given by CMS, refer beneficiaries to the CMS star rating information and give equal prominence to the Medicare star rating.
- Marketing representatives may refer to the results of studies or statistical data, for example in relation to customer satisfaction, quality, or cost, as long as specific study details and information on the relationship with the entity that conducted the study are given and they make it clear that the study or data are not endorsed by CMS.

Prohibited Practices: Inducements

- Marketing representatives must NOT:
  - Offer gifts or prizes to potential enrollees during an event that exceed $15 retail value. Such gifts must be offered to all potential enrollees without discrimination and regardless of whether they enroll.
  - Offer rebates or other cash inducements of any sort to entice beneficiary enrollment.
  - Offer post-enrollment promotional items that in any way compensate beneficiaries based on their utilization of services.
  - Provide any meal, or allow any other entity to provide or subsidize a meal at any event or meeting in which plan benefits are discussed or materials distributed, although light snacks are permitted. This prohibition on meals at marketing events applies to both existing enrollees and potential enrollees.

Prohibited Practices: Inducements, continued

- Marketing representatives must NOT offer
  - a gift or prize that is cash or monetary equivalent, such as a donation to a charity
  - a gift card that can be converted to cash.

Light Snacks versus Prohibited Meals

- Marketing representatives should contact plan sponsor regarding the appropriateness of the food products provided and must ensure that items provided could not be reasonably considered a meal and/or that multiple items are not being "bundled" and provided as if a meal.

- Examples of foods that may be considered "light snacks" include:
  - Fruit and raw vegetables
  - Pastries and muffins
  - Cookies or other small bite-size dessert items
  - Crackers
  - Cheese
  - Chips
  - Yogurt
  - Nuts

Prohibited Practices: Examples

- Marketing representatives **cannot** say:
  - The government wants you to join a Medicare health plan because it helps them.
  - I am certified by Medicare to sell this plan.
  - If your doctor accepts Medicare, she accepts this plan.
  - There are no limits on services.
  - We cover all drugs without restrictions.
  - If you don't like this plan, you can stop paying your premium and return to original Medicare anytime.
  - It is better to choose a different company if you are sick.
  - (Name of plan) is the best Medicare plan you can buy.
  - Medicare Advantage plans are the same as Medigap plans.
  - You should opt out of MMP enrollment because everyone knows you will get a higher quality care through a Medicare Advantage plan.

Promotional Activities

Promotional Activities: Nominal Gifts

- Marketing representatives may offer gifts to potential enrollees if they attend a marketing presentation as long as the gifts are of nominal value and provided regardless of enrollment and without discrimination.
  - Gifts are of nominal value if an individual item is worth $15 or less (based on retail purchase price of the item);
  - When more than one gift is offered, the combined value of all items must not exceed $15;
  - Gifts must not be in the form of cash or other monetary reward, even if their worth is less than $15. Cash gifts include charitable contributions on behalf of an attendee and those gift certificates or gift cards that can be readily converted to cash.
    - There is an exception where state law requires that the gift certificate or gift card must be convertible to cash and the cash value is no more than $2.00.
  - If the gift is one large one that is enjoyed by all attending an event, the total cost must be $15 or less when divided by the estimated attendance. Anticipated attendance may be used, but must be based on venue size, response rate, or advertisement circulation.

Promotional Activities: Drawings, Prizes, Giveaways

- Plan sponsors must include a disclaimer on all marketing materials promoting a prize or drawing or any promise of a free gift that there is no obligation to enroll in the plan.
- Plan sponsors must track and document promotional activities and items given to current enrollees during the year.
- Plan sponsors and their marketing representatives may not willfully structure pre-enrollment activities with the intent to give people more than $75 per year.

Promotional Activities: Drawings, Prizes, Giveaways, continued

- Promotional items may not:
  - consist of drug or health benefits (e.g., free checkup),
  - be tied directly or indirectly to the provision of any covered item or service, or
  - be structured to inappropriately influence the beneficiary's selection of a provider, practitioner or suppliers of any item or service.
- Promotional items must be free of benefit information.

Promotional Activities: Referral Programs

A marketing representative may not request a referral during an individual marketing appointment.

- You may request names and addresses, but not phone numbers. Information can be used **only for mail solicitation**.

- A letter sent from a marketing representative to enrollees soliciting referrals cannot offer a gift in return for a lead.
- Marketing representatives may NOT use cash promotions as part of a program through which current enrollees of MA or Part D plans refer prospective enrollees to the marketing representative, but may offer thank you gifts valued at up to $15 each or up to $75 in the aggregate for the year based on retail purchase price for the item.
- Thank you gifts must be available to all enrollees that provide a referral, and cannot be conditioned on actual enrollment of the person being referred. The following general guidelines apply to referral programs under which a Plan/Part D Sponsor solicits leads from enrollees for new enrollees. These include gifts that would be used to thank enrollees for devoting time to encourage enrollment.

Marketing to Current Enrollees

Marketing Activities: Current Enrollees

- Plan sponsors may:
  - Market non-Medicare health-related products to current enrollees only with any authorizations required by HIPAA Privacy Rules
  - Market health-related products, which may include, for example:
    - Long term care insurance
    - Dental or vision policies
- Plan sponsors must:
  - Allow enrollees and non-enrollees to opt out of communications describing non-Medicare health-related products
- Plan sponsors must NOT:
  - Market non-health related products to current enrollees unless they have obtained opt in authorization from the enrollees as required by HIPAA Privacy Rules

Marketing in a Health Care Setting

Marketing Activities: Marketing in a Health Care Setting

- Marketing representatives may:
  - Engage in marketing activities (i.e., conduct sales presentations and distribute and accept enrollment applications) in common areas of health care settings, for example:
    - At a hospital or nursing home – in a cafeteria, community or recreational room, or conference room;
    - At a retail pharmacy, in areas away from the pharmacy counter.
- Marketing representatives must NOT:
  - Engage in marketing activities in areas where patients receive health care services, for example:
    - In the area where a beneficiary waits for health care or pharmacy services, exam rooms, dialysis center treatment areas, or hospital patient rooms.
- Marketing that is prohibited in health care settings is prohibited during and outside of normal business hours.

Marketing Activities: Marketing in a Long-term Care Facility

- Long-term care facilities include, for example, nursing homes, assisted living facilities, and board and care homes.
- Plan sponsors/marketing representatives may schedule an appointment with a beneficiary in a long-term care facility ONLY upon request of the beneficiary (or authorized representative).
- Providers may
  - Provide residents that meet the I-SNP criteria an explanatory brochure, reply card, and phone number for additional information for each I-SNP with which the facility contracts to explain qualification criteria. (See Part 5 for enrollment information.)

Marketing Activities: Example

Agent Wiggins has a brother who is a contracting physician with AwesomePlan, an MA plan sponsor. Agent Wiggins gives his brother his business cards and asks his brother to personally hand it to patients who might be eligible for enrollment in AwesomePlan during their appointment. If his brother concedes, he will be violating the prohibition against marketing where a beneficiary receives care.

Marketing to Employer/Union Groups

Marketing to Employer/Union Groups

- When marketing an employer/union group waiver plan, marketing representatives must follow all marketing rules and guidelines except the following:
  - the prohibition against unsolicited contacts;
  - the prohibition against cross-selling other products;
  - the requirement to obtain prior documentation of the scope of an appointment;
  - the prohibition against providing meals;
  - marketing representative compensation requirements; and
  - the requirement that a marketing representative must pass an annual test, although the requirement for annual training does apply.
- Plans offering employer group health plans are not required to submit informational copies of their dissemination materials to CMS at the time of use. However, CMS may request and review copies if employee complaints occur or for any other reason to ensure the information accurately and adequately informs beneficiaries about their rights and obligations under the plan.

Educational Events

Educational Events

- Educational Events:
  - Are designed to inform Medicare beneficiaries about MA plans, PDPs, and/or other Medicare programs;
  - Do not steer or attempt to steer potential enrollees toward a specific plan or limited set of plans;
  - May be hosted by the Plan/Part D Sponsor or an outside entity; and
  - Are held in public venues and do not extend to in-home or one-on-one settings.
- CMS has slightly different rules for educational events for prospective enrollees and those events limited only to individuals currently enrolled in the plan.

Prospective Enrollee Educational Events

- Prospective enrollee educational events:
  - May not include any sales activities such as:
    - the distribution of marketing materials or
    - the distribution or collection of plan applications; or
    - the distribution of any material with plan-specific information (including plan-specific premiums, co-payments, or contact information).
  - Must be advertised as “educational” otherwise they will be considered marketing events.

Prospective Enrollee Educational Events, continued

- At educational events, marketing representatives may:
  - Distribute materials that are free of plan-specific information and any bias toward one plan type over another, or that inform the beneficiary generally about MA or other Medicare programs.
  - Use a banner with the plan name and/or logo displayed.
  - Distribute promotional items, including those with the plan name, logo, and toll-free number and/or website. These items must be free of benefit information and consistent with nominal gift rules.
  - Provide an objective presentation to educate beneficiaries about the different ways they can get their Medicare benefits.
  - Have a health care provider make an educational presentation on wellness or another health care related topic.

Prospective Enrollee Educational Events, continued

- At educational events, marketing representatives may:
  - Provide a business card if the beneficiary requests information on how to contact the marketing representative for additional information, as long as the business card is free of plan marketing or benefit information.
  - Provide meals that comply with the nominal gift requirements.
    - Meals for beneficiaries are prohibited at any event that does not meet the definition of an educational event, even if the setting is a State Fair, Expo, etc. where educational events are sometimes held.
  - Respond to questions provided the scope of the response does not go beyond the question asked.

Prospective Enrollee Educational Events, continued

- When an event has been advertised as "educational," marketing representatives may NOT:
  - Conduct sales presentations;
  - Discuss or distribute plan-specific premiums, benefits, or materials including provider and pharmacy directories;
  - Distribute or collect enrollment applications;
  - Collect names/addresses of potential enrollees;
  - Distribute or display business reply cards, scope of appointment forms, or sign up sheets;
  - Attach business cards or plan/agent contact information to educational materials (business cards free of marketing information may be provided upon beneficiary request);
  - Ask participants if they want information about a specific plan or limited number of plans;
  - Set up personal sales appointments or get permission for an outbound call to the beneficiary; or
  - Distribute or make available marketing materials.

Prospective Enrollee Educational Events, continued

- The following are examples of marketing/sales activities that are **prohibited** at any event that has been advertised as "educational."
  - An agent attends a community-sponsored health fair, and hands out plan-specific benefits information including premium and/or copayment amounts;
  - An agent participates in a health fair and hands out enrollment forms;
  - An agent hands out only educational materials but gives a brief presentation that mentions plan-specific premiums and/or copayment amounts;
  - An agent distributes business cards to attendees and asks them to call him about getting the best Medicare coverage.

Prospective Enrollee Educational Events, continued

- If an agent attends an event hosted by a State Health Insurance Counseling and Assistance Program (SHIP) that is not advertised to beneficiaries as “educational” and discusses plan-specific benefits, this also is a marketing/sales event and is not considered “educational.”

Enrollee Only Educational Events

- Plan sponsors may conduct enrollee only educational events.
  - Any marketing of these events must be done in a way that reasonably targets only existing enrollees (e.g., direct mail flyers), not the mass marketplace (e.g., radio or newspaper ad).
  - Educational events must be explicitly advertised as “educational;” otherwise they will be considered by CMS as sales/marketing events. Discussion of benefits at enrollee-only events is not considered a sales activity.
- For enrollee-only educational events, Plan sponsors:
  - May not conduct enrollment or sales activities.
  - May discuss plan-specific premiums and/or benefits and distribute plan-specific materials to enrollees.

Oversight and Enforcement

Oversight and Enforcement: By Plans

- Plan Sponsors are responsible for ensuring compliance with CMS' current marketing regulations and guidance, including monitoring and overseeing the activities of their subcontractors, downstream entities, and/or delegated entities (e.g. contracted marketing, FMOs, TMOs, and GAs)
- Plans are required to implement a strategy to prevent prohibited marketing practices from occurring, to detect prohibited marketing tactics at their early stages, and to take immediate corrective action to respond to aggressive and misleading marketing tactics.
- Plans must take corrective action in the event of verified misconduct, including disciplinary action in cases of aggressive marketing by marketing representatives. Examples include:
  - Withholding or withdrawing commissions;
  - Retraining;
  - Suspension of marketing;
  - Termination; and
  - Reporting agent terminations to State Departments of Insurance and CMS.

Oversight and Enforcement: By Plans, continued

- Plans must comply with requests from a State insurance or other department in connection with investigations of plan marketing representatives who are licensed by the department.
- Plans must terminate upon discovery and report to the State and CMS incidences of submission of applications by unlicensed agents or brokers.
  - Plan sponsors must notify any beneficiary who was enrolled in his/her plan by an unqualified agent and advise the beneficiary of the agent's status. Beneficiaries may request to change plans.
- Plans must report to States the termination of any agent or broker, including the reasons for the termination if required under State law. Plans must also report to CMS for-cause terminations.
- Upon CMS' request, the plan must provide CMS with information necessary for it to conduct oversight of marketing activities.

Oversight and Enforcement: By CMS

- Plan sponsors are subject to CMS penalties for non-compliance that include:
  - Corrective action plans;
  - Suspension of marketing and enrollment;
  - Monetary penalties; and/or
  - Contract termination.

Marketing Representative Compensation

Marketing Representative Compensation: Compensation Defined

- Compensation includes monetary or non-monetary remuneration of any kind relating to the sale or renewal of a policy including, but not limited to—
  - Commissions;
  - Bonuses;
  - Gifts;
  - Prizes or Awards; or
  - Referral or Finder fees.
- Compensation does not include—
  - Payment of fees to comply with State appointment laws, training, certification, and testing costs;
  - Reimbursement for mileage for appointments with beneficiaries or costs associated with beneficiary sales appointments such as venue rent, snacks, and materials.

Marketing Representative Compensation: Applicability of Rules

- Compensation structures for independent agents must comply with CMS guidance.
  - Compensation rules do not generally apply to marketing representatives who are plan employees, to “captive” agents who market for only one plan/Sponsor or when independent agents are marketing only to employer/union groups.
    - Employed and captive agents/brokers who only sell for one Plan/Part D Sponsor are subject to the requirements related to referral/finder fees.
  - Compensation to independent agents who market to and enroll beneficiaries is covered by the rules whether it is paid directly by a plan or paid by an agency, FMO, TMO, or similar organization.

Marketing Representative Compensation: When Compensation May Be Paid

- Plan Sponsors **may not** pay agents:
  - who have not been trained and tested.
  - who do not meet state licensure/appointment requirements.
  - who have been terminated for cause.
- When a Plan Sponsor and/or a contracted independent agent terminates an agent contract without cause, any future payment for existing business will be governed by the terms of the contract, subject to the limits in the regulation.
  - However, to continue receiving renewal fees, agents must remain trained, tested, licensed and appointed, regardless of whether they are actively selling.
- Non-agents/brokers receiving referral fees are not subject to the general compensation rules (such as training/testing/licensure).

Marketing Representative Compensation: Applicable Amounts

- Applicable compensation amounts depend on whether an enrollment is an initial year enrollment or a renewal year enrollment.
  - CMS reports provided to the plan specify whether an enrollment is initial or renewal.
- Renewal year enrollments include plan changes between "like plans."
  - Like plan changes are changes from one MAPD to another MAPD, from one MA plan to another MA Plan, from one PDP to another PDP, one MMP to another MMP and from one cost plan to another cost plan **REGARDLESS of whether the plans are offered by different organizations.**
  - Unlike plan changes include a PDP replaced with an MA-PD or an MA-PD replaced with a PDP; a PDP replaced with a cost plan or a cost plan replaced with a PDP; or an MA-PD replaced with a cost plan or a cost plan replaced with an MA-PD.

Marketing Representative Compensation: Applicable Amounts, continued

- For enrollments in two plans at once (for example, enrollment in an MA-only plan like an MSA and a stand-alone PDP or a cost plan and a PDP), the compensation rules apply independently to each plan. This is known as “dual plan” enrollment.
- However, when dual plans are replaced by an enrollment in a single plan, compensation is paid based on the MA or cost plan movement (e.g., movement from an MA-only plan and PDP to an MA-PD plan would be compensated at the renewal compensation amount for the MA to MA-PD “like plan type” move).

Marketing Representative Compensation: Limits on Amount of Compensation

- Compensation for initial year enrollments cannot exceed a fair market value (FMV) published annually by CMS.
- Compensation for renewal year enrollments cannot exceed 50 percent of the FMV cut-off.
- Referral or finders fees may not exceed $25 for PDPs or $100 for all other types of plans.
  - Referral fees may be made to an individual who is not an Agent/Broker. For example, a plan could compensate individuals who have a beneficiary call an agent/broker to find out more about the plan.
- Referral fees paid to agents must be part of total compensation. Thus any compensation paid for enrollments fee plus the any referral fee paid to an agent may not exceed the FMV cut-off.

Marketing Representative Compensation: Limits on Amount of Compensation, continued

- Plans must annually file with CMS whether they will use independent agents/brokers and, if so, the amounts or range of amounts that they intend to pay for enrollment commissions.
- Once the deadline for filing has passed, plans may not change the amounts they pay or types of brokers they use.

Marketing Representative Compensation: Limits on Amount of Compensation (General Rule) , continued

Compensation is paid on a calendar year basis. Thus, regardless of the month of a beneficiary's initial year enrollment, the renewal year begins on January 1 of the subsequent year, NOT on the beneficiary's enrollment anniversary date.

Example: Mr. X becomes eligible for Medicare for the first time in July and enrolled in a Medicare Advantage plan with an effective date of July 1. The Plan paid the agent the initial year compensation amount for the months of July through December. On January 1, the plan must start paying the agent the renewal amount if Mr. X remains enrolled.

Marketing Representative Compensation: Limits on Amount of Compensation, continued

- Compensation may only be paid for the months the beneficiary is enrolled in the plan.
  - If a plan pays compensation in advance, it must recoup amounts paid for months a beneficiary is not enrolled.
  - If a beneficiary enrolls mid-year, compensation must be prorated.

Example:
Mr. Adams moves out of his Medicare Advantage plan's service area in May. An agent in his new state helped him enroll in a new Medicare Advantage plan with a June 1 effective date. The new plan will pay the agent a renewal year compensation amount. The new plan may only pay for 7 months of enrollment (assuming Mr. Adams stays enrolled through December.) If his old plan paid the agent who enrolled him in that plan in advance, it must recoup any payment for months after May.

Marketing Representative Compensation: Exception to pro rata payment rule

- A plan may choose to pay for an entire initial enrollment year, despite less than 12 months of enrollment, for a beneficiary who has never been enrolled in a plan before or where a beneficiary moves from an employer group plan to a non-employer group plan.
- However, if the plan pays a full initial compensation and the enrollee disenrolls during the contract year, the plan must recoup a pro-rated amount for all months the enrollee is not enrolled.

Example: Mrs. J turns 65 in August and is eligible for Medicare for the first time. An agent helped her enroll in an MAPD with an September 1 effective date. The plan will pay the agent an initial year compensation amount. Depending on its contract with the agent, the plan may choose to pay for the entire year if she remains enrolled for the contract year or for only September through December (4 months).

Marketing Representative Compensation: Rapid Disenrollment

- If a beneficiary disenrolls within the first 3 months of enrollment (referred to as "rapid disenrollment"), the entire compensation amount must be recouped, except under certain circumstances.
  - Plans do not have to recoup when a beneficiary enrolls in a plan effective October 1, November 1, or December 1, and subsequently changes plans effective January 1 of the following year during the Annual Election Period.
  - Other examples of instances in which plans do not have to recoup include when a beneficiary disenrolls in the first 3 months because of
    - Becoming dually eligible for both Medicare and Medicaid
    - Qualifying for another plan based on special needs
    - Becoming LIS eligible
    - Death
    - Moving out of the service area
    - Non-payment of premium
    - Moving into a plan with a 5-star rating or out of a LPI plan into a plan with three or more stars

Marketing Representative Compensation: Rapid Disenrollment, continued

- Rapid disenrollment applies when an enrollee moves from one parent organization to another parent organization, or when an enrollee moves from one plan to another plan within the same parent organization.

Example of rapid disenrollment: An Agent assisted Ms. Spalding in enrolling in a Medicare Advantage plan during the Annual Enrollment Period. Her effective date is January 1st. On February 10th, Ms. Spalding disenrolls because she did not understand that the plan did not cover services furnished by non-network providers. The plan must recoup all compensation payments paid to the Agent for Ms. Spalding's enrollment.

Frequently Asked Questions

Frequently Asked Questions

Q: We purchased books on health maintenance that we plan to give away to anyone attending one of our marketing presentations, regardless of whether they enroll in our plan. Because we purchased a large number of these books, we were able to buy them at a cost of $14.99 per book. However, on the inside jacket, the retail price is shown as $19.99. May we give these books away at our marketing presentation?

A: No. The retail purchase price of the book is $19.99, which exceeds CMS's definition of nominal value.

Frequently Asked Questions

Q: We would like to offer gifts of nominal value to potential enrollees who call for more information about our plan. We would then like to offer additional gifts if they come to a separate marketing event. Each of the gifts meets CMS's definition of nominal value, but taken together, the gifts are more than nominal value. Is this permissible?

A: Yes, provided that the aggregate value of such gifts provided to potential enrollees does not exceed $75 per year. For example, if potential enrollees are eligible for 6 nominal value gifts, each with a fair market value of $10, then such gifts can be provided. But if the value of each gift is $15, the aggregate cap of $75 per year would be exceeded.

Frequently Asked Questions

Q: Listed below are some possible promotional items to encourage potential enrollees to attend marketing presentations. Are these types of promotions permissible?

- Light Snacks (no meals)
- Day trips
- Magazine subscriptions
- Event tickets
- Coupon book (total value of discounts is less than $15)

A: Yes. All these promotional items are permissible as long as they are offered to everyone who attends the event, regardless of whether or not they enroll and as long as the gifts are valued at $15 or less per marketing event. Cash gifts are prohibited, including charitable contributions made on behalf of people attending a marketing presentation and including gift certificates and gift cards that can be readily converted to cash, regardless of dollar amount.

Frequently Asked Questions

Q: Can a marketing representative advertise eligibility for a raffle or door prize of more than nominal value for those who attend a marketing presentation if the total value of the item is less than $15 per person attending?

A: No. You cannot have a door prize of more than nominal value. Such gifts or prizes are prohibited by CMS.

Frequently Asked Questions

Q: Can a marketing representative take people to a casino or sponsor a bingo night at which the enrollee's earnings may exceed the $15 nominal value limit?

A: No. The total value of the winnings may not exceed $15 and the winnings cannot be in cash or an item that may be readily converted to cash.

Frequently Asked Questions

Q: Can marketing representatives use providers to identify Medicare beneficiaries with certain illness or diseases for marketing purposes?

A: No, marketing must follow the HIPAA privacy requirements. HIPAA rules permit the provider to communicate with his/her patients about treatment options but they must not disclose to any entity contact information for those who have not signed the provider's HIPAA authorization. To prevent health screening, the provider can send CMS- and plan- approved marketing materials to ALL of the provider's Medicare patients explaining the MA product. The materials must not contain health screening information unless the plan is for individuals that are dually-eligible or have certain illness or diseases. The provider is responsible for ensuring that it does not violate any HIPAA rules when sending/mailing out such information to their patients.

CMS Identified Problem Areas

- Mischaracterizing an MA or Part D plan's star rating by identifying the rating in one measure and implying that it is the plan's overall plan rating.
- Pressuring attendees at marketing events to provide their contact information.
- Canceling marketing events without notifying CMS and without having someone at the location to inform people of the cancelation.
- Using absolute characterizations, such as XYZ MA plan is the "best" plan or the provider network is the "largest" without substantiation.
- Failing to include the CMS identification number on marketing materials.

For More Information

- Medicare Marketing Guidelines: http://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.html
- CMS Marketing Website: http://www.cms.gov/ManagedCareMarketing/
- CMS PFFS Addendum: Model Language for Sales Presentation http://www.cms.gov/PrivateFeeforServicePlans/
- Medicare Beneficiary Website: www.medicare.gov

Enrollment Guidance Medicare Advantage and Part D Plans

Part 5

Version 12
June 18, 2018

Terms and Conditions

- This training program is protected under United States Copyright laws, 17 U.S.C.A. §101, et seq. and international treaties. Except as provided below, the training program may not be reproduced (in whole or in part) in hard paper copy, electronically, or posted on any web site or intranet without the prior written consent of AHIP. Any AHIP member company in good standing sponsoring a Medicare Advantage or Part D plan may reproduce the training program for the limited purpose of providing training and education to the company's own employees and contractors on the subject matter contained in the training program. Employees or contractors participating in such training may not further reproduce (in whole or in part) the training program. No changes of any kind may be made to the training program and any reproduction must include AHIP's copyright notice. This limited license is terminable at will by AHIP.

- The training program is intended to provide guidance only in identifying factors for consideration in the basic rules and regulations governing coverage, eligibility, marketing, and enrollment for Medicare, Medicare supplement insurance, Medicare health plans, and Part D prescription drug plans and is not intended as legal advice. While all reasonable efforts have been made to ensure the accuracy of the information contained in this document, AHIP shall not be liable for reliance by any individual upon the contents of the training program.

Learning Objectives

- After reviewing "Part 5: Enrollment Guidance - Medicare Advantage and Part D Plans" you will be able to explain:
  - Eligibility and enrollment rules;
  - Who can complete an enrollment form;
  - When beneficiaries can enroll or change plans;
  - Post enrollment requirements;
  - Enrollee protections; and
  - The disenrollment process.

Training Roadmap: Part 5

- ☐ Who is eligible to enroll and basic enrollment rules
- ☐ Enrollment requests
- ☐ Beneficiary acknowledgements and enrollee discrimination prohibitions
- ☐ Enrollment periods
  - Overview
  - Initial enrollment periods
  - Annual election period
  - Open enrollment period
  - Enrollment period for newly eligible MA enrollees
  - Special enrollment periods
  - Open enrollment period for institutionalized individuals
  - Cost plan enrollment periods
- ☐ Post-enrollment activities and rules
- ☐ Enrollee protections: Appeals and Grievances
- ☐ Disenrollment

Who is Eligible to Enroll and Basic Enrollment Rules

Who is Eligible to Enroll in MA or Part D Plans?

- An individual is eligible to enroll in an MA plan if the individual is entitled to Medicare benefits under Part A and enrolled in Part B.
  - A narrow exception applies to MA Employer Group Waiver Plans (EGWPs) that may obtain approval to enroll Part B only retirees.
  - Generally, beneficiaries are not eligible to enroll in an MA plan if they have end-stage renal disease when first enrolling in the plan.

- An individual is eligible to enroll in a Part D plan if the individual is entitled to Medicare benefits under Part A and/or enrolled in Part B.

Who is Eligible to Enroll in MA or Part D Plans? Continued

- For MA and Part D plans the individual must
  - Permanently reside in the service area of the plan.
  - Submit a complete enrollment request (a legal representative may complete the enrollment request for the individual)
    - In certain cases, CMS will allow an abbreviated enrollment form to be completed, e.g., when the member wants to switch to an MA plan offered by the same sponsor.
  - Be fully informed of and agree to abide by the plan rules provided during the enrollment request.
  - Be a U.S. citizen or lawfully present in the United States on or before the enrollment effective date. (CMS makes this determination.)

Lawfully Present in the United States

An individual who is lawfully present in the U.S. includes, but is not limited to, a non-U.S. citizen (an alien) who is

- ☐ Lawfully admitted for permanent residence under the Immigration and Nationality Act;
- ☐ Granted asylum or is an applicant for asylum under section 208 of such Act;
- ☐ A refugee who is admitted to the U.S. under section 207 of such Act;
- ☐ A Cuban and Haitian entrant (as defined in section 501(e) of the Refugee Education Assistance Act of 1980);
- ☐ Currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President; or
- ☐ Currently in deferred action status.

Lawfully Present in the United States, continued

- Individuals are not required to provide evidence of U.S. citizenship or lawful presence status with the enrollment request, nor are MA organizations or their marketing representatives permitted to request such information or documentation.

Enrollment Rules

- Individuals' eligibility to enroll in a stand-alone PDP depends on how they receive their medical benefits.
- If enrolled in any Medicare coordinated care plan (HMO/PPO) or a PFFS plan with Part D drug coverage, the beneficiary may not be enrolled in a stand-alone PDP.
  - Enrollment in a stand-alone PDP will result in automatic disenrollment from a Medicare coordinated care plan regardless of whether the plan includes Part D coverage or a PFFS plan that includes Part D coverage.
- Enrollees may be enrolled in a stand-alone PDP only if they are enrolled in:
  - Original fee-for-service Medicare;
  - A PFFS plan that does not include Part D drug coverage;
  - A Medical Savings Account (MSA) plan; or
  - An 1876 Cost plan.

Enrollment Rules, continued

- The Medicare prescription drug benefit of a MA-PD is only available to enrollees of the MA-PD plan.
- If a beneficiary is enrolled in a MA coordinated care plan, the enrollee must receive his/her Medicare prescription drug benefit through that plan.
  - Enrollees in certain Employer/Union retiree group plans may have different options.
- Enrollees of 1876 cost plans have the option of receiving the prescription drug benefit from the 1876 cost plan, if offered, or from a freestanding prescription drug plan.

Enrollment Requests

Formats of Enrollment Requests

- Plan sponsors must accept enrollment requests, regardless of whether they are received in a face-to-face interview, by mail, by facsimile, or through other mechanisms defined by CMS.

- A short enrollment form may be used when an individual changes between plans offered by the same parent organization.

- Under certain circumstances, CMS allows a beneficiary to be automatically enrolled in a Medicare plan with the opportunity to opt out and select another option. These circumstance apply principally to certain dual eligible enrollments into integrated MA plans and enrollment in a PDP for a beneficiary who is eligible for the LIS subsidy.

Formats of Enrollment Requests -- Paper

- All plans must make available and accept a CMS-approved paper enrollment form appropriate to the plan type (MA, PDP, MA-PDP, MSA, or PFFS).

Formats of Enrollment Requests –Electronic Enrollment

- Enrollment via the internet:
  - CMS offers an on-line enrollment center through www.medicare.gov
    - Individuals can also enroll through: www.ssa.gov/medicare/apply.html
    - CMS on-line enrollment is disabled for MA and Part D plans with a low performer icon (LPI), which means the plan received less than 3 stars for three consecutive years.
  - MA and Part D plans may offer CMS-approved online enrollment on the plan sponsor's website.

Formats of Enrollment Requests –Electronic Enrollment, continued

- MA organizations may develop and offer electronic enrollment mechanisms made available via an electronic device or secure internet website.

- A number of requirements apply to electronic enrollment mechanisms, including, but not limited to:
  - Plan Sponsors must submit all materials, web pages (including mobile pages), and images (e.g. screen shots) related to the electronic enrollment process for CMS approval.
  - Individuals must be provided with all required pre-enrollment information (see module 4).
  - The mechanism must comply with CMS' data security policies.

Formats of Enrollment Requests –Electronic Enrollment, continued

- If a legal representative is completing the electronic enrollment request, he or she must attest that he or she has the legal authority to do so and that proof of such authority is available upon request.
- All required data elements must be captured through the electronic mechanism. For enrollment requests from one plan to another plan within the same parent organization, the short enrollment format may be used.
- The process must include a clear and distinct step that requires the applicant to activate an “Enroll Now,” or “I Agree,” type of button or tool.
- The mechanism must capture an accurate time and date stamp at the time the applicant hits the “Enroll Now” or “I Agree” button or tool.

Formats of Enrollment Requests –Electronic Enrollment, continued

- MA and Part D Plans may use downstream entities, such as a broker or third party website, as a means of facilitating and capturing the electronic enrollment request.

  - MA and Part D Plan Sponsors retain complete responsibility for ensuring compliance with all CMS enrollment policies.
  - From the point at which an individual selects the plan of his or her choice on the third-party website and begins the online enrollment process, CMS holds the organization responsible for the security and privacy of the information provided by the applicant and for the timely disclosure of any breaches.

Formats of Enrollment Requests - Telephone

- Plan Sponsors may accept telephonic enrollments where the following requirements are met:
  - Plans may accept telephonic enrollments on incoming calls **only.**
  - Plan Sponsors must ensure that the telephonic enrollment is effectuated entirely by the beneficiary or authorized representative and that the plan representative, agent or broker is not physically present with the beneficiary or present on the phone at the time of the request.
  - Calls must be recorded.
  - Individuals must be advised that they are completing an enrollment request.

Formats of Enrollment Requests – Telephone, continued

- Calls must include a statement of the individual's agreement to be recorded
- Telephonic enrollments must include all required elements necessary to complete an enrollment
- If the request is made by someone other than the beneficiary, the recording must include the attestation regarding the individual's authority under State law to complete the request, in addition to the required contact information.
- CMS also offers telephone enrollment through 1-800-Medicare.

Who May Complete the Enrollment?

- A Medicare beneficiary is generally the only individual who may execute a valid request for enrollment in or disenrollment from an MA plan. However, state law may allow another individual to execute an enrollment or disenrollment request.
- CMS will allow a legal representative or other individual to execute an enrollment or disenrollment request on behalf of a beneficiary if authorized under state law.
  - Depending on state law, this may include court-appointed legal guardians, individuals with durable power of attorney for health care decisions, or individuals authorized to make health care decisions under state surrogate consent laws.
- If there is uncertainty regarding whether another person may sign for a beneficiary, Plan Sponsors should check the State law. But, the Plan sponsor may not delay processing the request while this inquiry is being made.

Who May Complete the Enrollment? Continued

- When someone other than the Medicare beneficiary completes an enrollment or disenrollment request, he or she must:
  - Attest to having the authority under State law to do so;
  - Confirm that proof of authorization, if any, required by State law is available and can be provided upon request by CMS. (Plan Sponsors cannot require such documentation as a condition of enrollment or disenrollment); and
  - Provide contact information.

Who May Complete the Enrollment? Continued

- If a marketing representative assists in completion of a paper enrollment form, the representative must clearly indicate his/her name on the form.
- Exceptions -- The marketing representative does not need to include his/her name on the form:
  - If a beneficiary requests an enrollment form be mailed to him/her and the name and mailing address are pre-filled;
  - If the representative fills in the "office use only" block; and/or
  - If the representative corrects information on the enrollment form after verifying an individual's information and adding the representative's initials and date next to the correction.
- If the marketing representative pre-fills any other information, including the beneficiary's phone number, he/she MUST include his/her name.
- Marketing representatives must safeguard beneficiary information including enrollment forms. Significant penalties arise if beneficiary information is inappropriately released.

What Information is Required to Complete the Enrollment Request?

- CMS requires the following information for an enrollment request to be complete:
  - MA or Part D plan name
  - Beneficiary 's
    - Name;
    - Date of birth;
    - Sex;
    - Permanent residence address;
    - Medicare number;
    - Response to ESRD question; and
    - Signature or authorized representative's signature*
  - Authorized representative contact
  - Employer or union name and group number (if applicable)
  - Name of current MA plan (if applicable) and new plan
  - Verification of SNP eligibility (if applicable)
  - Acknowledgments (see next slide)
  - Release of information
  - For MSA plans, certain additional elements.

* For certain Employer/Union Group MA enrollment elections and some other CMS approved enrollment elections, a signature is not required. For paper enrollment forms submitted without a signature, Sponsors may verify with the applicant by telephone and document the contact instead of returning form. If a short form is permitted, fewer items need to be included in the enrollment request.

What Information is Required to Complete the Enrollment Request? Continued

- If enrollment is completed during a face-to-face interview, the plan representative should use the individual's Medicare card to verify the spelling of the name, sex, Medicare number; and Part A and Part B effective dates.

Beneficiary Acknowledgements and Enrollee Discrimination Prohibitions

Beneficiary Acknowledgements when Enrolling

- The enrollment application form requires the beneficiary to acknowledge that he/she :
  - Must keep Medicare Part A and Part B if enrolling into an MA plan and must keep Part A or Part B if enrolling into a Part D plan;
  - Agrees to abide by the plan's membership rules as outlined in the enrollee materials;
  - Consents to the disclosure and exchange of information necessary for the operation of the MA or Part D program;
  - Can be enrolled in only one MA plan, PDP or MA-PD plan. Enrollment in another MA plan, PDP or MA-PD plan automatically disenrolls him/her from his/her current plan; and
  - Understands his/her right to appeal service and payment denials the plan makes.

Enrollment Discrimination Prohibitions

- Marketing representatives may NOT:
  - Deny or discourage beneficiary enrollment based on:
    - anticipated need for health care services;
    - race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or sexual orientation; or
    - geographic location within the service area.
  - State or imply that only seniors may enroll, rather than all Medicare beneficiaries.

Enrollment Discrimination Prohibitions, continued

- Marketing representatives may not ask health screening questions during completion of the enrollment request.
- However, marketing representatives may ask very limited health status questions related to a beneficiary's eligibility to join an MA plan, such as whether the individual has ESRD, is enrolled in Medicaid, or is currently admitted to a certified Medicare/Medicaid institution.
- MA organizations are only permitted to send health assessment forms after enrollment.

Enrollment Discrimination Prohibition and Exceptions

- Certain plan products and services may only be available to enrollees with specific diagnoses (e.g., medication therapy management for those with chronic conditions).

- Only organizations offering SNPs or MMP demonstration plans may limit enrollment to individuals who:
  - are dual eligible;
  - are in an institution; or
  - have a severe or disabling chronic condition.

- Marketing representatives may target items and services to beneficiaries that correspond to these categories of SNP plans.

Enrollment Periods

Roadmap to Enrollment Periods

- Annual enrollment/disenrollment periods:
  - Annual election period (October 15 – December 7)
  - Open Enrollment Period (OEP) (January 1 – March 31)
- Enrollment periods based on special circumstances:
  - Initial election periods when beneficiary first eligible for Medicare
  - Special enrollment periods (SEPs) when special circumstances arise
  - Continual open enrollment for institutionalized individuals

Enrollment Periods -- Overview

- Beneficiaries may only enroll in or change plans at certain fixed times each year or under certain limited special circumstances.
  - If the application does not include information supporting a permissible election period, plans must contact the beneficiary to decide if enrollment is permissible.

- MA and Part D Enrollment periods are:
  - MA Initial Coverage Election Period (ICEP)
  - Part D Initial Enrollment Period (IEP)
  - MA and Part D Annual Election Period (AEP)
  - MA and Part D Special Enrollment Periods (SEP)
  - Open Enrollment Period for Institutionalized Individuals (OEPI)
  - MA Open Enrollment Period (OEP) (beginning in 2019)

Enrollment Periods

- Cost Plan Enrollment
  - Cost plans are required to be open to enrollment at least 30 days per year. Many cost plans are open for enrollment all year.
  - Cost plans may be, but are not required to be, open for enrollment during the MA Annual Election Period, but Cost plans that offer an optional supplemental Part D benefit must accept Part D enrollments during the AEP.
  - See "Cost Plan Enrollment Periods" section for more information on Cost Plan Enrollment Periods

MA and Part D Enrollment Periods Brief Summary

Enrollment Period	MA Options	PDP Options
MA Initial Coverage Election Period (ICEP) / Part D Initial Enrollment Period (IEP)	Enroll	Enroll
Annual Election Period (AEP) (Oct. 15-Dec. 7)	Enroll, Disenroll, Change Plans	Enroll, Disenroll, Change Plans
MA Open Enrollment Period (OEP) (Jan. 1 – March 31)	Disenroll from an MA or MA-PD plan and return to Original Medicare, Change MA Plans	After disenrolling from an MA or MA-PD plan, may enroll in a PDP
Special Election Period (SEP)	Most permit enrollment, disenrollment and plan changes, however some are limited.	Most permit enrollment, disenrollment and plan changes, however some are limited.
Open Enrollment Period for Institutionalized Individuals (OEPI)	Enroll, Disenroll, Change Plans	(See Part D SEP for Institutional Individuals)

Enrollment Periods

Initial Enrollment Periods

Enrollment Periods: MA Initial Coverage Election Period (ICEP)

- The MA ICEP is the period during which an individual newly eligible for MA may make an initial enrollment request to enroll in an MA plan.
- The ICEP begins three months immediately before the individual's first entitlement to both Medicare Part A and Part B and ends on the later of:
  - The last day of the month preceding entitlement to both Part A and Part B, or;
  - The last day of the individual's Part B initial enrollment period.
- The initial enrollment period for Part B is the seven (7) month period that begins 3 months before the month an individual meets the eligibility requirements for Part B, and ends 3 months after the month of eligibility.

Enrollment Periods: MA ICEP, continued

- During the ICEP:
  - An eligible individual may enroll in an MA plan.
  - An individual may also choose an MA-PD when the IEP and ICEP occur at the same time.
  - The individual can make one enrollment choice under the ICEP. Once enrollment is effective, the ICEP is used.
- The ICEP for an MA enrollment election will frequently relate to either the individual's 65th birthday or the 25th month of disability, but it must always relate to the individual's entitlement to both Medicare Part A and Part B.

Enrollment Periods: MA ICEP, continued

Example:

Mr. Crosby will turn 65 on July 13, 2019. He will become eligible for Medicare Part A and Part B beginning on July 1 and has decided to enroll in Part B for an effective date of July 1. Mr. Crosby's ICEP begins April 1, 2019 and ends on October 31, 2019.

Enrollment Periods: Part D Initial Enrollment Period (IEP)

- The Part D IEP
  - Begins 3 months before the month an individual meets the eligibility requirements for Part B, and ends 3 months after the month of eligibility.
- Individuals eligible for Medicare prior to age 65 (such as for disability) will have another IEP when attaining age 65.
- During the Part D IEP, beneficiaries may make one Part D enrollment choice, including enrollment in an MA-PD plan if they are eligible for MA.

Enrollment Periods: Part D Initial Enrollment Period (IEP), continued

- Generally, individuals will have an IEP for Part D that is the same period as the Initial Enrollment Period for Medicare Part B.

Example: Mr. Young's 65th birthday is November 12, 2018. He is currently working. He signed up for Medicare Part A benefits, effective November 1, 2018. However, he declined Part B, because he has employer based insurance. He is eligible for Part D since he has Part A and lives in the service area. Even though he did not enroll in Part B, his Part B IEP is still August 1, 2018 through February 28, 2019. Hence, his IEP for Part D is also August 1, 2018 through February 28, 2019.

Enrollment Periods: IEP and ICEP Occurring Together

- The MA ICEP and the Part D IEP occur together as one period when a newly Medicare eligible individual has enrolled in BOTH Part A and B at first eligibility.

Enrollment Periods

Annual Election Period

Enrollment Periods: Annual Election Period

- The Annual Election Period (AEP) takes place October 15 to December 7 and is available to all MA and Part D eligible beneficiaries.
- During the Annual Election Period:
  - Beneficiaries may add or drop MA and/or drug coverage, or return to Original Medicare.
  - No action is needed if the beneficiary chooses to keep his/her current plan. She/he should check for any benefit changes under the plan.
  - Beneficiaries may make more than one enrollment choice during the Annual Election Period, but the last one made prior to the end of the Annual Election Period, as determined by the date the plan or marketing representative receives the completed enrollment form, will be the election that takes effect.

Enrollment Periods: Annual Election Period, continued

- Marketing representatives may not accept enrollment forms before October 15 for enrollments under the Annual Election Period.

- If a beneficiary sends an unsolicited AEP paper enrollment request to the plan on or after October 1 but before the Annual Election Period begins, the plan will process the application beginning on the first day of the election period (October 15). Note, agents are prohibited from soliciting or accepting an enrollment form for a January 1 effective date before October 15, unless the enrollee has another election period.

- A beneficiary will receive an acknowledgment letter when the plan sponsor receives an early AEP enrollment form.

Enrollment Periods: Annual Election Period, continued

- Paper AEP enrollment requests received prior to the start of the AEP for which there is indication of sales agent or broker involvement in the submission of the request (i.e., the name or contact information of a sales agent or broker) must be investigated by the Plan Sponsor for compliance.

- Plan Sponsors must cease current year marketing activities to anyone other than beneficiaries who are eligible for a valid enrollment (e.g., aging-ins, special enrollment period (SEP)) once they begin marketing benefits for the new contract year

Enrollment Periods

MA Open Enrollment Period

Enrollment Periods: MA Open Enrollment Period (MA OEP)

- The MA OEP takes place from January 1 – March 31 of each year (beginning in 2019).
- During the MA OEP MA and MA-PD enrollees may:
  - Change to a different MA or MA-PD plan or disenroll from their plan and return to Original Medicare; and/or
  - Change Part D coverage.
- For example:
  - An MA–PD enrollee may use the OEP to switch to: (1) another MA–PD plan; (2) an MA-only plan; or (3) Original Medicare with or without a PDP.
  - An MA-only enrollee may use the OEP to switch to – (1) another MA-only plan; (2) an MA–PD plan; or (3) Original Medicare with or without a PDP.

Enrollment Periods: MA Open Enrollment Period (MA OEP), continued

- Beneficiaries may only change plans once during the OEP.
- As eligibility to use the OEP is available only for MA enrollees, the ability to make changes to Part D coverage is limited to any individual who uses the OEP; the OEP does not provide enrollment rights to any individual who is not enrolled in an MA or MA-PD plan.
- Marketing representatives may not do targeted marketing related to the OEP, for example, marketing that specifically mentions the OEP or that specifically targets individuals known to be MA enrollees.

Enrollment Periods: MA OEP, continued

Example: Mr. Gonzales has Original Medicare. He wishes to enroll in an MA-PD plan during the OEP. Because only persons enrolled in MA plans may use the OEP to change their election, Mr. Gonzales would be unable to enroll in an MA-PD plan during the OEP (unless another valid election period gave him that option).

Enrollment Periods: Newly Eligible MA Enrollees

- Beginning in 2019, a newly MA eligible individual who is enrolled in a MA plan may change his or her election once during the period that begins the month the individual is entitled to both Part A and Part B and ends on the last day of the third month of the entitlement.
- An individual who chooses to exercise this election may also make a coordinating election to enroll in or disenroll from Part D.
- The limitation to one election or change does not apply to elections or changes made during the AEP or a SEP.

Enrollment Periods

Special Enrollment Periods (SEP)

Enrollment Periods: Special Enrollment Periods (SEP)

- MA eligible and Part D eligible beneficiaries who experience certain qualifying events are provided a special period to change their election, known as a SEP.
- Timeframes for SEPs are variable, however, most begin on the first day of the month in which the qualifying event occurs and last for a total of three months.
- The SEP ends when the individual makes an allowed change to their enrollment, or the time period expires, whichever comes first.
- Where appropriate, SEPs allowing changes to MA coverage are coordinated with those allowing changes in Part D coverage.

Enrollment Periods: Special Enrollment Periods (SEP), continued

- Some (but not all) situations resulting in an SEP include:
  - Change in residence
  - Involuntary loss of creditable drug coverage
  - Exceptional conditions such as
    - Gaining or losing Medicaid eligibility
    - Gaining or losing the Part D low-income subsidy
    - Changing employer/union group sponsored MA coverage
    - Enrollment based on incorrect or misleading information
    - Non-U.S. citizens who become lawfully present in the United States.
    - Individuals who dropped a Medigap policy when they enrolled for the first time in an MA plan, and who are still in a "trial period"
    - Individuals with severe or disabling chronic conditions who wish to enroll in a SNP designed to serve individuals with those conditions.

Enrollment Periods: Special Enrollment Periods (SEP), continued

- Under Part D SEPs, qualifying beneficiaries generally have one opportunity to drop, add or change their Part D coverage.

- Under MA SEPs, qualifying beneficiaries generally have one opportunity to change their MA coverage. (Except for MSA plan enrollees.)
  - But, if a beneficiary disenrolls from his/her MA plan and returns to Original Medicare, he/she may subsequently select a new MA plan, as long as he/she does so before the SEP expires.

Typical SEPs -- Severe or Disabling Chronic Conditions

- Who is eligible for a SEP for Enrollment Into a Chronic Care SNP
  - Beneficiaries who have severe or disabling chronic conditions.
- When does the SEP take place?
  - Applies as long as the individual has the qualifying condition.
  - Ends once the individual enrolls in a MA Special Needs Plan (SNP).

Typical SEPs -- Severe or Disabling Chronic Conditions, Continued

- What can beneficiaries do during a SEP for severe of disabling chronic conditions?
  - Enroll in a SNP designed to serve individuals with those conditions.

Example: Mr. Landreth has diabetes. He currently is covered under original Medicare with a PDP for Part D benefits. There is a SNP in Mr. Landreth's area that specializes in caring for individuals with diabetes. Mr. Landreth may enroll in the SNP at any time.

Typical SEPs – Change of Residence

- Who is eligible for a SEP based on change of residence?
  - MA and Part D enrollees who move out of their existing plan's service area, or who have new options available to them as a result of a permanent move.
  - Beneficiaries who have moved into a plan service area from a location where there was no Part D plan available (e.g. overseas) qualify for an SEP just for Part D election purposes.

Typical SEPs – Change of Residence, continued

- When does a SEP based on change of residence take place?
  - Begins either the month before the permanent move if the plan is notified in advance or the month the beneficiary provides notice of the move.
  - Continues for two months following the month it begins or the month of the move, whichever is later.
  - The individual may choose an effective date of up to 3 months after the month in which the enrollment form is received by the plan, but it may not be earlier than the date of the permanent move.

- What can beneficiaries do during the SEP?
  - Qualifying beneficiaries have one opportunity to enroll into a new MA or Part D plan.

Typical SEPs - Involuntary Loss of Creditable Drug Coverage

- Who is eligible for a SEP based on loss of creditable drug coverage?
  - Beneficiaries eligible for Part D who involuntarily lose creditable prescription drug coverage including a reduction in coverage so it is no longer creditable.
- When does the SEP take place?
  - Begins with the month in which the beneficiary is advised of loss of creditable coverage.
  - Ends 2 months after loss of creditable coverage or the date the individual received the notice, whichever is later.
- What can beneficiaries do during the SEP?
  - One opportunity to select a PDP or MA-PD plan.

Example: Mr. Walker did not enroll in Part B or Part D when he first became eligible because he had excellent employer group coverage. Years later, Mr. Walker received notice on October 1 that as of January 1, his employer group plan's drug coverage will no longer be creditable. Mr. Walker has a SEP to enroll in Part D beginning October 1 and ending February 28th.

Typical SEPs - Exceptional Conditions Gaining or Losing Medicaid Eligibility

- Who is eligible for a SEP based on a change in Medicaid eligibility?
  - Beneficiaries who are entitled to Medicare Part A and/or Part B and receive any type of assistance from Medicaid (full or partial benefits).

- When does the SEP take place?
  - Begins the month the beneficiary gains or loses dual eligibility.
  - If gaining eligibility: continues as long as the beneficiary receives Medicaid benefits. Note: dual eligible beneficiaries have a continuous special election period as long as they retain dual eligible status.
  - If losing eligibility: begins the month that Medicaid eligibility is lost and continues for two additional months.

Gaining or Losing Medicaid Eligibility, continued

- What can beneficiaries do during a SEP based on gaining or losing eligibility?
  - Beneficiaries entitled to Part A and Part B can enroll in or disenroll from an MA and/or Part D plan at any time. Those entitled only to Part B can only do so for PDPs.

Typical SEPs - Exceptional Conditions Gaining Eligibility for Part D Low Income Subsidy

- Who is eligible for a SEP based on gaining eligibility for Part D LIS?
  - Non-dual beneficiaries who qualify for LIS but do not receive Medicaid benefits
- When does the SEP take place?
  - Begins on the month the individual becomes eligible for LIS.
  - Continues as long as he or she is eligible for LIS.
- What can beneficiaries do during the SEP?
  - Enroll in or disenroll from a PDP or MA-PD plan at any time.

Example: Ms. Perry is awarded LIS. CMS facilitates her enrollment into a PDP, effective October 1st. She decides she would rather be enrolled in another PDP or an MA-PD plan and submits a request in November. She does so using this SEP and her enrollment is effective December 1st.

Typical SEPs – Individuals Who Dropped a Medigap Policy to enroll For the First Time in an MA Plan

- Who is eligible for a SEP based on dropping Medigap to enroll in MA?
  - Any Medicare beneficiary who dropped a Medigap policy when they enrolled for the first time in an MA plan, if they are still in the "trial period."

- When does the SEP take place?
  - In most cases, a trial period lasts for 12 months after a person enrolls in an MA plan for the first time.

- What can beneficiaries do during the SEP?
  - Make a one-time election to disenroll from their first MA plan to Original Medicare. They will also have a guaranteed eligibility period to rejoin a Medigap plan.

Typical SEPs - Exceptional Conditions Employer/Union Group Coverage

- Who is eligible for a SEP based on change in Employer/Union group coverage?
  - Beneficiaries who elect into or out of employer-sponsored MA plans.
  - Beneficiaries disenrolling from an MA plan to enroll in employer/union sponsored coverage that includes medical and/or drug coverage.
  - Beneficiaries disenrolling from employer sponsored coverage (including COBRA coverage) to elect an MA plan.

- When does the SEP take place?
  - Begins when the employer/union plan would otherwise allow the individual to make changes to his/her coverage.
  - Ends 2 months after the month the employer or union-sponsored coverage ends.

Typical SEPs - Exceptional Conditions Employer/Union Group Coverage, continued

- What can be done during a SEP based on a change in employer group coverage?
  - Qualifying beneficiaries have one opportunity to
    - Enroll in an employer group/union-sponsored MA or Part D plan;
    - Disenroll from an MA or Part D plan to take employer/union-sponsored coverage of any kind; or
    - Disenroll from employer/union-sponsored coverage to enroll in an MA or Part D plan.

Typical SEPs - Exceptional Conditions 5-Star Plans

- Who is eligible for a SEP to allow enrollment in a 5-star plan?
  - Beneficiaries who live in the service area of a 5-star plan and are enrolled in an MA or PDP plan a Cost plan
  - Beneficiaries who live in the service area of a 5-star plan, are enrolled in Original Medicare, and meet the eligibility requirements for Medicare Advantage or Part D plans

- When does the SEP take place?
  - The SEP is available each year beginning on December 8 and may be used once through November 30 of the following year. For example, the SEP for calendar year 2019 can be used from December 8, 2018 through November 30, 2019.

Typical SEPs - Exceptional Conditions
5-Star Plans, continued

- What can be done during a 5-star plan SEP?
  - Disenroll from an MA plan, PDP or Cost plan or leave Original Medicare
  - Enroll in a 5-star MA plan, PDP or Cost plan
  - Eligible individuals may enroll in a 5-star plan through 1-800-MEDICARE, Medicare.gov, or directly through the 5-star plan.

Example: Ms. Gomez has Original Medicare and a PDP but has been considering enrolling in an MA plan. It is June, 5 months before the annual election period. However, she lives within the service area of SuperMA plan, which has a 5-star rating. Ms. Gomez may use the 5 –star SEP to enroll in SuperMA plan before the Annual Election Period.

Typical SEPs - Significant Change in Provider Network

- Who is eligible for a SEP based on a significant change in the provider network?
  - An individual enrolled in an MA plan that CMS has determined has had changes to its provider network that are significant based on the affect or potential to affect, current plan enrollees.
- When does the SEP take place?
  - The SEP will be in effect once CMS makes its determination and enrollees have been notified. The SEP begins the month the individual is notified of the network change and continues for an additional two months.
- What can beneficiaries do during the SEP?
  - Beneficiaries may disenroll from the MA plan and elect Original Medicare or another MA plan, including an MA-PD even if they did not have prescription drug coverage previously, or can enroll in a PDP.

Enrollment Periods

Open Enrollment Period for Institutionalized Individuals

MA Open Enrollment Period for Institutionalized (OEPI) Individuals/Part D SEP for Institutionalized Individuals

- The OEPI is a continuous open enrollment period.
- The OEPI is available for institutionalized individuals who move into, reside in, or move out of an institution including, for example, a skilled nursing facility, nursing facility, rehabilitation hospital, or hospital.
- In addition, the OEPI is available for individuals who meet the definition of "institutionalized" to enroll in or disenroll from an MA SNP for institutionalized individuals.
- The OEPI ends two months after the month the individual moves out of the institution.
- Beneficiaries Eligible for the OEPI can:
  - Make an unlimited number of MA enrollment requests and may disenroll from their MA plan.
  - Enroll in or disenroll from a Part D plan.
  - Return to Original Medicare.

Enrollment Periods

Cost Plan Enrollment Periods

Cost Plan Enrollment Periods

- Generally, Cost plans must establish an annual open enrollment period of at least 30 days.
- Many cost plans allow enrollment year round.
- For Cost plans that offer an optional supplemental Part D benefit, beneficiaries may select this benefit only during enrollment periods available under the Part D program, and Cost plans must accept Part D enrollments during these periods.
- A beneficiary who is enrolled in an MA plan must have a valid MA disenrollment period in order to switch to a Cost plan.

Cost Plan Enrollment Periods, continued

- Some cost plans transitioning to MA contracts will have "deemed" or facilitated enrollment at the end of 2018. That is, unless a cost plan enrollee opts out, he/she will be automatically enrolled in an MA plan offered by the same (or an affiliate) organization on January 1, 2019.

- Individuals subject to deemed enrollment will be notified by CMS and the plan and given the opportunity to choose another option.

Post-Enrollment Activities and Rules

Post-Enrollment Request: Outbound Verification Calls

- For enrollments effectuated by an agent or broker (independent or employed), plan sponsors must confirm beneficiaries are enrolled in the plan they requested and understand the features/rules of the plan.
  - The enrollment verification process may be completed by telephone, email (if beneficiary opted-in for email) or direct mail.
  - The beneficiary must be contacted within fifteen (15) calendar days of receipt of the enrollment request.
- Marketing representatives must **not** conduct the enrollment verification and must not be present with the applicant during a verification call or e-mail.
  - Exceptions: Plan sponsors are not required to conduct verifications for switches from one plan to another plan of the same type (e.g., PFFS to PFFS, or PDP to PDP) offered by the same MA or PDP organization or for enrollments into employer or union sponsored plans.

Post-Enrollment Request: Beneficiary Notifications Prior to Effective Date

- After the plan receives the request for enrollment and prior to the effective date of coverage all plans must provide the enrollee with:
  - A notice acknowledging receipt of the complete enrollment request and showing the effective date of coverage (must be provided no later than 10 calendar days after receipt of the completed enrollment request);
  - A copy of the completed paper enrollment if the beneficiary requests the form;
  - For enrollment requests submitted via the internet or telephone, evidence that the enrollment request was received (e.g., a confirmation number); and
  - Proof of health insurance coverage so that he/she may begin using plan services as of the effective date (must include the data necessary to access benefits).

Post-Enrollment Request: Beneficiary Notifications, Prior to Effective Date continued

Regardless of how enrollment request is made, Plan Sponsor must explain:

- ☐ The charges for which the prospective member will be liable (premiums, late enrollment penalty, coinsurance, deductible) if this information is available at the time the acknowledgement notice is issued.
- ☐ The prospective member's authorization for the disclosure and exchange of necessary information between the MA organization and CMS.
- ☐ The lock-in requirement.
- ☐ The potential for financial liability if it is found that the individual is not entitled to Medicare Part A and Part B at the time coverage begins and he/she has used MA plan services after the effective date.
- ☐ The effective date of coverage and how to obtain services prior to the receipt of an ID card (if the MA organization has not yet provided the ID card).

Post-Enrollment Request: Materials for the Beneficiary

In some instances the Plan Sponsor will be unable to provide the materials and required notifications to new enrollees prior to the effective date, for example, when an enrollment request is received late in a month with an effective date of the first of the next month. In these cases, all materials described in the previous slide must be provided no later than 10 calendar days after receipt of the completed enrollment request.

Post-Enrollment: When does coverage begin?

- If a beneficiary joins using the Annual Election Period option for enrollment/change, coverage begins January 1 of the following year.
- For Individuals using ICEP or IEP, coverage begins the first day of the month of entitlement to Medicare Part A and Part B or the first of the month following the month the enrollment request was made if after entitlement has occurred.
- At other times, coverage generally begins on the first day of the month following the month in which the beneficiary makes an enrollment request.

Post-Enrollment: When does coverage begin? Continued

- If a Plan Sponsor receives an enrollment request and determines the applicant is eligible for more than one election period, it must allow the individual to choose the enrollment effective date.

- Note: This requirement does not apply to beneficiary requests for enrollment into an employer/union sponsored plan using the group enrollment mechanism, as these may be submitted to CMS with the EGHP SEP election type code.

- If one of the election periods for which the individual is eligible is the ICEP, the individual may not choose an effective date any earlier than the month of entitlement to Medicare Part A and Part B.

Post-Enrollment: When does coverage begin? Continued

Example: Mr. Grisman turns 65 on November 20th. He has an ICEP that begins August 1 and ends February 1. The AEP begins October 15th and runs through December 7th. Mr. Grisman can choose whether he uses his ICEP or the AEP, but he cannot have an effective date prior to November 1. In addition, Mr. Grisman may use the OEP to change his election until March 31st.

Enrollee Protections
Appeals and Grievances

Enrollee Protections

- Enrollees of a plan have a right to:
  - File complaints (sometimes called grievances), including complaints about the quality of their care;
  - Get a decision about health care payment or services, or prescription drug coverage; and
  - Get a review (appeal) of certain decisions about health care payment, coverage of services, or prescription drug coverage.

Enrollee Protections: Complaints, Grievances, Coverage Decisions, Appeals

- Medicare health plan and prescription drug plan enrollees have two main processes to address concerns about or disagreements with their plan.
  - The grievance process is used for complaints about the operations of a plan or its network providers.
  - The appeals process is used to ask for a review of coverage decisions on plan benefits and coverage or payment.

Enrollee Protections: Grievances

- Enrollees or their representatives may file a grievance if they experience problems with their health care services such as timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item.
- Grievance issues also may include complaints that a covered health service, procedure, or item furnished during a course of treatment did not meet accepted standards for delivery of health care.
- An enrollee or their representative may make the complaint orally, in writing, or via a CMS website at: https://www.medicare.gov/MedicareComplaintForm/home.aspx.
- Plans must provide a link to the Medicare.gov website where the enrollee can enter a complaint.

Enrollee Protections: Coverage Decisions

- Coverage decisions are determinations made by a Medicare health plan or prescription drug plan with respect to whether medical care or prescription drugs are covered, the way in which they are covered, and problems related to payment .

- Examples of times when an enrollee may need a coverage decision include:
  - To obtain payment for certain items or services, such as the type or level of services the enrollee thinks should be furnished;
  - To obtain payment for services when the enrollee is temporarily out of the area;
  - To continue a service that the enrollee believes is medically necessary; or
  - To obtain payment for a prescription drug.

Enrollee Protections: Appeals of Coverage Decisions

- If an enrollee is not satisfied with the coverage decision, he/she or in some cases his/her physician can appeal the decision.

- An appeal is a formal way to ask the plan to review or change a coverage decision.

- An appeal can be filed if :
  - An enrollee believes a Medicare health plan does not pay for or authorize, or ends a service that should be covered; or
  - An enrollee believes a Medicare prescription drug plan has not authorized or paid for a Part D prescription drug that should be covered.
    - Enrollees can also ask for exceptions from a Plan Sponsor's formulary or tiering policy.

Enrollee Protections: Appeals of Coverage Decisions, continued

- Medicare health plans and prescription drug plans must provide enrollees with a written description of the appeal process.

- To file an appeal enrollees should look at their plan materials or call their plan.

- Part D plans:
  - Provide access via a secure website or secure e-mail address on the website for enrollees to quickly request a coverage determination or appeal a decision; and
  - Require network pharmacies to provide enrollees with a printed notice with the plan's toll-free number and website for requesting a coverage determination.

- Marketing representatives can learn about plan specific appeal processes in their product specific training.

Enrollee Protections
Network Requirements and Other Enrollee Rights

Enrollee Protections: Network Requirements

- Enrollees of a plan have a right to:
  - Select and/or change their primary care provider without interference from the plan. However, network restrictions may apply.
  - Have access to doctors, specialists and hospitals:
    - Enrollees in HMOs, PPOs, network-based PFFS plans and SNPs must have access to provider networks that include enough doctors, specialists, and hospitals to provide all covered services necessary to meet enrollee needs within reasonable travel time.
    - Exception – In limited circumstances, PPOs that serve regions established by CMS (Regional PPOs) may offer services through non-network providers at the in-network enrollee cost-sharing level.
  - Get emergency care when and where they need it.

Enrollee Protections: Network Requirements, continued

- Enrollees of a plan have a right to:
  - Have access to covered Part D drugs through network pharmacies:
    - Have access to plan networks that include retail, specialty, and home infusion pharmacies to provide convenient access to covered drugs.
      - Exception: PFFS plans may provide access to covered drugs through a network or by covering the drugs at any pharmacy.
    - Have convenient access to network long term care pharmacies, if the enrollee resides in a long term care facility.
    - Have convenient access to Indian Health Service, Tribal, and urban Indian organization (I/T/U) pharmacies, if enrollees are American Indians or Alaska Natives (AI/AN)

Enrollee Protections: Other Enrollee Rights

- Enrollees of a plan have a right to:
  - Be protected from discrimination;
  - Learn about all of their treatment choices and participate in treatment decisions;
  - Know how their doctors are paid;
  - Have personal and health information kept private; and
  - Obtain a treatment plan.

Disenrollment

Disenrollment from MA, Part D or Cost Plans

- There are two types of disenrollment:
  - Voluntary disenrollment:
    - An enrollee chooses to leave a plan because he/she wants to leave.
  - Involuntary disenrollment:
    - In certain situations, the plan may be required or may have the option to end an enrollee's membership.

Disenrollment from MA, Part D or Cost Plans, continued

- Plans or their marketing representatives may **not** either orally or in writing or by any action or inaction request or encourage any enrollee to disenroll from the plan except in specific situations authorized by CMS.

- Plans may contact enrollees to determine the reason for a voluntary disenrollment, but must not discourage an enrollee from disenrolling after he or she indicates a desire to do so.

Voluntary Disenrollment from MA or Part D Plans

- During a valid enrollment/disenrollment period, an enrollee may request disenrollment from an MA or prescription drug plan by:
  - Enrolling in another plan;
  - Sending or faxing a signed written notice to the plan sponsor (or employer/union group, if applicable);
  - Submitting a request via the internet to the plan sponsor (if the plan offers this option); or
  - Calling 1-800-MEDICARE or for TTY users call 1-877-486-2048.

- Enrollees making verbal requests must be instructed to make the request via one of the above methods.

Voluntary Disenrollment from MA or Part D Plans, continued

- Exceptions:
  - Employer or union sponsored plans may have other disenrollment mechanisms.
  - To disenroll from an MSA plan enrollees must write to the plan. The enrollee cannot disenroll via 1-800-MEDICARE.
  - To ensure disenrollment from a PDP, enrollees should submit a written request or call Medicare in the following situations:
    - Joining an MA PFFS plan without drug coverage;
    - Joining an MSA plan; and
    - When NOT joining any other health or prescription drug plan.

Voluntary Disenrollment from Cost Plans

- Medicare Cost plan enrollees may end their membership at any time during the year and enroll in Original Medicare.
  - The enrollee must submit a written request and cannot disenroll by calling Medicare.

- A beneficiary who disenrolls from a Cost plan may join an MA plan or a PDP during the Annual Election Period or other MA or Part D election period

Required Involuntary Disenrollment from MA or Part D Plans

- Plan sponsors must disenroll an enrollee from the plan in the following situations:
  - A permanent change in residence (including incarceration) makes the enrollee ineligible to be enrolled;
  - The enrollee does not stay enrolled in Part A and Part B for MA and MA/PD plans or does not stay enrolled in Part A or Part B for PDP plans;
  - A SNP enrollee loses special needs status (e.g., an enrollee of a dual eligible SNP loses Medicaid eligibility);
    - SNPs can choose to continue enrollment for an individual that no longer meets the special needs status if the individual can reasonably be expected to meet the criteria again within six months.

Required Involuntary Disenrollment from MA or Part D Plans, continued

- The enrollee dies;
- The plan sponsor's contract is terminated, withdrawn, or the service area is reduced and excludes the enrollee. (Exceptions apply);
- The member fails to pay his or her Part D-IRMAA to the government and CMS notifies the plan to effectuate the disenrollment; or
- The member is not lawfully present in the United States.

☐ A PDP must also involuntarily disenroll an individual who materially misrepresents information to the PDP sponsor regarding reimbursement for third-party coverage.

Temporary Exception to Involuntary Disenrollment When an Enrollee Moves from the Service Area

- Requirements concerning enrollees who change residence
  - MA Organizations:
    - May offer an extended visitor/traveler (V/T) benefit of up to 12 months. Under this benefit, enrollees may remain temporarily out of the service area for up to 12 months without being disenrolled.
    - Must disenroll enrollees who are not in these (V/T) programs who have been out of the area more than 6 months (PFFS plans can allow continued enrollment for up to 12 months)
    - Individuals who move outside the service area have a SEP to enroll in a MA, MA-PD , or PDP.
  - Part D Plan Sponsors:
    - Must disenroll an enrollee 12 months after identifying that the individual has moved outside of the service area if the plan has been unable to confirm the move with the enrollee.
    - Exceptions may apply for enrollees who have low income subsidy.

Required Involuntary Disenrollment from Cost and MSA Plans

- Medicare cost plans must disenroll an enrollee:
  - Who does not stay continuously enrolled in Part B
  - Moves out of the service area for more than 90 days (up to 12 months for some plans)

- MSA Plans must disenroll an enrollee:
  - Who no longer meets MSA eligibility requirements except the MSA Plan may not disenroll:
    - Beneficiaries who develop end stage renal disease (ESRD) while enrolled in the MSA Plan; or
    - Beneficiaries who elect the Medicare hospice benefit while enrolled in the MSA Plan.

Optional Involuntary Disenrollment from MA, Part D or Cost Plans

- Plan sponsors may involuntarily disenroll an enrollee from the plan if the enrollee:
  - Does not pay premiums on a timely basis;
  - Engages in disruptive behavior (CMS must approve the disenrollment after reviewing the evidence);
  - Provides fraudulent information on an enrollment request; or
  - Allows another individual to use his or her enrollment card.

- Plan sponsors must take action consistently among all enrollees of each plan.

Optional Involuntary Disenrollment from MA, Part D or Cost Plans – Failure to Pay Premium

If a member fails to pay the plan premium, a Plan Sponsor may choose to:

- ☐ Do nothing.
- ☐ Disenroll the member after a grace period and notice;
- ☐ For an MA plan, if the member fails to pay the premium for optional supplemental benefits (that is, a package of benefits that the member is not required to accept), but pays the premium for basic and mandatory supplemental benefits, reduce the member's coverage.
- ☐ For a cost plan member who fails to pay the premium for optional supplemental benefits, but pays the premium for the basic benefits, the cost plan may not disenroll the member. It may discontinue the optional benefits. If the optional supplement benefit is a Part D benefit, the cost plan must discontinue services and disenroll the individual from that optional supplemental benefit.

Optional Involuntary Disenrollment from MA, Part D, or Cost Plans, continued

- Enrollee's Rights:
  - For failure to pay plan premiums the plan sponsor must:
    - Notify the enrollee in writing and
    - Provide enrollees with a grace period of not less than 2 months.
    - Exceptions apply for payment of premiums for dual eligible individuals and those who qualify for the Part D low income subsidy.
    - CMS may extend the grace period for good cause and reinstate enrollment if the beneficiary pays the overdue premiums within 3 calendar months of disenrollment.
  - Enrollees have the right to make a complaint if the plan ends their membership.

Additional information

- Guidance for Eligibility, Enrollment and Disenrollment procedures for Medicare Advantage (MA) plans, including MA-PD plans, is provided in Chapter 2 of the Medicare Managed Care Manual.
  - https://www.cms.gov/MedicareMangCareEligEnrol/01_Overview.asp

- Similar guidance for 1876 Cost plans is provided in Chapter 17, Subpart D of the same manual.
  - http://www.cms.gov/MedicareMangCareEligEnrol/

- CMS provides instructions for enrolling Medicare beneficiaries in Medicare Prescription Drug Plans (PDPs) in the Agency's PDP Guidance for Eligibility, Enrollment and Disenrollment.
  - https://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicarePresDrugEligEnrol/index.html