TALKING MEDICARE

UPDATED FOR **2020**

A RESOURCE GUIDE FOR ADVISORS IN THE MEDICARE MARKET

DAN MANGUS

A Publication by
Senior Marketing Specialists

*talking*MEDICARE

A Resource Guide for Advisors in the Medicare Market

Revised March 2020

The following book was written by Dan Mangus, Vice President of Sales at Senior Marketing Specialists with information gathered from insurance carriers, Medicare, and other online sources.

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Amanda Griffin, Editor

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FORWARD

Don't be fooled by this book.

This is not a complete guide to Medicare. There is no such thing, and there never will be. Before it ever got to press, it would be wrong. Upon first glance, it may seem like talkingMEDICARE is merely references to solve common (and uncommon) problems in senior insurance.

I ask you to look deeper.

This work is far more than simply a list of topics, statistics, or links. If approached from a place of deep curiosity (instead of only picking it up when you have a problem), this book can be an immensely impactful and revolutionary tool for your business.

talkingMEDICARE is designed to help you, the agent, ask the right kinds of questions and to help find the direction to go in search of answers to help your clients through some of the most difficult times in their lives.

Dan Mangus has voraciously collected Medicare information over 30 years of research in the field. From age 16, he started connecting with seniors by knocking on doors in Southern Missouri to set appointments for his mother who was an agency owner. He has seen virtually every imaginable scenario; many of which are in this book. He saw firsthand how important finding relevant, reliable information was to serve his policyholders.

Following his grandfather and mother into the industry, Dan took up insurance as a third-generation agent. Inspired by their line of work in the service industry, an industry that allowed them to create a professional career solely from helping people, he saw firsthand the trust clients put in his family's business.

As an agency owner, Dan worked hard to get where he was by building his own book of business and finances following the core values established by his grandfather and his mother. Dan knew the clients he had earned expected honest, respectful, and straightforward answers to their toughest questions. Since then, he's given countless keynote speeches and taught classes to insurance agents, industry advisors and seniors across the country.

I have the privilege of working under Dan in Senior Marketing Specialists' Sales Department: an FMO where we answer tough questions daily from thousands of insurance agents nationwide. We help agents sell insurance through marketing, strategy, and creative problem solving. I've seen firsthand how Dan has more than a thirst for knowledge — he has a genuine and heartfelt drive to make a difference in peoples' lives.

The book you're holding is much more than links and scenarios. By using talkingMEDICARE to actively grow your knowledge instead of only using it as a source for a quick fix, you can be a step above the competition. You will be an asset to your clients, proving you're personally invested in their healthcare choices and not just their policy.

Look beyond the links and seek to understand how each subject can affect the bottom line of your business. By choosing to work in the insurance industry, you are more than simply a salesperson; you are a trusted advisor to your clients and their families. It's time to act like it. You've already made a great step by picking up this book, now it's time to dive deeper and find ways to make a difference in your clients' lives and in your community.

Felicity Skelton

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This book is for agent reference only. All links and references were in working order as of publication date. Medicare has neither reviewed nor endorsed the information in this publication. Insurance carriers referenced in this book have neither reviewed nor endorsed the information in this publication.

INTRODUCTION

As you explore this book, keep in mind each and every scenario has been tested from over 30 years of experience. Almost every subject has drawn inspiration from someone who needed the information to help those most in need in their unique communities.

If an agent is even somewhat successful at what they do, hundreds of people, if not thousands will depend on them. The statistics throughout this book are not merely numbers, but hard facts.

For example, out of 100 clients, if you know that statistically 1 in 2 men are diagnosed with cancer in their lifetime, you can estimate that about 50 of your clients, if not more, will be directly affected by cancer.

When clients choose to visit an insurance agent, they are often seeking out answers for questions they don't fully know how to ask. Questions like: How is this service covered? What will happen when I go to my doctor with my new plan? Or, what happens when I leave the hospital? As an agent, there's always the option to provide baseline answers, matching x to y and giving the same answer you gave someone a month ago.

Alternatively, you can choose to make a difference in the lives of your clients. You can go above and beyond your responsibility as a salesperson and take the role of advisor: sharing resources which can improve their quality of life during chemotherapy, anticipating the needs of caregivers when they come home from the hospital, or connecting them with a test to help catch a diagnosis early. You will never know what a difference you can make until you start choosing to make one.

If you're waiting to learn about an issue until you run across it in the field, you are missing a key component of growth: curiosity. For many, when they look up a piece of information, they find the answer and stop.

However, when you review a piece of information, let it spark further questions such as:

1. What other pages are linked to this page?
2. When did this resource get added?
3. Why did the person who built the website bring together this data?

4. Who is the target audience of this information?
5. What other resources can tell me more about this topic?

The difference is a genuine quest for understanding. The desire to learn for the sake of both personal and professional growth, and the ability to successfully apply your knowledge, if and when the situation arises.

Rest assured, the answers to your toughest Medicare questions will be there for you when you need them.

Imagine how you can use this information to help your clients just by applying your own education. Be ready to experience what a difference you can make in your community by simply connecting the right people with the right resources.

Dan Mangus
Senior Marketing Specialists

TOOLS FOR SENIORS

Annual Medicare Costs at a Glance

Includes:

- The standard Part B premium
- Part A deductible
- Co-payment for hospital stay days 61-90
- Co-payment for hospital stay days 91 and beyond
- Part A Premium
- Part A Deductible and Coinsurance

Medicare costs at a glance: https://www.medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-glance.html

- Part B Premium
- Part B Premium for Higher Income Beneficiaries
- Part B Deductible

Medicare part B costs outlined: https://www.medicare.gov/your-medicare-costs/part-b-costs/part-b-costs.html

- Part D Premiums

Part D premiums by income: https://www.medicare.gov/part-d/costs/premiums/drug-plan-premiums.html

Medicare Costs Sheet:

https://www.medicare.gov/Pubs/pdf/11579-Medicare-Costs.pdf

Annual Medicare and You Handbook

https://www.medicare.gov/medicare-and-you

Download Medicare & You Handbook in Different Formats

Download "Medicare & You" in different formats including PDF, large print PDF, eBook, audio, and Braille.

https://www.medicare.gov/forms-help-resources/medicare-you-handbook/download-medicare-you-in-different-formats

Choosing a Provider

In choosing a plan an individual often needs to choose a physician or a hospital from those within the network of a plan choice. Medicare.gov provides tools to help individuals compare their options of providers.

Hospital Compare:

https://www.medicare.gov/hospitalcompare/search.html

Physician Compare:

https://www.medicare.gov/physiciancompare/

Assignment:

Looking for physicians who accept assignment? If you would like to see only those accepting the Medicare-approved amount, select the "Additional search options" located just below the search button on physician compare.

When you are choosing a doctor, look for someone who:

- Treats you with respect
- Listens to your opinions and concerns
- Encourages you to ask questions
- Explains things in ways you can understand

Find more tips here on healthfinder.gov: https://healthfinder.gov/HealthTopics/Category/doctor-visits/regular-check-ups/choosing-a-doctor-quick-tips

Questions to ask your doctor: https://www.ahrq.gov/patients-consumers/patient-involvement/ask-your-doctor/index.html

Why is this important? Your clients need to choose a physician that fits their healthcare needs and one that accepts their benefit plan. This portion of your planning sets the stage for healthier and happier clients. It also avoids claims complications and added costs to your client.

Skilled Nursing Facility Care – Who's Eligible?

- Must be coded as a hospital inpatient for at least 3 consecutive days. (3 Midnights) (*Remember, any days you spend in a hospital as an outpatient - before you're formally admitted as an inpatient based on the doctor's order - aren't counted as inpatient days. An inpatient stay begins on the day you're formally admitted to a hospital with a doctor's order. That's your first inpatient day. The day of discharge doesn't count as an inpatient day.)*
- Must enter approved facility within 30 days after leaving hospital.
- Must be ordered by a physician.
- Must be for the same condition as the hospital confinement.
- Must be receiving skilled care on a daily basis.
- Must be showing signs of recovery.

Find out the details on Medicare.gov:

https://www.medicare.gov/coverage/skilled-nursing-facility-care.html

Medicare and Home Health Care

If you have Medicare, you can use your home health benefits if you meet all the following conditions:

1. You must be under the care of a doctor, and you must be getting services under a plan of care established and reviewed regularly by a doctor.
2. You must need, and a doctor must certify that you need, one or more of the following.
    - Intermittent skilled nursing care
    - Physical therapy
    - Speech-language pathology services
    - Continued occupational therapy
3. The home health agency caring for you must be approved by Medicare (Medicare-certified).

4. You must be homebound, and a doctor must certify that you're homebound. To be homebound means the following:
    - Leaving your home isn't recommended because of your condition.
    - Your condition keeps you from leaving home without help (such as using a wheelchair or walker, needing special transportation, or getting help from another person).
    - Leaving home takes a considerable and taxing effort. A person may leave home for medical treatment or short, infrequent absences for non-medical reasons, such as attending religious services. You can still get home health care if you attend adult day care, but you would get the home care services in your home.

Eligibility: If you meet the conditions above, Medicare pays for your covered home health services for as long as you're eligible and your doctor certifies you need them. If you need more than part-time or "intermittent" skilled nursing care, you aren't eligible for the home health benefit.

https://www.medicare.gov/coverage/home-health-services

This booklet provides an overview about eligibility, covered services, and how to find and compare home health agencies:

https://www.medicare.gov/sites/default/files/2018-07/10969-medicare-and-home-health-care.pdf

12 Yes/No Questions to Ask When Choosing a Home Health Agency

1. Medicare-certified?

2. Medicaid-certified (if you have both Medicare and Medicaid)?

3. Offers the specific health care services I need (like skilled nursing services or physical therapy)?

4. Meets my special needs (like language or cultural preferences)?

5. Offers the personal care services I need (like help bathing, dressing, and using the bathroom)?

6. Offers the support services I need, or can help me arrange for additional services, like Meals on Wheels, that I may need?

7. Has staff that can provide the type and hours of care my doctor ordered and start when I need them?

8. Is recommended by my hospital discharge planner, doctor, or social worker?

9. Has staff available at night and on weekends for emergencies?

10. Explained what my insurance will cover and what I must pay out-of-pocket?

11. Does background checks on all staff?

12. Has letters from satisfied patients, family members, and doctors that testify to the home health agency providing good care?

Visit Home Health Compare at:
www.medicare.gov/homehealthcompare for more information.

How Medicare covers Home Health services
https://www.medicare.gov/coverage/home-health-services.html

Why is this important? A quality home health care insurance protection plan is growing ever more important as part of a comprehensive benefit package. That means you will need to be prepared to help with questions about topics associated with home health care. As the number of older persons continues to grow along with their longevity, the need for long-term care will increase. Medicare and Medicaid spending on long term care is a significant federal budget concern and will be a focus for spending control.

How to Get a Replacement Medicare Card

- Use you're online "my Social Security" account. https://secure.ssa.gov/RIL/SiView.do

- Call 1-800-772-1213 (TTY 1-800-325-0778), Monday through Friday, from 7 a.m. to 7 p.m.
- Contact your local Social Security office.

New to Medicare? – 5 Things to Do

If you are working with prospects or clients new to Medicare get them started right.

Teach them the 5 things to do during their first year on Medicare:

- Fill out an Authorization Form
- Make a "Welcome to Medicare" Preventive Visit appointment
- Sign up for MyMedicare.gov
- Learn what Medicare covers
- Decide if you want to go paperless

https://www.medicare.gov/sign-up-change-plans/get-started-with-medicare/year-1-your-medicare-checklist

Find the Right Physician for Your Condition

If you need to find a physician but are not sure what kind of physician you need for your condition the Medicare physician compare tool will help you decide. Select a body part, Select the condition, choose from the specialty options and then enter your zip code. A list of physicians with their contact information will then be created. You can even narrow the list by selecting only physicians who accept assignment.

https://www.medicare.gov/physiciancompare/search.html

(After you go to the link click on the tab "Search another way")

Make Your Wishes Known - Planning Ahead Using Advance Directives

Everyone should have an advance directive in which you explain the type of health care you do or do not want when you can't make your own decisions.

A living will tells which treatment you want if your life is threatened, including:

- Dialysis and breathing machines
- Resuscitation if you stop breathing or if your heart stops
- Tube feeding
- Organ or tissue donation after you die

https://www.medicare.gov/manage-your-health/advance-directives/advance-directives-and-long-term-care.html

When planning for your future medical care, prepare your advance directives to be sure your loved ones make health choices according to your wishes. Just select your state from the drop-down menu on this site and download the free advance directive forms for you to use. You'll also find instructions on how to fill out the forms.

https://www.aarp.org/caregiving/financial-legal/free-printable-advance-directives/

Make Informed Care Choices - Advance Beneficiary Notice of Non-coverage

If you have Original Medicare and your doctor, other health care provider, or supplier thinks Medicare probably (or certainly) won't pay for items or services, they may give you a written notice called an "Advance Beneficiary Notice of Non-coverage" (ABN). However, an ABN isn't required for items or services that Medicare never covers. The ABN lists the items or services that Medicare isn't expected to pay for, an estimate of the costs for the items and services, and the reasons why Medicare may not pay.

https://www.medicare.gov/claims-appeals/your-medicare-rights/advance-beneficiary-notice-of-noncoverage

Identity Theft – Protect Your Clients

Identity theft is a serious and, unfortunately, common problem. Teach your clients how to protect themselves.

http://www.medicare.gov/forms-help-and-resources/identity-theft/identity-theft.html

Be familiar with how Medicare uses your personal information.

http://www.medicare.gov/forms-help-and-resources/privacy-practices/privacy.html

Seniors Can Avoid Online Scams

The Federal Trade Commission's free online security tips and resources can be found here: https://www.consumer.ftc.gov/features/feature-0038-onguardonline

Sign up for free scam alerts from the FTC at www.ftc.gov/scams. Get the latest tips and advice about scams sent right to your inbox.

Why is this important? Coverage getting canceled or changed due to an online scam can be difficult and time consuming to correct. Helping clients avoid this situation can assist both you and your clients.

Help Your Clients Preparing to Leave a Hospital, Nursing Home or Other Care Settings

This checklist helps your client and their caregiver make sure they have the information they need before discharge.

Medicare Publication: https://www.medicare.gov/Pubs/pdf/11376-discharge-planning-checklist.pdf

Fast Reference Site to Find Out if a Test, Item, or Service is Covered by Medicare

Medicare coverage for many tests, items, and services depends on where you live. This list only includes tests, items, and services that are covered no matter where you live. http://www.medicare.gov/coverage/is-your-test-item-or-service-covered.html

Hospital Compare on Medicare.gov

"Hospital Compare" is a consumer-oriented website that provides information on how well hospitals provide care to their patients. This information can help consumers make informed decisions about health care. "Hospital Compare" allows consumers to select multiple hospitals and directly compare performance measure information related to heart attack, heart failure, pneumonia, surgery, and other conditions. https://www.medicare.gov/hospitalcompare/search.html?

mymedicare.gov – Blue Button

"Blue Button" lets you easily access and download your personal health information as a file to your computer or mobile device.

You must be a registered user on mymedicare.gov to use this feature.

https://mymedicare.gov/

Get Medicare Information in Multiple Languages

Don't miss marketing opportunities. Be the source of assistance to all potential clients in your market.

https://www.medicare.gov/about-us/other-languages/information-in-other-languages.html

Find a Supplier on Medicare.gov

Enter your ZIP code to find suppliers of the following medical equipment and supplies:

- Durable Medical Equipment (DME)
- Prostheses & prosthetic devices
- Orthotics
- Supplies

http://www.medicare.gov/supplierdirectory/

Medicare Eligibility Tool

The "Eligibility & Premium Calculator" provides a quick estimate of a person's Medicare eligibility date and premium amount.
http://www.medicare.gov/eligibilitypremiumcalc

Tax Information for Seniors

The purpose of this publication is to provide a general overview of selected topics that are of interest to older taxpayers.

https://www.irs.gov/pub/irs-pdf/p554.pdf

Medicare Part A. If you are covered under social security (or if you are a government employee who paid Medicare tax), you are enrolled in Medicare Part A. The payroll tax paid for Medicare Part A isn't a medical expense. If you aren't covered under social security (or weren't a government employee who paid Medicare tax), you can enroll voluntarily in Medicare Part A. In this situation you can include the premiums you paid for Medicare Part A as a medical expense.

Medicare Part B. Medicare Part B is a supplemental medical insurance. Premiums you pay for Medicare Part B are a medical expense. Check the information you received from the Social Security Administration to find out your premium.

Social Security beneficiaries may quickly and easily obtain various information from SSA's website with a *my Social Security* account, including getting a replacement SSA-1099 or SSA-1042S.

The IRS tax code allow certain self-employed people to deduct the entire amount they pay in Medicare premiums from their self-employment income. This includes premiums paid for any parts of Medicare – A, B, C or D.

Department of the Treasury Internal Revenue Service Publication 502 Medical and Dental Expenses:

https://www.irs.gov/forms-pubs/about-publication-502

IRS - Tips for Seniors in Preparing their Taxes

"Taxable Amount of Social Security Benefits -When preparing your return, be especially careful when you calculate the taxable amount of your Social Security. Use the Social Security benefits worksheet found in the instructions for IRS Form 1040 and Form 1040A, and then double-check it before you fill out your tax return. See Publication 915, Social Security and Equivalent Railroad Retirement Benefits."

Source: *IRS - Tips for Seniors in Preparing their Taxes*

Tips Page: https://www.irs.gov/individuals/seniors-retirees/tips-for-seniors-in-preparing-their-taxes

AARP Member Advantage App

Download the AARP Member Advantages App to get access to AARP member offers, discounts, and coupons. Make sure you don't miss out on discounts for travel, dining, entertainment and more!

http://advantages.aarp.org/en/about-us/member-advantages-app.html

Medicare Made Clear SmartOrganizer

Medicare Made Clear offers a fantastic free organizer!
The SmartOrganizer helps you keep track of your health, your home, your money and more. The SmartOrganizer has one goal – to help you have more time to do the things you enjoy. It's a tool to help you:

- Keep important documents where they can be easily found
- Record vital health and personal information
- Keep track of medical bills and payments
- Manage your medications and preventive health screenings

It's As Easy As 1-2-3

1. Choose the design for your SmartOrganizer.
2. Decide which format you want: 3-ring binder (vertical) or hanging file (horizontal).
3. Download and print. Assembly instructions are included.

https://www.medicaremadeclear.com/information/medicare-smart-organizer

Using Longtermcare.gov

Detailed long-term care information and data is available from the U.S. Department of Health and Human Services on the site longtermcare.gov.

Video on Medicare and long-term care:

http://longtermcare.gov/medicare-medicaid-more/

Great for sharing with clients or staff training.

State specific costs of long-term care:

https://www.genworth.com/aging-and-you/finances/cost-of-care.html

This is data that can assist you and your clients determine the amount of coverage needed.

The Eldercare Locator

The Eldercare Locator, a public service of the Administration on Aging, U.S. Department of Health and Human Services, is a nationwide service that connects older Americans and their caregivers with information on senior services. https://eldercare.acl.gov/Public/Index.aspx

MyMoney.gov

This site organizes financial literacy research and data sets from over 20 different Federal agencies in one place. All site content was either published or sponsored by the Federal government, including the Federal Reserve Board and Banks. The electronic catalog is organized by the MyMoney 5: Earning, Borrowing, Saving & Investing, Spending, and Protecting.

The Clearinghouse is intended to promote research, policy and practice in the field of financial education and related fields by making it easy to find existing federal government-supported research and data.

Example: Learn more about employer-provided and personal retirement savings plans and options, and other ways to build a more secure retirement.

http://www.mymoney.gov/Fast/Pages/Results.aspx?k=Retirement%20OR%20Retiring&r=lifeevent

1-800-MEDICARE (1-800-633-4227)

For specific billing questions and questions about your claims, medical records, or expenses, login to MyMedicare.gov, or call 1-800-MEDICARE. If you want someone to be able to call 1-800-MEDICARE on your behalf or you want Medicare to give your personal information to someone other than you, you need to fill out a "Medicare Authorization to Disclose Personal Health Information." This is the location of the form needed:

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS10106.pdf

How to Choose a Medicare Plan

Step 1.) When you first become eligible for Medicare at age 65, ask yourself:

- Am I in good health?
- How often do I see the doctor?
- Do I take prescription drugs?
- How much can I afford each month?
- Am I willing to switch doctors if it means lower costs?

Step 2.) Apply for Original Medicare and see if you qualify for extra help paying for your medical or drug plan costs. Your local Social Security office can help.

Step 3.) Review the plans available in your area — what they cover and what they cost.

- Original Medicare covers some of your hospital and medical costs but doesn't include prescription drug coverage.
- You can add Medicare Part D for prescription drug coverage
- You can add Medigap, or Medicare supplement plans, to help cover some of the costs not paid by Original Medicare.
- Or you can enroll in a Medicare Advantage plan, which includes the coverage of Parts A and B, as well as extra benefits like hearing and vision services, gym memberships and prescription drug coverage.

Step 4.) Select a plan. Remember to review your coverage each year and make sure it still meets your needs. You can choose a new Part C or Part D plan every year during the Open Enrollment Period (OEP) from October 15 to December 7 if your needs change.

To see the full video on this topic, visit:

https://www.medicaremadeclear.com/information/medicare-videos

Source: Medicare Made Clear - Learning the basics of Medicare.

https://www.medicaremadeclear.com/basics

Keep Your Heart Healthy – Know What Your Cholesterol Levels Mean

American Heart Association Information

Total blood (or serum) cholesterol Your total cholesterol score is calculated using the following equation:

HDL + LDL + 20 percent of your triglyceride level.

HDL (good) cholesterol With HDL cholesterol, higher levels are better. Low HDL cholesterol puts you at higher risk for heart disease. People with high blood triglycerides usually also have lower HDL cholesterol. Genetic factors, type 2 diabetes, smoking, being overweight and being sedentary can all result in lower HDL cholesterol.

LDL (bad) cholesterol A low LDL cholesterol level is considered good for your heart health. However, your LDL number should no longer be the main factor in guiding treatment to prevent heart attack and stroke, according to new guidelines from the American Heart Association. For patients taking statins, the guidelines say they no longer need to get LDL cholesterol levels down to a specific target number. A diet high in saturated and trans fats raises LDL cholesterol.

Triglycerides Triglyceride is the most common type of fat in the body. Normal triglyceride levels vary by age and sex. A high triglyceride level combined with low HDL cholesterol or high LDL cholesterol is associated with atherosclerosis, the buildup of fatty deposits in artery walls that increases the risk for heart attack and stroke. More information:

http://www.heart.org/HEARTORG/Conditions/Cholesterol/AboutCholesterol/What-Your-Cholesterol-Levels-Mean_UCM_305562_Article.jsp#.WHMJjbkzWM

Why is this Important? Medicare Part B (Medical Insurance) covers screening blood tests for cholesterol, lipid, and triglyceride levels every 5 years, when ordered by a doctor. These screening tests help detect conditions that may lead to a heart attack or stroke.

No Cost Yearly Wellness Visit

If you've had Part B for longer than 12 months, you can get this visit to develop or update a personalized prevention help plan.

This plan is designed to help prevent disease and disability based on your current health and risk factors. Your provider will ask you to fill out a questionnaire, called a "Health Risk Assessment," as part of this visit. Answering these questions can help you and your provider develop a personalized prevention plan to help you stay healthy and get the most out of your visit.

It can also include:

- A review of your medical and family history
- Developing or updating a list of current providers and prescriptions
- Height, weight, blood pressure, and other routine measurements
- Detection of any cognitive impairment
- Personalized health advice
- A list of risk factors and treatment options for you
- A screening schedule (like a checklist) for appropriate preventive services. Get details about coverage for screenings, shots, and other preventive services.
- Advance Care Planning

This visit is covered once every 12 months (11 full months must have passed since the last visit).

Find out more details here:
https://www.medicare.gov/coverage/preventive-visit-and-yearly-wellness-exams.html

Why is this important? Helping your clients stay healthy and get the most benefit from the Medicare program is a key part of being an effective advisor.

Mutual of Omaha - My Wishes Record Keeper

The My Wishes Record Keeper is designed to keep all your client's important contact information, documentation and end of life decisions in one place. It's a great piece to provide your Living Promise clients with so they can get their affairs in order for their loved ones.

The booklet can also be customized with your contact information on the back page.

Form Number: UC8164_0714

http://blogs.mutualofomaha.com/express/files/2017/02/My-Wishes-Record-Keeper.pdf

Why is this important? Gathering this information in advance will make situations much easier during a difficult time. Your clients and their families will appreciate you providing this valuable planning tool.

Find Out When You're Eligible for Medicare

Use this handy Medicare tool to work through a series of questions to determine eligibility and costs.

https://www.medicare.gov/eligibilitypremiumcalc/

Why is this important? Many situations like death and divorce arise that make determining the cost and eligibility of Medicare part A and B difficult. This tool will allow you, as an agent, to answer these complex questions.

AARP On-Line Tools

AARP provides many tools that you and your clients can utilize. The following list shows just how comprehensive they are.

Health Tools

Drug Interaction Checker
Pill Identifier Tool

Health Encyclopedia Tool
Symptom Checker Tool
Drug Lookup Tool
Medicare Summary Notice Decoder

Money Tools

AARP Benefits QuickLINK
Credit Card Payoff Calculator
Retirement Calculator
Health Care Costs Calculator

Home & Family Tools

Caregiving Resource Center
Caregiving Question and Answer Tool
Long Term Care Cost Calculator
Caregiving Resource Center – State-by-State Guide
State-by-State Advance Directives

Work & Retirement

Retirement Calculator
Social Security Benefits Calculator
Health Care Costs Calculator
Social Security QA Tool

These and many more tools are available here:
http://www.aarp.org/tools/?intcmp=FTR-LINKS-top-TOOLS

Why this is important? Your ability to offer products that are endorsed by the AARP brand is a huge privilege and should be one of the most valued assets you have in your insurance business. Learn how to make the most of association benefits.

Reminder: Free membership is available to UHC agents of all ages. To learn more about AARP Membership and sign up, visit:
https://www.myaarpconnection.com/

Fact Sheets Full of Information about Deciding on When to Enroll Into Medicare

CMS Fact Sheet: Deciding Whether to Enroll in Medicare Part A and Part B When You Turn 65

This fact sheet will help you:

1. Determine your Initial Enrollment Period
2. Decide whether to enroll in Medicare Part A and Part B when you turn 65
3. Find out how to sign up for Medicare Part A and Part B (or opt out of Part B)

https://www.cms.gov/Outreach-and-Education/Find-Your-Provider-Type/Employers-and-Unions/FS3-Enroll-in-Part-A-and-B.pdf

CMS Fact Sheet: Medicare Decisions for Those Over 65 and Planning to Retire in the Next 6 Months

This fact sheet will help you:

1. Decide whether to enroll in Medicare Part A and Part B when you retire (if you haven't already)
2. Decide whether you need additional coverage (Medicare Advantage, Medigap)
3. Decide whether you need Medicare prescription drug coverage (Part D)

https://www.cms.gov/Outreach-and-Education/Find-Your-Provider-Type/Employers-and-Unions/FS4-Medicare-for-people-over-65-nearing-retirment.pdf

Interactive Decision Tool: Should I Enroll in Medicare?

This roadmap tool will help you advise individuals as to when to enroll into Medicare Part B.

https://www.medicareinteractive.org/resources/roadmaps/should-i-enroll-in-part-b

Why this is important? Deciding on enrollment into Medicare can be complicated by group coverage, VA benefits, Cobra, Tricare, etc. These fact sheets help you navigate through the maze.

Filing a Medicare Claim

Medicare claims must be filed no later than 12 months (or 1 full calendar year) after the date when the services were provided. If a claim isn't filed within this time limit, Medicare can't pay its share.

Fill out the claim form, called the Patient Request for Medical Payment form: https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS012949

Follow the instructions for the type of claim you're filing.

Find instructions here: https://www.medicare.gov/claims-and-appeals/file-a-claim/file-a-claim.html

Why is this important? Although it is rare to have to file your own claim you need to be prepared to assist your client if the occasion occurs. Future changes in Medicare numbers could increase the likelihood you will run into this type of situation.

Retirement May Be Longer Than You Think

The age you start receiving Social Security benefits can make a significant difference in your monthly benefit amount. You may need your monthly income for a long time, because more people are living longer. For example:

- The typical 65-year-old today will live to age 85
- More than one in three 65-year-olds will live to age 90
- More than one in seven 65-year-olds will live to age 95

For more information on life expectancy, go to:
https://www.ssa.gov/planners/lifeexpectancy.html

Why is this important? Helping your clients with their long-term planning after retirement requires looking beyond their current health and wealth status. Insurance, by nature, is designed to plan for the potential of loss or unexpected circumstances. It is more important than ever to be certain you are building comprehensive benefit packages.

Getting a Second Opinion Before Surgery

If your doctor says you need surgery to diagnose or treat a health problem that isn't an emergency, you should consider getting a second opinion. Medicare Part B helps pay for a second (or third) opinion and related tests just as it helps pay for other services that are medically necessary. "Getting a Second Opinion before Surgery":

https://www.medicare.gov/Pubs/pdf/02173-Getting-a-Second-Opinion-Before-Surgery.pdf

Why is this important? Avoiding the added medical complications and expenses from unnecessary surgery can help your clients stay healthier and happier. Helping clients in this way builds loyalty and trust.

Publication – Your Medicines and You: A Guide for Older Adults

The more you know about your medicines and the more you talk with your health care professionals, the easier it is to avoid problems with medicines. This helpful guide provided by The Council on Family Health Provided in cooperation with U.S. Department of Health and Human Services Food and Drug Administration and the Administration on Aging can help your clients make wise choices about their prescription medications.

https://www.fda.gov/drugs/resources-you-drugs/medicines-and-you-guide-older-adults

Why is this important? Medications account for much of the out of pocket medical expenses your clients have to pay. Giving them publications such as this gives them the tools for better decision making.

COMMON MEDICARE QUESTIONS

What Is the Minimum Essential Coverage Notice from Medicare?

This notice accompanies IRS Form 1095-B. You're getting Form 1095-B because you had Medicare Part A (Hospital Insurance) coverage for all or part of this tax year. The Affordable Care Act requires people to have health coverage that meets certain standards called minimum essential coverage.

Q.) When should I get it?

A.) Annually, mid-December through January

Medicare Information: https://www.medicare.gov/forms-help-resources/mail-you-get-about-medicare/qualifying-health-coverage-notice-irs-form-1095-b

IRS Information: https://www.irs.gov/uac/about-form-1095-b

Why is this important? Many clients are confused about the involvement of ACA with Medicare. As their Medicare advisor, you need to be aware of documents like these when your client asks about them.

Changing from a Marketplace plan to Medicare

https://www.healthcare.gov/medicare/changing-from-marketplace-to-medicare/

How Do I Appeal Part B Premium Income Related Monthly Adjustment Amounts?

From the Social Security Administration publication, What You Can Do if You Think Your Medicare Income-Related Premium is Incorrect:

"If you're a Medicare beneficiary who must pay more for your Medicare Part B or Medicare prescription drug coverage premium because of your income, and you disagree with the decision that you need to pay a higher premium amount, you may request an appeal. ***The fastest and easiest way to file an appeal of your decision is by visiting www.socialsecurity.gov/disability/appeal. You can file online and provide documents electronically to support your***

***appeal**. You can file an appeal online even if you live outside of the United States. You may also request an appeal in writing by completing a Request for Reconsideration (Form SSA-561-U2) that you can find on our website. If you don't have access to the internet, you can request a copy of the form by calling us at 1-800-772-1213 (TTY 1-800-325-0778). If your income has gone down, however, due to certain specific circumstances, or if you filed an amended tax return, you can ask for a new decision without having to file an appeal. See our fact sheet, Medicare Premiums: Rules for Higher-Income Beneficiaries (SSA Publication No. 05-10536) for more details. You don't have to file an appeal to get a new decision."*

Source: https://www.ssa.gov/pubs/EN-05-10125.pdf

Office of Medicare Hearings and Appeals:

Office of Medicare Hearings and Appeals (OMHA) handles appeals of the Medicare program's determination of a beneficiary's Income Related Monthly Adjustment Amount (IRMAA), which determines a Medicare beneficiary's total monthly Part B insurance premium.

Below are the situations which may qualify a beneficiary for a new Part B determination

- Tax return inaccurate or out of date
- A beneficiary filed an amended tax return for the year SSA is using to make an IRMAA decision
- There was an error in the IRS data
- The IRS provided SSA with older data and the beneficiary wants to use newer information
- You had a major life-changing event that significantly reduced your income

Life-changing event that affects the beneficiary's modified adjusted gross income. There are 7 qualifying life-changing events.

- Death of spouse
- Marriage
- Divorce or annulment
- Work reduction
- Work stoppage
- Loss of income from income producing property
- Loss or reduction of certain kinds of pension income

Appeals Process Outlined

http://www.hhs.gov/omha/Part%20B%20Premium%20Appeals/partb_appeals.html

You may request an appeal in writing by completing a Request for Reconsideration (Form SSA-561-U2), or you may contact your local Social Security office to file your appeal.
https://www.ssa.gov/forms/ssa-561.html

How Part B Premiums are Determined

https://www.medicare.gov/your-medicare-costs/part-b-costs/part-b-costs.html

This publication explains which beneficiaries may be affected.

https://www.ssa.gov/pubs/EN-05-10507.pdf

Initial IRMAA Determination Notices

The income-related monthly adjustment amount (IRMAA) sliding scale is a set of statutory percentage-based tables to adjust Medicare Part B and prescription drug coverage premiums. The higher the beneficiary's range of modified adjusted gross income (MAGI), the higher the IRMAA will be. https://secure.ssa.gov/poms.nsf/lnx/060110105

The MAGI used to determine if the income-related monthly adjustment amount (IRMAA) applies is the most recent tax information that IRS is able to provide. Generally, the information is from two years prior to the year for which the premium is being determined. Details are here: https://secure.ssa.gov/poms.nsf/lnx/0601101010#b

Why is this important? Helping higher income clients appeal increased Medicare premiums, if necessary, can generate referrals and build a potential networking opportunity with financial advisors in your community.

How Often Does Medicare Cover Mammograms?

Medicare Part B (Medical Insurance) covers a:

- Screening mammogram once every 12 months (11 full months must have passed since the last screening). You pay nothing for the screening test if the doctor or other qualified health care provider accepts assignment
- Diagnostic mammogram when medically necessary. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

https://www.medicare.gov/coverage/mammograms.html

How Does Medicare Protect Me When I Travel Outside The United States?

In general, health care you get while traveling outside the U.S. isn't covered by Medicare. The 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa are considered part of the U.S.

However, Medigap Plans C, D, E, F, G, H, I, J, M, and N pay 80% of the billed charges for certain medically necessary emergency care outside the U.S. after you meet a $250 deductible for the year. These Medigap policies cover foreign travel emergency care if it begins during the first 60 days of your trip, and if Medicare doesn't otherwise cover the care. Foreign travel emergency coverage with Medigap policies has a lifetime limit of $50,000.

https://www.medicare.gov/supplement-other-insurance/medigap-and-travel/medigap-and-travel.html

https://www.medicare.gov/coverage/travel-need-health-care-outside-us.html

Foreign Travel

There are three situations when Medicare may pay for certain types of health care services you get in a foreign hospital (a hospital outside the U.S.)

1. You're in the U.S. when you have a medical emergency, and the foreign hospital is closer than the nearest U.S. hospital that can treat your illness or injury.
2. You're traveling through Canada without unreasonable delay by the most direct route between Alaska and another state when a medical emergency occurs, and the Canadian hospital is closer than the nearest U.S. hospital that can treat your illness or injury. Medicare determines what qualifies as "without unreasonable delay" on a case-by-case basis.
3. You live in the U.S. and the foreign hospital is closer to your home than the nearest U.S. hospital that can treat your medical condition, regardless of whether it's an emergency. Remember, in these situations, Medicare will pay only for the Medicare-covered services you get in a foreign hospital.

To file a claim use form CMS 1490S

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS012949.html

Sources:

Medicare Publication 11037: *Medicare Coverage Outside the United States*

https://www.medicare.gov/Pubs/pdf/11037-Medicare-Coverage-Outside-United-Stat.pdf?

Choosing a Medigap Policy Publication 02110

https://www.medicare.gov/Pubs/pdf/02110-Medicare-Medigap-guide.pdf

Medicare If You Live Abroad

If you are 65 or older and qualify for Medicare, you can enroll in Medicare Parts A and B either before or after you leave the U.S. Medicare will typically not cover medical care you receive outside the U.S. If you do not qualify for premium-free Part A, you may only be able to enroll in Medicare if you live in the U.S. You may want to keep Part B if you plan to move back to the U.S. in the future or visit frequently. This will ensure that Medicare will cover your care whenever you travel to the U.S., and that you will not face premium penalties or gaps in coverage.

https://www.ssa.gov/benefits/medicare/

For more advice you can contact the US Federal Benefits Unit serving the country where you reside.

https://www.ssa.gov/foreign/foreign.htm

Source:

https://www.medicare.gov/Pubs/pdf/11871-Welcome-to-Medicare-package-outside-United-States.pdf

What is "Assignment"?

Assignment means that your doctor, provider, or supplier agrees (or is required by law) to accept the Medicare-approved amount as full payment for covered services.

https://www.medicare.gov/your-medicare-costs/part-a-costs/assignment/costs-and-assignment.html

If your provider does not accept assignment, they can charge you more than the Medicare-approved amount, but there's a limit called "the limiting charge." The provider can only charge you up to 15% over the amount that non-participating providers are paid. Non-participating providers are paid 95% of the fee schedule amount.

Why many physicians choose to accept assignment: (1) revenue that is primarily received directly from the Medicare program may be more dependable than collections from individual patients, and (2) some patients may be attracted to participating physicians as a way to reduce medical expenses.

Why some physicians choose not to accept assignment: (1) the opportunity to bill patients somewhat more than the amount paid by Medicare for items and services not subject to mandatory assignment; and (2) depending on the patient population, collection may be faster from individual patients than from Medicare.

How Does Medicare Work in a Small Employer Group?

If your employer has fewer than 20 employees, Medicare generally pays first.

However, if your employer joins with other employers or employee organizations (like unions) to sponsor a group health plan (called a multi-employer plan), and any of the other employers have 20 or more employees, Medicare would generally pay second. Your plan might also ask for an exception, so even if your employer has fewer than 20 employees, you'll need to find out from your employer whether Medicare pays first or second.

https://www.medicare.gov/supplements-other-insurance/how-medicare-works-with-other-insurance/which-insurance-pays-first

Where Can I Learn About the Mail I Get About Medicare?

View samples of and see overviews of mail sent from Medicare to Medicare beneficiaries.

http://www.medicare.gov/forms-help-and-resources/mail-about-medicare/mail-about-medicare.html

This guide will show you what pieces CMS mails, when they mail them and what action an individual should take regarding it. It also has links to important information regarding the notices.

https://www.cms.gov/Medicare/Prescription-Drug-Coverage/LimitedIncomeandResources/Downloads/Consumer-Mailings.pdf

Does Medicare Cover Durable Medical Equipment?

Medicare Part B (Medical Insurance) covers durable medical equipment (DME) that your doctor prescribes for use in your home. Only you doctor can prescribe medical equipment for you. DME meets these criteria:

- Durable (long-lasting)
- Used for a medical reason

- Not usually useful to someone who isn't sick or injured
- Used in your home

A complete list of DME that Medicare covers is available on Medicare.gov:

http://medicare.gov/coverage/durable-medical-equipment-coverage.html

Can Individuals Who Have Medicare Enroll in Individual Market Coverage, Such as Coverage Offered Through the Individual Marketplace?

No. Consistent with the longstanding prohibitions on the sale and issuance of duplicate coverage to Medicare beneficiaries (section 1882(d) of the Social Security Act), it is illegal to knowingly sell or issue an Individual Marketplace Qualified Health Plan (or an individual market policy outside the Marketplace) to a Medicare beneficiary.

Get answers to more questions about Medicare and Marketplace plans in the publication located here:

https://www.cms.gov/Medicare/Eligibility-and-Enrollment/Medicare-and-the-Marketplace/Overview1

Source: https://www.cms.gov/Medicare/Eligibility-and-Enrollment/Medicare-and-the-Marketplace/Overview1.html

Changing from the Marketplace to Medicare

Usually if you qualify for Medicare and have a qualified health plan (QHP) you should disenroll from your QHP. However, if you qualify for Medicare because of ESRD or you are not qualified for premium free Medicare Part A you should consider coverage and cost comparisons when making your decision.

Once you have Medicare you can keep your QHP plan, but it is illegal for someone to sell you a QHP if they know you have Medicare. Once your Medicare Part A coverage starts, you'll no longer be eligible for any premium tax credits or other cost savings you may be getting for your QHP. There is no guarantee that a QHP will pay for your care if you have or are eligible for other insurance so you may have little or no coverage.

IRS - Questions and Answers on the Premium Tax Credit

https://www.irs.gov/affordable-care-act/individuals-and-families/questions-and-answers-on-the-premium-tax-credit

Information on Healthcare.gov

https://www.healthcare.gov/medicare/changing-from-marketplace-to-medicare/

The transition from a marketplace plan to Medicare can be confusing. Many questions can be answered through this advanced training module from medicarerights.org

https://www.medicarerights.org/pdf/medicare-and-marketplaces-toolkit.pdf

Why is this important? The choices available to an individual can be confusing and moving from a QHP to Medicare requires careful consideration to coverage, premiums and dates.

What is the Annual Notices of Change (ANOC) and Evidence of Coverage (EOC)?

ANOC - If you're in a Medicare plan, your plan will send you a "Plan Annual Notice of Change" (ANOC) in September. The ANOC includes any changes in coverage, costs, or service area that will be effective in January.

https://www.medicare.gov/forms-help-resources/mail-you-get-about-medicare/plan-annual-notice-of-change-anoc

EOC - If you're in a Medicare plan, your plan will send you an "Evidence of Coverage" (EOC) each year, usually in the fall. The EOC gives you details about what the plan covers, how much you pay, and more.

https://www.medicare.gov/forms-help-resources/mail-you-get-about-medicare/evidence-of-coverage-eoc

Are You a Hospital Inpatient or Outpatient?

You're an **inpatient** starting when you're formally admitted to a hospital with a doctor's order. The day **before** you're discharged is your last inpatient day.

You're an **outpatient** if you're getting emergency department services, observation services, outpatient surgery, lab tests, X-rays, or any other hospital services, and the doctor **hasn't** written an order to admit you to a hospital as an inpatient. In these cases, you're an outpatient even if you spend the night at the hospital.

https://www.medicare.gov/Pubs/pdf/11435-Are-You-an-Inpatient-or-Outpatient.pdf

Why Are We Seeing More Observation Care Stays?

Medicare contracts with private companies as recovery audit contractors (RACs). RACs audit a lot more than whether a patient's stay is observational or an admission. Their incomes are linked to how much money their audits can recover and the observational-admission revenue differential has been seen as attractive for recovery efforts. To avoid these potentially costly RAC audits, hospitals and doctors began classifying more and more hospital visits as observational.

https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/

Does Medicare Cover a Flu Shot?

Anyone can get the flu (even healthy people), and serious problems related to the flu can happen at any age, but some people are at high risk of developing serious flu-related complications if they get sick. This includes people 65 years and older, people of any age with certain chronic medical conditions (such as asthma, diabetes, or heart disease), pregnant women, and young children.

Flu Facts: http://www.cdc.gov/flu/keyfacts.htm

Medicare and Flu shot - How often is it covered?

Medicare Part B (Medical Insurance) normally covers one flu shot per flu season.

Who is eligible?

All people with Part B are covered.

Your costs in Original Medicare

You pay nothing for a flu shot if the doctor or other qualified health care provider accepts assignment for giving the shot.

Visit the CDC site for more information on the influenza season:

https://www.cdc.gov/flu/index.htm

Encourage your clients to use all the benefits of Medicare at their disposal to keep healthy!

When Is the Cost of Living Adjustment Announced Each Year?

Social Security announces the upcoming year's Cost of Living Adjustment in mid-October. COLA is based on the inflation rate during the third quarter of the year compared to the last year. Since the COLA impacts Medicare premiums, it is important to watch. This is a link to the Social Security site the announcement will be posted to:

https://www.ssa.gov/news/press/releases/

Part B premium explained on Medicare.gov:

https://www.medicare.gov/your-medicare-costs/part-b-costs/part-b-costs.html

How Does Medicare Work With HSA Funds?

By law, people with Medicare are not allowed to put money into an HSA. This is because you generally cannot have any health coverage other than an HDHP if you are putting money into an HSA. However, you may withdraw money from your HSA after you enroll in Medicare to help pay for medical expenses (deductibles, premiums*, copays or coinsurances). If you use the account for qualified medical expenses, it will continue to be tax-free.

http://www.medicareinteractive.org/get-answers/types-of-medicare-advantage-plans-hmos-ppos-and-more/health-savings-accounts-hsas-and-medicare/health-savings-accounts-hsas-and-medicare

**Note: Medigap premiums are not eligible.*

https://www.irs.gov/forms-pubs/about-publication-969

Some employees may want to have premium-free Part A start when they stop working; however, premium-free Part A coverage begins 6 months back from the time the person enrolls (but no earlier than the first month of eligibility). People must stop contributing to their HSA 6 months before applying for Medicare in order to not be penalized by the IRS.

https://www.medicare.gov/Pubs/pdf/11036-Enrolling-Medicare-Part-A-Part-B.pdf

What is a Single Payer System?

A single payer refers to a system in which one entity (usually the government) pays all the medical bills for a specific population. And usually that entity sets the prices for medical procedures.

A single-payer system is not the same thing as socialized medicine. In a truly socialized medicine system, the government not only pays the bills

but also owns the health care facilities and employs the professionals who work there.

What Are Some of the Items and Services that Medicare Doesn't Cover?

- Long Term Care (Custodial Care)
- Eye exams related to prescribing glasses
- Cosmetic surgery
- Hearing Aids and Exam for fitting them
- Most Dental Care
- Dentures
- Acupuncture
- Routine foot Care

Group Health Plan Question - When to Apply for Part B?

When you sign up for Medicare, you will be asked if you want to enroll in Medical Insurance (Part B).

If you do not choose to enroll in Medicare Part B and then decide to do so later, your coverage may be delayed and you may have to pay a higher monthly premium unless you qualify for a "Special Enrollment Period."

This site will help get your questions clarified:

http://www.socialsecurity.gov/hlp/isba/10/hlp-isba080-grphlth.htm

Note: Group health plans of employers with 20 or more employees are required by law to offer workers and their spouses who are age 65 (or older) the same health benefits that are provided to younger employees.

When Should I Delay Part B Enrollment?

It's critical that employees and their dependents consider whether Part B is right for them when they're first eligible for Medicare. Decisions about Part B enrollment for people with employer–based insurance first depend on whether a person has insurance based on current employment.

Generally, if an individual (or their spouse) is still working and has employer-sponsored Group Health Plan coverage based on that employment, they can delay enrollment into Part B and can enroll later during a SEP. But there are special rules that they need to know. For example, employer coverage for retirees or through COBRA doesn't count as current employment, so these individuals don't qualify for a SEP to enroll in Medicare later. A different set of rules apply if the person has Medicare based on disability or ESRD.

https://www.cms.gov/Outreach-and-Education/Find-Your-Provider-Type/Employers-and-Unions/Top-5-things-you-need-to-know-about-Medicare-Enrollment.html

Enrolling in Medicare Part A & Part B Publication

https://www.medicare.gov/Pubs/pdf/11036-Enrolling-Medicare-Part-A-Part-B.pdf

Delayed Part B Enrollment Due to Employer Coverage

You can sign up for Part B without a penalty any time you have health coverage based on current employment. (COBRA and retiree health coverage don't count as current employer coverage.) When your employer coverage ends, you'll get a chance to enroll in Part B without a late enrollment penalty. That means your Medigap open enrollment period will start when you're ready to take advantage of it. If you enrolled in Part B while you still had the employer coverage, your Medigap open enrollment period would start. Unless you bought a Medigap policy before you needed it, you'd miss your open enrollment period entirely. https://www.medicare.gov/supplement-other-insurance/when-can-i-buy-medigap/when-can-i-buy-medigap.html

Note: Guarantee Issue rules may need to be considered:

- *Medigap: https://www.medicare.gov/supplements-other-insurance/when-can-i-buy-medigap*
- *Medicare Part C: https://www.medicare.gov/Pubs/pdf/11219-Understanding-Medicare-Part-C-D.pdf*

Once your employment (or your employer/union coverage) ends you have 8 months to sign up for Part B without a penalty, whether or not you choose COBRA. To sign up for Part B while you're employed or during the 8 months after employment ends, complete:

> Application for Enrollment in Part B (CMS-40B) Found here: https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS017339.html
>
> and a Request for Employment Information (CMS-L564) Found here: https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS009718.html

If you choose COBRA, don't wait until your COBRA ends to enroll in Part B. If you don't enroll in Part B during the 8 months after the employment ends you may have to pay a penalty for as long as you have Part B. You also won't be able to enroll until January 1–March 31, and you'll have to wait until July 1 of that year before your coverage begins. This may cause a gap in health care coverage. https://www.medicare.gov/sign-up-change-plans/get-parts-a-and-b/should-you-get-part-b/should-i-get-part-b.html

Why is this important? Deciding when to elect Part B is critical for individuals using Medicare. Since Cobra often lasts for 18 months the need for electing Medicare part B within 8 months can be confusing to your clients.

When and How Do I Use the Application for Enrollment in Medicare Part B?

When to use this application:

- If you're in your IEP and refused Part B or did not sign up when you applied for Medicare, but now want Part B.
- If you want to sign up for Part B during the General Enrollment Period (GEP) from January 1 – March 31 each year.
- If you refused Part B during your IEP because you had group health plan (GHP) coverage through your or your spouse's current employment. You may sign up during your 8-month Special Enrollment Period (SEP).
- If you have Medicare due to disability and refused Part B during your IEP because you had group health plan coverage through your, your spouse, or family member's current employment.
- You may sign up during your 8-month SEP.

Note: Your IEP lasts for 7 months. It begins 3 months before your 65th birthday (or 25th month of disability) and ends 3 months after you reach 65 (or 3 months after the 25th month of disability).

http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS40B-E.pdf

How Do I Understand a Part B "Medicare Summary Notice"?

Your Medicare Part B MSN shows all of the services billed by Medicare for doctors' services, hospital outpatient care, home health care, preventive services, and other medical services. You'll get your MSN every 3 months if you get any services or medical supplies during that 3-month period. If you don't get any services or medical supplies during that 3-month period, you won't get an MSN for that particular 3-month period.

Detailed outline of the MSN:
https://www.medicare.gov/pubs/pdf/SummaryNoticeB.pdf

Why is this important? Your clients need to be aware of charges that are billed to Medicare to be sure they received all the services, supplies, or equipment listed. As an agent you need to be familiar with this document in case your clients have questions about them.

What Is A Limiting Charge?

In Original Medicare, the highest amount of money you can be charged for a covered service by doctors and other health care suppliers who don't accept assignment is called a limiting charge. The limiting charge is 15% over Medicare's approved amount. The limiting charge only applies to certain services and doesn't apply to supplies or equipment.

Information on Medicare assignment:
https://www.medicare.gov/your-medicare-costs/part-a-costs/assignment/costs-and-assignment.html

Why is this important? Only Medigap plan options F and G offer coverage for Part B excess charges. Helping your clients understand limiting charges and to find providers who accept assignment can be a key to customer satisfaction with your plan recommendations.

Can I get Medicare if I am not a U.S. citizen?

If you are not a U.S. citizen, you might be able to get Medicare. It depends on the circumstances.

- You will qualify for Medicare even if you are not a US citizen if you qualify to receive or receive Social Security, Railroad retirement or disability benefits. In this case, you will qualify for Part A without needing to pay a premium. You will need to pay a premium for Part B.
- If you do not qualify for Social Security, railroad retirement benefits or disability benefits, you can qualify to buy Part A (and Part B) if you are a current US resident and either
    - A US citizen or
    - A permanent US resident having lived in the US for 5 continuous years before you apply for Medicare

https://www.medicareinteractive.org/get-answers/introduction-to-medicare/medicare-eligibility/can-i-get-medicare-if-i-am-not-a-u-s-citizen

Tool to determine your eligibility:
https://www.medicare.gov/eligibilitypremiumcalc/

Why is this important? Questions about immigrants are a primary subject in main stream media. As advisors to senior clients you need to be familiar with this topic.

Is Medicare Different for State/Local Government Employees and Retirees?

State and local government employees hired before April 1, 1986 were exempt from paying the Federal Insurance Contributions Tax (FICA), and therefore not subject to mandatory Medicare coverage. Find out how counseling these new-to-Medicare beneficiaries differs from counseling those who come from the private sector in this helpful document: https://www.ncoa.org/resources/medicare-for-state-employees-and-retirees/

Why is this important? You may come across people who currently work for or have retired from a state or local government job and you will need to offer educated advice.

How Did Medicare ID Numbers Change In 2018?

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, required CMS to remove Social Security Numbers (SSNs) from all Medicare cards by April 2019. A new Medicare Beneficiary Identifier (MBI) replaced the SSN-based Health Insurance Claim Number (HICN) on the new Medicare cards for Medicare transactions like billing, eligibility status, and claim status.

What's the Social Security Number Removal Initiative (SSNRI)?

https://www.cms.gov/Medicare/SSNRI/Index.html

Here's how the new Medicare Beneficiary Identifier (MBI) is formatted:

Pos.	1	2	3	4	5	6	7	8	9	10	11
Type	C	A	AN	N	A	AN	N	A	A	N	N

Where:

C – Numeric 1 thru 9

A – Alphabetic Character (A...Z); Excluding (S, L, O, I, B, Z)

N – Numeric 0 thru 9

AN – Either A or N

***NOTE: Alphabetic characters are Upper Case ONLY**

Position 1 – numeric values 1 thru 9
Position 2 – alphabetic values A thru Z (minus S, L, O, I, B, Z)
Position 3 – alpha-numeric values 0 thru 9 and A thru Z (minus S, L, O, I, B, Z)
Position 4 – numeric values 0 thru 9
Position 5 – alphabetic values A thru Z (minus S, L, O, I, B, Z)
Position 6 – alpha-numeric values 0 thru 9 and A thru Z (minus S, L, O, I, B, Z)
Position 7 – numeric values 0 thru 9
Position 8 – alphabetic values A thru Z (minus S, L, O, I, B, Z)
Position 9 – alphabetic values A thru Z (minus S, L, O, I, B, Z)
Position 10 – numeric values 0 thru 9
Position 11 – numeric values 0 thru 9

https://www.cms.gov/Medicare/SSNRI/MBI-Format-PDF.PDF

How Is the Medicare Part B Premium and Deductible Determined Each Year?

Medicare Rates and Deductibles for each year usually are announced in mid-November and are linked to the Cost of Living Adjustment (COLA), which is announced by Social Security each year in October.

The Secretary of the Department of Health and Human Services is required by section 1839 of the Social Security to announce the Part B monthly actuarial rates for aged and disabled beneficiaries as well as the monthly Part B premium. The Part B annual deductible is included because its determination is directly linked to the aged actuarial rate.

The premiums paid by (or on behalf of) all enrollees fund approximately one-fourth of the total incurred costs, and transfers from the general fund of the Treasury pay approximately three-fourths of these costs.

Learn about the formulas used for calculation here:
https://www.federalregister.gov/documents/2019/11/13/2019-

24440/medicare-program-medicare-part-b-monthly-actuarial-rates-premium-rates-and-annual-deductible

Why is this important? Your clients will need to know their potential out-of-pocket responsibilities each year. You can watch for the final numbers on the CMS website newsroom mid-November. Shortly after the CMS announcement, search for the document "Medicare Costs" on Medicare.gov under Publications.

Who Pays First - Medicare Or Other Health Insurance?

Medicare Secondary Payer is the term generally used when the Medicare program does not have primary payment responsibility - that is, when another entity has the responsibility for paying before Medicare.

Common Situations of Primary vs. Secondary Payer Responsibility

The following list identifies some common situations when Medicare and other health insurance or coverage may be present, and which entity will be the primary or secondary payer.

1. Working Aged (Medicare beneficiaries age 65 or older) and Employer Group Health Plan (GHP)

- *Individual is age 65 or older*, is covered by a GHP through current employment or spouse's current employment AND *the employer has less than 20 employees:*
- **Medicare pays primary**, GHP pays secondary
- *Individual is age 65 or older*, is covered by a GHP through current employment or spouse's current employment AND *the employer has 20 or more employees (or at least one employer is a multi-employer group that employs 20 or more individuals):*
  GHP pays primary, **Medicare pays secondary**
- *Individual is age 65 or older*, is *self-employed* and covered by a GHP through current employment or spouse's current employment AND *the employer has 20 or more employees (or at least one employer is a multi-employer group that employs 20 or more individuals):*
  GHP pays primary, **Medicare pays secondary**

2. Disability and Employer GHP

- *Individual is disabled*, is covered by a GHP through his or her own current employment (or through a family member's current employment) AND the employer has 100 or more employees (or at least one employer is a multi-employer group that employs 100 or more individuals):
  GHP pays primary, **Medicare pays secondary**

3. End-Stage Renal Disease (ESRD)

- *Individual has ESRD*, is covered by a GHP and is in the first 30 months of eligibility or entitlement to Medicare:
  GHP pays primary, **Medicare pays secondary during 30-month coordination period for ESRD**
- *Individual has ESRD*, is covered by a Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA plan) and is in the first 30 months of eligibility or entitlement to Medicare:
  COBRA pays primary, **Medicare pays secondary during 30-month coordination period for ESRD**

4. Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) – the law that provides continuing coverage of group health benefits to employees and their families upon the occurrence of certain qualifying events where such coverage would otherwise be terminated

- *Individual has ESRD*, is covered by COBRA and is in the first 30 months of eligibility or entitlement to Medicare:
  COBRA pays primary, **Medicare pays secondary during 30-month coordination period for ESRD**
- *Individual is age 65 years or older* and covered by Medicare & COBRA:
  Medicare pays primary, COBRA pays secondary
- *Individual is disabled* and covered by Medicare & COBRA:
  Medicare pays primary, COBRA pays secondary

5. Retiree Health Plans

- *Individual is age 65 or older* and has an employer retirement plan:
  Medicare pays primary, Retiree coverage pays secondary

6. No-fault Insurance and Liability Insurance

- *Individual is entitled to Medicare and was in an accident or other situation where no-fault or liability insurance is involved:* **No-fault or Liability Insurance pays primary for accident or other situation related health care services claimed or released**, Medicare pays secondary

7. Workers' Compensation Insurance

- Individual is entitled to Medicare and is covered under Workers' Compensation because of a job-related illness or injury: **Workers' Compensation pays primary for health care items or services related to job-related illness or injury claims**. Medicare generally will not pay for an injury or illness/disease covered by workers' compensation. If all or part of a claim is denied by workers' compensation on the grounds that it is not covered by workers' compensation, a claim may be filed with Medicare. Medicare may pay a claim that relates to a medical service or product covered by Medicare if the claim is not covered by workers' compensation. Prior to settling a workers' compensation case, parties to the settlement should consider Medicare's interest related to future medical services and whether the settlement is to include a Workers' Compensation Medicare Set-aside Arrangement (WCMSA).

Source: https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Medicare-Secondary-Payer/Medicare-Secondary-Payer.html

Resources

CMS – MLN Booklet on Secondary Payer

https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/msp_fact_sheet.pdf

Medicare Publication #02179 – Who Pays First

https://www.medicare.gov/Pubs/pdf/02179-Medicare-Coordination-Benefits-Payer.pdf?

Medicare Secondary Payer (MSP) Manual Chapter 5 - Contractor Prepayment Processing Requirements

https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/msp105c05.pdf

Medicare Publication #11546 - Coordination of Benefits: Getting Started

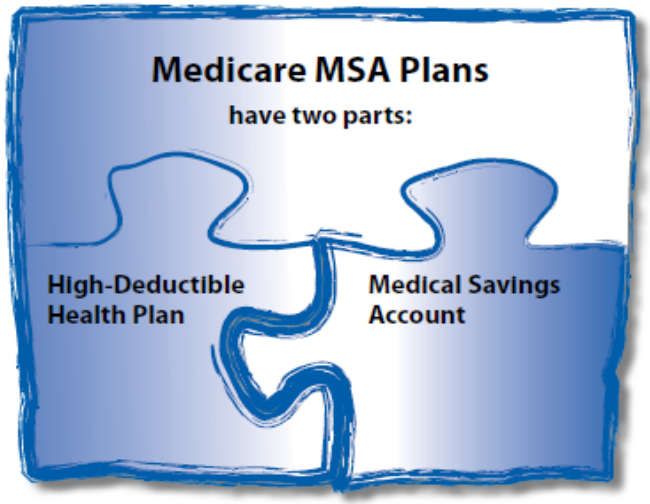
https://www.medicare.gov/Pubs/pdf/11546-coordination-of-benefits.pdf?

What Are Medicare Medical Savings Account (MSA) Plans?

If you are looking for a new product to talk about with your clients MSA plans could be the answer. Carriers are looking at plan designs that can attract the needs of clients who fit unique profiles. The MSA plan design is not new but it has only been available in limited markets. Below is an overview of the design and a few key points to remember if you decide to offer an MSA plan.

Key Points to Remember

- MSA Plans are MA only plans that allow you to enroll in a stand-alone PDP Plan.
- You won't have to pay a monthly premium for this plan. However, you will have to continue to pay the monthly Part B premium.
- The plan deposits some money into your account. The money in your account and any interest on that money isn't subject to taxes as long as the money is used for health care costs. If you use the money in your account for non-qualified expenses, it will be taxed as part of your income and will also be subject to an additional 50% tax penalty.
- Money left in your account at the end of the year stays in the account and may be used for health care costs in future years.
- You cannot enroll in an MSA plan if you get benefits from the Department of Defense (TRICARE) or the Department of Veterans Affairs.
- MSA Plans don't use provider networks thus allowing you to use any Medicare approved provider.



1. High-Deductible Health Plan

The first part of a Medicare MSA Plan is a special type of high-deductible Medicare Advantage Plan.

The plan will only begin to cover your costs once you meet a high yearly deductible, which varies by plan.

2. Medical Savings Account

The second part of a Medicare MSA Plan is a special type of savings account.

The Medicare MSA Plan deposits money into your account. You can choose to use money from this savings account to pay your health care costs before you meet the deductible.

Type of Expense	Can I use the money in my account for this expense?	Does this expense count toward my deductible?	Is the money that I use from my account for this expense taxed?
Medicare-covered Part A/Part B services Examples* • Doctor's visit • Inpatient hospital	Yes	Yes	No
Qualified Medical Expenses that aren't Medicare-covered Part A/Part B services Examples** • Dental • Vision • Part D prescription drugs	Yes	No	No
Non-medical spending Examples • Groceries • Utilities	Yes	No	Yes

* These are only examples of Medicare-covered Part A and Part B services. To find out what Medicare covers, look at your "Medicare & You" handbook.

** These are only examples of Qualified Medical Expenses. See IRS publication #969 for the year that you're filing to get a complete list of the services and products that count as Qualified Medical Expenses.

MSA Links

Medicare.gov on MSA Plans

https://www.medicare.gov/sign-up-change-plans/types-of-medicare-health-plans/medicare-medical-savings-account-msa-plans

Medicare.gov on MSA Plans Financial Considerations

https://www.medicare.gov/sign-up-change-plans/types-of-medicare-health-plans/medicare-medical-savings-account-msa-plans/10-steps-to-use-a-medicare-msa-plan

What Are Medicare Cost Plans?

Medicare Cost plans are essentially an HMO with the option to see any doctor using traditional fee-for-service Medicare out of the network.

Medicare Cost plans provided a managed care option in areas of the country that traditionally had few Medicare Advantage plans. Original Medicare steps in only when the enrollee goes out-of-network for care. This was a popular option in areas that individuals would leave the network areas for long vacations and wanted to use original Medicare while out of network.

How Do I Understand The Consolidated Omnibus Budget Reconciliation Act (COBRA) and How It Is Impacted By Medicare?

COBRA requires continuation coverage to be offered to covered employees, their spouses, former spouses, and dependent children when group health coverage would otherwise be lost due to certain specific events.

In order to be entitled to elect COBRA continuation coverage, your group health plan must be covered by COBRA; a qualifying event must occur; and you must be a qualified beneficiary for that event. The following are qualifying events for covered employees if they cause the covered employee to lose coverage:

- Termination of the employee's employment for any reason other than gross misconduct; or
- Reduction in the number of hours of employment.

The following are qualifying events for the spouse and dependent child of a covered employee if they cause the spouse or dependent child to lose coverage:

- Termination of the covered employee's employment for any reason other than gross misconduct;
- Reduction in the hours worked by the covered employee;
- Covered employee becomes entitled to Medicare;
- Divorce or legal separation of the spouse from the covered employee; or
- Death of the covered employee.

In addition to the above, the following is a qualifying event for a dependent child of a covered employee if it causes the child to lose coverage:

- Loss of dependent child status under the plan rules. Under the Affordable Care Act, plans that
  offer coverage to children on their parents' plan must make the coverage available until the
  adult child reaches the age of 26.

Qualifying Event	Qualified Beneficiaries	Maximum Period of Continuation Coverage
Termination (for reasons other than gross misconduct) or reduction in hours of employment	Employee Spouse Dependent Child	18 months (In certain circumstances, qualified beneficiaries may become entitled to a disability extension of an additional 11 months or an extension of an additional 18 months due to the occurrence of a second qualifying event.)
Employee enrollment in Medicare	Spouse Dependent Child	36 months (The actual period of continuation coverage may vary depending on factors such as whether the Medicare entitlement occurred prior to or after the end of the covered employee's employment or reduction in hours.)
Divorce or legal separation	Spouse Dependent Child	36 months
Death of employee	Spouse Dependent Child	36 months
Loss of "dependent child" status under the plan	Dependent Child	36 months

Medicare and COBRA

If you or a family member is covered by Medicare, it may affect your rights to group health plan coverage, in particular COBRA continuation coverage or the right to take advantage of certain enrollment rights you may have for COBRA continuation coverage.

If you are currently covered under your spouse's or parent's group health plan and you are losing coverage under that plan because either your spouse or your parents are becoming covered by Medicare, you may have the right to elect 36 months of COBRA continuation coverage. If you are entitled to receive or are already receiving 18 months of COBRA continuation coverage because your spouse or parent terminated employment or reduced hours of employment, and your spouse or parent becomes covered by Medicare, you may be able to extend the maximum period of COBRA continuation coverage for yourself from 18 months to a maximum of 36 months."

Source: *elaws: Employment Laws Assistance for Workers & Small Businesses - Health Benefits Advisor Eligible for Medicare*
https://webapps.dol.gov/elaws/ebsa/health/68.asp

- If you have COBRA when you become Medicare-eligible, your COBRA coverage usually ends on the date you get Medicare. You should enroll in Part B immediately because you are not entitled to a Special Enrollment Period (SEP) when COBRA ends.
- If you have Medicare Part A or Part B when you become eligible for COBRA, you must be allowed to enroll in COBRA. Medicare is your primary insurance, and COBRA is secondary. You should keep Medicare because it is responsible for paying the majority of your health care costs. Special rules apply to ESRD.
- Medicare.gov on Cobra: https://www.medicare.gov/supplements-other-insurance/how-medicare-works-with-other-insurance/cobra-7-important-facts

Resources

Medicare Publication #02179: "Who Pays First"

https://www.medicare.gov/pubs/pdf/02179-Medicare-Coordination-Benefits-Payer.pdf

"AN EMPLOYEE'S GUIDE TO HEALTH BENEFITS UNDER COBRA"

https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/an-employees-guide-to-health-benefits-under-cobra.pdf

"AN EMPLOYER'S GUIDE TO GROUP HEALTH CONTINUATION COVERAGE UNDER COBRA"

https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/an-employers-guide-to-group-health-continuation-coverage-under-cobra.pdf

Protecting Retirement Benefits

https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/questions-and-answers-for-dislocated-workers.pdf

IRS - Health Coverage Tax Credit Information

https://www.irs.gov/credits-deductions/individuals/hctc

Cobra FAQ

https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/cobra-continuation-health-coverage-consumer.pdf

Department of Labor- Changing Jobs and Job Loss

https://www.dol.gov/agencies/ebsa/workers-and-families/changing-jobs-and-job-loss

AGENT RESOURCES AND RESEARCH

Finding a Star Rating

Each year, you are required to communicate the Star Rating for the plan(s) you present during marketing/sales events, one-on-one marketing appointments, or telephonically. You can access the new ratings on the Medicare.gov website.

- Click the bottom on the home screen that says, "find health and drug plans" (they keep moving it so I would not specify where on the home page)
- If your client has an account, click "log in" or "Create an Account" of they would like one. If you do not have an account, then click "continue without logging in."
- Select the type of coverage the client is looking for
- Enter the client's zip code and county
- Select the level of help, if any, that your client receives
- Select if you want to see drugs included in the comparison and, if so, how those drugs will be filled. If you selected yes, then you will now enter all of your client's drugs into the search feature. Lastly, select the pharmacies that your client will use.
- Now that you are on the comparison screen, you will find each company's star ratings in the top right of each company's box in the comparison.

Monitor CMS Sanctions and Other Enforcement Actions

CMS has the authority to take enforcement or contract actions when CMS determines that a Medicare Plan Sponsor either:

- Substantially fails to comply with program and/or contract requirements,
- Is carrying out its contract with CMS in a manner that is inconsistent with the efficient and effective administration of the Medicare Part C and Part D program requirements, or
- No longer substantially meets the applicable conditions of the Medicare Part C and D program. Enforcement and contract actions include:
- Civil money penalties (CMP)

- Intermediate sanctions (i.e., suspension of marketing, enrollment, payment), and
- Terminations

This is a link to the list of recent CMP, Intermediate Sanction, and Termination notices issued by CMS:

https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/PartCandPartDEnforcementActions-.html

Need a CMS Form?

Help your clients find what they need to get the best service from Medicare. This site gives you access and/or information for many CMS forms. You may also use the "Search" feature on this site to more quickly locate information for a specific form number or form title.

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List.html

For example, use this form if one of your clients gets unsatisfactory care: The Medicare Quality of Care Complaint Form - Complaints from beneficiaries about the quality of services not meeting professionally recognized standards of health care.

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms10287.pdf

Your Guide to Government Information and Services

https://www.usa.gov/explore/

USA Gov is the federal program that guides you to tips and tools in English and in Spanish from hundreds of government agencies, departments, and programs. Find information online, by phone or chat, and in print.

For example, this is a link to an A-Z index of government agencies: https://www.usa.gov/federal-agencies/a

Purchase Social Security publications from the government bookstore: https://bookstore.gpo.gov/agency/1008

An Agent Can Order Bulk Supplies from CMS by Setting up an Account

http://productordering.cms.hhs.gov/login.aspx

USA.gov The Official U.S. Government Web Portal

As the U.S. government's official web portal, USA.gov makes it easy for the public to get U.S. government information and services on the web. http://www.usa.gov/

Information Resources: MedlinePlus®: Key Resource for Both Health Consumers and Health Professionals

MedlinePlus is the National Institutes of Health's Web site for patients and their families and friends. Produced by the National Library of Medicine, the world's largest medical library, it brings you information about diseases, conditions, and wellness issues in language you can understand. MedlinePlus offers reliable, up-to-date health information anytime, anywhere, for free. You can use MedlinePlus to learn about the latest treatments, look up information on a drug or supplement, find out the meanings of words, or view medical videos or illustrations. http://www.nlm.nih.gov/medlineplus/

Medicare Web Resources to Help Employees – Great for Assisting Employers

Help on:

- New Enrollees
- Marketplace

- Coordination of Benefits
- HSA Questions
- Continuation of Coverage
- VA Benefits
- Caregiving.

https://www.cms.gov/Outreach-and-Education/Find-Your-Provider-Type/Employers-and-Unions/Web-resources-to-help-employees

View MA Landscapes as They Are Released By CMS

The link below is to the source of the file on CMS.gov:

https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/index.html

Watch MA Enrollment Activity in Every County Month by Month

As the carriers begin releasing their product offerings, you will want to monitor what the current enrollment looks like in each county to find areas of opportunity. CMS puts out a monthly enrollment report that can be found here: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-MA-Enrollment-by-State-County-Contract.html

As of 1/1/16 CMS Required Agent Compensation Adjustments for MA and PDP Sales

- New to Medicare – To pay Initial rate for Full 12 months
- Unlike plan changes – To pay pro-rated commissions of the initial rate
- Like plan changes – To pay pro-rated commissions of renewal rate

Definitions

- New to Medicare is defined as aging into Medicare or no prior plan history.
- An unlike plan change is defined as a member with prior plan history changing from:
  - MA or MAPD to PDP or cost plan
  - PDP to cost plan or MA or MAPD
  - Cost plan to MA or MAPD or PDP
- A like plan change is defined as a member changing from:
  - PDP to another PDP
  - MA or MAPD or MMP* to another MA or MAPD or MMP*
  - Cost plan to another cost plan

"110.6.4 – Paying Compensation 42 CFR §§ 422.2274, 423.2274

- *The compensation year is January 1 through December 31. Payments must be calculated and made during the January 1 through December 31 enrollment year (including AEP enrollments).*
- *Plans/Part D sponsors may determine their payment schedule (e.g., monthly, quarterly). However, compensation must be paid during the enrollment year.*
- *Compensation is based on the number of months a member is enrolled.*
- *Compensation paid to third parties selling MA/Part D products must adhere to compensation requirements."*

-Page 55 Medicare Communications and Marketing Guidelines (MCMG)

https://www.cms.gov/medicare/health-plans/managedcaremarketing/finalpartcmarketingguidelines.html

*A Medicare-Medicaid Plan (MMP) is a private health plan that has been competitively selected and approved to provide integrated care to eligible full-benefit Medicare-Medicaid enrollees under the CMS Financial Alignment Demonstration.

Over 60 Million Person Market – And It's Growing by 10,000 a Day!

All agents should be taking the opportunities in the senior market very seriously. About 10,000 baby boomers (Born 1946 to 1964) are now enrolling in Medicare every day and will be until 2030.

https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Fast-Facts/index

Know the Demographics of Your Market by Using Census.gov

If you need the 65-and-older population census statistics you can research data here:

https://www.census.gov/quickfacts/table/PST045215/00

CMS Statistics Reference Booklet

The annual CMS statistics reference booklet provides a quick reference for summary information about health expenditures and the Medicare and Medicaid health insurance programs. The CMS statistics reference booklet is published in June of each calendar year and represents the most currently available information at the time of publication.

https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Statistics-Reference-Booklet/index.html

Who is the U.S. Railroad Retirement Board?

The Railroad Retirement Board (RRB) is an independent agency in the executive branch of the Federal Government. The RRB's primary function is to administer comprehensive retirement-survivor and unemployment-sickness benefit programs for the nation's railroad workers and their families, under the Railroad Retirement and Railroad Unemployment Insurance Acts. https://rrb.gov/

Medicare for Railroad Workers and Their Families

The Medicare program covers railroad workers just like workers under social security. Railroad retirement payroll taxes include a Medicare hospital insurance tax just like social security payroll taxes.

Find out more in this helpful booklet:

https://rrb.gov/sites/default/files/2019-01/RB-20%20%2801-19%29.pdf

Cost of Care

While some people may qualify for a public program to help pay for long term care expenses, most people use a variety of options, including long-term care insurance, personal income and savings, life insurance, annuities and reverse mortgages to ensure they can pay for the care they require.

https://longtermcare.acl.gov/costs-how-to-pay/costs-of-care.html

Why is this important? Help your clients understand that the lack of proper planning can result in a financial disaster.

Using MedicareInteractive.org to Understand the Types of Advantage Plans (HMO's, PPO's, PFFS, SNP's etc.)

This section of Medicare Interactive gives you an in-depth look at the type of Medicare Advantage plans available. It also gives you information on how Medicare works with HSA plans.

https://www.medicareinteractive.org/get-answers/types-of-medicare-advantage-plans-hmos-ppos-and-more

Why is this important? Studying the basics gives you a solid foundation for your Medicare education. Making sure you thoroughly understand the types of plans available enables you as an agent to make a proper recommendation to your client.

How is Medicare Funded?

The Centers for Medicare & Medicaid Services (CMS), a branch of the Department of Health and Human Services (HHS), is the federal agency that runs the Medicare Program. Medicare is paid for through 2 trust fund accounts held by the U.S. Treasury. These funds can only be used for Medicare. They are the Hospital Insurance (HI) Trust Fund and Supplementary Medical Insurance (SMI) Trust Fund. You can find out more about these funds on Medicare.gov here: https://www.medicare.gov/about-us/how-is-medicare-funded

Why is this important? Being familiar with the funding will help you to understand the impact of changes Congress may propose.

What's an ACO?

Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients. A primary care physician coordinates all levels of care of an individual including seeing specialist, receiving ongoing care or going into the hospital. Beneficiaries do not enroll they are assigned through participation of their physician. The physician is required to notify the Medicare beneficiary that they are participating in an ACO. The goal is to increase quality of care and reduce unnecessary cost by documenting and coordinating care for quality and efficiency and taking advantage of any preventive care possible. This provider payment model is in lieu of the traditional fee for service model. Only people with Original Medicare can be assigned to an ACO. You can't be assigned to an ACO if you have a Medicare Advantage Plan (Part C), like an HMO or a PPO.

When an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program.

https://www.medicare.gov/manage-your-health/coordinating-your-care/accountable-care-organizations

ACO Video: https://youtu.be/MZaa1QROQAU

CMS Alternative Payment Models - The Medicare Shared Savings Program (Shared Savings Program), Next Generation Accountable Care Organization (ACO) Model, Comprehensive End-Stage Renal Disease (ESRD) Care Model (CEC) and Comprehensive Primary Care Plus (CPC+) Model all apply the concept of paying for quality and effectiveness of care given to patients in different health care settings.

ACOs in Your State: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/ACOs-in-Your-State.html

The AP-NORC Center's Long-Term Care Poll

Key Points From the AP-NORC Center's Long-Term Care Poll.

Among adults age 40 and older:

1. Two-thirds feel the country is not prepared for the rapid growth of the older adult population.
2. More than half believe that Medicare should be responsible for paying the costs of long-term care.
3. More than 3 in 4 favor tax breaks for family caregivers, to encourage savings for long-term care, and for purchasing long-term care insurance.
4. As in prior years, a majority (67 percent) say they have done only a little or no planning at all for their own care needs.

See more at: https://www.longtermcarepoll.org/

Age 65+ Population Analyses – Examining Markets for Opportunity

https://aoa.acl.gov/aging_statistics/profile/index.aspx

Fast Reference Source Links

Healthcare Resources

Physician Compare - *Looking for physicians who accept assignment? If you would like to see only those accepting the Medicare-approved amount or other filters, enter the type of specialty in the search bar then filter options will appear at the top of the list.*

https://www.medicare.gov/physiciancompare/

Find and Compare a Home Health Agency

https://www.medicare.gov/homehealthcompare/search.html

Find and Compare a Hospital

https://www.medicare.gov/hospitalcompare/search.html?

Find and Compare a Nursing Home

https://www.medicare.gov/nursinghomecompare/search.html?

Find a Dialysis Facility

https://www.medicare.gov/dialysisfacilitycompare/

Find a Hospice Agency

https://www.medicare.gov/hospicecompare/

Find an Inpatient Rehabilitation Facility

https://www.medicare.gov/inpatientrehabilitationfacilitycompare/

Check Your Medicare Enrollment

https://www.medicare.gov/find-a-plan/enrollment/check-enrollment.aspx

Medicare Term Glossary

https://www.medicare.gov/find-a-plan/staticpages/glossary/planfinder-glossary.aspx

Mail you get about Medicare

https://www.medicare.gov/forms-help-resources/mail-you-get-about-medicare

Medicare Contact Information

https://www.medicare.gov/Contacts/

Find a Medicare Publication

https://www.medicare.gov/Publications/

Get a Replacement Medicare Card

https://www.medicare.gov/forms-help-resources/your-medicare-card

Medicaid Information

https://www.medicaid.gov/

MA and PDP Landscapes

https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/index.html

MA Enrollment by State/County – Month to Month CMS Report

https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-MA-Enrollment-by-State-County-Contract.html?DLSort=1&DLEntries=10&DLPage=1&DLSortDir=descending

Medicare.gov - Is your test, item, or service covered?

https://www.medicare.gov/coverage/is-your-test-item-or-service-covered

BenefitsCheckup.org - Researching Assistance Programs

https://www.benefitscheckup.org/cf/frmwelcome2.cfm?subset_id=39&partner_id=0&sc_partner_id=0

CMS - Caregiver Resources

https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/Caregiver.html

Pharmacy Assistance - Needymeds.org

http://www.needymeds.org/

ssa.gov – Disability Benefits

https://www.ssa.gov/benefits/disability/

Social Security Information for Financial Planners

https://www.ssa.gov/thirdparty/financial-planners.html

Social Security Publications

https://www.ssa.gov/pubs/

CMS Resources for Employers/Employees

https://www.cms.gov/Outreach-and-Education/Find-Your-Provider-Type/Employers-and-Unions/Web-resources-to-help-employees.html

COMPLIANCE

Medicare Marketing Guidelines

The guidelines allow organizations offering both Medicare Advantage and Prescription Drug Plans the ability to reference one document when developing marketing materials.

Reminder: Third-party websites that market MA/MAPD and PDP must meet applicable CMS marketing guidance.

Guidelines: https://www.cms.gov/medicare/health-plans/managedcaremarketing/finalpartcmarketingguidelines.html

Why is this important? Using multiple forms of marketing can bring tremendous rewards but it must be done compliantly. Compliance is put in place to protect Medicare beneficiaries and applied properly it does not hinder your ability to help your clients.

MA/PDP Effective Date Must Be After the Date the Agent Receives the Application

"For requests submitted to sales agents, including brokers, the application date is the date the agent and/or broker receives (accepts) the enrollment request and not the date the organization receives the enrollment request from the agent and/or broker. For purposes of enrollment, receipt by the agent or broker employed by or contracting with the organization, is considered receipt by the plan, thus all CMS required timeframes for enrollment processing begin on this date." – *Definitions Chapter 2 CMS Medicare Managed Care Manual*

https://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/Downloads/CY_2019_MA_Enrollment_and_Disenrollment_Guidance.pdf

MA/PDP Marketing Starts October 1st - Taking Applications Starts October 15th

DO begin marketing Medicare plans and marketing/sales events for upcoming plan year no sooner than October 1.

DO begin soliciting/accepting enrollment applications for a Jan. 1 effective date no sooner than start of AEP (Oct. 15) unless beneficiary is entitled to another enrollment period.

https://www.cms.gov/medicare/health-plans/managedcaremarketing/finalpartcmarketingguidelines.html

A Call to Medicare about Benefits Could Be Considered a Violation

If your client calls 1-800 MEDICARE and is confused by their plan, this may be considered a CMS violation for inadequate plan/benefit information. Take the extra time to make sure your client understands their plan and if they have questions to contact you, the agent, first.

Use of the term "Medicare" in Advertising

Paraphrased
from: https://www.ssa.gov/OP_Home/ssact/title11/1140.htm

Use of the word "Medicare" or a symbol or emblem of Medicare in a manner which conveys that such item is approved, endorsed, or authorized by the Centers for Medicare and Medicaid Services is prohibited.

Complying with The Do Not Call Registry Rules

Who Is Covered by The National Do Not Call Registry?

The National Do Not Call Registry applies to any plan, program, or campaign to sell goods or services through interstate phone calls. This includes telemarketers who solicit consumers, often on behalf of third-party sellers. It also includes sellers who provide, offer to provide, or arrange to provide goods or services to consumers in exchange for payment.

The National Do Not Call Registry does not limit calls by political organizations, charities, or telephone surveyors.

What About an Established Business Relationship?

> A telemarketer or seller may call a consumer with whom it has an established business relationship for up to 18 months after the consumer's last purchase, delivery, or payment - even if the consumer's number is on the National Do Not Call Registry. In addition, a company may call a consumer for up to three months after the consumer makes an inquiry or submits an application to the company. And if a consumer has given a company written permission, the company may call even if the consumer's number is on the National Do Not Call Registry.
>
> One caveat: if a consumer asks a company not to call, the company may not call, even if there is an established business relationship. Indeed, a company may not call a consumer - regardless of whether the consumer's number is on the registry - if the consumer has asked to be put on the company's own do not call list.

Both the FTC and FCC have regulations implementing the National Do Not Call List, which are required by statute to be coordinated with each other. There is only one list, and it is maintained by the FTC.

Access the National Do Not Call Registry online at:
https://telemarketing.donotcall.gov/

Find more details regarding DNC in this FAQ:

https://www.donotcall.gov/faq/faqbusiness.aspx#who

If your business or organization uses telemarketing, the link below to an in-depth guide is a "must read." Review the dos and don'ts to make sure you're up on the law, including the ban on most prerecorded robocalls.

https://www.ftc.gov/tips-advice/business-center/guidance/complying-telemarketing-sales-rule

Why is this important? It's against the law to call (or cause a telemarketer to call) any number on the registry (unless the seller has an established business relationship with the consumer whose number is being called, or the consumer has given written agreement to be called). Violators may be subject to very large fines. Each call may be considered a separate violation.

Marketing/Sales Events - Formal and Informal

Marketing/Sales events are defined both by the range of information provided and the way in which the content is presented. In addition, marketing/sales events are defined by the plan's ability to collect enrollment applications and enroll Medicare consumers during the event. A marketing/sales event is designed to steer, or attempt to steer, consumers toward a plan or limited set of plans.

- A formal marketing/sales event is structured in an audience/presenter style with sales personal or plan representative formally providing specific sponsor information via a presentation on the products being offered.
- An informal marketing/sales event is conducted with a less structured presentation or in a less formal environment like a retail booth, kiosk, table, recreational vehicle, or food banks where an agent can discuss plan information when approached by a consumer.

Educational Event

An educational event is an event designed to inform Medicare consumers about MA, Prescription Drug or other Medicare programs but do not steer, or attempt to steer, consumers toward a specific plan or limited number of plans. Educational events may not include any sales or marketing activities such as the distribution of marketing materials or the distribution or collection of enrollment applications. When advertised, educational events must be advertised as educational; otherwise they are considered marketing/sales events. Educational events are held in public venues, do not extend to personal/individual appointments, and cannot include lead generation activities.

48 Hour Cooling Off Period

Scope of Appointment (SOA) cooling off period:

At an appointment, agents are not to discuss, leave enrollment documentation, or conduct marketing activity related to a healthcare

product not previously identified and agreed upon by the consumer at the time the appointment was originally scheduled.

If, however, the consumer requests the presentation of previously unidentified and agreed upon products, the agent must secure a new SOA and then can proceed with the discussion.

If during an appointment the agent determines that a MA or PDP outside of the original SOA may be a better fit, the following would apply:

- A future appointment may be scheduled to discuss the newly identified healthcare related product as long as the new appointment is no less than 48 hours in the future from the present appointment. A new SOA will need to be immediately obtained for the future appointment.
- A new SOA form must be completed, signed by the consumer, and filed for the future appointment scheduled to discuss the newly identified healthcare related product.
- An Enrollment Guide may be left with the consumer. No discussion or related marketing activity may be conducted.

Product cross-selling, marketing, and/or selling non-healthcare related products during marketing activity related to Medicare Advantage or Part D is strictly prohibited. Discussion of non-healthcare related products initiated by a consumer at a personal/individual marketing appointment requires a separate appointment at least 48 hours later (but would not need a Scope of Appointment form).

Agent Do's and Don'ts of Selling Medicare Advantage Plans

Medicare.gov outlines what a client should expect an agent to do and not to do during an appointment.

For example, during the meeting, Medicare plans and people who work with Medicare can:

- Give you plan materials.
- Tell you how to get more plan information.
- Tell you about the plan options you agreed to discuss.
- Give you an enrollment form.
- Collect your completed enrollment form.

- Leave business cards for you to give to friends and family.

https://www.medicare.gov/forms-help-resources/help-fight-medicare-fraud/rules-medicare-plans

Why is this important? As you plan your upcoming AEP, it is a good time each year to review the list as a refresher.

Understanding HIPPA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA)

- HIPAA gives us the right to access our health information.
- Many individuals were unaware or didn't believe they had a right to an electronic copy of their medical record or have never even seen their health information.

https://www.hhs.gov/hipaa/

Entities that must follow the HIPAA regulations are called "covered entities."

- Covered entities must put in place safeguards to protect your health information and ensure they do not use or disclose your health information improperly.
- Covered entities must reasonably limit uses and disclosures to the minimum necessary to accomplish their intended purpose.
- Covered entities must have procedures in place to limit who can view and access your health information as well as implement training programs for employees about how to protect your health information.
- Business associates also must put in place safeguards to protect your health information and ensure they do not use or disclose your health information improperly.

Video overview and helpful information:
https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html

Why is this important? Your client can ask to change any wrong information in their file or add information to their file if they think something is missing or incomplete. As an agent, you should be aware of how to properly treat confidential information.

ENROLLMENT PERIODS

Signing Up for Medicare: Special Conditions

Under certain special conditions, you may be able to sign up for Medicare outside of regular enrollment periods. If you run into an unusual enrollment question this section of Medicare.gov can be very helpful.

https://www.medicare.gov/sign-up-change-plans/when-can-i-join-a-health-or-drug-plan/special-circumstances-special-enrollment-periods

Example:

Q.) My spouse has never worked. If they turn 65 before I do, can they get Medicare at 65? Or, do they have to wait until I turn 65 and have Medicare?

A.) If you're at least 62 and have worked at least 10 years in Medicare-covered employment, your spouse can get Part A and Part B at 65.

If you've worked at least 10 years in Medicare-covered employment but aren't yet 62 when your spouse turns 65, they won't be eligible for premium-free Part A until your 62nd birthday. In this case, your spouse should still apply for Part B at 65, so they can avoid paying a higher Part B premium.

However, if you're still working and your spouse is covered under your group health plan, they could delay their Part B enrollment without paying higher premiums.

Part A and B General Enrollment Period

If you didn't sign up for Part A and/or Part B (for which you must pay premiums) when you were first eligible, and you aren't eligible for a Special Enrollment Period, you can sign up during the General Enrollment Period between January 1 and March 31 each year. Your coverage will start July 1. You may have to pay a higher premium for late enrollment in Part A and/or a higher premium for late enrollment in Part B.

https://www.medicare.gov/sign-up-change-plans/get-parts-a-and-b/when-how-to-sign-up-for-part-a-and-part-b.html

5-star Special Enrollment Period

Medicare uses information from member satisfaction surveys, plans, and health care providers to give overall performance star ratings to plans. A plan can earn a rating between 1 and 5 stars. A 5-star rating is considered excellent. These ratings help you compare plans based on quality and performance. Medicare updates these ratings each fall for the following year. These ratings can change each year.

You can only switch to a 5-star Medicare Prescription Drug Plan if one is available in your area. You can only use this Special Enrollment Period once. You can switch to a 5-star Medicare Advantage Plan, Medicare Cost Plan, or Medicare Prescription Drug Plan once from December 8– November 30.

https://www.medicare.gov/sign-up-change-plans/when-can-i-join-a-health-or-drug-plan/5-star-special-enrollment-period

You Cannot Use the SEP for Service Area Reductions until December 8th

When completing Medicare Advantage applications, you cannot use the SEP for SAR's until that enrollment period opens. If an individual losing their plan wants to apply for a new plan during AEP, use the election period code AEP.

The Special Enrollment Period for discontinued plans (or Service Area Reductions) will start on December 8th and continue through February 28, with your new plan coverage beginning on the first day of the month following enrollment.

Medicare Supplement Guarantee Issue Right due to SAR

If you're in a Medicare Advantage Plan, and your plan is leaving Medicare, stops giving care in your area, or you move out of the plan's service area.

- You have the right to buy Medigap Plan A, B, C*, D*, F*, G*, K, or L that's sold in your state by any insurance company. You only have this right if you switch to Original Medicare rather than join another

Medicare Advantage Plan. *Note: Plans C and F will no longer be available to people who are new to Medicare on or after January 1, 2020. However, if you were eligible for Medicare before January 1, 2020 but not yet enrolled, you may be able to buy Plan C or Plan F. People eligible for Medicare on or after January 1, 2020 have the right to buy Plans D and G instead of Plans C and F.

- You can/must apply for a Medigap policy as early as 60 calendar days before the date your coverage will end, but no later than 63 calendar days after your coverage ends. Medigap coverage can't start until your Medicare Advantage Plan coverage ends.

Understanding Medicare Part C & D Enrollment Periods

Enrollment in Medicare is limited to certain times. You can't always sign up when you want, so it's important to know when you can enroll in the different parts of Medicare. This tip sheet is designed to help you learn more about enrolling in Medicare Advantage Plans (Part C) and Medicare Prescription Drug Plans (Part D), including who can sign up, when you can sign up, and how the timing (including signing up late) can affect your costs.

https://www.medicare.gov/Pubs/pdf/11219-Understanding-Medicare-Part-C-D.pdf

California "Birthday Rule" for Medigap Plans

If a person already has Medigap insurance, they have 30 days of "open enrollment" following their birthday each year when they may buy a new Medigap policy without a medical screening or a new waiting period. The new policy must have the same or lesser benefits as the old policy.

http://www.insurance.ca.gov/0200-industry/0120-notices/upload/NoticeMedigapChanges2010.pdf

Note: Although the California Birthday Rule specifies that you can apply for coverage during the 30 days after your birthday each year, some insurance

carriers have more liberal policies, and they let you apply during the 30 days before or after your birthday.

Restoration of the Medicare Advantage Open Enrollment Period

The 21st Century Cures Act eliminated the existing MA disenrollment period that took place from January 1st through February 14th of every year and, effective 2019, replaced it with a new Medicare Advantage open enrollment period (OEP) that takes place from January 1st through March 31st annually.

The OEP allows individuals enrolled in an MA plan, including newly MA-eligible individuals, to make a one-time election or to go to another MA plan or Original Medicare. Individuals using the OEP to make a change may make a coordinating change to add or drop Part D coverage. Allows:

- MA-Only to MA-Only
- MA-Only to MA-PD
- MA-PD to MA-Only
- MA-PD to MA-PD
- MA-Only or MA-PD to Original Medicare without PDP
- MA-Only or MA-PD to Original Medicare with PDP
- Switching between Plan benefit packages (PBP's) of one organization
- Beneficiaries in original Medicare and Cost plans cannot use the new OEP, regardless of Part D coverage. Also enrollment into a cost plan during OEP is not allowed.

Why is this important? Agents need to be aware that a client essentially has a three month "free look" at their plan and should be making sure that their providers and drug lists are carefully reviewed to avoid the client leaving their plan.

Sources:

https://www.cms.gov/newsroom/fact-sheets/cms-finalizes-policy-changes-and-updates-medicare-advantage-and-prescription-drug-benefit-program

https://www.federalregister.gov/documents/2018/04/16/2018-07179/medicare-program-contract-year-2019-policy-and-technical-changes-to-the-medicare-advantage-medicare

Two Special Enrollment Periods (SEPs) Introduced in 2018/2019

The 2019 Medicare Managed Care Manual, Chapter 2, includes new Special Enrollment Periods (SEPs) at §§30.4.4.17 and .18:

1.) SEP for Providing Individuals who Requested Materials in Accessible Formats Equal Time to Make Enrollment Decisions –effective 01-01-2019;

This generally includes formats such as Braille, Data, and Audio files, or other formats accepted by the member in place of, or in addition to, the original print material. This limited SEP ensures that beneficiaries who have requested information in accessible formats are not disadvantaged by any additional time necessary to fulfill their request, including missing an election period deadline. The SEP begins at the end of the election period during which the beneficiary was seeking to make an election. The start and length of the SEP, as well as the effective date, are dependent upon the situation, and are at least as long as the time it took for the information to be provided to the individual in an accessible format.

2.) SEP for Individuals Affected by a FEMA-Declared Weather-Related Emergency or Major Disaster, effective 07-30-2018;

A SEP exists for individuals affected by a weather-related emergency or major disaster who were unable to and did not make an election during another valid election period. This includes both enrollment and disenrollment elections. Individuals will be considered "affected" and eligible for this SEP if they:

- *Reside, or resided at the start of the incident period, in an area for which FEMA has declared an emergency or a major disaster and has designated affected counties as being eligible to apply for individual or public level assistance;*
- *Had another valid election period at the time of incident period; and*
- *Did not make an election during that other valid election period. In addition, the SEP is available to those individuals who don't live in the affected areas but rely on help making healthcare decisions from friends or family members who live in the affected areas. The SEP is available from the start of the incident period and for four full calendar months thereafter.*

Source: https://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/Downloads/CY_2019_MA_Enrollment_and_Disenrollment_Guidance.pdf

Why is this important? When we meet with clients in special circumstances, we want to be certain of all the benefit options available to them. SEPs are a way of increasing enrollment opportunities beyond the normal enrollment periods.

ICEP, IEP and other Election Period Codes – What to Use When

The election period ICEP is to be used on MA Only Plans in most cases. For anything regarding drugs (PDP/MAPD), the election is IEP. However, if you have a client who delayed their Medicare Part B enrollment because they were still working and had creditable coverage, they can use the ICEP Part B delayed enrollment period for a MAPD plan. The effective date of the MAPD plan must match the effective date of their Medicare Part B.

Acronym	What it Stands For	Acronym	What it Stands For
AEP	Annual Election Period	**MA-PD**	Medicare Advantage-Prescription Drug Plan
CMS	Centers for Medicare & Medicaid Services	**MSP**	Medicare Savings Programs *(such as QMBs, SLMBs, & QIs)*
EGHP	Employer Group Health Plan	**OEP**	Open Enrollment Period
ESRD	End-Stage Renal Disease	**OEPI**	Open Enrollment Period Institutional
GEP	General Enrollment Period	**PACE**	Program of All-Inclusive Care for the Elderly
HMO	Health Maintenance Organization	**PDP**	Prescription Drug Plan
ICEP	Initial Coverage Election Period *(Consumer is first eligible to enroll in an MA plan)*	**PFFS**	Private Fee-For-Service
IEP2	Initial Election Period 2 *(Consumer is first eligible to enroll prior to the age of 65)*	**POS**	Point of Service Plan
IEP-Part D	Initial Enrollment Period *(Consumer is first eligible to enroll in a Part D plan)*	**PPO**	Preferred Provider Organization
LIS	Low Income Subsidy	**SEP**	Special Election Period
MA	Medicare Advantage	**SNP**	Special Needs Plan
MA-Only	Medicare Advantage Plan without Prescription Drug coverage	**SPAP**	State Pharmaceutical Assistance Program

Why is this important? Although during the Annual Election Period most apps will be submitted using AEP, other situations will arise, and you must know how to submit the application.

PDP & MEDICATIONS

PDP Points to Ponder

- There are two ways to get Medicare Prescription Drug coverage: through adding a Medicare Prescription Drug Plan (Part D) **OR** getting a Medicare Advantage Plan (Part C) such as an HMO or PPO that offers Medicare prescription drug coverage.
- To get Medicare drug coverage, you must join a plan run by an insurance company or other private company approved by Medicare. Each plan can vary in cost and drugs covered.
- If your Medicare Advantage Plan (Part C) includes prescription drug coverage and you join a Medicare Prescription Drug Plan (Part D), you'll be disenrolled from your Medicare Advantage Plan and returned to Original Medicare.
- Clients need to consider that their prescription needs will potentially change throughout the year. That means that they need to purchase a plan that would properly insure them even if they currently do not take any medications.

Medication Therapy Management

If you see MTM under drug restrictions when you are doing a part D comparison on Medicare.gov, it stands for Medication Therapy Management programs for complex health needs. It is explained here:

https://www.medicare.gov/drug-coverage-part-d/what-drug-plans-cover/medication-therapy-management-programs-for-complex-health-needs

Drug Interaction Checker

Enter any list of prescription drugs, over-the-counter drugs, herbals and supplements to see how they interact with each other and with other substances.

http://healthtools.aarp.org/drug-interactions

What Happens if Someone Fails to Pay Their Part C or Part D Premium?

A plan can choose to disenroll a member who fails to pay plan premiums after proper notice and the plan's grace period. This tip sheet explains what happens if a person with Medicare doesn't pay the premiums for his or her Medicare Advantage Plan (like an HMO or PPO) or Medicare Prescription Drug Plan.

https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/downloads/11338-P.pdf

Once a person with Medicare is disenrolled from his or her plan, they must wait until the next available enrollment period to join another plan. Someone who's disenrolled from a Medicare Advantage Plan will automatically be enrolled in Original Medicare.

What is a Network Pharmacy, and What is a Preferred Network Pharmacy?

A network pharmacy is a pharmacy which a plan contracts with to offer drugs at a certain price. Some plans distinguish network pharmacies as preferred over other pharmacies, because they can offer better drug prices or better benefits.

Creditable Prescription Drug Coverage

Prescription drug coverage (for example, from an employer or union) that's expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.

https://www.medicare.gov/Pubs/pdf/11109-Your-Guide-to-Medicare-Prescrip-Drug-Cov.pdf

Remind your clients: Don't go 63 days or more in a row without a Medicare drug plan or other creditable prescription drug coverage. Creditable prescription drug coverage could include drug coverage from a former employer or union, TRICARE, the Department of Veteran Affairs (VA), or the Indian Health Service. Your plan must tell you each year if your drug coverage is creditable. It may send you

this information in a letter, or let you know in a newsletter or other piece of mail. Keep this information, because you may need it if you join a Medicare drug plan later.

A prescription drug plan is deemed creditable if the plan:

1) Provides coverage for brand and generic prescriptions;

2) Provides reasonable access to retail providers;

3) Is designed to pay on average at least 60% of participants' prescription drug expenses; and

4) Satisfies at least one of the following:

   a) The prescription drug coverage has no annual benefit, maximum benefit, a maximum annual benefit payable by the plan of at least $25,000, or

   b) The prescription drug coverage has an actuarial expectation that the amount payable by the plan will be at least $2,000 annually per Medicare eligible individual.

   c) For entities that have integrated health coverage, the integrated health plan has no more than a $250 deductible per year, no annual benefit maximum, or maximum annual benefit payable by the plan of at least $25,000, and has no less than a $1,000,000 lifetime combined benefit maximum.

https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/Downloads/CCSimplified091809.pdf

Costs During the Part D Coverage Gap "Donut Hole"

The coverage gap begins after your initial coverage limit is reached and prior to your catastrophic coverage threshold. The specific amounts are listed on Medicare.gov on the links listed below:

https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/costs-in-the-coverage-gap

https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage

Stand Alone PDP Reminder

Members of MA only coordinated care plans (HMO, POS, PPO) cannot also enroll in a stand-alone PDP. If they enroll in a stand-alone PDP, they will be disenrolled from their MA only coordinated care plan.

What if I'm taking a drug that isn't on my plan's drug list when my drug plan coverage begins?

Generally, your drug plan will give you a one-time, temporary supply of your current drug during your first 90 days in a plan. Plans must give you this temporary supply so that you and your prescriber have time to find another drug on the plan's formularies (drug list) that will work as well as what you're taking now, or you or your prescriber can contact the plan to ask for an exception.

Your Guide to Medicare Prescription Drug Coverage Booklet:

https://www.medicare.gov/Pubs/pdf/11109-Your-Guide-to-Medicare-Prescrip-Drug-Cov.pdf

Q. What if you need a drug not covered by your plan?

A. Learn how to appeal for an exception on Medicare.gov: https://www.medicare.gov/claims-appeals/file-an-appeal/medicare-prescription-drug-coverage-appeals

Helpful Ideas to Help Lower Spending on Prescription Drugs

- Talk with your doctor.
- Take your medications as directed.
- Check your bill, like you would at a restaurant. Use your plan's preferred pharmacies.
- Try a mail-order pharmacy.
- Sign up for a pharmacy discount program.
- Switch to generics whenever possible.
- Check into state subsidy programs.
- Find out about discounts from pharmaceutical companies.
- See if you qualify for Extra Help.
- Review your Medicare Part D plan.

- Use your preventive care benefits.
- Choose a healthier lifestyle.

Why is this important? Finding savings for an individual can help to fund the additional coverage a person needs or help to maintain current coverage they may have.

Generic Drugs

Generic drugs are important options that allow greater access to health care for all Americans. They are copies of brand-name drugs and are the same as those brand name drugs in dosage form, safety, strength, route of administration, quality, performance characteristics and intended use.

FDA on Generics

https://www.fda.gov/drugs/buying-using-medicine-safely/generic-drugs

First Generic Drug Approvals - "First generics" are just what they sound like—the first approval by FDA which permits a manufacturer to market a generic drug product in the United States. Find the list, updated yearly, here: https://www.fda.gov/Drugs/DevelopmentApprovalProcess/HowDrugsareDevelopedandApproved/DrugandBiologicApprovalReports/ANDAGenericDrugApprovals/default.htm

Patents are a property right granted by the United States Patent and Trademark Office anytime during the development of a drug and can encompass a wide range of claims. Exclusivity refers to certain delays and prohibitions on approval of competitor drugs available under the statute that attach upon approval of a drug or of certain supplements.

How long is a patent term?
Patent terms are set by statute. Currently, the term of a new patent is 20 years from the date on which the application for the patent was filed in the United States. Many other factors can affect the duration of a patent.

How long does an exclusivity period last?
It depends on what type of exclusivity is at issue.

- Orphan Drug Exclusivity (ODE) – 7 years
- New Chemical Entity Exclusivity (NCE) – 5 years
- Generating Antibiotic Incentives Now (GAIN) Exclusivity– 5 years added to certain exclusivities
- New Clinical Investigation Exclusivity – 3 years
- Pediatric Exclusivity (PED) – 6 months added to existing Patents/Exclusivity
- Patent Challenge (PC) – 180 days (this exclusivity is for ANDAs only)

See 21 C.F.R. 314.108, 316.31, 316.34 and sections 505A, 505E, and 505(j)(5)(B)(iv) of the FD&C Act.

https://www.fda.gov/drugs/developmentapprovalprocess/ucm079031.htm#howlongpatentterm

Why is this Important? The use of generics is one of the largest ways your clients can save out of pocket expenses. If you can save money it can be redirected into building a more comprehensive benefit package.

Drugs Covered by Medicare Part B

- Drugs used with an item of durable medical equipment (DME): Medicare covers drugs infused through an item of DME, like an infusion pump or drugs given by a nebulizer.
- Some antigens: Medicare will help pay for antigens if they're prepared by a doctor and given by a properly instructed person (who could be you, the patient) under appropriate supervision.

- Injectable osteoporosis drugs: Medicare helps pay for an injectable drug for osteoporosis for certain women.
- Erythropoiesis–stimulating agents: Medicare will help pay for erythropoietin by injection if you have End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant) or need this drug to treat anemia related to certain other conditions.
- Blood clotting factors: If you have hemophilia, Medicare will help pay for clotting factors you give yourself by injection.
- Injectable and infused drugs: Medicare covers most injectable and infused drugs given by a licensed medical provider.
- Immunosuppressive drugs: Part B covers immunosuppressive drug therapy if Medicare helped pay for your organ transplant.
    - Note: Medicare Prescription Drug Plans may cover immunosuppressive drugs, even if Medicare didn't pay for the transplant. Part D also may cover other immunosuppressive drugs that aren't covered by Part B.
- Oral cancer drugs: Medicare will help pay for some cancer drugs you take by mouth if the same drug is available in injectable form or is a prodrug of the injectable drug. As new oral cancer drugs become available, Part B may cover them.
- Oral anti-nausea drugs: Medicare will help pay for oral anti-nausea drugs used as part of an anti-cancer chemotherapeutic regimen. The drugs must be administered immediately before, at, or within 48 hours after chemotherapy, and must be used as a full therapeutic replacement for an intravenous ant nausea drug.

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

Why is this important? When running drug comparisons, you may run across very expensive medications showing as not covered by Part D plans. Often these are drugs covered under Medicare Part B.

Opioid Drugs

Opioid drugs can treat both acute and chronic pain. While these types of drugs can have benefits for many patients with serious pain-related conditions, these drugs cause serious and substantial harm when used improperly. Even when used as directed, they contribute to overdose or lead to development of substance use disorder in some individuals.

CDC looks at four categories of opioids:

1. **Natural opioid analgesics,** including morphine and codeine, and **semi-synthetic opioid analgesics,** including drugs such as oxycodone, hydrocodone, hydromorphone, and oxymorphone;
2. **Methadone,** a synthetic opioid;
3. **Synthetic opioid analgesics** other than methadone, including drugs such as tramadol and fentanyl; and
4. **Heroin,** an illicit (illegally-made) opioid synthesized from morphine that can be a white or brown powder, or a black sticky substance.

"We now know that overdoses from prescription opioids are a driving factor in the 15-year increase in opioid overdose deaths. Since 1999, the amount of prescription opioids sold in the U.S. nearly quadrupled, yet there has not been an overall change in the amount of pain that Americans report. Deaths from prescription opioids—drugs like oxycodone, hydrocodone, and methadone—have more than quadrupled since 1999."

Source: https://www.cdc.gov/drugoverdose/epidemic/index.html

Why is this important? Due to this epidemic you can expect insurers to respond to CMS requests by removing some drugs from formularies, prior authorization, quantity limits, and drug utilization review.

Part D Late Enrollment Penalty

The cost of the late enrollment penalty depends on how long you went without Part D or creditable prescription drug coverage. Creditable prescription drug coverage is coverage that's expected to pay, on

average, at least as much as Medicare's standard prescription drug coverage.

Medicare calculates the penalty by multiplying 1% of the "national base beneficiary premium" times the number of full, uncovered months you didn't have Part D or creditable coverage. The monthly premium is rounded to the nearest $.10 and added to your monthly Part D premium.

https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/part-d-late-enrollment-penalty

> Q.) Can a person who doesn't agree with the late enrollment penalty pay only the premium and ignore the penalty?
>
> A.) No. According to Medicare law, the late enrollment penalty is part of the premium, so a person who has a late enrollment penalty must pay it with the premium. A person with a late enrollment penalty must also pay the penalty even if he or she asked Medicare's contractor to review its decision, and the person hasn't yet gotten a decision. Medicare drug plans can disenroll members who don't pay their premiums, including the late enrollment penalty portion of the premium.

Late Enrollment Penalty (LEP) Appeals Information

https://www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/Late-Enrollment-Penalty-LEP-Appeals.html

Medicare Appeals Publication (Form 11525)

https://www.medicare.gov/Pubs/pdf/11525-Medicare-Appeals.pdf?

Why is this important? Late enrollment penalties stay with you for life, so the costs can really add up. Clients often decline PDP plans because they do not currently take prescriptions and do not see the need. It is important for them to realize that like any other risk their situation can change at any time and they are limited as to when they can enroll. A delayed decision can cost money for their medications and their penalties.

MEDICARE SUPPLEMENT

Medicare Supplements

Medicare Supplements are a staple for agents in the senior market. It is vital that agents know the differences in plans and carriers. Agents that compare only price when selling ultimately hurt both themselves and their clients. You can expect these products to continue to evolve due to changes in laws affecting them as well as companies offering new plans, rate changes, or carriers entering or exiting the market. All these changes create sales opportunities for you, the agent.

Medicare Supplement Points to Ponder:

- A Medigap policy is different from a Medicare Advantage Plan (like an HMO or PPO). Medicare Advantage plans are ways to get Medicare benefits, while a Medigap policy only supplements the costs of your Original Medicare benefits.
- In most states, standardized policies, or plans, are identified by the letters A, B, C, D, F, G, K, L, M, and N. Each type of plan generally contains the same benefits in all states. In Massachusetts, Minnesota, and Wisconsin, benefits will be labeled differently, but the policies are still standardized within each state.
- Any Medigap policy is guaranteed renewable even if you have health problems. This means the insurance company can't cancel your Medigap policy as long as you pay the premium.
- Plans F and G also offer a high-deductible plan in some states. With this option, you must pay for Medicare-covered costs (coinsurance, copayments, and deductibles) up to the deductible amount of $2,340 in 2020 before your policy pays anything. (Plans C and F won't be available to people who are newly eligible for Medicare on or after January 1, 2020.)

Plan F or G?

Remember that carriers that offer plan F Medicare supplements almost always withhold the amount of the part B deductible or more from the annual premium amount before calculating your commissions. Since offering plan G offers possible savings for your client that can be used for added benefits it also offers the opportunity to increase your income.

Medigap Policies Can Be Priced or "Rated" In Three Ways

Community-rated (also called "no age-rated")

How it's priced: Generally, the same monthly premium is charged to everyone who has the Medigap policy, regardless of age.

What this pricing may mean for you: Your premium isn't based on your age. Premiums may go up because of inflation and other factors, but not because of your age.

Issue-age-rated (also called "entry age-rated")

How it's priced: The premium is based on the age you are when you buy the Medigap policy.

What this pricing may mean for you: Premiums are lower for people who buy at a younger age and won't change as you get older. Premiums may go up because of inflation and other factors, but not because of your age.

Attained-age-rated

How it's priced: The premium is based on your current age, so your premium goes up as you get older.

What this pricing may mean for you: Premiums are low for younger buyers but go up as you get older. They may be the least expensive at first, but they can eventually become the most expensive. Premiums may also go up because of inflation and other factors

https://www.medicare.gov/supplements-other-insurance/whats-medicare-supplement-insurance-medigap/medigap-costs/costs-of-medigap-policies

Medigap Plans in Massachusetts, Minnesota, and Wisconsin

In Massachusetts, Minnesota, and Wisconsin, Medigap policies are standardized in a different way. These are called waiver states. This means that they:

- Provide different kinds of Medigap policies NOT labeled with letters
- Provide comparable benefits to standardized plans
- Have a different system that includes basic ("core") and optional ("rider") benefits

Massachusetts: https://www.medicare.gov/supplements-other-insurance/how-to-compare-medigap-policies/medigap-in-massachusetts

Minnesota: https://www.medicare.gov/supplements-other-insurance/how-to-compare-medigap-policies/medigap-in-minnesota

Wisconsin: https://www.medicare.gov/supplements-other-insurance/how-to-compare-medigap-policies/medigap-in-wisconsin

Plan F Did Not Go Away in 2020

Many are concerned and thinking that Plan F was going away in 2020 because of changes made by the MACRA law. It did not. The only change was in availability to newly eligible individuals, not benefits. An estimated 60 million individuals were able to keep or purchase plan F after 01/01/2020.

> **SEC. 401. LIMITATION ON CERTAIN MEDIGAP POLICIES FOR NEWLY ELIGIBLE MEDICARE BENEFICIARIES.**
>
> Section 1882 of the Social Security Act (42 U.S.C. 1395ss) is amended by adding at the end the following new subsection:
>
> ''(z) LIMITATION ON CERTAIN MEDIGAP POLICIES FOR NEWLY
>
> ELIGIBLE MEDICARE BENEFICIARIES. —
>
> ''(1) IN GENERAL.—Notwithstanding any other provision of this section, on or after January 1, 2020, a Medicare supplemental policy that provides coverage of the part B deductible, including any such policy (or rider to such a policy) issued under a waiver granted under subsection (p)(6), may not be sold or issued to a newly eligible Medicare beneficiary.

''(2) NEWLY ELIGIBLE MEDICARE BENEFICIARY DEFINED. —

In this subsection, the term 'newly eligible Medicare beneficiary' means an individual who is neither of the following:

''(A) An individual who has attained age 65 before

January 1, 2020.

''(B) An individual who was entitled to benefits under part A pursuant to section 226(b) or 226A, or deemed to be eligible for benefits under section 226(a), before January 1, 2020.

Medicare Access and CHIP Reauthorization Act of 2015:
https://www.congress.gov/114/plaws/publ10/PLAW-114publ10.pdf

Dropping Group Coverage for a Medicare Supplement

Employers (with 20 or more employees) may not offer any incentives, financial or otherwise, to discourage Medicare beneficiaries from enrolling in the group health plan. Medicare beneficiaries are free to reject employer plan coverage, in which case they retain Medicare as their primary coverage. When Medicare is primary payer, employers cannot offer such employees or their spouse's secondary coverage for items and services covered by Medicare. Employers may not sponsor or contribute to individual Medigap or Medicare supplement policies for beneficiaries who have or whose spouse has current employment status.

https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Medicare-Secondary-Payer/Medicare-Secondary-Payer

https://www.govinfo.gov/content/pkg/CFR-2012-title42-vol2/pdf/CFR-2012-title42-vol2-sec411-103.pdf

You have Original Medicare and an employer group health plan (including retiree or COBRA coverage) or union coverage that pays after Medicare pays and that plan is ending.

When to apply for a Medigap policy...

- If you have COBRA coverage, you can either buy a Medigap policy right away or wait until the COBRA coverage ends.

You can apply for a Medicare Supplement no later than 63 calendar days after the latest of these 3 dates:

- Date the coverage ends
- Date on the notice you get telling you that coverage is ending (if you get one)
- Date on a claim denial, if this is the only way you know that your coverage ended

https://www.medicare.gov/supplements-other-insurance/when-can-i-buy-medigap/guaranteed-issue-rights

An employee who receives a W-2 Form and receives Medicare benefits is a likely suspect for review. So, employers who have employees who voluntarily decline the group health plan, you need to be watching for a Data Match form.

https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/EmployerServices/IRS-SSA-CMS-Data-Match.html

Medigap Guaranteed Issue Rights

Guaranteed issue rights (also called "Medigap protections") are rights you have in certain situations when insurance companies must offer you certain Medigap policies. In these situations, an insurance company:

- Must sell you a Medigap policy
- Must cover all your pre-existing health conditions
- Can't charge you more for a Medigap policy because of past or present health problems.

Learn more about the details on Medicare.gov

https://www.medicare.gov/find-a-plan/staticpages/learn/rights-and-protections.aspx

What's Medicare SELECT?

Medicare SELECT is a type of Medigap policy sold in some states that requires you to use hospitals and, in some cases, doctors within its network to be eligible for full insurance benefits (except in an emergency). Medicare SELECT can be any of the standardized Medigap plans. These policies generally cost less than other Medigap policies. However, if you don't use a Medicare SELECT hospital or doctor for non-emergency services, you'll have to pay some or all of what Medicare doesn't pay. Medicare will pay its share of approved charges no matter which hospital or doctor you choose.

https://www.medicare.gov/Publications/#results&keyword=02110

Why is this important? Medicare SELECT plans can offer your clients a potential low-cost alternative Medigap plan. Note, Medicare SELECT plans have SEP rights similar to Medicare Advantage plans.

MEDICARE ADVANTAGE

MA Points to Ponder

- Medicare Advantage Plans, sometimes called "Part C" or "MA Plans", are offered by private companies approved by Medicare. Medicare pays these companies to cover your Medicare benefits.
- You must have Medicare Parts A and B and live in the plan's service area to be eligible to join.
- Medicare Advantage Plans must cover all services Original Medicare covers except hospice care. Original Medicare covers hospice care even if you're in a Medicare Advantage Plan
- Most Medicare Advantage Plans include Medicare prescription drug coverage (Part D).
- Medicare Advantage Plans are a twelve-month sales opportunity!

Using Medicare.gov to Compare MA and PDP Plans

On the right side of the plan finder section of Medicare.gov there is a five-part video training series for using the plan finder. This step by step tool is a fantastic refresher, or agent training tool. You can find it here: https://www.medicare.gov/find-a-plan/questions/home.aspx

Determine Eligibility or Calculate Medicare Premium Amounts

If you are unsure of what a client's Medicare premium will be, use this calculator to get an estimate of when they are eligible for Medicare and their premium amount. Find it here:

https://www.medicare.gov/EligibilityPremiumCalc/

Medicare Advantage Trial Period

Medicare Advantage Trial Period applies if you joined a Medicare Advantage Plan or Programs of All-inclusive Care for the Elderly (PACE) when you were first eligible for Medicare Part A at 65, and within the first year of joining you decide to switch to Original Medicare. (Trial Right)

- You have the right to buy any Medigap policy that's sold by any insurance company in your state.
- You can/must apply for a Medigap policy as early as 60 calendar days before the date your coverage will end, but no later than 63 calendar days after your coverage ends.

Scenario 1: you joined a Medicare Advantage Plan or Programs of All-inclusive Care for the Elderly (PACE) when you were first eligible for Medicare Part A at 65, and within the first year of joining, you decide to switch to Original Medicare. (Trial Right) You have the right to buy any Medigap policy that's sold by any insurance company in your state. You can/must apply for a Medigap policy as early as 60 calendar days before the date your coverage will end, but no later than 63 calendar days after your coverage ends.

Medicare Advantage Trial Period also applies if you dropped a Medigap policy to join a Medicare Advantage plan (or to switch to a Medicare SELECT policy) for the first time, you've been in the plan for less than a year, and you want to switch back (Trial Right).

- You have the right to buy the Medigap policy you had before you joined the Medicare Advantage Plan or Medicare SELECT policy, if the same insurance company you had before still sells it.
- If your former Medigap policy isn't available, you can buy a Medigap Plan A, B, C*, F*, K, or L that's sold by any insurance company in your state. *Plans C and F won't be available to people who are newly eligible for Medicare on or after January 1, 2020. Plans D and G would replace them for individuals eligible after January 1, 2020.
- You can/must apply for a Medigap policy as early as 60 calendar days before the date your coverage will end, but no later than 63 calendar days after your coverage ends.

Scenario 2: you dropped a Medigap policy to join a Medicare Advantage Plan (or to switch to a Medicare SELECT policy) for the first time, you've been in the plan less than a year, and you want to switch back (Trial Right). You have the right to buy the Medigap policy you had before

you joined the Medicare Advantage Plan or Medicare SELECT policy, if the same insurance company you had before still sells it. If your former Medigap policy isn't available, you can buy a Medigap Plan A, B, C*, F*, K, or L that's sold by any insurance company in your state.

*Plans C and F won't be available to people who are newly eligible for Medicare on or after January 1, 2020. Plans D and G would replace them for individuals eligible after January 1, 2020.

https://www.medicare.gov/Pubs/pdf/02110-Medicare-Medigap-guide.pdf

What if I need Durable Medical Equipment and I'm in a Medicare Advantage Plan?

Medicare Advantage Plans (like an HMO or PPO) must cover the same items and services as Original Medicare. Your costs will depend on which plan you choose. If you're in a Medicare Advantage Plan and you need DME, call your plan to find out if the equipment is covered and how much you'll have to pay. If you're getting home care or using medical equipment and you choose to join a new Medicare Advantage Plan, you should call the new plan as soon as possible and ask for "Utilization Management". They can tell you if your equipment is covered and how much it will cost.

Find details in this Medicare publication:

https://www.medicare.gov/Pubs/pdf/11045-Medicare-Coverage-of-DME.PDF?

Rapid Disenrollment

A Rapid Disenrollment is when the member leaves the plan voluntarily within the first three months.

The key difference between the Cancelled Application program and the Rapid Disenrollment program is that cancelled applications take place prior to the effective date, whereas rapid disenrollments take

place after the effective date. Complete commission loss happens when a client voluntarily disenrolls within the first three months (i.e. a rapid disenrollment), and the full amount of commission paid is charged back.

MEDICAID & SPECIAL ASSISTANCE PROGRAMS

Qualifying for Medicare Savings Programs: QMB, SLMB, QI and QDWI

You can get help from your state paying your Medicare premiums. In some cases, Medicare Savings Programs may also pay Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) deductibles, coinsurance, and copayments if you meet certain conditions.

There are four kinds of Medicare Savings Programs

- Qualified Medicare Beneficiary (QMB) Program
- Specified Low-Income Medicare Beneficiary (SLMB) Program
- Qualifying Individual (QI) Program
- Qualified Disabled and Working Individuals (QDWI) Program

https://www.medicare.gov/your-medicare-costs/help-paying-costs/medicare-savings-program/medicare-savings-programs.html

Find programs available in your state:

https://www.medicare.gov/contacts/#resources/msps

The following is an excerpt from Medicareinteractive.org:

"How your income and assets are counted to determine eligibility varies from state to state.

In all states, the following income will never be counted:

- *The first $20 of all income*
- *The first $65 of monthly wages*
- *One-half of your monthly wages (after the $65 is deducted)*
- *Food stamps*

Some states may not count more income, and/or may exclude things from your income, such as the money you use to pay health insurance premiums (like Part B premiums). Also, if there are more than two people in your household, in some states you can have higher income.

In all states, the following assets will never be counted:

- *Your primary house*

- *Your car*
- *Burial spaces*
- *Household goods and wedding/engagement rings*
- *Burials funds for you and your spouse valued up to $1,500 each*
- *Life insurance with a cash value of less than $1,500*

Many states do not count other types of assets. Some states have no asset test."

http://www.medicareinteractive.org/get-answers/programs-for-people-with-limited-income/medicare-savings-programs-qmb-slmb-qi/should-i-apply-for-a-medicare-savings-program-if-i-am-over-the-income-limit

QMB/SLMB/QI/QDWI Dual Eligible Standards

Based on Percentage of Federal Poverty Level

- Qualified Medicare Beneficiary (QMB): Monthly Income Limits: (100% FPL + $20) *
- Specified Low-Income Medicare Beneficiary (SLMB): Monthly Income Limits: (120% FPL + $20) *
- Qualifying Individual (QI): Monthly Income Limits: (135% FPL + $20) *
- Qualified Disabled Working Individual (QDWI): Monthly Income Limits: (200% FPL + $20) *

**$20 = Amount of the Monthly SSI Income Disregard*

Annual poverty guidelines: https://aspe.hhs.gov/poverty-guidelines

Medicaid.gov Info: https://www.medicaid.gov/medicaid/eligibility/medicaid-enrollees/index.html

What Is SSI?

SSI stands for Supplemental Security Income. Social Security administers this program. Social Security pays monthly benefits to people with limited income and resources who are disabled, blind, or age 65 or older.

Blind or disabled children may also get SSI. Understanding SSI: https://www.ssa.gov/ssi/text-understanding-ssi.htm

States pay the Medicare premiums for people who receive SSI benefits if they are also eligible for Medicaid. If you get SSI and have Medicare, you will also be eligible for Extra Help with Medicare Prescription Drug Coverage without filing a separate application. See the web site at: www.socialsecurity.gov/medicare/prescriptionhelp/

Why this is important? For an agent in the senior market there are many networking opportunities within your community with governmental organizations, attorneys and others who work with Medicare dual eligible individuals. If you work in this market a basic understanding of SSI will prove helpful.

Part D Plans and Assistance Programs

HUD Housing Assistance

If you get housing assistance from the Department of Housing and Urban Development (HUD), you may want to join a Medicare Prescription Drug Plan.

If you qualify for extra help, you won't lose your housing assistance. However, your housing assistance may be reduced as your prescription drug spending decreases. The value of the Extra Help paying your drug costs will make up for any decrease in your housing assistance.

https://www.hud.gov/topics/rental_assistance/phprog

Food Stamps

If you get food stamps, you may want to join a Medicare Prescription Drug Plan. If you qualify for Extra Help, your food stamp benefits may decline, but that decline will be offset by Extra Help.

If you're near the food stamps eligibility cutoff, you may lose your minimum food stamp benefits because you'll be paying less for your prescription drugs.

Why is this important? When meeting with clients it is very important to take a holistic look at their situation. Enrollment in one plan can impact their other health or assistance programs.

Additional Resources

Information on Medicare.gov:

https://www.medicare.gov/part-d/how-part-d-works-with-other-insurance/part-d-and-other-insurance.html#collapse-5022

Social Security Publication: *Understanding the Extra Help with Your Medicare Prescription Drug Plan*

https://www.ssa.gov/pubs/EN-05-10508.pdf

Eligible for Medicaid?

An individual can apply for Medicaid any time of year — Medicaid does not have an Open Enrollment Period. If your client makes you aware of situations that may warrant looking into Medicaid coverage be sure to explore this option.

Links for your clients to find out if they qualify:

- https://www.healthcare.gov/medicaid-chip/
- https://www.medicaid.gov/medicaid/eligibility/medicaid-enrollees/index.html

Why is this important? Your client having Medicaid often opens opportunities to enrollment into DSNP plans. It also allows your client to access much needed assistance. Be sure to complete the required certification to offer these plans.

Dual Eligible SNP (D-SNP): You Have Both Medicare and Medicaid

Some people who are eligible for both Medicare and Medicaid are called "dual eligibles." If you have Medicare and full Medicaid coverage, most of your health care costs are likely covered. You can join a Medicare SNP if you have Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance), live in the plan's service area, and meet the plan's eligibility requirements.

You can stay enrolled in a SNP only if you continue to meet the special conditions served by the plan. For example, if you joined a Medicare SNP that only serves members with both Medicare and Medicaid and you lose your Medicaid eligibility, Medicare requires the plan to disenroll you if you don't become eligible for Medicaid again within the plan's grace period.

The grace period is at least one month long, but plans can choose to have a longer grace period. If you lose eligibility for the plan, you'll have a Special Enrollment Period to make another choice.

This Special Enrollment Period starts when your Medicare SNP notifies you that you're no longer eligible for the plan. It continues during the plan's grace period, and if you're disenrolled from the plan at the end of the grace period, it continues for two months after your coverage ends.

https://www.medicare.gov/sign-up-change-plans/types-of-medicare-health-plans/how-medicare-special-needs-plans-snps-work

BenefitsCheckUp

Developed and maintained by the National Council on Aging (NCOA), BenefitsCheckUp is the nation's most comprehensive Web-based service to screen for benefits programs for seniors with limited income and resources. It includes more than 2,000 public and private benefits programs from all 50 states and the District of Columbia.

Answer a few simple questions and get a personalized report with tips on how you can better manage your budget, save money, and set financial goals. It's free, confidential, and from a trusted source—the nonprofit National Council on Aging.
https://www.benefitscheckup.org/esi-home/

Core Benefits Cheat Sheet

Explains eligibility, determinations, and funding for core benefits for Medicare beneficiaries.

LIS/QMB/SLMB/QI/Energy Assistance/Medicaid/Food Stamps/SSI

https://www.ncoa.org/wp-content/uploads/Core-Benefits-Cheat-Sheet.pdf

Online Access to Government Benefit and Assistance Programs

The site's core function is the eligibility prescreening questionnaire or "Benefit Finder." Answers to the questionnaire are used to evaluate a visitor's situation and compare it with the eligibility criteria for more than 1,000 Federally-funded benefit and assistance programs. Each program description provides citizens with the next steps to apply for any benefit program of interest.
http://www.benefits.gov/

Researching Market Potential? - Check out This Benefits Map

What does enrollment in core benefits look like in your state? Use this data mapping tool to find out. Discover key figures related to Medicare enrollment and enrollment in the Part D Low Income Subsidy (LIS), Medicare Savings Programs, Supplemental Nutrition Assistance Program (SNAP), Medicaid, and more.

https://www.ncoa.org/economic-security/benefits/visualizations/

State Medicaid Information

Some people who are eligible for both Medicare and Medicaid are called “dual eligibles.” If you have Medicare and full Medicaid coverage, most of your health care costs are likely covered. You can get your Medicare coverage through Original Medicare or a Medicare Advantage Plan (Part C).

Use the map located on Medicaid.gov to find details about eligibility, benefits and much more about the Medicaid program in your state.

https://www.medicaid.gov/medicaid/by-state/by-state.html

Why is this important? The dual eligible market is one of the most open and profitable markets available to agents today. If you are not familiar with the products available to individuals with Medicaid, we strongly encourage you to contact us as soon as possible.

Part D Extra Help Notices

Purple Deemed Status Notice

If you get this PURPLE notice it means you automatically qualify for Extra Help, because of any of the following:

You have both Medicare and Medicaid.

You're in a Medicare Savings Program.

You get Supplemental Security Income (SSI) benefits.

https://www.medicare.gov/forms-help-resources/mail-you-get-about-medicare/deemed-status-notice

Yellow or Green Auto-Enrollment Notice

If you get this YELLOW notice it means you automatically qualify for Extra Help because you qualify for Medicare and Medicaid and currently get benefits through Original Medicare. You'll be automatically enrolled in a Medicare Prescription Drug Plan unless you decline coverage or join a plan yourself.

https://www.medicare.gov/forms-help-resources/mail-you-get-about-medicare/auto-enrollment-notice

Social Security LIS & MSP Outreach Notice

Mailed in May

If Medicare thinks you might be eligible for a Medicare Savings Program (MSP), this notice tells you about MSPs and the Extra Help available for Medicare prescription drug coverage.

https://www.medicare.gov/forms-help-resources/mail-you-get-about-medicare/social-security-lis-msp-outreach-notice-may

Orange Change in Extra Help Copayment Notice

You'll get this ORANGE notice if Social Security determines that you still automatically qualify for Extra Help but will have different copayment levels next year.

https://www.medicare.gov/forms-help-resources/mail-you-get-about-medicare/change-extra-help-copayment-notice

Extra Help with Medicare Prescription Drug Plan Costs

Medicare beneficiaries can qualify for Extra Help with their Medicare prescription drug plan costs. The Extra Help is estimated to be worth about $4,000 per year. To qualify for the Extra Help, a person must be receiving Medicare, have limited resources and income, and reside in one of the 50 States or the District of Columbia.

Extra help outlined on medicare.gov:

https://www.medicare.gov/your-medicare-costs/get-help-paying-costs/save-on-drug-costs

If interested in qualifying for financial "Extra Help" with the Medicare Part D Prescription Drug plans individuals should visit:

https://secure.ssa.gov/i1020/start

Medicare Publication on how to apply online:

https://www.ssa.gov/pubs/EN-05-10531.pdf

Providing proof to a plan of your extra help:

https://www.medicare.gov/index.php/your-medicare-costs/get-help-paying-costs/find-your-level-of-extra-help-part-d

State Pharmaceutical Assistance Programs: https://www.medicare.gov/pharmaceutical-assistance-program/state-programs.aspx?varstate=NY&pp=Savings

What to do if You No Longer Automatically Qualify for Extra Help with Medicare Prescription Drug Costs

You may no longer qualify for Extra Help if your income and resources changed since last year and that caused you to no longer to qualify. If the level of Extra Help you qualify for is changing, you will get a notice (on orange paper) in the mail in early October that will show your new copayment amounts. If you don't get a notice from Medicare, then you'll get the same level of Extra Help the year prior although your copayment may change. You'll still get a notice from your drug plan letting you know what your copayments will be.

Medicare Publication: https://www.medicare.gov/Pubs/pdf/11215-No-Longer-Automatically-Qualify-Extra-He.pdf

State Pharmaceutical Assistance Programs (SPAP)

Many states offer help paying drug plan premiums and/or other drug costs. These plans are called state pharmaceutical assistance programs. An individual who is eligible for and enrolled in a SPAP also has a onetime special enrollment period. (SPAP SEP - If you're enrolled in a State Pharmaceutical Assistance Program (SPAP) you may join either a Medicare Prescription Drug Plan or a Medicare Advantage Plan with prescription drug coverage once during the calendar year. https://www.medicare.gov/pharmaceutical-assistance-program/state-programs.aspx

County by County Look at Dual Eligible Enrollment

The visualization enables you to view enrollment in each dual eligible (Medicaid and Medicare Savings Programs) program at the state and county level. To view national data, select (All) for State and (All) for County. To see state-level data, select your State and choose (All) for County. County-level data can be viewed by selecting your state and then your county from the list.

https://www.ncoa.org/economic-security/benefits/visualizations/medicare-savings-program-visualization/

Why is this important? Building your marketing plan needs to include any consumers for the products you market. If you are marketing Medicare advantage plans the dual eligible market can unlock tremendous opportunity. Note: Make sure you have completed all necessary certifications.

QMB versus QMB Plus

Qualified Medicare Beneficiary (QMB Only)

A "QMB" is an individual who is entitled to Medicare Part A, has income that does not exceed 100% of the Federal Poverty Level (FPL), and whose resources do not exceed twice the Supplemental Security Income (SSI) limit. A QMB is eligible for Medicaid payment of Medicare premiums, deductibles, co-insurance and co-pays (except for Part D). QMBs who do not qualify for any additional Medicaid Benefits are called "QMB Only."

For the QMB Only population, Medicaid does not pay for services not covered by Medicare Part A or Part B.

Qualified Medicare Beneficiary (QMB): Monthly Income Limits: (100% FPL + $20*)

*$20 = Amount of the Monthly SSI Income Disregard

QMB Plus

A "QMB Plus" is an individual who meets all the standards for QMB eligibility as described above, but who also meets the financial criteria for full Medicaid coverage. Such individuals are entitled to all benefits available to a QMB, as well as all benefits available under the State Plan to a fully eligible Medicaid recipient. These individuals often qualify for full Medicaid benefits by meeting the Medically Needy standards, or through spending down excess income to the Medically Needy level.

List and Definition of Dual Eligible

https://www.medicaid.gov/medicaid/eligibility/seniors-medicare-and-medicaid-enrollees/index.html

Federal Poverty Levels

https://aspe.hhs.gov/poverty-guidelines

Why is this important? The dual eligible market is one of the largest populations available to the senior agent for Medicare advantage sales.

Medicaid Spend Down

Even if your income exceeds Medicaid income levels in your state, you may be eligible under Medicaid "spend down" rules. Under the spend down process, some states allow you to become eligible for Medicaid as "medically needy," even if you have too much income to qualify. This process allows you to "spend down," or subtract, your medical expenses from your income to become eligible for Medicaid.

To be eligible as "medically needy," your measurable resources also must be under the resource amount allowed in your state. Call your state Medicaid program to see if you qualify and learn how to apply.

List of State Medicaid Offices - Contact Information:

https://www.medicaid.gov/about-us/contact-us/contact-state-page.html

Why is this important? Individuals often need to decide if they want to continue to carry their Medicare supplement coverage when they become eligible for spend down. Understanding spend down is necessary to help your clients make this important decision.

Medicare and Medicaid Milestones 1937-2015

Understanding Medicare through looking at its history.

https://www.cms.gov/About-CMS/Agency-Information/History/Downloads/Medicare-and-Medicaid-Milestones-1937-2015.pdf

Why is this important? Watching the progress of Medicare can help you better understand the programs now in place and why they are important.

HELPING CLIENTS WITH SPECIAL CONDITIONS

Nursing Home Stays – Medicare and Medicaid Facts and Resources

The most significant difference between Medicare and Medicaid when it comes to nursing home coverage is that Medicaid covers nursing home care, while Medicare, largely, does not. Medicare Part A covers only up to 100 days of care in a "skilled nursing" facility per spell of illness. The care in the skilled nursing facility must follow a stay of at least three midnights in a hospital. And for days 21 through 100, you must pay a copayment.

Medicaid is a joint federal and state government program that helps people with low income and assets. It covers long-term care services in nursing homes, and long-term care services provided at home, such as visiting nurses and assistance with personal care. Unlike Medicare, Medicaid does pay for custodial care in nursing homes and at home.

Medicaid

Applying for Medicaid

https://longtermcare.acl.gov/medicare-medicaid-more/medicaid/applying-for-medicaid.html

Links to view Medicaid qualifications:

https://www.healthcare.gov/medicaid-chip/

https://www.medicaid.gov/medicaid/eligibility/medicaid-enrollees/index.html

What is Covered by Medicaid in Nursing Facilities:

https://www.medicaid.gov/medicaid/ltss/institutional/nursing/index.html

"Commonly an individual will enter a Medicare SNF following a hospitalization that qualifies him or her for a limited period of SNF services. If nursing home services are still required after the period of SNF coverage, the individual may pay privately, and use any long-term care insurance they may have. If the individual exhausts assets and is eligible for Medicaid, and the nursing home is also a Medicaid certified nursing facility, the individual may continue to reside in the nursing home under the Medicaid NF benefit. If the nursing home is not Medicaid certified, he or she would have to transfer to a NF to be covered by the Medicaid NF benefit." – Medicaid.gov

Medicare.gov Resources

Comparing Nursing Homes

https://www.medicare.gov/nursinghomecompare/search.html

Skilled Nursing Facility (SNF) Care Benefits

https://www.medicare.gov/coverage/skilled-nursing-facility-snf-care

Skilled Nursing Facility Rights

https://www.medicare.gov/what-medicare-covers/what-part-a-covers/skilled-nursing-facility-rights

Situations that may impact your SNF coverage and costs:

https://www.medicare.gov/what-medicare-covers/skilled-nursing-facility-snf-situations

Information for nursing home residents, family members, and care givers:

https://www.medicare.gov/NursingHomeCompare/Resources/inforesidents.html

Medicare Publications

Medicare Coverage of Skilled Nursing Facility Care (Publication #10153)

https://www.medicare.gov/Pubs/pdf/10153-Medicare-Skilled-Nursing-Facility-Care.pdf

Medicare & Skilled Nursing Facility Care Benefits Getting Started (Publication #11359)

https://www.medicare.gov/Pubs/pdf/11359-Medicare-Skilled-Nursing-Facility-Care-Getting-Started.pdf

Your Guide to Choosing a Nursing Home or Other Long-Term Services & Supports

(Publication #02174)

https://www.medicare.gov/Pubs/pdf/02174-Nursing-Home-Other-Long-Term-Services.pdf?

Skilled Nursing Facility (SNF) Checklist

https://www.medicare.gov/sites/default/files/2018-07/skilled-nursing-facility-checklist_0.pdf

Additional Resources

Long Term Care Ombudsman Program

https://ltcombudsman.org/

Longtermcare.gov on Medicare

https://longtermcare.acl.gov/medicare-medicaid-more/medicare.html

Longtermcare.gov Home Page

https://longtermcare.acl.gov/index.html

LTC Planning Information for Individuals Turning 65

https://longtermcare.acl.gov/pathfinder/65plus.html

"Someone turning age 65 today has almost a 70% chance of needing some type of long-term care services and supports in their remaining years."

Source: https://longtermcare.acl.gov/the-basics/how-much-care-will-you-need.html

End Stage Renal Disease (ESRD) and Medicare

You can get Medicare no matter how old you are if your kidneys no longer work, you need regular dialysis, or have had a kidney transplant, and one of these applies to you:

- You've worked the required amount of time under Social Security, Railroad Retirement Board, or as a government employee.
- You're already getting or are eligible for Social Security or Railroad Retirement benefits.
- You're the spouse or dependent child of a person who meets either of the requirements listed above.

Kidney failure, also called end-stage renal disease (ESRD), is the last stage of chronic kidney disease. When your kidneys fail, it means they have stopped working well enough for you to survive without dialysis or a kidney transplant.

The most common causes of ESRD are diabetes and high blood pressure since they can affect your kidneys.

Link to details: https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/End-Stage-Renal-Disease-ESRD/ESRD.html

Medicare Advantage and ESRD

Medicare Advantage (MA) Plans are generally not available to people with ESRD. For most people with ESRD, Original Medicare is usually the only option. There are exceptions that allow an individual to keep a Medicare Advantage if you are diagnosed after you have a MA plan.

Find more details at this site: https://www.medicare.gov/manage-your-health/i-have-end-stage-renal-disease-esrd/signing-up-for-medicare-if-you-have-esrd

Medicare Supplement and ESRD (Under 65) - If you have ESRD, you may not be able to buy the Medigap policy you want, or

any Medigap policy, until you turn 65. Federal law doesn't require insurance companies to sell Medigap policies to people under 65.

Medicare Supplement and ESRD (Turning 65) - Individuals with ESRD can apply for coverage during their open enrollment period when turning 65.

Part D and ESRD

Part D, Medicare prescription drug coverage, is available to all people with Medicare, including those entitled because of ESRD or a disability. Additional information can be found on MedcareInteractive.org: https://www.medicareinteractive.org/get-answers/medicare-covered-services/medicare-and-end-stage-renal-disease-esrd

Social Security's Disability Program

To receive disability benefits, a person must meet the definition of disability under the Social Security Act (Act). A person is disabled under the Act if he or she can't work due to a severe medical condition that has lasted, or is expected to last, at least one year or result in death. The person's medical condition must prevent him or her from doing work that he or she did in the past, and it must prevent the person from adjusting to other work.

https://www.ssa.gov/news/press/factsheets/disability.htm

Apply Online For Disability Benefits:

https://www.ssa.gov/disabilityssi/apply.html

Laws Regulating Medigap Policies for Individuals under Age 65

Federal law doesn't require insurance companies to sell Medigap policies to people under 65. However, as of 2020, the following states do require Medigap insurance companies to sell you a Medigap policy, even if you're under 65:

- Arkansas
- California
- Colorado
- Connecticut
- Delaware
- Florida
- Georgia
- Hawaii
- Illinois
- Idaho
- Kansas
- Kentucky
- Louisiana
- Maine
- Maryland
- Massachusetts
- Michigan
- Minnesota
- Mississippi
- Missouri
- Montana
- New Hampshire
- New Jersey
- New York
- North Carolina
- Oklahoma
- Oregon
- Pennsylvania
- South Dakota
- Tennessee
- Texas
- Vermont
- Wisconsin

Some states provide these rights to all people with Medicare under 65, while others only extend them to people eligible for Medicare because of

disability or only to people with ESRD. Check with your State Insurance Department about what rights you might have under state law.

Source: https://www.medicare.gov/Pubs/pdf/02110-Medicare-Medigap-guide.pdf

Social Security Disability Benefits

Social Security pays benefits to people who cannot work because they have a medical condition that is expected to last at least one year or result in death. SS will automatically enroll you in Medicare after you get disability benefits for two years. Social Security disability program Booklet: http://www.socialsecurity.gov/pubs/EN-05-10029.pdf

Why Understand Diabetes? – Because 25% of Your Clients Probably Have It!

Type 1 diabetes

A condition characterized by high blood glucose levels caused by a total lack of insulin. Occurs when the body's immune system attacks the insulin-producing beta cells in the pancreas and destroys them. The pancreas then produces little or no insulin. Type 1 diabetes develops most often in young people but can appear in adults.

Type 2 diabetes

A condition characterized by high blood glucose levels caused by either a lack of insulin or the body's inability to use insulin efficiently. Type 2 diabetes develops most often in middle-aged and older adults but can appear in young people.

http://www.diabetes.org/

American Diabetes Association

Fact: The percentage of Americans age 65 and older remains high, at 26.8%, or 14.3 million seniors (diagnosed and undiagnosed).

Learn more about Diabetes and Medicare from the American Diabetes Association here:

https://www.diabetes.org/resources/statistics/statistics-about-diabetes

Reminder: Diabetes is a qualifier for Chronic Medicare Advantage plans. These plans can be enrolled year-round not just during AEP.

Diabetes and Medicare - Equipment & Supplies

Part B covers home blood sugar (glucose) monitors under durable medical equipment and supplies used with the equipment, including blood sugar test strips, lancet devices, and lancets. There may be limits on how much or how often you get these supplies.

Diabetes supplies

Part D covers certain medical supplies for administration of insulin (like syringes, needles, alcohol swabs, gauze, and inhaled insulin devices).

Insulin

Medicare Part D covers insulin that isn't administered with an insulin pump.

Insulin pumps

Medicare Part B covers external insulin pumps and the insulin that the device uses under durable medical equipment for people who meet certain conditions.

Diabetic Supplies Covered by Medicare Part B

- Blood sugar (glucose) test strips
- Blood sugar testing monitors
- Insulin
- Lancet devices and lancets
- Glucose control solutions
- Therapeutic shoes or inserts

https://www.medicare.gov/coverage/blood-sugar-test-strips

Note: Some providers attempt to submit these claims to Part D instead of Part B so be sure to check this if your client tells you they have been improperly charged for their diabetic supplies.

Blood Sugar (Glucose) Test Strips

Medicare Part B (Medical Insurance) covers some diabetic test supplies, including blood sugar test strips as durable medical equipment (DME).

https://www.medicare.gov/coverage/blood-sugar-test-strips.html#1378

You, however, may need to use specific suppliers for some types of diabetic testing supplies. Find a list of suppliers for your area here: https://www.medicare.gov/SupplierDirectory/

National Institute on Aging - Diabetes

Resource Page - "Diabetes in Older People"

Information on Symptoms/Tests/Managing/Etc.

https://www.nia.nih.gov/health/diabetes-older-people

Diabetes Screenings

How often is it covered?

Medicare Part B (Medical Insurance) covers screenings to check for diabetes. You may be eligible for two diabetes screenings each year.

Who is eligible?

Part B covers these lab tests if you have any of these risk factors:

- High blood pressure (hypertension) - History of abnormal cholesterol and triglyceride levels (dyslipidemia)
- Obesity - History of high blood sugar (glucose)

Part B also covers these tests if 2 or more of these apply to you:

- Age 65 or older - Overweight - Family history of diabetes (parents, brothers, sisters)
- History of gestational diabetes (diabetes during pregnancy), or delivery of a baby weighing more than 9 pounds

Your costs with Original Medicare – You pay nothing for these tests

http://www.medicare.gov/coverage/diabetes-screenings.html

Diabetes Self-Management Training

Medicare Part B (Medical Insurance) covers outpatient diabetes self-management training (DSMT) to teach you to cope with and manage your diabetes. It includes tips for eating healthy, being active, monitoring blood sugar, taking drugs, and reducing risks. Medicare may cover up to 10 hours of initial DSMT.

https://www.medicare.gov/coverage/diabetes-self-mgmt-training.html

Medicare & You: diabetes (video) http://youtu.be/ikwjsNWBMDM

The National Institute of Diabetes and Digestive and Kidney Diseases - Diabetes in Older Adults

This site contains both educational information and tools you will find helpful including an infographic you can embed on your blog or website. https://www.niddk.nih.gov/health-information/health-communication-programs/ndep/living-with-diabetes/older-adults/Pages/index.aspx

Why is this important? Chronic Condition Medicare Advantage Special Needs Plans are designed for consumers diagnosed with chronic conditions such as diabetes. These plans can be very helpful and can be marketed 12 months a year. To take advantage of this market and truly help your clients you must first understand the basics of diabetes.

Medicare Advantage Opportunity - Diabetes

Chronic Condition Special Needs Plans are designed for consumers diagnosed with chronic conditions such as diabetes, chronic heart failure, and/or cardiovascular disorders. These plans offer benefits in addition to those covered under Original Medicare such as routine dental, vision, hearing, transportation, and routine podiatry services. Consumers must have a qualifying chronic condition to enroll. They can be marketed and enrolled 12 months a year.

https://www.medicare.gov/Pubs/pdf/11022-Medicare-Diabetes-Coverage.pdf

Prepare for Health and Medication Questions About Diabetes

Diabetes affects more than 25 percent of Americans aged 65 or older. Its prevalence is projected to increase approximately two-fold for all U.S. adults (ages 18-79) by 2050 if current trends continue. Medicare spent an estimated $1,500 more on Part D prescription drugs, $3,100 more for hospital and facility services, and $2,700 more in physician and other clinical services for those with diabetes than those without diabetes.

Example: Insulin - How often is it covered?

Medicare Part B (Medical Insurance) doesn't cover these:

- Insulin (unless use of an insulin pump is medically necessary)
- Insulin pens
- Syringes
- Needles
- Alcohol swabs
- Gauze

Medicare prescription drug coverage (Part D) may cover these:

- Insulin
- Certain medical supplies used to inject insulin, like syringes, gauze, and alcohol swabs

If you use an external insulin pump, insulin and the pump may be covered as durable medical equipment (dme) (DME).

Why is this important? Since 1 in 4 of your clients are statistically going to have diabetes, AEP reviews of health and drug coverage are sure to generate questions. Many of those will include questions about insulin and diabetic supplies. The links below are invaluable resources to verify Medicare coverage for specific questions.

Resources

- CMS Medicare Learning Network- Coverage Overview https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0738.pdf
- Medicare.gov – Diabetes Supplies and Services https://www.medicare.gov/coverage

Medicare and Cancer - Facts and Resources

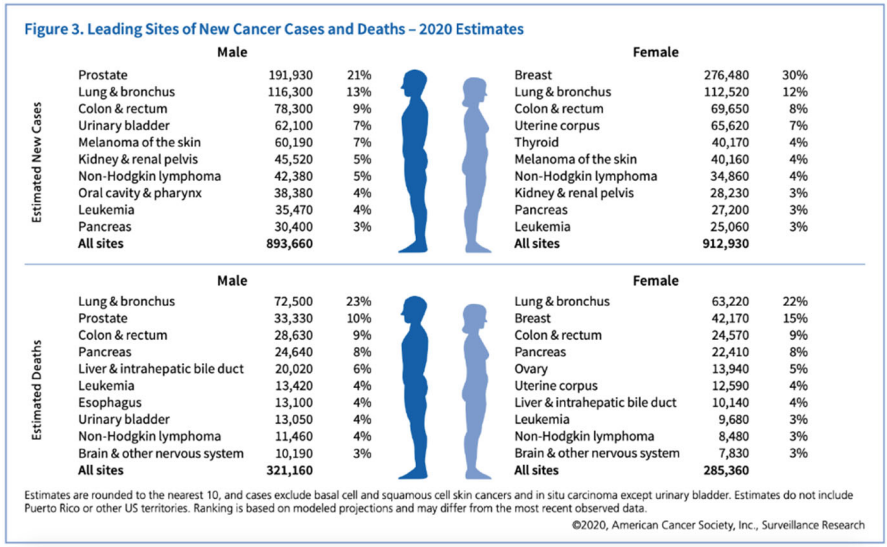


Figure 3. Leading Sites of New Cancer Cases and Deaths – 2020 Estimates

Estimated New Cases

Male			Female		
Prostate	191,930	21%	Breast	276,480	30%
Lung & bronchus	116,300	13%	Lung & bronchus	112,520	12%
Colon & rectum	78,300	9%	Colon & rectum	69,650	8%
Urinary bladder	62,100	7%	Uterine corpus	65,620	7%
Melanoma of the skin	60,190	7%	Thyroid	40,170	4%
Kidney & renal pelvis	45,520	5%	Melanoma of the skin	40,160	4%
Non-Hodgkin lymphoma	42,380	5%	Non-Hodgkin lymphoma	34,860	4%
Oral cavity & pharynx	38,380	4%	Kidney & renal pelvis	28,230	3%
Leukemia	35,470	4%	Pancreas	27,200	3%
Pancreas	30,400	3%	Leukemia	25,060	3%
All sites	**893,660**		**All sites**	**912,930**	

Estimated Deaths

Male			Female		
Lung & bronchus	72,500	23%	Lung & bronchus	63,220	22%
Prostate	33,330	10%	Breast	42,170	15%
Colon & rectum	28,630	9%	Colon & rectum	24,570	9%
Pancreas	24,640	8%	Pancreas	22,410	8%
Liver & intrahepatic bile duct	20,020	6%	Ovary	13,940	5%
Leukemia	13,420	4%	Uterine corpus	12,590	4%
Esophagus	13,100	4%	Liver & intrahepatic bile duct	10,140	4%
Urinary bladder	13,050	4%	Leukemia	9,680	3%
Non-Hodgkin lymphoma	11,460	4%	Non-Hodgkin lymphoma	8,480	3%
Brain & other nervous system	10,190	3%	Brain & other nervous system	7,830	3%
All sites	**321,160**		**All sites**	**285,360**	

Estimates are rounded to the nearest 10, and cases exclude basal cell and squamous cell skin cancers and in situ carcinoma except urinary bladder. Estimates do not include Puerto Rico or other US territories. Ranking is based on modeled projections and may differ from the most recent observed data.

More Information: https://www.cancer.org/research/cancer-facts-statistics.html

Cancer Resources from Medicare

Medicare Coverage of Cancer Treatment Services Publication

https://www.medicare.gov/Pubs/pdf/11931-Cancer-Treatment-Services.pdf?

Medicare & Clinical Research Studies Publication

https://www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf?

Colorectal Cancer Screenings

https://www.medicare.gov/coverage/screening-colonoscopies

Prostate Cancer Screenings

https://www.medicare.gov/coverage/prostate-cancer-screenings

Cervical & Vaginal Cancer Screenings

https://www.medicare.gov/coverage/cervical-vaginal-cancer-screenings

Mammograms

https://www.medicare.gov/coverage/mammograms

Lung Cancer Screening

https://www.medicare.gov/coverage/lung-cancer-screening

Preventive & Screening Services

https://www.medicare.gov/coverage/preventive-screening-services

Part B Covered Drugs

Medicare Part B covers a limited number of outpatient prescription drugs including oral cancer drugs under limited conditions. Generally, drugs covered under Part B are drugs you wouldn't usually give to yourself.

https://www.medicare.gov/coverage/prescription-drugs-outpatient#

Other Resources

CDC Cancer Media Resource Library

https://www.cdc.gov/cancer/dcpc/resources/index.htm

https://www.cdc.gov/cancer/

American Cancer Society Cancer Facts & Figures 2020

https://www.cancer.org/research/cancer-facts-statistics.html

In-Depth Information Sheets

https://www.oncolink.org/treatment-binder

Expedite Social Security Benefits

Social Security supports people who are fighting cancer. They offer support to patients dealing with this disease through their disability program. People with certain cancers may be eligible for a Compassionate Allowance. Compassionate Allowances are cases where individuals have medical conditions so severe, they obviously meet Social Security's disability standards, allowing them to process the cases

quickly with minimal medical information. When Social Security determines you are eligible, they expedite your disability application.

https://www.ssa.gov/compassionateallowances/

Q.) Should a Client Carry Cancer Insurance?

A.) YES

Cancer plans help cover a large amount of added expenses tied to cancer treatment. They include additional drug costs, copays and coinsurance amounts, added travel to special treatment facilities, and much more that impacts your client's ability to both physically and financially survive cancer.

Medicare doesn't cover:

- Room and board in assisted living facilities.
- Adult day care.
- Long-term nursing home care.
- Medical food or nutritional supplements (except enteral nutrition equipment).
- Services that help you with activities of daily living (like bathing and eating) that don't require skilled care.

Actual Client Testimonial:

"I am 70 years old and on Medicare and I also have a good Medicare supplement. When I was diagnosed with Cervical cancer 3 years ago, I knew the medical bills would be covered. However, the treatment, (Chemo therapy and radiation for 8 weeks) was at a cancer center 180 miles from home. That's when I found out how valuable my cancer insurance proved to be. The motel bill for two months, the travel expenses, eating out, even someone to take care of the house while we were gone were all taken care of with the funds we received from the cancer insurance policy. Our daughter took time off work to be with me and we were able to cover her expenses too. We had the peace of mind that all the unexpected expenses were covered. It was a stressful time, but the cancer insurance sure eased the financial burden." *Virginia M. – Missouri*

Presenting and Selling Cancer Insurance

You can't insure your car after the accident.

You can't insure your house when it's on fire.

And you can't get cancer insurance after your diagnosed.

You must plan ahead!

Possible Objections

I don't know how much more I can afford. - I certainly understand that. That is exactly why I bring up Cancer Insurance to you. Can you even imagine coming up with the money to cover the expenses related to treating a long-term illness?

What if I never get cancer? - That would be wonderful. In fact, I hope you never have to use this policy. But if you do, you will never regret having it. Plus, there is a provision available in many policies to get the majority of premiums you paid in back if you don't have to use it.

Why is this important? Which would you prefer? Your client contacts you to tell you that they have cancer and you have never talked to them about cancer insurance. They have good health insurance but are still going to be out thousands of dollars for their care and related expenses. Or your client contacts you to tell you they have cancer and they have cancer insurance with you. They have good health insurance and a good cancer plan so they will receive thousands of dollars to help pay expenses when they need it most.

Cancer Drugs Covered by Medicare Part B

Oral cancer drugs

Medicare helps pay for some oral cancer drugs you take by mouth if the same drug is available in injectable form or is a prodrug of the injectable drug. A prodrug is an oral form of a drug that when ingested breaks down into the same active ingredient found in the injectable form of the drug. As new oral cancer drugs become available, Part B may cover them.

Oral anti-nausea drugs

Medicare helps pay for oral anti-nausea drugs used as part of an anti-cancer chemotherapeutic regimen. The drugs must be administered immediately before, at, or within 48 hours after chemotherapy, and must be used as a full therapeutic replacement for an intravenous anti-nausea drugs.

https://www.medicare.gov/coverage/prescription-drugs-outpatient.html

Chemo and other drugs – paid by Part B or Part D?

Medicare Part B covers cancer drugs that you have put in your veins or can take by mouth. If your drug is only made to be taken by mouth, your Medicare Part D plan should cover it.

http://www.cancer.org/treatment/findingandpayingfortreatment/understandinghealthinsurance/medicare/medicarepartd/medicare-part-d-things-people-with-cancer-need-to-think-about

Want to learn about how Medicare covers other drugs? This CMS tip sheet provides an overview of drug coverage under Medicare Part A, B, C and Part D: https://www.cms.gov/outreach-and-education/outreach/partnerships/downloads/11315-p.pdf

Prepare Your Clients with Cancer for Possible Out of Pocket Expenses – Off-Label Drug Usage

The term "off-label usage" applies to any use of a medication in a manner not specifically approved by the FDA and delineated on the label given to the drug during the approval process. Drugs are most commonly used off-label for combating cancer or controlling extreme pain. Your client could be responsible for the costs of drugs being used off-label. If they want to appeal a denial of coverage they can follow the procedure outlined on Medicare.gov located here: https://www.medicare.gov/claims-appeals/file-an-appeal/medicare-prescription-drug-coverage-appeals

Yet another reason to be offering cancer insurance coverage to your clients.

Understanding the Stages of Cancer

Cancer plans often pay according to the stage a cancer is in when discovered. Stage refers to the extent of your cancer, such as how large the tumor is, and if it has spread. The TNM system helps describe cancer in great detail. But, for many cancers, the TNM combinations are grouped into five less-detailed stages.

Stage 0 - Abnormal cells are present but have not spread to nearby tissue. Also called carcinoma in situ, or CIS. CIS is not cancer, but it may become cancer.

Stage I, Stage II, and Stage III - Cancer is present. The higher the number, the larger the cancer tumor and the more it has spread into nearby tissues.

Stage IV - Cancer has spread to distant parts of the body.

There is another staging system, used for all types of cancer, which groups the cancer into one of five main categories. This staging system is more often used by cancer registries than by doctors. But you may still

hear your doctor or nurse describe your cancer in one of the following ways:

- In Situ Abnormal: Cells are present but have not spread to nearby tissue.
- Localized: Cancer is limited to the place where it started, with no sign that it has spread.
- Regional: Cancer has spread to nearby lymph nodes, tissues, or organs.
- Distant: Cancer has spread to distant parts of the body.
- Unknown: There is not enough information to figure out the stage.

Learn more at www.cancer.gov.

Specific information on stages: http://www.cancer.gov/about-cancer/diagnosis-staging/staging

Cancer Information Service

The Cancer Information Service (CIS), a program of the National Cancer Institute (NCI), provides the latest and most accurate cancer information to patients, their families, the public, and health professionals. http://www.cancer.gov/contact/contact-center

Medicare and Stroke - Facts and Resources

What is a stroke?

"A stroke is a "brain attack". It can happen to anyone at any time. It occurs when blood flow to an area of brain is cut off. When this happens, brain cells are deprived of oxygen and begin to die. When brain cells die during a stroke, abilities controlled by that area of the brain such as memory and muscle control are lost." http://www.stroke.org/

How big of a problem are strokes?

- Each year more than 500,000 people over the age of 65 suffer a stroke.
- A stroke happens every 40 seconds.
- Stroke is the fifth leading cause of death in the U.S.
- Every 4 minutes someone dies from stroke.
- Up to 80 percent of recurring strokes can be prevented through lifestyle changes and medical interventions.
- 2X more women die from stroke each year compared to breast cancer.

Acting F.A.S.T. is Key for Stroke

Recognizing the Signs and Symptoms of Stroke

When someone is having a stroke, every minute counts. Just as putting out a fire quickly can stop it from spreading, treating a stroke quickly can reduce damage to the brain. If you learn how to recognize the telltale signs of a stroke, you can act quickly and save a life—maybe even your own.

Acting F.A.S.T. can help stroke patients get the treatments they desperately need. The stroke treatments that work best are available only if the stroke is recognized and diagnosed within 3 hours of the first symptoms. Stroke patients may not be eligible for these if they don't arrive at the hospital in time.

If you think someone may be having a stroke, act F.A.S.T. and do the following simple test:

F—Face: Ask the person to smile. Does one side of the face droop?

A—Arms: Ask the person to raise both arms. Does one arm drift downward?

S—Speech: Ask the person to repeat a simple phrase. Is the speech slurred or strange?

T—Time: If you see any of these signs, call 9-1-1 right away

Why is this important? As you meet with your clients you offer products that provide peace of mind through protecting their finances and offering them access to care. Access to care can come in many forms. Help your clients through knowing when and where a person can get care and just how much Medicare can be involved during an especially trying period. Strokes can be especially difficult because they can create sudden and extreme life changes. If you find out your client's life has been impacted by stroke the attached links to resources can prove to be invaluable tools for them to get the care they need. The information on prevention can head off many issues and the education to watch for the signs of a stroke can buy lifesaving seconds to a victim.

Caregiver Guide to Stroke

Stroke is the #5 cause of death and the leading cause of adult disability in the United States.

Stroke recovery can be a difficult and confusing process for the survivor and the caregiver. This guide is meant to help the caregiver better navigate the recovery process and the financial and social implications of a stroke.

https://www.stroke.org/en/help-and-support/for-family-caregivers/the-caregiver-guide-to-stroke

Medicare Stroke Related Coverage Resources

Skilled Nursing Facility

https://www.medicare.gov/coverage/skilled-nursing-facility-snf-care

Medicare Coverage of Skilled Nursing Facility Care Publication

https://www.medicare.gov/Pubs/pdf/10153-Medicare-Skilled-Nursing-Facility-Care.pdf

Durable Medical Equipment (DME) Coverage

https://www.medicare.gov/coverage/durable-medical-equipment-dme-coverage

Home Health Services

https://www.medicare.gov/coverage/home-health-services

Physical Therapy/Occupational Therapy/Speech-language Pathology Services

https://www.medicare.gov/coverage/physical-therapy

Inpatient Rehabilitation Facility

https://www.medicare.gov/inpatientrehabilitationfacilitycompare/

Medicare Cardiovascular Disease Screenings

https://www.medicare.gov/coverage/cardiovascular-disease-screenings

Cardiovascular Disease (behavioral therapy)

https://www.medicare.gov/coverage/cardiovascular-disease-behavioral-therapy

Smoking & Tobacco Use Cessation (counseling to stop smoking or using tobacco products)

https://www.medicare.gov/coverage/smoking-tobacco-use-cessation-counseling-to-stop-smoking-or-using-tobacco-products

Staying Healthy Medicare's Preventive Services

https://www.medicare.gov/Pubs/pdf/11100-Staying-Healthy.pdf?

Additional Resources

Stroke Association - Finances After Stroke Guide Publication:

https://www.stroke.org/en/life-after-stroke/recovery/managing-your-stroke/finances-insurance-and-assistance/finances-after-stroke

Types of Stroke

https://www.cdc.gov/stroke/types_of_stroke.htm

Prevalence of Stroke by County:

https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/CCDashboard

CDC Media Kit

https://www.cdc.gov/stroke/communications_kit.htm?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fstroke%2Fmedia%2Findex.htm

- Social Media Messages
  - Facebook/LinkedIn/Instagram/Pinterest
  - Twitter
- Shareable Graphics
- Videos

Medicare and Alzheimers and Dementia - Facts and Resources

Dementia

The loss of cognitive functioning—thinking, remembering, and reasoning—and behavioral abilities to such an extent that it interferes with a person's daily life and activities. These functions include memory, language skills, visual perception, problem solving, self-management, and the ability to focus and pay attention. Alzheimer's is the most common cause of dementia.

Alzheimer's Disease

A degenerative brain disease and the most common form of dementia.

EVERY 65 SECONDS

SOMEONE IN THE UNITED STATES

DEVELOPS ALZHEIMERS DISEASE.

Other Facts

It is estimated that there are more than 5 million people living with Alzheimer's disease in the United States. This includes the over 5 million people age 65 and older and 200,000 people younger than age 65 with younger-onset Alzheimer's disease. By 2050 the number of Americans living with Alzheimer's is projected to rise to nearly 14 million.

At this time, there is no treatment to cure, delay or stop the progression of Alzheimer's disease. FDA-approved drugs temporarily slow worsening of symptoms for about 6 to 12 months, on average, for about half of the individuals who take them.

Alzheimer's disease has no survivors. It destroys brain cells and causes memory changes, erratic behaviors and loss of body functions. It slowly and painfully takes away a person's identity, ability to connect with others, think, eat, talk, walk and find his or her way home.

Alzheimer's kills more than breast cancer and prostate cancer combined. 1 in 3 seniors dies with Alzheimer's or dementia.

16.1 million Americans provide unpaid care for people with Alzheimer's or other dementias.

People with Alzheimer's or other dementias have twice as many hospital stays per year as other older people. Almost two-thirds of Americans with Alzheimer's are women.

Of the total lifetime cost of caring for someone with dementia, 70 percent is borne by families — either through out-of-pocket health and long-term care expenses or from the value of unpaid care.

Average per-person Medicare spending for those with Alzheimer's and other dementias is more than three times higher than average per-person spending across all other older adults. Medicaid payments are 23 times higher.

Medicare Benefits Available for Alzheimer's

Annual Wellness Visit's Cognitive Assessment Benefit

https://www.medicare.gov/coverage/preventive-visit-yearly-wellness-exams

https://www.medicareinteractive.org/get-answers/medicare-covered-services/preventive-services/annual-wellness-visit

Tests or Services Covered

https://www.medicare.gov/coverage/is-your-test-item-or-service-covered

Long Term Care Choices

https://www.medicare.gov/what-medicare-covers/what-part-a-covers/what-are-my-other-long-term-care-choices

Home Healthcare

https://www.medicare.gov/coverage/home-health-services

State by State Resources

https://www.medicare.gov/contacts/

Medicaid Information by State

https://www.medicaid.gov/state-overviews/index.html

Alzheimer's Information and Education Resources

The Alzheimer's Association

www.alz.org

Medications for Memory

https://www.alz.org/alzheimers-dementia/treatments/medications-for-memory

Media Kit

https://www.alz.org/press/press_resources

National Institute on Aging

https://www.nia.nih.gov/health/alzheimers

Alzheimer's Disease Education and Referral Center

(ADEAR)

https://www.nia.nih.gov/health/about-adear-center

Medline Plus

http://medlineplus.gov

Alzheimer's Caregivers

https://medlineplus.gov/alzheimerscaregivers.html

Resource Library on Alzheimer's

https://medlineplus.gov/alzheimersdisease.html

Resource Library on Dementia

https://medlineplus.gov/dementia.html

Eldercare Locator

https://eldercare.acl.gov/Public/Index.aspx

Financial Caregiving

https://www.consumerfinance.gov/consumer-tools/managing-someone-elses-money/

Benefits.gov - Official government benefits website. It is a free, confidential tool that helps individuals find government benefits they may be eligible to receive.

https://www.benefits.gov/

Alzheimer's Help for Veterans and Their Families

Geriatrics and Extended Care - Dementia Care (including Alzheimer's)

https://www.va.gov/GERIATRICS/Alzheimers_and_Dementia_Care.asp

VA Caregiver Support

https://www.caregiver.va.gov/

VA Nursing Homes, Assisted Living, and Home Health Care

https://www.va.gov/health-care/about-va-health-benefits/long-term-care/

Veteran-Directed Home and Community Based Services

https://www.va.gov/geriatrics/guide/longtermcare/veteran-directed_care.asp

Veterans and survivors who are eligible for a VA pension and require the aid and attendance of another person, or are housebound, may be eligible for additional monetary payment. These benefits are paid in addition to monthly pension, and they are not paid without eligibility to Pension.

https://www.benefits.va.gov/pension/aid_attendance_housebound.asp

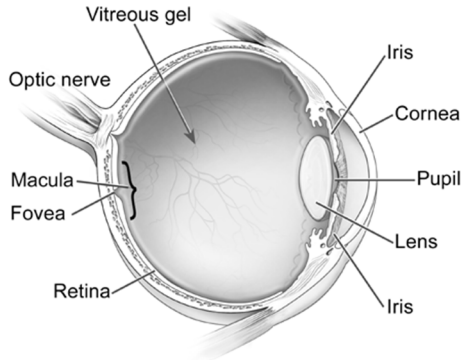
Dementia

The ability to comprehend finances and care choices is often among the first signs of dementia. To avoid problems in planning, the following steps can be taken:

- **Advanced Care Directive**: to make sure care choices reflect preferences
- **Medical Power of Attorney**: to make sure decisions can be made for persons no longer able to communicate their wishes
- **Power of Attorney**: to make sure financial and estate decisions can be made to pay for care, apply for assistance (i.e. Medicaid, state-based programs), or for the ongoing management of an estate.

Eye Health – Medicare and Medicaid Facts and Resources

The most common eye diseases and conditions that affect older adults include age-related macular degeneration (AMD), cataract, diabetic retinopathy, dry eye, glaucoma, and low vision. Many of these diseases and conditions do not have noticeable symptoms in their early stages, but they can be detected through a comprehensive dilated eye exam. Treatment is most effective when an eye disease is diagnosed early.



Source: https://www.nei.nih.gov/health/eyediagram

Medicare Part B Covers These Preventive and Diagnostic Eye Exams

- Eye exams, if you have diabetes
  Medicare Part B covers eye exams for diabetic retinopathy once a year if you have diabetes
  https://www.medicare.gov/coverage/eye-exams-for-diabetes

- Glaucoma tests
  Medicare Part B covers glaucoma tests once every 12 months if you're at high risk for glaucoma.
  https://www.medicare.gov/coverage/glaucoma-tests

- Macular degeneration tests and treatment
  Medicare Part B may cover certain diagnostic tests and treatment (including treatment with certain injected drugs) of eye diseases and conditions if you have age-related macular degeneration (AMD).
  https://www.medicare.gov/coverage/macular-degeneration-tests-treatment

NOTE:

- Medicare doesn't cover eye exams (sometimes called "eye refractions") for eyeglasses or contact lenses.
- Medicare doesn't usually cover eyeglasses or contact lenses. However, Medicare Part B (Medical Insurance) helps pay for corrective lenses if you have cataract surgery to implant an intraocular lens. Corrective lenses include one pair of eyeglasses with standard frames or one set of contact lenses.
  https://www.medicare.gov/coverage/eyeglasses-contact-lenses

Vision Resources and Tools

Vision and Aging: Social Media Toolkit

https://www.nei.nih.gov/nehep/programs/visionandaging/social-media

Vision and Aging Resources

https://www.nei.nih.gov/nehep/programs/visionandaging

National Eye Institute

https://www.nei.nih.gov/health

Information on Prevent Blindness.org

https://www.preventblindness.org/medicare-benefits-and-your-eyes

Social Security Publication: *"If You're Blind or Have Low Vision — How We Can Help"*

https://www.ssa.gov/pubs/EN-05-10052.pdf

Common Age-related Eye Diseases and Conditions

Age-related Macular Degeneration (AMD)
AMD is a disease associated with aging that gradually destroys sharp, central vision. Central vision is needed for seeing objects clearly and for common daily tasks such as reading and driving.

https://nei.nih.gov/health/maculardegen/armd_facts

Cataract
A cataract is a clouding of the lens in the eye. Vision with cataract can appear cloudy or blurry, colors may seem faded and you may notice a lot of glare.

https://nei.nih.gov/health/cataract/cataract_facts

Diabetic Eye Disease
Diabetic eye disease is a complication of diabetes and a leading cause of blindness. The most common form is diabetic retinopathy which occurs when diabetes damages the tiny blood vessels inside the retina.

https://nei.nih.gov/diabetes/

Glaucoma

Glaucoma is a group of diseases that can damage the eye's optic nerve and result in vision loss and blindness. It is usually associated with high pressure in the eye and affects side or peripheral vision.

https://nei.nih.gov/glaucoma/

Dental Health & Medicare

Proper Dental Coverage Helps Ensure Better Health!

As a senior there are many dental insurance coverage options. It important to consider in-network providers, types of services covered, deductibles and co-pays.

Dental – Medicare, VA and Medicaid Resources

Why Oral Health Is Vital to Overall Good Health

- Gum disease, an active bacterial infection in your mouth (also called periodontal disease), is linked to other chronic conditions such as diabetes, heart disease, stroke, and pneumonia. In fact, if you have chronic gum disease, you're almost twice as likely to suffer from heart disease as someone with healthy gums.
- Gum disease may increase the risk of stroke. Harmful bacteria in your mouth can make you more susceptible to developing blood clots and eventually increase the chance of a stroke.
- If you have diabetes, it can be even harder for your body to fight infections. That puts you at greater risk for gum disease. What's more, gum disease may make it more difficult for people with diabetes to stabilize their blood sugar levels. Good daily oral hygiene and early detection of gum disease are essential for people with diabetes.

Source: http://seniorsoralhealth.org/general-oral-health/

Medicare

"Medicare doesn't cover most dental care, dental procedures, or supplies, like cleanings, fillings, tooth extractions, dentures, dental plates, or other dental devices. Medicare Part A (Hospital Insurance) will pay for certain dental services that you get when you're in a hospital. Part A can pay for inpatient hospital care if you need to have emergency or complicated dental procedures, even though the dental care isn't covered."

Source: https://www.medicare.gov/coverage/dental-services

Medicaid

"States are required to provide dental benefits to children covered by Medicaid and the Children's Health Insurance Program (CHIP), but states choose whether to provide dental benefits for adults."

Source:
https://www.medicaid.gov/medicaid/benefits/dental/index.html

VA Benefits

VA offers comprehensive dental care benefits to certain qualifying Veterans.

- To determine benefits and eligibility visit: https://www.va.gov/dental/
- Find a VA Dental Clinic: https://www.va.gov/DENTAL/Dental-Clinic-Locations-Finder.asp

Resources

National Institutes of Health U.S. National Library of Medicine

This site includes information on terms, prevention, treatments, tests, resources and more:

https://medlineplus.gov/dentalhealth.html

Medicare Interactive

This site includes helpful information as well as a video on Medicare dental coverage:

https://www.medicareinteractive.org/get-answers/medicare-covered-services/limited-medicare-coverage-vision-and-dental/resources-if-you-need-dental-coverage

Oral Care for Older Adults
https://newsinhealth.nih.gov/2015/10/keep-your-mouth-healthy

Reduced Cost or Free Dental Clinics

Needymeds Database

The clinics in this database offer dental services to area residents and are free, low cost, low cost with a sliding scale based on income, or offer some type of financial assistance.

- https://www.needymeds.org/dental-clinics

Free Clinics.com Database

https://www.freeclinics.com/

HHS.gov Source List

https://www.hhs.gov/answers/health-care/where-can-i-find-low-cost-dental-care/index.html

Community Health Centers

Health centers supported by the Health Resources and Services Administration provide health care to patients even if they can't pay. There are nearly 1,400 health centers around the country. About three-quarters of the centers also provide dental care.

https://findahealthcenter.hrsa.gov/

Dental Schools

For a complete list of dental schools, visit the American Dental Association website:

https://www.ada.org/en/education-careers/dental-schools-and-programs

Programs for Dental Assistance

The Eldercare Locator

A public service of the U.S. Administration on Aging will connect you to services for older adults and their families. For more information visit https://eldercare.acl.gov/Public/Index.aspx or call 1-800-677-1116.

Oral Health in Rural Communities

https://www.ruralhealthinfo.org/topics/oral-health

Caregiver Tools - Oral Health & Aging from Health Resources & Services Administration

- Brushing: Information for Caregivers

  https://www.nidcr.nih.gov/sites/default/files/2019-09/oral-health-aging-brushing.pdf

- Flossing: Information for Caregivers

  https://www.nidcr.nih.gov/sites/default/files/2019-09/flossing-info-for-caregivers_1.pdf

- Dry Mouth & Older Adults: Information for Caregivers

  https://www.nidcr.nih.gov/sites/default/files/2019-09/dry-mouth-and-older-adults.pdf

- Finding Low-Cost Dental Care: Information for Caregivers

  https://www.nidcr.nih.gov/sites/default/files/2019-09/finding-low-cost-dental-care_0.pdf

Medicare and Dental Care

Medicare doesn't cover most dental care, dental procedures, or supplies, like cleanings, fillings, tooth extractions, dentures, dental plates, or other dental devices. Medicare Part A (Hospital Insurance) will pay for certain dental services that you get when you're in a hospital.

Why is this important? Dental coverage is popular among those on Medicare and offering dental plans can open the door to new clients.

Note: Dental plan mailers often see very high return rates.

Disability Resources - Connect People with Disabilities, Their Families, and Caregivers to Helpful Resources

Visit the website below for information on disability policies, programs, and services in communities nationwide. Thousands of resources are available from government agencies, academic institutions, and nonprofit organizations across 10 topics: Benefits, Civil Rights, Community Life, Education, Emergency Preparedness, Employment, Health, Housing, Technology, and Transportation.

https://www.dol.gov/odep/topics/disability.htm

Medicare Special Needs Plans (SNP)

Medicare SNPs are a type of Medicare Advantage Plan (like an HMO or PPO). Medicare SNPs limit membership to people with specific diseases or characteristics, and tailor their benefits, provider choices, and drug formularies to best meet the specific needs of the groups they serve.

A plan must limit membership to these groups:

1) People who live in certain institutions (like a nursing home) or who require nursing care at home
2) People who are eligible for both Medicare and Medicaid
3) People who have specific chronic or disabling conditions (like diabetes, End-Stage Renal Disease (ESRD), HIV/AIDS, chronic heart failure, or dementia). Plans may further limit membership. You can join a SNP at any time.

https://www.medicare.gov/sign-up-change-plans/types-of-medicare-health-plans/special-needs-plans-snp

FOR FAMILY & CAREGIVERS

Detailed Nursing Home Information on Medicare.gov

"Nursing Home Compare" has detailed information about every Medicare and Medicaid-certified nursing home in the country.

http://www.medicare.gov/nursinghomecompare/search.html

Requesting Personal Health Information for a Deceased Medicare Beneficiary, or a Personal Representative

If you want to allow Medicare to give your personal health information to someone other than you or if you are requesting personal health information for a deceased beneficiary, you need to let Medicare know in writing by using the "Medicare Authorization to Disclose Personal Health Information" form.

https://www.medicare.gov/MedicareOnlineForms/PublicForms/CMS10106.pdf

Helping Caregivers

If you're one of the nearly 66 million Americans caring for an aging, seriously ill, or disabled family member or friend, this information will help make your life a little easier. Get resources, stories, and newsletters about taking care of someone with Medicare from this site:

https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/Caregiver.html

Want to Improve Client Satisfaction and Earn Referrals? Keep Their Family Involved

"A Quick Look at Medicare" - This booklet is a guide for families and friends of people with Medicare. It highlights several topics related to the health and care of a person with Medicare.

https://www.medicare.gov/Pubs/pdf/11514-A-Quick-Look-at-Medicare.pdf

Federal Trade Commission Funeral Costs and Pricing Checklist

Thinking ahead allows you to choose the specific items you want and need, and compare the prices offered by several funeral providers. It also spares your survivors the stress of making these decisions under the pressure of time and strong emotions. Using the check list on this site can help your family make sure that they get the most with the money from your final expense plan.

http://www.consumer.ftc.gov/articles/0301-funeral-costs-and-pricing-checklist

Find a Hospice Agency

Find hospices that serve your area and compare them based on the quality of care they provide. Hospice agencies most often provide services where you live, whether it's at home, an assisted living facility, or a nursing home.

https://www.medicare.gov/hospicecompare/

Among People Older Than 65, 1 in 6 Suffers from Depression

Depression in older adults is estimated to occur in 25% of those with other illness including cancer, arthritis, stroke, chronic lung disease, and cardiovascular disease. Other stressful events, such as the loss of friends and loved ones, are also risk factors for depression. Opportunities are missed to improve health outcomes when mental illness is under-recognized and under-treated in primary care settings.

Medicare covers an annual screening for depression (up to 15 minutes) for people with Medicare in primary care settings that have staff-assisted depression care supports in place to ensure accurate diagnosis, effective treatment, and follow-up. You pay nothing for this test if the doctor or other qualified health care provider accepts assignment.

https://www.medicare.gov/coverage/depression-screenings.html

Guide to Medicare's Preventive Services

https://www.medicare.gov/Pubs/pdf/10110-Medicare-Preventive-Services.pdf?

Durable Power of Attorney vs. Power of Attorney

A regular power of attorney ends when its purpose is fulfilled or at a person's incapacity or death.

A durable power of attorney serves the same function as a power of attorney. However, as its name implies, the agency relationship remains effective even if a person becomes incapacitated. This makes the durable power of attorney an effective estate planning tool. If incapacity should strike a person, their agent can maintain their financial affairs until they are again able to do so, without any need for court involvement. That way, their family's needs continue to be provided for, and the risk of financial loss is reduced. A durable power of attorney ends at their death.

Toolkit for Advanced Medical Planning:

http://www.americanbar.org/groups/law_aging/resources/health_care_decision_making/consumer_s_toolkit_for_health_care_advance_planning.html

Estate Planning FAQ:

https://www.americanbar.org/groups/real_property_trust_estate/resources/estate_planning/diy_estate_planning/

Medicare and Respite Care

Respite care is defined as *temporary care provided in a nursing home, hospice inpatient facility, or hospital so that a family member or friend who is the patient's caregiver can rest or take some time off.*

Medicare will only pay for respite care if the Medicare beneficiary has a life-threatening illness and qualifies for the hospice benefit.

If an individual's usual caregiver (like a family member) needs a rest, a patient can get inpatient respite care in a Medicare-

approved facility (like a hospice inpatient facility, hospital, or nursing home). The hospice provider will arrange this for them. They can stay up to 5 days each time they get respite care. They can get respite care more than once, but it can only be provided on an occasional basis. They may need to pay 5% of the Medicare-approved amount for inpatient respite care.

Medicare publication on hospice and respite care:

https://www.medicare.gov/Pubs/pdf/02154-Medicare-Hospice-Benefits.PDF

Respite program locator map: https://archrespite.org/us-map

Why is this important? Helping your clients and their families through their most difficult times requires you to be aware of ways they can make the best of a bad situation.

10 Tips to Help Keep a Caregivers Stress in Check

1. Put your physical needs first.
2. Connect with friends. Isolation increases stress.
3. Ask for help.
4. Call on community resources.
5. Take a break.
6. Deal with your feelings.
7. Find time to relax.
8. Get organized.
9. Just say no. Accept the fact that you simply can't do everything!
10. Stay positive.

http://www.aarp.org/relationships/caregiving/info-06-2010/crc-10-caregiver-stress-managment-tips.html

Why is this important? Your clients and their families will be truly grateful for helpful and comforting information like this.

Need a Copy of a Birth, Marriage, Death or Divorce Certificate?

CMS can direct you to the exact information you need to get a copy of a death, marriage, birth or divorce certificate. The links are provided for those users who want direct access to individual state and territory information. To use this valuable tool, you must first determine the state or area where the birth, death, marriage, or divorce occurred, then click on that state or area. See the state list here:
https://www.cdc.gov/nchs/w2w/index.htm

Why is this important? As an agent you help your clients move through some of life's most traumatic circumstances. You need to be able to help them get the documents needed accurately and as quickly as possible.

An Individual Should Know Their Rights When in a Nursing Home

As a resident in a Medicare and/or Medicaid-certified nursing home, you have certain rights and protections under federal and state law. These rights and protections help ensure you get the care and services you need. Find out all of your rights here:
https://www.medicare.gov/what-medicare-covers/what-part-a-covers/skilled-nursing-facility-rights

Why is this important? Helping both your clients and their caregivers get the best possible care while in a nursing home will be a huge help to them and prove the value of securing you, their agent, as a trusted advisor.

Medicare and Long-Term Care

Medicare does not pay the largest part of long-term care services or personal care—such as help with bathing, or for supervision often called custodial care.

https://longtermcare.acl.gov/medicare-medicaid-more/index.html

Video – "Long-term care: Does health insurance cover it?"
https://youtu.be/Livh4CoWvlM

Medicare.gov on Long Term Care
https://www.medicare.gov/coverage/long-term-care.html

Glossary

https://longtermcare.acl.gov/the-basics/glossary.html

Powers of Attorney Are Not Recognized By the SSA

Having power of attorney, being an authorized representative or having a joint bank account with the beneficiary is not the same thing as being a payee. These arrangements do not give legal authority to negotiate and manage a beneficiary's Social Security and/or SSI payments. In order to be a payee a person or organization must apply for and be appointed by SSA.

https://www.ssa.gov/payee/faqbene.htm

Why is this important? If your client becomes unable to handle their finances assuming an existing POA handles their SS benefits would be in error. Giving proper advice to caregivers and loved ones is important to maintaining your advisor role.

Fibromyalgia: A Toolkit for the Male Caregiver

Being a caregiver isn't always easy. Each day can throw new challenges your way. With that in mind this toolkit was designed to provide insight, tips and tools for the male caregivers of patients with fibromyalgia.

http://www.menshealthnetwork.org/pdf/FibroToolkit.pdf

Why is this important? An estimated 44 million Americans age 18 and older provide unpaid assistance and support to adults. Since the multi-faceted role that family and caregivers play, they need a range of support services to remain healthy, improve their caregiving skills, and remain in their caregiving role.

Dealing With The Loss Of A Loved One

If your loved one received Medicare, Social Security will inform Medicare of the death. If the deceased had been enrolled in Medicare Prescription Drug Coverage, Medicare Advantage plan or had a Medicare Supplement policy, contact the carriers at the phone numbers provided on each plan membership card to cancel the insurance.

Grief Support

Mourning Help from The National Institutes on Aging

https://www.nia.nih.gov/health/mourning-death-spouse

Grief Support and Funeral Planning from The National Funeral Directors Association

http://www.nfda.org/consumer-resources/grief-support

Helpful Grief Articles from The Hospice Foundation of America

https://hospicefoundation.org/End-of-Life-Support-and-Resources/Grief-Support/Journeys-with-Grief-Articles

Geriatric Mental Health Foundation

www.gmhfonline.org

National Library of Medicine MedlinePlus: Bereavement

www.medlineplus.gov/bereavement.html

USA.gov -- Search “grief” or “bereavement”

www.usa.gov

Obtaining Death Certificates

State by State Listing: https://www.cdc.gov/nchs/w2w/index.htm

Requesting Medical Records for a Deceased Individual

https://www.cms.gov/Regulations-and-Guidance/Legislation/FOIA/filehow.html

Legal Assistance

LawHelp helps people of low and moderate incomes find free legal aid programs in their communities, answers to questions about their legal rights and forms to help them with their legal problems.

https://www.lawhelp.org/

Estate Planning

Q/A Regarding Wills – American Bar Association: https://www.americanbar.org/groups/real_property_trust_estate/resources/estate_planning/an_introduction_to_wills/

Additional Estate Planning Q/A – American Bar Association:

https://www.americanbar.org/groups/real_property_trust_estate/resources/estate_planning/diy_estate_planning/

Medicaid Estate Recovery

If you receive Medicaid coverage for long-term care services, federal law requires states to recover the amount Medicaid spent on your behalf from your estate after you die. This is called "estate recovery."

https://www.medicaid.gov/medicaid/eligibility/estate-recovery/index.html

Railroad Retirement Board (RRB)

Reporting a Death - If you get benefits from the RRB, call them to report a death. 1-877-772-5772

https://www.rrb.gov/

Veterans

How to Apply for a Veterans Burial Allowance

https://www.va.gov/burials-memorials/veterans-burial-allowance/

Find out how to apply for a Veterans burial allowance to help cover burial, funeral, and transportation costs (sometimes called "Veterans death benefits").

Veterans Survivors Pension

https://www.va.gov/pension/survivors-pension/

Find out if you're eligible and how to apply for a VA survivors' pension (some people call this a "VA widows' pension" or "VA death pension").

Social Security

Social Security Survivors Benefits

https://www.ssa.gov/benefits/survivors/

https://www.ssa.gov/planners/survivors/ifyou.html

Publication: How Social Security Can Help You When a Family Member Dies

https://www.ssa.gov/pubs/EN-05-10008.pdf

Social Security Death Benefits

A one-time payment of $255 can be paid to the surviving spouse if he or she was living with the deceased; or, if living apart, was receiving certain Social Security benefits on the deceased's record.

If there is no surviving spouse, the payment is made to a child who is eligible for benefits on the deceased's record in the month of death.

To report the death of a person with Medicare:

- Make sure you have the person's Social Security Number.
- Call Social Security at 1-800-772-1213 (TTY: 1-800-325-0778).

Important Planning Reminder to Insurance Agents

"78% of life insurance shoppers with a previous relationship with their agent bought life insurance when their agent presented it to them." - *LIMRA -facts about life 2010*

GOVERNMENT AGENCIES

State Insurance Departments

This is a quick link page to all state insurance departments: https://www.medicare.gov/contacts/#resources/sids

Finding a Government Agency

The link to the site below gives you an A-Z Index of U.S. Government Agencies. Find contact information for federal government departments and agencies. https://www.usa.gov/federal-agencies/a

Finding Local Government Offices to Help Your Clients

If your client needs to apply for Medicare:

https://secure.ssa.gov/ICON/main.jsp (Local Social Security Office)

If your client needs to apply for Medicaid:

https://www.medicaid.gov/about-us/contact-us/contact-state-page.html

State Health Departments:

https://www.cdc.gov/publichealthgateway/healthdirectories/healthdepartments.html

Why is this important? Providing clients with local assistance for key Medicare issues is an important way to build rapport in your community. You then become part of the local senior resource circle.

Social Security Retirement & Survivors Benefits: Life Expectancy Calculator

According to data compiled by the Social Security Administration:

- A man reaching age 65 today can expect to live, on average, until age 84.3.
- A woman turning age 65 today can expect to live, on average, until age 86.6.

Those are just averages. About one out of every four 65-year-olds today will live past age 90, and one out of 10 will live past age 95.

This calculator will show you the average number of additional years a person can expect to live, based only on the gender and date of birth you enter.

https://www.ssa.gov/OACT/population/longevity.html

As an agent, it is important to know the average age of your client base. Using the above calculator, you can calculate the average "Life Expectancy" of your block of business.

How to Apply for a New or Replacement Social Security Number Card

You can apply on line or in person for a replacement card. Generally, you will get your card within 10 business days from the date your application is processed.

You can use a *my* Social Security account to request a replacement Social Security card online if you:

- Are a U.S. citizen age 18 years or older with a U.S. mailing address;
- Are not requesting a name change or any other change to your card; and
- Have a valid driver's license or a state-issued identification card for select states.

Learn more in the FAQ section of ssa.gov: https://www.ssa.gov/

Social Security Information for Financial Planners

This site provides information to financial planners regarding the various Social Security programs and Medicare and is a valuable resource in helping your clients plan for retirement or other life events.

https://www.ssa.gov/thirdparty/financial-planners.html

Social Security Credits

The number of work credits you need to get retirement benefits depends on your date of birth. If you were born in 1929 or later, you need 40 credits (10 years of work). People born before 1929 need fewer than 40 credits (39 credits if born in 1928; 38 credits if born in 1927; etc.).

Credits are the "building blocks" Social Security uses to find out whether you have the minimum amount of covered work to qualify for each type of Social Security benefits. For example, in 2019, you receive one credit for each $1,360 of earnings, up to the maximum of four credits per year. Each year the amount of earnings needed for credits goes up slightly as average earnings levels increase. The credits you earn remain on your Social Security record even if you change jobs or have no earnings for a while.

"How You Earn Credits" Pamphlet: https://www.ssa.gov/pubs/EN-05-10072.pdf

Schedule of Social Security Benefit Payments

These annual calendars show the dates that an individual can expect their Social Security payments.

https://www.ssa.gov/pubs/calendar.htm

Average Monthly Social Security Benefit

https://www.ssa.gov/policy/docs/quickfacts/stat_snapshot/

Estimate Your Social Security Benefit

Social Security provides online calculators that can provide everything from rough estimates of benefits to in-depth detailed benefit estimates. Calculators can't provide your actual benefit amount until you apply for benefits.

Social Security Benefit Estimator

https://www.ssa.gov/retire/estimator.html

The link below will give you access to the type of calculator that will meet your needs.

https://www.ssa.gov/oact/anypia/index.html

Why is this Important? Many clients considering retirement and their options with Medicare need to factor in the Social Security benefits that they will be living on. Since eligibility for Medicare at 65 precedes their eligibility for 100% of their social security retirement benefit this often comes into question.

The Full Retirement Age is Increasing

If you were born from 1943 to 1954, your full retirement age is 66. If you choose to delay receiving your retirement benefit beyond full retirement age, your benefit can increase as much as 8 percent a year up to age 70. Your benefits will no longer increase if you delay beyond age 70. If you were born between 1955 and 1959, your full retirement age increases gradually until it reaches age 67 for those born in 1960 or later. Social Security has an online calculator that can provide immediate and accurate retirement benefit estimates to help you plan for your retirement.

Full retirement age (also called "normal retirement age") had been 65 for many years. However, beginning with people born in 1938 or later, that age gradually increases until it reaches 67 for people born after 1959.

Use this retirement age calculator to find out the effect on benefits of early retirement

Age to Receive Full Social Security Benefits

(Called "full retirement age" or "normal retirement age.")

Year of Birth *	Full Retirement Age
1937 or earlier	65
1938	65 and 2 months

1939	65 and 4 months
1940	65 and 6 months
1941	65 and 8 months
1942	65 and 10 months
1943 - 1954	66
1955	66 and 2 months
1956	66 and 4 months
1957	66 and 6 months
1958	66 and 8 months
1959	66 and 10 months
1960 and later	67

*If you were born on January 1st of any year you should refer to the previous year. (If you were born on the 1st of the month, your benefit (and your full retirement age) is received as if your birthday was in the previous month.)

http://www.socialsecurity.gov/planners/retire/ageincrease.html

The earliest you can start receiving Social Security retirement benefits will remain age 62.

https://www.ssa.gov/planners/retire/retirechart.html

Helpful SSA Publications

Retirement Information for Medicare Beneficiaries:
https://www.ssa.gov/pubs/EN-05-10529.pdf

Retirement Toolkit:
https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/retirement-toolkit.pdf

The Veteran Market - State Specific Veteran Fact Sheets

Many of your clients and prospects are likely veterans. Being familiar with VA benefits enables you as their advisor to be a better resource. The fact sheets provided from the U.S. Department of Veterans Affairs will give you data that is specific to your state.

http://www.va.gov/opa/publications/factsheets.asp

You can have both Medicare and Veterans Affairs (VA) benefits. However, Medicare and VA benefits do not work together. Medicare does not pay for any care that you receive at a VA facility. Many Veterans choose to carry additional coverage to cover care outside the VA system.

National Center for Veterans Analysis and Statistics

This site provides simple and interesting graphical statistics on a variety of topics related to Veterans.

http://www.va.gov/vetdata/Maps.asp

- The largest living cohort of male Veterans served during the Vietnam Era (August 1964 to April 1975) while the largest living cohort of female Veterans served during Post 9/11 (September 2001 or later).
- 9,087,000 military personnel served on active duty during the Vietnam Era.

Source: Profile of Veterans: 2015 Data from the American Community Survey:

https://www.va.gov/vetdata/Veteran_Population.asp

Veterans Demographics

Projected U.S. Veterans Population: 21,368,000 {Female 2,051,000 10%}

Percentage of Veteran Population 65 or Older: 46.08%

https://www.va.gov/vetdata/

Link to webinar "Unlocking the Door to Veterans' Benefits" An introduction to veterans benefits terms, processes, and how they work with Medicare:

https://www.ncoa.org/resources/webinar-unlocking-the-door-to-veterans-benefits/

Why is this important? With such a large population of veterans, you will need to be familiar with veteran programs and how they work with Medicare. Many products are often beneficial to veterans including Medicare Supplement plans and Medicare Advantage plans.

VA Priority Groups – Levels of Benefits

Veterans have a comprehensive medical benefits package, which VA administers through an annual patient enrollment system. The enrollment system is based on priority groups to ensure health care benefits are readily available to all enrolled Veterans.

http://www.va.gov/healthbenefits/resources/priority_groups.asp

Remember that VA benefit levels are not set in stone and vets can lose eligibility if their situation changes or if VA programs change.

ChampVA and Tricare

The Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) is a comprehensive health care program in which the VA shares the cost of covered health care services and supplies with eligible beneficiaries. Due to the similarity between CHAMPVA and the Department of Defense (DoD) TRICARE program (sometimes referred to by its old name, CHAMPUS), the two are often mistaken for each other. CHAMPVA is a Department of Veterans Affairs program; TRICARE is a regionally managed health care program for active duty and retired members of the uniformed services, their families, and survivors. In some cases, a Veteran may appear to be eligible for both/either program on paper. However, if you are a military retiree, or the spouse of a Veteran

who was killed in action, you are and will always be a TRICARE beneficiary; you can´t choose between the two.

Info on CHAMPVA:

https://www.va.gov/health-care/family-caregiver-benefits/champva/

If you have Medicare Part A (Hospital Insurance) and TRICARE, you must have Part B to keep your TRICARE coverage. Info on Retiring and Tricare: http://www.tricare.mil/LifeEvents/Retiring.aspx

Tricare For Life

Individuals with Tricare can be potential clients for MA only plans due to the added benefits not normally covered by Medicare that they can provide. TRICARE For Life may work with either a Medicare Advantage plan or Original Medicare. TRICARE For Life (TFL) is Medicare-wraparound coverage for TRICARE beneficiaries who have Medicare Part A and Medicare Part B, regardless of age or where you live. You must have Medicare Part A and Part B to have TFL. The TRICARE drug benefit is considered "creditable coverage," which means it is at least as good as a Part D plan.

Handbook: http://www.tricare.mil/~/media/Files/TRICARE/Publications/Handbooks/TFL_HBK.pdf

Tricare and
Medicare: http://www.tricare.mil/Home/Plans/HealthPlans/TFL

Beneficiaries Eligible for TRICARE and Medicare

If you're eligible for both TRICARE and Medicare Part A, then in most cases you must have Medicare Part B to keep TRICARE. Understanding how Medicare and TRICARE work together and when to buy Part B can be confusing. You can access the detailed information at this site:

http://www.tricare.mil/Plans/Eligibility/MedicareEligible.aspx

Reminder – There is a possible MA Only marketing opportunity due to added plan benefits of an MA plan.

Veterans Burial

Burial in a National Cemetery

"Burial benefits available include a gravesite in any of our 131 national cemeteries with available space, opening and closing of the grave, perpetual care, a Government headstone or marker, a burial flag, and a Presidential Memorial Certificate at no cost to the family. Some Veterans may also be eligible for Burial Allowances."

https://www.cem.va.gov/burial_benefits/

For Burial in a Private Cemetery

Burial benefits available for Veterans buried in a private cemetery may include a Government headstone, marker or medallion, a burial flag, and a Presidential Memorial Certificate, at no cost to the family.

http://www.benefits.va.gov/BENEFITS/factsheets/burials/Burial.pdf

VA Benefits as Credible Coverage – Part D Yes/Part B No

"If you are eligible for Medicare Part D prescription drug coverage, you need to know that enrollment in the VA health care system is considered creditable coverage for Medicare Part D purposes. This means that VA prescription drug coverage is at least as good as the Medicare Part D coverage. Since only Veterans may enroll in the VA health care system, dependents and family members do not receive credible coverage under the Veteran's enrollment.

However, there is one significant area in which VA health care is NOT creditable coverage: Medicare Part B (outpatient health care, including doctors' fees). Creditable coverage for Medicare Part B can only be provided through an employer. As a result, VA health care benefits to Veterans are not creditable coverage for the Part B program. So, although a Veteran may avoid the late enrollment penalty for Medicare Part D by

citing VA health care enrollment, that enrollment would not help the Veteran avoid the late enrollment penalty for Part B."

Source:
https://iris.custhelp.com/app/answers/detail/a_id/3032/related/1/session/L2F2LzEvdGltZS8xNDg4Njg0MTU5L3NpZC80cFB3NUxjbg%3D%3D

Why is this important? Medicare can be confusing for even the most seasoned agents. Your clients can easily feel there is no harm in delaying Part B enrollment.

Social Security Entitlement Requirements

To be eligible for Social Security benefits as a worker you must be:

- Age 62 or older, or disabled or blind; and
- "Insured" by having enough work credits

Social Security measures work in "work credits." You can earn up to four work credits per year based on your annual earnings. The amount of earnings required for a work credit increases each year as general wage levels rise.

To be eligible for most types of benefits (such as benefits based on blindness or retirement), you must have earned an average of one work credit for each calendar year between age 21 and the year in which you reach age 62 or become disabled or blind, up to a maximum of 40 credits. A minimum of six work credits is required, regardless of age.

To qualify for Social Security benefits based on a disability other than blindness, you must have worked long enough and recently enough under Social Security. The number of work credits you need for disability benefits depends on your age when you became disabled. You generally need 20 work credits earned in the last 10 years ending with the year you become disabled. However, younger workers may qualify with fewer credits.

Source: https://www.ssa.gov/ssi/text-entitle-ussi.htm

Why is this important? Social Security and Medicare are separate programs but Social Security works closely with individuals to educate them about Medicare, sign them up into the program, process their applications and collect premiums.

Social Security Lump-Sum Death Payment

A surviving spouse or child may receive a one-time special lump-sum death payment of $255 if they meet certain requirements.

Find out more here:
https://www.ssa.gov/planners/survivors/ifyou7.html

Pamphlet – 2019 Survivors Benefits: https://www.ssa.gov/pubs/EN-05-10084.pdf

Why is this important? According to LIMRA, "A large portion of people procrastinate when it comes to shopping for life insurance – not knowing what kind of life insurance they should buy or how much coverage they need. Only about one third of adults have someone they consider their agent or financial advisor, who could help them determine what they need. Research shows an advisor's ability to educate, listen and develop trust are the qualities most desired by consumers."

VA Fiduciary

Upon determining a beneficiary is unable to manage his or her financial affairs, VA will appoint a fiduciary. The fiduciary, normally chosen by the beneficiary, must undergo an investigation of their suitability to serve. This investigation includes a criminal background check, review of credit report, personal interview, and recommendations of character references. Only after a complete investigation is a fiduciary appointed to manage a beneficiaries VA benefits.

http://www.benefits.va.gov/fiduciary/index.asp

Why is this important? The purpose of the Department of Veterans Affairs (VA) Fiduciary Program is to protect Veterans and beneficiaries

who are unable to manage their VA benefits through the appointment and oversight of a fiduciary.

MARKETING OPPORTUNITIES

Ancillary Plans

Ancillary products play a vital role in the profitability of an agent. They are also more important than ever to clients, who need additional funds to cover copays, coinsurance, deductibles, or uninsured expenses.

Ancillary Point to Ponder:

- Cancer Plans catch phrase: *Until there's a cure – Insure.*
- Hospital Indemnity Plans: Help fill the gaps of Medicare Advantage plans. You sell Medicare Supplements because original Medicare leaves gaps in coverage. Why not sell a plan to fill the gaps in a Medicare Advantage plan?
- Selling additional plans to an individual works to create a client instead of just a policyholder.
- Fast food restaurants usually ask, "*Would you like fries with that?"* This is because they complement a meal and they are what adds real profit to the restaurant. An agent needs to always ask clients to consider ancillary products because they complement base coverage and can add tremendous profit to an agent.

A Thought about Adding Ancillary Products to Your Presentation

If you are going on an appointment to present your primary product anything you make from additional products offered is pure profit. Your fixed expenses have not changed. No additional fuel, no additional time, no additional office expense, only additional words spoken and you are the one that can decide to speak them or not. But if you will speak them you will make more income and protect your clients more fully.

Hospital Indemnity Plans Should be Considered with Medicare Supplements

Why? – Observation Care Stays!

Generally, the prescription and over-the-counter drugs you get in an outpatient setting, sometimes called "self-administered drugs," aren't

covered by Part B. Even if you stay in a hospital overnight, you might still be considered an "outpatient".

https://www.medicare.gov/what-medicare-covers/what-part-a-covers/inpatient-or-outpatient-hospital-status-affects-your-costs

Post AEP Hospital Indemnity Phone Script

Now is the Perfect Time to Sell Additional Hospital Indemnity Plans!

Current Client Follow Up Phone Script:

> *Hello, Mr(s) Client,*
>
> *While looking at your file I noticed that you have what I like to call an "unassisted" Medicare Advantage plan. This means that you have a Medicare Advantage plan which we reviewed during the Annual Enrollment Period and is definitely the best plan for you; however, you do not have any additional coverage to help offset the out- of-pocket expenses that these plans leave you exposed to. I've got some time available on or _____ and would like to discuss helping you cover these areas, what time would be best for you?*

Here Is a Way to Bring Hospital Indemnity into Your Presentation

> "We are ____ miles from *(Your Local Hospital Name)* and there are roughly ____ *(Find out your local hospitals normal occupancy)* patients who will spend the night there tonight. Some have prepared ahead and some have not. Those not prepared will receive bills with no help to pay them. Those who prepared with a plan will receive bills but will also receive cash in the mail to help offset the bills. I want to share with you one of the best ways to prepare for a potential hospital stay. It's a program known as hospital indemnity…"

Bring Health Topics Into Your Newsletters and On-Line Media

February is American Heart Month

Heart disease is the leading cause of death for men and women in the United States. Every year, 1 in 4 deaths are caused by heart disease. All of us can do our part to increase awareness of the warning signs and treatment of this disease.

Source: https://www.heart.org/

This toolkit is full of ideas to help you take action today:

https://health.gov/myhealthfinder/topics/health-conditions/heart-health

March is National Nutrition Month – Great Material for Your Client Newsletter

National Nutrition Month® is a nutrition education and information campaign created annually in March by the Academy of Nutrition and Dietetics. The campaign focuses attention on the importance of making informed food choices and developing sound eating and physical activity habits. Use your monthly newsletter to your clients to promote healthy living. The eatright.org site has marketing materials, event ideas, social media material and more to help you share in National Nutrition Month.

http://www.eatright.org/resource/food/resources/national-nutrition-month/toolkit

June is Men's Health Month

Anchored by a Congressional health education program, Men's Health Month is celebrated across the country with screenings, health fairs, media appearances, and other health education and outreach activities.

http://www.menshealthmonth.org/

September Is Life Insurance Awareness Month

Throughout September, advertising for Life Insurance Awareness Month will appear in national media coverage, so that makes it a perfect time

for you to contact clients and prospects to perform a review of their life insurance coverage.

Great Information for Content from the CDC

The Healthy Aging for Older Adults Website sponsored by the National Center for Chronic Disease Prevention and Health Promotion provides information on a wide range of topics including: Health-Related Behaviors, Chronic Diseases, Infectious Diseases, Immunizations for Adults, and Injuries Among Older Adults.
https://www.cdc.gov/aging/index.html

Why is this important? An informative and helpful newsletter and online content will keep your clients engaged.

Enrich Your Website by Linking to Outside Sources

CMS

CMS.gov is the official web site of the Centers for Medicare & Medicaid Services (CMS), an operating division of the U.S. Department of Health & Human Services (HHS). It is a public domain web site. You may link to CMS.gov at no cost and no special permission is required.

When you link to CMS.gov, please do it in an appropriate context as a service to your customers when they need to find official U.S. government information and services.

Though any site is welcome to link to CMS.gov, CMS.gov does not engage in reciprocal linking.

https://www.cms.gov/About-CMS/Agency-Information/Aboutwebsite/Link-to-Us.html

Myhealthfinder

Myhealthfinder is a tool that provides consumers with personalized, evidence-based health recommendations in just a few clicks. The recommendations come from the U.S. Preventive Services Task Force,

the CDC Advisory Committee on Immunization Practices, the Bright Futures Guidelines, and the Institute of Medicine's Committee on Preventive Services for Women.

There are 3 ways to incorporate Myhealthfinder into your website. A widget, a full-scale tool on your site or an application programming interface (API).

https://health.gov/our-work/health-literacy/consumer-health-content/free-web-content

National Institute on Aging

National Institute on Aging now offers a free way for you to get health and aging information for your website. Keep your site fresh with credible material that automatically updates. Choose from information on Alzheimer's disease, cancer, arthritis, diabetes, and other health topics for older adults.

Publications: https://order.nia.nih.gov/

Videos and Images: https://www.nia.nih.gov/alzheimers/alzheimers-scientific-images-and-video

USA.gov

USA.gov (www.usa.gov) is the official web portal for the U.S. government. It is a public domain website. At USA.gov, you can apply for benefits online, contact a government agency, or use the Internet's most comprehensive search of government websites—all from one easy location.

You may link to USA.gov at no cost here: https://www.usa.gov/link-to-us

Why is this important? If you have a website it is beneficial to make it a source of useful information for your clients. Links such as this can add free, informative content.

LTC State Certification

This LTC education site has listed each state's DRA/NAIC and Partnership initial and refresher mandatory training.

https://www.ltcconnection.com/page/staterequirements

Chronic Plans – A 12 Month Opportunity for Sales

Chronic Condition Special Needs Plans are designed for consumers diagnosed with chronic conditions such as diabetes, chronic heart failure, and/or cardiovascular disorders. These plans offer benefits in addition to those covered under Original Medicare such as routine dental, vision, hearing, transportation, and routine podiatry services. Consumers must have a qualifying chronic condition to enroll.

The following chronic conditions qualify a person for a chronic plan with UnitedHealthcare:

- Chronic heart failure
- Diabetes
- Cardiovascular disorders:
  - Cardiac arrhythmia
  - Coronary artery disease
  - Peripheral vascular disease
  - Chronic venous thromboembolism disorder

One in four Americans has multiple chronic conditions, defined as those that last a year or more and require ongoing medical attention or that limit activities of daily living.

That number rises to three in four Americans aged 65 and older.

https://www.cdc.gov/chronicdisease/about/index.htm

Things to do Right after Every AEP

- Make sure you have called or meet with all your clients to verify that they have the right plan set up for the following year.
- Make sure they understand their benefits and know to call you if they have questions about them. Remember: A client call to

Medicare with benefit questions is considered a complaint against the agent by Medicare because Medicare will think you did not do a good enough job explaining the benefits.

- Verify with the carriers that they received all your applications, that no outstanding items are required, and that they set up the plan you applied for.
- Set as many follow up appointments as you possibly can for the first quarter to verify that each individual's coverages are working properly. Also discuss coverage options you either did not have the opportunity to review or that you could not compliantly review during your AEP appointment. By doing this, your first quarter can be as profitable to you as AEP.

Why is this important? Once AEP is over your clients still need you, it's not a 'selling season' as some call it. Your clients trust you to set their plans up properly, your reputation depends on it.

Turn-Key Final Expense Marketing System - Legacy Safeguard

Legacy Safeguard was created to help you and your clients leave a lasting legacy and assist a member's family through some of the most difficult times in their lives. It provides members with legacy planning and end of life planning, assistance, support, and guidance. Legacy Safeguard has a comprehensive network of services that can provide complete end-of-life planning to ensure that a member's family will be taken care of in their time of need and to help a member be remembered long after they are gone. Legacy Safeguard can be added at no charge to many final expense carriers.

If you market final expense you need to know the details of Legacy Safeguard. Legacy Safeguard is a turn-key final expense marketing tool. Here are a few highlights:

- Target Market
- Direct Mail
- Newspaper Inserts
- Magazine Ads
- Group Seminar Presentation

- Flip Chart Presentation
- Client Presentation DVD
- PowerPoint Presentation
- Stand-Up Banners

www.LegacySafeguardUniversity.com

Can You Name Your Great Grandparents?

Involve your client in a bigger goal than just using life insurance to pay final expenses.

How about this as a goal? – Help 200 of your clients leave a significant mark on their family and community history.

You could tell a client – "I want a least 200 of my clients to be remembered by their great grandchildren and beyond."

Ask – "What can you tell me about your great grandfather or grandmother? Probably very little – I want to change that for the future!"

What can we help them do that will be remembered by their family and community long after they are gone?

How and what do they want to share? Perhaps it's experiences, lessons or values.

What community, family or religious projects would they love to create or support?

We must start to insure beyond just financial loss. Money and memories must be left to create a legacy.

Use the tools in the Legacy Safeguard program to create legacies.
http://legacysafeguard.org/index.php

Why is this important? As agents, we are often stopping too soon by just covering the potential loss. Let's help our clients build, create and change the future long after they are gone. Everyone deserves to be remembered!

Always Ask for Referrals

Customer referrals are one of the most powerful selling and marketing tools available to agents. In fact, the best source of new business is a referral from a satisfied customer. Time spent developing the phrase you use for asking for a referral or building an e-mail, letter or on-line tool for acquiring referrals will be some of the most valuable time spent in your career.

$30/$40 Options

Give your clients a menu of products they can choose from to complement their base coverage plan. Clients can choose for about $30 per month for clients up to age 60, or about $40 per month for those over 60 any of the following:

- Life Insurance Prepare for Final Expenses
- Recovery Care Insurance Covers You in Your Home or a Nursing Facility
- Cancer Insurance Covers the Expenses Unique to Cancer Care
- Hospital Indemnity Insurance Helps Cover the Unexpected Hospital Charges
- Tele-Medicine Program 24/7/365 Access to a Physician by Phone

Why Networking with Providers is a Vital Part of Building Your Business

A ready source of leads is an effective referral business from Doctors, Hospitals, Dentists, and Pharmacists. Remember that our products finance their services and their services create a need for our product. It only makes sense to work closely with providers. The decisions you make with your clients during AEP and throughout the year have tremendous impact on access to care.

Have You Asked an Underwriting Health Question This Week?

If you are not asking individuals health questions you are probably not offering your clients all the plans you need to. Many of the base health plans do not require you to ask health questions. Base plans like Medicare Advantage and Medicare Supplements being sold during a guarantee issue period or open enrollment are examples of that. The ancillary plans that can add much needed benefits for your clients and much needed profit for you usually ask health underwriting questions. If it has been more than a few days since you have asked a health question, consider it a red flag to your business.

Why is this important? To stay in business and be there when your clients need you, you must generate a profit. Base insurance plans like Medicare Advantage and Medicare Supplements help to fund your business operations and pay your client acquisition cost. The true profit of your business comes from building comprehensive benefit packages for your clients that include all needed coverages not just the base plans.

Senior Centers Serve More Than 1 Million Older Adults Every Day

- Approximately 70% of senior center participants are women; half of them live alone. The majority are Caucasian, followed by African Americans, Hispanics, and Asians respectively.
- Compared with their peers, senior center participants have higher levels of health, social interaction, and life satisfaction and lower levels of income.
- The average age of participants is 75.
- 75% of participants visit their center 1 to 3 times per week. They spend an average of 3.3 hours per visit.

Source: https://www.ncoa.org/news/resources-for-reporters/get-the-facts/senior-center-facts/

Why is this important? Senior centers serve as a gateway to the nation's aging network—connecting older adults to vital community services that can help them stay healthy and independent. As an agent, you can become involved in and network through these centers.

Transition Phrases - Expand Your Presentation to Include New Products

Final Expense Transition Phrase

"If you were to pass away tomorrow, would you and your family be financially prepared? Let me show you how you can have some peace of mind."

Cancer Insurance Transition Phrase

"Now I would like to talk to you about something that in one way or another impacts all our lives."

Hospital Indemnity Transition Phrase

"We can't stop medical costs from rising and we can't prevent all gaps in coverage from occurring, but we can prepare for it. Let me show you an important way we can prepare."

Dental/Hearing/Vision Plans Transition Phrase

"Although Medicare supplement plans provide excellent benefits to cover most healthcare needs, you need to take another step to make sure that quality coverage is in place for your dental, vision and hearing health. There is no need to go unprotected."

Recovery Care Transition Phrase

"Are you aware of how Medicare works when you leave the hospital?"

Last Minute AEP Reminders

- Make sure you have called or met with all your clients to verify that they have the right plan set up.
- Make sure they understand their benefits and know to call you if they have questions about them. Remember, a client call to Medicare with benefit questions is considered a complaint against the agent by Medicare because Medicare will think you did not do a good enough job explaining the benefits. Also due to OEP, your clients will be able to change their MA plan from January 1st thru March 31st.
- Verify with the carriers that they received all your applications, that no outstanding items are required, and that they set up the plan you applied for.
- Set as many follow up appointments as you possibly can for the first quarter to verify that each of your client's coverages are working properly. Also discuss coverage options you either did not have the opportunity to review or that you could not compliantly review during your AEP appointment. By doing this, your first quarter can be as profitable to you as AEP.

Why is this important? AEP is almost over, and your clients are depending on you to set their plans up properly. Your reputation depends on it.

IRS - Home Office Deduction

"If you use part of your home for business, you may be able to deduct expenses for the business use of your home. The home office deduction is available for homeowners and renters and applies to all types of homes."

Regardless of the method chosen, there are two basic requirements for your home to qualify as a deduction:

- Regular and exclusive use
- Principal place of your business

Source: https://www.irs.gov/businesses/small-businesses-self-employed/home-office-deduction

Self-Employed Individuals Tax Center

https://www.irs.gov/businesses/small-businesses-self-employed/self-employed-individuals-tax-center

Effectively Using Facebook

Audience: Friends, Family and Community

What to post: Short stories, promos, personal interests

When to post: 2-5:00pm weekdays, 1-4:00pm weekends

How often: 5-10 times weekly

Tips: No Sales Pitches – Facebook is a personal network

Use Relatable Posts

- Stories about clients (with their permission)
- Hobbies
- Local Events

Learn how to set up a business page here: https://www.facebook.com/business/learn/set-up-facebook-page

Why is this important? Facebook can be a powerful tool to maintain clients and attract referrals.

EDUCATION

Medicare Glossary of Terms

For a comprehensive list of terms used by Medicare, visit:

https://www.medicare.gov/glossary/a

Keep Clients Healthy

If you have Medicare, then you have access to a variety of preventive tests and screenings, most at no cost to you. Encourage the use of Medicare covered preventative services like cardiovascular disease screening, flu shots, and bone mass measurements.

The full list is on Medicare.gov under the "What Medicare Covers" tab:

http://www.medicare.gov/coverage/preventive-and-screening-services.html

Information on a "Welcome to Medicare" preventive visit:

http://www.medicare.gov/coverage/preventive-visit-and-yearly-wellness-exams.html

This fact sheet gives an overview of Medicare-covered preventive services:

https://www.medicare.gov/Pubs/pdf/11100-Staying-Healthy.pdf

Medicare Podcasts on Medicare.gov

Podcasts can be great tools for educating staff, refresher courses, and client education.

https://www.medicare.gov/pub/medicare-podcasts

Complete Medicare Basic Training Using Medicare Made Clear

Start on this link and work down through the selections on the right side of the page.

https://www.medicaremadeclear.com/basics/medicare-coverage-and-costs

Medicare Basics

- Medicare Coverage & Costs
- Medicare vs Medicaid
- Who Can Get Medicare
- Enrollment Time Periods
- What Medicare Doesn't Cover
- Medicare Supplement Insurance
- Get Help Paying for Medicare

Medicare Infographics

Infographics are a great way to illustrate Medicare to your clients. MyMedicareMatters.org is brought to you by the National Council on Aging and has a large collection of these teaching tools. You can find them here:

https://www.mymedicarematters.org/resource-library/infographics/?SID=57ba695bc74f7

Learn and Teach Your Staff and Clients Important Medicare Terms

This glossary explains terms in the Medicare program:

https://www.medicare.gov/glossary/a.html

CMS Requires You to Register Your Website

Any MA/PDP agent that has a website must be registered with each MA/PDP carrier they are appointed with.

Recommended search on the UnitedHealthcare portal: "Sales Policy Job Aid Agent Website Guidelines"

Know Your Medicare History?

Medicare program was signed into law July 30, 1965.

http://www.ssa.gov/history/lbjsm.html

Life Happens - Videos

Life Happens offers numerous life insurance videos from which to choose and incorporate into your online marketing outreach.

https://www.lifehappens.org/industry-resources/videos/

Life Happens is a nonprofit organization dedicated to helping Americans take personal financial responsibility through the ownership of life insurance and related products, including disability and long-term care insurance.

As an Agent - Do You Carry Your Own Products?

As agents, you spend your entire day teaching people how important it is to protect against the unexpected. Life insurance, home healthcare plans, hospital indemnity plans and so many more plans are just as important for you as they are for your clients. Your commissions allow you to carry the coverage for substantially less than the general public. So, the next time you encourage someone else to purchase a product do it with the conviction that you purchased it for yourself.

Medical Encyclopedia

This online medical encyclopedia on MedlinePlus offers thousands of articles about diseases, tests, symptoms, injuries, and surgeries. It also contains an extensive library of medical photographs and illustrations.

Find it here: https://medlineplus.gov/encyclopedia.html

MedlinePlus is the National Institutes of Health's web site for patients and their families and friends. MedlinePlus is produced by the National Library of Medicine.

Why is this important? A reliable source of information about healthcare helps you find bits and pieces of information to share with your clients in newsletters and on social media. This site is helpful because it brings you information about diseases, conditions, and wellness issues in language you and your clients can understand.

Know the Carrier Ratings – Sell Stability

A.M. Best

Best's Financial Strength Rating (FSR) Scale			
Rating Categories	Rating Symbols	Rating Notches*	Category Definitions
Superior	A+	A++	Assigned to insurance companies that have, in our opinion, a superior ability to meet their ongoing insurance obligations.
Excellent	A	A-	Assigned to insurance companies that have, in our opinion, an excellent ability to meet their ongoing insurance obligations.
Good	B+	B++	Assigned to insurance companies that have, in our opinion, a good ability to meet their ongoing insurance obligations.
Fair	B	B-	Assigned to insurance companies that have, in our opinion, a fair ability to meet their ongoing insurance obligations. Financial strength is vulnerable to adverse changes in underwriting and economic conditions.
Marginal	C+	C++	Assigned to insurance companies that have, in our opinion, a marginal ability to meet their ongoing insurance obligations. Financial strength is vulnerable to adverse changes in underwriting and economic conditions.
Weak	C	C-	Assigned to insurance companies that have, in our opinion, a weak ability to meet their ongoing insurance obligations. Financial strength is very vulnerable to adverse changes in underwriting and economic conditions.
Poor	D	-	Assigned to insurance companies that have, in our opinion, a poor ability to meet their ongoing insurance obligations. Financial strength is extremely vulnerable to adverse changes in underwriting and economic conditions.
** Each Best's Financial Strength Rating Category from "A+" to "C" includes a Rating Notch to reflect a gradation of financial strength within the category. A Rating Notch is expressed with either a second plus "+" or a minus "-".*			

Source: http://www.ambest.com/ratings/guide.pdf

Understanding Best's Credit Ratings:
http://www.ambest.com/ratings/ubcr.pdf

Find an A.M. Best Rating for a carrier:
http://www.ambest.com/home/default.aspx

Note: Access to view Best's Credit Ratings and detailed company information is complimentary for registered A.M. Best members. However, you are required to login once every 90 days or if your browser's cookie files have been deleted.

Standard and Poor's

Rated AAA to D

Ratings from 'AA' to 'CCC' may be modified by the addition of a plus (+) or minus (-) sign to show relative standing within the major rating categories. Understanding S&P Ratings:
http://www.spratings.com/en_US/understanding-ratings

Moody's

Global Long-Term Rating Scale AAA to C

Ratings Symbols and Definitions:
https://www.moodys.com/researchdocumentcontentpage.aspx?docid=pbc_79004

Carrier Ratings Sample - Mutual of Omaha:

http://www.mutualofomaha.com/about/ratings/

Research Carrier Complaint Information:

https://eapps.naic.org/cis/

Why is this important? Selling stability puts you into a more stable long-term relationship with your client. Each time your client has to change carriers for cost or any other reason, you are at risk of losing your client. Don't make the naive assumption that they will automatically choose you to be the agent for the new product. Look beyond price when recommending a plan. Smart advisers create smart consumers.

Encryption – Protect yourself from liability

Encryption is the process of converting data to an unrecognizable or "encrypted" form. It is commonly used to protect sensitive information so that only authorized parties can view it. This includes files and storage devices as well as data transferred over wireless networks and the Internet. An encrypted file will appear scrambled to anyone who tries to view it. It must be decrypted in order to be recognized. Some encrypted files require a password to open, while others require a private key, which can be used to unlock files associated with the key. Many carriers require this.

Help Your Clients Set Goals

Get involved with helping your clients set good financial and wellness goals.

Play it SMART... Good goals are meaningful. A goal that means something to you is one you are bound to achieve. To be meaningful, your goals must be SMART:

Specific

Measurable

Action-oriented

Realistic

Time-bound

New Agent Preparing for Your Exam?

New agents who need to prepare for the state license exam go to: http://www.webce.com/smsteam and then click on "Prepare for Your State Licensing Exam". Follow the prompts. This will give you a significant discount on Pre-Licensing materials.

Why is this important? A quick and inexpensive way to prepare to take your insurance exam saves you time, stress and money.

Some Practical Ways to Reduce Anxiety

- Set appropriate priorities – Important (long term) vs. Urgent (short term)
- Have realistic expectations
- Make room in your schedule for some quite time each day
- Find inspiration in nature
- Keep a sense of humor
- Get regular exercise
- Get sufficient sleep

Why is this important? As insurance agents we listen to individuals on a regular basis as they explain their concerns about health and financial issues. We then are commissioned to help them find solutions for those issues. All of this coupled with our own health and financial pressures can carry with it a lot of anxiety. Learning to cope and thrive in this environment is paramount to our long-term success.

Types of Business Structure

- **Sole Proprietorship**
  - A sole proprietorship is the most basic type of business to establish. You alone own the company and are responsible for its assets and liabilities.
- **Limited Liability Company (LLC)**
  - An LLC is designed to provide the limited liability features of a corporation and the tax efficiencies and operational flexibility of a partnership.
- **Cooperative**
  - People form cooperatives to meet a collective need or to provide a service that benefits all member-owners.
- **Corporation**
  - A corporation is more complex and generally suggested for larger, established companies with multiple employees.
- **Partnership**

    - There are several different types of partnerships, which depend on the nature of the arrangement and partner responsibility for the business.
- **S Corporation**
    - An S corporation is similar to a C corporation, but you are taxed only on the personal level.

Find out the details regarding forming a corporation here:

https://www.sba.gov/starting-business/choose-your-business-structure

Why is this important? If you are building an agency, it is vital to choose the appropriate business structure. In addition to legal and tax implications, this also impacts your ability to sell your business if you ever decide to.

Who is AHIP?

America's Health Insurance Plans (AHIP). You may be familiar with AHIP because of doing your annual certifications to market MA and PDP products but they are so much more than that. AHIP serves as a strong, unified voice for an industry that is leading the way in transforming health care. Tens of thousands of industry professionals rely on AHIP to provide first-class advocacy, education, and information on our changing health care system, covering topics such as delivery and payment reform, high-cost drugs, Medicare Advantage (MA), Medicaid, and provider networks. https://www.ahip.org/

Why is this important? AHIP can help you not only prepare for certification, but it can also help keep you up to date about changes in our industry with their blogs and newsletters. This year view taking your AHIP certification as an opportunity to learn more about our industry.

Understanding Star Ratings

The Overall Star Rating gives an overall rating of the plan's quality and performance for the types of services each plan offers. For plans covering health services, this is an overall rating for the quality of many medical/health care services that fall into 5 categories:

- **Staying healthy: screening tests and vaccines**
- **Managing chronic (long-term) conditions**
- **Member experience with the health plan**
- **Member complaints and changes in the health plan's performance**
- **Health plan customer service**

Detail Source: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/2020-Star-Ratings-Fact-Sheet-.pdf

Note: 5 Star Ratings Create a Special SEP

Learn more here: https://www.medicare.gov/sign-up-change-plans/when-can-i-join-a-health-or-drug-plan/5-star-special-enrollment-period

Why is this important? The first part of October of each year, CMS releases the star ratings for each plan. You are required to share a plan's rating with your client, and you need to understand what they are based on.

5 Star Rating System

https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcomplianc/fsqrs.html

When Setting Goals – Remember Zig Ziglar's Wheel of Life

The Wheel of Life has seven spokes, and each spoke a core area of life.

- Mental
- Spiritual
- Physical
- Family
- Financial
- Personal
- Career

Why is this important? In order to achieve balanced success, we need to be successful in each spoke of the Wheel.

ABOUT SENIOR MARKETING SPECIALISTS

Senior Marketing Specialists has been helping agents succeed since 1993. We are at the forefront of the Senior Insurance Market with support, training, and education.

Beyond Contracts

Having partnerships with some of the top names in the industry, Senior Marketing Specialists offers support to agents in the following fields:

- **Medicare Supplement**
- **Medicare Advantage**
- **Dual Special Needs Plans**
- **Prescription Drug Plans**
- **Final Expense and Life Plans**
- **Annuities**
- **Cancer and Other Specified Disease Plans**
- **Dental, Hearing, and Vision**
- **Hospital Indemnity Plans**
- **Short and Long Term Care Plans**
- **Home Healthcare**

Beyond our Market and our Carriers

We go above and beyond just contracts with personalized service, sales, and product training and support to make sure you are confident and compliant in your sales.

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- Over 9,000 agents have partnered with us.
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- Do you have 15, 20, 30+ years of experience? We provide support, knowledge, and tools for all stages of business, Agents and agency owners alike.

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