DAY 2 GUIDE

MEDICARE PRODUCTS

SENIOR MARKETING SPECIALISTS

Senior Marketing Specialists Medicare Quick Start

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OVERVIEW

Welcome to day two of Medicare Quick Start– Medicare Products

We will be reviewing the following:

- Core Medicare Products
- Ancillary Medicare Products
- Underwriting Tips
- MA vs Medicare Supplements

RESOURCES

Day 1 Guide
We will be referencing the Day 1 guide throughout this day. Make sure to have it handy!

Senior Marketing Specialists Resources
Quote Engine – Can be found on the home page of our website: SMSTeam.net
For SMS contracted agents – separate login is required

CORE & ANCILLARY PRODUCTS

CORE PRODUCTS

The Core Products are the products that your clients will have to supplement their Medicare coverage. As mentioned in the Medicare Overview, there are 2 main ways to supplement your client's Medicare coverage:

Medicare Supplements paired with a stand-alone prescription drug plan (PDP)

Or

Medicare Advantage Plan with Prescription Drug Coverage (MAPD)

ANCILLARY PRODUCTS

Ancillary products are lines of coverage that would cover other lines Medicare and core lines may not cover. These lines of coverage may include:

Dental / Vision / Hearing
Cancer Plans
Hospital Indemnity Plans
Home Healthcare Plans
Final Expense (Life Insurance)

Core products will maintain your business, ancillary products will excel your agency

MEDICARE COVERAGE CHOICES

Source: Medicare & You 2021 Page 6

Your Medicare options

When you first enroll in Medicare and during certain times of the year, you can choose how you get your Medicare coverage. There are 2 main ways to get Medicare:

Original Medicare

- Original Medicare includes Medicare Part A (Hospital Insurance) and Part B (Medical Insurance).
- If you want drug coverage, you can join a separate Medicare drug plan (Part D).
- To help pay your out-of-pocket costs in Original Medicare (like your 20% coinsurance), you can also shop for and buy supplemental coverage.
- Can use any doctor or hospital that takes Medicare, anywhere in the U.S.

☑ **Part A**

☑ **Part B**

You can add:

☐ **Part D**

You can also add:

☐ **Supplemental coverage**

This includes Medicare Supplement Insurance (Medigap). Or, you can use coverage from a former employer or union, or Medicaid.

See Section 3 (starting on page 53) to learn more about Original Medicare.

Medicare Advantage
(also known as Part C)

- Medicare Advantage is an "all in one" alternative to Original Medicare. These "bundled" plans include Part A, Part B, and usually Part D.
- Plans may have lower out-of-pocket costs than Original Medicare.
- In many cases, you'll need to use doctors who are in the plan's network.
- Most plans offer extra benefits that Original Medicare doesn't cover—like vision, hearing, dental, and more.

☑ **Part A**

☑ **Part B**

Most plans include:

☑ **Part D**

☑ **Extra benefits**

Some plans also include:

☐ **Lower out-of-pocket costs**

See Section 4 (starting on page 57) to learn more about Medicare Advantage.

DELAYING MEDICARE PART B

If an individual is still working, they may delay their Medicare Part B when they turn 65 to avoid paying both their Medicare Part B premium and their group/employer plan premium if they are enrolled in a group/employer plan which has more than 20 employees (see page 21 in the 2021 Medicare & You book).

Once they decide to leave their group plan, they can enroll into Medicare Part B through Social Security. They will need a letter of credible coverage from their group/employer plan.

From this point, they can:

- Enroll in a Medicare Part C plan within 2 months of leaving their group plan
- Enroll in a Medicare Part D plan within 2 months of leaving their group plan
- Enroll guaranteed issue (GI) into a Medicare Supplement plan within 6 months of their Medicare Part B start date

They may pre-enroll into any of the above plans, usually 2 months prior to leaving their group/employer plan, to prevent any lapse in coverage.

For more information see Medicare.gov page:
Should I get Parts A & B?

COMPLIANCE
MEDICARE PART C & D

CMS HAS STRICT GUIDELINES WHEN OFFERING MEDICARE C AND D COVERAGE.

SOA
A Scope Of Appointment (SOA) form is required for all Medicare C and D sales. This must be completed at the beginning of the appointment if the appointment was initially set up as a Medicare C or D appointment.

If the appointment was established for a different product, you may present a SOA form should the prospect bring up a Medicare C or D plan, and the appointment must follow the lines of coverage listed on the SOA form.

Lines of Coverage on the SOA:
- Medicare Advantage Plans
- Medicare Drug Coverage
- Medicare Supplements
- Dental / Vision / Hearing Plans
- Hospital Indemnity Plan

Certification
Agents are required to be certified from each carrier annually to offer Medicare C and D plans.

You must be certified for each product line you wish to offer. Example: There may be Medicare Advantage certification and separate certification for Special Needs Plans with the same carrier.

Many carriers require American Health Insurance Plans (AHIP) certification as well.

MEDICARE PART C – MEDICARE ADVANTAGE PLANS

History of Medicare Advantage Plans (Part C)

Started in the mid-1970's
Funded by Congress in the early 1980's
Became Medicare + Choice in 1997
Became Medicare Part C in 2005

Why Offer:

- Over 30% of Medicare beneficiaries are in a Medicare Advantage plan
- Low Premiums
- SNP – Dual market – There are special needs plans which are specifically designed for people who have both Medicare and Medicaid
- May work with other coverage such as group retirement plans
- Limited Underwriting

How they work:

Medicare Advantage plans become the primary over Medicare. All claims and benefit administration are handled through the insurance carrier.

Plans are Area Based

Usually based by county
Some plans may be statewide

Funding

Plans are funded by CMS (Medicare) based on the area which they service. This is called a capitation rate. This rate can vary greatly from county to county.

MEDICARE PART C – MEDICARE ADVANTAGE PLANS

Medicare Advantage is similar to group insurance plans

GROUP INSURANCE	MA PLANS
Must be part of the group	Must live in the service area
Employer / Group pays for some or all the premium	CMS pays the carrier which they use to pay for some or all the premium
No underwriting	No underwriting
Network based	Network based
Has deductible and co-pays	Has deductible and co-pays
Enrollment may change annually	Open enrollment is annually

This is one example of how to explain how MAPD plans work to your clients who are coming off group plans.

We will talk more about selling products on Day 4.

MEDICARE ADVANTAGE PLANS

2 Main Differences Between All Medicare Advantage Plans

1. COST
2. NETWORKS

COST
Medicare Advantage plans are laid out the same when it comes to overall structure, but the costs (co-payments, co-insurance, and deductibles) may change from plan to plan such as:

- Premium
- Max Out of Pocket
- Hospitalization
- Primary Doctor Visits
- Specialists Visits

NETWORK
Each plan is responsible for establishing their own network. It is important to check with each carrier your client is considering.

- Primary Doctor
- Specialists
- Hospitals
- Skilled Nursing Facilities

NOTE: Always use the online directory from the carrier for the most up-to-date information about providers.

MEDICARE PART D PRESCRIPTION DRUG PLANS

Beneficiaries are not required to have a Part D plan but will be penalized if they are eligible for coverage and do not have credible coverage, such as group/employer coverage or Veterans Administration coverage (VA).

The penalty is 1% of the national premium average for all Part D plans (listed on the Medicare Cost Sheet). Social Security will establish the exact amount and the penalty will stay with the beneficiary for life.

All drug plans follow the same structure

- Deductible
- Initial Coverage Limit
- Coverage Gap
- Catastrophic Coverage

Drug tier levels change from plan to plan
Formulary – List of covered drugs
Tier 1 – Preferred Generic
Tier 2 – Generic
Tier 3 – Preferred Name Brand
Tier 4 – Non-Preferred Name Brand
Tier 5 – Specialty Drugs
What is tier 2 with one plan may be tier 3 in another plan

Medicare Part B Drugs
Some drugs, which as usually administered by a medical professional, may be covered by Medicare Part B and not Medicare Part D. Example: Chemotherapy drugs.
Reference: Medicare.gov Prescription Drugs (Outpatient)

MEDICARE SUPPLEMENTS
MEDIGAP

How do I compare Medigap plans?

The chart below shows basic information about the different benefits that Medicare Supplement Insurance (Medigap) plans cover for 2020. If a percentage appears, the Medigap plan covers that percentage of the benefit, and you're responsible for the rest. Out-of-pocket costs (like deductibles) might change for 2021.

	Medigap plans									
Benefits	**A**	**B**	**C**	**D**	**F***	**G***	**K**	**L**	**M**	**N**
Medicare Part A coinsurance and hospital costs (up to an additional 365 days after Medicare benefits are used)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Medicare Part B coinsurance or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%***
Blood (first 3 pints)	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Part A hospice care coinsurance or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Skilled nursing facility care coinsurance			100%	100%	100%	100%	50%	75%	100%	100%
Part A deductible		100%	100%	100%	100%	100%	50%	75%	50%	100%
Part B deductible			100%		100%					
Part B excess charges					100%	100%				
Foreign travel emergency (up to plan limits)			80%	80%	80%	80%			80%	80%
							Out-of-pocket limit in 2020**			
							$5,880	$2,940		

* 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. (You can't buy Plans C and F if you were newly eligible for Medicare on or after January 1, 2020. See previous page for more information.)

** For Plans K and L, after you meet your out-of-pocket yearly limit and your yearly Part B deductible ($198 in 2020), the Medigap plan pays 100% of covered services for the rest of the calendar year.

*** Plan N pays 100% of the Part B coinsurance. You must pay a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that don't result in an inpatient admission.

MEDICARE SUPPLEMENTS
MEDIGAP

Networks

Medicare Supplements do not have a network besides Medicare. This makes them an ideal choice for people who travel for extended periods of time.

Medicare Supplement carriers may offer Medicare Select Plans which have a network, usually hospitals, that clients are required to use for scheduled procedures. These may not be offered in all areas. These plans are usually less in premium vs. regular Medicare Supplement plans.

The three most common plans

Plan F – Covers everything a Medicare Supplement can cover
Plan G – Same as Plan F but does not cover the Medicare Part B deductible ($233 in 2022)
Plan N – 3 Moving Parts:

1. Does not cover the Part B deductible
2. Does not cover Excess Charges
3. Has co-payments of up to $20 for certain doctor visits and up to $50 for ER visits that do not result in a hospital admission

The more a Medicare Supplement covers, generally the more expensive the premium. Plan F is usually the most expensive, followed by Plan G and then Plan N.

Example – 65yo Female – Non-smoker – ZIP 65203

PLAN	MONTHLY PREMIUM
Plan F	$155.22
Plan G	$119.85
Plan N	$103.75

MEDICARE SUPPLEMENTS
MEDIGAP

2 Main Differences Between All Medicare Supplement Plans:

1. COST
2. UUNDERWRITING

COST
Medicare Supplement carriers establish their own monthly premiums, which can vary greatly.

Medicare Supplement carriers also establish their own rate increases, which typically occur annually. It is important to take a look at historical data to see rate increase trends and make sure you are not placing your clients into a low cost plan now that may not be affordable in a few years. The SMS quote engine shows, for most carriers, the past few rate increases.

UNDERWRITING
Medicare Supplement carriers also establish their own underwriting guidelines. This too can vary from one carrier to another. What one carrier may decline, other carriers may accept.

Example: Some carriers may not accept insulin dependent diabetics while others will.

It is important to consider underwriting guidelines when establishing what carriers you are going to represent to make sure you have options for not only your client's fiscal needs, but also their health considerations. You can review these guidelines in the carrier's field underwriting guidelines or reviewing the carrier's application.

UNDERWRITING CONSIDERATIONS

Things to ask / consider when working with underwritten clients

Look Back Periods

This is when you are looking over their past medical history for a set amount of time.
Example: Some plans may have a 5 year look back for heart conditions, while others may have a 7 year look back.

Medication Changes

Many health conditions may be controlled via medication. However, many plan will look back for medication changes (especially increases in dosages) for instability or condition changes. It is important to ask your clients if they have had any changes in their medications over the past few years.

Why are they on that med?

Some prescription medications have off-label uses, meaning the drug is designed to treat one condition but can help with others.
Example: Clonidine (Catapres) is a high blood pressure medication but can also treat ADHD, restless leg syndrome, smoking sensations, and other conditions.

When / Why / Result

When talking to your clients and they tell you about a medical occurrence, such as a hospitalization, ask:
When it tool place – how long ago did this happen
Why the hospitalization occurred (accident, illness, outpatient procedure, etc.)
What was the result – was the occurrence satisfied or is it an ongoing treatment – do they need to see the doctor every year for check-ups, are they on a medication, etc.

3 Strike Rule

The more conditions your client has, the less likely they will pass underwriting. Example: While some plans may take insulin depending diabetics, combined this with high blood pressure, high cholesterol that has had a medication change in the past year, they may decline the application.

WHICH IS BETTER FOR MY CLIENT? MA OR SUPP?

We hear this question a lot!
There is no universal answer for this question, as each of your client's needs are different.

This may also differ with spouses. What is good for one may not be good for the other.

However, here are some considerations:

Medicare Supplements:
Offer more freedom as they are not network based
If you have a client who has high utilization (will be using the plan a lot)
Simplicity – No-copayments or co-insurance (depending on the level of coverage)
Can change plans at anytime (provided they can pass underwriting)
Stability – plans do not change from year to year

Medicare Advantage:
Wants a lower premium and willing to pay as they use it
Almost no underwriting – may not qualify for an affordable Medicare Supplement plan
Providers are in-network
Specialized plans depending on illness or dual eligible (depending on the service area)
Has a maximum out of pocket vs. original Medicare

ANCILLARY PRODUCTS

Coving Concerns Beyond Medicare Coverage

There are numerous options out there
The most common options for people on Medicare are:

- Dental / Vision / Hearing
- Hospital Indemnity
- Final Expense
- Home Healthcare Plans
- Cancer Plans

We are going overview each line of coverage. Don't get bogged down with the above. Choose one or two that you can comfortably offer to your clients and prospects. Once that product becomes second nature, add another, and continue.

Which carrier should I choose? This may be dependent on the area you are offering the coverage, which plan type you are most comfortable offering, and other factors. There is no one-size-fits-all in most cases. We will work with you and create a well-balanced portfolio with you.

DVH
If you don't know where to start with ancillary products, THIS IS IT!

- Medicare has virtually no coverage for DVH
- No underwriting
- Simple to understand (very similar to group dental plans)
- Listed on SOA forms

Dental / Vision / Hearing (DVH) plans usually come as one package, where all three benefits are tied together. This may vary depending on the carrier and plan option you are offering.

How to offer:
Ask your prospects and clients, when they had coverage prior to Medicare, did they have dental? If they answer yes (88% of group coverage offer some type of dental coverage), ask if they want to dental coverage in Medicare. Some people, more than you think, may assume Medicare has some dental, vision or hearing coverage, which for routine care, is false.

ANCILLARY PRODUCTS

Coving Concerns Beyond Medicare Coverage

HIP

Hospital Indemnity Plans (HIP) pair excellent with MAPD plans!

- They cover some or all the inpatient co-payment
- Listed in the SOA
- Work with any MA plan

HIP work in once a client is hospitalized, they will receive a set benefit (depending on the level of coverage they select) sent directly to them. Example: Their hospital co-payment is $500 but they have a $600 HIP benefit, the client can take $500 and pay off the medical bill and use the remaining $100 for what they choose.

Most plans offer limited underwriting, additional benefits beyond just hospital co-payments (such as ambulance riders, skilled nursing benefits, and more), and are guaranteed renewable (as long as the premium is paid, the plan will continue).

If you are offering MA plans, you should have these plans available to your clients!

FINAL EXPENSE

Final Expense (FE) plans are simplified issue whole life insurance plans. Whole life meaning as long as the premiums are paid, the plan will not terminate.

- Easy to no underwriting
- Many people lose their life insurance when the leave their group coverage
- Cremations can reach over $5,000 with a viewing

GI Options

Some carriers offer guaranteed issue (GI) final expense plans, which ask no underwriting questions. These plans typically will pay back the client's premiums within a set time (example, the first two years) if the client passes during that time. Beyond that time frame, the full death benefit is paid. However, an underwritten plan offers more benefit for less premium if you can get your client through underwriting.

ANCILLARY PRODUCTS

Coving Concerns Beyond Medicare Coverage

HOME HEALTHCARE PLANS

Home Healthcare plans (HH) are indemnity plans that work when you have a client who is receiving home health benefits through Medicare to give them extra funds they can use for additional expenses, including in-home private duty care.

- Virtually no underwriting
- Prescription drug rebate
- Low premium
- Easy to offer – can sell right from the brochure

The prescription drug rebate can be used regardless if there is a home healthcare claim or not, and usually rebates between $250 and $300 annually depending on the state which your client resides.

CANCER PLANS

Your clients may have a lot of additional expenses when they are treating cancer, which cancer plans can help offset or eliminate. Cancer plans work when you have client who is diagnosed with cancer, usually internal cancer, and pay either a lump sum or per-treatment benefit.

Cancer plans can be used to pay:

- Travel expenses
- Alternative treatment methods
- Additional medical costs – including additional medications which may not be covered through Medicare Part D
- Extra in-home care

Note on MA Plans: Cancer treatment is a weak point for many MA plans as they client may owe 20% for cancer treatment costs, which can add up quickly.

ANCILLARY PRODUCTS

Coving Concerns Beyond Medicare Coverage

DO I REALLY NEED TO OFFER ADDITIONAL LINES OF COVERAGE?

YES. **Medicare thinks so too.**

From Medicare.gov:

> **Note**
>
> Your doctor or other health care provider may recommend you get services more often than Medicare covers. Or, they may recommend services that Medicare doesn't cover. If this happens, you may have to pay some or all of the costs. Ask questions so you understand why your doctor is recommending certain services and whether Medicare will pay for them.

Listed on most Medicare.gov pages that talk about cancer

Other Excerpts from Medicare.gov:

Medicare doesn't cover most dental care, dental procedures, or supplies, like cleanings, fillings, tooth extractions, dentures, dental plates, or other dental devices.

Medicare doesn't cover:
•Hearing exams
•Hearing aids
•Exams for fitting hearing aids

Why you should offer DVH

Eye exams related to prescribing glasses

What isn't covered? Here are some examples of what Medicare doesn't pay for:

- 24-hour-a-day care at home
- Meals delivered to your home
- Homemaker services, like shopping, cleaning, and laundry
- Custodial or personal care like bathing, dressing, and using the bathroom when this is the only care you need

A home healthcare plan can help offset these costs

WHAT TO DO FROM HERE

Establish which carriers you want to represent – Your Sales Director at Senior Marketing Specialists can help you build a well-balanced portfolio.

Example:
2-3 Medicare Supplement Carriers
2 Part D plans (2 most popular in your area)
Review MA carriers in your area and contract accordingly
Pick 1-2 ancillary plans to offer (DVH and Cancer?)

Get to know the basic underwriting guidelines of each line of coverage you represent. You don't want to get your client interested in a product only to "take it away" from them.

Should you have questions, comments, concerns, or anything else we can help you with, please contact us! You can call, live chat on our webpage, SMSteam, or if you have a client issue, fill out a support ticket.

Tomorrow – Day 3
Marketing Medicare Products

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