





2024 Medicare AGENT GUIDE

As more Baby Boomers navigate retirement, you can be their trusted Medicare advisor. Explore the world of Medicare supplemental insurance, including plan options, basic compliance guidelines, case studies, and essential resources for your business.

the KRAUSE AGENCY

WELCOME TO THE 2024 MEDICARE AGENT GUIDE

Baby Boomers are turning 65 at a rate of 10,000 per day, which means more and more individuals are seeking guidance to prepare for their future healthcare costs. After all, planning for health-related costs and other financial necessities is vitally important during the retirement process. From long-term care to cancer to critical illness to dental and beyond, your clients deserve to have a plan for covering these possible medical bills.

Are you talking to your clients about Medicare? If not, someone else is.

Medicare presents a vital opportunity for you to cultivate stronger connections with current clients while also creating new connections with prospective clients. If you have avoided speaking to your clients about their healthcare needs because you feel overwhelmed by all the different options, let us help you be the trusted advisor your client's need.

So, what is in it for you? Aside from providing a necessary service in your community, incorporating Medicare and other health products into your business will help you:

- Enhance your business and boost your revenue
- Better reach new clients and retain existing clients
- Grow your referral network by positioning yourself as an expert to other industry professionals

"The first step towards getting somewhere is to decide you're not going to stay where you are." —JP Morgan

Let us help you provide the best for your clients.

E-mail

Medicare-Specific Inquiries
medicare@thekrauseagency.com

Work with Krause & General Inquiries:
info@thekrauseagency.com

Marketing, Educational Materials, & Events:
marketing@thekrauseagency.com

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Chat with Us Live

Start a live chat with one of our friendly staff members at thekrauseagency.com during our standard operating hours.

Not sure where to start?
Book a Discovery Call with one of our in-house advisors to learn how we can best serve you.

thekrauseagency.com/schedule

TABLE OF CONTENTS

01

About The Krause Agency 4

- Who We Are 4
- How We Got Here 4
- Executive Leadership 6
- Sales 7
- Administration & Accounting 9
- Marketing 10

02

Products & Services 11

- Our Products 11
- Our Services 13

03

Resources 14

- Education and Training 14
- Agent Access 16
- Our Medicare Process 17

04

The Medicare Opportunity 18

- The Medicare Program & Products 18
- Veterans and Medicare 23
- Extra Help 23

05

Building Your Medicare Business 24

- Why Offer Medicare Products 24
- Finding the Right Medicare Product for Your Client 24
- How to Be a Successful Medicare Advisor 24
- How to Get Referrals 26
- The Financial Opportunity 27

06

Medicare Compliance 28

- Ready to Sell 28
- AHIP Medicare Training 28
- Medicare Enrollment Periods 30
- Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) 30
- Marketing Medicare Products 31
- Marketing/Sales and Education Events 36
- Marketing with Social Media 38
- Marketing in a Health Care Setting 38
- Marketing in a Long-Term Care Facility 38
- Marketing Prohibitions During Open Enrollment Period 39
- Compensation Rules 39
- More Information About Medicare Compliance 40

07

Medicare FAQs 41

08

Medicare Case Studies 43

Advantage Plan vs. Community Rated Medicare Supplement [Minnesota] 44

Advantage Plan vs. Issue Age Rated Medicare Supplement [Florida] 45

Medicare Advantage vs. Attained Age Rated Medicare Supplement [Wisconsin] 46

Attained Age Rated Plan G vs. High Deductible Plan G [Iowa] 47

Medicare Prescription Drug Penalty Calculation 49

9

Funeral Expense Trusts 50

State Funeral Expense Trust Limits 52

10

Long-Term Care Insurance 53

Traditional Long-Term Care Insurance 54

Asset-Based Long-Term Care Insurance 54

11

Medicaid Compliant Annuity 55

What is a Medicaid Compliant Annuity? 55

When is an MCA Appropriate? 56

MCA Strategies 57

12

Appendix 58

2024 Medicare Costs & Premiums 59

Medicare Supplement Plans 61

Medigap Policy Coverage in Massachusetts 63

Medigap Policy Coverage in Minnesota 65

Medigap Policy Coverage in Wisconsin 67

Veteran Medical Benefits with Medicare 69

Medicare Enrollment Guide 71

Additional Medicare Supplement Open Enrollment Periods 73

States with Under Age 65 Requirements 75

01

CHAPTER 1:

About The Krause Agency

Who We Are

We are a national wholesaler of insurance products designed for the senior market. We help agents like you offer meaningful solutions for clients looking to secure their financial future while boosting your revenue in the process. In addition to our products, we provide specialized support and resources to enhance your business and help you stay up to date on everything from changing Medicaid regulations to marketing and prospecting trends.

When you work with us, you're never working alone.

How We Got Here

Back in the 1980s, our President and CEO, Dale M. Krause, J.D., LL.M., began his career as an estate planning attorney. He became ingrained in a dilemma many financial professionals face: how do I help my clients protect their savings as they age and face a potential long-term care need? His answer was insurance. No matter what stage of the process a client is in, there is an insurance product that can help protect their hard-earned assets.

In January 2015, Dale created The Krause Agency. While the company quickly became a thriving financial services firm, the business was centered around crisis Medicaid planning through the use of

a specialized SPIA product. Through the years, Dale and his team expanded to offer a more well-rounded collection of senior market products.

Although The Krause Agency has always offered long-term care insurance to our agents and their clients, in 2021, we took our commitment to LTCI to the next level by acquiring LTC Solutions—a nationally licensed LTCI specialty firm based out of Cape Coral, Florida. In 2023, we acquired USA-LTC, a California-based brokerage firm that specializes in LTCI, further securing our place as a key player in the long-term care planning industry. Now, our LTCI services are backed by even more experts in the industry, and we have access to all the top LTCI carriers nationwide.

In 2022, we added Medicare products to our ever-growing arsenal as well as a Medicare specialist to provide the training, guidance, and support agents need to offer Medicare products to their clients. Then, in 2023, we added a funeral expense trust and preneed specialist to expand our funeral planning product offerings.

Simply put, we're better equipped than ever to serve your senior market needs.

30+
YEARS OF EXPERIENCE

1,300+
ACTIVE AGENTS

30+
PROFESSIONALS ON STAFF

$500M
PREMIUM WRITTEN ANNUALLY

Executive Leadership

Dale M. Krause, J.D., LL.M.

President and CEO

Dale founded The Krause Agency over 30 years ago and currently acts as our President and CEO. Originally an estate planning attorney, he developed the first short-term Medicaid Compliant Annuity and used his vast experience to train and advise attorneys, agents, and other professionals on incorporating long-term care planning into their business. Today, Dale focuses his time on developing educational tools and identifying new opportunities for our agents. Dale earned his Juris Doctor from WMU-Cooley Law School and his Master of Laws in Taxation from DePaul College of Law.

Thomas Krause, J.D.

Vice President of Sales and Marketing

As Vice President, Tom plays a primary role in the growth and development of our company. As a co-creator of the short-term Medicaid Compliant Annuity, his industry knowledge runs deep. Tom has a strong foundation in the elder care industry, which he uses to continually enhance the experience of our agents. This includes developing educational resources like Agent Access, improving our websites, and adopting new technologies to create a streamlined sales process. Tom has a bachelor's degree in Economics, and he earned his Juris Doctor from California Western School of Law.

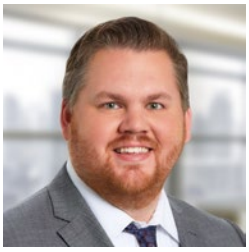
Scott Engstrom, J.D.

Corporate Counsel and COO

As Chief Operating Officer, Scott works closely with the executive team, department leaders, and other team members to maintain smooth company operations. As Corporate Counsel, he conducts legal research, drafts agreements, and resolves issues relating to litigation, risk management, and compliance. In both roles, Scott aims to facilitate effective and clear communication in order to help the company thrive. Scott has a bachelor's degree in Political Science, and he earned his Juris Doctor from Penn State Law.

Sales

Connie Ashley
Director of Agent Relations



Travis Bitters
Benefits Planner

Denise Fessler
Licensing Specialist

Don Levin, J.D., MPA, CLTC
Strategic Relations Director

La Rae Mills
Senior Relationship Manager

Paula Pike
Senior Account Manager

Kayla Puckett
Sales and Licensing Administrator

Richard Rusoff
Relationship Manager

Mary Sizemore
Sales and Admin Coordinator

Ryan Squires
Relationship Manager

Collin Terry, MBA, CLTC
Sales Director

Carolyn Vader
Senior New Business Specialist

Damon Wenig, MBA, CFSP
National FET and Preneed Director

Nate Ziolkowski
Sales Manager

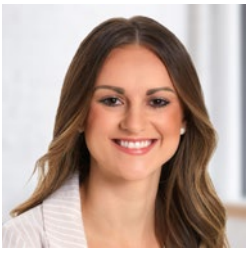
SCHEDULE A DISCOVERY CALL

Not sure where to start? Book a Discovery Call with one of our in-house advisors to learn how we can best serve you. If you're interested in learning more about our products and services and how we can work together, you can connect with a specialist at ***thekrauseagency.com/schedule.***

SCAN THE QR CODE TO BOOK YOUR FREE CALL!

Administration & Accounting

Rachael Capek
Administrative Specialist



Andrea Geyer, MBA
Administration Manager

Denise Krause
Accounts Administrator

Sarah Lippens
Sales and Administration Coordinator

Cadence Raymond
Administrative Specialist

Ellie VanHorn
Corporate Paralegal

Erin Vertin
Accounting Manager

Marketing

Amy Beacham, MBA
Marketing and Communications Director

Katie Camann
Content Marketing Specialist

Brandon Erieau
Senior Web Developer

Abby Frank, MBA
Creative Specialist

Bri Hemby
Digital Marketing Specialist, CRM Support

Andrew Krause
Digital Marketing Specialist

Trisha Lor
Marketing Associate

Katie Turner
Education and Events Coordinator

Brian Vogel
Digital Operations Director

Katy Willenbring
Event Marketing Coordinator

Jim Wolverton, J.D.
Director of Legal Education

Learn more about our staff at ***thekrauseagency.com/team.***

02

CHAPTER 2:

Products & Services

Our Products

MEDICAID COMPLIANT ANNUITY

A Medicaid Compliant Annuity (MCA) is a SPIA used in crisis planning that has certain provisions to comply with Medicaid's requirements. An MCA is designed to protect assets and accelerate Medicaid eligibility by converting excess countable resources into an income stream with no cash value.

LONG-TERM CARE INSURANCE

Long-term care insurance (LTCI) is the ultimate pre-planning tool for healthy clients looking to secure their financial future and set aside funds for a long-term care stay. We offer traditional and asset-based policies that can be structured to meet your client's specific circumstances, budget, and projected care needs. LTCI can be customized with a variety of funding options and may include features such as state partnership protection or a guaranteed death benefit.

MEDICARE PRODUCTS

Medicare products and other health policies provide supplemental health coverage for those who are planning for or in retirement as well as for those under the age of 65 who are eligible for Medicare. We offer consultation, certification, training, and case guidance on Medicare products, including Medicare Supplements, Medicare Advantage Plans, Prescription Drug Plans, Critical Illness and Cancer Plans, Hospital Indemnity, Accident plans, and more.

FUNERAL EXPENSE TRUST

A funeral expense trust (FET) is a small whole life insurance policy assigned to a funeral trust controlled by an insurance company. Upon the death of the insured, the funds can be used for their funeral and burial services. Policies below a state-specific limit are exempt for Medicaid purposes.

PRENEED INSURANCE

Preneed insurance consists of a small whole life policy assigned to a specific funeral home used for the policyholder's funeral and related expenses. Changes in assignment can take place before or after death to ensure the transferability of funds to the preferred funeral provider. A growth rate helps to offset inflation and price changes at the time of death.

SHORT-TERM CARE INSURANCE

With simplified underwriting, short-term care insurance offers an alternative for clients looking to pre-plan for care costs associated with a chronic illness. Short-term care insurance offers coverage for individuals up to age 89, whereas traditional LTCI usually cuts off applicants at age 79.

ESTATE TRUST

An estate trust allows individuals to allocate assets into a guaranteed-issue insurance contract with a built-in trust mechanism to help pre-plan for funeral expenses and leave a legacy for their heirs. Upon the owner's death, the benefit amount provides immediate financial liquidity and avoids probate. An estate trust may have a face value up to $100,000 and is only considered exempt for Medicaid purposes after the 5-year lookback period.

NON-MEDICAID SPIA

A non-Medicaid single premium immediate annuity (SPIA) is a contract funded with a lump sum that begins making payments immediately for a specified period of time, but it does not comply with Medicaid's restrictions. This type of annuity can be used to fund a Personal Services Contract (PSK) in Florida.

SINGLE PREMIUM DEFERRED ANNUITY

A single premium deferred annuity is a traditional insurance contract that is funded with a one-time deposit, and the funds receive a rate of return on a tax-deferred basis. The contract term is often 3 to 10 years, during which time most contracts allow for penalty-free withdrawals of the interest earned, while some allow for up to 15% of the principal to be withdrawn annually. The interest is tax-deferred until it is withdrawn from the contract.

FLEXIBLE PREMIUM DEFERRED ANNUITY

A flexible premium deferred annuity is a traditional insurance contract that can be funded with multiple deposits over a period of time. This annuity earns a rate of return that is tax-deferred until withdrawn. This type of annuity is a great option for individuals who can't afford to invest a lump sum or who are looking to reinvest their annuals RMDs.

WHOLE LIFE INSURANCE

A whole life insurance policy is a type of permanent life insurance designed to stay in force until the owner's death. This type of life insurance can be funded with a single premium or recurring premiums. Some whole life insurance policies are guaranteed issue, meaning the owner does not need to qualify medically for the policy. For Medicaid purposes, a small policy with a face value of $1,500 or less is considered an exempt asset in most states.

REFUSAL LETTERS

Refusal letters are letters from secondary annuity buyers indicating their inability to purchase an annuity due to its restrictive provisions. These letters may be needed to secure a Medicaid Compliant Annuity in some states or demonstrate undue hardship in certain cases involving a non-compliant annuity.

Our Services

CRISIS MEDICAID CASE ANALYSIS

Based on your client's unique case facts, we develop a custom solution using a Medicaid Compliant Annuity. This proposal includes a strategy to accelerate Medicaid eligibility, an annuity recommendation, and the projected economic results of the plan. If your client chooses to proceed, we'll guide you through the annuity application, purchasing process, and issuance of the contract.

LONG-TERM CARE INSURANCE CONSULTATION

Whether you have a pre-planning client or want to learn how LTCI fits into your business, we offer complimentary consultations. We'll provide guidance on the policy options available as well as strategies for choosing the right policy and how it can help when long-term care is needed. If your client chooses to proceed, we'll work with you to secure the purchase and protect your client's financial future.

MEDICARE CONSULTATION

If you're interested in learning more about Medicare products and how they fit into your business, schedule a complimentary Medicare consultation with us. We'll provide guidance on the Medicare products available as well as advice for helping clients choose the right plan for their situation.

MEDICAID PLANNING REFERRAL SERVICE

If you don't have the time to devote to learning crisis Medicaid planning, allow us to help. When you refer a Medicaid planning case to us, we'll pass it along to our strategic partner, and you can rest assured your client is in good hands. Plus, you can decide how involved you want to be AND earn a competitive bonus for the referral.

FAIR HEARING SUPPORT

If your client receives a Medicaid denial due to a product purchased through our office, our in-house attorneys will work with you throughout the fair hearing process. This free service includes a thorough review of your client's denial, support before and during the case, and guidance to help your client gain eligibility for the benefits they deserve.

ANNUITY VALUATION

In crisis planning situations, an existing annuity may impede a client's Medicaid eligibility. In these cases, we will review the contract and determine its fair market value. Then, we will purchase the annuity for cash, allowing your client to pursue crisis planning options. From valuation to sale, the process can take as little as two weeks. **Plus, agents earn a commission on the sale of the annuity.**

Not Sure Where to Begin?

Whether you're looking to take advantage of one of our services, or you have questions about a specific product, schedule a call with one of our in-house advisors. We look forward to hearing from you!

▶▶▶ **thekrauseagency.com/schedule**

03 CHAPTER 3: Resources

Education and Training

eACADEMY WEBINARS

Our eAcademy webinars provide essential information about a variety of topics associated with long-term care planning and the senior market, including real-life case studies that illustrate popular products and strategies. Each webinar is led by one of our in-house professionals or a trusted guest presenter and concludes with a live Q&A session.

CARRIER WEBINARS

Stay up to date on the products, resources, and services available through our insurance carriers. Throughout the year, we feature a variety of carrier webinars tailored to long-term care planning and the senior market.

▶▶▶ Register for our upcoming webinars at *thekrauseagency.com/webinar*.

CARRIER ANNOUNCEMENTS

Stay in the know with these important updates from our trusted insurance carriers. In order to get the right information for your business, you can search for a specific carrier or filter announcements by product.

CONSUMER RESOURCES

View flyers, handouts, PowerPoints, and more designed specifically for your target audience. With resources for all our major products, we have the tools you need to explain the value of your offerings to your prospective clients.

VIDEO LIBRARY

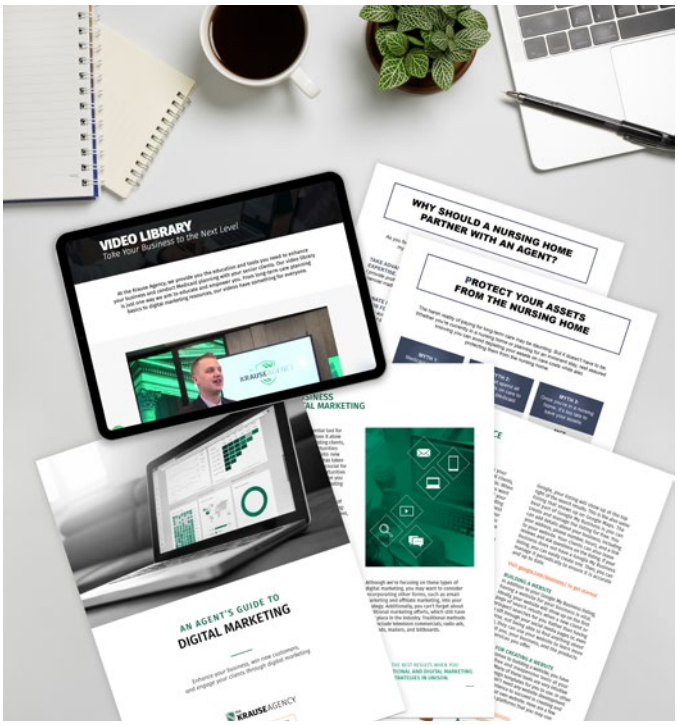
Our videos are designed to bolster your growth by breaking down complex topics into straightforward and understandable concepts, providing insight from industry leaders, and taking an in-depth look at marketing strategies for your business.

MARKETING RESOURCES

In addition to offering the right products and services, a solid marketing strategy is crucial to achieving success in your business. That's why we provide videos, white papers, blogs, and other resources to help you promote your business online as well as with traditional marketing efforts.

CASE STUDIES

See our most popular planning strategies in action with our comprehensive case studies, which take real-life examples and break them down into easily digestible steps toward a long-term care solution.



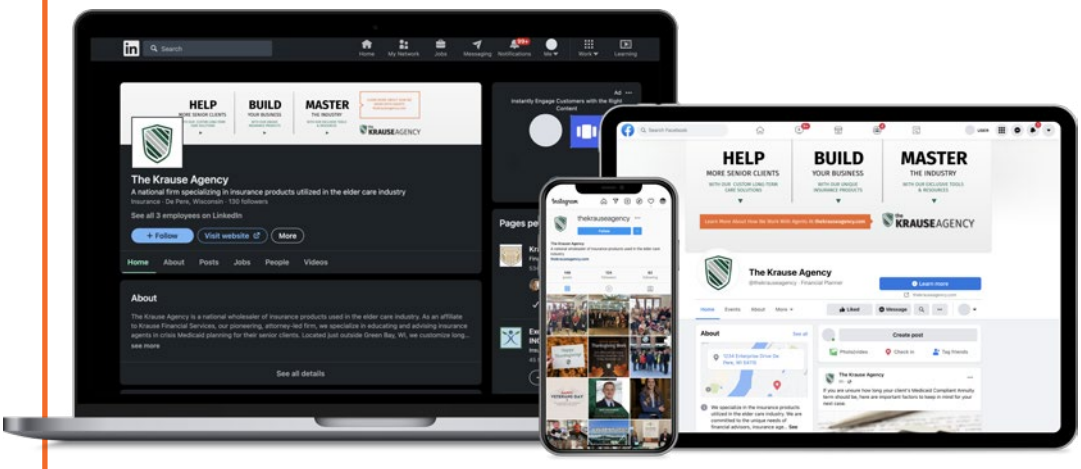
BLOGS

Stay up to date with the latest planning tips, industry updates, and news. Our blogs go in depth on long-term care planning strategies, important issues in the long-term care planning industry, and breaking news relevant to your clients and your business.

SOCIAL MEDIA

Follow The Krause Agency on Facebook, LinkedIn, X, and Instagram for regular updates on the senior market, upcoming webinars, recent blogs, national news, and an inside look at our company culture.

FOLLOW US ON SOCIAL MEDIA!



Agent Access

Agent Access is our exclusive online portal designed to help insurance agents, advisors, and other financial professionals succeed in providing senior market solutions and long-term care products to their clients.

By creating your free account, you get instant access to:

EXCLUSIVE CONTENT
Take advantage of exclusive content meant to enhance your offering to clients and grow your business in the process. This content includes educational video series, crucial planning updates, and our archive of past webinars.

MEDICAID RESOURCES
When it comes to crisis planning, it's crucial to stay up to date on Medicaid's rules and regulations. That's why we provide the latest state-specific information, including Medicaid planning figures, your state's Medicaid manual, and relevant legal changes.

LTCI QUOTING TOOLS
Obtain an online quote for your client's traditional or asset-based long-term care insurance policy. Simply provide a few details about your client's case, get a realistic quote, and walk into your next meeting prepared with a proposal.

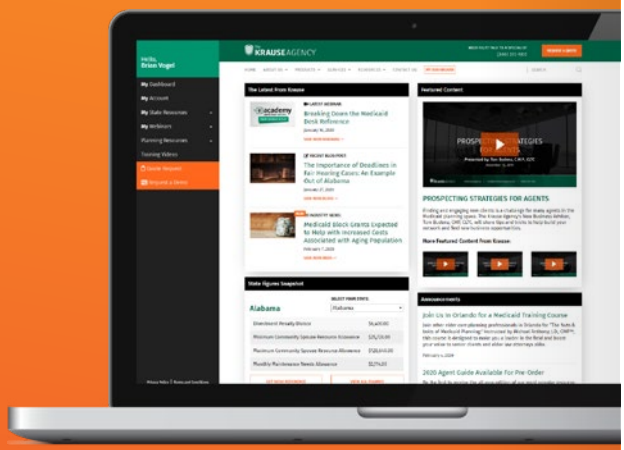
MEDICARE SEARCH & SAVE
Search & Save is your all-encompassing Medicare quoting and client management system for Medicare Supplements, Advantage Plans, and Prescription Drug Plans. This tool simplifies the selling process and helps keep you compliant.

PERSONALIZED DASHBOARD
Your personalized dashboard features the latest resources from our office, suggested content, educational materials, and important account information. From the dashboard, you can easily request a quote or product assistance from one of our in-house advisors.

EXCLUSIVE CONTENT INCLUDES:

- White papers
- Consumer Resources
- Important announcements
- And more!

Visit ***thekrauseagency.com/start*** to create your free account today!



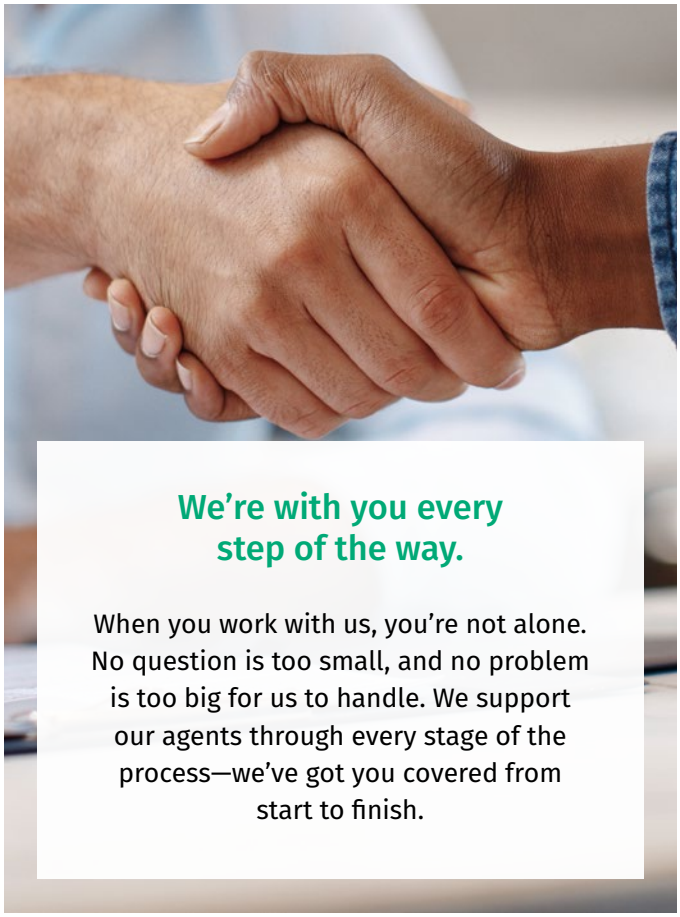
Our Medicare Process

If you want to incorporate Medicare products into your business, we can help. We offer the tools to educate and empower you, so you can better serve your clients while simultaneously enhancing your business. If you have a client who you think could benefit from Medicare products or any of our other unique products, simply contact us to get started.

!

WE DO MORE THAN JUST PROVIDE A PRODUCT.

We offer the **service**, **support**, and **education** you need to use that product successfully and increase your bottom line in the process.



We're with you every step of the way.

When you work with us, you're not alone. No question is too small, and no problem is too big for us to handle. We support our agents through every stage of the process—we've got you covered from start to finish.

1

GETTING STARTED

Whether you're new to Medicare or looking for guidance on a specific case, simply get in touch with us. You can call or email our office directly or schedule a Discovery Call at a time that works well for you. Our main priority is helping you get started so you can write Medicare business with ease.

2

CASE GUIDANCE AND SUPPORT

We provide training, guidance, and support for you to successfully market and sell Medicare products to your clients, whether you're brand-new to this product area or looking to expand your expertise. We also work closely with insurance carriers for extra support.

3

SEARCH & SAVE*

If you're looking to get a Medicare Advantage Plan, Medicare Supplement, or Prescription Drug Plan quote for a specific client, use the Search & Save tool. This tool allows you to simplify the selling process and compare different plan options for your clients.

**For Medicare-contracted writing agents only.*

04 CHAPTER 4: The Medicare Opportunity

As the population grows older and people live longer, the number of Medicare beneficiaries will continue to increase. As of September 2023, 66.5 million people were enrolled in Medicare. According to Kaiser Family Foundation, that number is projected to grow to 93 million by 2060. This presents an essential opportunity for senior market agents and advisors.

Now more than ever, people need your guidance with their retirement and healthcare costs.

While many people retire before or at age 65, a growing number of individuals are retiring after age 65. This new reality is changing the enrollment process for many beneficiaries as well as when and how agents should target their marketing for Medicare business. That's why it's crucial for you to understand the Medicare program, the opportunity it presents to your business, and the products that are available to your clients.

The Medicare Program & Products

Medicare is a federal health insurance program for individuals aged 65 or older as well as certain younger people who have had a disability for at least 24 months and people with End-Stage Renal Disease (ESRD). In order to qualify for Medicare, an individual must be a U.S. citizen or lawfully present in the U.S. for at least five consecutive years. Medicare consists of different parts, each of which is designed to cover specific healthcare costs and services.

ORIGINAL MEDICARE

Original Medicare includes Medicare Part A and Part B. It pays for much, but not all, of the covered healthcare costs. Typically, beneficiaries pay a deductible before Medicare pays its share. Then, the recipient pays a copayment or coinsurance for covered services and supplies. A supplemental Medicare policy can help cover these additional costs and services that Original Medicare does not cover.

Medicare Part A – Hospital Insurance

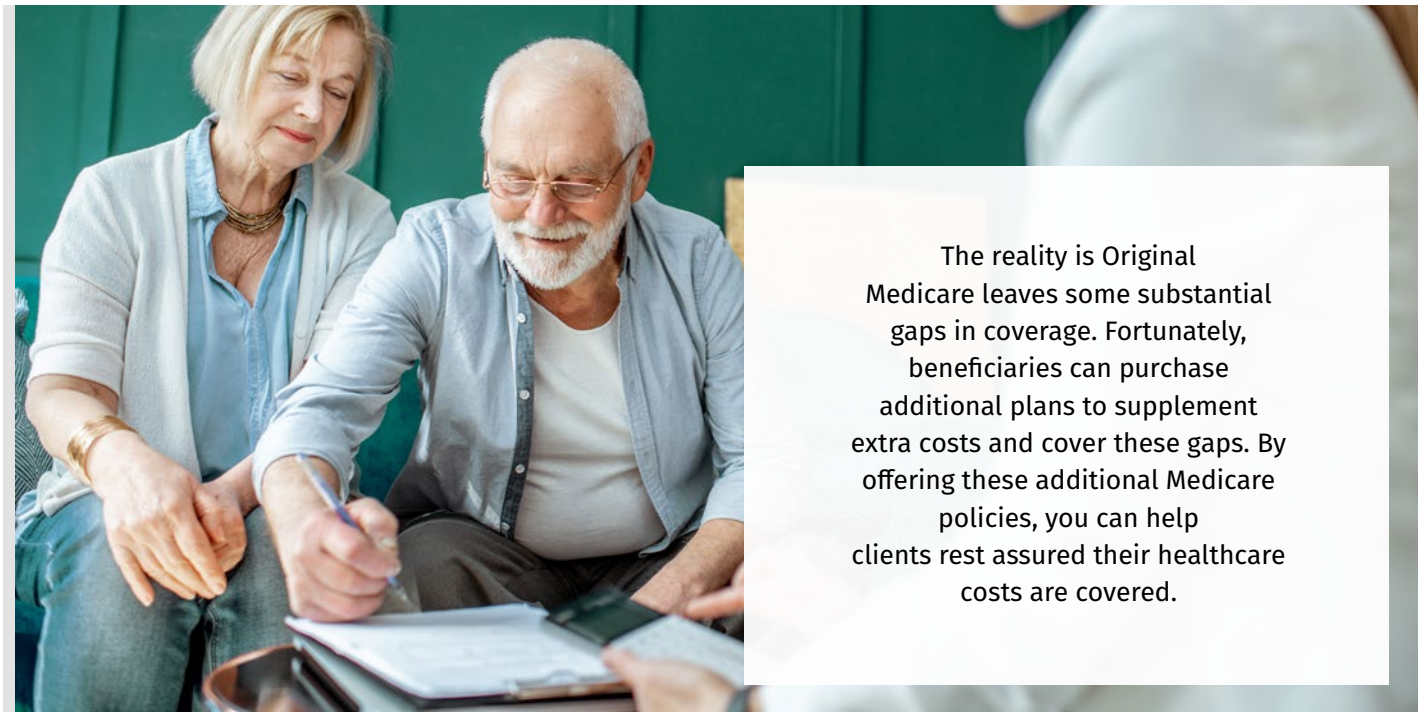
Part A covers inpatient hospital stays, rehabilitative care in a skilled nursing facility, hospice care, and some home health care. Most beneficiaries do not pay a premium as long as they have worked at least 40 quarters (10 years total), though a deductible of $1,632 (in 2024) may apply.

Medicare Part B – Medical Insurance

Part B covers certain doctors' services, outpatient care, medical supplies, and preventive services. Most beneficiaries pay an annual premium based on their income, and a deductible of $240 (in 2024) may apply.

For more information about Medicare Part A and Part B costs, see page 59.

Medicare 2024 Part B Premiums by Income If your filing status and yearly income in 2022 was:			
File Individual Tax Return	**File Joint Tax Return**	**Income-Related Monthly Adjustment Amount**	**Total Monthly Premium Amount**
$0 – $103,000	$0 – $206,000	$0	$174.70
$103,000 – $129,000	$206,001 – $258,000	$69.90	$244.60
$129,001 – $161,000	$258,001 – $322,000	$174.70	$349.40
$161,001 – $193,000	$322,001 – $386,000	$279.50	$454.20
$193,001 – $499,999	$386,001 – $749,999	$384.30	$559.00
$500,000 +	$750,000 +	$419.30	$594.00



The reality is Original Medicare leaves some substantial gaps in coverage. Fortunately, beneficiaries can purchase additional plans to supplement extra costs and cover these gaps. By offering these additional Medicare policies, you can help clients rest assured their healthcare costs are covered.

Medicare 101

For more information about Original Medicare, be sure to watch the Medicare 101 training.

Scan the QR Code or visit
thekrauseagency.com/medicare101

MEDICARE SUPPLEMENTS

Medicare Supplements, also known as Medigap, are private insurance policies designed to fill gaps in original Medicare coverage. While Medicare pays for a great deal of medical expenses, a Medicare Supplement policy can help cover some remaining costs, such as copayments, coinsurance, and deductibles. Enrollees can choose from a variety of supplemental plans with different benefits and costs.

Medicare Supplement plans are guaranteed renewable as long as the owner is paying premiums. They require underwriting only if enrollment occurs outside of the open enrollment or guaranteed issue period.

Medicare Supplement Plans	G*	N
Part A coinsurance and hospital costs (up to an additional 365 days after Medicare benefits are used)	100%	100%
Part B coinsurance or copayment	100%	100%†
Blood (first 3 pints)	100%	100%
Part A hospice care coinsurance or copayment	100%	100%
Skilled nursing facility care coinsurance	100%	100%
Part A deductible	100%	100%
Part B deductible		
Part B excess charges	100%	
Foreign travel emergency (up to plan limits)	80%	80%

▶▶▶ See the full chart on page 61.

** Plan G also offer high-deductible plans in most states. With this option, you must pay for Medicare-covered costs (coinsurance, copayments, and deductibles) up to the deductible amount of $2,800 in 2024 before your policy pays anything.*

† Plan N pays 100% of the Part B coinsurance, except of 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.

Top Medicare Supplement Insurers	Percentage of Market (2022)
UnitedHealthcare (AARP)	31%
Mutual of Omaha	9%
CVS	8%
Anthem	7%
Humana	4%
Cigna	3%

Source: American Association for Medicare Supplement Insurance

MEDICARE PART C – ADVANTAGE PLANS

Medicare Advantage Plans, also known as Part C or MA plans, are insurance plans provided by a Medicare-approved private company and must follow specific rules set by Medicare. These plans offer an alternative for Medicare Part A and Part B coverage, and many also include drug coverage (Part D). These plans are required to be as good or better than Original Medicare and have limits on the out-of-pocket costs.

Medicare Advantage Plans are a one-year contract, and benefits can be changed each year. These plans do not require underwriting and are guaranteed acceptance but can typically only be changed during the annual enrollment period.

44% 44% of Medicare beneficiaries are enrolled in a Medicare Supplement.

2022 Medicare Trustees Report

47% of Medicare beneficiaries are enrolled in a Medicare Advantage Plan.

2022 Medicare Trustees Report

43 Medicare Advantage Plans In 2024, the average beneficiary can choose from 43 Medicare Advantage Plans. This does not include employer or union-sponsored group plans, Special Needs Plans, PACE plans, cost plans, nor Medicare-Medicaid plans.

(Kaiser Family Foundation)

97% of MA plans offer vision, fitness, telehealth, hearing, and/or dental benefits.

(Kaiser Family Foundation)

MEDICARE PART D – PRESCRIPTION DRUG COVERAGE

Prescription Drug Plans, also known as Part D or PDP plans, provide Medicare drug coverage for prescription drugs and vaccines as a standalone plan that cannot be paired with a Medicare Advantage Plan. Enrollees can choose from a variety of Prescription Drug Plans with different costs and coverage.

While Medicare drug coverage is optional and is offered to everyone with Medicare, delaying enrollment without creditable coverage can result in a late enrollment penalty. Prescription Drug Plans can be changed annually but typically only during the annual enrollment period. No underwriting is required, and the plans are guaranteed acceptance.

▶▶▶ Visit ***medicare.gov*** to learn more about Medicare costs and coverage.

77% of Medicare beneficiaries are enrolled in Part D plans—56% in standalone PDPs and 44% Medicare Advantage drug plans.

(Kaiser Family Foundation)

MEDICARE PART C AND D STAR RATINGS

Medicare Star Ratings are designed to help consumers learn which plans perform the best in a variety of categories, including customer service, member experience, and quality of care. Each year, the Center for Medicare and Medicaid Services (CMS) provides Star Ratings to Medicare Advantage Plans (Part C) and Prescription Drug Plans (Part D). Each plan gets a Star Rating from 1 to 5 with 5 being the highest and 1 being the lowest. They assign a Star Rating for each category as well as an overall rating based on the average of all categories.

While Star Ratings may be an important part of the decision for your client, it's also crucial to choose a plan with their desired doctors and care sites as well as the benefits and prescription drugs they need. If a plan does not have these, a high Star Rating should not be a deciding factor for them.

It's also important to note that high-performing plans get a bonus from CMS, so the higher the rating, the more benefits the plan can offer. That's why a high-rated plan typically offers extra benefits. Additionally, if a plan gets lower than three stars for three years in a row, they will be flagged as a low-performing plan and members will be notified. While members can remain on the plan, they may want to consider another option.

Star Ratings are released each year in the fall, allowing beneficiaries to use this information during Annual Enrollment. A plan needs to be in the market for at least two years before receiving a Star Rating. Receiving a 5-star rating not only gives the plan the highest bonus, but it also allows beneficiaries to enroll into that plan anytime during the year (no special circumstance needed).

▶▶ Visit ***go.cms.gov/partcanddstarratings*** to view the 2023 Medicare Star Ratings.

CUSTOMER SERVICE
MEMBER EXPERIENCE
QUALITY OF CARE

OTHER POLICIES

In certain states, people can opt for other special Medicare supplemental plans, such as Cost Plans, a Medicare Savings Account, and Select Plans. Even with a supplemental plan, many individuals must seek additional coverage for health costs, including dental, vision, hearing, and hospital copays.

Dental, Vision, and Hearing Plans

These plans are designed to help cover preventative dental, vision, and hearing services that are not covered by a standard health plan nor Medicare. Coverage amounts vary by plan and company, and some provide coverage outside of a network. Some plans give first-day coverage, and some also have discounts if bundled with another policy, such as a Medicare Supplement.

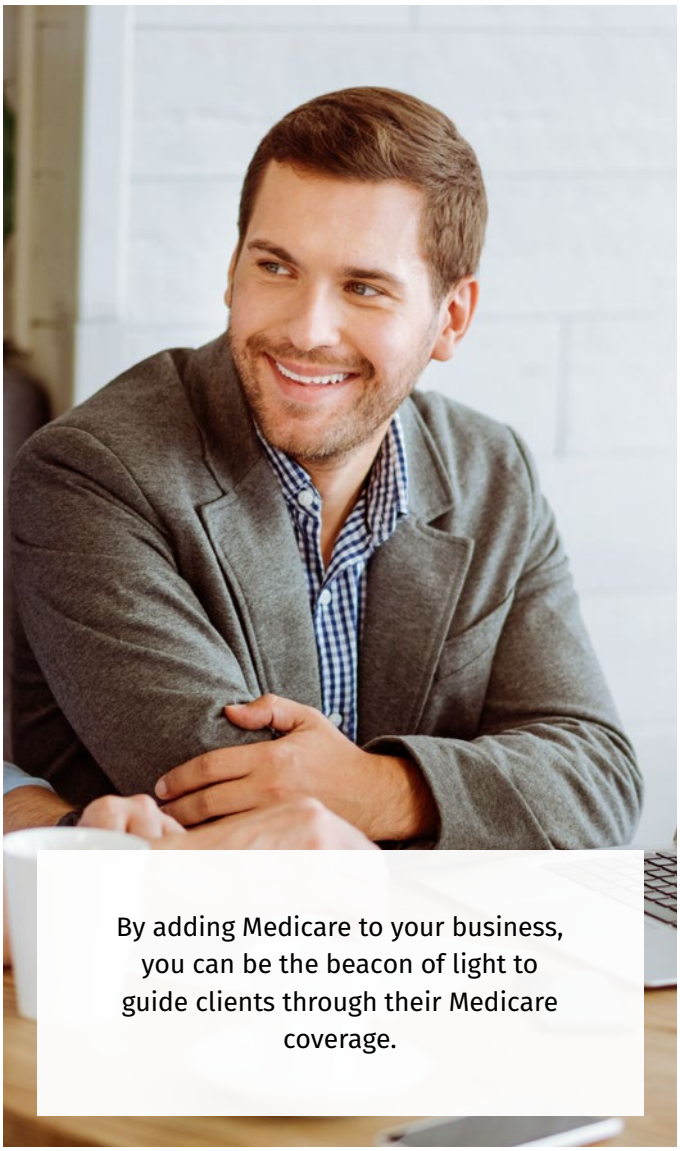
Critical Illness, Accident, and Cancer Plans

These plans can be either lump-sum or indemnity payout policies. Each plan can be set to cover a high deductible on a health plan or to give payouts for other expenses, such as travel, out-of-network bills, new treatments not covered by insurance, or missed work.

TRAINING, CERTIFICATION, & CASE GUIDANCE

Since healthcare costs are one of the main contributors to financial distress, many people planning for or entering retirement are seeking a trusted advisor to help them plan for these costs and obtain coverage for gaps in Medicare.

In addition to our products, we offer training, certification, and case guidance for Medicare Supplements, Advantage Plans, Prescription Drug Plans, and other supplemental plans to meet your clients' needs.



By adding Medicare to your business, you can be the beacon of light to guide clients through their Medicare coverage.

Veterans and Medicare

Those who have served our country through our military (and in some cases their spouses and dependents) can qualify for special coverage, though these benefits vary depending on their length of service, when they served, whether they have a service-related disability, and their income. In some cases, it's best for veterans to have only Original Medicare with their offered benefits. Therefore, it's crucial for you to know the coverage options available to your veteran clients.

▶▶▶ Turn to page 69 to understand the different veteran medical plans available and how they coordinate with Medicare.

Extra Help

DUAL ELIGIBILITY FOR MEDICARE AND MEDICAID

Once someone becomes eligible for both Medicare and Medicaid, they are considered Dual Eligible and typically pay very little to nothing for their medical expenses. Medicare pays first, and Medicaid provides secondary coverage. In these cases, the individual does not need nor are they allowed to have a Medicare Supplement. Their Part A and Part B premiums are covered, and they may qualify for a dual-eligible Medicare Advantage plan. Some states allow agents to write and sell these plans, but the plans and availability vary greatly depending on the area and state.

LOW INCOME SUBSIDIES

Medicare beneficiaries with a low income may be able to qualify for Low Income Subsidies (LIS) and receive extra help to pay for a Prescription Drug Plan.

▶▶▶ Learn more at ***secure.ssa.gov/i1020/start.***

05 CHAPTER 5: Building Your Medicare Business

Why Offer Medicare Products?

Offering Medicare supplemental product advisement not only strengthens your relationships with existing clients, but it can also open doors to additional clients. Healthcare costs are one of main contributors to financial depletion, so your clients need a trusted advisor to help them plan for these costs and cover gaps to avoid financial surprises.

▶ Medicare is complicated. You can help your clients navigate this maze.

Finding the Right Medicare Product for Your Client

Each Medicare product can help clients in different ways and at different stages of their lives. The key is ensuring the plan is suitable for your client's specific needs. We provide training and guidance to assist you in determining suitability for each case, taking into account a variety of factors, including travel, provider preference, health needs, location, and more.

How to Be a Successful Medicare Advisor

If you are considering adding Medicare products to your office or becoming a Medicare agent, it's important you understand what it takes to achieve success. Below are some of the key characteristics of a successful Medicare advisor. If these traits describe you or a person in your office, you are on your way to being a successful Medicare advisory office. If you identify an area of growth, we encourage you to utilize resources to expand your skills or seek help from a colleague to progress in that area.

EDUCATOR

Medicare is complicated and comes with a lot of detailed information. Being able to simplify the options and products available to your clients will give you creditability and boost your referrals. When it comes to exploring healthcare coverage, people like having someone they can trust to explain the details and processes in a logical and understandable way.

PROBLEM SOLVER

Each Medicare beneficiary comes with a different profile for suitability, and it's crucial for you to be able to take their information and find specific choices and solutions to meet their needs. As a Medicare agent, you may also encounter enrollment or claims issues or stumble upon other unique situations. Being a problem solver allows you to provide great support to your clients.

SERVICE ORIENTED

People want to know they'll be taken care of if they need help, especially when they join a new program or purchase a new plan. Take every opportunity to show your dedication to serving your clients, no matter their situation. This provides assurance to them that they're in good hands and can be confident in their choice.

TECH SAVVY

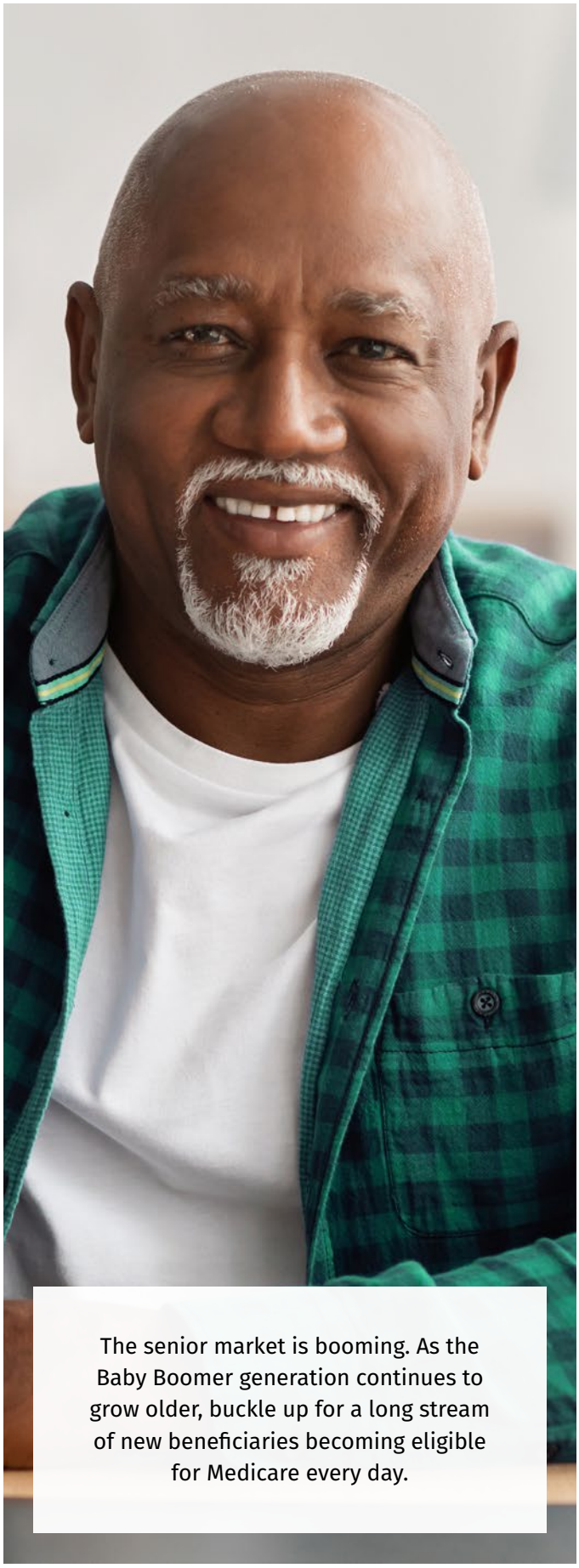
The insurance industry has almost completely moved online. While many people may still come to meet you in person at your office, all companies prefer e-apps. Some even pay more for e-app submissions. In addition, most individuals exploring Medicare do online research. Therefore, it's vital for you to be online with a website and social media. If you are not very tech savvy, seek assistance from someone on your staff or a third-party company.

STUDENT

The senior market is ever-changing. Not to mention, Medicare Advantage and Prescription Drug plans change every year, and it's important that you stay up to date on all the rules and regulations. Being a lifelong student helps you to stay on top of the constant fluctuations and year-to-year-changes.

RELATABLE

An important aspect of building a business around referrals is the ability to relate to people. Whether it's a prospect you just met or a client you have had since day one, people want to work with someone who is interested in them and can relate to them. While you might not be able to relate to everything, make a point to find similar interests or other areas where you can connect with them.



The senior market is booming. As the Baby Boomer generation continues to grow older, buckle up for a long stream of new beneficiaries becoming eligible for Medicare every day.

How to Get Referrals

Referrals are a key part of any business, and it all boils down to building relationships. But how exactly can you do that? Here are a few tips for building referrals for your business.

1 BE INTERESTED IN PEOPLE AND REMEMBER THEIR NAMES.

When you meet new people, be sure to get their names and remember them. If you are not good at remembering names, search for tips to help. For example, use the person's name in conversation immediately after learning it, and try to use it three more times as you speak with them. After the introduction, you can respond, "It's nice to meet you, Sally." Then, a bit later in the conversation, you can insert something like "So, Sally, tell me about..." During the close of the conversation, you can say, "I hope to see you again soon Sally." This simple tactic inspires a positive introduction and can really help you remember someone's name.

2 GET INVOLVED IN YOUR COMMUNITY.

Whether you're interested in volunteering or simply joining local groups, it's crucial to be involved. These opportunities may include:

- Religious organizations or churches
- City or township activities
- Chamber of Commerce or business networking groups
- Local sporting events, especially if your kids, grandkids, or other loved ones are involved
- Book club, knitting group, golf league, or another group of interest

You can also sponsor educational events in your community to teach seniors about Medicare and other topics of interest. If you build relationships with senior centers, community education organizations, churches, and libraries, you can offer to sponsor free events about Medicare. You could also bring in guest speakers to share about other topics, such as Social Security, health-related topics, or retirement planning.

3 KEEP CLIENTS AND LOVED ONES UP TO DATE ON YOUR BUSINESS.

Share details about your business, including what you do and who your ideal client is, to your current clients as well as your family and friends. The strongest leads are referrals from existing clients and loved ones, so make sure you take advantage of opportunities to discuss your business. Check in regularly with your Medicare clients to ensure they are taking advantage of their benefits, their plan still meets their needs, and if they have any upcoming changes that will impact their plan or coverage.

The Financial Opportunity

As the need for Medicare products continues to increase, so does the opportunity for financial growth. When you work with us, you get access to products, services, and support designed to enhance your business, boost your revenue, and help your clients achieve peace of mind as they age. Plus, we'll be with you every step of the way, supporting you through the entire process.

AN ARSENAL OF PRODUCTS

No matter your client's situation or what stage of life they're in, we offer a diverse selection of products designed to help cover gaps in Medicare. We also offer long-term care products and retirement investment products that can benefit clients of any age.

COMMISSIONS

Commissions are key to succeeding in the insurance business. Fortunately, you can earn competitive commissions on all Medicare policies, including Medicare Supplements, Advantage Plans, and Prescription Drug Plans.

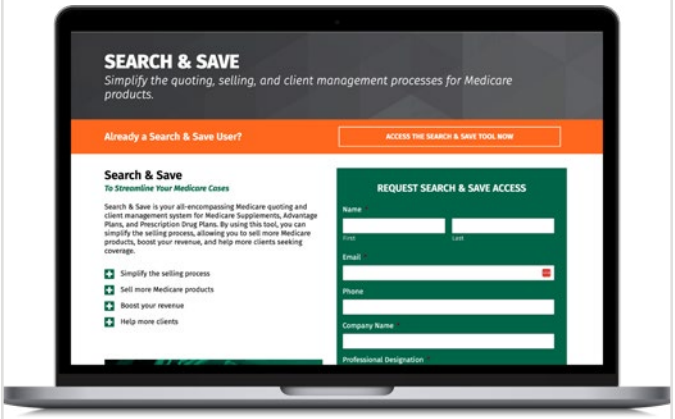
For 2024, the Medicare Advantage Plan (Part C) commission for national carriers in most states is $611, and renewals are $306 for as long as the client is enrolled. Prescription Drug Plans (Part D) provide a commission of $100, or $50 for renewal. (Please note that renewals on either type of plan is considered when clients have had that type of plan with a different carrier.)

Our other products, including funeral expense trusts, long-term care insurance, and tax-deferred annuities, also offer competitive commissions. The commission amount is dependent on the insurance carrier as well as the agent's level of experience.

▶ Earn competitive commissions on all Medicare products.

Understanding the need for Medicare products and the financial opportunity is just the beginning. Are you ready to take the first step and add this essential service to your business? If you're feeling a bit overwhelmed, don't worry. Although there's a lot of information for you to understand and keep up with, we're here to support both you and your clients through the entire process.

IT'S NOT JUST ABOUT OUR PRODUCTS AND SERVICES—WE'RE HERE TO PROVIDE THE TRAINING AND TOOLS YOU NEED TO SUCCEED IN YOUR BUSINESS.



06 CHAPTER 6: Medicare Compliance

Ready to Sell

First and foremost, you must be ready to sell in order to write products regulated by the Centers for Medicare and Medicaid Services (CMS). These products include Medicare Advantage Plans, Prescription Drug Plans, Cost Plans, and Medicare Savings Account Plans. To write CMS-regulated Medicare products, you must:

1. Have an active and up-to-date Health Insurance license.
2. Work with carriers who offer products in your selling area(s).
3. Be contracted and approved with the carriers and products that you would like to have available to your clients.
4. Complete AHIP or an equivalent to be certified to sell CMS-regulated products.
5. Complete carrier product annual certifications along with any other requirements.
6. Watch for a notification from the carrier to be Ready to Sell. (Some send emails and others have this available in the carrier agent portal.)

> **!**
>
> Make sure you are up to date with your AHIP and specific carrier certifications to avoid losing out on commissions.

AHIP Medicare Training

America's Health Insurance Plans (AHIP) is a national association of members who are connected with or work in healthcare. For Medicare purposes, AHIP provides a training program that is accepted by all carriers for insurance agents to become certified to sell CMS-regulated products, such as Medicare Advantage Plans and Prescription Drug Plans.

REQUIREMENTS

AHIP certification is an annual course that meets all basic carrier requirements for certification. This certification is typically made available for the following year around the third week of June and must be completed by October 1 to be able to offer most products and receive renewal commissions. Each carrier also has its own annual product-specific training that is required to become certified in a specific carrier's product.

Cost

AHIP costs $175, though most carriers offer a $50 discount. Please contact our office or reach out to the carriers you are contracted with to find out how to apply the discount prior to purchasing the course through AHIP directly.

Course Design

The AHIP segment is usually made up of five modules followed by a timed 50 multiple choice question exam. In order to pass the certification, you must score 90% or better. The exam is open-book, and you have three chances to pass. If you do not pass within the first three attempts, you can purchase the course again and

receive three more attempts to pass. If you do not pass after the second course and three additional exam attempts, you cannot certify for that year and must wait until the following year to take the course again.

Tips for Success

1. Download the PDF at the beginning of each module and store it in a folder where you can easily access it during the exam and for future reference.

2. Take your time during the review quizzes and make sure you know the answer for each question. Many of the questions on the final exam are very similar or directly from these quizzes.

3. Read the questions and answers out loud. Some of the questions may be worded a little strange and can be easily misread. Don't let a misread question result in a wrong answer.

4. You have two hours to complete the exam. Do not let the time expire or your computer to time out. This will cause you to automatically fail that attempt.

5. Open your module PDFs during the exam and use Ctrl-F to find keywords or topics associated with a question you're not sure about.

Additional Trainings

After the AHIP section, you must also complete the Fraud, Waste, and Abuse section, which includes additional segments on nondiscrimination along with a general compliance segment. These sections require you to complete each segment with an exam score of 70% or higher.

Please do not forget to complete any additional trainings that are required for certification to sell a product with each carrier you are contracted with. This is required for both writing products and receiving renewal commissions on products.

▶▶▶ Visit ***ahipmedicaretraining.com*** to create an account or log in.

AHIP FAQs

Get answers to common questions regarding AHIP certification.

Scan the QR code or visit ***https://bit.ly/3WImcjf***

AHIP User Guide

Get answers to common questions regarding AHIP certification.

Scan the QR code or visit ***https://bit.ly/3GgEzop***

Medicare Enrollment Periods

Medicare has very specific rules for when an individual can enroll in or change plans, and these rules vary depending on the type of plan. For instance, the enrollment periods for Original Medicare are different from the enrollment periods for Medicare Supplements, and so on. Using an incorrect enrollment period could result in a gap in coverage, incorrect compensation, or a possibly carrier or CMS violation.

▶▶▶ To see a more detailed overview of Medicare's enrollment periods, turn to page 71.

Certain states have their own specific rules for Medicare Supplements Open Enrollment.

▶▶▶ To see an overview of these rules for California, Connecticut, Idaho, Illinois, Louisiana, Maine, Maryland, Missouri, Nevada, New York, Oklahoma, Oregon, Vermont, and Washington, turn to page 73.

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

Since MACRA was signed into law, Medicare Supplement plans can no longer offer plans to newly eligible Medicare enrollees that cover the Part B deductible. This includes Plans C and F (including high deductible F). MACRA defines "newly eligible" as anyone who: (a) attains age 65 on or after January 1, 2020, or (b) who first becomes eligible for Medicare benefits due to age, disability, or end-stage renal disease on or after January 1, 2020. Anyone whose Part A eligibility was prior to January 1, 2020, and is eligible for guaranteed issue rights into a plan must enroll into Plan F over Plan G. States can change rules quickly, so please consult your state information or contact our office for the most up-to-date information.

Since new healthy beneficiaries will not be joining them, the blocks for many of these plans will age more quickly. Therefore, many advisors have helped their clients move to another plan as long as the client is able to through state law or by passing underwriting.

Since Medicare Supplements are regulated by the states, each state has different rules when it comes to Medicare Supplement plans for beneficiaries under the age of 65.

▶▶▶ See page 75 for a full listing of states that offer plans to those under age 65, which plans are offered, and the Open Enrollment requirements for those states.

Marketing Medicare Products

When it comes to marketing and selling Medicare products, there are a lot of rules to follow. Below is an overview of the marketing regulations, though this is not an exhaustive guide. For more information, please refer to the Medicare Communications and Marketing Guidelines (MCMG) or Module 4 of your AHIP certification.

Medicare Marketing and Communications Guide

Scan the QR code or visit
go.cms.gov/3QflTKv

MARKETING DISCLAIMER

Effective October 1, 2023, when marketing plans for 2024 and subsequent years, independent agents, brokers, and other third-party marketing organizations must use the following disclaimer:

> *"We do not offer every plan available in your area. Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. Please contact Medicare.gov, 1–800–MEDICARE, or your local State Health Insurance Program (SHIP) to get information on all of your options."*

The disclaimer must be:

- Verbally conveyed within the first minute of a sales call
- Electronically conveyed when communicating with a beneficiary through email, online chat, or other electronic means of communication
- Prominently displayed on websites (12pt font)
- Included in any marketing materials, including print materials and television advertising

COMMUNICATIONS

According to CMS, "communications" refer to materials and activities that provide information to current and prospective enrollees on Medicare Health Plans and Part D Plans. CMS considers a communication to be very basic information that does not direct a person to a plan or give plan details.

Example of a Communication

Agent Watson hands out flyers for his insurance agency at a senior expo. The brochures state that his agency can help seniors find a health plan that is right for them and lists the eight different Medicare Advantage organizations with which his agency contracts. The flyer also includes a telephone number that beneficiaries can call if they would like additional information. This activity is considered communication only and not marketing.

MARKETING

"Marketing" is a subset of communications and is distinguished from communications-only material and activity based on intent and content. Marketing materials typically come from a carrier and have been approved by CMS prior to an agent's use. Any activity that would intend to steer a person towards a plan, list plan details, encourage a person to remain or change plans, or accept enrollment forms would be considered marketing. All marketing materials must be submitted to CMS for approval, which is typically done by a carrier.

Examples of Marketing

- Direct mailings, newspaper ads, and websites that promote specific plans and star ratings
- Brochures that promote enrollment into a plan and discuss reward programs
- Presentation materials explaining the benefits of enrolling into a particular plan
- Social media posts that mention a plan's star rating, notes low premium, or promotes its benefits

THE DOS AND DON'TS OF MARKETING

Allowed Marketing Practices

- Sending emails with an opt-out option and the required disclaimer
- Sending direct mail to a residence including the disclaimer
- Returning phone calls from prospects who inquire or request more information

Prohibited Marketing Practices

- Door-to-door solicitation, including leaving leaflets, flyers, or door hangers at a residence or on a vehicle

  Note: Business Reply Cards and Permission to Contact forms do not give an agent permission to door knock that home.

- Approaching beneficiaries in common areas, such as parking lots, hallways, lobbies, sidewalks, stores, or parks

- Making unsolicited telephone calls and voicemail messages without having Permission to Contact

- Sending text messages or other forms of electronic direct messaging through social media platforms without Permission to Contact

- Contacting a beneficiary because a friend or family member told you to call

- Misleading, confusing, or providing materially inaccurate information to beneficiaries

- Targeting enrollees based on income levels (except in the case of Dual Eligible SNPs)

- Targeting enrollees based on health status (except in the case of a chronic care SNP)

- Stating or implying plans are only available to seniors, rather than all eligible Medicare beneficiaries, such as younger disabled individuals

PROHIBITED PRACTICES: MARKETING AND COMMUNICATIONS

Marketing representatives must NOT:

- Market any non-healthcare related products (such as annuities and life insurance) during any MA or Part D sales activity or any other marketing activity for existing enrollees (this is considered cross-selling)

- Use or disclose the enrollee's protected health information (PHI) for marketing purposes, including sending any non-plan or non-health-related information or otherwise contacting them for purposes unrelated to plan benefits administration or CMS contract execution, without first obtaining HIPAA required authorization from the enrollee

- Use a Medicare beneficiary to endorse a plan unless the beneficiary was an enrollee of the plan when the endorsement was created

- Solicit enrollment applications for the following contract year before the start of the annual election period on October 15

- Use marketing materials that have not been submitted by the plan for review and/or approval by CMS, including approval by all carriers mentioned in the materials

- Charge beneficiaries marketing fees

- Engage in bait and switch strategies, such as making unsolicited outbound calls to beneficiaries about other lines of business (e.g., calling Medicare beneficiaries about Affordable Care Act plans) as a means of generating leads for Medicare plans

- Engage in any discriminatory activity, such as attempting to recruit Medicare beneficiaries from higher-income areas without making comparable efforts to enroll Medicare beneficiaries from lower-income areas

- Encourage individuals to enroll based on their health status unless the plan is a special needs plan that focuses on the beneficiary's particular condition

- Conduct health screening or other activities that could give an impression of "cherry-picking"

- Assert that their plan is the "best" plan or use other unsubstantiated absolute or qualified superlatives or pejoratives (however, unsubstantiated absolute and/or qualified superlatives may be used in logos/taglines)

- Make explicit comparisons between plans, unless they can support them, such comparisons are factually based, and the comparisons are not misleading
- Engage in marketing practices that may mislead or confuse beneficiaries
- Engage in scare tactics, such as pressuring a hesitant beneficiary to decide in a very short period of time by misleading them to believe they would not have any health benefits if they did not enroll in a plan
- Provide false or misleading information about the plan, including about benefits, provider rules, and other plan information, such as claiming that a PFFS plan is the same as Original Medicare or a Medigap plan
- Claim that Medicare, CMS, or any government agency endorses or recommends a particular plan
- State that they are from Medicare or use words or symbols, including "Medicare" in a misleading manner (e.g., agents cannot state that they are approved, endorsed, or authorized by Medicare; are calling on behalf of Medicare; or that Medicare asked them to call or see the beneficiary)
- Fail to obtain prior authorization from CMS to use its logos, including the image of the Medicare card
- Use the term "free" to describe a zero-dollar premium
- Use the term "free" in conjunction with any reduction in premiums, deductibles, or cost-share, including Part B premium buy-down, low-income subsidy, or dual eligibility
- Lead beneficiaries to believe the broker or agent works for Medicare, CMS, or any government agency
- Imply an MSA plan operates as a supplement to Medicare
- Market that the plan sponsor will not disenroll individuals due to failure to pay premiums
- Advertise benefits in areas where they are not available
- Fail to include specific amounts for any benefits mentioned

ONE-ON-ONE SALES MEETINGS

At these meetings, you can only discuss health plans—no accident only plans nor life or annuities. Prior to the meeting and discussion, you must have the beneficiary fill out a Scope of Appointment (SOA) 48 hours prior to the appointment (except for walk-ins and the last four days of an enrollment period), and you can only discuss the products indicated on the form. If the beneficiary wants to speak about products not indicated on the SOA, a new form must be completed. SOA forms can be documented in any manner, including electronic, paper, oral reading, and so on.

During individual appointments, marketing representatives may:

- Distribute plan materials such as an enrollment kit or marketing materials
- Provide educational information
- Discuss benefits, premiums, and cost sharing
- Talk about plan rewards and incentives programs
- Provide and collect enrollment forms

Agent Checklist for a Compliant One-on-One Sales Meeting

- Explain that to enroll in a Medicare Advantage Plan or a Medicare Supplement, the beneficiary must be enrolled in Medicare and continue to pay the Part B premium.
- Explain the Income Related Monthly Adjustment Amount (IRMAA) for Part B and Part D, if applicable.
- Explain the Part B and Part D late enrollment penalty, if applicable.
- Explain the public assistance program, if applicable.
- Explain the enrollment periods and disenrollment process.
- Describe Original Medicare, Medicare Supplement, Medicare Advantage, and Prescription Drug Plans.
- Explain the plan's deductibles, copays, coinsurance, and out-of-pocket costs.
- Verify the enrollee's primary care physician, if applicable, and explain how to look up a provider.
- Explain in-network vs. out-of-network, emergency, and urgent care coverage.
- Explain the Part D copays and deductibles.
- Explain the Part D coverage stages (deductible, initial, coverage gap, and catastrophic).
- Verify the enrollee's prescription drug list against the plan's formulary if the client gives consent.
- Explain certain prescription drug restrictions (e.g., prior authorization, quantity limits, step therapy).
- Explain the use of preferred pharmacists, if applicable, and how to use the pharmacy directory.
- Review Star Ratings.
- Avoid taking AEP applications prior to October 15.
- When conducting a phone appointment, the call must be recorded, and the disclaimer must be included within the first minute of the call. The recording must be saved for 10 years and made available to the carrier or CMS if requested.

Questions?

If you have any questions about one-on-one sales meetings or want more tips for a successful client meeting, schedule a Discovery Call with our team.

▶▶▶ ***thekrauseagency.com/schedule-medicare***

Marketing/Sales and Educational Events

Marketing/sales events are designed to steer potential enrollees toward a plan or limited set of plans or to encourage current enrollees to remain in their plans. On the other hand, educational events are designed to inform potential enrollees about Medicare, including MA, Part D, or other Medicare programs and do not include marketing materials or activities.

Educational events may be held in public venues and hosted by the Plan/Part D sponsor or an outside entity. These events may also be put on by providers or other groups and sponsored by one or more health plans. Sales representatives may no longer conduct a marketing event immediately following an educational event and must wait at least 12 hours after the educational event.

Advertisements and invitations (in any form of media) that are used to invite beneficiaries to a marketing/sales or educational event must include the following statement:

> *"For accommodation of persons with special needs at meetings, call [insert phone and TTY number]."*

EDUCATIONAL EVENTS

Educational events must be explicitly advertised as "educational." At educational events, marketing representatives may:

- Engage in communications activities and distribute communication materials
- Use a banner with the plan sponsor name and/or logo displayed
- Distribute promotional items, including those with the plan name, logo, and toll-free number and/or website. These items must be free of marketing content and consistent with nominal gift rules.
- Provide an objective presentation to educate beneficiaries about the different ways they can get their Medicare benefits
- Have a healthcare provider make an educational presentation on wellness or another healthcare-related topic

If you're planning an event, it's crucial that you understand the difference between a marketing/sales event and an educational event and follow the regulations for that specific type of event.

PERMITTED ACTIVITIES AT EDUCATIONAL EVENTS	PROHIBITED ACTIVITIES AT EDUCATIONAL EVENTS
At educational events, marketing representatives may:	When an event has been advertised as "educational," marketing representatives may **NOT:**
+ Distribute and collect Business Reply Cards or Permission to Contact forms.	– Conduct sales or marketing presentations.
+ Answer beneficiary-initiated questions about Medicare health or drug plans.	– Discuss, display, or distribute plan-specific premiums, benefits, or marketing materials.
+ Distribute business cards and agent/agency or plan contact information for beneficiaries to initiate contact.	– Distribute and collect Scope of Appointment (SOA) forms.
+ Provide meals, refreshments, or snacks as long as they comply with the nominal gift requirements.	– Engage in marketing activities.
	– Distribute or collect enrollment applications.
	– Set up future personal sales appointments.

Gifts and Promotional Items

Section 1128A (a) (5) of the Social Security Act prohibits offering or giving anything of value to a Medicare or Medicaid beneficiary that is likely to influence the beneficiary to order or receive from a particular provider, practitioner, or supplier any item or service covered under Medicare or Medicaid. However, there is an exception to this rule if the gift is below nominal value, which is $15.

Marketing representatives may provide gifts, prizes, or promotional items to beneficiaries as part of an event or for marketing purposes as long as the nominal value exception is met, and the gift is provided regardless of enrollment and without discrimination. Gifts are of nominal value if an individual item is worth $15 or less based on the retail purchase price of the item, even if the plan or representative pays less for the item.

▶ The nominal value exception applies to gifts worth $15 or less.

When more than one gift is offered on one occasion, the combined value of all items must not exceed $15. Multiple gifts given to a beneficiary on different occasions may not exceed $75 aggregate, per person, per year. Gifts or prizes must not be in the form of cash, cash equivalents, or other monetary reward or rebate, even if their worth is less than $15.

A gift card that can be used for a more limited selection of items or food would not be considered a cash equivalent (e.g., Starbucks, Shell Gas gift card). Rebates would include, for example, a discount on the first month's premium or on a copayment. Gifts or prizes may not be charitable contributions.

Cash equivalents include:

- Gift certificates or cards that can be readily converted to cash
- General gift cards that are not restricted to specific retail chains or to specific items and categories, such as VISA gift cards
- Gift cards for retailers or online vendors that sell a wide variety of consumer products (e.g., Walmart and Amazon)
- Debit cards

Marketing with Social Media

Social media posts are generally subject to any marketing and communications content requirements, such as prohibitions on using certain language. In order to post anything that meets the definition of marketing materials (e.g., plan-specific benefits, premiums, cost-sharing, or Star Ratings), Plans or Part D sponsors must submit posts to CMS social media (e.g., Facebook, X, YouTube, LinkedIn, Scan Code, or QR Code). This also applies to posts made by agents.

Any reposts of an individual's post, content, or comment that promotes a Plan's or Part D sponsor's product from social media sites (e.g., Facebook, Twitter, YouTube, LinkedIn, Scan Code, or QR Code) is considered a product endorsement/testimonial and must adhere to the guidance on testimonials.

SOCIAL MEDIA EXAMPLE

Agent LaVette is excited about the 2023 Medicare Advantage Plan that will be offered by BetterMedicare. She would like to make a post stating:

"Call me to learn more about BetterMedicare's Medicare Advantage Plan offering comprehensive eye care and dental benefits at only $25 per month."

Because it contains marketing content, this post must be submitted to CMS. In most cases, the carrier would submit this for approval since individual agents do not typically submit marketing for CMS approval.

However, Agent LaVette could send out a post stating:

"BetterMedicare offers an array of benefit packages, including one that might be right for you. Call me to find out more!"

That is, as long as her contract with BetterMedicare does not prohibit her from posting such communications.

Marketing in a Health Care Setting

Marketing representatives must NOT engage in marketing activities in areas where patients receive health care services. This includes exam rooms, dialysis center treatment areas, hospital patient rooms, pharmacy counter areas, and other treatment areas where patients interact with a provider and their clinical team and receive treatment.

However, marketing representatives may engage in marketing activities (i.e., conduct sales presentations and distribute and accept enrollment applications) in common areas of health care settings (e.g., cafeteria, community or recreational room, waiting room, common entryway, vestibule, or conference room) and at a retail pharmacy in areas away from the pharmacy counter. Representatives may also provide communication materials to be distributed and displayed in the health care setting.

Marketing in a Long-Term Care Facility

Long-term care facilities include, for example, nursing homes, assisted living facilities, and board and care homes. Plan sponsors and marketing representatives may schedule an appointment with a beneficiary in a long-term care facility ONLY upon request of the beneficiary (or authorized representative). They may

NOT, however, visit individuals in a long-term care facility without an appointment. Marketing representatives may set up in common areas of a long-term care facility and allow residents to approach them.

MA institutional special needs plans (I-SNPs) may use staff operating in a social worker capacity to provide information, including marketing materials concerning I-SNPs to residents. Such information must not include an enrollment form and the social worker may not accept or collect an SOA or enrollment form on behalf of the plan sponsor.

Marketing Prohibitions During Open Enrollment Period

The Medicare Advantage Open Enrollment Period (MA-OEP) is a period during which an individual enrolled in an MA or MA-PD plan can make a one-time change to another MA plan, elect Original Medicare, or change Part D coverage. For individuals enrolled in an MA plan on January 1, the MA-OEP is the first three months of the calendar year. Different rules apply to individuals choosing an MA plan during their initial coverage election period (ICEP). The MA-OEP is further described in AHIP certification Module 5.

PROMOTING HEALTH PLANS DURING OEP

However, during the OEP, marketing representatives may conduct marketing activities that focus on other enrollment opportunities, including but not limited to:

- Marketing to individuals turning 65 who have not yet made an enrollment decision
- Marketing by 5-star plans regarding their continuous enrollment SEP
- Marketing to dual-eligible and LIS beneficiaries who, in general, may make changes once per calendar quarter during the first nine months of the year

During the Open Enrollment Period, marketing representatives may **NOT:**

- Send unsolicited materials advertising the ability or opportunity to make an additional enrollment change or referencing the OEP
- Specifically target beneficiaries who are in the OEP because they chose an MA or MA-PD plan during the Annual Enrollment Period (AEP) by the purchase of mailing lists or other means of identification
- Engage in or promote activities that intend to target the OEP as an opportunity to make further sales
- Call or otherwise contact former enrollees who have selected a new plan during the AEP

During the OEP, marketing representatives may also:

- Send marketing materials when a beneficiary makes a proactive request
- At the beneficiary's request, have one-on-one meetings with a sales agent
- At the beneficiary's request, provide information on the OEP through the Plan's call center

Compensation Rules

Compensation includes monetary or non-monetary compensation of any kind relating to the sale or renewal of a policy including, but not limited to, commissions, bonuses, gifts, prizes, and awards.

Plan sponsors may not pay agents when they have not been trained and tested and when they do not meet state licensure and appointment requirements.

When a plan sponsor and/or a contracted independent agent terminates an agent contract, any future payment for an existing business will be governed by the terms of the contract that specifies the agent's payment, subject to the limits in the CMS regulation. However, to continue receiving renewal fees, agents must remain trained, tested, licensed, and appointed (to the extent required under state law), regardless of whether they are actively selling.

APPLICABLE COMPENSATION AMOUNTS

Applicable compensation amounts depend on whether enrollment is an initial year enrollment or a renewal year enrollment. CMS provides reports to the plan that specifies whether enrollment is initial or renewal. Renewal year enrollments include plan changes between "like plans."

Like Plan Type Enrollments
A PDP to another PDP
An MA or MA-PD to another MA or MA-PD
A Section 1876 Cost Plan to another Section 1876 Cost Plan

Unlike Plan Type Enrollments
An MA or MA-PD plan to a PDP or Section 1876 Cost Plan
A PDP to a Section 1876 Cost Plan or an MA (or MA-PD) plan
A Section 1876 Cost Plan to an MA (or MA-PD) plan or PDP

The following does NOT count as compensation:

- Payment of fees to comply with state appointment laws, training, certification, and testing costs
- Reimbursement for mileage for appointments with beneficiaries
- Reimbursement for placing ads or purchasing flyers
- Actual costs associated with beneficiary sales appointments such as venue rent, snacks, and materials

More Information About Medicare Compliance

Medicare Marketing Guidelines
cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.html

CMS Marketing Website
cms.gov/ManagedCareMarketing/

Medicare Beneficiary Website
medicare.gov

For more information on compensation rules and amounts for Medicare products, please see carrier information, AHIP documents, or schedule a Discovery Call with us.

Scan the QR code or visit
thekrauseagency.com/schedule-medicare

07

CHAPTER 7:
Medicare FAQs

WHAT SERVICES DO YOU PROVIDE?

We work with agents to get appointed with carriers and to write health solutions. In most cases, we do not work directly with clients. Instead, we provide you with the training and information you need to successfully make the sale. We also provide quoting tools and added support to you as you market and write health policies. We have relationships with the carriers, so we can assist with issues and, in some cases, put you in direct contact for assistance.

WHAT TYPES OF HEALTH SOLUTIONS CAN I COME TO THE KRAUSE AGENCY FOR?

- Medicare (Medicare supplement, prescription drugs, advantage & cost)
- Long-term care insurance (both traditional and asset-based)
- Medicaid Compliant Annuities for crisis planning
- Funeral expense trust
- Final expense insurance
- Short-term care insurance
- Short-term medical
- Dental/vision/hearing
- Critical illness/cancer
- Accident and hospital indemnity

HOW DO I SUBMIT BUSINESS?

In most cases, you can submit business directly to the carrier. However, some cases may need to come to our office for submission. Your Relationship Manager will help guide through submitting business to The Krause Agency.

DO I NEED TO GET APPOINTED WITH ALL THE CARRIERS?

No. In fact, we highly recommend keeping it as simple as possible. In many cases, one or two carriers are adequate to meet your clients' health solutions. We are happy to consult with you and provide guidance as you develop your product portfolio.

WHAT ARE THE QUALIFICATIONS TO SELL MEDICARE SUPPLEMENTS?

In most cases, there are not any additional certifications required to write Medicare Supplements outside of having an active Health Insurance license. However, we strongly encourage agents to take AHIP to fully understand all the moving parts of Medicare. Some carriers do require an annual AHIP or equivalent certification to get contracted to write Medicare Supplements. Please contact our office for details on which carriers do or do not require additional certifications. We also provide training on Medicare for agents that are new or want a refresher.

WHAT ARE THE QUALIFICATIONS TO SELL CMS-REGULATED PRODUCTS, LIKE PRESCRIPTION DRUG AND ADVANTAGE PLANS?

To sell CMS-regulated products, you need to complete an annual AHIP certification or equivalent. The full price for certification is $175 in 2024. However, most carriers provide a discount of $50 off, making the starting cost as low as $125. AHIP takes an average of 8 to 12 hours to complete, and you can complete it online at your own pace. The recommendation is to complete the certification within two weeks or less for the best success. There is an exam at the end, which you need to pass with 90% accuracy. You have three attempts to pass, or you can purchase three more attempts for $175.

All carrier lines are required to have their own annual product certification. On average, it takes 2 to 3 hours to complete the certification for each carrier. Some are longer, and some may be shorter, depending on the year and the carrier.

You can earn commissions on CMS-regulated plans. For 2024, the Medicare Advantage Plan (Part C) commission for national carriers in most states is $611, and renewals are $306 for the remainder of the plan. Prescription Drug Plans (Part D) provide a commission of $100, or $50 for renewal. (Please note that renewals on either type of plan is considered when clients have had that type of plan with a different carrier.)

CAN I HAVE AN EMPLOYEE IN MY OFFICE WRITE MEDICARE BUSINESS?

Yes, as long as they have a current Health Insurance License with the state where the plan(s) will be written as well as E & O coverage.

HOW DO I GET PAID? AND HOW MUCH? CAN WE SPLIT COMMISSIONS?

In most cases, commissions are paid directly to you from the carrier. Commission amounts vary by product, state, and carrier. Please contact our office for details about a specific product or case.

With certain products and carriers, you are able to split commissions. In many cases, however, this is not possible with CMS-regulated products, such as Advantage Plans and Prescription Drug Plans. Please contact us for more details.

DO YOU OFFER TRAINING?

We provide regular live and on-demand webinars about various senior market products. We can also provide you with guides, resources, and other tools to streamline your business and make your job easier.

IF I NEED SOMEONE ELSE TO WRITE THE PLAN, CAN I CONTACT THE KRAUSE AGENCY TO WRITE IT?

In most cases, we are not able to write the plan for you. We may be able to provide a referral in your area, but that varies by product, state, and specific area.

WHAT ARE MY NEXT STEPS TO GET STARTED?

To get started, you can simply contact our office or schedule a Discovery Call. We are happy to consult with you on a specific case or product and provide you with a strategic plan for success.

08 CHAPTER 8: Medicare Case Studies

When discussing Medicare options with a client, it's important to evaluate their specific circumstances, including their state, area, budget, needs, and other crucial aspects. The following case studies represent true examples of the costs and risks to consider. To most accurately show cost comparisons, a 65-year-old female is used unless otherwise indicated.

MEDICARE ADVANTAGE PLANS

When considering Advantage Plans for your clients, it's important you understand the network, travel benefits, and Maximum Out of Pocket (MOOP) risk. Please keep in mind the additional benefits may vary widely on an Advantage Plan, and it is extremely important to consider when and how those benefits can be used.

MEDICARE SUPPLEMENTS

Medicare Supplement companies prefer to use Attained Age for price rating unless the state requires a specific price rate. Two waiver states are used as examples along with a variety of rate examples to show a variety of outcomes and considerations. Most examples do not use the lowest price available, but a competitive price that is typically from a large Medicare Supplement company in that state.

PRESCRIPTION DRUG PLANS

Last, the case study on a Prescription Drug Plan with late enrollment is meant to show the importance of enrolling into a plan at the time the beneficiary becomes eligible. It also shows how the penalty is determined and how it can change each year.

Advantage Plan vs. Community Rated Medicare Supplement [Minnesota]

- Medicare Advantage Plans (and like plans) comprise 58% of all plans.
- Minnesota requires Community Rated for all Medicare Supplement plans with standard rates for tobacco users, even during open enrollment.
- The Medicare Supplement shown is a basic plan with Part A deductible, excess charges, and preventive riders.

65-year-old female	MN - Medicare Advantage PPO	MN - Basic with Riders Community Rated
MOOP or Part B Deductible	$3,000	$240
Drug Coverage Premium	Included	$416.40*
Hospital Stay	$200 per stay	$0
Part B Drugs	20%	$0
Doctor Visit	$0	$0
Specialist Visit	$35	$0
ER Visit	$90	$0
Preventive Dental Services (Cleaning & X-Rays)	$0	est. $225
Vision Services (Annual Exam)	$0	est. $95
Additional Benefits	OTC, Gym, Meals	Gym
Part B Annual Premium	$2,096.40	$2,096.40
Policy Annual Premium	$1,152	$3,214.12
Known Premium & Deductible Costs	$3,248.40	$5,966.92
Risk	Network limitations plus $3,000	Preventive $200-500

** Prescription Drug coverage premium calculated using the 2024 national average.*

Advantage Plan vs. Issue Age Rated Medicare Supplement [Florida]

- Advantage Plans are held by 55% of beneficiaries.
- Issue age for a Medicare Supplement is the rate required by the state.
- The Medigap or Supplement Plan used in the case study is plan G.

65-year-old female	FL - Medicare Advantage HMO	FL - Plan G Issue Age
MOOP or Part B Deductible	$3,800	$240
Drug Coverage Premium	Included	$416.40*
Hospital Stay	$200	$0
Part B Drugs	Varies	$0
Doctor Visit	$0	$0
Specialist Visit	$0-35	$0
ER Visit	$100	$0
Preventive Dental Services (Cleaning & X-Rays)	$0	est. $225
Vision Services (Annual Exam)	$0	est. $95
Additional Benefits	OTC, Gym, Meals	Gym
Part B Annual Premium	$2,096.40	$2,096.40
Policy Annual Premium	$0	$2,331
Known Premium & Deductible Costs	$2,096.40	$5,083.80
Risk	Narrow network plus $3,800	Preventive $300-500

** Prescription Drug coverage premium calculated using the 2024 national average.*

Medicare Advantage vs. Attained Age Rated Medicare Supplement [Wisconsin]

- Medicare Advantage is at a 55% penetration.
- The Medicare Supplement rating is attained age.
- The Medicare Supplement is base plus Part A deductible, excess charges, and home health care riders.

	Medicare Advantage HMO	Base with 3 riders Attained Age 65	Base with 3 riders Attained Age 75
MOOP or Part B Deductible	$4,500	$240	$240
Drug Coverage Premium	Included	$416.40*	$416.40*
Hospital Stay	$295 per stay	$0	$0
Part B Drugs	20%	$0	$0
Doctor Visit	$5	$0	$0
Specialist Visit	$40	$0	$0
ER Visit	$90	$0	$0
Preventive Dental Services (Cleaning & X-Rays)	$0	est. $225	est. $225
Vision Services (Annual Exam)	$0	est. $95	est. $95
Additional Benefits	OTC, Gym, Meals	Gym	Gym
Part B Annual Premium	$2,096.40	$2,096.40	$2,096.40
Policy Annual Premium	$408	$1,492.63	1,866.99 at 75 years of age
Known Premium & Deductible Costs	$2,504.40	$4,245.43	$4,619.79
Risk	Narrow network plus $4,500	Preventive $300-500	Preventive $300-500

** Prescription Drug coverage premium calculated using the 2024 national average.*

Attained Age Rated Plan G vs. High Deductible Plan G [Iowa]

- While there are some Advantage Plans in the state (35% penetration), most areas have Medicare Supplements.
- This study uses Plan G vs. High Deductible Plan G.
- The High Deductible G plans will cover 100% of Medicare-covered services once the maximum out-of-pocket is met. The amount paid by the beneficiary is the amount owed after Original Medicare pays its amount due. These are Medicare-negotiated amounts and may include excess charges (if allowed) and deductibles.

65-year-old female	IA - Plan G Age 65	IA – Plan HDG Age 65
MOOP or Part B Deductible	$240	$240 included in MOOP
Drug Coverage Premium	$416.40†	$416.40†
Hospital Stay	$0	100% until MOOP
Part B Drugs	$0	100% until MOOP
Doctor Visit	$0	100% until MOOP
Specialist Visit	$0	100% until MOOP
ER Visit	$0	100% until MOOP
Preventive Dental Services (Cleaning & X-Rays)	est.$225	$225
Vision Services (Annual Exam)	est. $95	$95
Additional Benefits	Gym	Gym
Part B Annual Premium	$2,096.40	$2,096.40
Policy Annual Premium	$1,264.92	$436.44
Known Premium & Deductible Costs	$4,017.22	$2,949.19
Risk	Preventive $300-500	$2,800* plus preventive

**Risk changes annually.* *† Prescription Drug coverage premium calculated using the 2023 national average.*

75-year-old female	IA – Plan G Age 75	IA – Plan HDG Age 75
MOOP or Part B Deductible	$240	$240 included in MOOP
Drug Coverage Premium	$416.40†	$416.40†
Hospital Stay	$0	100% until MOOP
Part B Drugs	$0	100% until MOOP
Doctor Visit	$0	100% until MOOP
Specialist Visit	$0	100% until MOOP
ER Visit	$0	100% until MOOP
Preventive Dental Services (Cleaning & X-Rays)	est.$225	est.$225
Vision Services (Annual Exam)	est. $95	est. $95
Additional Benefits	Gym	Gym
Part B Annual Premium	$2,096.40	$2,096.40
Policy Annual Premium	$1,707.72	$571.13
Known Premium & Deductible Costs	$4,460.52	$3,083.93
Risk	Preventive $300-500	$2,800* plus preventive

**Risk changes annually.* *† Prescription Drug coverage premium calculated using the 2023 national average.*

Medicare Prescription Drug Penalty Calculation

MEET MRS. MARTINEZ

Mrs. Martinez has Medicare, and she missed her first chance to get Medicare drug coverage during her Initial Enrollment Period, which ended on July 31, 2020. She doesn't have prescription drug coverage from any other source. Instead, she joined during the Open Enrollment Period that ended December 7, 2022. Her Medicare drug coverage started January 1, 2023.

Since Mrs. Martinez was without creditable prescription drug coverage from August 2022 to December 2022, her penalty in 2023 was 29% (1% for each of the 29 months) of $33.37 (the national base beneficiary premium for 2023), or $9.68 each month. The monthly penalty is always rounded to the nearest $0.10, so she paid $9.70 each month in addition to her plan's monthly premium.

Penalty (1% x 29):	29%
2023 Base Beneficiary Premium:	x $33.37
2023 Monthly Penalty:	$9.68 **≈ $9.70**

In 2024, Medicare recalculated Mrs. Martinez's penalty using the 2024 base beneficiary premium ($34.70). So, Mrs. Martinez's new monthly penalty is 29% of $34.70, which is $10.06 each month. Since the monthly penalty is always rounded to the nearest $0.10, she will pay $10.10 each month in 2024 in addition to her plan's monthly premium.

Penalty (1% x 29):	29%
2024 Base Beneficiary Premium:	x $34.70
2024 Monthly Penalty:	$10.06 **≈ $10.10**

09

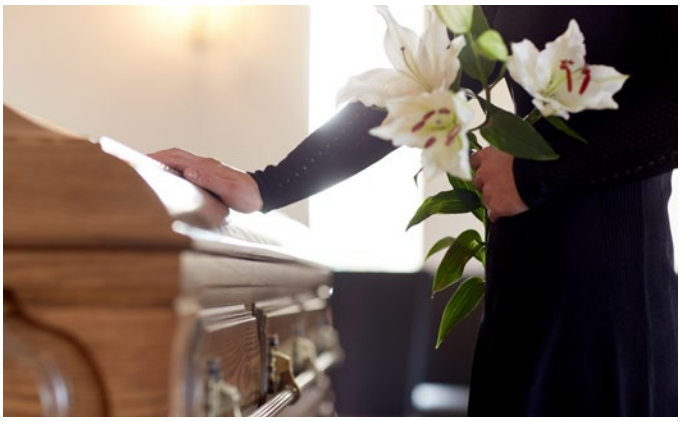
CHAPTER 9:
Funeral Expense Trusts

A funeral expense trust (FET) is a staple in any estate plan. It consists of a small whole life insurance policy that is irrevocably assigned to a funeral trust controlled by an insurance company. It allows seniors to set aside funds for their end-of-life expenses and protects these funds from Medicaid and other potential creditors. An FET serves as a simple add-on for clients who are planning for their long-term care.

Qualified expenses covered under an FET include:

- Funeral services
- Embalming and preparation for viewing
- Casket or cremation
- Burial services
- Headstone

Help clients set aside funds for end-of-life expenses with a Funeral Expense Trust.



BENEFITS OF PURCHASING A FUNERAL EXPENSE TRUST

An FET serves as a flexible planning tool that allows your clients to control their choice of a funeral home and burial location as well as the goods and services they receive. There is no age limit to qualify, so this product can be added regardless of where your client is in the planning process. Plus, the funds are immediately available to pay for funeral expenses upon the owner's death.

FET Benefits

- No fees
- Anyone can qualify
- Proceeds are free from income tax
- Funds can be used at any funeral home provider
- Don't have to choose specific services ahead of time
- Cash available as soon as 24 hours after the death of the insured

FETS AND LONG-TERM CARE PLANNING

Funeral planning is important for clients of any age at any stage of their lives, including those planning for retirement. Since anyone under the age of 100 can qualify, a funeral expense trust is a simple add-on product for clients securing a long-term care plan. Encourage your clients planning for retirement or purchasing a long-term care insurance policy to also consider investing in an FET. Setting aside funds for their funeral expenses provides peace of mind and allows them to alleviate the burden of their loved ones covering these costs.

PURCHASING AN FET

If your client is looking to purchase a Funeral Expense Trust, the process is simple.

- First, your client must complete a short, two-page application where they choose their desired face value for the trust, which dictates the premium amount.
- Next, send the application paperwork and premium funds to our office, and we'll pass it along to the insurance carrier. There is no processing fee for an FET.
- If your client would like to transfer an existing life insurance or annuity contract to fund an FET, they can do so using a 1035 Tax-Free Exchange. They just have to complete an additional form with the application, and the insurance company will obtain the funds directly from the old custodian.

State Funeral Expense Trust Limits

STATE	IFET LIMIT	STATE	IFET LIMIT
ALABAMA	$15,000*	MONTANA	$15,000
ALASKA	$1,500	NEBRASKA	$5,654
ARIZONA	$9,000*	NEVADA	$15,000*
ARKANSAS	$15,000*	NEW HAMPSHIRE	$15,000*
CALIFORNIA	$15,000	NEW JERSEY	$15,000*
COLORADO	$15,000	NEW MEXICO	$15,000
CONNECTICUT	$10,000	NEW YORK	N/A
DELAWARE	$15,000	NORTH CAROLINA	$15,000
DISTRICT OF COLUMBIA	$15,000	NORTH DAKOTA	$6,000
FLORIDA	$15,000	OHIO	$15,000
GEORGIA	$10,000	OKLAHOMA	$10,000
HAWAII	$15,000	OREGON	$15,000
IDAHO	$15,000	PENNSYLVANIA	VARIES BY COUNTY
ILLINOIS	$6,562 WITHOUT G&S $15,000 WITH G&S	RHODE ISLAND	$15,000
INDIANA	$15,000	SOUTH CAROLINA	$15,000
IOWA	$13,125 WITHOUT G&S, $15,000 WITH G&S	SOUTH DAKOTA	$10,000
KANSAS	$10,000*	TENNESSEE	$6,000*
KENTUCKY	$15,000*	TEXAS	$15,000
LOUISIANA	$10,000	UTAH	$7,000
MAINE	$12,000	VERMONT	$10,000
MARYLAND	$15,000	VIRGINA	$15,000
MASSACHUSETTS	$15,000*	WASHINGTON	$15,000
MICHIGAN	N/A	WEST VIRGINIA	$15,000*
MINNESOTA	$15,000*	WISCONSIN	$15,000*
MISSISSIPPI	$15,000	WYOMING	$15,000*
MISSOURI	$9,999*		

*A Letter of Goods and Services may be required.

10

CHAPTER 10:
Long-Term Care Insurance

Long-term care insurance (LTCI) is the ultimate pre-planning tool for healthy clients looking to secure their financial future in retirement and set aside funds for a long-term care crisis. LTCI provides coverage in the event a person requires professional care and allows for flexibility in choosing the type of care they receive and where they receive it. LTCI policies may cover home health care (including home modifications, such as wheelchair ramps and grab bars), assisted living, adult day care, memory care, hospice, and a skilled nursing facility.

We offer traditional and asset-based LTCI policies that can be structured to meet your client's specific circumstances, budget, and projected care needs.

BENEFITS OF LTCI

Long-term care insurance remains one of the most affordable pre-planning tools to protect your client against the risk of dependency. In addition to providing coverage in most care settings, most LTCI policies also include a care coordinator provided by the carrier. The care coordinator can advise a plan of care specifically designed for the policyholder's limitations and needs. As licensed Registered Nurses, care coordinators will arrange for and monitor your clients' care periodically to ensure their care needs are being met.

Our policies can be customized with a variety of funding options and may include features such as state partnership protection and a guaranteed death benefit. Other features include benefit dollars for home modifications and medical alert systems. These elements enable the policyholder to remain at home longer rather than moving to a facility.
On top of safeguarding assets from paying out of pocket for care, LTCI also protects the policyholder's loved ones from being full-time caregivers. Their loved ones can manage their care rather than be fully responsible for it. Needless to say, LTCI provides peace of mind for both clients and their loved ones.

▶ Protect your clients and increase your revenue with LTCI.

SO, WHAT'S THE CATCH

Well, LTCI must be purchased when the individual is healthy before they require long-term care. Unfortunately, many people fail to plan ahead. That's why we highly recommend discussing Long-Term Care Insurance with your younger clients and encouraging them to plan ahead.

MOTIVATORS FOR PURCHASING LTCI

The primary reasons your clients may be considering long-term care insurance include protecting assets, achieving peace of mind, and avoiding being a burden on their loved ones. More than half of policyholders are motivated to purchase LTCI because they have provided care for someone with a chronic illness or disability, so they understand the emotional, physical, and financial toll of providing long-term care for a loved one.

Traditional Long-Term Care Insurance

Traditional LTCI is a tax-qualified insurance policy that functions like a typical insurance policy where the owner pays regular premiums in exchange for future benefits. Each policy can be tailored to a client's specific premium tolerance and projected needs. Traditional LTCI does not hold cash value, so it may be a viable option for a healthy community spouse whose partner is seeking Medicaid benefits.

Discounts are available for partners or married couples as well as for those with preferred health status. The issue ages for traditional LTCI vary among our carrier partners, but policies are typically available for individuals aged 18 to 79. Since LTCI policies are portable, your client can use their policy anywhere in the U.S. regardless of the state in which they originally purchased it. Certain carriers also offer international LTCI coverage. Traditional LTCI offers state partnership protection in the event the policyholder exhausts their LTCI benefits and pursues Medicaid eligibility.

Asset-Based Long-Term Care Insurance

Asset-based long-term care insurance, also known as hybrid, linked-benefit, or life combination LTCI, consists of a life insurance or annuity contract with long-term care benefits attached. This type of policy can be funded with a single premium or recurring payments. Each policy can be tailored to a client's specific premium tolerance and projected needs. Plus, recurring premiums of asset-based LTCI policies remain level throughout the life of the policy, meaning the insurance carrier will not increase premiums. The main difference between traditional and asset-based LTCI is this policy has cash value that continues to grow.

The issue ages for asset-based LTCI vary among our carrier partners, but policies are typically available for individuals aged 30 to 80. Asset-based LTCI offers tax-deferred growth and a guaranteed death benefit if the policyholder never requires care.

Want to learn more about LTCI?

Schedule a Discovery Call to explore our long-term care insurance offerings and discover how you can add this vital product to your business.

Scan the QR code or visit ***thekrauseagency.com/schedule-ltci*** to schedule a call.

CHAPTER 11:
Medicaid Compliant Annuity

What is a Medicaid Compliant Annuity?

A Medicaid Compliant Annuity (MCA) is a powerful spend-down tool designed to help agents and advisors achieve Medicaid eligibility for their senior clients who are facing a costly nursing home stay. An MCA is a Single Premium Immediate Annuity (SPIA) that converts assets into an income stream with zero cash value. When properly structured, this annuity allows you to legally eliminate the excess countable assets preventing your senior clients from qualifying for Medicaid and accelerate their eligibility for benefits.

This product is available in 49 states plus D.C. We offer MCA terms as short as two months, meaning we can customize the perfect spend-down strategy based on your client's information.

> The MCA is a revolutionary product for those who failed to plan ahead and need crisis planning for long-term care.

Our MCA Carriers

ELCO MUTUAL LIFE & ANNUITY

Unity Financial

Nationwide®

TheStandard

CROATIAN FRATERNAL UNION OF AMERICA 18 94

REQUIREMENTS OF AN MCA

IRREVOCABLE	The payment amount, term, and parties of the annuity contract cannot be altered.
NON-ASSIGNABLE	The contract cannot be assigned to another party or sold on the secondary market.
ACTUARIALLY SOUND	The term of the annuity must be fixed and equal to or shorter than the owner's Medicaid life expectancy.
EQUAL PAYMENTS	The annuity must provide equal monthly payments with no deferral or balloon payments.
STATE AS BENEFICIARY	In most cases, the state Medicaid agency must be named primary death beneficiary to the extent of benefits paid on behalf of the institutionalized individual.

When is an MCA Appropriate?

A Medicaid Compliant Annuity may be right for your client if they:

- Reside in a Medicaid-approved facility
- Have exhausted Medicare or long-term care insurance benefits
- Are paying out of pocket for care
- Have excess countable assets

When your senior client enters a nursing home, they want to find a way to pay for care without depleting their entire live savings. An MCA is a quick and easy way to do both. The entire process, from the initial quote to receiving the contract in hand, can be completed in as little as seven days.

MCAs allow you to help your clients gain financial relief while enhancing your offering as an agent. You have the power to help them preserve their hard-earned savings when the alternative is draining it all on the nursing home bill. Trust us—they will be eternally grateful.

MCA Strategies

MARRIED COUPLE MCA STRATEGIES

Community Spouse MCA

Any excess countable assets—the couple's spend-down amount—are funded into an MCA for the community spouse. The MCA payments will go to the community spouse, allowing them to continue their lifestyle at home.

Institutionalized Spouse MCA

This strategy is typically used when the community spouse has a low enough income to qualify for an income shift under the Monthly Maintenance Needs Allowance rules. The spend-down amount is funded into an MCA for the institutionalized spouse. The MCA payments will go to the institutionalized spouse as income, but a portion or all of their income will shift to the community spouse.

"Name on the Check Rule"

This strategy may be used when the institutionalized spouse owns an IRA that is considered countable. They transfer their IRA to an MCA that is owned by them but made payable to the community spouse. The MCA payments will go to the community spouse, since their name is on the check.

NOTE: The success of the "Name on the Check Rule" strategy varies by state, so get in touch with us before moving forward.

SINGLE PERSON MCA STRATEGIES

Gift/MCA Plan

Rather than fund the entire spend-down amount into an MCA, the individual gifts about half of their assets to a loved one and incurs a penalty period of ineligibility. Then, they use their remaining assets to purchase an MCA that will help them pay for their care during the penalty period.

Standalone Plan

This strategy is typically used when the Gift/MCA plan is not viable or if the individual is not expected to live long. The individual funds their entire spend-down amount into an MCA. They immediately qualify for benefits, and the MCA payments become part of their Medicaid co-pay. Upon their passing, after the state Medicaid agency makes their claim, the contingent beneficiary receives the remaining amount.

Want to learn more about MCAs?

Schedule a Discovery Call to explore Medicaid Compliant Annuities and discover how you can add this vital product to your business.

Scan the QR code or visit ***thekrauseagency.com/schedule-mca.***

12

CHAPTER 12:
Appendix

2024 Medicare Costs & Premiums

PART A (Hospital)

Inpatient Hospital Stay – You Pay... *(benefit period ends 60 days after release from care)*

- **Deductible: $1,632** per benefit period
- Coinsurance (days 1-60): $0 per day of each benefit period
- Coinsurance (days 61-90): $408 per day of each benefit period
- Coinsurance (60 lifetime reserve days): $816 per day after day 90 of each benefit period

Skilled Nursing Facility Stay – You Pay... *(3-day inpatient hospital stay required first)*

- Coinsurance (days 1-20): $0 per day of each benefit period
- Coinsurance (days 21-100): $204 per day of each benefit period

PART B (Medical)

Part B Deductible – You Pay... **$240** per calendar year

Part B Coverage – You Pay... Generally 20%, after $240 deductible is met

Part B Premium (including high income Part B & Part D) [paid to Medicare]

Those enrolled in **Part B** will pay at least the standard **$174.70/mo premium (based on income)**. Higher income earners will pay a **Part B IRMAA (Income Related Monthly Adjustment Amount) in addition** to the $174.70/mo standard premium.

Higher income earners who are enrolled in **Part D Prescription Drug** coverage also pay a **Part D IRMAA in addition** to the monthly insurance premium for a Part D prescription drug plan or Medicare Advantage plan that includes Part D coverage (see table below).

If your MAGI (Modified Adjusted Gross Income*) in 2022 was...			You pay in 2024 (per person) monthly premiums to Medicare	
Individual Tax Return	**Joint Tax Return**	**Married & Separate Tax Return**	**Part B Premium + IRMAA**	**Part D IRMAA** (in addition to Part D plan premium)
$103,000 or less	$206,000 or less	$103,000 or less	**$174.70**	**—**
$103,001 to $129,000	$206,001 to $258,000	N/A	**$244.60** ($174.70 + $69.90)	**+ $12.90**
$129,001 to $161,000	$258,001 to $322,000	N/A	**$349.40** ($174.70 + $174.70)	**+ $33.30**
$161,001 to $193,000	$322,001 to $386,000	N/A	**$454.20** ($174.70 + $279.50)	**+ $53.80**
$193,001 to $499,999	$386,001 to $749,999	$103,001 to $396,999	**$559.00** ($174.70 + $384.30)	**+ $74.20**
$500,000 or more	$750,000 or more	$397,000 or more	**$594.00** ($174.70 + $419.30)	**+ $81.00**

** 2022 MAGI = Adjusted Gross Income (Form 1040 line 11) + Tax-Exempt Interest (Form 1040 line 2a)*

Medicare Supplement Plans										
Benefits	**A**	**B**	**C**	**D**	**F***	**G***	**K†**	**L†**	**M**	**N**
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%
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 (2024)							$7,060	$3,530		

** High-deductible F and G are also offered in some states. With this option, you must pay for Medicare-covered costs (coinsurance, copayments, and deductibles) up to the deductible amount of $2,800 in 2024 before your policy pays anything.*

†For Plans K and L, after you meet your out-of-pocket yearly limit and your yearly part B deductible ($240 in 2024), the Medigap plan pays 100% of covered services for the rest of the calendar year.

§ Plan N pays 100% of the Part B coinsurance, except of 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 Supplement Waiver States

Medigap Policy Coverage in Massachusetts			
Medigap Benefits	**Medigap Plans**		
	Core Plan	**Supplement 1**	**Supplement 1A**
Basic benefits	Yes	Yes	Yes
Part A: inpatient hospital deductible	No	Yes	Yes
Part A: skilled nursing facility coinsurance	No	Yes	Yes
Part B: deductible*	No	Yes*	No
Foreign travel emergency	No		Yes
Inpatient days in mental health hospitals	60 days per calendar year	120 days per benefit year	120 days per benefit year
State-mandated benefits (yearly Pap tests and mammograms, check your plan for other state-mandated benefits)	No	Yes	Yes

**Supplement 1 Plan (which includes coverage of the Part B deductible) will no longer be available to people who are new to Medicare on or after January 1, 2020. These people can buy Supplement 1A Plan. However, if you were eligible for Medicare before January 1, 2020, but not yet enrolled, you may be able to buy Supplement Plan 1.*

Medigap Policy Coverage in Minnesota

	Basic	Extended Basic	$20 & $50 Copay for Part B Similar to Plan N	High Deductible* Similar to Plan F*	50% Part A Deductible Similar to Plan M	50% Similar to Plan K	75% Similar to Plan L
Annual out-of-pocket limit 2023	None	$1,000	None	$2,800*	None	$7,060	$3,530
Part A deductible	100% if rider purchased	100%	100%	100%*	50%	50%	75%
Part A coinsurance	100%	100%	100%	100%*	100%	100%	100%
Skilled nursing facility coinsurance For days 21-100	100%	100%	100%	100%*	100%	50%	75%
Part B coinsurance	100%	100%	$20 & $50 copays	100%*	100%	50%	75%
Part B Excess	100% if rider purchased	100%	–	–	–	–	–
Medicare preventive care	100%	100%	100%	100%*	100%	100%	100%
Preventive services not covered by Medicare	100% up to $120 if rider purchased	100% up to $120	–	–	–	–	–
Foreign travel – Emergency	80%	80%	80%	100%*	80%	–	–
Foreign travel – Hospital and medical expenses and supplies	–	80%	–	–	–	–	–

**You must pay for the Medicare-covered costs up to $2,800 before the policy pays.*

Medigap Policy Coverage in Wisconsin

Basic Benefits

- Inpatient hospital care: covers the Part A coinsurance
- Medical costs: covers the Part B coinsurance (generally 20% of the Medicare-approved amount)
- Blood: covers the first 3 pints of blood each year
- Part A hospice coinsurance or copayment

Medigap Plan

The Basic Plan covers:

- Basic benefits
- Part A: skilled nursing facility coinsurance
- 175 days per lifetime in addition to Medicare's benefit of inpatient mental health coverage
- 40 home health care visits in addition to those paid for by Medicare
- State mandated benefits

Important plan information

Plans known as "50% and 25% Cost-sharing Plans" are available. These plans are similar to standardized Plans K (50%) and L (25%). A high-deductible plan is also available.

Insurance companies are also allowed to offer these riders to a Medigap policy:

- Part A deductible
- Additional home health care (365 visits including those paid by Medicare)
- Part B deductible
- Part B excess charges
- Foreign travel emergency
- 50% Part A deductible*
- Part B copayment or coinsurance
- State mandated benefits

**Coverage of the Part B deductible 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 get this benefit.*

Veteran Medical Benefits with Medicare

	TRICARE for Life	CHAMPVA (Civilian Health and Medical Program of the Department of Veterans Affairs)	VA Benefits
Who it's for	Retired military members and their families	Spouses and dependents of veterans who have been rated permanently and totally disabled for a service-connected disability, or who falls into one of these categories: http://bit.ly/3vS9Jhd	Veterans, based on their service and qualification of financial status and service-related injury
What it is	Healthcare coverage similar to a Medicare Supplement plan but includes prescription drug benefits	Healthcare coverage similar to a Medicare Supplement plan but includes prescription drug benefits	Care and services to treat illnesses and injuries, prevent future health problems, improve ability to function, and increase quality of life
When it's effective	Immediately upon signing up for Medicare Part A and Part B	Upon enrolling in Medicare	After discharge but veterans must apply
Where it works	Anywhere in the U.S. and overseas, any provider who accepts Medicare patients	Anywhere in the U.S., any provider who accepts Medicare patients	VA hospitals and clinics, possible community care access in certain situations
How it works with other health insurance	Not recommended to be paired with a Medicare Advantage plan, can sign up for Individual Dental or Vision through Benefeds or any other private insurer	Must enroll in Medicare to keep benefits, not recommended to be paired with a Medicare Advantage Plan, can sign up for Individual Dental or Vision through VA Dental Insurance Program (VADIP) or any other private insurer	Does not bill Medicare and is completely separate, all veterans should enroll in Medicare, an MA Plan or Medicare Supplement may help to fill gaps and expand access outside VA facilities

Medicare Enrollment Guide

Original Medicare Initial Enrollment Period

Turning 65 – 7 month period, 3 months before eligible birth month and 3 months after eligible birth month. (Eligible the month of your birthday, unless birthday is the first of the month, you are eligible the month prior to your birth month.)

Under 65 with Disability – begins 2 years after the first month Social Security benefits begin.

End-Stage Renal Disease (ESRD) – please check for additional information on eligibility and start date.

Original Medicare Special Enrollment Period

If you are age 65 or older, you or your spouse are still working and you are covered under a group health plan based on that current employment, you may not need to apply for Medicare medical insurance (Part B) at age 65. You may qualify for a (SEP) that will let you sign up for Part B at a later time:

- During any month you remain covered under the group health plan and your, or your spouse's, current employment continues; or
- In the eight-month period that begins with the month after your group health plan coverage or the current employment it is based on ends, whichever comes first.
- If your group health plan coverage is based on severance or retirement pay and the job your coverage is based on ended in the last eight months.

Exception: If your group health plan coverage or the employment it is based on ends during your IEP for Medicare Part B, you do not qualify for a SEP.

Things to Know

- If you did not sign up for Part A when first eligible, the effective date for part A will be retroactive 6 months prior or your birth month (whichever is soonest).
- COBRA and retiree health plans aren't considered coverage based on current employment. If you have that type of coverage, you will not be eligible for a SEP into OM when it ends.

Original Medicare General Enrollment Period

For those eligible and did not sign up for Part B during IEP or SEP (late enrollees):

- Members who lost Part B due to non-payment and re-enrolling.
- January 1 - March 31 of each year to sign up for Part A & B.
- Effective date is 1st of the following month and if signing up for an MA Plan, the application must be submitted prior to the effective date. The enrollment period is ICEP.
- May have to pay a Part B late enrollment penalty.

General things to know

1. Original Medicare (with or without PDP), you may enroll in a Medicare Supplement anytime subject to underwriting.
2. Some states have Anniversary and Birthday Rules for Medicare Supplement Enrollment. Please check your state rules or inquire.
3. MA and PDP, you can only enroll/disenroll during valid enrollment periods.
4. Check Medicare.gov or call 1-800-MEDICARE for more detailed information on enrollment and GI periods.
5. If on employer coverage you can contribute to a HSA past 65 as long as you do not sign up for Part A & B.
6. If someone wishes to return to employer coverage they can drop Part A & B.
7. Those beneficiaries on LIS or those who move in or out of a nursing institution do have additional enrollment period options.
8. The Krause Agency specialists support all Senior Products such as Medicaid Compliant Annuities, LTC Insurance, Accident and Critical Illness, Funeral Expense Trust and other Health Products.

Medicare Supplement Open Enrollment

Turning 65 – 1st day of the month you turn 65 + 6 months. (Those on Disability have a new Open Enrollment.)

65 or older – Part B effective date + 6 months.

On Disability for 24 months, Carriers do not have to sell to under 65 – check with your state (32 out of 50 states require carriers to offer at least 1 supplement).

Things to know:

- Must have Parts A & B to enroll.
- If enrolled in Part B while on employer coverage, 6 months open enrollment begins even if member does not sign up for a Supplement.
- No waiting periods for Pre-Existing Conditions if enrolling within 6 months of creditable prior coverage (no break longer than 63 days).

Medicare Supplement Guaranteed Issue

60 days before and up to 63 days after.

Common Circumstances for GI

- Moved out of MA or Medicare Select Plan service area.
- MA plan ends.
- Group Health Plan coverage ends

Things to know:

- Carrier must accept enrollment.
- Must cover and can't charge more for Pre-Conditions.
- Limited Available Plans A, B, C*,D*, F*, G*, K, L or Basic (if offered) Other plans may require underwriting.
  ***based on Medicare Eligibility** – if Jan 2020 or sooner cannot choose D or G. If after, cannot choose plan C or F.

Trial Rights

- Joined MA when first eligible for Part A at 65, can switch back to OM and enroll in any Supplement offered in State, anytime during first 12 months.
- Left a Supplement to enroll in MA, during first 12 months can only return to the same plan. Can only be used once in lifetime.

Must actively disenroll if returning to a Supplement – do not disenroll until approved for coverage.

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Medicare Advantage and Drug Plan Initial Enrollment Period

Turning 65 – 7 month period, 3 months before (month of) and 3 months after birth month.

Under 65 with Disability – begins 21 months after Social Security benefits, coverage starts after 24 months.

Things to know

- If on Medicare due to disability U65, also have 7 month IEP around member's 65th birthday.
- Member may drop MA, MAPD or PDP during 12 month 'Trial Right Period' and return to Original Medicare.
- PDP late enrollment Penalty – 63 days or more of no creditable coverage – Penalty last as long as member has PDP.
- Only Part A is required to be eligible for PDP. If a person signs up for PDP after their IEP, they will need to have an SEP for coverage to start.
- If subject to a significant LEP – members may choose an MA only without penalty.

Medicare Advantage and Drug Plans Special Enrollment Period

Eligible for SEP if impacted by certain life events such as loss of health coverage or moving.

Common examples:

- Moving out of service area
- Returning to the USA
- Leaving employer coverage
- MA or PDP plan isn't renewed
- CMS terminates MA or PDP plan's contract
- Medicaid or low income subsidy status changes
- Individuals impacted by an emergency or disaster
- Health plan or employer error
- Formerly incarcerated individuals

Things to know

- One time opportunity to enroll.
- Submit application before change occurs to ensure seamless coverage.

Annual Enrollment Period

October 1 - 14 - following year plans may be discussed.

October 15 – December 7 – enrollments are accepted.

Coverage Begins January 1

During AEP, Members Can...

- Switch from OM to MA or vice versa.
- Switch MA, MAPD, or PDP plans.
- Switch from MA only to MAPD or vice versa
- Join or drop a PDP.

Things to know

- If more than one application is submitted, the last application submitted will be the one accepted.
- Must obtain SOA before presentation.
- Must not enroll or submit plan before October 15.
- Applications must be submitted within 24-48hrs of receipt*.
- Only Health insurance plans may be discussed – this includes Dental, Vision, and Hospital Indemnity plans.
- Other products such as Life, Cancer, Accident Plans cannot be discussed at a CMS regulated meeting.
- Must complete annual certification and carrier training before presenting CMS regulated plans.

**Follow carrier rules per annual training*

Medicare Advantage Open Enrollment Period

Jan 1-Mar 31 and 1st three months after IEP
Coverage begins the first of the following month

Eligibility

Member must have a Medicare Advantage Plan

Things to know

One-time opportunity to switch MA or MAPD Plan or return to OM and sign-up for a PDP.

What is NOT allowed?

- Switch from OM to a MA Plan.
- Join a PDP if enrolled in OM.
- Switch from one PDP to another if enrolled in OM.

5-star Special Enrollment Period

December 8 through November 30

Availability of a 5-star MA, MAPD, PDP or Cost Plan in service area.

Things to know

- One-time opportunity to use.
- May disenroll from their current Cost Plan, MA, MAPD or PDP in order to utilize the 5-Star SEP.
- Medicare beneficiaries may switch from one 5-star plan to another 5-star plan.
- An individual using this SEP can enroll in an MA-only, an MAPD, a Cost Plan, or a PDP with a 5-star rating.

Acronym Key

- Original Medicare – OM
- Medicare Advantage Plan or Part C – MA
- Medicare Advantage with Prescription Drugs – MAPD
- Medicare Prescription Drug Plan or Part D – PDP
- Initial Enrollment Period – IEP
- Initial Coverage Enrollment Period – ICEP
- Annual Enrollment Period - AEP
- Special Enrollment Period – SEP
- Open Enrollment Period – OEP
- Guaranteed Issue – GI
- Scope of Appointment – SOA
- Late Enrollment Penalty – LEP
- Turning 65 – T65
- Under 65 – U65
- Centers for Medicare and Medicaid Services – CMS
- Low Income Subsidy – LIS
- End Stage Renal Disease - ESRD

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Additional Medicare Supplement Open Enrollment Periods

CALIFORNIA

Annual Open Enrollment lasts 90 days, beginning 30 days before and ending 60 days after the individual's birthday, during which time a person may replace any Medicare Supplement policy with a policy of equal or lesser benefits. Coverage will not be made effective prior to the individual's birthday or beyond 60 days from the application date.

CONNECTICUT

Year-round Open Enrollment

IDAHO

Annual Open Enrollment lasts 63 days, beginning on an individual's birthday, during which time an individual may replace any Medicare Supplement policy with a policy of equal or lesser benefits. Coverage will not be made effective prior to the individual's birthday or beyond 60 days from the application date.

ILLINOIS

Annual Open Enrollment lasts 45 days, beginning on an individual's birthday, during which time a person may replace a policy equal to or lesser benefits from the same company. An individual must be between the ages of 65 through 75 to be eligible. Coverage will not be made effective prior to the individual's birthday or beyond 60 days from application. This option is not available on closed blocks.

LOUISIANA

Annual Open Enrollment lasts 63 days, beginning on an individual's birthday, during which time a person may replace any policy of equal or lesser benefits from the same company. Coverage will not be made effective prior to the individual's birthday or beyond 60 days from the application date. This option is not available on closed blocks.

MAINE

There is a one-month Open Enrollment period every year in June for Plan A. Individuals who have had a Medicare Supplement plan or another health plan that supplements benefits provided by Medicare within 90 days are eligible for a plan that provides equal or lesser benefits. Applicants replacing a current 1990 Standardized plan with a 2010 Modernized plan may apply for a 2010 Modernized Medicare Supplement plan of equal or lesser benefits and would not be subject to underwriting guidelines.

MARYLAND

Annual Open Enrollment lasts 30 days. It begins on the beneficiary's birthday and ends 30 days from that date. During this time, a Medicare Supplement policy can be replaced with a policy of equal or lesser benefits. Coverage cannot be made prior to the birth date or beyond 60 days of the application.

MISSOURI

Individuals who terminate a Medicare Supplement policy within 30 days of the annual policy anniversary date may obtain the same plan with no health questions asked for a period of 63 days after the termination of their existing policy, from any issuer that offers that plan. For policies with an effective date of June 10, 2010, or after, individuals with existing Plans E, H, I, and J can convert to one of the following Plans: A, B, C, F, K, or L.

NEVADA

Annual Open Enrollment lasts 60 days, beginning the first day of an individual's birthday month ending 60 days from that date, during which time an individual may replace any Medicare Supplement policy with a policy of equal or lesser benefits. Coverage will not be made effective prior to the individual's birthday or beyond 60 days from the application date.

NEW YORK

Year-round Open Enrollment

OKLAHOMA

Open Enrollment Period is available for 60 days beginning on the beneficiary's birthday. The beneficiary must already be enrolled in a Medicare Supplement with no gap in coverage greater than 90 days. The replacement policy must be equal or lesser benefits.

OREGON

Annual Open Enrollment lasts 60 days, beginning 30 days before and ending 30 days after the individual's birthday, during which time a person may replace any standardized Medicare Supplement policy with a policy of equal or lesser benefits. Coverage will not be made effective prior to the individual's birthday or beyond 60 days from the application date.

VERMONT

Year-round Open Enrollment

WASHINGTON

Individuals already enrolled in a Medicare Supplement Plan B through N can switch at any time to another Medicare Supplement Plan B through N. Individuals who have a Medicare Supplement Plan A can switch to any other Medicare Supplement Plan A. In either of these situations, individuals will not have to complete the health or medication information on the application. Individuals who currently have a standardized Medicare Supplement plan may replace the plan as indicated below on an Open Enrollment basis:

- Persons with a Plan A may only move to another Plan A.
- Persons with a Plan B, C, D, E, F, G, M or N may move to any other Plan B, C, D, F (including high deductible), G, M, or N (whether higher or lower in benefits compared to current plan).
- Persons with a standardized Plan H, I, or J may move to another less comprehensive Plan B, C, D, F, G, M, or N.

Please note some states may have additional Open Enrollment rights under state law and state laws can change.

States with Under Age 65 Requirements

State	Plans Available	Open Enrollment Requirements
AR, IN, MD, OK, TX	A	Open Enrollment if applied for within six months of Part B enrollment
CA	A, F*, G†, N	Open Enrollment if applied for within six months of Part B enrollment
CO, DE, FL, GA, HI, ID, IL, KS, LA, ME, MO, MS, MT, NH, PA, SD	All plans§	Open Enrollment if applied for within six months of Part B enrollment
CT	A	Open Enrollment year-round
KY	All plans§	No Open Enrollment. Guaranteed Issue available (not all plans) only if a person has an employer-sponsored group plan or a Medicare Advantage plan that is being terminated or no longer available.
MN	All plans and riders§	Open Enrollment if applied for within six months of Part B enrollment
NC	A, F*, G†	Open Enrollment if applied for within six months of Part B enrollment
NJ	C*, D† available to people ages 50-64	Open Enrollment if applied for within six months of Part B enrollment. Newly eligible beneficiaries receive Open Enrollment if applied for within twelve months of Part B enrollment. Individuals who are entitled to Medicare benefits due to disability prior to Jan. 1, 2020, that are still within six months of enrolling in Part B and not currently covered by any other Medicare Supplement plan will have the option of purchasing Pans C and D.
NY	All plans§	Open Enrollment year-round
OR	All plans§	**Open Enrollment Requirements:** Open Enrollment if applied for within six months of Part B Enrollment. **Special Open Enrollment Period** for those who move to OR and qualify for Medicare due disability. This Open Enrollment period is for those who move to OR from a state that does not require the sale and issue of policies to applicants Under Age 65. This period begins on the day residency has been established in OR and ends 63 days after.
TN	All plans§	Open Enrollment if applied for within six months of Part B enrollment for persons no longer having access to alternative forms of health insurance coverage due to the individual's status, conduct, or failure to pay premium, or persons being involuntarily disenrolled from Title XIX (Medicaid) or Title XXI (State Children's Health Insurance Program) of Social Security Act. Alternative forms of health insurance in the statement above include accident and sickness policies, employer-sponsored group health coverage, or Medicare advantage plans.
VA	A	Open Enrollment if applied during six-month period beginning with the first month the individual is eligible for Medicare and enrolled in Medicare Part A and B. Guaranteed issue during the 63-day period following voluntary or involuntary termination of coverage under a group health plan. People disabled prior to Jan. 1, 2021, have a six-month OE period beginning on Jan. 1, 2021.
VT	All plans§	Not available for persons with end-stage renal disease
WI	Base policy and riders	Open Enrollment if applied for within six months of Part B enrollment

** Plans C and F are not available to newly eligible Medicare beneficiaries.* *† Plans D and G are only available to newly eligible Medicare beneficiaries.*

§ Plans C and F (including High Deductible F) are not available to "newly eligible" Medicare beneficiaries.

States can change rules quickly, so please consult your state information or us for the most up to date information.

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