BETTER MEDICARE

ALLIANCE

ADVOCACY TOOLKIT

CONTENTS

HOW MEDICARE ADVANTAGE IS AFFECTED BY WASHINGTON

- When a law is passed by Congress, the appropriate regulatory agency then creates the regulations necessary to implement the law.
- Through regulatory agencies, the Executive Branch translates law into action.

What is the difference between a lawmaker or a bureaucrat?

- **A lawmaker** is an elected official who is elected by voters to be a member of city, district, state or national level legislative assembly that drafts and approves law.
- **A bureaucrat** is a non-elected employed government official selected by the President or governor on national, state, or local level who writes policies, procedures, and payment rules to implement laws.

How can the public impact regulatory decisions?

- The Administrative Procedure Act (APA) governs regulatory agencies and requires that regulatory agencies publish all proposed new policies at least 30 days before they take effect to allow the public to comment.
- To comment on proposed policies for Medicare Advantage, the public can send letters to the Administrator at the Centers for Medicare and Medicaid Services (CMS).
- As a political appointee selected by the President, the CMS Administrator has to be confirmed by the U.S. Senate and is not an elected official. The CMS Administrator has the authority to finalize policies impacting Medicare Advantage.

- The Congressional Review Act allows Congress to review and possibly reject new federal regulations issued by the regulatory agencies. Congress does not always exercise this authority.

Key Terminology and Tools

- New policies or amendments to existing policies are called '**proposed rules**.'
- Notices of public hearings or requests for comments on proposed rules are published in the Federal Register, and on the websites of the regulatory agencies.
- The period of time when the Centers for Medicare and Medicaid Services introduces proposed changes to Medicare Advantage is known as the 'rate notice'.
- Once a policy becomes effective, it is called a '**final rule**' and is printed in the Federal Register, and may also be posted on the website of the regulatory agency.
- Occasionally, a final rule allows for a second comment period on specific issues.

How Better Medicare Alliance Protects Medicare Advantage

- Better Medicare Alliance monitors and comments on policy actions by the Centers for Medicare & Medicaid Services (CMS) that impact Medicare Advantage. BMA also monitors legislative activity in Congress and how Medicare Advantage is working.
- The coverage and reimbursement decisions made by the Medicare program have a profound impact on the health services as a whole, since Medicare is currently the largest payor of health care in the United States.
- The Better Medicare Alliance (BMA) carefully monitors, analyzes, and responds to proposed policies during the rate notice that impact Medicare Advantage.
- During the comment period, BMA develops its position on numerous issues. Letters, petitions, and feedback from BMA Ambassadors and Advocates allow BMA to include the perspective of beneficiaries during the comment period.

- Given the short timeframe for public comment, it is important for Better Medicare Alliance to actively monitor CMS actions as a key part of our advocacy activities, and to appropriately respond to policies that will impact Medicare Advantage and its beneficiaries.

Key Dates

- From February to April each year, CMS releases its proposed changes for the following year to policies and payments to Medicare Advantage.
- The public may submit comments on the proposed changes during this period. BMA provides information on the proposed changes and its impact on beneficiaries and other stakeholders, submits formal comments, and encourages BMA advocates to offer their opinions to us and directly to elected officials and administrators.
- CMS releases their final rate notice on the first Tuesday of April. The proposals within the final rate notice become effective on the following January 1.

JOIN TOP ADVOCATES: HOW TO PARTICIPATE IN BMA

Do you want to be an advocate for other seniors and people with disabilities?

The Better Medicare Alliance (BMA) wants your voice to be heard in Washington, D.C. to speak for the value of Medicare Advantage for yourselves, and for other seniors and people with disabilities who have Medicare Advantage. Participation in BMA is free and volunteer-based.

There are two ways you can be involved with BMA:

1 Sign up as a **BMA Advocate** to receive policy updates, advocacy alerts, and a monthly newsletter. Activities that BMA Advocates participate in include: answering surveys, signing petitions, and sharing experiences with BMA. Check out our BMA Advocate Checklist to see a full list of BMA Advocacy activities. When you participate in at least five advocacy activities with BMA in a calendar year, one of which is a high-value "rate notice action" (e.g., a letter to the editor or a comment letter), you automatically become an **All-Star BMA Advocate**. These advocates will likely also be recruited to become BMA Ambassadors.

2 Request to join "**BMA Ambassadors**", a group of top BMA advocates who volunteer to work directly with BMA staff to further engage in advocacy activities for Medicare Advantage. BMA Ambassadors will receive prizes for their advocacy activities such as BMA stickers, t-shirts, and totes. If you would like to become a BMA Ambassador, please e-mail BMA Community Manager Raven Garris at community@bettermedicarealliance.org.

Why You Should Become a BMA Ambassador

BMA Ambassadors are a self-selected committee of the Better Medicare Alliance's most engaged advocates dedicated to strengthening healthcare for the 18 million seniors with Medicare Advantage.

BMA Ambassadors activities include:

- Joining the BMA Ambassador private Facebook group
- Participating in a monthly conference call to discuss Medicare Advantage policy updates
- Contacting members of Congress or other policymakers
- Sharing information in their community about Medicare Advantage
- Hosting an event (i.e. coffee chat, Medicare Advantage workshop, fitness class) in their community
- Organizing trips to Washington to advocate for Medicare Advantage
- Connecting with other advocates nationwide

BMA's Community Manager will plan special events to engage the BMA Ambassadors, which may include travelling to D.C. to meet your representatives on The Hill.

If you have not yet signed up to be a BMA Advocate, please sign-up on the BMA Action Center!

MEDICARE ADVANTAGE 101

FAQ

What is Medicare Advantage?

Medicare Advantage, sometimes referred to as Medicare Part C, is the option within Medicare that allows beneficiaries to enroll in a healthcare plan offered through private companies. If you join a Medicare Advantage Plan, you still have Medicare. You will receive your Medicare Part A and Medicare Part B coverage from the Medicare Advantage Plan, instead of through traditional Medicare. Under traditional Medicare, the government pays for your Medicare benefits when you are eligible to receive them. Under Medicare Advantage Plans, Medicare pays private companies a set amount per person per month to cover your benefits.

What is the difference between Medicare Advantage and traditional Medicare?

Traditional Medicare includes Part A (hospital) and Part B (medical) coverage, if you enroll in both. Most people pay a monthly, income-based premium for Medicare Part B. Traditional Medicare does not cover visual, hearing, and dental benefits, and there is no limit on yearly amounts of out-of-pocket care costs. Under Traditional Medicare, you can go to any doctor or hospital in the United States that accepts Medicare. If you want Medicare drug coverage (Part D), you must purchase a separate Prescription Drug Plan (PDP) from a private insurance company. If you have traditional Medicare, you may also choose to purchase a supplemental insurance policy to cover out-of-pocket physician costs called Medigap.

Under Medicare Advantage, you still pay Part B premiums. However, over 97% of Medicare Advantage plans offer at least a vision, hearing, or dental benefit, and half of Medicare Advantage plans offer all three benefits. Medicare Advantage Plans does have yearly limits on your out-of-pocket health care costs. Once you reach your maximum out-of-pocket spending, you pay nothing. The most common types of Medicare Advantage Plans are HMOs (Health Maintenance Organizations) and PPOs (Preferred Provider Organizations). Under Medicare Advantage, the providers you can visit depend on the type of plan you select. This is referred to as the “provider network” and plans offer information on which providers are in their plan. If

you want a plan that includes Medicare drug coverage (Part D), you can sign up for a Medicare Advantage Prescription Drug Plan (MA-PD) which includes both health and drug coverage.

If I'm in a Medicare Advantage plan, will I receive Part A and B benefits? Will I receive Part D?

Medicare Advantage plans are required to cover all Parts A and B benefits provided under traditional Medicare. Medicare Advantage is not required to cover Part D benefits. However, approximately 90% of Medicare Advantage plans offer Part D prescription drug coverage that you may select from.

What are the plan types under Medicare Advantage?

Medicare Advantage offers the following types of plans:

- Health Maintenance Organization (HMO): In most HMOs, you can only go to doctors, other health care providers, or hospitals in the plan's network, except in an urgent or emergency situation. You may also need to get a referral from your primary care doctor for tests or to see other doctors or specialists.
- Preferred Provider Organization (PPO): In a PPO, you pay less if you use doctors, hospitals, and other health care providers that belong to the plan's network. You usually pay more if you use doctors, hospitals, and providers outside of the network.
- Private Fee-for-Service (PFFS): PFFS plans are similar to Original Medicare in that you can generally go to any doctor, other health care provider, or hospital as long as they accept the plan's payment terms. The plan determines how much it will pay doctors, other health care providers, and hospitals, and how much you must pay when you get care.
- Special Needs Plan (SNP): SNPs provide focused and specialized health care for specific groups of people, like those who have both Medicare and Medicaid, live in a nursing home, or have certain chronic medical conditions.
- Health Maintenance Organization Point-of-Service (HMO-POS): These are HMO plans that may allow you to get some services out-of-network for a higher copayment or coinsurance.

- Medical Savings Account (MSA): These plans combine a high-deductible health plan with a bank account. Medicare deposits money into the account (usually less than the deductible). You can use the money to pay for your health care services during the year. MSA plans don't offer Medicare drug coverage. If you want drug coverage, you have to join a Medicare Prescription Drug Plan.

To research plans and determine which plan may be right for you, click here.

What are the Medicare Advantage eligibility requirements?

If you are eligible for traditional Medicare, you generally are eligible to choose a Medicare Advantage page. To be eligible for a Medicare Advantage plan, you must be enrolled in Medicare Parts A and B, and live in the Medicare Advantage service area. You can join a Medicare Advantage plan even if you have a pre-existing condition, except for End-Stage Renal Disease (ESRD) (dialysis patients). There are also other special circumstances under which you can enroll in a Medicare Advantage plan. The chance to enroll or change plans occurs when you first become eligible for Medicare, or once a year between October 15 – December 7.

Under what special circumstances can I sign up for Medicare Advantage outside of open enrollment?

There are special circumstances when individuals can sign up for Medicare Advantage outside of the open enrollment period including if:

- You find out that you will not be eligible for Extra Help for the following year.
  - » Extra Help is a Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, like premiums, deductibles, and coinsurance.
- You retire from your employer or union and have an employer sponsored retiree plan.
- You drop your coverage in a Program of All-inclusive Care for the Elderly (PACE) plan.

What does initial enrollment period mean?

The Initial Enrollment Period is when you first become eligible for Medicare, and is defined as the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65. In general, you can enroll in Medicare Part A, B and C (Medicare Advantage) during your Initial Enrollment period.

Once I am eligible for Medicare Advantage, when can I enroll in a Medicare Advantage plan?

You can enroll in a Medicare Advantage plan when you first become eligible for Medicare or during annual open enrollment which lasts from October 15 to December 7 every year. If you are enrolled in Medicare Parts A and B, you will not have to re-enroll each year unless you switch between traditional Medicare and Medicare Advantage.

Who will my doctor be?

Medicare Advantage plans provide a list of doctors and hospitals for your review. The providers you can visit depend on the type of Medicare Advantage plan you choose. More information on providers under Medicare Advantage plans can be found here.

What is the difference between a Medicare Advantage Plan and a Medigap Plan?

Medigap provides supplemental coverage that pays for all or most of Medicare Parts A & B out-of-pocket costs including: co-payments, coinsurance, and deductibles. Medigap is only available to traditional Medicare beneficiaries because Medicare Advantage plans already generally cover these additional costs. Medigap does not cover Part D (drug) coverage. Under Medigap, beneficiaries must be at least 65 years old, and may enroll in Medigap in the first six months after they sign up for Medicare Part B. After that period, people in most states can be turned down by Medigap, or charged extra for pre-existing conditions. Medicare Advantage Plans and Medigap Plans are both provided through private insurance companies.

Can I enroll in both a Medicare Advantage Plan and a Medigap Plan?

No, you are not permitted to enroll in both a Medicare Advantage plan and a Medigap plan simultaneously. Medigap plans are generally not needed if you chose a Medicare Advantage plan because Medicare Advantage plans cover these services.

What if I receive benefits from Social Security or the Railroad Retirement Board?

When you turn 65, you will automatically be enrolled in Medicare Part A and Medicare Part B if you are already receiving benefits from Social Security or the Railroad Retirement Board. You may still choose to enroll in a Medicare Advantage plan.

KEY DATES

The Annual Election Period runs from October 15 to December 7.
Except for the initial sign up when you turn 65, your coverage will begin January 1 of the following year, as long as the plan gets your enrollment request by December 7. You have the opportunity to change your plan every year during open enrollment which is from October 15 – Dec 7 each year.

What can I do during this period?

- Change from traditional Medicare to a Medicare Advantage plan.
- Change from a Medicare Advantage plan to traditional Medicare.
- Switch from one Medicare Advantage plan to another Medicare Advantage plan.
- Switch from a Medicare Advantage plan that does not offer drug coverage to a Medicare Advantage plan that offers drug coverage.
- Switch from a Medicare Advantage plan that offers drug coverage to a Medicare Advantage plan that does not offer drug coverage.

If you are getting Part B for the first time you can sign up for an Advantage plan during your initial coverage election period between April 1-June 30.

TALKING POINTS FOR BMA ADVOCATES

What is Medicare Advantage?

- Medicare Advantage is the option within Medicare that allows beneficiaries to enroll in healthcare plan offered through private companies.
- Medicare Advantage is sometimes referred to as Medicare Part C.
- There are more than 18 million Medicare Advantage beneficiaries across the U.S. This is almost one third of all Medicare beneficiaries.

What makes Medicare Advantage special/important?

- Medicare Advantage is the managed care option under Medicare.
- Medicare Advantage plans generally are different from traditional Medicare because they are paid a monthly amount for each beneficiary. This kind of payment system, unlike fee-for-service, encourages early intervention and care coordination for its enrollees.
- Medicare Advantage plans encourage beneficiaries to have a primary care clinician and to us preventive care. Many plans have care managers who help patients get the care they need.
- Medicare Advantage plans often have lower cost sharing in co-pays or premiums than traditional Medicare.
- Medicare Advantage plans often cover supplemental benefits at no additional cost including dental, vision, and hearing, which are not covered by traditional Medicare plans.
- Medicare Advantage provides high quality, affordable health care coverage for its beneficiaries.
- Research has found that Medicare Advantage beneficiaries experience fewer avoidable hospitalizations and better chronic disease management.
- Approximately 90% of Medicare Advantage beneficiaries are satisfied with the quality, value, and preventive care coverage they receive.

What is the Better Medicare Alliance?

- The Better Medicare Alliance is a non-profit coalition of advocacy organizations, aging service agencies, plans, providers, retiree organizations, and beneficiaries who support Medicare Advantage as an option under Medicare.
- The Better Medicare Alliance works to protect and strengthen Medicare Advantage through information, research, education, and united support among providers, plans, organizations and beneficiaries to sustain and strengthen this important coverage for seniors and the disabled.

Why does Medicare Advantage need protecting and strengthening?

- Each year, from February to April, the Administration proposes new policies that impact Medicare Advantage beneficiaries.
- Sometimes, the new policies result in cuts to funding for Medicare Advantage which can lead to an increase in premiums and a decrease in supplemental benefits for Medicare Advantage beneficiaries.
- A significant portion of Medicare Advantage beneficiaries are over the age of 75 and live on incomes below $20,000 per year, so it is important to keep Medicare Advantage stable and sustainable.
- The Better Medicare Alliance works to make the voice of beneficiaries heard during the regulatory process, and in Washington D.C. to prevent cuts and harmful proposals to Medicare Advantage.

How to debunk common Medicare Advantage myths

Myth #1: Enrolling in a Medicare Advantage plan means that you no longer have Medicare.

> **Truth:** If you enroll in a Medicare Advantage plan, you still have Medicare. Medicare Advantage covers Parts A and B of traditional Medicare, as well as additional benefits.

Myth #2: Medicare Advantage plans are more expensive than traditional Medicare.

> **Answer:** There are several types of Medicare Advantage plans, some of which have $0 premiums. When selecting a plan, it is important to choose one that will best meet your needs.

Myth #3: Once you enroll in one Medicare Advantage plan, you cannot switch to a different plan.

Answer: Medicare Advantage beneficiaries are able to switch plans or go back to traditional Medicare during Open Enrollment which occurs every year between October 15 – December 7.

Myth #4: Seniors do not have dental, vision, or hearing coverage under Medicare Advantage.

Answer: 97% of Medicare Advantage plans offer at least a vision, hearing, or dental benefit, and half of Medicare Advantage plans offer all three benefits. Traditional Medicare does not cover these benefits.

Myth #5: There is no cap on out-of-pocket costs for Medicare Advantage beneficiaries.

Answer: Medicare Advantage plans have a yearly cap on out-of-pocket costs for medical services. Once you reach this limit, you'll pay nothing for covered services. This limit is set by the government, but can change each year.

In addition to the yearly cap, Medicare also requires Medicare Advantage plans include cost sharing. Cost sharing refers to the out-of-pocket payments that enrollees are required to make when they receive health care. In general, cost-sharing requirements in Medicare Advantage plans are lower than those in the fee-for-service program and more closely resemble requirements in private insurance plans. In general, premiums spread the cost of medical care across all enrollees, whereas cost sharing concentrates costs on people who use more medical care.

Why should I become a Better Medicare Alliance Ambassador?

- Becoming a BMA Ambassador will place you among a group of BMA's most active advocates and agrees to work closely with Better Medicare Alliance, individually, and as a group to speak up for Medicare Advantage.
- As a beneficiary of Medicare Advantage your voice is critically important and should be heard. BMA can help you use your voice effectively.
- Your voice can have an impact on decisions involving programmatic changes to and funding for Medicare Advantage.

- Your experiences, stories, interests, and actions can enhance awareness of why Medicare Advantage is working for you, and how Medicare Advantage could work for other seniors.
- BMA is here to help you be your own best advocate, for yourself, your family, your community, and for the overall cause of supporting and strengthening Medicare Advantage.
- Activities BMA Ambassadors are involved in could include:
  - Hosting an event (i.e. coffee chat, Medicare Advantage workshop, fitness class) in their community
  - Contacting members of Congress
  - Organizing trips to Washington to advocate for Medicare Advantage
  - Sharing information in their community about Medicare Advantage
  - Joining the BMA Ambassador private Facebook group
  - Participating in a monthly conference call to discuss Medicare Advantage policy updates
  - Connecting with other advocates nationwide
- The Community Manager will plan special events to engage the BMA Ambassadors, which may include traveling to D.C. to meet your representatives on The Hill.

UNDERSTANDING CUTS TO MEDICARE ADVANTAGE RETIREE PLANS

Over three million retirees across the country are enrolled in a Medicare Advantage health plan sponsored by a former employer. This type of Medicare Advantage retiree coverage, officially known as an Employer Group Waiver Plans (EGWPs) is an important option for retirees and employers, including state and local governments, industries, and unions.

Smooth Transition from Employee to Retiree Healthcare Coverage

Employers, including state and local government entities, industries, and unions, have turned to Medicare Advantage to provide a seamless transition from employee to retiree health insurance coverage for people turning 65. Employers report that Medicare Advantage retiree coverage gives them the ability to continue coverage that offers the comprehensive, coordinated care their retirees expect, and in many cases have negotiated in labor contracts. Medicare Advantage retiree coverage delivers high-quality, value-based care. Unlike Traditional Medicare, Medicare Advantage often provides important additional benefits and services to enrollees, such as vision, dental, hearing, in-home care, and case management. Prescription drug coverage is also available. Retirees in employer-sponsored Medicare Advantage plans also have cost protections that are not available in Traditional Medicare, such as an annual cap on out-of-pocket costs.

Decrease in Funding and Access to Medicare Advantage Retiree Plans

According to a Kaiser Family Foundation report, while the number of companies offering retiree plans dropped from 66 percent in 1988 to 28 percent in 2013, demand for retiree plans have increased among retirees. The number of Medicare beneficiaries with retiree health benefits offered via

Medicare Advantage group plans increased between 2008 and 2013 by more than 30 percent.

In April 2017, the Administration decided to cut funding for Medicare Advantage retiree coverage.

Experts say the proposed change would result in a **2.5% reduction** in funding for Medicare Advantage retiree plans which could raise costs and disrupt access to Medicare Advantage coverage for retirees.

BMA wrote CMS when the cut was proposed and offered analysis of the impact on employers and beneficiaries. We asked CMS not to implement this change at all, or at least, implement the change over 2-3 years to reduce the negative impact. CMS did decide to implement the change in payment policy over 2 years.

BMA engaged our advocates, and many called offices of members of congress, wrote letters and op-eds about their positive experiences, wrote Medicare Advantage letters that were forwarded to CMS, and had several op-eds published in local newspapers. BMA appreciated our advocates speaking up for themselves and other retirees. They were an important part of our advocacy on this issue.

BMA will continue to monitor the impact of the reduction in payment to employer-sponsored plans. Particularly its impact on beneficiaries.

> A growing number of employers, including state and local governments, businesses, and labor unions are turning to Medicare Advantage to provide quality health coverage with out-of-pocket cost protections for retirees. EGWPs have proven to be an affordable way to provide care coordination, disease management and enhanced benefits for Medicare-eligible retirees that are not available in Fee-for-Service. Access to this important option for retirees could be stymied if employer's ability to adequately cover retired employees is impacted.
>
> **– Allyson Y. Schwartz,**
> **Better Medicare Alliance CEO and President**

> We are concerned about the potential beneficiary impact of this proposal. In fact, CMS acknowledges that the result could be "...that employers would choose to reduce the supplemental coverage provided to employees under these plans." If finalized, we agree that this proposal would likely reduce coverage or increase premiums. This would result in a significant cost-shift to retirees who depend on these plans to help pay for their health care.
>
> **– AARP on March 28, 20**