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Agent Retraining

Plan's Member Support Programs

Once a member enrolls, they become part of MA/MAPD. Most provide them with health and wellness services and other support programs* to ensure their continued good health and well being.

- 24/7 Health Hotline staffed by experienced healthcare professionals
- Preventive services/care management
- Personal health assessments
- Health coaching
- Care coordination
- After-care support
- Plus, the Value Added Programs are available with some plans.

*Services and programs may vary by product type

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Preventive Services*

Annual Physical– one exam per year

Bone Mass Measurement – for people with Medicare who are at risk

Colorectal Screening Exams – for people with Medicare age 50 and older

Immunizations – includes Flu, Hepatitis B-for people with Medicare who are at risk,
Pneumonia

Mammograms(annual screening) – for women with Medicare age 40 and older

Pap smears and Pelvic Exams – for women with Medicare

24/7 Health Hotline– connect with a trained health professional-anytime you need
one

*Copays and benefits vary by product and plan.

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DO

1. Make sure the member feels good about their plan
2. Listen actively and check in frequently
3. Focus on the 2012 Benefit rather than the change for 2011
4. ***Highlight the good things – deliver the value proposition!***
5. Offer review of other plan options (if member requests)

DON'T

1. Do not say the word “change” in the first sentence
2. Do not allow plan change discussions to take over the call
3. Do not be negative

REMEMBER:

Every conversation YOU have has the potential to influence a members' decision to stay or leave!

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Agent Reminder



- When communicating be confident, warm, and professional
- Members are counting on you to be informed and understand their plan benefit choices
- Always “do the right thing” for the member based on their benefit need
- ***Remember: You represent Trusted Senior Specialists and you have the ability to influence a Medicare Beneficiary experience and their enrollment/renewal decision***

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2011 Enrollment Training

2011 Enrollment Season Timeline

Dates	Abbreviation	Enrollment Period
Oct. 1 – Nov. 14, 2010		Marketing Period Agents may distribute and assist in the completion of AEP enrollment forms. Agents may sign AEP enrollment forms, but may not collect them from the prospective members
Nov. 15 – Dec. 31, 2010	AEP	Annual Enrollment Period Agents may complete and collect 2011 enrollment forms
Jan. 1 – Feb. 14, 2011	ADP	Annual Disenrollment Period* People with Medicare can disenroll from Medicare Advantage plans and return to Original Medicare for the remainder of 2011
Oct. 2, 2010 – Jan. 31, 2011	SEP	Special Enrollment Period for Plan Non-Renewal Agents may complete SEP enrollments for plan non-renewal during this timeframe

*The Open Enrollment Period (OEP) is **no longer** applicable (formerly January 1 – March 31)



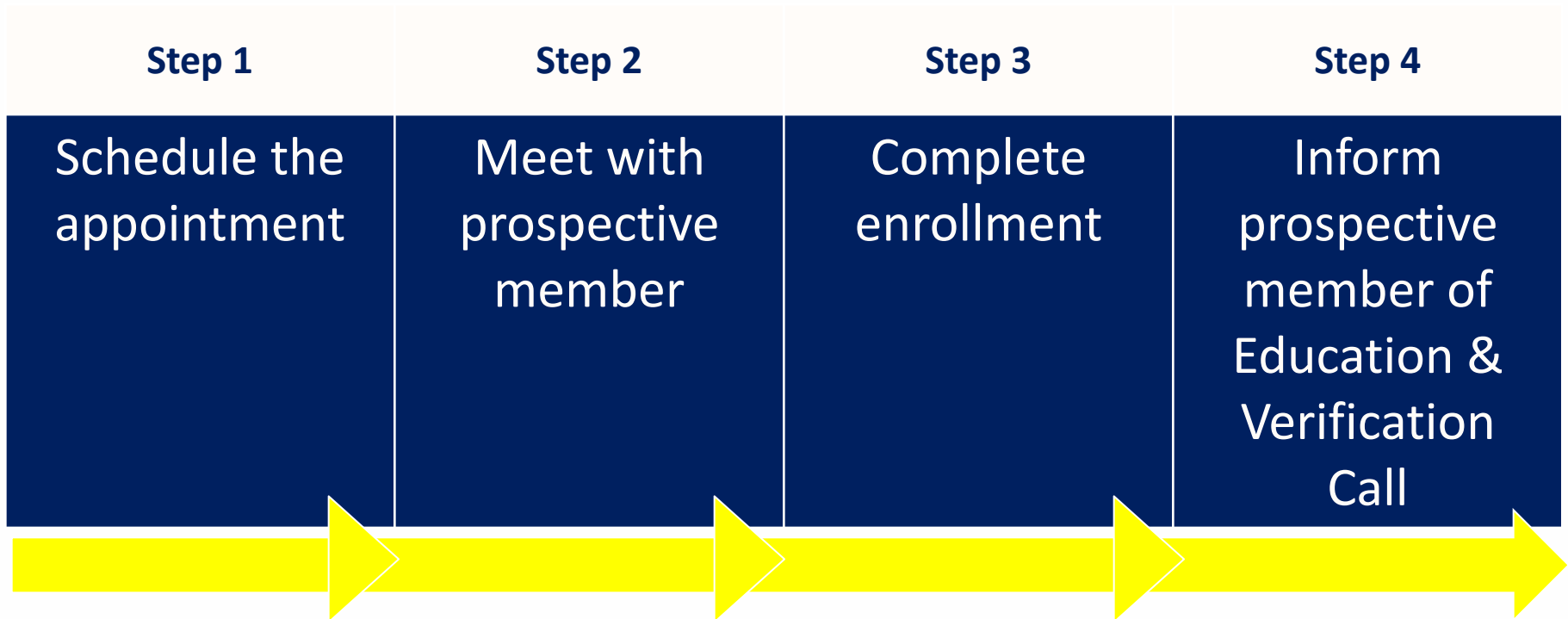
2011 Enrollment Election Periods

Election Period	Frequency	Dates
Initial Coverage Election Period (ICEP)	Once in a Beneficiary's Lifetime	Depending on Medicare Beneficiary's Entitlement or birthday (applies only to newly eligible Medicare Beneficiaries)
Initial Election Period (IEP) for Medicare Part D *	Once in a Beneficiary's Lifetime	3 months before becoming eligible for Part D, the month of eligibility, and the 3 months following eligibility for Part D
Annual Election Period (AEP)	Each Year	November 15 th – December 31st (will change for 2012 plan year)
Special Election Period (SEP)	When Circumstances Apply	When Circumstances Apply
Annual Disenrollment Period(ADP)	Each Year	January 1st – February 14th – Can only switch from existing MA (or MAPD) plan back to Original Medicare. However, member may select a stand-alone PDP to accompany Original Medicare .
Open Enrollment Period for Newly Eligible Individuals (OEPNEW)	Once in a Beneficiary's Lifetime	Begins the month of entitlement to both Medicare Part A and Part B and ends on the last day of the 3rd month of entitlement, or on December 31st of the same year, whichever occurs first

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Enrollment Processes at a Glance*



***2011 Certification required**

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Scope of Appointment

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Scope Of Appointment Requirements

Scope of Appointment is a consumer protection established by the MIPPA Marketing rules regulated by CMS and monitored by MA and PDP plans. Prospective members must consent in advance to the product information they wish to discuss with an agent during a scheduled meeting.

Scope of Appointment may be satisfied through paper or recorded telephonic process.

Scope of Appointment Requirements:

- Agents **must** complete the Scope requirements for all MA and PDP enrollments
- Agents **must** complete the Scope of Appointment process whenever meeting face-to-face with prospective members
- Agents **must** discuss only the agreed upon products during the scheduled sales appointment

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Scope of Appointment: Paper Process

The paper/printed *Scope of Appointment* form ***must*** be....

- Sent to prospective members via mail, fax, or e-mail ***in advance of*** the sales meeting, if feasible. Exceptions include*:
 - When the prospective member requires same-day service
 - When the scheduled meeting is attended by unexpected guests
 - When an agent meets with “walk-ins”****Any such exception must be documented by the agent and submitted to the Plan***
- Locate the Scope of Appointment form on plan’s website. Simply download and print, or order in quantity through the plan’s supply ordering site

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Scope of Appointment: Paper Process

Paper Scope of Appointment requirements:

- Agent: **must** complete and sign the form and send it to the prospective member
- Prospective member: **must** sign and date the form and return to agent
- If enrollment does *not* occur: agent **must** retain the form for 10 years
- If enrollment does occur: agent **must fax** the form to the company

WATCH THE CLOCK! Scope of Appointment forms must be faxed within 24-hours of a completed online enrollment.



- Direct mail cards must contain all CMS-required information in order to be used in lieu of Scope of Appointment form

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Scope of Appointment: Telephone Process

This year, the telephone Scope of Appointment process must be conducted by the Plan, **not** by the agent. Agents may satisfy this requirement by using the plan's SOA line. When using plan's SOA line, there's no need to mail, retrieve, submit, or preserve the paper Scope of Appointment form.

Note: Plan SOA processes will vary from plan to plan

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2011 Enrollment

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Enrollment Timeline

- CMS requires **immediate** processing of enrollments
 - **Enrollments must be submitted within 24 hours**
- CMS requires plans to transmit enrollment transactions **within 7 days of receipt**
- CMS requires plans to send an enrollment acknowledgement letter to the new member **within 10 days** of receipt



WATCH THE CLOCK! Delays will stall enrollment processing and may result in non-compliance with CMS regulations and/or member complaints.

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Benefits of Clean Enrollments

- Faster processing
- Improved member experience and satisfaction
 - Reduced “buyer’s remorse”
 - Greater “word of mouth”
- Higher member retention
- Fewer member cancellations
- More timely commission crediting
- Fewer administrative requirements resulting in more time for new sales

Even the smallest mistakes can result in processing and commission delays. Proofreading and validation will save you time and money.

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Applicable Enrollment Materials

It is critical to fax all applicable materials with, or immediately following, your enrollments. Applicable items may include:

- Scope of Appointment form (if not using telephone process)
- Bank information and voided check
- Proof of Health Care Power of Attorney
- Proof of non-renewal/loss of coverage
- Medicare entitlement information
- New Member Acknowledgement Form

WATCH THE CLOCK! These forms must be faxed within 24-hours of a completed enrollment. Mark each document with the enrollment confirmation number.



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Applicable Enrollment Materials

Requirements:

- Scope of Appointment form
 - Submit this form if not using telephone Scope of Appointment process
- Bank information and voided check
 - PAC/ACH form
- Proof of Health Care Power of Attorney
 - Spouse, child, friend, or other person
 - Signature required
- Proof of non-renewal/loss of coverage
- Medicare entitlement information
- New Member Acknowledgement Form

Paper Enrollments

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Completing Paper Enrollment Forms

MA and PDP enrollment forms include:

- Plan selection
- Original Medicare I.D. card/contact information
- Payment method
- Answers to important questions
 - ESRD status
 - Resident of LTC facility or nursing home
 - Enrollment in Medicaid
 - Employment status
 - Other prescription drug coverage
- Primary Care Selection (for network plans)
- Member signature and date
- Power of Attorney/Authorized Representative information
- Agent signature, date, ID number, more

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New Member Education & Verification Call

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New Member Acknowledgement Form

- A New Member Acknowledgement Form is available in plans' enrollment kits This form **must** be completed for all enrollments

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New Member Education & Verification Call

Following MA and PDP enrollments, The Plan will call prospective members as part of the New Member Education & Verification Call process, as required by CMS.





- Education & Verification Calls are conducted:
 - To confirm that prospective members understand their enrollment in the plan
 - To assist prospective members in better understanding plan benefits
 - To ensure that prospective members understand how to access benefits timely
- At the completion of enrollment, agents are **required** to notify prospective members of the pending Education & Verification call

“What Happens Next?”




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Next Steps After Enrollment

Steps	Description
 Education & Verification Phone Call	This required call is issued to the prospective new member to ensure that he or she understands the plan in which he or she has enrolled
 Receipt of Enrollment is Confirmed	Member receives acknowledgement letter with ID card to confirm receipt of enrollment
 Member ID Card Mailed	Member receives ID card for use at provider office or pharmacy once his or her plan becomes effective
 Medicare's Confirmation of Enrollment	Member receives letter from Medicare to confirm his or her plan enrollment

Next Steps After Enrollment

Steps	Descriptions
 Welcome Kit	Member receives package containing important plan information
 Welcome Call	Member receives this welcome call and is offered the opportunity to ask questions about his or her plan. The member may be asked some general health questions to determine how best to serve his or her needs
 Personal Health Survey Phone Call	Member receives this call if he or she does not complete the Personal Health Survey included in the Welcome Kit

Avoid Member Complaints

What does CTM mean?

- CTM is the acronym for ‘Complaint Tracking Module’ – This is the CMS tracking system for complaints that come in through 1-800-MEDICARE
- We refer to the actual complaints as CTMs
- In conjunction with other performance measures, CTMs are used by CMS to assign customer service ratings, which are referred to as STAR ratings

Top Member Complaints to CMS

1. Deceptive Marketing Practices
2. Misrepresentation
3. Inappropriate Enrollment
4. Inappropriate Disenrollment
5. Incorrect Premium Quoted or communication that there will be No Premiums
6. Provider is not in the Network
7. Medicare Prescription (Part D) Card did not work at Pharmacy
8. Duplicate Enrollments

Deceptive Marketing Practices

- Appointments
 - Use only approved Medicare Advantage Leads
 - Use Scope of Appointment every time
- Seminars
 - Use only approved materials with registered events
- Scripts
 - Do not modify

Approved plan material may NOT be modified. If you require clarification on any script, please contact your compliance partners.

Misrepresentation

- Distinguish between products and how the selection of a particular product may impact the beneficiary
- Difference between Original Medicare and Medicare Advantage
 - Medicare Supplements and Medicare Advantage
 - Differences between HMO, PPO and PFFS

Inappropriate Disenrollment

- Clearly explain to the beneficiary that disenrollments may not occur outside of specified enrollment periods
- Demonstrate the importance of the “lock in” period and that, subject to a special election exception, they may not disenroll between April 1st and the following AEP election period
- Never encourage a beneficiary to avoid paying premiums or to make inaccurate claims to 1-800-Medicare in order to be disenrolled
- The verification call may not be used to “close the sell”

Provider Not in the Network

- Verify the doctors or hospitals that the beneficiary selects are in the network by visiting universalamerican.com
 - During the sales call, do not indicate that the can add doctors or hospitals
 - Inform prospective members that they are required to work within the network of the plan and will likely have a higher cost-share if they go out of network
 - Educate the beneficiary on the use of the provider and pharmacy locator tool (per plan)
- Thoroughly explain the prior authorization and referral processes to beneficiaries
- Please do not imply that we are able to automatically add doctors or hospitals. This process is lengthy and some providers may choose not to participate

Complaints CMS Receives About Agents

- “My Agent lied to me”
- “My Agent pressured us to enroll”
- “My doctor does not accept the plan”
- “My Agent said he’d get my doctor in the network”
- “My Agent did not have an appointment - just showed up”

Examples of Misrepresentation

- “I just wanted information and did not (or did not intend to) enroll”
- “I thought it was a Medicare Supplement”
- “I did not know this would replace my Original Medicare (or didn't know Medicare would no longer be paying my bills)”
- “I thought it included Prescription Drug Coverage (MA only plans)”
- “I did not know it was an HMO”

Preventing Member Complaints - During the Appointment

- Use practical techniques to make sure your client clearly understands what you're saying before closing the sale – Ask clarifying questions
 - “Based on our discussion, what do you expect to pay each month for your coverage?”
 - “Do you understand the difference between how Medicare Advantage and Original Medicare work?”
- Take the extra time during the sale to make sure the prospective member with Medicare clearly understands the plan
- Provide clear, concise answers to members' questions during the appointment. If you are unsure, don't be embarrassed to ask for help
- Don't rush the appointment – the client must be comfortable with their choice before you leave
- Be willing to walk away!
 - No pressure sales are worth more than the CTM that comes from pressure
- Close well and always *“Do the Right Thing”*

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Preventing Member Complaints - After the Sale

- Call the member to thank them for their business. Demonstrate that you care about their choices and their health care
- Respond in a timely manner to member's concerns (e.g., answer their phone calls within 24 hours)
- Facilitate any access-to-care issues immediately with the plan (e.g., pharmacy will not fill a prescription)
- Coordinate calls with the plan to discuss and resolve issues raised by the member. Escalate appropriately to the plan's Appeals & Grievances team

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Preventing Member Complaints

Always...

- Treat each interaction with a prospective member or a current member as if they may be a “secret shopper”
 - Plan’s will have Secret Shoppers in the field during the 2011 sales season
- If you are not confident with the information you are providing, please ask!
- Treat each customer with courtesy and kindness - take the extra time during and after the sale to help them feel comfortable with you as well as the product they are selecting/have selected for their health care
- Encourage members to call the plan’s Member Services before calling 1-800-Medicare
- **Always “Do the Right Thing”**

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How to Make Complaints & CTMs History

- Set appropriate expectations with the client
- Always do the right thing for the client
 - Be prepared to walk away from appointment if it's in the members best interest
- Always encourage prospective members and active members to take their time and make their own decisions
- Represent your company well
- If you don't know an answer or need help, ask
- Always leave the client with your phone number & our customer service number. Encourage them to contact you if they have any questions or concerns.
- Always do your best!

Dual Eligible and Low Income Subsidy Beneficiaries

The Benefits of Low Income Programs

- Low-Income Programs can ease the burden of costs related to having Medicare
 - Help paying coinsurance and copays for prescription drugs
 - Coverage through the coverage gap
 - No late enrollment penalty
 - Qualify for a Special Election Period (SEP)
- There are a variety of programs to assist.
- **Every individual's situation is different.**
 - The Special Sales Unit (SSU) is here to help!

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Medicare	Medicaid	Medicare Savings Programs	Low Income Subsidy also known as “Extra Help”	SPAPs (State Pharmaceutical Assistance Programs)
Federal Government Program	Joint Federal and State Government Program	Joint Federal and State Government Program	Federal Government Program	State Funded Program
Eligibility based on age (65) or disability	Eligibility is “means-tested” – people must meet certain income and resource criteria to be eligible	Eligibility is “means-tested” – people must meet certain income and resource criteria to be eligible	Eligibility is “means-tested” – people must meet certain income and resource criteria to be eligible	Eligibility is “means” and “age” tested
Program is uniform for all states	Program is state specific	Program is state specific	Program is uniform for all states	Program is state specific . All states do not have SPAPS
Provides partial medical coverage and services such as transportation, dental and hearing benefits	Provides medical coverage and services such as transportation, dental and hearing benefits	3 different programs – all cover the costs of Medicare Part D and automatically qualify you for the Low Income Subsidy	Provides assistance to Part D premiums and drug co-pays	Pay premiums, deductibles, copayments and/or provide coverage during the gap



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Medicaid

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Medicaid

- Medicaid is a public health insurance program for eligible individuals and families with low incomes and assets. It is a “means tested” (based on income and assets) program that is jointly funded by the state and federal governments, and is managed by the States
- Medicaid varies in every state. Medicaid qualification requires an application with the State agency that administers Medicaid in the residents state
- People with Medicare who also receive Medicaid are often referred to as “**Dual Eligible**” or “**Duals**” we will refer to them all as one classification: **Low Income Beneficiaries (LIBs)**
- Some States may ask the person with Medicaid to pay a copayment for medical/drug services
- Most States have annual recertification requirements

Mandated Medicaid Benefits

- **Early and Periodic Screening, Diagnosis, and Treatment**
- **A program of regular medical and dental checkups for persons under age 21 which includes treatment of any conditions identified as medically necessary**

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Optional Medicaid Health Benefits

- Optional Services (at the discretion of each State) Podiatry, Optometrists' services and eyeglasses, Chiropractic services, Private duty nurses, Dental services for people over 21, Physical therapy, Occupational therapy and transportation services
- Medicare Advantage plans may subsidize some of the benefits not covered by Medicaid.

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Medicare Savings Programs

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Medicare Savings Programs (MSPs)

- MSPs are different in every state. The individual must apply in the state of residence through the State agency that administers Medicaid.
- MSPs have higher income thresholds than Medicaid
- **Medicare Savings Programs –**
Provides assistance for Medicare Part B premiums and co-insurance associated with Part B of Medicare
- **MSPs pay for some of the costs associated with Medicare**
 - Monthly Part B premiums (\$110.50 in 2011) & penalties
 - Automatic enrollment in the Low Income Subsidy
 - Deductibles and coinsurance/co-payments
- **Eligibility based on income**
 - Higher income levels than full Medicaid
- They are typically referred to as **“partial-duals” unless they are getting Medicaid, as well, then they are referred to as “full dual-eligibles”**
 - **We classify this group as simply Low Income Beneficiaries (LIBs)**
- Most States have annual MSP recertification requirements

Extra Help (Low Income Subsidy)

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Extra Help (Low Income Subsidy- LIS)

- LIS is a Federal Program that began with Part D in 2006 as part of the Medicare Modernization Act
- LIS Provides assistance for Part D premiums and copayments
- LIS Determination
 - LIS eligibility and coverage level is determined by the Social Security Administration, people with Medicare can apply on-line at SSA.gov
 - Depending on Income levels a person may receive Full Extra Help (Full LIS) or Partial Extra Help (Partial LIS). Partial Extra Help pays for a percentage of premium assistance and has higher copayments
 - **People who have Medicaid or a Medicare Savings Programs automatically qualify for Full Extra Help and do not have to apply separately**
 - Starting in 2010(MIPPA) all people who apply for LIS will automatically be screened for an MSP

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Extra Help (Low Income Subsidy)

- Applies only to covered Part D drugs. Plan formulary & coverage rules apply
- Does NOT apply to Medicare Excluded Medications
 - Many State Medicaid programs or State Pharmaceutical Assistance Programs (SPAPs) cover some excluded medications (e.g., benzodiazepines, cold/cough medicines)
 - If the member has Medicaid or an SPAP, these claims should be submitted to the appropriate State Agency
- Does NOT apply to covered Medicare Part B Medications or Diabetic Supplies, even if purchased at a pharmacy

Extra Help (Low Income Subsidy) Income Chart

Countable Income

Premium Subsidy

Less than or equal to 135% of FPL **and** resources are less than or equal \$6,600/individual (\$9,910/couple)

100% (Full LIS)

Less than or equal to 135% of FPL **and** resources exceed \$6,600/individual (\$9,910/couple) but do not exceed \$11,010/individual (\$22,010 couple)

100% premium subsidy (but less help with co-pays and deductibles) (Partial LIS)

Greater than 135% FPL, but not more than 140%

75% (Partial LIS)

Greater than 140% FPL, but not more than 145%

50% (Partial LIS)

Greater than 145% FPL, but less than 150%

25% (Partial LIS)

150% or more

None

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A Closer Look at SPAPs

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State Pharmaceutical Assistance Programs (SPAPS)

- State Pharmaceutical Assistance Programs help state residents pay for prescription drugs
- Coordinate with Medicare prescription drug benefit (Part D) to:
 - Pay premiums
 - Pay deductibles
 - Pay prescription copayments
 - Give coverage during the coverage gap (“doughnut hole”)
- Every SPAP is different, all of them now require Part D enrollment
- Not all States have an SPAP
- SPAP Assistance applies to Part D benefits only

SPAP Assistance Levels

- Varies by State
- Calculating Premium for MAPD plans for SPAP members
 - SPAP members will receive premium assistance for the Part D portion of their premium only
 - Refer to SPAP Premium Breakdown – 100% subsidy if on a “fee” or “premium only” SPAP program

SPAP and Plan Coordination

- Not all companies or plans coordinate with SPAP programs
- If a Part D or MAPD plan does not coordinate with a SPAP, the person with Medicare may lose the SPAP benefits when they enroll in that Part D or MAPD plan
- An agent **MUST** always check with the plan to verify whether or not the plan coordinates with the SPAP prior to enrolling people with Medicare into a Part D or MAPD plan

SEP for people with Medicare who belong to a Qualified SPAP or who lose eligibility

Individuals who belong to a qualified SPAP have one and only one time SEP to switch:

- From an MA-PD plan to a PDP or MA-PD plan
- From Original Medicare without a PDP to Original Medicare with a PDP or to an MA-PD plan
- From a PDP to another PDP or MA-PD plan or from an MA only plan (no prescription drug coverage) to a PDP or MA-PD plan

Once this effective date comes into play the person with Medicare is “locked-in” to the MAPD or PDP plan and may not make changes until the next AEP.

Individuals who lose SPAP Eligibility:

Individuals who are no longer eligible for SPAP benefits will have an SEP beginning with the month they lose eligibility plus two additional months to make an enrollment choice in another PDP or MA-PD.

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Questions to help determine status:

Question	Goal
What cards do you show your doctor or other providers?	May have coverage other than Medicare and/or Medicaid – such as Veterans Administration coverage, discount card or another carrier
Do you have end-stage renal disease?	If yes, the person is ineligible for Medicare Advantage. Note – UAM does offer Chronic Care Special Needs Plans in limited markets. These Special Needs Plans maybe appropriate for a person with ESRD
Do you pay your Part B premium?	If yes, the person does not have a Medicare Savings Program
Is \$96.40 automatically deducted from your monthly social security check?	If no, indicative of Medicare Savings Program , possibly Medicaid
Do you receive assistance from the state or qualify for Medicaid?	If yes, indicative of Medicaid coverage
Do you pay coinsurances or co-pays for your medical care?	If no, indicative of having Medicaid coverage

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Questions to help determine status:

Question	Goal
Are you enrolled in a Medicare Savings Program?	Indicative of Medicare Savings Program Status
Do you show a Medicaid card when you see your doctor or other providers?	Indicative of Medicaid coverage
Do you get “Extra Help” or assistance in paying for your prescription drugs?	Indicative of Extra Help also called the Low Income Subsidy (LIS)
Do you pay a premium for your prescription drug coverage?	If no, indicative of any low income assistance, Medicaid, or a Medicare Savings Program
How much of a co-pay do you pay for your prescription drugs?	<p>\$1.10 (for Generic) Indicative of Full Dual-Eligible</p> <p>\$2.50 (for Generic) Indicative of Partial Dual-Eligible (MSP or LIS)</p> <p>\$3.30 (for Brand-name) Indicative of Full Dual-Eligible</p> <p>\$6.30 (for Brand-name) Indicative of Partial Dual Eligible (MSP or LIS)</p> <p>15% of drug cost Indicative of Partial LIS</p> <p>Other Dollar Amount that is not a plan co-pay. Indicative of SPAP or other coverage. (SPAP is a State Assistance Program that has diff copays)</p>

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Questions?

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Thank You!

We appreciate your cooperation and your continued efforts to....

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