California Senior Medicare Patrol
and
Center for Medicare Advocacy

Webinar Series
MEDICARE ANNUAL ENROLLMENT PERIOD: UPDATES & CONCERNS

October 11, 2023

David Lipschutz
The Center for Medicare Advocacy is a national non-profit law organization that works to advance access to comprehensive Medicare, health equity, and quality health care for older people and people with disabilities.

- Founded in 1986
- Headquartered in CT and Washington, DC, additional attorneys in CA, MA, and MD
- Staffed by attorneys, advocates, a nurse consultant, and technical experts
- Provides education, legal analysis, writing and assistance
- Systemic change – Policy & Litigation, based on our experience with the problems of real people
- Inappropriate Medicare denials – and appeals
- Medicare/Medicaid Third Party Liability Projects
Agenda

▪ Background
▪ Informed Decision-Making
▪ Trade-Offs Between Medicare Advantage and Traditional Medicare
▪ 2024 Updates
▪ New Marketing Rules
▪ Senior Medicare Patrol (SMP) – California Health Advocates
▪ Q&A/Discussion
BACKGROUND
Overview Of Medicare

Four “Parts” of Medicare:

• **Part A** – Hospital Insurance
  Traditional or Original Medicare (Administered by Centers for Medicare and Medicaid Services - CMS)

• **Part B** – Medical Insurance
  - Supplemental Policies (e.g. Medigap Plans, Medicare Savings Programs, Retirement, VA/Military Plans)

• **Part C** – Medicare Advantage program – Private Insurance Companies
  - MA – Medicare Advantage Plan without Part D drug coverage
  - MA-PDs – Medicare Advantage with Part D drug coverage

• **Part D** – Prescription Drug Program – Private Insurance Companies
  - PDP – Stand-Alone Prescription Drug Plans
Medicare Enrollment Periods – Parts A and B

- **Initial Enrollment Period (IEP)** – first 7 months of eligibility
  - Before 2023, enrollment in last months could lead to 2+ month delay; now month after enrollment

- **General Enrollment Period (GEP)** – January through March
  - Before 2023, coverage not effective until July 1; now month after enrollment

- **Special Enrollment Periods (SEPs)**
  - Before 2023, limited to loss of employer-based coverage based on current, active employment
  - Now can include additional scenarios, including:
    - Loss of Medicaid
      - Important for redeterminations due to end of PHE
    - Health plan or employer error
    - For formerly incarcerated individuals
Medicare Enrollment Periods – Parts C and D

• Initial Enrollment Period (Part D), Initial Coverage Election Period (MA)

• **Annual Election Period** (Oct 15 – Dec 7, coverage effective Jan 1)

• Medicare Advantage – Open Enrollment Period (MA-OEP)
  • Jan – March of every year

• Special Enrollment Periods (SEPs) – various triggering circumstances
  • Eg, move, dually eligible, marketing misconduct, etc.
Annual Enrollment Period (AEP) aka “Open Enrollment”

• October 15 through December 7 (choice locks on Dec 7)

• An individual is eligible to enroll in an MA Plan OR to change from one MA Plan to another OR to change from an MA Plan to traditional Medicare

• Enrollment is effective on the first day of the next calendar year

• The AEP co-ordinates with the annual enrollment period for Medicare Part D, also effective on January 1 of the next year

• Medicare beneficiaries should look for insurance options on www.medicare.gov. (Do not look on the Market Place Exchange – Medicare is not open enrollment for Affordable Care Act insurance)
Medicare Advantage
Open Enrollment Period (MA OEP)

• Open enrollment takes place from January 1 – March 31, annually. Effective the first of the month after the change.

• Allows individuals enrolled in either an MAPD or an MA only plan, including newly MA-eligible individuals, to make a one-time election to go to another MA plan or to traditional Medicare.

• Individuals using the MA OEP to make a change may make a coordinating change to add or drop Part D.
Choice of Coverage is Unequal

- Unequal rights to choose coverage options
  - Can get in and out of an MA plan on an annual basis
    - Plus MA-OEP options, if begin year with MA – no similar opportunities to change a PDP
  - Medigap rights limited in most states
    - Limited periods when plans must sell to you
    - No federal right for individuals under 65
  - “Choice” promoted when searching for a plan, more limited once enrolled (re: who provides and what care you can get)
Some People Don’t Have a Choice

- Nearly 1 in 5 (18%) MA enrollees are in group plans through former employers, unions
  - Many don’t have a choice of other options if they wish to retain retiree coverage
    - KFF: almost 45% of employers offering MA plans do not give retirees the choice to keep other, non-MA coverage
INFORMED DECISION-MAKING: HOW DO PEOPLE GET THEIR INFORMATION?
Annual Changes

- Every year MA plans can change premium, cost-sharing (including out-of-pocket limit), coverage and coverage rules (including prior auth requirements), type and scope of extra benefits covered, provider networks, drug formularies, etc. (or even decide whether to continue offering a plan)
  - Part D plans can also change premiums, formulary, pharmacies, etc.
  - Entire system of choice relies on active, annual engagement of informed consumers maximizing coverage options
  - BUT most people don’t make changes to their coverage
Where Do People Get Information About Medicare?

- KFF (Nov. 2022): “Medicare’s Information Resources—Especially the 1-800 Medicare Toll-Free Number—Are Not Widely Used by Beneficiaries”
  - 7 in 10 reported that they either never called 1-800-MEDICARE or were aware it existed
  - 51% have never read, didn’t receive (or know if they had received) the Medicare & You Handbook
  - 56% reported they never visited medicare.gov or did not have access to internet or had no one to access it for them

- Commonwealth Fund “Traditional Medicare or Medicare Advantage: How Older Americans Choose and Why” (Oct. 2022)
  - About 1 in 3 Medicare beneficiaries – regardless of coverage—used insurance brokers or agents to choose a plan, compared with approximately 5% who used a State Health Insurance Assistance Program (SHIP).
Marketing

- KFF report (Sept. 2023) – 85% of ads during 2022 AEP were for MA plans
  - “Ads rarely mentioned traditional Medicare, or potential limitations with plan coverage, such as provider networks or prior authorization requirements, leaving beneficiaries with an incomplete view of their coverage options and the tradeoffs among them.”

- A companion KFF report surveyed beneficiaries and found that “[m]any participants said they relied on agents and brokers when making coverage decisions. Few used government resources, such as the Medicare Handbook or 1-800 Medicare, but those who did generally found them helpful”
Marketing MA Plans

  - During last year’s AEP, “Nearly all people age 65 and older said they received some plan marketing, with three-quarters seeing one or more television or online ads per day. One in three reported receiving seven or more phone calls per week.”
  - “Reports of seeing, reading, or receiving advertising information that was later found to be untrue were significantly more common among people with incomes of less than $25,000 than those with incomes above that level”; and “[a] larger share of Black adults than white adults reported unsolicited calls in the past 12 months” (88% vs. 76%)
  - “Switching from Medicare Advantage to traditional Medicare can be difficult. In most states, there are limited opportunities to purchase a Medigap policy without medical underwriting or denial of coverage. More than half of adults age 65 and older in our survey said they weren’t sure how easy or difficult it would be to switch (Exhibit 9). This suggests beneficiaries may choose their coverage without knowing they may not be able to change it easily if the plan they select doesn’t meet their needs [emphasis added].)”
Marketing Misconduct

- Aggressive Agent/Broker Behavior
  - Commission incentives – see, e.g., Commonwealth Fund (2021) - max. national commission for initial enrollment in MA plans in 2022 was $573 per beneficiary in most parts of the country vs. max. national commission for first-time Part D plan enrollment of $87; Also see, e.g. MedPage Today (Oct. 14, 2022) commissions for sales of MA plans can be twice as much compared to a Medigap plan

- In 2022, Medicare reported that beneficiary complaints about MA marketing more than doubled between 2020 and 2021; a review of complaints lodged with 1-800-MEDICARE found “numerous beneficiary complaints that they were not aware their current coverage, such as an existing MA plan, a Medigap plan, or their Tri-care plan, would end once they enrolled in an MA plan” and that in over 80% of marketing and enrollment audio calls the agency reviewed, “agents and brokers failed to ask pertinent questions to help a beneficiary enroll in a plan that best meets the individual’s needs.” (Proposed Part C&D Rule, Dec. 2022)
TRADE-OFFS BETWEEN MEDICARE ADVANTAGE & TRADITIONAL MEDICARE
Overview: Medicare Advantage Enrollment in 2023

- Kaiser Family Foundation (KFF): In 2023, 51% of eligible Medicare population is in MA
  - Average beneficiary has access to 43 MA plans
  - In 26 states, at least half of all Medicare beneficiaries are enrolled in MA
  - Nearly 1 in 5 (18%) MA enrollees are in group plans through former employers, unions
  - Enrollment is concentrated: UnitedHealthcare and Humana account for nearly half of all MA enrollees nationwide (47%)
Medicare Advantages Tradeoffs for Beneficiaries

Potential Advantages

• One stop shopping – no need for Medigap or separate Part D plan
• Lower premiums than Medigap; most pay no premium other than Part B
• Plans typically offer additional benefits (like dental)
• Plans have an out-of-pocket limit for benefits covered under Parts A and B
• Potential for better coordinated care

Potential Disadvantages

• Limited provider network
• Potential for higher out-of-pocket costs for certain services
• More utilization review than traditional Medicare
• No choice of separate drug plan to reduce drug costs
• Limited ability to switch back to traditional Medicare with Medigap
Many Factors to Consider When Choosing Among the Many Medicare Part D and Advantage Plans

**How Part D Plans Vary:**
- Premiums
- Deductibles
- Covered drugs
- Number of tiers
- Cost-sharing or coinsurance
- Tier placement (e.g., preferred or not)
- Preferred pharmacies
- Savings/cost of mail order
- Quality ratings

**How Medicare Advantage Plans vary:**
- Premiums, in addition to Part B premiums
- Cost-sharing for inpatient care and other Medicare-covered benefits
- Provider networks
- Extra benefits – scope of coverage
- Quality ratings
- Prior Authorization and other cost management restrictions
- All the same ways Part D plans vary
### Share of Medicare Advantage Enrollees in Plans with Extra Benefits by Benefit and Plan Type, 2023

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Individual Plans</th>
<th>Special Needs Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye exams and/or eyeglasses</td>
<td>100%</td>
<td>97%</td>
</tr>
<tr>
<td>Hearing exams and/or aids</td>
<td>99%</td>
<td>92%</td>
</tr>
<tr>
<td>Fitness</td>
<td>99%</td>
<td>95%</td>
</tr>
<tr>
<td>Telehealth</td>
<td>98%</td>
<td>96%</td>
</tr>
<tr>
<td>Dental</td>
<td>98%</td>
<td>88%</td>
</tr>
<tr>
<td>Over the Counter Benefits</td>
<td>90%</td>
<td>84%</td>
</tr>
<tr>
<td>Meal Benefit</td>
<td>78%</td>
<td>86%</td>
</tr>
<tr>
<td>Remote Access Technologies</td>
<td>73%</td>
<td>82%</td>
</tr>
<tr>
<td>Acupuncture</td>
<td>46%</td>
<td>51%</td>
</tr>
<tr>
<td>Transportation</td>
<td>44%</td>
<td>91%</td>
</tr>
<tr>
<td>In-Home Support Services</td>
<td>17%</td>
<td>31%</td>
</tr>
<tr>
<td>Bathroom Safety Devices</td>
<td>10%</td>
<td>15%</td>
</tr>
<tr>
<td>Part B rebate</td>
<td>10%</td>
<td>7%</td>
</tr>
<tr>
<td>Telemonitoring Services</td>
<td>4%</td>
<td>2%</td>
</tr>
</tbody>
</table>

**NOTE:** Dental includes plans that only provide preventive benefits, such as cleanings. Analysis excludes employer group health plans (EGHPs). Individual plans are plans open for general enrollment and exclude EGHPs and SNPs. There are about 19.6 million Medicare Advantage enrollees in non-EGHP and non-SNP plans. There are about 5.7 million Medicare Advantage enrollees in SNPs. **SOURCE:** KFF analysis of CMS Medicare Advantage Enrollment and Benefit Files, 2023.
Benefits

- MA Plans must offer benefits that are at least equal to traditional Medicare and cover everything traditional Medicare covers.
- MA Plans can waive certain restrictions on coverage (e.g. 95% of MA Plans don’t require 3-day prior hospital stay for SNF coverage).
- MA plans can provide extra benefits not available in trad. Medicare using rebate dollars (including bonus payments).
  - But plans are not required to report data about utilization of these benefits or associated costs, so it is not clear the extent to which supplemental benefits are used by enrollees (KFF).
MA Prior Authorization

- Nearly all MA enrollees (99%) are in plans that use prior authorization for some services - “most often required for relatively expensive services, such as Part B drugs (99%), skilled nursing facility stays (99%), and inpatient hospital stays (acute: 98%; psychiatric: 93%), and is rarely required for preventive services (7%)” (KFF, Aug. 2023)

- HHS Office of Inspector General (OIG)
  - 2018 Report – plans overturn 75% of prior auth and payment denials, but beneficiaries and providers appeal only 1% of denials
  - 2022 Report – among sample of 2019 denials, found 13% of prior auth denials met Medicare coverage rules, 18% of payment denials met rules
Provider Networks

- **HMOs** usually have no out-of-network coverage (other than emergency, urgent services)
- **PPOs** usually have out-of-network coverage at a higher cost to the beneficiary
- Network providers may choose to join or leave a network at any time; plans can also terminate providers at any time, whereas most enrollees are locked in for a year
- Plan networks may not always have adequate specialists or other providers to serve patient needs.
  - Online provider/hospital/supplier/network provider directories are not always accurate or updated
MA Enrollee Costs

- Many MA plans do not charge premiums, and unlike traditional Medicare, there is required out-of-pocket cap (MOOP) in MA plans, however despite MOOP, people in MA plans can pay more for care than those in trad. Medicare
  - A KFF report found that about half of all MA enrollees would incur higher costs than beneficiaries in traditional Medicare for a 7-day hospital stay (See report, Aug. 2022)
  - As the MOOP grows higher, the cost-benefit analysis of monthly premiums for a Medigap and PDP for someone in TM looks more favorable
- Among the conclusions of KFF reports analyzing beneficiary costs:
  - Rates of cost-related problems are higher among MA enrollees than those in traditional Medicare with supplemental coverage and “[a]mong Black beneficiaries specifically, a larger share of those in Medicare Advantage reported cost-related problems than those in traditional Medicare (32% vs. 24%).” (See report, June 2021)
MA Enrollee Costs

- Commonwealth Fund report (Sept. 2023)
  - While Medicare Advantage plans limit enrollees’ out-of-pocket expenses, often have lower premiums for Part D drug coverage, have the option of lower cost-sharing requirements, and typically include some coverage for dental care, **there doesn’t appear to be much difference between these plans and traditional Medicare with respect to affordability.** Adults age 65 and older in Medicare Advantage plans were as likely as those in traditional Medicare to report problems affording premiums and health care expenses, including dental care and prescription drugs, as well as problems with medical debt and bills” [emphasis added].
  - Among “[p]eople who incur high out-of-pocket costs from using health care […] [t]he likelihood of having problems paying medical bills or debt was significantly higher for older adults with Medicare Advantage than those with traditional Medicare.”
Take Away Messages

▪ It pays to compare your options
▪ Get the assistance of a trusted professional
▪ Be mindful of the main reason for health insurance - access to quality health care when you need it
▪ Take advantage of reviewing coverage during the Annual Enrollment Period each year
▪ Don’t be pressured by aggressive marketing & beware of scams!
2024 Updates
Medicare Resources

- *Medicare & You 2024* and other Medicare Materials
  - Continued improvement re: MA info and bias, but still work to do (see *CMA Alert*)
    - For example – [www.medicare.gov](http://www.medicare.gov) website – hard to find reference to MA prior auth
  - Email campaign
Medicare Plan Finder

- Medigap info will be reflected alongside other enrollments
- Inflation Reduction Act changes re: Part D –
  - Insulin copay cap now incorporated into drug searches (was not available in 2023)
  - $0 catastrophic phase cost-sharing = Part D out-of-pocket limit reflected in Plan Finder
    - In 2025, cap will lower to $2,000
  - $0 out-of-pocket reflected for covered vaccines also reflected
  - Elimination of partial LIS subsidy (in 2024 anyone who qualifies for LIS will get full LIS)
MA Maximum Out-of-Pocket (MOOP) Limit

KFF: in 2023, the average out-of-pocket limit for MA enrollees is $4,835 for in-network services and $8,659 for both in-network and out-of-network services (PPOs).

In general, the lower the MOOP, the higher the cost-sharing that can charged before reaching the MOOP
# 2024 MA MOOP Amounts

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Lower MOOP Limit (*50%)</th>
<th>Intermediate MOOP Limit (*40%)</th>
<th>Mandatory MOOP Limit (*30%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HMO</td>
<td>$0 - $3,850</td>
<td>$3,851 - $6,350</td>
<td>$6,351 – $8,850</td>
</tr>
<tr>
<td>Local PPO</td>
<td>$0 - $3,850 in network</td>
<td>$3,851 - $6,350</td>
<td>$6,351 – $8,850</td>
</tr>
<tr>
<td></td>
<td>Combined in-network</td>
<td></td>
<td>Combined $6,351 - $13,300</td>
</tr>
<tr>
<td></td>
<td>and out-of-network</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$0 - $5,570</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regional PPO</td>
<td>$0 - $3,850 in network</td>
<td>$3,851 - $6,350</td>
<td>$6,351 – $8,850</td>
</tr>
<tr>
<td></td>
<td>Combined $0 - $5,570</td>
<td></td>
<td>Combined $6,351 - $13,300</td>
</tr>
<tr>
<td>PFFS</td>
<td>$0 - $3,850</td>
<td>$3,851 - $6,350</td>
<td>$6,351 – $8,850</td>
</tr>
</tbody>
</table>
NEW MARKETING PROVISIONS
Marketing Rules

- The final rule makes a number of important changes to Medicare Advantage (MA) and Part D Communications and Marketing requirements. These provisions are now in effect.

- New rules apply to both how plans are marketed and described and certain agent/broker conduct, includes:
  - Reinstatement of time/distance separation between educational and marketing events
  - Required elements/topics that agents/brokers must discuss with beneficiaries prior to enrollment in MA or Part D plan
  - See CMA [Special Report](https://www.medicareadvocacy.org) for summary of new marketing rules (May 2023)
Advertising Limits

Include:

• Placing discrete limits around the use of the Medicare name, logo, and Medicare card.

• Prohibiting the use of superlatives (for example, words like “best” or “most”) in marketing unless the material provides documentation to support the statement, and the documentation is based on data from the current or prior year.

• Prohibiting marketing of benefits in a service area where those benefits are not available, unless unavoidable because of use of local or regional media that covers the service area(s).
Advertising Limits (cont’d)

• Requiring third-party marketing organizations (TPMOs) to list or mention all of the MA organizations or Part D sponsors that they represent on marketing materials.

• Prohibiting the marketing of information about savings available that are based on a comparison of typical expenses borne by uninsured individuals, unpaid costs of dually eligible beneficiaries, or other unrealized costs of a Medicare beneficiary.

• Modifying the Third Party Marketing Organization (TPMO) disclaimer to add State Health Insurance Assistance Programs (SHIPs) as an option for beneficiaries to obtain additional help, and to disclose the number of all entities the TPMO represents.
Plan Obligations

- Plans must:
  - Notify enrollees annually, in writing, of the ability to opt out of phone calls regarding MA and Part D plan business.
  - Have a searchable provider directory – “searchable by every element, such as name, location, and specialty, required in CMS’ model provider directory” and must also “include providers’ cultural and linguistic capabilities.” (p. 22249)
  - Simplify plan comparisons by requiring medical benefits be in a specific order and listed at the top of a plan’s Summary of Benefits (SB).
  - Have an oversight plan that monitors agent/broker activities and reports agent/broker non-compliance to CMS.
Education v. Marketing

- **Educational Events** “are meant to provide generic, factual, non-biased information about different coverage options” compared to **Marketing Events** where information designed to persuade beneficiaries to enroll in a particular type of plan (for example, MA–PD or Medigap), or in a plan offered by a specific organization is provided.

- CMS prohibits the collection of Scope of Appointment cards at educational events.

- CMS still allows agents to collect business reply cards (BRCs) at educational events, while prohibiting agents from setting up future marketing appointments at such events.
Agent/Broker

- CMS prohibits a marketing event from occurring within 12 hours of an educational event at the same location.
  - NOTE: this reinstates policy in effect prior to 2018 (requiring separation in time and distance between such events)
Agent/Broker Requirements

- Requiring 48 hours between a Scope of Appointment (SOA) and an agent meeting with a beneficiary, with exceptions for beneficiary-initiated walk-ins and the end of a valid enrollment period (e.g. last 4 days of AEP, MA-OEP, ICEP, SEP).
- Clarifying that the prohibition on door-to-door contact without a prior appointment still applies after collection of a business reply card (BRC) or scope of appointment (SOA).
Agent/Broker

- Limiting the time that a sales agent can call a potential enrollee to no more than 12 months following the date that the enrollee first asked for information.
- Limiting the requirement to record calls between third-party marketing organizations (TPMOs) and beneficiaries to marketing (sales) and enrollment calls.
- Clarifying the requirement to record calls between TPMOs and beneficiaries, such that it is clear that the requirement includes virtual connections such as video conferencing and other virtual telepresence methods.
Agent and Plan

- Agents must “explain the effect of an enrollee’s enrollment choice on their current coverage whenever the enrollee makes an enrollment decision.”

- **Pre-Enrollment Checklist (PECL)** – provided along with hard-copy enrollment forms, agents must review during telephonic enrollments
  - “Effect on current coverage” added to list of information plans must provide to prospective enrollees
  - Plan discretion re: whether agents/brokers read PECL in entirety or require each item be discussed
Agent/Broker Limitations

- **Separate from the PECL**, CMS has added a list of required elements agents and brokers must discuss with beneficiaries prior to enrollment in an MA or Part D plan.
- The final rule adds new language at 42 CFR §422.2274(c)(12) (for Part D, see §423.2274(c)(12)); MA organizations must: “(12) Ensure that, prior to an enrollment, CMS’ required questions and topics regarding beneficiary needs in a health plan choice are fully discussed. Topics include information regarding primary care providers and specialists (that is, whether or not the beneficiary’s current providers are in the plan’s network), regarding pharmacies (that is, whether or not the beneficiary’s current pharmacy is in the plan’s network), prescription drug coverage and costs (including whether or not the beneficiary’s current prescriptions are covered), costs of health care services, premiums, benefits, and specific health care needs.”
Resources: Choosing Between MA & Traditional Medicare

- See CMA “Choosing Between Traditional Medicare and Medicare Advantage” at: https://medicareadvocacy.org/choosing-between-traditional-medicare-and-a-medicare-advantage-plan/
More Detailed Info

- CMA webinars: 
  https://medicareadvocacy.org/webinars/
- “Medicare Enrollment Matters” webinar, 10/13/22 – more in-depth discussion of open enrollment: 
  https://attendee.gotowebinar.com/register/1886611744264195342
Senior Medicare Patrol -
Open Enrollment Scam Awareness

Tatiana Fassieux
Training and Education Specialist
California Health Advocates

October 11, 2023
Providing quality Medicare and related healthcare coverage information, education and policy advocacy.

Advocacy & Policy
Improving rights and protections for Medicare beneficiaries and their families

Education
Website, fact sheets and educational workshops

Senior Medicare Patrol
Fraud prevention education

California Health Advocates
www.cahealthadvocates.org
<table>
<thead>
<tr>
<th>PREVENT</th>
<th>DETECT</th>
<th>REPORT</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREVENT: SMPs provide focused outreach and messaging designed to protect Medicare beneficiaries from Medicare fraud.</td>
<td>DETECT: As local trusted connections in the community the SMPs are often the first to hear of new issues as they begin to emerge.</td>
<td>REPORT: SMPs provide in-depth one-on-one assistance to Medicare beneficiaries and other complainants.</td>
</tr>
</tbody>
</table>
“Guard the Medicare card”

Scammers do not discriminate between Original Medicare and Medicare Advantage enrolled beneficiaries. Their target is anyone with this Medicare card.
Top Complaints

1. Medicare Part C/D Communications & Marketing Violations
2. Billing Issues
3. Deceptive Hospice Enrollments
4. Medicare Card Phone Scam
5. DME Brace Scams
6. Genetic Testing Scams
7. COVID test kits

Keep an eye and ear on this!
Currently very prevalent
New Marketing Rules – Some of the “NO NO’s”

• advertisements that (1) do not mention a specific plan or (2) use the Medicare name or logo in a misleading way
• marketing of benefits in a service area where those benefits are not available
• the use of superlatives (e.g., words like “best” and “most”) in marketing unless the material provides documentation to support the statement and the documentation is based on data from the current or prior year
• Cold calls showing “Health Care” in caller ID or spoofing (pretending to be from a government source)

What advertising or media promotion have you seen that looks too good to be true OR does not align with the conditions above?

Call the Senior Medicare Patrol and report it!

• Call 1-855-613-7080 or Nationwide 877-808-2468
• Also we like to see samples of questionable promotion
Misleading Marketing
A way to get your Medicare number

Tri-fold mailer
Unemployment Benefits Guide??
Bait & Switch!
Fine print:
Insurance solicitation!

Looks like an IRS form!
Urgently marked postcards notifying beneficiaries of pending eligibility for free Medicare-covered back and/or knee braces.
Does this ad look right?

Does it mention which company it represents?

Published in the Sacramento Bee, Sunday October 8
Does this ad look right?

Does it mention which company it represents?
The Real Thing! Medicare.gov
Detect

Keep track of medical appointments
- Use journal or calendar

Medicare Summary Notice (MSN)
- Sent to FFS Medicare beneficiaries

Explanation of Benefits (EOB)
- Sent to MA members and beneficiaries with a Part D plan

Check statements for accuracy. Look for:
- Charges for services not rendered
- Charges for services different than those rendered (upcoding)
- Services/items charged twice
- Charges for services not ordered by primary care physician
What to Look Out For:

- **Keep track of medical appointments**
  - Use journal or calendar

- **Medicare Summary Notice (MSN)**
  - Sent to FFS Medicare beneficiaries

- **Explanation of Benefits (EOB)**
  - Sent to MA members and beneficiaries with a prescription drug plan

Check statements for accuracy. Look for:

- Charges for services not rendered
- Charges for services different than those rendered (upcoding)
- Services/items charged twice
- Charges for services not ordered by primary care physician
Report

Nationwide Toll-Free: 877-802-2468
California: 855-613-7080
Cold calls and TV ads that offer:
- attractive benefits
- may misinform the beneficiary about keeping their current providers and specialists

Mail about Medicare that:
- looks official, but has a small disclaimer saying they are not affiliated with CMS
- indicates a response is needed, urgent request

Call the local Health Insurance Counseling and Advocacy Program (HICAP) for free, unbiased Medicare info:
1-800-434-0222
cahealthadvocates.org

Scroll to the bottom of the page:

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First Name
Last Name
Last Name
Email address:
Your email address

Choose the news you’d like to receive

- Medicare Updates and More
- Fraud Alerts
- Upcoming Webinar Announcements

Sign up
Additional Resources for Advocates

State Departments of Insurance
- License insurance agents
- Can submit/report cases of agent or plan misbehavior
- File complaint against insurance agent

State Health Insurance Assistance Program (SHIP)
- Provide local Medicare counseling and help
- [https://www.shiphelp.org/](https://www.shiphelp.org/)
- In California, call 800-434-0222
THANK YOU!

• To report Medicare fraud:
  • in California: call 855-613-7080
  • Nationwide: call 877-808-2468
  • To find your state SMP:  
    https://smpresource.org/contact-us/
• Marketing rules: https://www.medicare.gov/health-drug-plans/health-plans/your-coverage-options/plan-marketing-rules

• California Health Advocates: 916-465-8104
  • https://cahealthadvocates.org/
Questions & Discussion
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