



6 STEPS OF MEDICARE ENROLLMENT

STEP THREE: Picking Specific Medicare Plans

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MEET YOUR PRESENTER:



Melinda A. Caughill, CSA

- Co-Founder of HeyMOE® and the i65® Medicare Software
- Professional Medicare educator
- Almost two decades of helping business and consumers make sense of Medicare
- Featured in national news media
- Speaker at national events for Charles Schwab, Raymond James, LPL, and more
- Melinda does NOT sell Medicare insurance

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CR Consumer Reports THE WALL STREET JOURNAL MORNINGSTAR U.S. NEWS & WORLD REPORT Forbes The Washington Post

I don't want to
be a Medicare
expert.

So, how can I
realistically help
my clients?

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Learn the **six steps**
of Medicare enrollment.

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Most people believe Medicare is a
three-step process:



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Medicare enrollment actually has
six steps. Here's what is missing:



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Let's look at all **six steps** of the
Medicare enrollment process.



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STEP ONE:
Check Your **Timing**.



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STEP ONE:

Check Your **Timing**.



Is it best for you to enroll at age 65 or delay Medicare?

DON'T MAKE ASSUMPTIONS!



Melinda's “Golden Rule” for Medicare

The only thing in Medicare that is true for everyone is...

...**NOTHING** in Medicare is true for everyone.



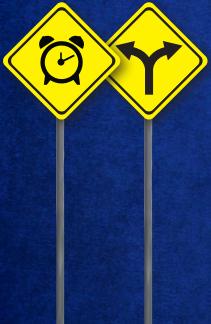
STEP TWO:

Choose Your **Medicare Path**.



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Choose Your **Medicare Path**.



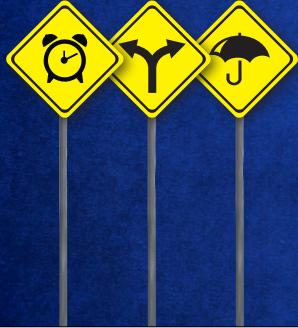
Which type of coverage is best for YOUR needs?

- Original Medicare with a Medigap
- Medicare Advantage
- Retiree coverage
- Military coverage
- Federal employee benefits



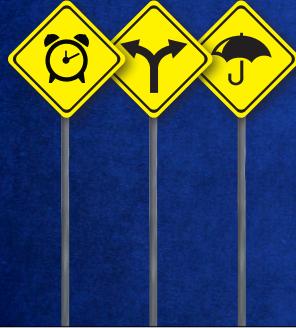
STEP THREE:

Select Your **Specific Plans.**



STEP THREE:

Select Your **Specific Plans.**



DON'T HURRY!

Wait until step
three to pick plans.



STEP FOUR:

Enroll in Medicare.

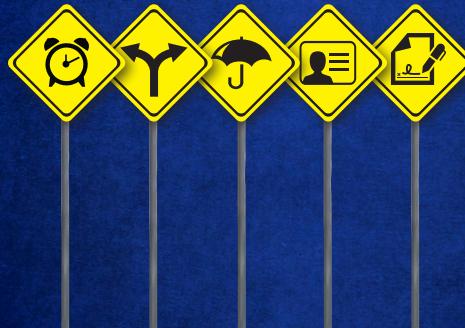


Through the
SocialSecurity.gov
website



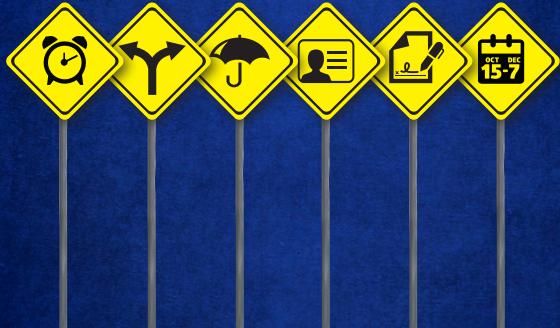
STEP FIVE:

Enroll in Your Specific Plans.



STEP SIX:

Review Your Coverage **Annually**.



STEP SIX:

Review Your Coverage **Annually**.

Each year, plans change.
Review your coverage options
or pay the difference.

**DO NOT PUT MEDICARE ON
AUTO-PILOT.**



THE IMPORTANT “STUFF”

*It's a **HUGE WIN** if you can just get
clients to understand that
Medicare is **NOT** all about
picking plans.*



Hospital Insurance

- Inpatient care in hospitals
- SKILLED nursing facilities
- SKILLED Home health care
- Hospice
- Premium-free for people who've paid taxes 10+ years





Medical Insurance



- Medically necessary services to diagnose or treat a medical condition
- Preventive services
- \$185.00/month per person
- Premiums are adjusted for higher-income people



Drug Coverage



- Administered by private insurance companies, not the government
- Only help cover the costs of prescription medications; expect co-pays



The two paths of Medicare



- Administered by the U.S. Government
- Also known as Traditional Medicare or Fee-for-service Medicare
- See any provider who accepts Medicare
 - **99% of physicians accept Medicare**
 - Including Mayo Clinic, Cleveland Clinic, etc.
 - Your doctors are in charge; Prior Authorization is rare

Physician Compare www.medicare.gov/care-compare
<https://www.kff.org/medicare/issue-brief/most-office-based-physicians-accept-new-patients-including-patients-with-medicare-and-private-insurance/>





- Starts with Part A, Part B
 - Part A: \$1,676 hospitalization deductible
 - Part B: 20% coinsurance on healthcare services
 - No out-of-pocket limit**
- For comprehensive coverage, add:
 - Medigap policy
 - Part D prescription drug plan

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A “Melinda Tangent”: MEDIGAP POLICIES & GUARANTEED ISSUE

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What is a Medigap policy?

- Also called a Medicare Supplement
- It is NOT health insurance—**It is COST INSURANCE**
 - It covers the payment “gaps” of Medicare
- Federally-standardized Plans A through N
 - Every standardized plan must provide **the same basic coverage regardless of carrier or price**
- MA, MN, WI use unique standardizations
- IMPORTANT** — A Guaranteed Issue Right ensures that you can get a Medigap policy

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Guaranteed Issue Right (GIR)

- Ensures that you can get a Medigap policy **without medical underwriting**
 - Insurance companies cannot deny coverage or raise premiums based upon your medical history
- This GIR begins when you are 65 or older AND enrolled in Medicare Part B
 - It lasts for six months or, depending on if you qualify, after 12 months after first enrolling in a Medicare Advantage plan
- Without a GIR, you may NOT be able to get OR change a Medigap policy, depending on the state**
 - You go through medical underwriting to get a policy

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Guaranteed Issue Right (GIR)

- Some states offer additional opportunities to make changes:
- "Birthday rules" (BR)** in CA, ID, IL, IN, KY, LA, MD, NV, OK, OR, UT, VA, WY give the ability to change policies in a specific period of time around your day of birth
- "Anniversary rules"** in MO allow you to change policies in a time period around the date you purchased your policy
- "Continuous open enrollment rules" (COE)** in ME, WA allow you to change policies any time during the year
- You must have an existing policy to change policies.**
 - Additional rules dictate which Medigap policies you may switch to without underwriting.



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Guaranteed Issue Right (GIR)

- States with Continuous Guaranteed Issue (CGI):
 - In NY, CT, get/change Medigap policies *at any time*:**
 - If you have a Medicare Advantage plan, you must be able to disenroll from that plan before getting a Medigap policy
 - Proposed in MN for 2026 start
 - In MA:**
 - Policies can offer CGI with new coverage beginning the first day of the next month after the change, OR
 - If not CGI, all carriers must participate in Medigap Open Enrollment Feb. 1-March 31 with the new coverage beginning June 1
 - In ME, CGI for Plan A only:**
 - If you have a Medicare Advantage plan, you must be able to disenroll from that plan before getting a Medigap policy



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- Pay a monthly premium for Part B, Medigap and the Part D drug plan
- Then have little to no out-of-pocket costs for healthcare services
- A predictable approach to receiving healthcare services and budgeting expenses**



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Parts A & B Costs are Identical on Either Path	
Part A	\$0 As long as you qualify
Part B	\$185.00
Medigap Policy	\$164
Part B Annual Deductible	\$257 (\$21.50 per month)
Part D Plan	\$36
Out-of-Pocket Healthcare Costs	Basically \$0

Original Medicare
TOTAL: About \$400



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Now let's look at the other path.



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- Medicare administered by a private insurance company:
 - Insurance companies are in charge
 - Identified by an insurance card



For Advocates. By Advocates®
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THE IMPORTANT “STUFF”

You do NOT have the government's Medicare when you choose Medicare Advantage.

You give that up.

Instead, you have Medicare provided by a private insurance company.



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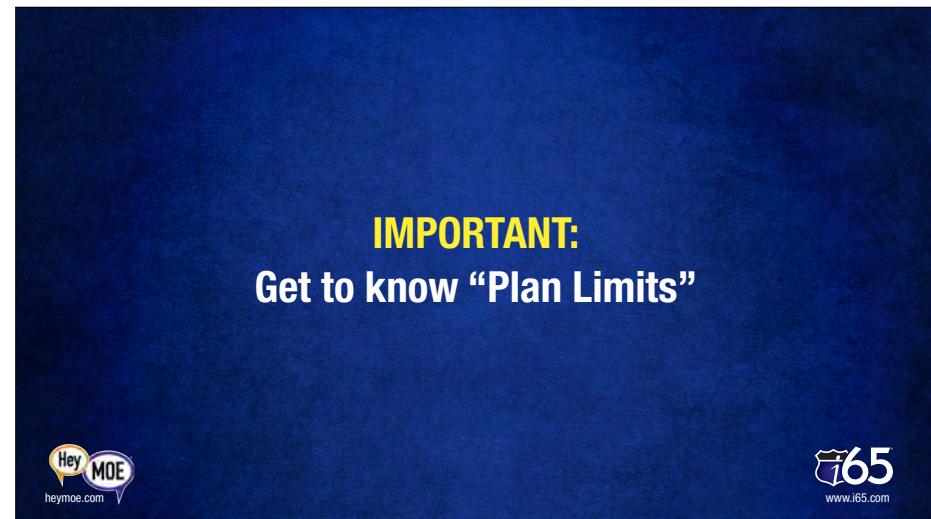
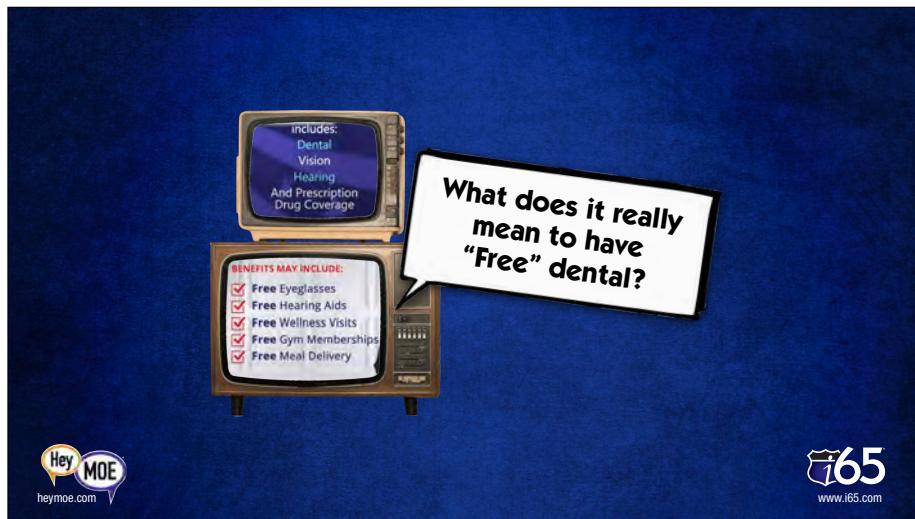
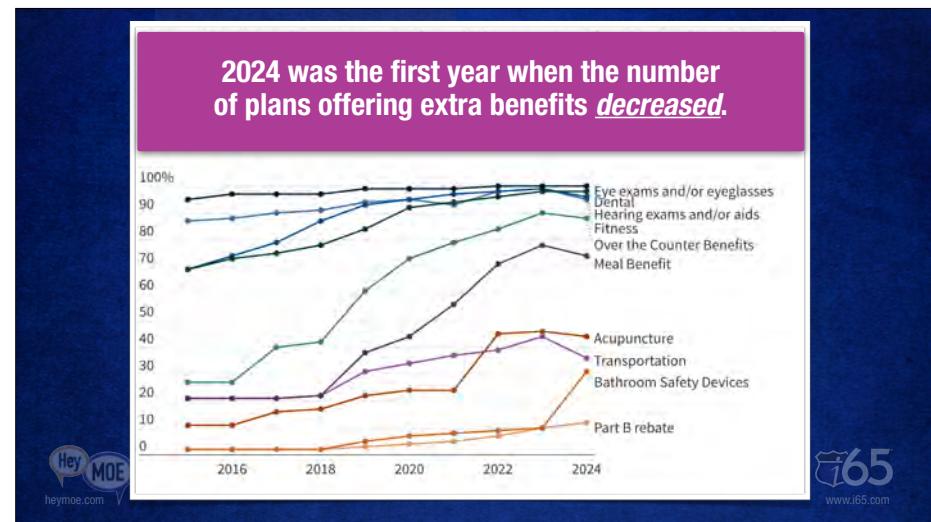
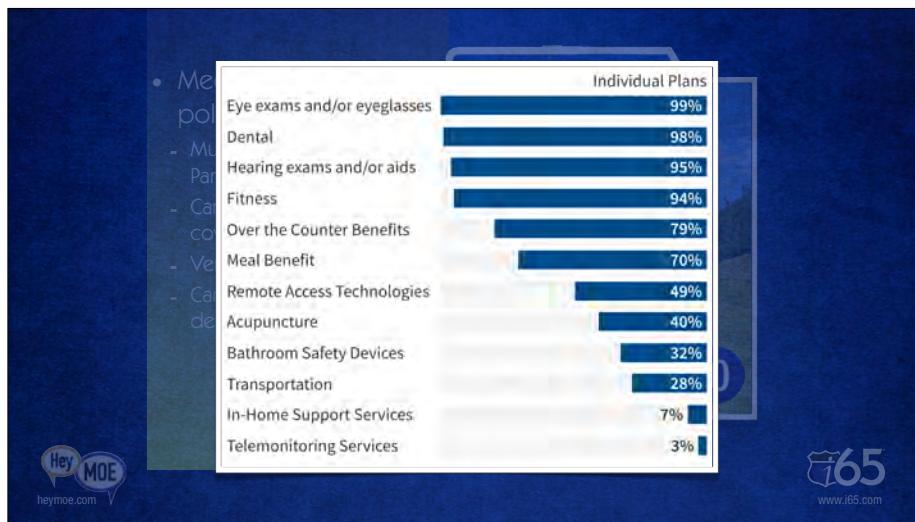


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- Medicare Advantage policies:
 - Must provide Part A and Part B services
 - Can include Part D coverage
 - Very low or no premiums
 - Can add vision, hearing, dental coverage



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THE IMPORTANT “STUFF”

“Don’t take your eye off the ball.”

Remember why any of us have health insurance. It’s for the big things, like cancer, strokes, heart attacks, etc.

Not for a free gym membership.

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- Medicare Advantage policies:
 - Must provide hospital and medical services
 - Can include drug coverage
 - Very low or no premiums
 - Can add vision, hearing, dental coverage
- Labeled Part C
- You must follow the rules to use the plan

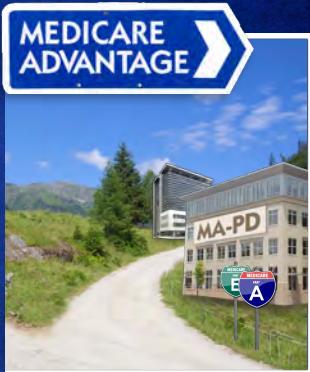
MEDICARE ADVANTAGE

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RULE #1

- Networks matter:
 - Networks can change at any time
 - Having out-of-network coverage does NOT necessarily mean you can see out-of-network providers...



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BECKER'S Hospital CFO Report

Updated Oct. 25, 2024

Physicians Leadership Strategy Executive Moves Transaction & Valuation IGLPs HR Capital Finance

Patient Experience Pharmacy Care Coordination Legal & Regulatory Compensation Payer Rankings

Financial Management

30 health systems dropping Medicare Advantage plans in 2024

Jakob Emerson - Updated 6 hours ago



Medicare Advantage plans are dropping at some hospitals and health systems, but administrative challenges are the main reason.

Among the most common reasons are administrative challenges, such as slow

In 2023, Becker's began reporting on hospitals and health systems nationwide that dropped some or all of their Medicare Advantage contracts.

Data on this topic is limited. In January, the Healthcare Financial Management Association released a survey of 135 health system CFOs, which found that 16% of systems are planning to stop accepting one or more MA plans in the next two years. Another 45% said they are considering the same but have not made a final decision. The report also found that 62% of CFOs believe collecting from MA is "significantly more difficult" than it was two years ago.

Updated to 45 systems across 25 states

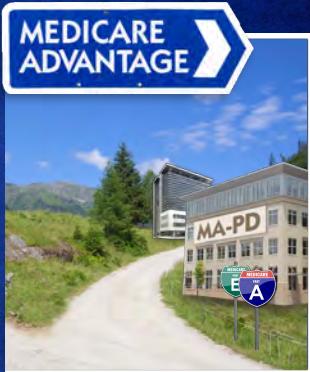
July 2025



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RULE #2

- Subject to prior authorization (PA) rules:
 - You must get PA from the insurance company before using services, especially costly ones like surgery, hospitalization, and skilled nursing stays
 - PA delays critical care
 - No PA means NO COVERAGE and NO SPENDING LIMIT applies



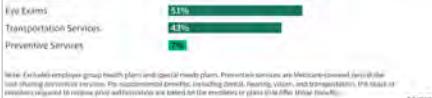
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RULE #2

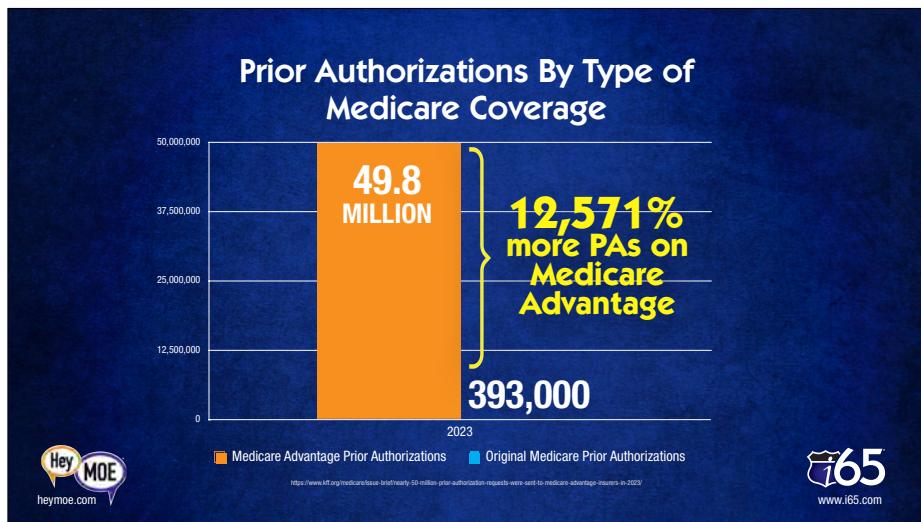
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Prior Authorization is used most often when patients are in dire need.

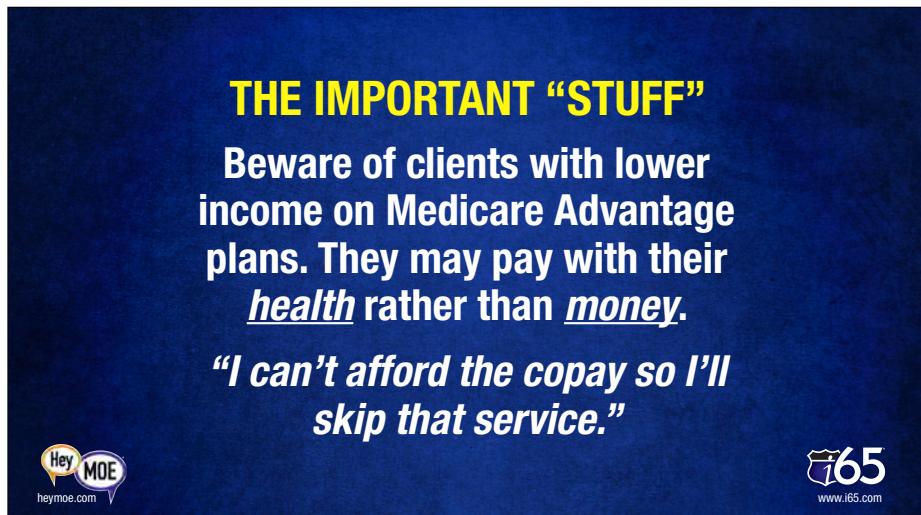
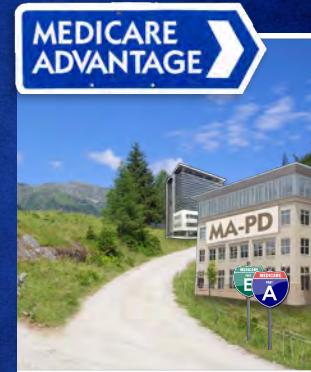


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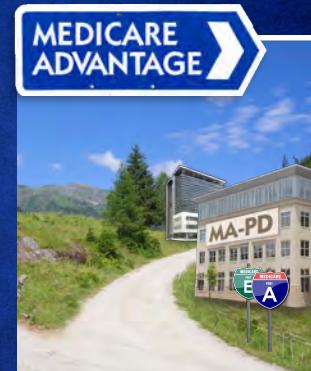


RULE #3

- Must pay deductibles, co-pays and coinsurances up to an out-of-pocket limit
 - 2025 max:
 - \$9,350 in-network
 - \$14,000 in- and out-of network
- Beware that these are not small limits



- Pay no monthly premiums but then pay every time you use healthcare services up to plan's spending limit
 - But, if you don't follow the rules, you will pay the full cost of the health care service
 - **The spending limit only applies when you follow the rules of the plan**



Parts A & B Costs are Identical on Either Path

Part A	\$0 As long as you qualify
Part B	\$185.00
MA-PD plan	\$0 – \$100+
Out-of-Pocket Healthcare Costs	???

You pay every time you use healthcare services up to the plan limit.

Medicare Advantage
TOTAL: \$185.00 – ??
Cost depends on total healthcare needs


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In 47 states:




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STEP THREE:
Choosing Specific Plans.



DON'T HURRY!
Wait until step three to pick plans.


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THE IMPORTANT “STUFF”

Check logic at the door!

So many things in Medicare just do not make sense. *Expect it to make sense at your own peril!*


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Step Three, Choose Plans:

Part D, Prescription Drug Coverage

- All drug coverage is provided and administered by private insurance companies in two ways
- A stand-alone Part D drug plan:
 - Those with Original Medicare Path or need drug coverage
 - Enrolled in Part A, Part B, or Part A and Part B
- A Medicare Advantage plan with prescription drug coverage (MA-PD plan): Enrolled in Part A and Part B



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Step Three, Choose Plans:

Part D, Prescription Drug Coverage

- Each plan has formulary, list of covered drugs
 - Plans do NOT have to cover all medications
 - Must cover all or “**substantially all**” protected drugs of six classes
 - Anticonvulsants, antidepressants, antineoplastics, antipsychotics, antiretrovirals, and immunosuppressants
 - Rebates for medications in protected classes are significantly less than other categories/drugs
 - For all the rest of the medications...



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<https://www.healthaffairs.org/doi/10.1377/hlthaff.2024.00273>

“Part D plan formularies include at least 2 drugs in the most commonly prescribed categories and classes.”

medicare.gov – www.medicare.gov/drug-coverage-part-d/what-medicare-part-d-drug-plans-cover



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Step Three, Choose Plans:

Part D, Prescription Drug Coverage

- In-network pharmacies can be either standard or preferred
 - Do not assume a preferred pharmacy costs are cheaper
- Costs:
 - Almost all standalone Part D plans have premiums
 - **Premiums average is \$46.50 in 2025**
 - Medicare Advantage plans often have low or no premiums
 - **Premiums average is \$7.00 in 2025**
- Cost sharing can be in the form of copayments or coinsurance
- Coverage rules can apply
 - Quantity limits, prior authorization, step therapy



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Step Three, Choose Plans:

Part D, Prescription Drug Coverage

- **Coverage:**
 - Find a plan to cover all prescribed medications, if possible
 - Evaluate the impact of any coverage rules
 - Confirm that your pharmacy is in-network and cost-effective
- **Cost:**
 - Compare TOTAL out-of-pocket costs — NOT monthly premium
- **Quality:**
 - Each plan receives an overall quality rating (five-star scale)
 - Choose a 2.5-star or higher plan whenever possible



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Step Three, Choose Plans:

Part D, Prescription Drug Coverage

Monthly Premium + Deductible + Copays at a **Specific Pharmacy** =



* Up to a \$2,000 out-of-pocket spending limit, (\$2,100 in 2026). The spending limit does not apply for medications that are not covered by the Part D plan.



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AARP Medicare Rx Preferred from UHC (PDP)	Humana Premier Rx Plan (PDP)	Cigna Healthcare Saver Rx (PDP)
\$103.50 Monthly premium	\$128.90 Monthly premium	\$12.60 Monthly premium
Enroll Plan Details	Enroll Plan Details	Enroll Plan Details
★★★★☆	★★★★☆	★★★★☆
\$103.50	\$128.90	\$12.60
\$0.00	\$0.00	\$590.00
4 of 4 Prescription drugs covered. Restrictions may apply.		

AARP Medicare Rx Preferred from UHC (PDP)
\$103.50
Monthly premium

Humana Premier Rx Plan (PDP)
\$128.90
Monthly premium

Cigna Healthcare Saver Rx (PDP)
\$12.60
Monthly premium

Step Three, Choose Plans:

Medicare Advantage Plans

Coverage:

- Check that physician networks
- Confirm that drugs are covered, pharmacies in-network
- Evaluate impact of any coverage rules, value of benefits

Cost:

- Ignore the monthly premium; focus on the costs for necessary services and maximum limit

Quality:

- Star ratings are controversial for Medicare Advantage plans

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Step Three, Choose Plans:

Medicare Advantage Plans



Part B premium (minus any "giveback") + Monthly Premium + Any Health and/or Part D Deductible + Health Service Copays/ Coinsurance + Drug Copays at a **Specific Pharmacy** = 

*** Up to a maximum out-of-pocket spending limit, but the spending limit does not apply if you do not follow plan rules**

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A "Melinda Tangent":

Star Ratings

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Star Ratings & Medicare Advantage

- Star ratings are tied to Medicare Advantage “Bonus Payments”
- **\$12.7 billion in Bonus Payments in 2025**, \$87 billion since 2015
- The Medicare Advantage Star Rating system suffers from:
 - Score inflation and overly generous bonuses as a result
 - Limitations in underlying data sets
 - Measures are focused on the needs of younger and healthier beneficiaries rather than beneficiaries facing serious illnesses
 - Performance not being measured at the plan or local level
 - Star ratings are ultimately not useful for choosing plans



https://www.medicare.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun20_ih3_reporttocongress_sec.pdf
<https://medicareadvocacy.org/medicare-advantage-plans-receive-bloated-bonus-payments-with-little-to-show-for-it/>



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AARP UHC Part D Drug Plan - Ratings

Drug plan star rating

Drug plan customer service

Availability of TTY services and foreign language interpretation when prospective members call the drug plan

Member complaints & changes in the drug plan's performance

Complaints about the drug plan (more stars are better because it means fewer complaints)

Members choosing to leave the plan (more stars are better because it means fewer members choose to leave the plan)

Improvement (if any) in the drug plan's performance

Member experience with the drug plan

Members' rating of drug plan

Ease of getting prescriptions filled when using the plan

Drug safety & accuracy of drug pricing

1 Star Ratings for all Member Experience Categories



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Drug plan star rating

AARP UHC Medicare Advantage Drug Plan - Ratings

Availability of TTY services and foreign language interpretation when prospective members call the drug plan

Member complaints & changes in the drug plan's performance

Complaints about the drug plan (more stars are better because it means fewer complaints)

Members choosing to leave the plan (more stars are better because it means fewer members choose to leave the plan)

Improvement (if any) in the drug plan's performance

Member experience with the drug plan

Members' rating of drug plan

Ease of getting prescriptions filled when using the plan

Drug safety & accuracy of drug pricing

4 Star Ratings for the same Member Experience Categories



Bottom line:

Be wary of Medicare Advantage star ratings.

Talk to important doctors/hospitals about their experiences.



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Step Three, Choose Plans:
Medigap Policy (Medicare Supplement Insurance)

A Medigap policy is COST Insurance... NOT Health Insurance.

Once you choose a standard plan structure, it doesn't matter who the carrier is. The benefits are exactly the same.

Step Three, Choose Plans:
Medigap Policy (Medicare Supplement Insurance)

- Coverage of these plans is **standardized**
 - Every standardized plan must provide the same basic coverage regardless of carrier or price
 - Insurers can add "Wellness Benefits" at no additional cost OR with an additional amount added into the premium
- Medicare Open Enrollment does not give you extra abilities to change Medigap policies
 - In 25 states, medical underwriting is required to change plans
- **"You date your drug plan/Medicare Advantage plan, but you marry your Medigap policy"**

Your Out-of-Pocket Costs of Original Medicare		MEDIGAP POLICY COVERAGE DETAILS									Not Available to New Beneficiaries ¹	
		PLAN A	PLAN B	PLAN D	PLAN G ¹	PLAN K	PLAN L	PLAN M	PLAN H	PLAN C	PLAN F	
Hospitalization Deductible \$1,876 per benefit period		100%	100%	100%	100%	50%	75%	50%	100%	100%	100%	
Hospitalization Copayments Days 1-60: No cost Days 61-90: \$419 per day Days 91-150: \$838 per day		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Hospice Care Coinsurance: 5% for inpatient respite stay		100%	100%	100%	100%	50%	75%	100%	100%	100%	100%	
Part A (Hospital Insurance) Costs & Benefits												
Part B Annual Deductible: \$257 ²		—	—	—	—	—	—	—	—	100%	100%	
Part B Service Coinsurance: 20% of allowed amount after deductible		100%	100%	100%	100%	50%	75%	100%	100% ³	100%	100%	
Part B Excess Charges: Physical plans who do not accept Medicare assignment can charge up to 15% more than what Medicare covers. ³		—	—	—	100%	—	—	—	—	—	100%	
Part B (Medical Insurance) Costs & Benefits												
Skilled Nursing Facility Stay Copayment: Days 1-20: No cost Days 21-100: \$209.50 per day		—	—	100%	100%	50%	75%	100%	100%	100%	100%	
Blood: First three pints: 100+		100%	100%	100%	100%	50%	75%	100%	100%	100%	100%	
Foreign Travel Expenses: Up to 30 days for medically-necessary emergency care outside the U.S. within the first 60 days of a trip. Deductible of up to \$250. Lifetime limit of \$50,000.		—	—	✓	✓	—	✓	✓	✓	✓	✓	
2025 Out-of-pocket Limit ⁴		—	—	—	—	\$7,220	\$3,610	—	—	—	—	

Step Three, Choose Plans:
Medigap Policy (Medicare Supplement Insurance)

Choosing a Medigap policy is about choosing a plan with the **lowest price today AND the lowest potential for premium increases in the future.**

Step Three, Choose Plans:

Medigap Policy (Medicare Supplement Insurance)

- Premium increases are derived from:
 - The size and health of the risk pool (the people enrolled in a plan)
 - The profitability of the plan
 - Plans show profitability in Medical Loss Ratios (MLR)
 - Medigap carriers must have a minimum loss ratio of 65%
 - The higher an MLR is above 65%, the higher the next premium increase will be
 - The policy pricing structure (Attained Age, Issue Age, Community-rated)

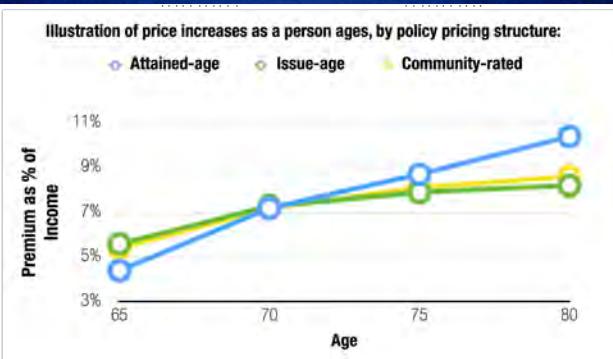
Step Three, Choose Plans:

Medigap Policy (Medicare Supplement Insurance)

- Attained-Age rated plans** have lower premiums for younger beneficiaries but increase every year as one “attains” a new age (having a birthday).
- Issue-Age rated plans** have premiums based upon the age you were when the policy was issued to you and cannot increase because you increased in age.
- Community-rated plans** have premiums based upon the overall health of the “community” enrolled in the plan. Many insurers offer special discounts to attract new members that reduce over time, meaning these plans often resemble attained-age-rated plans.

Illustration of price increases as a person ages, by policy pricing structure:



Age	Attained-age (%)	Issue-age (%)	Community-rated (%)
65	4.5	5.5	6.0
70	7.0	7.5	7.5
75	8.5	8.0	8.0
80	10.5	8.5	8.5

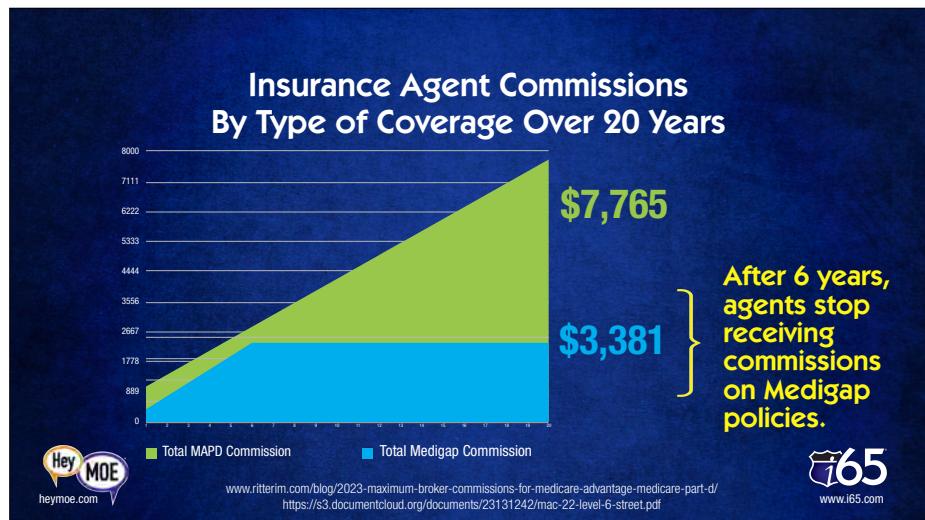
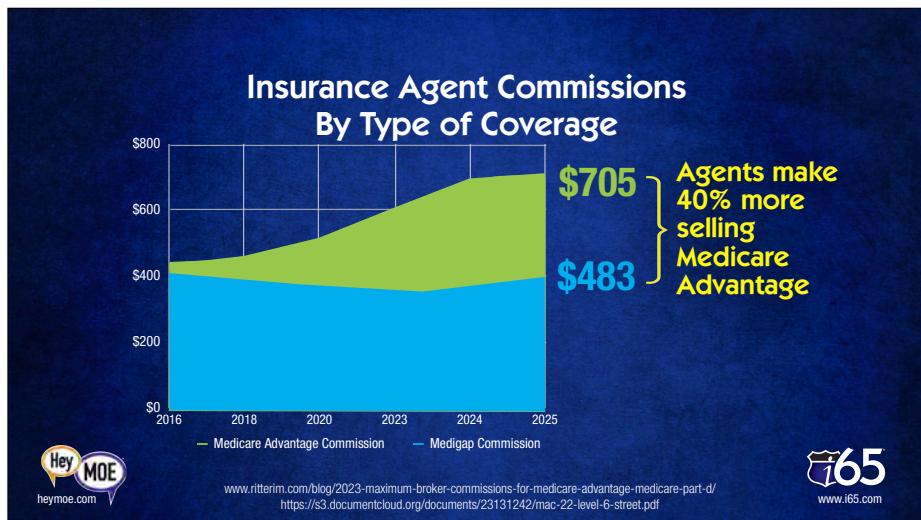
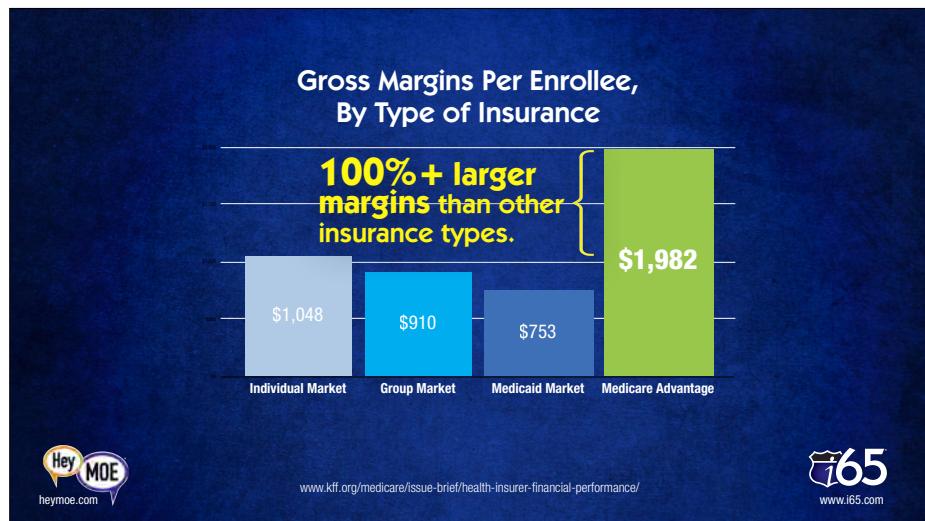
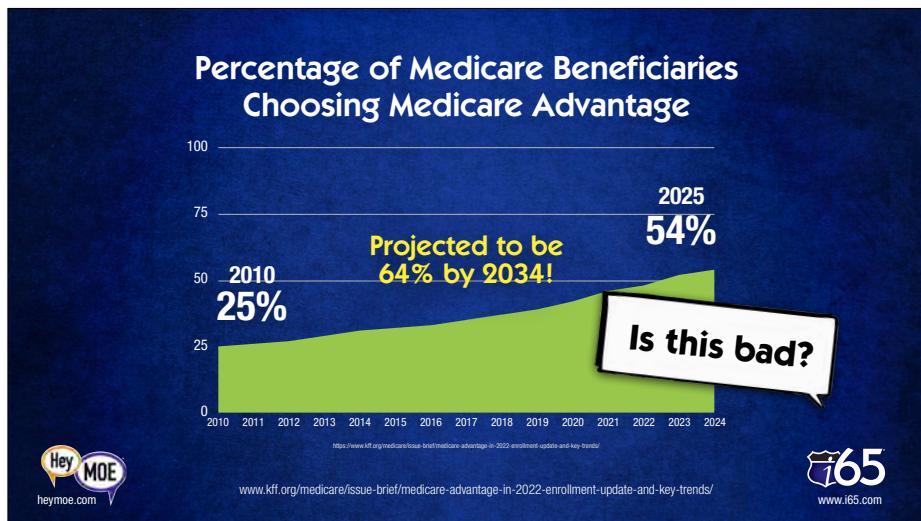
 



I'll just send my clients to Medicare insurance agents.

OK. But, did you qualify that agent first?





This does not mean Medicare Advantage plans or insurance agents are “bad”...

It means that the business of Medicare insurance sales incentivizes agents to promote one type of product over another, **regardless of what may actually be in the consumer's best interest.**



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Tips to Qualify an Insurance Agent:

1. Do you sell Medicare Advantage, Part D and Medigap policies?
2. What is your sales ratio of Medicare Advantage v. Medigap policies?
3. How many companies are you allowed to sell?
4. Pay attention during the sales conversation.
 - Does the agent prioritize discussions about low monthly premiums and extra free benefits? (**Not good.**)
 - Does the agent talk about today only, stating that you can always change your coverage later on? (**Not good.**)
 - Does the agent talk about provider networks, medication formularies, prior authorization, and Guaranteed Issue Right? (**Good!**)



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