OFFICE of the INSURANCE COMMISSIONER
SHIBA WASHINGTON STATE

SHIBA MA OEP CE workbook

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Statewide Health Insurance Benefits Advisors (SHIBA)

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Message from the SHIBA CTC

Dear Volunteers,

As the curriculum & training coordinator (CTC), I deeply value your input in shaping effective training materials. Your feedback is crucial as we strive to refine and enhance resources to better support you in your role as Medicare counselors.

This workbook is designed to build your skills and knowledge through case scenarios and activities that encourage reflection and discussion. You are welcome to focus on the sections most relevant to your experience and expertise—there's no need to study all the material. Please take time to engage with the parts that interest you, jot down your insights, and share your thoughts during our sessions.

Your dedication to learning makes a meaningful difference in the lives of beneficiaries. Thank you for your commitment and for being an integral part of our team. I look forward to hearing your feedback and suggestions!

Best regards,

Elena Garrison
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Medicare Open Enrollment

ACTIVITY 1: MEDICARE OPEN ENROLLMENT EXPERIENCE

Objective: To help you reflect on your experiences with Medicare Open Enrollment and identify strategies to address common challenges.

Instructions:

1. **Think**: Reflect on a time when you assisted a beneficiary during the Medicare Open Enrollment period.

What challenges did you face?	How did you overcome them?

What worked well?	Why do you think it worked so well?

2. **Pair**: Share your thoughts with other volunteers. Discuss the strategies you used to address these challenges.

What challenges did others face?	How did they overcome them?

What worked well?	What did not work well?

3. **Share**: After discussion with other volunteers, write down two or three key strategies that you found most effective in overcoming the challenges you faced.

Challenges	Effective strategies

Medicare Advantage Open Enrollment

Medicare Advantage Open Enrollment (MAOE) Period runs from January 1 through March 31. It's for people who are already enrolled in a private Medicare Advantage plan (with or without drug coverage).

During the MAOE, people with Medicare Advantage plans can:

- **Choose a different Medicare Advantage plan**

For individuals who enrolled in a Medicare Advantage (MA) plan during the Medicare Open Enrollment Period (OEP) but are dissatisfied with their choice, this period offers an opportunity to change to a different MA plan.

It may be their final chance to switch plans until the next Open Enrollment Period, unless they qualify for a Special Enrollment Period (SEP).

- **Switch to traditional Medicare & enroll in a stand-alone Part D plan**

It may be their final chance to switch plans until the next Open Enrollment Period, unless they qualify for a Special Enrollment Period (SEP).

NEW COVERAGE START DATE

The new coverage will start the first day of the month after a beneficiary applies to join a plan.

Example:

Maria applies to join a new Medicare Advantage plan on February 10. Her new coverage will begin on March 1, the first day of the month following her application.

Counselor corner: Plan details

Medicare Advantage plans can limit access to specific doctors and medications, making it crucial for beneficiaries to understand plan details. However, research

shows that most people do not compare their Medicare coverage options during the Open Enrollment Period[1].

Encourage beneficiaries to carefully review their options and remind them to contact their current healthcare providers to confirm they are in the plan's network.

Counselor corner: Medicare.gov accounts

Encourage clients to create a Medicare.gov account, even if they don't actively use the internet. The account provides several important benefits, including features that can be highly useful during counseling sessions:

- Access to their medication history.
- The ability to save medication lists.
- Easy retrieval of usernames and passwords.
- Reordering and printing Medicare cards.

Loss of coverage: MA plan leaves Medicare or the service area

If someone loses their Medicare Advantage (MA) coverage, they enter a Special Enrollment Period (SEP) to switch to a new plan or enroll in Original Medicare.

If they don't join another Medicare Advantage Plan before their current plan ends, they will be enrolled in Original Medicare (they still need to get Part D coverage & possibly Medigap).

[1] https://www.kff.org/medicare/issue-brief/what-to-know-about-the-medicare-open-enrollment-period-and-medicare-coverage-options/#:~:text=People%20who%20are%20enrolled%20in,access%20to%20providers%20and%20costs.

KEY POINTS TO REMEMBER[2] SEP:

- **Medigap[3]:** The Special Enrollment Period (SEP) to join a Medigap starts as early as 60 calendar days before their coverage ends, but no later than 63 calendar days after their coverage ends. Their Medigap can't start until their MA plan ends. There is **no pre-existing condition wait period.**
- **MAPD or Part D[4]:** The Special Enrollment Period (SEP) to join a Medicare Advantage Plan with drug coverage or a stand-alone Medicare Part D drug plan begins the month the individual is informed their coverage will end. This SEP lasts either:
    - Two months after the individual loses their coverage, or
    - Two months after they receive notice, whichever occurs later.

EXAMPLE: SEP DUE TO LOSS OF COVERAGE

John is a Medicare beneficiary whose Medicare Advantage Prescription Drug (MAPD) plan ends effective December 31, 2024. Unfortunately, John didn't read the letters his plan sent him about this change, so he was unaware of the termination until after it happened. On January 1, 2025, John was automatically enrolled in Original Medicare (Parts A and B), but he now needs to address his drug coverage and Medigap options to avoid gaps in care and financial penalties. Alternatively, John can enroll in a new MAPD plan.

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[2] https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods#:~:text=Your%20chance%20to%20join%20lasts%202%20full%20months%20after%20the,What%20can%20I%20do%3F

[3] https://www.insurance.wa.gov/sites/default/files/documents/what-you-need-to-know-medigap-plans_6.pdf https://www.insurance.wa.gov/sites/default/files/documents/medicare-supp-plans_76.pdf

[4] https://www.medicareinteractive.org/pdf/SEP-Chart.pdf

Here are the deadlines John must meet:

Medigap Special Enrollment Period:

John has through February (63 days starting January 1, 2025) to get a Medigap policy.

- If John applies for Medigap during this period, there will be no pre-existing condition waiting period since this is a guaranteed issue right.
- If John misses his Medigap SEP, he may face a pre-existing condition waiting period, or his application for a Medigap policy could be denied.

Part D Special Enrollment Period:

John's SEP will remain open until February 28, 2025 (two months after he lost his MAPD coverage).

- If John chooses a new plan during this SEP, the coverage start date will depend on when he enrolls. For example, if he enrolls in a Part D plan on February 15, 2025, his drug coverage will begin March 1, 2025.
- If John misses the SEP deadline, he should be aware that a Part D late enrollment penalty may apply if he experiences a gap of more than 63 consecutive days without creditable drug coverage. Unless he qualifies for a new SEP, his next opportunity to enroll will be during the Open Enrollment Period from October 1 to December 7, 2025.

Part D penalty[5]:

Medicare calculates the Part D late enrollment penalty by multiplying 1% of the "national base beneficiary premium" ($36.78 in 2025) by the number of full, uncovered months the individual did not have Part D or other creditable drug coverage. The resulting amount is rounded to the nearest $0.10 and added to the individual's monthly Part D premium.

[5] https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/part-d-late-enrollment-penalty#:~:text=How%20much%20is%20the%20Part,increase%20or%20decrease%20each%20year.

Part D counselling reflections

ACTIVITY 2: PART D PRESCRIPTION DRUG COVERAGE

Instructions: Write down the different topics you typically discuss with beneficiaries regarding prescription drug coverage and resources you used.

Topics	Resources

Share your feedback with us.

How easy was it to find the helpful resources?

How can SHIBA help?

Part D in 2025

Counselor corner: Plan Finder in 2025

To learn more about new Pan Finder features, please see the following video published by CMS: https://www.youtube.com/watch?v=ISaNFdfvGQw&t=4s

MEDICARE.GOV PLAN FINDER AS A RESOURCE

You can find explanations for various *Medicare* concepts in the Plan Finder by looking for underlined blue text, accompanied by an information icon or words with a dashed underline

2025 Part D structure (phases)[6]

A significant update this year is the introduction of a $2,000 out-of-pocket maximum for beneficiaries, along with the Medicare Prescription Payment Plan. These changes will be reflected in drug costs when comparing plans using the Plan Finder.

In CY 2025, the structure of Part D benefit includes the following three phases:

- Annual deductible.
    - This is the amount an enrollee must pay each year for their prescriptions before their Medicare drug plan pays its share.
        - In some plans that do have a deductible, drugs on some tiers are covered before the deductible.
    - Deductibles vary between Medicare drug plans. No Medicare drug plan may have a deductible more than $590 in 2025.
        - Some Medicare drug plans don't have a deductible.

[6] P.34 https://www.cms.gov/files/document/final-cy-2025-part-d-redesign-program-instructions.pdf
Also see Appendix A

- Initial coverage:
    - The enrollee pays 25 percent coinsurance for covered Part D drugs.
    - The plan typically pays 65 percent of the costs of applicable drugs and 75 percent of the costs of all other covered Part D drugs.
    - The manufacturer, through the Discount Program, typically covers 10 percent of the costs of applicable drugs.
    - This phase ends when the enrollee has reached the annual OOP spending threshold of $2,000.
- Catastrophic coverage (after enrollee reaches $2000 OOP).
    - The enrollee pays no cost sharing for Part D drugs.

Key points about the Part D $2,000 out-of-pocket

WHAT COUNTS AND WHAT DOESN'T

This cap includes all Part D costs for covered (on plan's formulary[7]) medications, including deductibles, copayments, and coinsurance as well as certain payments made through Extra Help program. It's a True-Out-Of-Pocket cost (TrOOP).

Items that don't count toward and getting through the coverage gap include:

- The drug plan premium
- What the plan pays toward the pharmacy dispensing fee
- What beneficiary pays for drugs that aren't covered

Once client reaches the TrOOP $2,000 limit, they enter the "catastrophic coverage" phase where they pay nothing **for covered** Part D drugs.

[7] **Formulary** A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits.

TRUE OUT-OF-POCKET VS OUT-OF-POCKET COSTS

“TrOOP" refers to the total amount a beneficiary pays towards their prescription drug costs that counts towards reaching the catastrophic coverage phase, while "OOP" simply means "Out-of-Pocket" and represents the total amount a beneficiary pays directly for their prescriptions, which may not include all payments considered towards TrOOP, like manufacturer discounts or certain third-party assistance programs; essentially, TrOOP is a more comprehensive calculation of out-of-pocket costs that determines when a person enters the catastrophic coverage phase in Medicare Part D.

Thus, most Medicare beneficiaries will not actually spend $2,000 before they reach the catastrophic limit.

ENTERING CATASTROPHIC PHASE PRIOR TO HITTING THE $2,000 CAP

Even if a beneficiary hasn't spent $2,000 out-of-pocket, they might be considered to have reached the catastrophic phase based on the higher calculated TrOOP.

Example: Entering the catastrophic phase
A Medicare beneficiary, Alice, is enrolled in a **Part D Plan** for her prescription drug coverage. Alice has been filling several prescriptions under her plan. Her actual out-of-pocket spending for prescriptions is $1,500.

Alice’s Prescription Costs:

- **TrOOP Calculation**: When Alice’s spending is calculated, her true out-of-pocket spending is **$2,000**, even though her actual out-of-pocket costs are only $1,500. This is due to the way her plan calculates TrOOP.
- **Early Entry into Catastrophic Coverage**: Because the TrOOP calculation shows that Alice has spent $2,000, she’s considered to have reached the catastrophic phase, even though her actual out-of-pocket costs $1,500 are below $2,000. As a result, Alice enters the catastrophic phase early.
- **Plan Finder Display**: On the Medicare Plan Finder, it now shows that Alice has reached catastrophic coverage, which would indicate that she should not pay any additional drug costs for the remainder of the year.

Impact on Alice:

Alice's remaining drug costs for the year are **zero**, even though she actually spent only $1,500 out-of-pocket.

HOW IS TROOP AFFECTED IF A PERSON SWITCHES MEDICARE DRUG PLANS?[8]

Drug plans keep track of their enrollees' TrOOP costs. When a person switches plans during the year, his or her TrOOP balance transfers to the new Medicare drug plan. Medicare has established processes for transferring the TrOOP balance.

Example: Deductibles and TrOOP when switching plans
Maria disenrolls from a plan that had no deductible, and then joins a new plan that has a deductible of $275. The coinsurance or copayments Maria paid during the initial coverage period in her former plan and what the plan paid will all count toward the deductible in the new plan.

Although what the former plan paid counts toward the new plan's deductible, those payments won't count toward Maria's TrOOP. But all the TrOOP costs accumulated in the former plan will transfer to the TrOOP balance the person will start accumulating in the new plan.

How it works:

- Maria was enrolled in Plan X, which had no deductible.
- She switches mid-year to Plan Y, which has a $275 deductible.

While in Plan X:

- Maria filled a prescription with a total cost of $100.

[8] https://www.cms.gov/files/document/11223-ppdf#:~:text=The%20coinsurance%20or%20copayments%20the%20person%20paid,toward%20the%20deductible%20in%20the%20new%20plan.&text=But%2C%20all%20the%20TrOOP%20costs%20accumulated%20in,will%20start%20accumulating%20in%20the%20new%20plan.

- Maria paid $25 as a copayment (this counted toward her TrOOP).
- Plan A paid the remaining $75.

After switching to Plan Y:

- The $75 that Plan X paid for Maria's prescription is credited toward Plan Y's deductible.
  - This reduces Maria's new deductible from $275 to $200.
- However, the $75 does not count toward Maria's TrOOP because it wasn't paid out-of-pocket by her.
- The $25 Maria personally paid for the prescription under Plan X does count toward her TrOOP and is carried over to Plan Y.

Counselor corner: TrOOP

Medicare tracks your costs:

Medicare keeps track of "True Out-of-Pocket Costs" (TrOOP) which means that even if a person switches plans mid-year, their progress towards meeting their deductible will carry over to the new plan.

Check with your new plan:

Remind beneficiaries to always confirm with their new Part D plan that it have properly applied their previous deductible progress.

If there's a discrepancy, a person may need to give a copy of their most recent EOB to the new plan to show the current TrOOP balance.

Drug coverage costs[9]

A beneficiary's actual drug coverage costs can vary based on several factors:

- The specific prescriptions they need and whether these drugs are included in their plan's list of covered drugs, or **formulary**.
- **The "tier"** in which their drug is categorized, as different tiers may have varying cost levels.
- The drug benefit **phase** they're currently in, such as whether they have met their deductible or reached the out-of-pocket limit.
- **The pharmacy** networks can significantly impact drug costs.
- Whether they qualify for **Extra Help** assistance with drug coverage costs.

Each of these elements plays a role in determining the final out-of-pocket cost for the beneficiary's medication.

FORMULARY

A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. All Medicare drug plans generally must cover at least 2 drugs per drug category, but plans can choose which drugs covered by Part D they will offer. A Medicare drug plan can make some changes to its drug list during the year if it follows guidelines set by Medicare.

FORMULARY TIERS

Formulary tiers are categories within a health plan's drug list (or formulary) that group medications by their cost and coverage level. Insurance companies and Medicare Part D plans use these tiers to determine how much a beneficiary will pay for a prescription. Each plan can divide its tiers in different ways. Medications are divided into these tiers based on factors such as their cost, effectiveness, and

[9] https://www.medicare.gov/drug-coverage-part-d/what-medicare-part-d-drug-plans-cover

whether generic or lower-cost alternatives are available. Generally, a drug in a lower tier will cost less than a drug in a higher tier.

Teir example:

- Tier 1—lowest copayment: most generic prescription drugs
- Tier 2—medium copayment: preferred, brand-name prescription drugs
- Tier 3—higher copayment: non-preferred, brand-name prescription drugs
- Specialty tier—highest copayment: very high-cost prescription drugs

Counselor corner: Formulary

1. Remind beneficiaries that all plans must provide written notice to affected members prior to the formulary change effective date. The written notice for a year and mid-year formulary changes must include the following information:

    - Name of the affected drug
    - Whether the drug is being removed from the formulary or changing its preferred or tiered cost-sharing status
    - Alternative drugs in the same therapeutic class or cost-sharing tier and expected cost-sharing for those drugs; and
    - How enrollees may obtain a coverage determination

2. Remind beneficiaries that each month they fill a prescription, their Medicare Prescription Drug Plan mails them an "Explanation of Benefits" (EOB). This notice gives them a summary of their prescription drug claims and costs.

Prescription Payment Plan[10]

The Medicare Prescription Payment Plan is a new payment option that works with the drug plan to help participants manage their out-of-pocket Medicare Part D drug costs by spreading them across the calendar year (January-December).

If a beneficiary selects this payment option, they will continue to pay their plan premium (if applicable) each month and will receive a bill from their health or drug plan to pay for prescription drugs, instead of paying the pharmacy directly.

PPP key features

- All plans offer this payment option and participation is voluntary. Program participants can also opt out at any point during the plan year.
- This payment option might help manage monthly expenses, but it doesn't save money or lower drug costs.
- A beneficiary's payments might change each month, making it difficult to predict the exact bill in advance. Future payments may increase when the beneficiary fills a new prescription (or refills an existing one) because as new out-of-pocket costs are added to the monthly payment, there are fewer months remaining in the year to distribute the remaining balance.

Counselor corner: PPP Enroll or not

MAY BE BENEFICIAL

A beneficiary is most likely to benefit from the Medicare Prescription Payment Plan if they incur high drug costs earlier in the calendar year. Although it is possible to enroll in this payment option at any time, starting earlier in the year provides more months to spread out drug costs.

[10] Please see Medicare Fact Sheet: https://www.medicare.gov/publications/12211-whats-the-medicare-prescription-payment-plan.pdf & SHIBA September 2024 Workbook for more information.

Beneficiaries can visit Medicare.gov/prescription-payment-plan/will-this-help-me to answer a few questions and determine if they are likely to benefit from this payment option.

MAY NOT BE BENEFICIAL IF:

- Their yearly drug costs are low.
- Their drug costs remain consistent each month.
- They are considering enrolling in the payment option late in the calendar year (after September).
- They prefer not to change their current method of paying for drugs.
- They receive or are eligible for Extra Help from Medicare.
- They receive or are eligible for a Medicare Savings Program.
- They receive assistance paying for drugs from other organizations, such as a State Pharmaceutical Assistance Program (SPAP), a coupon program, or other health coverage.

PPP EXAMPLE[11]

A beneficiary takes several high-cost drugs with a total out-of-pocket cost of $500 each month. In January 2025, the beneficiary enrolls in the Medicare Prescription Payment Plan through their Medicare drug plan or Medicare health plan with drug coverage:

[11] For more examples & Example 1 explanation, please see Medicare Fact Sheet: https://www.medicare.gov/publications/12211-whats-the-medicare-prescription-payment-plan.pdf

Example 1: Start participating in January with high drug costs early in the year			
Month	**Your drug costs** (without this payment option)	**Your monthly payment** (with this payment option)	**Notes**
January	$500	$166.67	This is when you started participating in this payment option. Remember, your first month's bill is based on the "maximum possible payment" calculation. We calculate your bill for the rest of the months in the year differently.
February	$500	$75.76	
March	$500	$125.76	
April	$500	$181.31	This month you reached the annual out-of-pocket maximum ($2,000 in 2025). You'll have no new out-of-pocket drug costs for the rest of the year.
May	$0.00	$181.31 *	*You'll still get your $500 drugs each month, but because you've reached the annual out-of-pocket maximum, you won't add any new out-of-pocket costs for the rest of the year. You'll continue to pay what you already owe.
June	$0.00	$181.31 *	
July	$0.00	$181.31 *	
August	$0.00	$181.31 *	
September	$0.00	$181.31 *	
October	$0.00	$181.31 *	
November	$0.00	$181.31 *	
December	$0.00	$181.31 *	
Total	**$2,000.00**	**$2,000.00**	**You'll pay the same total amount for the year, even if you don't use this payment option.**
If you're concerned about paying $500 each month from January to April, this payment option will help you manage your costs. If you prefer to pay $500 each month for 4 months and then pay $0 for the rest of the year, this payment option might not be right for you. Contact your health or drug plan for personalized help.			

Programs to lower drug costs

Many people qualify for savings and don't realize it. If a beneficiary has limited income and resources, they might be eligible for one of these programs:

Extra Help: A Medicare program that helps pay your Medicare drug costs.

- Visit ssa.gov/medicare/part-d-extra-help to find out if you qualify and apply.
- You can also apply with your State Medical Assistance (Medicaid) office.
- Visit Medicare.gov/ExtraHelp to learn more.

Medicare Savings Programs: State-run programs that might help pay some or all Medicare premiums, deductibles, copayments, and coinsurance.

- Visit Medicare.gov/medicare-savings-programs to learn more.

State Pharmaceutical Assistance Programs (SPAPs): Programs that might include coverage for Medicare drug plan premiums and/or cost sharing. SPAP contributions may count toward Medicare drug coverage out-of-pocket limit.

- Early Intervention Program for HIV & Aids patients https://doh.wa.gov/you-and-your-family/illness-and-disease-z/hiv/hiv-care-client-services/early-intervention-program

- See HCA website for more information on the Washington Prescription Drug Program (WPDP)

  https://www.hca.wa.gov/free-or-low-cost-health-care/get-help-paying-prescriptions

  https://www.hca.wa.gov/about-hca/programs-and-initiatives/prescription-drug-program

    - The Washington Prescription Drug Program (WPDP) Discount Card, ArrayRx, a state-sponsored program (www.arrayrxcard.com

Manufacturer Pharmaceutical Assistance Programs (sometimes called Patient Assistance Programs (PAPs)): Programs from drug manufacturers to help lower drugs costs for people with Medicare.

- Visit go.medicare.gov/pap to learn more.

Eligibility criteria vary by assistance program. It may include the following:

- Patient must be enrolled in Medicare.
- Patient cannot be enrolled in or qualify for any other federal, state, or government program such as Medicaid, Low Income Subsidy, or Veterans (VA) Benefits (with the exception of Medicare Part D).
- Patients with Medicare Part D must have spent at least 3% of yearly household income on out-of-pocket costs for prescriptions this year.

Additional sources of help can be found through the Needymeds site www.needymeds.org.

Special Enrollment Period (SEP)

There are other opportunities for Medicare beneficiaries to make coverage changes outside of the open enrollment periods. Some Medicare beneficiaries can make certain changes to their coverage at other times of the year. For example, beneficiaries who experience disruptions to existing coverage (such as a cross-county move or a loss of employer- or union-sponsored coverage) or changes in eligibility for Medicaid or other programs, may qualify for a Special Enrollment Period[12] at any time of year.

New 2025 Special Enrollment Periods (SEP) for dually eligible and Extra Help (LIS)-eligible individuals[13]

Individuals who are eligible for both Medicaid and Medicare are called dual-eligible beneficiaries. There are two types of dual-eligible beneficiaries[14]:

Partial-benefit dual-eligible beneficiaries

- Receive assistance with Medicare premiums and cost sharing through the Medicare Savings Programs (MSPs), but don't receive full Medicaid benefits.

Full-benefit dual-eligible beneficiaries

- Receive full Medicaid benefits through other pathways, and may also receive assistance through the MSPs

[12]Special Enrollment Periods https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods

[13]New Special Enrollment Periods (SEPs) for Dually Eligible and Extra Help-eligible Individuals https://cmsnationaltrainingprogram.cms.gov/sites/default/files/shared/2025%20SEPs%20for%20dual%20and%20LIS%20individuals%20job%20aid_Final.pdf

[14] Dually Eligible Individuals – Categories https://www.cms.gov/medicare-medicaid-coordination/medicare-and-medicaid-coordination/medicare-medicaid-coordination-office/downloads/medicaremedicaidenrolleecategories.pdf

Extra Help (LIS)-eligible beneficiaries

The Social Security Administration (SSA) determines eligibility for Medicare Part D Extra Help, also known as the Low-Income Subsidy (LIS).

THE NEW DUAL/LIS SEP

The dual/LIS SEP will allow full-benefit dually eligible individuals (QMB+, SLMB+, FBDE), partial-benefit dually eligible individuals (QMB, SLMB, QI, QDWI), and Extra Help-only eligible individuals to make a once-per-month election into Original Medicare and a standalone prescription drug plan (PDP). It will also allow a once-per-month election to switch between standalone PDPs. This replaces the quarterly dual/LIS SEP.

THE NEW INTEGRATED CARE SEP

The integrated care SEP will allow full-benefit dually eligible individuals (QMB+, SLMB+, FBDE) a once-per-month election into a D-SNP.

The table shows who's eligible to use the dual/LIS SEP and integrated care SEP.

SEPs	LIS-only eligible individual	Partial-benefit dual	Full-benefit dual
Dual/LIS SEP	✓	✓	✓
Integrated care SEP	x	x	✓

The table below shows the plans that may be selected using the dual/LIS SEP and integrated care SEP.

SEPs	Standalone PDP	Non-D-SNP Medicare Advantage	Highly integrated D-SNPs*
Dual/LIS SEP	✓	x	x
Integrated care SEP	x	x	✓

*There two D-SNPs categories in WA: highly integrated D-SNPs & coordination-only D-SNPs. The new monthly SEP is for integrated D-SNPs only. Most of WA D-SNPs are highly integrated. However, Humana D-SNPs are coordination-only D-SNPs, they are not integrated.

SEP Examples

Case #1

Mrs. Lee is a full dual-eligible beneficiary (Medicare and Medicaid) enrolled in a new standard Medicare Advantage prescription drug plan (MA-PD) last year during the Open Enrollment Period. She is not happy with her new plan and wants to know her options for switching plans in 2025.

Explanation

Mrs. Lee has several options for switching her Medicare Advantage Prescription Drug Plan (MA-PD) in 2025, given her dual-eligible status (Medicare and Medicaid). Below is a detailed explanation of her options:

1. Special Enrollment Periods (SEPs) for Full Dual-Eligible Beneficiaries

Mrs. Lee can make the following changes any month.

She can use her SEP to:

- Switch from her Medicare Advantage prescription drug plan (MA-PD) to traditional fee-for-service (Original) Medicare along with a standalone prescription drug plan (PDP).
- Switch her standalone Part D plan.
- Switch from a regular MAPD plan to a Dual-Eligible Special Needs Plan (D-SNP).

Note: Changes made during these periods will take effect on the **first day of the following month.**

2. Medicare Advantage Open Enrollment Period (January 1 – March 31, 2025)

If Mrs. Lee is dissatisfied with her current Medicare Advantage plan, she can:

- Switch to another Medicare Advantage plan (with or without drug coverage).
- Drop her Medicare Advantage plan and return to Original Medicare, with the option to enroll in a standalone Part D plan.

Changes take effect on the **first day of the month after the plan receives her enrollment request.**

3. Medicare Open Enrollment Period (October 15 – December 7, 2025)

During this period, Mrs. Lee can:

- Switch to a different MA-PD plan.
- Drop her MA-PD plan and return to Original Medicare with the option to enroll in a standalone Part D plan.

Changes made during this time will take effect on **January 1, 2026**.

4. Special Situations (Other SEPs)

Certain life events or changes in circumstances could trigger additional Special Enrollment Periods, such as:

- Moving out of her plan's service area.
- Losing Medicaid eligibility (though she would have a grace period to transition plans).
- Plans leaving the Medicare program.

Important consideration

By understanding these options, Mrs. Lee can make changes that better fit her needs throughout the year.

Note: Switching plans multiple times within the allowed periods could affect continuity of care, so it's wise to review provider networks and covered medications carefully.

Case # 2

Last year, Mr. Davis, who is a partial-benefit dual-eligible individual with **SLMB (Specified Low-Income Medicare Beneficiary)** status, switched his Medicare Advantage (MA) plan in the middle of the year and learned that because of his SLMB status, he could make changes quarterly. However, in 2025, he is confused by the new rules and wants to know if he can still switch plans every quarter.

1. Can Mr. Davis switch Medicare Advantage plans on a quarterly basis in 2025?

Answer: No, Mr. Davis is a partial-benefit dual-eligible individual, so he can no longer switch Medicare Advantage plans on a quarterly basis in 2025.

However, he can make the following changes any month:

- Switch from his Medicare Advantage prescription drug plan (MA-PD) to traditional fee-for-service (Original) Medicare along with a standalone prescription drug plan (PDP).
- Switch his standalone Part D plan.

2. When is Mr. Davis eligible to switch standard Medicare Advantage plans?

Answer: Mr. Davis can switch during Open Enrollment (October 15–December 7, 2025), the Medicare Advantage Open Enrollment period (January 1-March 31, 2025), or if he qualifies for one of the other SEP options available.

Case work: counseling session

Imagine a Medicare beneficiary named Maria who has been on a Medicare Advantage plan with drug coverage (MA-PD) for several years. Maria felt her plan was reliable and affordable. However, when she went to refill one of her regular prescriptions in January, she was shocked by a big jump in cost. Last year, she had been paying a manageable amount out-of-pocket, but this year the same prescription was much pricier.

Now Maria is left wondering:

Is it too late to change plans?

What are her options for managing this new, higher prescription cost?

If she switches plans, when would the new coverage start?

Would her deductible start over if she changed plans?

Counseling session preparation

LEARNING OBJECTIVE

By preparing for the call with a beneficiary, you will be equipped to provide them with accurate information, guidance, and support regarding their options.

Question	Answer
What do you do to prepare for this session?	
What information do you need to convey? What resources will you use?	
What would you consider to be in your scope for this session?[15] What topics do you need help with?[16]	

[15] Can be answered after listening to or reading the transcript for the counseling session.
[16] Reach out to SHIBA (see Appendix C).

Counseling session transcript & activities

ACTIVITIES

- Read and study the transcript in detail.
- Review the breaks and reflect on how you might have approached this session.
- Consider alternative strategies and their potential impact.
- Identify challenges you might encounter and think of solutions.
- Share & discuss your reflections with peers during the CE to gain diverse perspectives.
- Outline a plan for how you would apply your approach in a real session or practice through role-play.

COUNSELING SESSION TRANSCRIPT

Counselor
Hi, Maria! This is [NAME] from SHIBA. I received a referral that you have some concerns about your MA-PD plan. It says you've been in this plan for a couple of years, but when you went to the pharmacy, one of your medications was much more expensive than expected. It sounds like you're confused about why that's happening and wondering if it's too late to change to a different plan. Do I understand this correctly?

Beneficiary
Yes, that's right. During open enrollment, I didn't want to make any changes, but now I'm thinking maybe I should have.

When I went to pick up my medications yesterday, one of them was outrageously expensive. I've been taking this medication for years, and it's never been this costly. Is there anything I can do?

Counselor

I'm sorry to hear that, Maria. Let's talk about your options and try to figure this out together.

What would you ask next?

Counselor

First, I will need to gather some information from you. What kind of insurance do you have?

Beneficiary
I have a Humana Medicare Advantage plan.

Counselor
Does your Humana Medicare Advantage plan pay for both your doctor visits and your medications?

Beneficiary
Yes, I use the same card for both.

Counselor

When you pay for your medications, do you always use your insurance or pay out of pocket?

Beneficiary
I use my insurance.

Counselor

Do you get help with your Medicare health or drug costs?

Why do we ask this?

Beneficiary

No, I don't receive any assistance.

What would you ask next?

Counselor
When you went to pick up your medications yesterday, were you using the same insurance card you had last year? Did you get a new insurance card this year?

Why do we ask this?

Beneficiary
It's the same insurance I've used for the past few years. I haven't made any changes

Counselor

Ok, perfect.

Counselor
Here's what we'll do next:

Let's check the Medicare Plan Finder tool to see what MA-Plans provide the best coverage for your medications and which are their preferred in-network pharmacies.

Reviewing the different plans will help us evaluate your expected costs for the rest of the year and show us if and when you are expected to meet your deductible, which might lower your costs for the remainder of the year and reach the $2,000 maximum out of pocket cost (MOOP).

Do you have time to go through this now, or should we schedule a follow-up call?

Beneficiary
I have my medication list on hand, so we can go through it now.

Counselor
Perfect! Let's get started. I'll enter your information into the Plan Finder, and we'll review the pricing and any potential changes.

Plan Finder: The counselor enters medications and conducts search.

What would you do next?

Counselor

After reviewing the Plan Finder results, it appears your Humana plan, in comparison to other plans in your area, is still the best value in terms of prescription drug coverage.

This also shows us when you meet your deductible, and when your monthly costs will start to go down and you'll have fewer out of pocket expenses.

Additionally, your yearly maximum out-of-pocket for covered prescription drugs is limited to $2,000. Even if there are changes made to the drugs you take.

If you're comfortable with the coverage overall, staying with your Humana plan might be the right choice.

What else would you add?

Beneficiary
Ah, okay. I like the extra benefits my Humana plan has, so I think I'll stay with what I currently have.

Counselor

Alright, then it seems like you're all set. You don't need to make any changes. I'm glad we could go over this and help you feel more confident in your current plan. You're in a good position for the rest of the year with Humana.

Do you have any other questions that I can help you with?

Beneficiary

No, I think I am okay for now. Thank you! This has been a productive call!

Notes:

COUNSELING SESSION CRITIQUE & COACHING:

System-centered (technical)	Person-centered (relational)
Tip: Outline the different choices and options available to the person.	Tip: Facilitate a conversation that explores the advantages and disadvantages of each option, taking into consideration the individual's preferences and needs.

What did they do well?	What can they do better next time?
Technical: Information conveyed Tip: Told a client about Part D $2,000 OOP	***Technical: information should have been conveyed*** Tip: Explained to a client how Part D $2,000 OOP works
Relational: did well	***Relational: didn't do well***

Final reflections

Learning outcomes

1. **Reflection:**

   Take 10 minutes to think about the content of this workbook. Focus on what stood out to you as new, surprising, or particularly valuable. These could be concepts, tools, examples, or even ways of thinking.

   - *Consider describing the concept or idea and why it stood out to you.*
   - *Consider how you might apply or share this knowledge with others.*

2. **Write Your Insights:**
   In the space provided, write down three things you've learned:

   #1:

   #2:

   #3:

Thank you for your participation.

Appendix A: Dual eligible categories

FULL VS PARTIAL MEDICAID

The main difference between full Medicaid and partial Medicaid is the range of services covered:

Full Medicaid
Covers a wide range of healthcare services, including doctor visits, hospital stays, prescription drugs, mental health services, and rehabilitation services.

Full-benefit dually eligible individuals[17] include qualified Medicare beneficiaries with full Medicaid (QMB+), specified low-income Medicare beneficiaries with full Medicaid (SLMB+), and full-benefit dually eligible individuals (FBDE).

Partial Medicaid
Covers services that are also covered by Medicare, but not the full range of Medicaid benefits.

Partial-benefit dually eligible individuals[18] include qualified Medicare beneficiaries without other Medicaid (QMB only), specified low-income Medicare beneficiaries without other Medicaid (SLMB only), qualifying individuals (QI), qualified disabled and working individuals (QDWI).

Full vs partial benefits example: QMB & QMB+
The main difference between Qualified Medicare Beneficiary (QMB) and Qualified Medicare Beneficiary Plus (QMB+) is that QMB+ beneficiaries also qualify for full Medicaid benefits:

QMB
A partial Medicaid program that helps pay for services covered by Medicare, such as Part A and Part B premiums, deductibles, copays, and coinsurance.

QMB+
Also known as being dual-eligible, QMB+ beneficiaries receive both QMB benefits and full Medicaid benefits. This means that QMB+ beneficiaries may be

[17] Please see Appendix A
[18] Please see Appendix A

eligible for services not covered by Medicare, such as vision, hearing, and dental care. They may also be eligible to receive supplies through Medicaid.

DUAL CATEGORIES

Duals can fall into several MSP categories that offer various benefits, impose certain restrictions, and differ based on income:

QMB program. This program supports the payment of Medicare Part A, Part B premiums for individuals with an income of 100 percent FPL.

> ***QMB Plus.*** This group receives QMB benefits and full Medicaid benefits.

Specified Low-Income Medicare Beneficiary (SLMB) program. This program supports the payment of Part B premiums for individuals with an income greater than 100 percent FPL but less than 120 FPL

> ***SLMB Plus.*** This group receives benefits from the SLMB program and full Medicaid benefits.

Qualified Disabled Working Individual (QDWI) program. Individuals who lost their Medicare Part A coverage when they returned to work can buy back these benefits and have an income up to 200 percent FPL.

Qualifying Individual (QI) program. This group receives Medicare Part A benefits and has an income of 120 percent FPL but less than 135 percent FPL. There is also an annual cap on the money available for this group.

Pharmacy duals. Medicare Part D covers premiums, deductibles, and other cost sharing for prescription drugs up to a regional benchmark for all duals.

"Other" duals. This group includes select cases such as medically needy beneficiaries in a nursing home who are not eligible for prescription drugs or individuals in a state's Pharmacy Plus demonstration. States should use the code for this category only with CMS's approval.

BENEFITS COVERED BY MEDICAID

Dual eligibility groups	Medicare Part A premiums (when applicable)	Medicare Part B premiums	Co-insurance under Medicare Part A and Part B	Full Medicaid coverage
QMB Only	X	X	X	
QMB Plus	X	X	X	X
SLMB Only		X		
SLMB Plus		X		X
QDWI	X			
QI		X		
Other				X

Appendix B

2025 Medicare Quick Reference Job Aid

Part B		
Part B Premium Monthly		**$ 185.00**
Part B – ESRD/Immunosuppressive		$ 110.40
Part B Deductible 1x per calendar year		**$ 257.00**
Part B IRMAA Based on 2023 Income	$ $106K-129K/M $212K-258K (x1.4)	$ 259.00
Part A		
Part A Deductible		
Hospital per benefit period		**$1,676 (60 days)**
Day 61-90		$ 419/day
Lifetime reserve days		$ 838/day
Skilled Nursing Facility (SNF) Days 21-100		$209.50/day
Part A Premium		
30-39 months credit		**$ 285**
<30 months credit		**$ 518**
Part D		
Part D Maximum Deductible		**$ 590**
Part D Out-of-pocket Limit		**$ 2,000**
Part D Catastrophic Out-of-pocket Limit		**$ 0**
Part D IRMAA Based on 2023 Income	$ $106K-133K/M $212K-266K	**$13.70**
Medigap		
Deductible - F, G & J High Deductible		**$ 2,870**
Maximum Out of Pocket		
Plan K		**$ 7,220**
Plan L		**$ 3,610**
Medicare Advantage		
Medicare Advantage Max. MOOP		
In-Network		**$ 9,350**
In & Out-of-Network (PPOs)		**$14,000**

Source: https://www.insurance.wa.gov/volunteer-only-resource-materials

Appendix C

How can SHIBA staff help?

Contact your RTC:

- Brisson, Noreen (OIC) Noreen.Brisson@oic.wa.gov
    - Office 509-818-1017
    - Cell 360-349-2850
- Dieckman, Lynda (OIC) Lynda.Dieckman@oic.wa.gov
    - Office 360-725-7257
    - Cell 360-742-4949
- Lee, Rosie (OIC) Rosie.Lee@oic.wa.gov
    - Office 360-725-7253
    - Cell 360-701-0933
- Skye-Dugovich, Shannon (OIC) Shannon.Skye-Dugovich@oic.wa.gov
    - Office 360-725-7108
    - Cell 360-250-4900
    - Cell 360-701-0933
- Figoni, Amy (OIC) Amy.Figoni@oic.wa.gov Amy is temporarily covering Sarah's territory.
    - Office 360-725-7084

For any curriculum & training related questions & suggestions:

Contact SHIBA Curriculum & Training Coordinator, Elena Garrison Elena.Garrison@oic.wa.gov or OICMedicareTrainingFeedback@oic.wa.gov or call: 360-725-7107