

NCC National Contracting Center

Medicare Sales Training Guide

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Updated 2025

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NCC's Medicare Agent Training Guide

Introduction

Throughout the planning and structuring of this guide, we resolved to use no wasted words while still providing the necessary foundation for a 21st Century Medicare insurance agent to succeed. Helping us construct and edit this guide were multiple professionals with decades of combined insurance experience.

The authors and editors of this guide have a proven track record of efficient insurance service, and their experience heavily influenced its writing. As you proceed, don't be overwhelmed by the amount of information. Resolve to continue learning, even beyond what is covered in this guide.

Also, move forward with a dedication to seek understanding before you seek to be understood. As you do so, you'll be well on your way to a fulfilling and successful career in Medicare insurance sales. Albert Einstein said this: I never teach my pupils. I only attempt to provide the conditions in which they can learn. That well describes the purpose of this guide.

We are providing the conditions to learn in, but we still ask you to put in the study, work, and practice. **That's the only way you'll be truly successful.**

Medicare 101

What is Medicare?

Medicare is a federally funded health insurance program that covers:

- People 65 and older.
- Those with End-Stage Renal Disease (ESRD), which is kidney failure that requires dialysis or a transplant.
- Some people under 65 with disabilities.

How is Medicare Funded?

Medicare is funded by a branch of the Department of Health and Human Services (HHS) called The Centers for Medicare & Medicaid Services (CMS). CMS also monitors Medicaid programs offered by each state.

What is Original Medicare?

There are two fundamental parts of Original Medicare: Parts A and B.



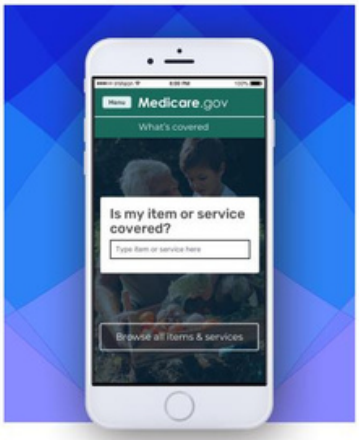
Helps cover:

- *Inpatient care in hospitals.*
- *Skilled nursing facility care.*
- *Hospice care.*
- *Home health care.*



Helps cover:

- *Services from doctors and other health care providers.*
- *Outpatient care.*
- *Home health care.*
- *Durable medical equipment (wheelchairs, hospital beds, and other equipment).*
- *Many preventative services (screenings, vaccines, and related services).*



There is also a helpful IOS/Android application provided by Medicare called **"What's Covered."** Not sure if Medicare will cover your medical test or service? Medicare's free, official app delivers accurate cost and coverage information right on your mobile device. Now you can quickly see whether Medicare covers your service in the doctor's office, the hospital, or anywhere else you use your phone.



What Are the Costs Associated with Medicare?

Most people assume that Medicare is free, but in fact, it is not. Beneficiaries are generally responsible for premiums, deductibles, copays, and coinsurances. Some of these costs, however, may be covered by programs like Extra Help and Subsidies. We'll cover those programs in detail in Chapter 3 of this guide.

Part A

Premiums for 2026

Most Medicare beneficiaries don't pay a monthly premium for Part A (sometimes called "premium-free Part A") as long as the beneficiary or their spouse worked and paid Medicare taxes for at least 40 quarters. If the beneficiary or spouse paid Medicare taxes for fewer than 30 quarters, the standard Part A premium is $565. If the beneficiary or spouse paid Medicare taxes for 30-39 quarters, the standard Part A premium is $311.

With Part A Hospital Inpatient Deductible and Coinsurance, the Beneficiary Pays:

- $1,736 deductible for each benefit period.
- Days 1-60: $0 coinsurance for each benefit period.
- Days 61-90: $434 coinsurance per day of each benefit period.
- Days 91 and beyond:$868 coinsurance per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime).
- Beyond lifetime reserve days: all costs.

Part B

Premiums for 2026

Medicare beneficiaries must pay a premium each month for Part B. For 2024, the standard Part B premium amount is $202.90, and this is what most beneficiaries will pay. Their Part B premium will be automatically deducted from their benefit payment if they receive benefits from:

- Social Security
- Railroad Retirement Board
- Office of Personnel Management

If they don't receive these benefit payments, they'll be billed for the premium.

However, if the beneficiary's modified adjusted income – as reported by their IRS tax **return from 2 years before** – is above a certain amount, they will pay an Income Related Monthly Adjustment Amount (IRMAA) in addition to their premium.



If your annual income in 2024 was…

FILE INDIVIDUAL TAX RETURN	FILE JOINT TAX RETURN	PART B PREMIUM	PART D PREMIUM*
Less than or equal to $109.000	Less than or equal to $218,000	$202.90	Premium (varies)
$109,001 to $137,000	$218,001 to $274,000	$284.10	Premium + $14.50
$137.001 to $171,000	$274,001 to $342,000	$405.80	Premium + $37.50
$171.001 to $205,000	$342,001 to $410,000	$527.50	Premium + $60.40
$205,000 to $499,999	$410,001 to $749,999	$649.20	Premium + $83.30
Greater than or equal to $500.000	Greater than or equal to $750,000	$689.90	Premium + $91.00

*Part D premiums vary based on carrier

Beneficiaries may appeal for a new Part B determination if they fit into one of two categories:

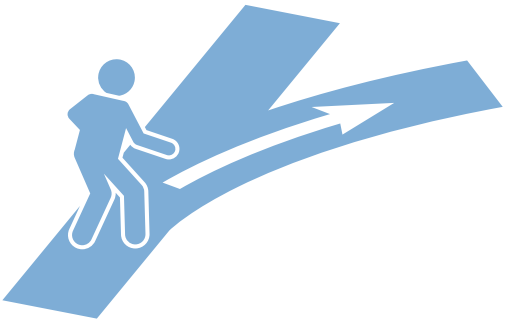
Inaccurate or Out-of-Date Tax Return

Tax returns may be classified as inaccurate or out of date for the following reasons:

- The beneficiary's tax return for the year SSA is using to make the decision was amended.
- The IRS data was incorrect.
- The IRS provided SSA with older data, and the beneficiary prefers to use updated information.
- A beneficiary had a major life-changing event that significantly reduced their income.

Life-Changing Event

A beneficiary may qualify for a new Part B determination after experiencing one of seven life- changing events that affect their modified adjusted gross income. Events that meet these criteria are:



- Death of spouse.
- Marriage.
- Divorce or annulment.
- Work reduction.
- Work stoppage.
- Loss of income from an income-producing property.
- Loss or reduction of certain kinds of pension income.

Deductible & Coinsurance

In 2026, Medicare beneficiaries pay $283 for their Part B deductible. After they meet their yearly deductible, they typically pay 20% of the Medicare-approved amount for the following services:

- Most doctor services (including those performed while the beneficiary is a patient in the hospital).
- Outpatient therapy.
- Durable medical equipment (DME).
- Ambulance Services.
- Medicines administered by a Doctor (i.e., Chemotherapy or Injectables).
- Dialysis.

How to Apply for Medicare

Some beneficiaries receive Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) automatically, while others have to sign up for it. In most cases, it depends on whether or not they're receiving Social Security benefits.

When applying, the beneficiary selects one of the following situations that applies to them:

- "I'll be getting benefits from Social Security or the Railroad Retirement Board (RRB) at least four months before I turn 65." Typically, they would receive Original Medicare, Parts A & B.
- "I won't be getting benefits from Social Security or the Railroad Retirement Board (RRB) at least four months before
- I turn 65." In this case, they would need to apply for Medicare.
- "I'm under 65 and have a disability." After 24 months of full disability, they will automatically receive their Original Medicare, Parts A & B.
- "I have ALS (Amyotrophic Lateral Sclerosis, also called Lou Gehrig's disease)." They will automatically receive Original Medicare, Parts A & B the month that disability benefits begin.
- "I have End-Stage Renal Disease (ESRD)." They will be eligible to apply for Medicare.

Doing so via this website would direct them to the appropriate enrollment platform.
Some beneficiaries choose to delay Part B when they initially become eligible for Medicare, often so that they may keep the group health coverage provided through their employment. To delay Part B, the beneficiary would indicate such to the Social Security Administration upon notice of becoming eligible for Medicare.

Conversely, a beneficiary desiring to enroll in Part B after initially delaying it would do so by applying for Part B via the Social Security Administration office or website.

It should be noted that a client delaying Part B without having creditable coverage would be restricted in reacquiring it. They would be required to enroll during the Part B general enrollment period (January 1 – March 31 with coverage starting the first of the month after you sign up) and would be penalized for time-lapsed in which they were eligible for Medicare and not covered by creditable coverage. The penalty would be assessed monthly for the rest of their life.

However, loss of creditable group coverage triggers a Part B special enrollment period, and the beneficiary would not be subject to a penalty in that scenario.

How Are Prescriptions Covered?

in order for a Medicare beneficiary's prescriptions to be covered, the beneficiary must have Part D coverage through either a standalone Prescription Drug Plan (PDP) or a Medicare Advantage plan that includes drug coverage.



Helps cover:

- The cost of prescription drugs, including many vaccines and other shots.
- Part D Plans follow Medicare's rules but are managed by private insurance carriers.

Requirements to Enroll

A Medicare beneficiary having only Part A or Part B may still acquire drug coverage through a standalone Prescription Drug Plan (PDP).

Part D Late Enrollment Penalty

The late enrollment penalty is an amount added to the Medicare beneficiary's Part D monthly premium. They may owe a late enrollment penalty if, for any continuous period of 63 days or more after their Initial Enrollment Period is over, they go without one of these:

- A Medicare Prescription Drug Plan (**Part D**)
- A Medicare Advantage Plan (**Part C**) (like an **HMO** or **PPO**) or another Medicare health plan that offers Medicare prescription drug coverage.
- Creditable prescription drug coverage (Like group health coverage or VA/ChampVA/Tricare).

The cost of the late enrollment penalty depends on how long the beneficiary went without Part D or creditable prescription drug coverage and will be added to your monthly premium. They will pay an extra 1% for each month (12% per year) you could have signed up for Part D, but didn't.

Drug Plan Formulary

Most Medicare drug plans have their own list of covered medications, called a formulary. Plans cover both generic and brand-name prescription drugs. The formulary includes at least two drugs in each therapeutic category. This ensures that people with different medical conditions can get the prescription drugs they need. All Medicare drug plans generally must cover at least two drugs per drug category, but plans can choose which specific drugs they cover.

Tiers

To lower costs, many plans place drugs into different "tiers" on their formularies. Each plan can divide its tiers in different ways. Each tier costs a different amount. Generally, a drug in a lower tier will cost the beneficiary less than a drug in a higher tier. See the example below:

Example of a Drug Plan's Tiers

- **Tier 1**—Preferred Generic: *This tier consists of commonly prescribed generic drugs. Beneficiaries pay the least for drugs in this tier.*
- **Tier 2**—Generic: *Drugs in this tier are generic and slightly more costly than those in Tier 1.*

- **Tier 3**—Preferred Brand: *This tier consists of brand-name prescription drugs without a generic equivalent. They're lower-cost than conventional branded drugs.*
- **Tier 4**— Brand: *Drugs in this tier are brand-name and do not have a generic equivalent. They're typically more expensive than those in Tier 3*
- **Tier 5**—Specialty: *This tier consists of high-cost specialty drugs that treat complex conditions like cancer. They may be generic or brand-name. Beneficiaries typically pay the most for drugs in this tier.*

In some cases, if the beneficiary's drug is in a higher (more expensive) tier and their prescriber thinks they need that drug instead of a similar drug on a lower tier, they can file an exception and ask their plan for a lower-tier placement/copayment.

Inflation Reduction Act and Part D Changes

The Inflation Reduction Act of 2022 has several provisions to lower prescription drug cost for Medicare Beneficiaries and reduce the drug spending by the federal government. These changes include a cap on out-of-pocket drug spending for enrollees and requiring Part D plans to carry a greater share of the cost.

In 2025, Part D enrollees' out-of-pocket costs will be capped at $2,000. This amount will be subject to rise each year after 2025 at the rate of the growth per capita in Part D costs.

The coverage gap phase, or Donut Hole, was eliminated in 2025. Part D will now have three phases: the Deductible Phase, the Initial Coverage Phase, and the Catastrophic Phase. With these new phases, a beneficiary will only spend money on two of them.

- Annual Deductible (**$615** for 2026)
  - The beneficiary pays 100% of drug costs
  - Once the deductible is met (if applicable) the beneficiary enters the next phase
- Initial coverage:
  - The beneficiary pays 25% coinsurance for covered Part D Drugs
  - The insurance carrier typically pays 65% of the cost of applicable drugs and 75% of the cost of all other covered Part D drugs.
  - Through the Manufacturer Discount Program, the drug manufacturer typically covers 10% of the cost of applicable drugs.
  - Once the enrollee has reached the annual OOP threshold of $2,100, they'll move into the next phase

- Catastrophic:
  - The beneficiary pays no cost-sharing for covered Part D drugs
  - The insurance carrier typically pays 60% of all covered Part D drugs costs.
  - Through the Manufacturer Discount Program, the drug manufacturer typically covers 20 percent of the cost of applicable drugs
  - CMS pays a reinsurance subsidy equal to 20% of the costs of applicable drugs and equivalent of 40% of the costs of all other covered Part D drugs

The example below shows the phases of Part D.



source: https://www.kff.org/medicare/issue-brief/changes-to-medicare-part-d-in-2024-and-2025-under-the-inflation-reduction-act-and-how-enrollees-will-benefit/

What is a Medicare Supplement/ Medigap Insurance?

Medicare Supplement (often called Medigap) helps fill "gaps" in Original Medicare and is sold by private companies. Original Medicare pays for much, but not all, of the cost for covered health care services and supplies. A Medicare Supplement Insurance (Medigap) policy can help pay some of the remaining health care costs, like:

- Deductibles – Like Part A/Hospital Deductible.
- Copayments – Like Emergency Room and Medical Doctor Copays.
- Coinsurance – Like Part B Coinsurance (20%)
- Excess Charges – Like the Part B Excess Charges.

Medicare Supplements impose no hospital/medical network restrictions and do not replace Medicare. They pay – according to the plan contract – the cost that remains after Original Medicare has paid. If you have Original Medicare and you buy a Medigap policy, here's what happens:

- Medicare will pay its share of the Medicare-approved amount for covered health care costs.
- Then, the beneficiary's Medigap policy pays its share.

Medigap policies generally don't cover long-term care, vision or dental care, hearing aids, eyeglasses, or private-duty nursing. Some Medigap policies do cover services that Original Medicare doesn't cover, like medical care when you travel outside the US.

Medicare Supplement (Medigap) Plans

BENEFITS	A	B	C	D	F*	G*	K**	L**	M	N***
Part A coinsurance + hospital costs up to an additional 365 days after Medicare benefits are used	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Part B coinsurance or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Blood (first 3 pints)	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Part A hospice care coinsurance or copayment			100%	100%	100%	100%	50%	75%	100%	100%
Skilled nursing facility care coinsurance		100%	100%	100%	100%	100%	50%	75%	100%	100%
Part A deductible			100%	100%	100%	100%	50%	75%	50%	100%
Part B deductible			100%		100%					
Part B excess charge					100%	100%				
Foreign travel exchange (up to plan limits)			80%	80%	80%	80%			80%	80%
							Out-of-pocket limits in 2026			
							$8,000	$4,000		

Source: Medicare.gov

Note: Plan C & F aren't available if you turned 65 on or after 1/1/2020, and to some people under age 65. You might be able to get these plans if you were eligible for Medicare before 1/1/2020, but not yet enrolled

**Plans F and G also offer a high-deductible plan in some states. You must pay for Medicare-covered costs(coinsurance, copayments, and deductibles) up to the deductible amount of $2,950 in 2026 before the policy pays anything.*

*** For Plans K and L, after you meet your out-of-pocket yearly limit and your yearly Part B deductible ($283 in 2026), the Medigap plan pays 100% of covered services for the rest of the calendar year.*

**** Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that don't result in inpatient admission.*

Medicare Supplement policy premiums vary depending on age, gender, and – when underwritten – tobacco use and the health of the insured. No underwriting stipulations are in effect during the Medigap Open Enrollment period; otherwise, underwriting is mandated. For more information, see the "Enrollment Periods" section.

Source: Medicare.gov

Wait a Second, What About "Part C"?

Medicare Part C is commonly called Medicare Advantage (MA). Medicare Advantage Plans are a type of Medicare health plan offered by a private company that contracts with Medicare to provide Part A and Part B benefits. Most MA plans also offer prescription drug coverage.



Helps cover:

- Medicare Part C is an alternative to Original Medicare that includes Parts A and B, and usually Part D.
- Beneficiaries may be able to find MA plans with lower out-of-pocket costs than Original Medicare.
- Part C plans usually require beneficiaries to see in-network providers.
- Most MA plans offer additional benefits not found in Original Medicare, like dental, hearing, and vision services.

If a Medicare beneficiary is enrolled in a MA Plan, most Medicare services are covered through the plan. While the premium is typically less than a Medicare Supplement (in many cases, as little as $0), MA enrollees will incur copays and coinsurances that would be paid by a Medicare Supplement. However, an MA plan's Maximum Out of Pocket limits the amount of copays/coinsurances the beneficiary would potentially pay per year.

Another way that Medicare Supplement differs from Medicare Advantage is Hospital/Medical networks. MA's have network restrictions; Med Sup's do not. Below are the most common types of MA Plans:

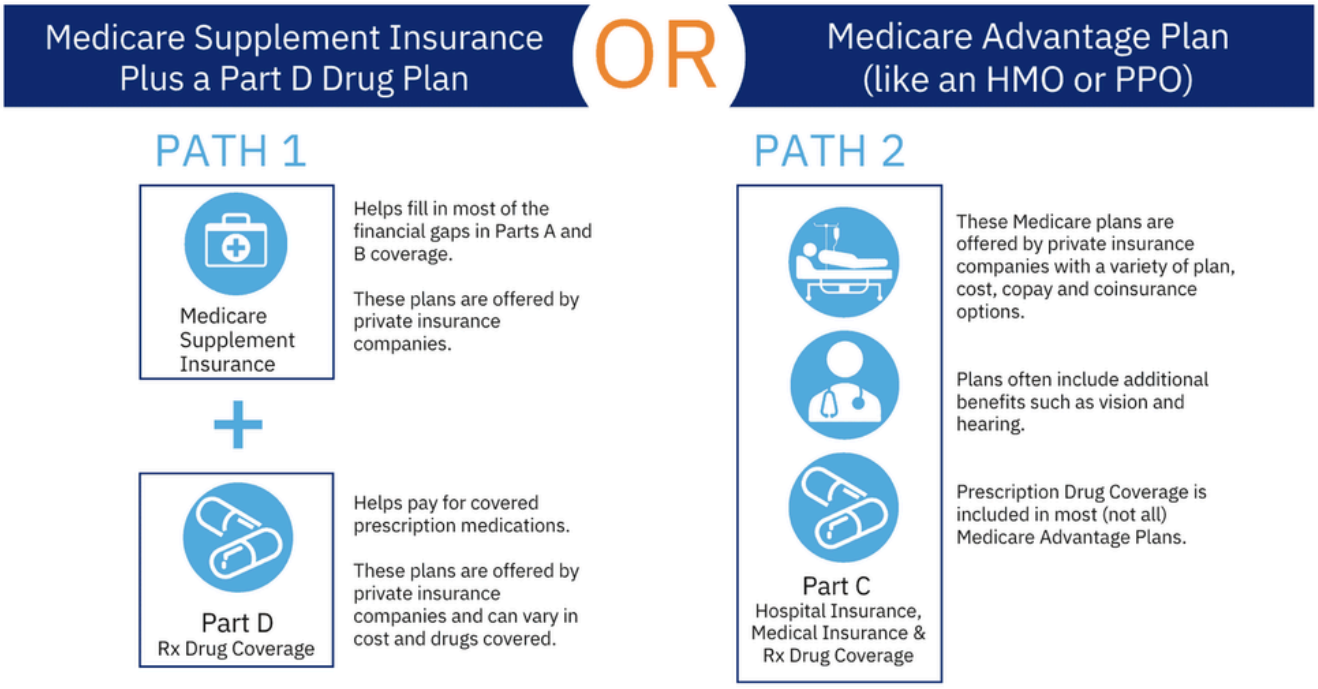
- Health Maintenance Organization (HMO) Plans
- Preferred Provider Organization (PPO) Plans
- Special Needs Plans (SNP's)

Eligibility

In order to be eligible for a Medicare Supplement/Medigap or Medicare Advantage/Part C coverage, the insured must be a beneficiary of both Medicare Parts A and B. Again, a beneficiary having only Part A or B may enroll into a standalone Prescription Drug/Part D Plan.

Can A Person Have Both a Medicare Advantage Plan and A Medicare Supplement?

No. Medicare beneficiaries should choose one "Path" or the other.



MSA Plans

What is a Medicare MSA Plan?

Some private insurance companies offer a consumer-directed Medicare Advantage Plan, called a Medicare MSA Plan. These plans are similar to Health Savings Account Plans available outside of Medicare. Beneficiaries can go to any Medicare-participating provider and use the money in their account to pay for any covered services. An MSA Plan must cover all of the same services any MA plan is required to cover.

Medicare MSA Plans Have Two Parts

Medicare MSA Plans combine a high-deductible insurance plan with a medical savings account that beneficiaries can use to pay for their health care costs.

1. High-deductible health plan: The first part is a special type of high-deductible Medicare Advantage Plan (Part C). The plan will only begin to cover the beneficiary's costs once they meet a high yearly deductible, which varies by plan.

2. Medical Savings Account (MSA): The second part is a special type of savings account. The Medicare MSA Plan deposits money into the beneficiary's account. They can use money from this savings account to pay for health care costs before they meet the deductible. Once a beneficiary meets their deductible, the plan will pay 100% for covered services.

Note: MSA plans do not cover Part D benefits. Beneficiaries in an MSA must get a standalone PDP for drug benefits.

Which Path is Better?

Better coverage depends on the needs/resources of the client. Both Medicare Supplement and Medicare Advantage have a vital role to play in the lives of Medicare beneficiaries. Determining which path is best takes place during the consultation/positioning process with you, the agent.

How Does A Beneficiary Enroll into Medicare Supplement/Part D or Medicare Advantage Coverage?

That's where you come in! In the Sales Techniques portion of this guide, you'll learn how to position, present, and sell these coverages properly.

Enrollment Periods

What Is an Enrollment Period?

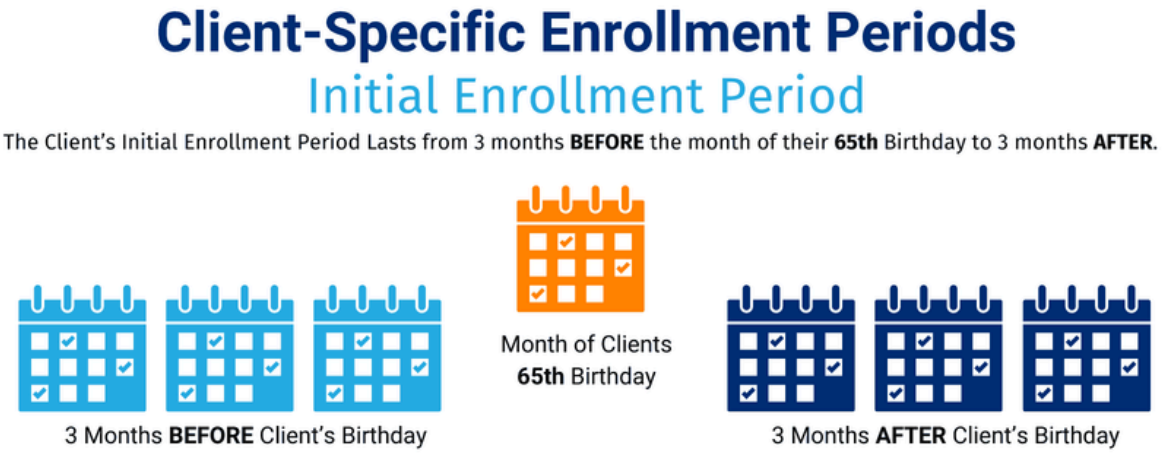
An enrollment period is the timeframe for enrolling in or changing a Medicare plan.

Medicare Supplements vs. Medicare Advantage & Prescription Drug Plans

Medicare Supplement/Medigap

It's recommended that beneficiaries buy a Medicare Supplement/Medigap policy during their 6-month Medigap open enrollment period because, during that time, they can buy any Med Supp policy available for open enrollment that is sold in their state, even if they have health problems. This period automatically starts the month they're 65 or older and enrolled in Medicare Part B.

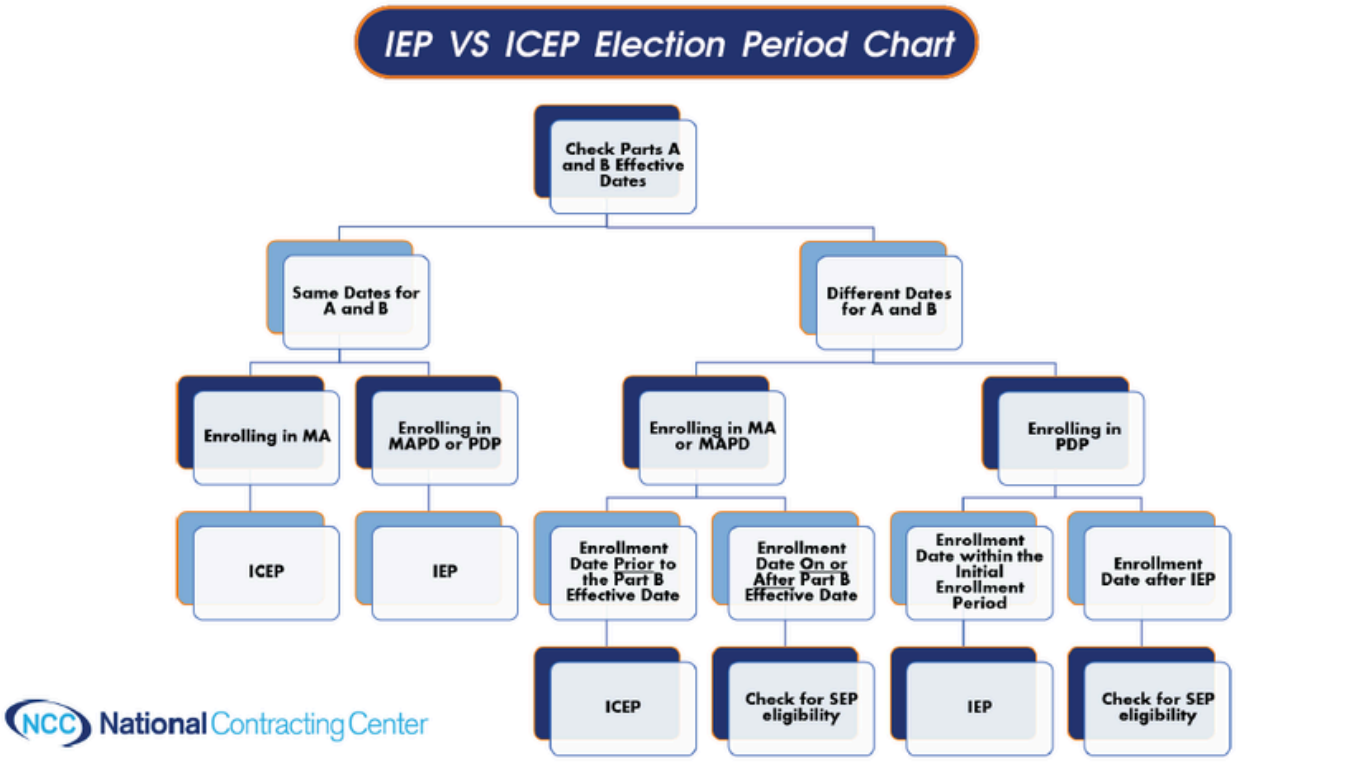
Virtually all Medigap carriers permit applications to be submitted three months prior to the beneficiary's 65th birthday month and/or Part B effective date. Some carriers permit applications to be submitted as early as six months prior to/after said dates with open enrollment considerations.



If a Medicare beneficiary applies for Medicare Supplement coverage after their open enrollment period, they will have to pass medical underwriting unless they're eligible for guaranteed issue considerations due to a special situation. Virtually all Medigap carriers permit applications to be submitted three months prior to the beneficiary's 65th birthday month and/or Part B effective date. Some carriers permit applications to be submitted as early as six months prior to/after said dates with open enrollment considerations.

Medicare Advantage/PDP

- To enroll in a Medicare Advantage or PDP plan, the beneficiary is required to have a valid election or enrollment period (separate and distinct from their Med Supp open enrollment).
- For beneficiaries that are new to Medicare and have the same Parts A & B effective date, they can enroll in an MAPD or PDP for three months before, the month of, and three months after they turn 65 using IEP. When enrolling before Medicare being in effect, their effective date will be the same as their A & B effective date. When enrolling after Medicare is in effect, their effective date will be the first day of the month following enrollment.
- If they enroll in an MA-only during that time, they can use ICEP. If a beneficiary delays their Part B, they can enroll in an MAPD or MA-only using ICEP. If a beneficiary is enrolling in a PDP past their IEP, they will need to use another election period.



General Enrollment Periods



October 15 - December 7
Annual Enrollment Period

- Applies to current Medicare Beneficiaries
- Those eligible can join, change, or drop a Medicare Advantage or PDP plan, making an unlimited number of elections.
- The last election made during the Annual Enrollment Period will go into effect on January 1.

January 1 - March 31
Open Enrollment Period

- Applies to those currently enrolled in an MA. MAPD, or SNP.
- Enrollees can make 1 change to a different Medicare Advantage plan, OR
- They may disenroll from am MA/MAPD, return to Original Medicare, and add a PDP
- Changing from one PDP to another is not allowed.

SEP: Special Enrollment Period

Clients may also enroll and change their coverage outside of the standard enrollment periods if they qualify for a Special Enrollment Period. Coverage obtained during SEP is effective the first day of the month following the date of the application.

Low-Income

- Medicare beneficiaries maintaining their Dual-Eligible or LIS status can add, change, or drop an MA or PDP plan once per calendar quarter for the first three calendar quarters. If a beneficiary gains, loses, or experiences a change in their Dual-Eligible or LIS status, they can make one election during the three months after their change or after they are notified of the change, whichever is later. The coverage effective date for this SEP will be the first day of the month following the date of their application.

Moving

- Medicare beneficiaries who move out of their current plan's service area, move within their current plan's service area with new options available to them, or are released from incarceration are granted a SEP. Beneficiaries can make one election from the day they notify the plan in advance of the move to the end of the 2nd full month after the move. Or if they notify their plan after the move, from the day they notify the plan to the end of the 2nd full month after they notify the plan. The coverage effective date for this SEP will be the first day of the month following the date of their application.

FEMA

- From the start of a FEMA-declared emergency or major disaster incident period and for four full calendar months after, Medicare beneficiaries that had a valid election period but did not use it can make one change. The coverage effective date for this SEP will be the first day of the month following the date of their application.

5 Star

- From December 8 to November 30 of the following year, Medicare beneficiaries living in the service area of a 5-star rated plan can make one election to enroll in that plan. The coverage effective date for this SEP will be the first day of the month following the date of their application.

These are not all the Special Election Periods available. The list would be too long to place in this guide. For more guidance around SEP's reach out to your Sales Development Manager.

Extra Help/Subsidies

Categories

FBDE - Full Benefit Dual-Eligible

Full Benefit Dual-Eligible beneficiaries are eligible for both Medicare and full Medicaid benefits. These beneficiaries must meet the qualifications for Medicare mentioned on Page 2 and the qualifications for their state-specific Medicaid program.

MSP's - Medicare Savings Programs

Based on income/assets, individuals who are partial dual-eligible typically fall into one of the following four Medicare Savings Program (MSP) categories.

CATEGORY	INCOME/ASSET LIMITS	BENEFITS
Qualified Medicare Beneficiary (QMB) Program	Monthly Income limits $1,325 for an individual $1,783 for a couple Asset Limits $9,660 for an individual $14,470 for a couple	Helps pay for Part A and/or Part B premiums, deductibles, coinsurance, and copayments
Specified Low-Income Medicare Beneficiary (SLMB) Program	Monthly Income limits $1,585 for an individual $2,135 for a couple Asset Limits $9,660 for an individual $14,470 for a couple	Helps pay for Part B premiums
Qualifying Individual (QI) Program	Monthly Income limits $1,781 for an individual $2,400 for a couple Asset Limits $9,660 for an individual $14,470 for a couple	Helps pay for Part B premiums
Qualified Disabled Working Individual (QDWI) Program	Monthly Income limits $5,302 for an individual $7,135 for a couple Asset Limits $4,000 for an individual $6,000 for a couple	Pays the Part A premium for certain people who have disabilities and are working

It should also be noted that QMB beneficiaries are, in many cases, eligible for Special Needs Plans along with FBDE beneficiaries. In some cases, other MSP beneficiaries are eligible for SNPs as well. Eligibility should always be confirmed with every carrier before applying for enrollment.

LIS - Low-Income Subsidy

Medicare beneficiaries with limited income and assets may qualify for the Part D Low Income Subsidy, also known as LIS or Extra Help. This subsidy helps pay for premiums, deductibles, and copays related to Medicare drug coverage. Beneficiaries enrolled in both Medicaid and Medicare, a Medicare Savings Program, or Supplemental Security Income (SSI) will qualify for LIS automatically and do not need to submit an application.

Low-Income Subsidy (LIS)/Extra Help (2025) - 48 STATES + DC							
Beneficiary Group	**Annual Income Eligibility Requirement**	**Monthly Income Eligibility Requirement**	**Asset Eligibility Requirement**	**Need to apply for LIS?**	**Monthly Premium**	**Annual Deductible**	**Copay/Coinsurance Plan's Formulary Drugs**
Full-Benefits Duals: Institutionalized or receiving Home and Community-based Services	Meet State Medicaid financial eligibility	Meet State Medicaid financial eligibility	Meet State Medicaid financial eligibility	No, receive it automatically	No	No	None
Full-Benefit Duals: income ≤ 100% FPL	Meet State Medicaid/MSP financial eligibility	Meet State Medicaid/MSP financial eligibility	Meet State Medicaid/MSP financial eligibility	No, receive it automatically	No	No	*Copay:* $1.60 generic/$4.80 brand *Catastrophic Copay:* $0
Full-Benefit Duals: income > 100% FPL	Meet State Medicaid/MSP financial eligibility	Meet State Medicaid/MSP financial eligibility	Meet State Medicaid/MSP financial eligibility	No, receive it automatically	No	No	*Copay:* $4.90 generic/$12.15 brand *Catastrophic Copay:* $0
Non duals with income between ≤ 150% FPL	Single: $23,715* Couple: $31,965*	Single: $1,976* Couple: $2,664*	Single: /$17,600** Couple: /$35,130**	Yes	No	No	*Coinsurance: 0% Copay: $4.90 generic/$12.15 brand Catastrophic Copay: $0*

*Income amounts reflect threshold with the $20 monthly income disregard (annually = $240); income is rounded to the nearest whole dollar.
** Asset limits include amount with $1,500/person burial allowance
Income Levels Source: https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines
Asset/Resource Levels: https://www.cms.gov/files/documents/lis-memo
Part D Cost-Sharing Source: https://www.cms.gov/files/document/2026-announcement.pdf

Source: NCOA.ORG

How to Apply

Medicare beneficiaries may apply for LIS in one of three ways:

1. Apply online at http://www.socialsecurity.gov/extrahelp.

2. Call Social Security at 1-800-772-1213 (TTY 1-800-325-0778) and request an application by mail or apply over the phone. Social Security representatives are available by phone Monday through Friday, from 7 AM to 7 PM.

3. Apply in person at their local Social Security office.

Application for MSP's (QMB/SLMB, etc.) may be completed in one of two ways:

1. In conjunction with LIS application via http://www.socialsecurity.gov/extrahelp if the beneficiary does not already receive LIS benefits.

2. Via the applicant's resident state e-app or paper app. Check the beneficiary's resident state Medicaid website.

Converting Approval into a Sale

Upon approval of any subsidy/extra help, advise the applicant/beneficiary of the effect that the subsidy will have on their plan eligibility, coverage premium, and/or drug coverage costs. You should also offer updated coverage to correlate with increased benefits.

Remember, beneficiaries receiving LIS/MSP/FBDE benefits are eligible for a Special Election Period. Affirming you helped a beneficiary acquire extra help is the perfect time to write updated Medicare coverage and/or ancillary benefits as well.

The typical response time for these applications is 3-4 weeks. The applicant will be notified via mail of approval/benefit level or denial. If denied, the decision may be appealed.

Ancillary Products

Every Medicare and non-Medicare beneficiary should be advised to consider adding ancillary health/life insurance benefits to their coverage portfolio. Unlike Medicare, CMS does not govern these benefits according to age, disability, and/or election/enrollment periods.

Therefore, offering them to both your Medicare clients and non-Medicare clients, as well as their friends and family members, is most advisable. The more products you have in effect with a client and their friends/family, the more likely they will be to keep you as their agent. If you don't sell ancillary products, you are directing your clients to see another agent who could eliminate your place in their coverage portfolio. We'll say more about providing these benefits effectively in the Sales Techniques portion of this guide.

Hospital Indemnity - HI

Hospital Indemnity insurance is a supplemental (although not a Medicare Supplement) insurance plan designed to pay for the costs of a hospital admission that may not be covered by other insurance. In most cases, MA/MAPD clients purchase HI due to the hospital copays associated with their coverage.

Guarantee Trust Life and Medico are two of the most popular providers of HI coverage in the US. In most cases, HI applicants will answer health-related "Knock-out Questions" as a form of underwriting and be subject to further underwriting after a claim is made. However, GTL, for instance, offers Guaranteed Issue HI coverage to applicants purchasing coverage between the ages of 64 ½ and 68 ½.While the coverage is designed to compensate for expenses incurred as a result of a hospital stay, there are no stipulations on how the beneficiary spends the benefit of an approved claim. Most HI plans can be coupled with riders that provide benefits for other medical needs such as ambulance costs, cancer, rehabilitation, and outpatient care.

Critical Illness/Cancer/Heart Attack Stroke

Critical illness coverage has increased in viability and popularity over the past several years. It is advisable for adult clients of all ages, including both MA and Med Supp beneficiaries. While some carriers offer treatment plans, "Lump Sum" benefit policies are generally recommended. In most cases, critical illness applicants will answer health-related "Knock-out Questions" as a form of underwriting and be subject to further underwriting after a claim is made.

Upon approval of a claim, which is triggered by diagnosis, there are no stipulations on how the beneficiary spends the benefit. As increased value add-ons, some carriers offer optional plan riders that cover specified diseases such as Alzheimer's, Dementia, ALS, End-Stage Renal Failure, MS, and Coma.

Short Term Care (STC)/Home Health Care (HHC)

Short-term policies typically cover home care or assisted living when the beneficiary can't take care of themself. But instead of paying for years of care, short-term care insurance, also known as recovery care, typically provides benefits for 12 months or less.

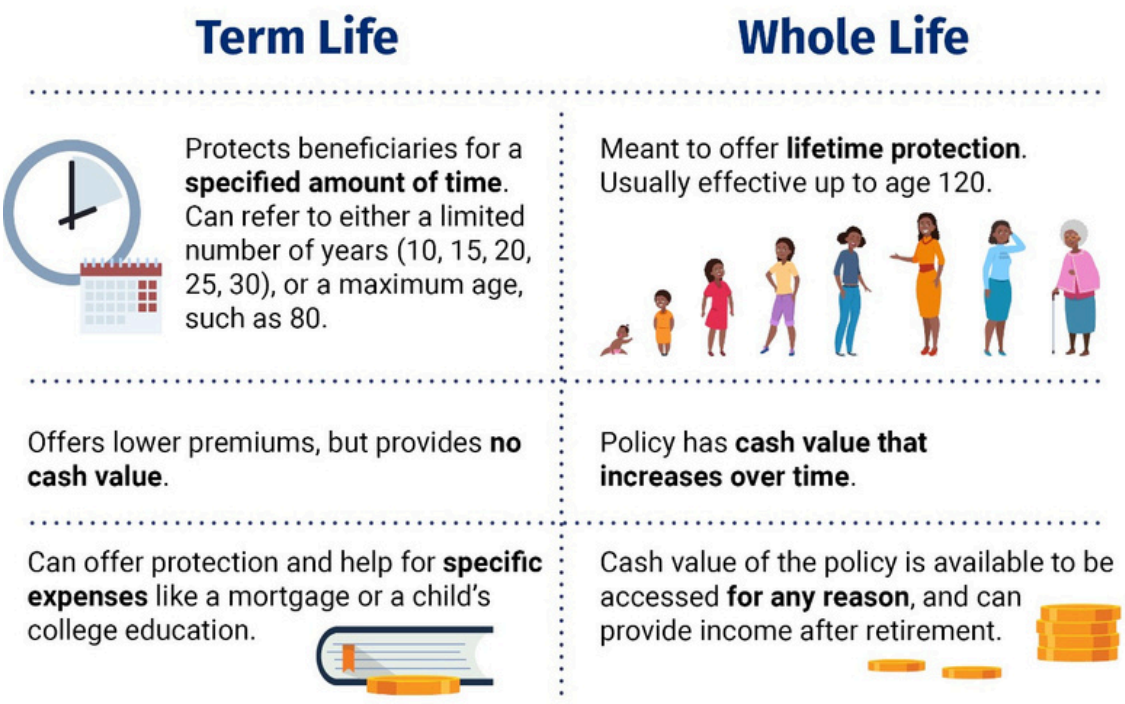
Most commonly, short-term care insurance is used to cover gaps in Medicare coverage or as an alternative option to inpatient rehab and long-term care insurance. Guarantee Trust Life's STC/HHC plan also offers riders that cover ambulance expenses, as well as a medication reimbursement that helps offset the cost of the coverage.

Dental Vision Hearing (DVH)

Dental, Vision, and Hearing insurance provides additional coverage for fillings, extractions, cleanings, contact lenses, eyeglasses, hearing aids, and more. Plans will have a maximum aggregate payout of $1,000 or $10,000 per year. Some operate as indemnity coverage, while others offer network-based coverage. Some plans function both ways.

Life Insurance/Final Expense

Although the majority of sales that a Medicare agent produces will be health-based, it is most advisable to be prepared to serve your clients' Life Insurance/Final Expense needs as well. Basically, the most common products you'll offer will be either Term or Whole Life policies.



As you can see in the above illustration, the majority of your Medicare clients will benefit most from Whole Life rather than Term coverage. Most commonly, life insurance purchasers older than 60 purchase Whole Life coverage to alleviate final expenses that would otherwise be left for the surviving family and friends to pay.

Based on the applicant's health, the agent will be able to advise what level of underwriting will be suitable for the insured. Multiple carriers offer underwritten coverages that provide full death benefit upon issue of the policy, while others offer Guaranteed Issue policies that require no underwriting questions to be answered but pay a decreased death benefit the first few years of the life of the policy. Both types of policy have their place, and a knowledgeable agent doing appropriate field underwriting will offer the correct option.

It should be noted that it is not compliant to offer and sell life products in conjunction with Medicare products. An agent authorized to sell both should schedule a separate appointment allowing **at least 72 hours** to pass in between the sale of the two products in order to remain compliant.

Sales Techniques

In this section, we'll outline a tested and proven process of successful sales techniques. As you study these principles, you'll notice that they have an order and flow that naturally leads to a sales opportunity. When followed, you will see how making sales based on understanding rather than coercion is most appropriate, especially when covering health and life risks. Your objective as the agent should be to use your product knowledge to meet the client's specific needs, thus leaving them more comprehensively covered than before you met with them.

Self-Introduction/Purpose of Meeting/Call

Whether on the phone or face-to-face with your client, your introduction should be prompt, precise, warm, and friendly. Here's an example: "Hello _____, my name is _____ and we have an appointment to discuss your medical benefits." This step will set the tone for the entirety of the business relationship you share with your client. Don't skip it!!

Getting to Know the Client - "Warm-up"

This is the portion of the consultation that cannot be substituted with anything else. Here you will get to know your client. If you pay attention during this phase, the client will inform you of what's most important to them, their concerns, and their preferences. Ask questions of interest and follow up based on their response. Be personable, open, and attentive. Know how to talk about something other than insurance. Take as long to warm up as your client prefers. You will not regret knowing your client well when it comes time to ask for the sale.

Setting Expectation for the Appointment

At this juncture, you bring the conversation to its purpose: "Basically the purpose of our appointment today is to make sure that you're receiving all the benefits you're eligible for and to make sure that your coverage best suits your needs as it relates to medicines, doctors, medical concerns… things like that.."

The First Yes

Following the expectation setting, you should always ask: "Can I ask you a few questions?" Here's how you'll get the first YES! And, after you get the first one, the others will flow much more

freely. Also, when a client consents to this request, the agent may ask for whatever they will need to complete the sale. Skip this step, and you'll be playing catch-up indefinitely and miss more sales than you close.

Positioning Questions

It's a long-proven fact that sales are made by asking questions more than making statements. Properly positioning insurance products is a process of Q&A. It must be noted that these questions should remain conversational. Otherwise, the client will feel like you're conducting an interrogation.

Medicare

Before beginning a Medicare discussion involving Medicare Advantage or Prescription Drug Plans, you must acquire a signed Scope of Appointment (SOA) from your client in order to be compliant. Not doing so will result in applications being declined and you losing your credentials to sell Medicare products. No SOA is required when selling ancillary products or not presenting MA's, MAPD's, and PDPs.

There are two categories of Medicare consultation.

T-65 and/or New to Medicare

In this category, you must assess your client's desire to enroll in Medicare and contrast the value/cost of Medicare to their current coverage. Here are a few pertinent questions to ask them:

- "**Are you currently working? If so, do you plan to continue working?"**

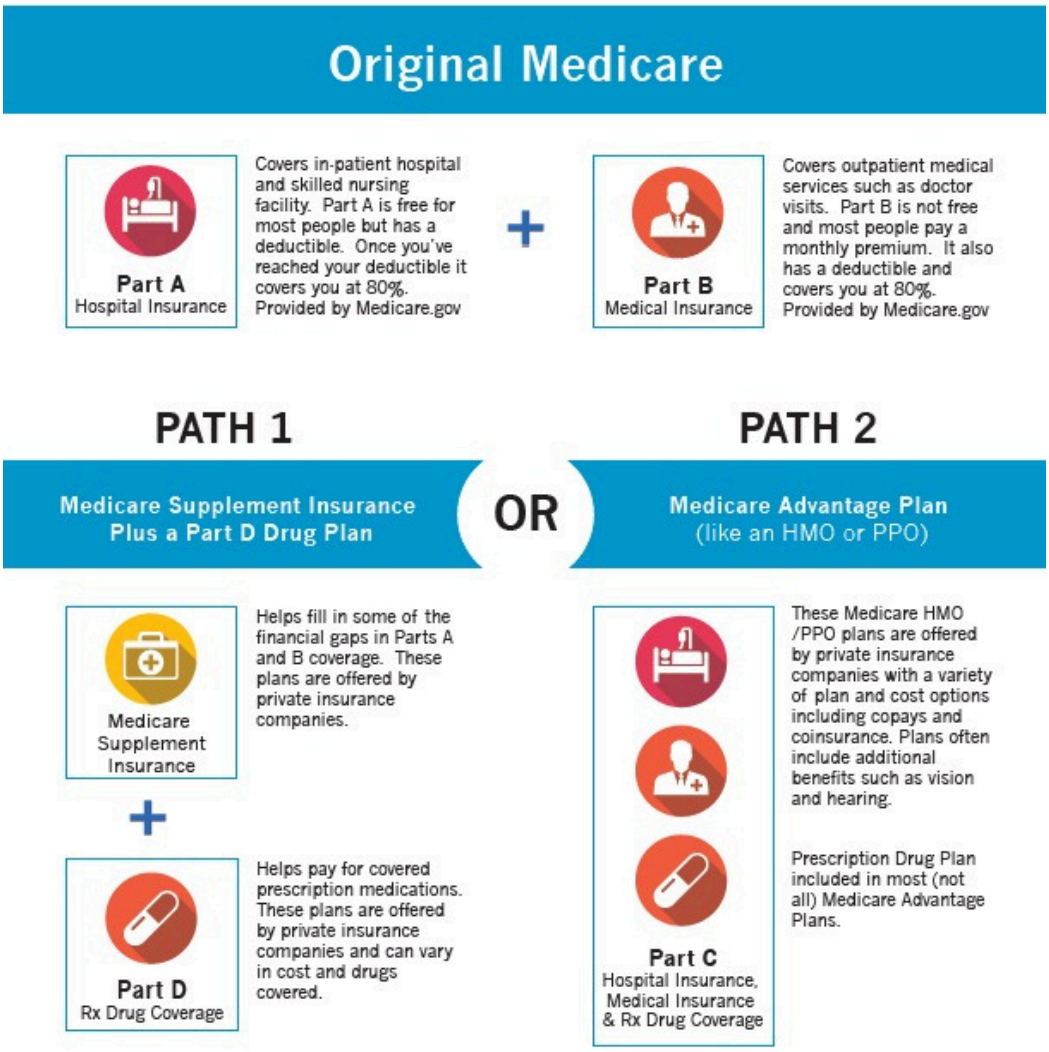
  The reason for asking this question is, if affirmed, to verify that the client has group coverage through their employer/spouse and whether or not they will be permitted to keep that coverage upon becoming eligible for Medicare. If they are not granted the option of keeping group coverage, their decision is obvious. If they do have the option to keep group coverage and delay Medicare, the value/costs of their group coverage should be assessed and compared to Medicare so the client can make an educated decision.

- **"Are you planning to start drawing your Social Security benefit at 65, or do you plan to delay it?"**

  The purpose of asking this question is relevant to the Part B premium. If they are drawing their SS benefit, the premium will be automatically withheld from the SS check. If the SS benefit is delayed, they will have to pay their part B premium one of two ways: quarterly through the mail or monthly via bank draft. **"Do you know how Medicare works, and are you interested in any specific type of coverage?**"

The intention of this question is to identify the knowledge of the client as it relates to Medicare so you can affirm, correct, and educate your client most effectively on making the right decision.

At this juncture, you should educate the client on the two paths of Medicare:



Current Medicare Beneficiary

In this category, the agent must assess the client's current Medicare coverage as well as their current benefit of/eligibility for extra help. Here are a few pertinent questions to ask them:

- **"Do you currently have a Medicare Supplement or Advantage?"**

  This question is to identify the type of coverage the client currently has and offer updated coverage that would be most beneficial to them.

- **"Which plan do you have, and how much is your premium?"**
  This will help affirm which coverage the client has and whether or not they have any subsidies/extra help.
- "**Have you had any trouble with your coverage? . . . Any doctors that refused to accept your plan? . . . Any medicines that your plan refused to cover?"**

  These questions are to uncover the red-button issues that are important to all Medicare beneficiaries. It is impossible to properly position a coverage upgrade without the information that these questions provide.

- **"Are you concerned about the cost of any of your medications?"**
  This will help solidify whether or not the beneficiary has LIS/Extra Help. While inexpensive medications are not an absolute indicator of Extra help, high copays, and experiencing the Coverage Gap (Donut Hole) is an indicator of not receiving LIS. Questions regarding medication should remain generic and open-ended so as to remain compliant. To absolutely verify, you may do so by checking Medicare.gov or by calling any one of the MA/MAPD/PDP carriers to confirm eligibility.

- **"Do you have a QMB or Medicaid Card?"**

  QMB/Medicaid beneficiaries are eligible for Special Needs plans. Knowing someone's SNP eligibility is paramount to properly positioning Medicare coverage.

Medications

Whether positioning an MAPD or PDP, this step is paramount to the quality of coverage provided to the beneficiary. It is recommended that you check all of the client's medications against the formularies of the plans available to them in the region where they live.

"How much monthly income do you receive from your Social Security benefit?... Any other income?"

The reasoning behind these questions is to ensure that the benefit level the beneficiary receives matches their income amounts.

The most efficient process of completing this step is using the Enrollment Central platform or medicare.gov. It should also be noted that a medicine not listed on any given formulary is not an
automatic disqualifier of coverage, but it should be fully disclosed/discussed when presenting the plan.

In completing this medication check, your goal should be to both educate the client and familiarize yourself with the formularies of the plans you offer. The most user-friendly way to complete this step is by using Enrollment Central.

Doctors

Once the client's medication needs have narrowed the coverage options, narrow then further by reviewing the client's doctors. Primary care, specialist physicians, and hospitals should be checked against the network of all potential MA products. We also recommend specifically mentioning pain specialists when completing this step, as some clients do not associate them with customary specialists. In completing this physician check, your goal should be to both educate the client and familiarize yourself with the networks/medical groups covered by the plans you offer. Enrollment Central has direct links to the doctor finder websites hosted by the carriers offering coverage where your client lives.

Benefits

While you shouldn't use value-adding benefits exclusively to make a sale, it is important to educate the applicant of the full scope of the plan's value. Making clients aware of options like dental, vision, hearing, and other ancillary coverages is helpful when beneficiaries are selecting their Medicare coverages. Ask questions like:

- **"Do you have dental work that needs to be done?"**
- **"Is your eyewear expensive?"**
- **"Could you benefit from hearing aid coverage?"**

This will give you the information needed to serve the needs of your client best. The Enrollment Central platform is a great tool for comparing coverage benefits.

How to Learn and Know the Products

There is no substitute for product knowledge. Whether offering Medicare coverage, ancillary benefits, or a blend of the two, you must establish yourself as an expert when positioning and presenting products. The best way to do so is to study, practice, then study and practice some more . . . and then do it again.

Read and memorize benefit summaries. Study product brochures. Talk to beneficiaries about how their coverage works. Do presentations with friends or family members and let them scrutinize your knowledge and techniques. Don't be ashamed to say: "I'm not sure, but I'll find out." Finally, make the commitment to yourself that you'll never stop learning.

Ancillary

Not unlike Medicare products, positioning ancillary products is completed best through a series of questions. The following questions are recommended when preparing to present the following products:

Hospital Indemnity - HI

"Are you concerned about the $_____ per day copay that you would incur in the event that you were admitted into the hospital?"

This question both informs the client of the risk of loss as well as opens the door for the agent to offer the solution to that risk.
Another good positioning question to ask is: "Did you notice that an ambulance ride with your coverage would cost you $_____?"

Cancer/Heart Attack Stroke/Critical Illness

"Are you aware that out-of-pocket healthcare costs are a problem for 25% of cancer survivors?"

This question helps the client understand that cancer costs are not limited to treatment and that no medical coverage will eliminate all liability upon diagnosis.
Another good positioning question to ask is: "Approximately 60% of cancer costs are non-medical . . . do you have a cancer benefit to help you cover that?"

Short Term Care (STC)/Home Health Care (HHC)

"If you had to have rehabilitation, would you rather receive that care in your home or in the nursing home?"

This question makes the client aware of both the potential risks of rehab and the potential opportunity to have it at home.
Another good positioning question to ask is: "Did you know that most Medicare Advantage plans charge a daily fee for inpatient rehab after day 20 and the average cost is $170 per day?"

Dental Vision Hearing - DVH

"Have you given any thought to dental, vision, and hearing expenses since Medicare doesn't cover all of those needs?"

This question brings the client to a comprehensive understanding of what Medicare does and doesn't cover. It also opens the door for you to provide a benefit that compensates for those risks.

Another good positioning question to ask is: "Were you aware that gum disease (periodontitis) is associated with an increased risk of developing heart disease?"

Life Insurance/Final Expense

"Have you made arrangements for your final expense?"

This question highlights the financial risk of the inevitable. It also presents an opportunity to displace that risk.

Another good positioning question to ask is: "Would your purpose in having a life insurance policy be to cover final expense only, or do you wish to leave a benefit to someone in particular when you pass?"

Making the Presentation

Here we are. This is where your conversation with your client was designed to bring you. Here you present coverage/coverages that have been purposefully positioned to best fit the needs of your client. To be most effective, you should contrast the client's current coverage (if any) with the coverage update options you're offering.

During the presentation, watch your client closely. Their expressions and responses to your presentation will confirm what is most important to them. Once the presentation is complete, allow them a moment to consider the information and ask for any questions they may have.

Recap the most important aspects of the coverage and ask: "Does this look good to you?" or: "Do you feel like this coverage would be beneficial to you?" When they say yes, begin the application process.

Staying Compliant

When presenting Medicare Advantage or Prescription Drug Plan coverage, you should always include the following in order to stay compliant:

- A Summary of Benefits.
- Star Ratings.
- A Multi-Language Insert.

Completing the Application

Depending on the product sold, the application process will differ slightly. However, it is most advisable to use electronic application processes when selling both Medicare and non-Medicare products. Doing so helps to eliminate mistakes and rejected applications.

When positioning, presenting, and completing an application for Medicare Supplements, Medicare Advantage, and Prescription Drug Plans, you should use Enrollment Central. It is the most user-friendly process of completing applications. For other products, virtually all carriers offer e-applications through their agent portals. Some also offer IOS and Android apps to complete applications as well.

After the Sale

You've done it! After successfully becoming acquainted, positioning the proper product, making a compliant presentation, and completing the sale, you should **always, always, ALWAYS** ask for referrals. A client marketing for you in the form of a referral is the most efficient way to grow your business. Leave behind business cards, ink pens, notepads, etc. that will serve as a constant reminder of the pleasant interaction you shared with your client.

Follow up as well. A good time to reconnect with your clients is around the time they receive their policy and/or coverage IDs. Also, touching base as the annual renewal of coverage approaches is advisable as well. When your clients share the experience they had with you to their friends and family, your credibility, trustworthiness, and book of business grows. Each agent will be different in their follow up. Our strategy at NCC is to promote a 30/60/90-day follow-up. This ensures a consistent process that you can implement from day one.

Related Resources:

3 Steps to Client Retention

Overcoming Objections

Objections are a challenging part of any sales role. Whether sales are made over the phone or in person, objections can stop you right in your tracks. Here are three tips for overcoming objections, as well as 11 examples of the most common challenges you will hear in your appointments.

3 Tips for Overcoming Objections

Objections are not necessarily “No’s”. They are requests for more information. Do not be afraid to answer questions from your beneficiaries. Whether your goal is to set up a follow-up appointment, get into a presentation on the same phone call, or close a sale in person, keep these tips in mind.

1. Listen Actively.

By listening carefully and seeking to understand your prospects well, you'll learn what's important to them. Once you know what's important to them, you can position your products in a way that solves their problems and answers potential objections before they even become an issue. **Remember: the best way to overcome objections is to prevent them in the first place.**

2. Ask Questions.

Start asking simple questions from the very beginning. Get to know your prospect personally. We like to tell agents: "Know how to talk about something besides insurance." Building rapport early helps to prevent objections later on. Once you turn the conversation toward insurance, always start by asking, "Can I ask you a few questions?" Getting someone to say yes early on will make it easier when you ask for the sale.



3. Always Acknowledge and Address the Objection.

Phrases like "I completely understand," "I know how you feel," or "That makes perfect sense" will disarm the prospect and ease some of the tension. Once you acknowledge the objection, always

address it. If you leave it unanswered, the sale will be much more difficult, and the chances of the prospect canceling their new coverage soon after are higher.

11 Common Objections Answered

Now here are 11 common objections you will come across and how to address them.

1. "I'm not interested."

"I completely understand that. But if you have just a few minutes, I think we can save you some significant money on your drug costs and get you more coverage for your dental needs."

After you acknowledge the objection, restate the purpose of your call or meeting and jump straight to the point. Keep in mind the most significant benefits you can offer to a client: lower drug costs, more options for doctors/network, dental coverage, hearing aids, and glasses.

2. "Can you mail me the information?"

"Absolutely! Since I represent all of the major carriers in the area, can I ask you a few questions to make sure I send you the right information?"

If they agree, go through a needs assessment as needed. If they decline, ask if you can mail them your business card with a letter or brochure. No matter what, send the information and **follow up**.



3. "I've already taken care of my Medicare."

"That's fantastic. Did someone already explain to you all the differences between a Medicare Supplement and a Medicare Advantage plan?"

If they pause or hesitate, that gives you the option to review with them and make sure they have the plan they need.

4. "I'm not on Medicare yet."

"No problem. I want to make sure you know about the penalties for enrolling in Medicare too late. Have you been advised of the best time to come off of your group/spouse plan? /Have you set up a plan for when you do eventually retire?"

If the prospect has a retirement date set, ask if you can call them on a specific date to get them enrolled and make it a seamless transition from employer coverage.

5. "Why are you calling me?"

"I work with people on Medicare in your area. I got your information from the card you returned in the mail/when you submitted your request on Facebook/when you requested a quote online. Could I ask you a few questions?"

In general, tell the prospect exactly where you got their information and get right into the discovery part of your process.

6. "I already have an agent."

"I'm really glad to hear that. When was the last time you spoke to them?"



If it has been in the last few months, you can ask them if their agent talked about specific ancillary products like Hospital Indemnity or Cancer insurance.

If it has been around a year or more, you can say:

"That's really disappointing. A lot can change in the amount of time. Let's make sure you're getting all of the benefits you deserve. Can I ask you a few questions?"

7. "I don't want to make any changes right now."

"I completely understand that. I don't think a big change would be good for you right now, but I think we can get you a nice little upgrade/update. Here's how this would work better for you."

If they are adamant about not making any changes, you might ask:

"Can I call you back [on X date and time]? There will be some new information I can share with you then."

Or you could ask:

"Can I mail you my information so you know how to get in touch with me?"

8. "I can't afford that."

"Of course, you know your budget much better than I do. Are you paying for any other coverages?"

Acknowledge the objection and be very careful never to push someone financially. It will never work out.

One agent recently discovered that a prospect was paying $70/month for a $1,000/day Hospital Indemnity plan by using this method. The agent was able to quote a more reasonable daily benefit that saved the beneficiary $30/month.

9. "I need to talk to my son/daughter/POA first."

"Absolutely. This is a very important decision to make. Is there a time that would work better for you and your son/daughter/POA? When would be the best time to schedule a meeting for all of us to discuss your needs?"

Do not try to pressure a prospect like this to make a decision, even if they don't have a POA.

10. "I need to talk to my doctor/pharmacist."

Offer to call the doctor or pharmacist with the prospect right then to verify they accept the coverage you are presenting. If they insist they talk to the doctor or pharmacist by themselves, you might say:

"Sure thing! Talk to them, and I'll call you back on Monday."

Kindly remind the client that their doctor or pharmacist can't legally offer them insurance advice, just as you can't legally offer them medical advice.

11. "I don't want to give you that information over the phone."

"I totally understand why you may not want to share your information over the phone, but I need all of this information to make sure I can help get you these drug savings/dental benefits/ lower monthly costs we've talked about."

You may start to hear this more and more if you are making presentations over the phone. While you don't want to pry, you should reiterate why you need the prospect's information. If they refuse, offer to meet them in person, even just briefly.

Don’t let objections derail your sales process. Use there tips; figure out what works for you, and start closing more sales today!

Lead Generation

Now that you know how to handle an appointment, you need to set one. Lead generation does take some money, but more than that, it takes a lot of time and attention. What separates the good agents from the great ones is the ability to generate more quality leads. You could close 100% of the appointments you set, but you won't make it in this business if you don't have enough leads.

Not all lead generation techniques cost tons of money. The most successful, long-term techniques cost as much as it takes to print a business card. As you read through the following information, aim to create a well-rounded plan for yourself that incorporates many types of lead generation. Set a goal to try a new technique or reach out to a new business contact once a month. Before you know it, you will have as many leads as you can work.

What You Need

- Marketing materials – business cards, flyers, etc.
- Digital presence – Facebook, Google, Yelp, Nextdoor, LinkedIn, etc.
- A lead purchasing program you're comfortable with.
- Referrals.

Essential Marketing Materials

Business Cards

Business Cards are easy to carry and a great way to get your name out there. You can post it on a local bulletin board, drop it in a fishbowl at a networking event, or leave a few with a client and ask that they give them to friends or family who could use your help. Having a blank backside is beneficial for taking notes if needed.

Fliers

Fliers with a professional photo introducing yourself as the local Medicare education specialist are great for leaving at local offices to build your professional reference base. You can also mail these out to locals turning 65 or 65+ who may reach out with questions for you. If you are

hosting an educational event at a local senior center or setting up a table at a doctor's office, make sure to hang fliers and have them on-hand at your event.

Pens

Pens with your name and number on them are a great resource to give out anywhere! They keep you in someone's pocket if they need anything and build familiarity by putting your name in their hand. Everyone needs a pen!

Digital Presence

Facebook

Facebook is the social media preference for the Medicare age demographic. It's essential to have a business page set up and active. Having people like and follow your Facebook page is a great way to build trust in your community since people are more likely to call someone their peers recommend. Facebook is also a great way to share knowledge and information with your followers. Make sure you're posting consistently to show you're available if anyone has questions. Find even more tips & tricks for Facebook here!

YouTube

It may surprise you to learn just how much time senior citizens spend watching videos online. Recent research shows that 70% of those aged 50-64 use YouTube, as do 38% of those over 65. That means your potential clients are very likely getting their Medicare information from videos. Consider making your own and include the names of the states and counties you serve in your video description to boost your content above your competitors in local search.

Google/ Google My Business

Google is how everyone is searching for what they need. Setting up your "Google My Business" profile will make it much easier for someone to find you when searching for Medicare information near them. Google also provides a call button and a free website platform if you choose to utilize that.

Next Door

Nextdoor is a growing platform that is specifically designed for your local neighborhood. People will put in their address, and, based on where they live, they will be assigned a network of people to share news and recommendations, as well as ask questions. They offer business profiles that make it easy for neighbors to recommend your business.

Business Website

A website is a great way to step up your digital game and be accessible to even more people. It gives you a platform for sharing education, you can place a form on your website for people to fill out if they have questions, and it will help you show up on Google easier. Several companies offer easy-to-create website options, or you can have a company create your website for you. Check out our article Free Websites for Medicare Agents to find out more.

Lead Purchasing

Purchasing leads is an investment in your business. When starting out, you want to make sure you're investing your money in the right place. Keep in mind, before you can contact a prospective client specifically regarding Medicare Advantage or PDPs, you need Permission to Contact (PTC). You can't make cold calls for those products. A completed Business Reply Card (BRC), an email requesting contact, or a generic PTC form are examples of PTC. If someone initiates contact with you first, there is no need for a separate PTC (see Referrals section below for specific ideas).

Business Reply Cards (BRCs)

Business Reply Cards (BRC) are a great type of lead to start with. They send out 1,000 pieces of a generic mailer that goes to your targeted demographics (age, counties, income). The person receiving the mailer can fill it out and mail it back, requesting more information. This gives you PTC and the freedom to call, mail, or even knock on their door to talk to them. Typically, 1,000 pieces will run around $600 with a 3-4-week turnaround time and a 1-2% return rate.

Lead Lists

Lead Lists are a much smaller investment, but they don't give you the permission to contact you get from a BRC. You receive 1,000 names & addresses within your targeted demographics (age, counties, income). Lead lists are an excellent option if you want to do your own personalized mailer, flyer, or postcard. You can also request, at no extra cost, the list to have scrubbed phone numbers. Be prepared to provide broader demographics in order to hit 1,000 names. If you're calling from one of those lists, remember not to market Medicare Advantage and PDPs unless asked about it first.

Internet Leads

Internet leads are another option. These can range from someone filling out a form via Facebook ads to using a lead company specializing in internet leads. The prices here vary, but they typically range from $10-30 per lead. If the prospect fills out a form for more information and acknowledges that a licensed agent will be reaching out to them, this gives you permission to contact.

Referrals

Referrals are so important because they cost nothing, they build your brand, and they provide a significant boost to retention. It's important to get familiar and comfortable with asking for referrals. Closing ratios for referrals are significantly higher than any other referral program.

Professional Referrals

Professional referrals are vital to have in your back pocket. These are people who have a customer base and may need to recommend a local Medicare expert. Remember: just as you as an insurance agent can't offer investment or tax advice, unlicensed agents can't offer advice on Medicare insurance. Some examples of professionals to build connections with are:

- *Realtors - They know who has just moved into the area.*
- *Senior Centers - This is a great place to set up a booth for education, leave a flyer, and just make sure the employees know your name if asked about Medicare.*
- *Accountants - People trust their accountants with their finances, so they will also trust their opinion on insurance agents.*
- *Moving Companies - They also know when someone is moving into the area.*
- *Alumni Groups - Show up to events and post in your online groups, and make sure your peers know what you do. Everyone knows someone on Medicare.*
- *Financial Planners - Generally working with seniors, this is an excellent resource.*
- *P&C Agents/ Agencies - Offer consultations with their clients as a service to them and send them P&C business if you come across it.*
- *HR Staff - Offer consultations with their retiring employees who need a smooth transition from group coverage to Medicare.*
- *Parole Officers - They know individuals over 65 have 60 days to enroll in Medicare when they get out of jail.*

Networking Groups

Networking Groups are a great way to connect with even more professional referrals. Networking groups usually allow only one group member to be in a specific industry, so there shouldn't be much competition for Medicare business. Don't forget to give plenty of referrals; the people who provide the most referrals are typically the ones who get the most in return. Check in with your Chamber of Commerce to see what networking events they have coming up. Even if you're not a member, some chambers will give you a directory of members as well.

Client Referrals

Your current book of business is your single most significant resource. Don't hesitate to ask your existing clients to give one of your cards and recommend you to friends and family. After meeting with someone, give them 10 of your business cards or send them a handwritten thank you card with some business cards thrown in. If you ask for referrals from every single person you help, you'll soon generate enough free leads to keep you busy all the time.

When you get a referral from a current client, be sure to call and thank them, send them a card, or drop off a small (less than $15) thank you gift. A little gesture like that will go a long way in showing your clients you care and generating referrals in the future.

Marketing & Lead Generation Timeline

When purchasing leads or preparing for AEP, it's essential to know what to expect and when. The last thing you want to do is wait too long to order your BRC's or not prepare for AEP in the best way possible.

Use the timeline on the next page to help you organize your marketing calendar.

Marketing and Lead Generation Timeline

January

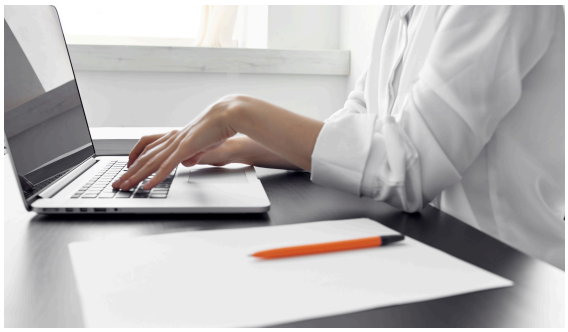
January 1 - March 31: MA OEP

- While you can't advertise OEP, pay attention for beneficiaries who may have failed to switch plans during AEP, or aren't happy with their choices.
- Start your marketing to T-65s and Low-Income prospects early in the year. You'll be glad you did over the summer.
- Get in touch with current clients and offer ancillary products.



February

March



April

April: Start Working Your Leads

Most of the business you write from now through September will be T-65 and Low-Income business. If you start marketing early in the year, you'll have plenty of leads to work over the slow half of the year. Cash can get a little tight later in the summer, so make sure you are taking advantage of low- or no-cost marketing like referrals and professional relationships.

May

June

Early June: Take AHIP

You must take the AHIP exam if you want to sell Medicare Advantage and/or Part D. See the Contracting section for more details.

July

Early July: First Looks

Most of the business you write from now through September will be T-65 and Low-Income business. If you start marketing early in the year, you'll have plenty of leads to work over the slow half of the year. Cash can get a little tight later in the summer, so make sure you are taking advantage of low- or no-cost marketing like referrals and professional relationships.

August

Late July: Order BRCs

Order as soon as possible to be guaranteed addresses in your geographic target areas. Most lead companies won't double mail in the same area for different agents. Order your BRCs at the end of July and plan to mail in Mid-August.

September

Mid-August : Verify BRCs are Being Shipped

You want your leads to have mailers going into AEP. There is a 3-4-week turnaround, so expect to see BRCs coming in around mid to late September.

October

October 1: Begin Marketing AEP Plans

You can't get signatures on any applications yet, but this is a great time to start contacting your leads or current book of business to set appointments and give presentations so your clients are ready to sign when AEP begins.



November

October 15 - December 7: AEP

Use your leads, current book of business, referrals, and all other resources you have available to you to sell as much as you can. Don't forget to post reminders on your social media for your followers to reach out if they have questions or need to review their coverage.

December - Get Ready for a New Year!

- Order leads for January and February by the 15th so they mail right after Christmas.
- If you didn't sell ancillaries during AEP, reach out to current clients and offer them now.
- Make a lead generation plan for the coming year. See our guide to lead generation for more ideas.

Commissions

You're reading this guide because you want to make a sound, stable living for you and your family. To do that, you need to know how money works in this business. Most agents don't have a great grasp on commissions, so you'll be ahead of your competition from the start by reading this.

Medicare Advantage/ PDP

We'll start with Medicare Advantage and PDP commissions. Don't be confused: no, PDPs and Medicare Advantage plans aren't sold together, but they are regulated the same way, including their commissions.

CMS sets agent commissions for Medicare Advantage and PDP sales at Fair Market Value (FMV).
FMV rates for Medicare Advantage have increased by over 40% in the last six years, and PDP rates have increased more than 55%. Now is the time to be in this business.

Medicare Agent Commission Growth		
Year	**MA (Renewal)**	**PDP (Renewal)**
2026	$694 ($347)	$114 ($57)
2025	$626 ($313)	$109 ($55)
2024	$611 ($306)	$100 ($50)
2023	$601 ($301)	$92 ($46)
2022	$573 ($287)	$87 ($44)
2021	$539 ($270)	$81 ($41)
2020	$510 ($255)	$78 ($39)

Understanding Rates: Initial vs. Renewal

The chart above shows two rates: Initial (also called New-to-Medicare) and Renewal/Replacement. The renewal commission is half of the initial.

Initial/New-to-Medicare

- You receive the entire Initial Rate when your client is enrolling in a Medicare Advantage plan for the first time.
- You should receive the commission within a few weeks of writing the application, no matter the time of year.

Renewal/Replacement Rate

- You receive a prorated version of the Renewal Rate when you move a client from one Medicare Advantage plan to another.

  You will receive a proportionate amount based on the number of months that the client will be on their new plan through the rest of the year.

- All Medicare Advantage plans renew in January each year, and all 2nd-year renewal payments are made at the Renewal Rate.
- Most carriers make 2nd-year renewal payments in monthly installments.

Example 1

When Mrs. Smith enrolls in Part B, you help her enroll in an MA plan. If she has a 4/1/2025 effective date, you will receive $626 because Mrs. Smith is "new to Medicare."

Example 2

Mrs. Smith has been on an MA plan for two years. She is eligible for an SEP, and you help her enroll in a new MA plan with an 8/1/2025 effective date. You will receive $144.58. Mrs. Smith will be on the new MA plan for five months during 2025, and she made a "like plan change" (5/12 x $347= $144.58).

In both examples, Mrs. Smith's policy would renew on 1/1/2024 at the renewal rate.

Carriers can only pay commissions for a plan year during that plan year, so commissions for AEP business (effective January 1) are paid in January.

Here is a helpful chart for calculating your Medicare Advantage commission for any particular client.

Effective Date	Renewal
1 / 1	$347.00
2 / 1	$318.08
3 / 1	$289.17
4 / 1	$260.25
5 / 1	$231.33
6 / 1	$202.42
7 / 1	$173.50
8 / 1	$144.58
9 / 1	$115.67
10 / 1	$86.75
11 / 1	$57.83
12 / 1	$28.92

Getting started selling Medicare Advantage brings a couple of obvious financial difficulties, but the long-term payoff is well worth it.

As you get further into the year, you will earn less per sale for a plan-to-plan change. There are three ways to make up for this: sell more, keep a steady stream of New-to-Medicare clients, or sell ancillary products.

Selling more is the first solution as long as you can make the necessary investments. Constantly working your book of business and asking for referrals can help you find more clients turning 65. Ancillary sales pay the same commission levels year-round; they cover liabilities in Medicare Advantage coverage, helping boost client retention. Please refer to the Lead Generation section

of this guide if you want more information on generating leads. We'll talk about ancillary commissions in a minute.

Example

You write 10 Medicare Advantage apps per month and an additional 50 1/1 effectives during AEP. **If we assume 20 percent are New-to-Medicare, here's how the commissions look:**

MAPD Commission Timelines			
Month	**New to Medicare**	**Rollovers**	**Total Commission**
January	2 x $694 = $1,388 (+ 10 AEP sales = $6,940) = $8,328	8 x $347 = $2,776 (+ 40 AEP sales = $13,880) = $16,656	$24,984
February	2 x $694 = $1,388	8 x $318.08 = $2,544.67	$3,932.67
March	2 x $694 = $1,388	8 x $289.17 = $2,313.33	$3,701.33
April	2 x $694 = $1,388	8 x $260.25= $2,082.00	$3,470.00
May	2 x $694 = $1,388	8 x $231.33 = $1,850.67	$3,238.67
June	2 x $694 = $1,388	8 x $202.42 = $1,619.33	$3,007.33
July	2 x $694 = $1,388	8 x $173.50 = $1,156.67	$2,776.00
August	2 x $694 = $1,388	8 x $144.58 = $1,156.67	$2,544.67
September	2 x $694 = $1,388	8 x $115.67 = $925.33	$2,313.33
October	2 x $694 = $1,388	8 x $86.75 = $694.00	$2,082.00
November	2 x $694 = $1,388	8 x $57.83 = $462.67	$1,850.67
December	2 x $694 = $1,388	8 x $28.92 = $231.33	$1,619.33
		Totals	$55,520.00

*It's important to remember that any 1/1 effective business will be paid in January, **not** when the application is written. In this scenario, you would earn around $30,000 your first year, with another $10,000 or so coming in January, for a total of $40,000 based on year one production.*

Keep in mind that this business is a long-term play. If you did the same production in year 2, you would earn an additional $25,000 - 30,000 just in renewals because you would have over 100 policies renew in January. That's an additional $2,000 per month coming in with little or no work required. In a few years, you could earn $100,000+ just in renewal income.

The first year is always the hardest. That's why we will strongly push you to sell ancillary products to boost your commissions. Here is how ancillary commissions work.

CMS Final Rule 2025 Agent Compensation Changes Update

CMS' 2025 Medicare Advantage & Part D Final Rule included sweeping changes to Medicare agent compensation. As a result, many in the industry expected to see standardized commissions and a cap on agent/broker non-salary compensation in 2025. However, on July 3, 2024, a federal judge in Texas granted a stay in Americans for Beneficiary Choice's (ABC's) and Council for Medicare Choice's (CMC's) lawsuits against the Department of Health and Human Services (HHS).

Right now, the effective date of CMS' Medicare Final Rule 2025 commission changes is on hold while court proceedings decide if these changes exceed CMS' statutory authority, are arbitrary and capricious, and were made following the proper procedures. **The current ABC and CMC v. HHS lawsuits will determine if the CMS Medicare agent and broker compensation changes below can go into effect in the future.**

- Eliminating separate administrative fees
- Setting clear, fixed amounts for MA and Part D sales, adjusted annually based on fair market value
- Capping agent and broker non-salary compensation
- Prohibiting enrollment incentives that may bias agent recommendations
-

These changes would require carriers to pay the same, set commissions, established by CMS, for MA and Part D sales. They may also affect and, potentially, eliminate health risk assessments (HRA) fees, marketing co-op, and enrollment-based bonuses offered by plans. A final court outcome is not expected until sometime in 2025, or possibly even 2026.

The recent Medicare commissions court cases and changes can make it difficult to understand what's happening with Medicare commissions. However, we can say that, as long as the court-ordered stay is in place, you can expect commission structure and opportunities to maintain the current status quo!

Ancillary Products

Ancillary products don't renew on a calendar year basis but instead on a rolling 12-month basis from the policy effective date. That means the commissions aren't prorated through the end of the year. You get paid the same no matter the time of year. Ancillary commissions are based on percentages of annualized premium (AP).

EXAMPLE 1

Cigna Flex Choice Cancer - 60% Year 1 commission * average AP of around $500 = $300 Year 1 commission, 9-month advance = $225

EXAMPLE 2

Medico Hospital Indemnity - 55% Year 1 commission * average AP of around $400 = $220 Year 1 commission, 9-month advance = $165

Most ancillary commissions are paid on a 9-month advance, with commissions paid monthly starting with the 10th month. So, in the Cigna example, you would get $225 when the policy issues and $25/month for the 10th, 11th, and 12th months. Most ancillaries drop to a much lower commission in years 2+ (roughly 5-12%). Still, that first-year commission can get you through times of the year when Medicare Advantage commissions are lower or when business is slower.

We generally see that one-third of clients will buy an ancillary plan **if** you present one. If you sell just one per week, it could mean another $15,000 in first-year commissions. We have agents who cover their car payments and more with only their ancillary commissions. Refer to the Ancillaries section and the Ancillaries portion of the Sales Techniques section for more information.

Don't forget to offer appropriate ancillary products to clients on a Medicare Supplement, as well.

Medicare Supplements

Medicare Supplement commissions work the same way as Ancillaries, just with different percentages. Everything is based on a 12-month policy year, not a calendar year. Typical Medicare Supplement annualized premiums are around $1,500 depending on the client, and commission rates are generally 21-22% for at least the first six years.

EXAMPLE

Mutual of Omaha Med Supp Plan G- 22% Years 1-6 commission * $1,500 AP = $330/year Years 1-6, 12-month advance

Most Med Supp carriers will pay a 12-month advance, so you'll get a full year's commission no matter what time of year you write the application. Renewals are paid monthly starting on the 13th month, so $27.50/month in the example above.

Understanding Commissions is Vital

The first year is the toughest in this business, but you're in a much better position to be successful when you understand how commissions work. Keep in mind how important Ancillary products are and how valuable client retention is to your renewal growth. If you do, you'll be on track to build a profitable business and a secure financial future for you and your family.

Licensing and Contracting

Licensing

Once you've decided Medicare sales is right for you, you need to get licensed in the states where you want to sell. Each state will have its own requirements, but most require a high school diploma, pre-licensing education, an insurance license application, fingerprinting, and a background check.

Insurance licenses have different lines of authority, allowing you to sell different types of insurance. For Medicare sales, most agents have Life & Health lines of authority, but be sure to research which lines of authority are required to sell Medicare products in all states where you wish to conduct business.

Once you've decided the lines of authority you need, you need to find out what your state requires for pre-licensing education. Many states require around 20 hours of education per line of authority, but each state is slightly different. We recommend using Kaplan Financial. You can search licensing requirements, sign up for in-person or virtual classes, and review study materials for all 50 states in one place. We have a discount code ("**NCC**") that will give you 15% off any pre-licensing or continuing education purchases you make.

After you finish your pre-licensing work, you can schedule and take your licensing exam. Once you've passed the exam, you can apply for a license, get fingerprinted, and go through a background check, depending on state requirements. Within a few weeks of passing your exam, you should be ready to go ahead and move on to contracting.

Continuing Education

To maintain your insurance license, you'll need to complete a certain number of approved Continuing Education (CE) credit hours, typically every two years. Many states require 24 CE credit hours, with at least three being ethics training. Again, we recommend Kaplan (use code "**NCC**" for a 15% discount). You can search and sign up for continuing education classes in all 50 states from their site. We highly recommend taking continuing education courses regularly and not waiting till the 2-year deadline.

Contracting

Different products and carriers have different contracting requirements. Below you will see a breakdown of contracting needs, including certifications, by product and carrier.

Basics for Starting the Contracting Process

- Health and Life Insurance license(s) for any state in which you intend to sell products.
- Errors and Omissions (E&O) coverage – NAPA is a good carrier to get a basic policy with
- https://www.napa-benefits.org/errors-and-omissions.
- Voided Check.
- Username and Password to any website through which you have taken a certification.
- **i.e.,** Limra if you have taken AML.
- Explanations of anything that may be on your background, i.e., Bankruptcies, Arrests, Complaints, etc. The explanations need to be as specific as possible with dates and any supporting document that you may have. We suggest that every explanation covers these basic points:
    - What happened, the county in which it occurred,
    - Why it happened, the outcome, and
    - Why the issue will not happen again.

Once you have all the basics together, it is time to start the process. When contracting with NCC, there are two main ways contracts can be submitted: A link for contracting, which is sent to your email address or through our online contracting platform SureLC.

- Online contracting – allows you to enter your information once to request multiple carrier contracts without retyping it repeatedly. There are minimum additional carrier-specific questions when requesting contracts, and SureLC allows you to upload your signature to be affixed to each contract.
- Carrier-specific links – are required by the carrier to shorten their back-end processing. Some carrier-specific contracts will allow you to roll right into their certification process.
- See our website for current NCC carriers.

Certifications

After completing all necessary information and submitting the contracts, you move into the approval and certification phase. If you choose to focus on selling Medicare Supplements and ancillary products, certifications are not required (UHC does require certifications to sell their Medicare Supplements). Medicare Advantage and Prescription Drug Plans do, however, require certifications.

Completing carrier certifications starts with passing AHIP. There are five modules to AHIP, with quizzes throughout and a final exam. You must pass the final exam within three attempts by obtaining 90% or better. Each year the new AHIP exam releases at the end of June (release dates vary by year) and covers the remainder of the current calendar year and the next full year. AHIP costs $175, but by linking to AHIP through a carrier, you will receive a $50 discount. Carriers provide links within their certification modules, or you can click here to visit AHIP directly and still receive the $50 discount.

Once you have completed AHIP, you will move on to the carrier-specific product modules. As with AHIP, there are modules to review (difficulty and time investment varies by carrier) and then testing. Most carriers require the test be passed within three attempts. UnitedHealthcare, however, allows for six attempts. After passing the carrier-specific product modules, you will then receive ready-to-sell notices with your carrier-specific writing numbers.

Please Note:

1. You **MAY NOT** sell a Medicare Advantage or Prescription Drug Plan without having received a ready-to-sell notice from the carrier you are representing for the current contract year.
2. Yearly Recertifications (AHIP and Carrier Specific) are required to continue to sell and/or receive renewal payments.

About National Contracting Center

National Contracting Center is an insurance Field Marketing Organization (FMO, also known as an IMO, VMO, or NMO). Founded in 1992, we have helped thousands of independent insurance agents and agencies to grow their sales of Medicare and senior health and financial products.

"I spent a considerable amount of time evaluating field marketing organizations (FMO) for my new agency. I'm so glad I chose National Contracting Center! They have excellent training, resources and regular follow up which is much needed for a new agent. They've made me feel like family. I highly recommend NCC!" - Stephanie C.

What We Do for You

- Marketing and lead generation support
- Sales and compliance training
- Supplies and product information
- Questions about carriers and commissions
- Back office support so you can focus on selling
- Contracting and licensing
- Agent and agency development

We Know the Business Because We're in the Business



National Contracting Center is the kind of FMO that every agent wants because an agent designed it. Jerold Johnson created NCC to be a different kind of FMO. He started selling insurance in 1983 and founded NCC in 1992. The readers of City View magazine named Jerold "Best Insurance Agent in Knoxville" 5 years in a row. An agent built NCC, we're here for agents, and many members of our staff are agents themselves. **Our team of insurance pros delivers the advice, answers, and services our clients need.** In other words, we do all the things that take time and don't make money.

That frees you to focus on selling.