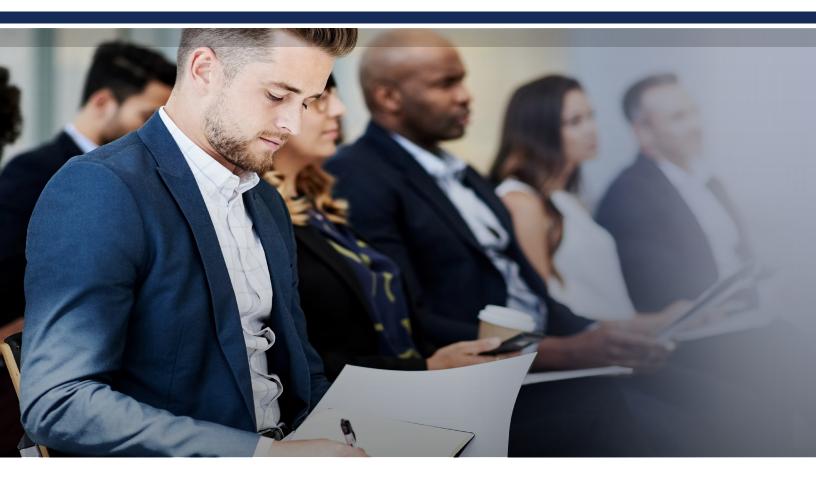


AN INTEGRITY COMPANY



AGENT MEDICARE COMPLIANCE GUIDE

BEST PRACTICES IN MEDICARE COMPLIANCE & MARKETING

2021

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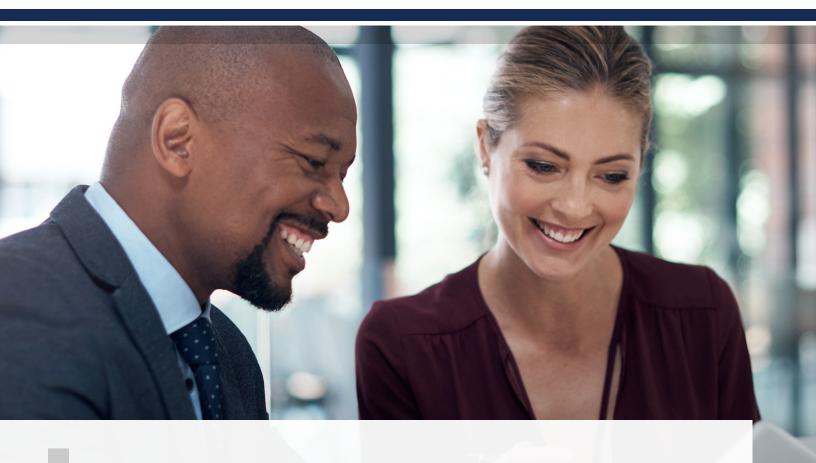
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SECTION 1:

LEAD GENERATION

Before the sale, before actual contact with the consumer is even made, you need to make sure your Lead Generation practices are compliant. In this section, we'll cover the rules and regulations that govern this process including Permissible Contact rules, BRC guidelines and Compliant use of Marketing Materials (which includes your Website and Social Media).

CONTACT RULES

Agents may only make unsolicited direct contact with potential clients using the following methods:

- Conventional mail and other print media (e.g., advertisements, direct mail)
- Email provided all emails contain an opt-out function (text messaging, including messaging on social media platforms, falls under unsolicited contact and is not permitted)

NOTE: Unsolicited contact is contact that is not asked for or requested by the consumer. Whereas solicited contact means a consumer has given express consent to be contacted by a sales agent for the purpose of receiving information about Medicare insurance plans.

All other unsolicited contact is prohibited when making contact with potential clients. Examples of unsolicited contact include:

- Door-to-Door Solicitation (Door Knocking)
- Leaving Flyers, Leaflets, etc. at residences or on cars (Note: this is only permissible if you have a pre-scheduled appointment who is a "no-show")
- Approaching potential enrollees in common areas such as parking lots, lobbies, sidewalks, retail stores, etc.
- Telephonic or electronic (cold-calling, texting, etc.)
- Calling attendees of a Sales Event (unless express permission is given for a follow-up call)
- Calling a "referral" from a current client

So what can you do? Agents may:

- Call individuals when valid, documented "permission to call/contact" is given
- Give contact info to current clients who want to refer a friend/relative (the referred individual needs to contact you directly)



CONTACT RULES

- Call their current clients to promote other Medicare plan types or to discuss plan benefits (ex. contact your PDP enrollees to promote MA-PD products)
- Call their current clients to discuss/inform them about general plan information, such as Annual Enrollment Period (AEP) dates, plan changes, educational events, etc.
- Return phone calls/messages or leave information at a residence if your prescheduled appointment becomes a No-Show
- Email potential enrollees, provided all emails contain an opt-out function and follow other generic marketing material guidelines

Other Important Information

 Permission to Call/Contact is event-specific and not open-ended permission for future contact

NOTE: Permission applies only to the entity from which the individual requested contact and for the duration and topic of that transaction

- Bait-and-Switch strategies are also prohibited (ex. making unsolicited contact about other business as a means of generating leads for Medicare plans)
- Referrals from current clients do not give you "permission to contact"
- Cannot make calls to market plans or products to former enrollees/clients who have disenrolled, or those in the process of disenrolling
- Cannot call attendees of a sales or educational event, unless they have given permission to be contacted (permission must be documented)
- Cannot call potential clients to confirm receipt of mailed information



MARKETING AND ADVERTISING MATERIALS

We understand that marketing materials play a critical role in your daily business activities, but it is vital that you ensure your generic marketing materials are compliant with CMS guidelines. Follow the guidance below when creating your own marketing materials. Also, keep in mind **Lead Vendors' materials aren't always compliant so it's a good idea to review those,** as well, to ensure they are compliant.

As you develop marketing and advertising materials for Medicare audiences, it's important to know that CMS makes a distinction between "Communications" and "Marketing."

COMMUNICATIONS:

are all activities and materials used to provide information that is targeted to current and prospective enrollees, including their caregivers and other decision makers.

NOTE: Generic mailers and advertising materials you create to promote your business and generate leads fall under the definition of "communication" materials (given they are free of carrier names and specific plan information).

MARKETING:

is a subset of communications and is determined based on both the content and intent of the activity or materials. Marketing includes activities and materials with the intent to draw a beneficiary's attention to a specific plan or plans and to influence a beneficiary's decision-making process when selecting a plan for enrollment or deciding to stay enrolled in a plan (retention-based marketing). Additionally, marketing contains information about the plan's benefits, cost sharing, measuring, or ranking standards.

NOTE: CMS excludes materials that might meet the definition of marketing based on content, but do not meet the intent requirements of marketing.



MARKETING AND ADVERTISING MATERIALS

GENERAL GUIDANCE:

- To be considered "Generic," materials can't include Company Names or Logos, Plan Specific Names, Product Specific Names, Specific Plan Benefit Info, STAR Ratings, etc. (anything that can be used to identify a specific plan or carrier)
- All text on materials, including footnotes and disclaimers, should be printed with a font size equivalent to or larger than <u>Times New Roman 12pt font.</u>
 - While CMS guidelines no longer include requirements of 12pt font on marketing materials, due to the vision realities of people as they age, it is still recommended and the practice of most carriers to use the larger font size in their marketing materials.
- On mailers, Agency/Broker name and address should appear on the envelope or postcard—carrier guidance says you **must identify who the sender is.**
- Any time you first mention a Medicare Plan, you should use the full name or plan type:
 - Medicare Advantage Plan
 - Medicare Supplement Plan
 - o Part D Prescription Drug Plan
- It must be clear to beneficiaries that you are **not affiliated with or endorsed by the Federal Medicare program or the government.** Recommended disclaimer (and required in some states so we always suggest to use some variation of it):
 - NOT AFFILIATED WITH OR ENDORSED BY THE GOVERNMENT OR FEDERAL MEDICARE PROGRAM.



MARKETING AND ADVERTISING MATERIALS

- Any advertisement or invitation to a sales / marketing event inviting beneficiaries to a group session to possibly enroll must include the following disclaimer:
 - A sales person will be present with information and applications. For accommodations of persons with special needs at sales meetings, call <toll-free number> (TTY 711), <days and hours of operation>.
- Marketing materials that include a phone number for the consumer to call should also include language near the phone number that conveys the following:
 - o By calling this number you will reach a licensed insurance agent.
- Websites and Social Media are governed by the same regulations as normal print material.



MARKETING AND ADVERTISING MATERIALS

PROHIBITED TERMS AND LANGUAGE

- **DO NOT use the word "Entitled"** when referring to plan benefits. Use "Eligible" instead.
 - o Can only use "Entitled" in relation to Part A for Federal Medicare Products.
- Use caution when using the word "Senior".
 - o Can't limit your audience to those over 65, some Medicare beneficiaries are under 65.
- **DO NOT use absolute superlatives** like "the best," or "highest rated," or "the most doctors," unless it can be substantiated.
- Avoid use of the word "free":
 - When describing services like, "Free Medicare Plan Comparison", need to include "no obligation to enroll" in same sentence or in close in proximity to the FREE reference. If there are space issues, an asterisk maybe used to reference language in a footnote.
 - o To describe a zero dollar premium, reduction in premiums (including Part B buy-down), reduction in deductibles or cost-sharing, low-income subsidy (LIS), or cost sharing for individuals with dual eligibility. Suggest using "no additional cost" as an alternative.
 - o In relation to a Benefit or \$0 Plan Premium.

NOTE: It is only permissible to use the term "free" with respect to plan benefits when describing mandatory, supplemental, and preventive benefits provided at a zero-dollar cost sharing for all members.

- Do not use exaggerative words/phrases such as "all," "full," "complete," "comprehensive,"
 "unlimited" to describe benefits (these are only examples)
- Other Words to avoid include the following:
 - o "Customized" or "personalized" when describing Medicare plans or benefit as plans cannot be customized for an individual's needs.



MARKETING AND ADVERTISING MATERIALS

- o "Advocate" or "expert" in reference to a Licensed Insurance Agent unless it can be substantiated, it's approved, and is used in conjunction with "licensed sales agent" or "licensed insurance agent".
- Avoid using High-Pressure Sales Tactics in your marketing/communication materials (also known as Scare tactics)
 - Avoid using language to create undue fear, anxiety, or confusion in members/prospects, such as "beware of some plans whose copays could bust your budget", etc.
 - Avoid words that would cause a false sense of urgency, such as "Act now, or you may lose your benefits!" etc.
 - Avoid repetitive phrases, certain font/colors, and/or punctuation that may communicate this to a potential enrollee. Examples may include "URGENT!" used on a material with font that is in all caps, oversized and red

Approved phrases to communicate the end of AEP that don't create false sense of urgency:

- Don't delay
- Enroll now
- Now's the time
- The time is now
- Don't Miss Out
- Get the answers you need
- AEP is ending soon (may only be used 2 weeks before 12/7)
- AEP ends on 12/7
- Avoid improper use of Qualifying Language:
 - o Do not use declarative phrases like, "You will save thousands of dollars", "This is the best plan for you", etc.
 - Instead use phrases like "you may be able to save money" (if accurate)
 - Use other words such as "eligible" or "you might", "you may" "you could potentially save", "should" or "maybe" (if accurate)



MARKETING AND ADVERTISING MATERIALS

DISCLAIMERS

When creating your own marketing, communication, or advertising pieces, it is suggested to use the following disclaimers:

- NOT AFFILIATED WITH OR ENDORSED BY THE GOVERNMENT OR FEDERAL MEDICARE PROGRAM.
- (if calling on the consumer to contact you): CALLING THE NUMBER ABOVE WILL DIRECT YOU TO A LICENSED INSURANCE AGENT.
- (if capturing permission to contact): BY PROVIDING THE INFORMATION ABOVE, I GRANT PERMISSION FOR A LICENSED INSURANCE AGENT TO CONTACT ME REGARDING MY MEDICARE OPTIONS INCLUDING MEDICARE SUPPLEMENT, MEDICARE ADVANTAGE, AND PRESCRIPTION DRUG PLANS.

If you are promoting a specific carrier's product(s) in the marketing piece, you may be required to include additional legal lines or disclaimers, as instructed by the carrier. The table that follows reflects the most commonly required disclaimers for marketing materials.



MARKETING AND ADVERTISING MATERIALS

DISCLAIMER	EXAMPLE OR REQUIRED TEXT	APPLICABLE DOCUMENTS
Federal Contracting Statement (marketing	Example Text: "[carrier's legal or marketing name] is a [plan type] with a Medicare contract. Enrollment in [carrier's legal or	Required on all materials except those specifically excluded by CMS Required elements in statement (see Note below):
materials)	marketing name] depends on contract renewal."	Legal or marketing name
		Type of plan (e.g., HMO, PPO, PFFS, PDP)
		Enrollment depends on contract renewal
Star Ratings (marketing)	Required Text: "Every year, Medicare evaluates plans based on a 5-star rating system."	Required on any document that references Star Ratings.
Promoting Drawings, Prizes or Free Gifts	Example Text: "Eligible for a free drawing, gift, or prizes with no obligation to enroll."	Required when promoting drawings, prizes, or free gifts. The statement must make it clear that that there is no obligation to enroll in the plan.
(marketing)	Example Text: "Free gift without obligation to enroll."	
Materials Developed by a Third Party (marketing)	Required Text: "For a complete list of available plans please contact 1-800- MEDICARE (TTY users should call 1-877-486-2048), 24 hours a day/7 days a week or consult www.medicare. gov."	Required on third party materials when the material lists or markets a subset of plans.

NOTE: Disclaimers are not required on the following material types: call scripts, banners and banner-like ads, envelopes, outdoor advertising, text messages, and social media.



MARKETING AND ADVERTISING MATERIALS

PERSONAL BUSINESS CARDS:

- MAY NOT be attached to marketing pieces, but can be included with them.
- **DO NOT** use the word "Medicare" in your title (ex. Medicare Specialist, Medicare Advisor, etc.).
- **DO NOT** list Benefits on business cards.
- Use caution using images of Flags or the colors Red, White & Blue that could be misinterpreted as being affiliated with a state or United States government agency.



MARKETING AND ADVERTISING MATERIALS

BUSINESS REPLY CARDS (BRC) AND PERMISSION TO CONTACT FORMS:

A BRC (Business Reply Card) is designed and intended to be used as a direct marketing material for the purpose of gathering permission to contact. A BRC is generally mailed to potential clients in hopes they will return the BRC giving permission to be contacted. Agents can also display or distribute permission to contact forms at sales and educational events, or place them on a Website or Social Media platform (electronic BRC).



Things to Remember:

- BRCs must include a statement informing the consumer that an agent may call them as a result of returning or submitting the BRC / Permission to Contact form
 - **Example:** By providing the information above, I grant permission for a licensed insurance agent to contact me regarding my Medicare options including Medicare Supplement, Medicare Advantage, and Prescription Drug Plans.
- MAY provide BRCs at Educational and Sales Events
- Should **NOT** ask for a consumer's Date of Birth
- MAY ask for Age or Date of Medicare Eligibility
- MUST be retained for documentation purposes and available upon request for the remainder of the selling year plus 10 additional years



MARKETING AND ADVERTISING MATERIALS

ENDORSEMENTS AND TESTIMONIALS

Product endorsements and testimonials are permitted but must adhere to the following requirements:

- Should receive permission when using client endorsements or testimonials
- Refrain from using full names, that would individually identify the person providing the testimonial
- If an individual is paid or has been paid to endorse or promote you, the advertisement must clearly state this (e.g., "paid endorsement")
- If an individual, such as an actor, is paid to portray a real or fictitious situation, the advertisement must clearly state it is a "Paid Actor Portrayal"
- The claims made in the endorsement or testimonial must be able to be substantiated

NOTE: Reuse of an individual's content or comment from social media sites that promotes a product is considered an endorsement/testimonial and must adhere to the guidance in this section.



LEAD GENERATION MARKETING AND ADVERTISING MATERIALS

CMS SUBMISSION

When do agent created materials need to be submitted to and approved by CMS?

Only materials defined as "marketing" need to be submitted to CMS for approval. Remember, to be considered "marketing," there must be intent to draw a beneficiary's attention to a specific plan or plans. Additionally, "marketing" contains information about a specific plan's benefits, cost sharing, measuring, or ranking standards.

If you have a marketing piece that needs CMS approval, you must submit it through a carrier with which you are contracted. Be aware that materials have a potential review timeframe of 10 or 45 days, which begins on the date the material is submitted.



MARKETING AND ADVERTISING MATERIALS

MARKETING BEST PRACTICES

With 10,000 people aging into Medicare every day, there's never been a greater opportunity to reach and serve this demographic. And remember, the people turning 65 today are among the youngest of the Boomer generation. These are smart, vibrant consumers who are roaring into Medicare like none other. Think Bill Gates. Whoopi Goldberg. Billie Idol. So get ready to build your business by following some of these best practices in Medicare marketing.

Below are some tips and best practices to help you better reach your intended audience and drive sales.

- It all starts and ends with the trust your clients have in YOU so be sure to build and stay true to your personal brand. If something doesn't feel authentic to you, don't do it or say it. Always act with integrity and let your personality shine through.
- Position yourself as a valuable resource that your clients will feel comfortable going to with any questions and especially when they're ready to make an enrollment decision.
- Create your own library of content and offer to be a presenter at educational events.
 Whether it's Medicare basics or a health and wellness topic—providers, faith-based organizations and local senior centers are often eager to fill up their community calendars and agents are permitted to provide business reply cards at these events.
- If you don't already, you should have a year-round strategy for reaching people who are turning 65. Although prospects can only enroll during their 7-month IEP, a nurturing, educational campaign can start any time giving you plenty of time to build your relationship and position yourself as their go-to Medicare resource. Simple direct mail or email drips, or a combination of both, that provide progressively more information and a sense of urgency are a great way to go.
- Direct Mail is still an industry workhorse, but you definitely need to up your digital game.
 Develop your own content calendar and use social media. Integrity Marketing Group has a great social media guide and other resources that can help with ideas and tactics to expand your influence.



MARKETING AND ADVERTISING MATERIALS

- To avoid the cost and aggravation of returned mail, work with a best-in-class list vendor and ensure the mail list is scrubbed against the SSA list of deceased individuals, the national change of address data base, and any other suppression lists.
- Partner with a reputable print vendor who can recommend print formats and help your mail get noticed—this can be a cost-effective way to boost your response rates and increase your book of business.
- Follow other industry leaders. Like and Share their posts.
- Subscribe to industry research to stay abreast of consumer trends.

When it comes to creative, make sure yours gets noticed.

- Photos Most people see themselves as 10-15 years younger than they really are. Select photos that are a little younger than your target audience but keep them realistic. Most 65- to 70-year olds aren't jogging along a beach or riding tandem bikes. Photos should convey emotion, be relatable, and take into consideration local flavor and diversity.
- Colors Be careful using subtle shades as background elements. As people age, their ability to discern lighter shades and certain colors diminishes and a graphic element like a shaded box may look like a blur, or may not be seen at all.
- Other images, such as icons, are helpful in creative layouts to help guide readers efficiently through different copy sections to your call to action.
- Reverse Type It's highly recommended to only use reverse/white type with large fonts, such as headlines and sub heads. Stay away from using reversed type on lightly colored backgrounds (especially yellow) or reversing out smaller type at all. Same with reversing type out of a photo.



MARKETING AND ADVERTISING MATERIALS

- When it comes to direct mail, you want your piece to stand out in the mailbox. Envelopes the size of standard greeting cards or oversized postcards are more noticeable from standard business mail.
- As mentioned, while CMS guidelines no longer include requirements of Times New Roman 12pt font on marketing materials, due to the vision realities of people as they age, it is still recommended and a best practice to use this font size in marketing materials.
- Help keep your copy compliant by staying away from superlatives and absolute statements unless they can be substantiated.



MARKETING AND ADVERTISING MATERIALS - CHECKLIST

REGULATIONS

Material(s) cannot "market" for the upcoming plan year prior to October 1.

IN ORDER FOR MATERIAL TO BE CONSIDERED GENERIC, THEY MUST NOT CONTAIN:

- Carrier Logos or Brands
- Plan Specific Names
- Product Specific Names
- Benefit Information
- Star Ratings

LEAD CARDS / BUSINESS REPLY CARDS (BRC)

The marketing piece cannot "require" the consumer(s) to provide contact information.

The marketing piece should not ask for the consumer's "date of birth." May request date of Medicare eligibility and/or age.

BRCs must include a statement informing the consumer that an agent may call them as a result of returning or submitting the BRC / Permission to Contact form

Example: BY PROVIDING THE INFORMATION ABOVE, I GRANT PERMISSION FOR A LICENSED INSURANCE AGENT TO CONTACT ME REGARDING MY MEDICARE OPTIONS INCLUDING MEDICARE SUPPLEMENT, MEDICARE ADVANTAGE, AND PRESCRIPTION DRUG PLANS.

NOTE: These regulations pertain to electronic BRCs or permission to contact forms on websites.

CONTENT / STYLE

The marketing piece must clearly identify the sender.

The content of the marketing piece when printed, should as a best practice have text with a font size equivalent to or larger than Times New Roman twelve (12)-point, including headers, footnote and/or disclaimers.

The content cannot be inaccurate, misleading, or otherwise make misrepresentations (e.g., incorrect enrollment period title).

The content cannot include the use of absolute superlatives (e.g., the best, the biggest, the "highest ranked").



MARKETING AND ADVERTISING MATERIALS - CHECKLIST CONT.

The content cannot include words or symbols, including "Medicare," "Centers for Medicare & Medicaid Services," "Department of Health and Human Services" or "Health & Human Services", in a manner that would convey the false impression that the business or product mentioned is approved, endorsed, or authorized by Medicare or any other government agency.

• TIP: Use this disclaimer (especially in mailers): NOT AFFILIATED WITH OR ENDORSED BY THE GOVERNMENT OR FEDERAL MEDICARE PROGRAM.

If the piece contains general benefits common among multiple plans, it is recommended that the benefits are cited individually and bulleted out with no branding, logos and/or titles included.

Recommended example below.

Some Medicare Advantage/Part C plans may offer benefits like:

- Dental
- Vision
- Hearing
- Transportation

EVENTS

Is the material an invitation for an event (educational or sales)?

If yes, must include:

 "For accommodation of persons with special needs at sales meetings call <insert phone and TTY number>."

If yes, and a <u>Sales/Marketing</u> Event:

The invitation must include these two disclaimers verbatim:

• "A sales person will be present with information and applications."

If yes, and an **Educational** Event:

The invitation must explicitly advertise the event as "educational."

If a drawing or prize is advertised with the event must include:

- "Eligible for a free drawing and prizes with no obligation" or
- "Free drawing without obligation." (note the retail nominal gift amounts may not exceed \$15.00)



MARKETING AND ADVERTISING MATERIALS - CHECKLIST CONT.

AGENT TITLES

Agent Titles must not mislead consumers into thinking the agent is affiliated with the Federal Medicare Program. Titles that include the term 'Medicare' can be considered misleading.

Examples of prohibited titles:

- Medicare Sales Agent
- Senior Advisor
- Medicare Specialist
 Medicare Agent

Recommended titles:

- Licensed Insurance Agent
- Licensed Sales Agent
- Licensed Insurance Representative

PROHIBITED TERMS

Free: If the term 'free' is used in relation to a benefit (example: Free Exam; Free Gym Membership)

Senior: If the term 'senior' used in reference to your audience in a way that may imply plans or an agents Medicare related services are only available to "seniors"? (example: Sales Meeting for Seniors). Cannot limit your audience to "seniors" only, as there are Medicare beneficiaries that are under the age of 65.

Entitled: Do not use the term 'entitled' in reference to plan benefits. CMS reserves this term to be used only in relation to Part A for Federal Medicare products. You may use 'eligible'.

PRODUCT NAMES

Does the material use full product names when first disclosed? CMS has requested use of full product specific titles when referring to Medicare Advantage Plans and Part D Prescription Drug Plans. Simply using "Medicare plans" is only appropriate when speaking to multiple product types (MA/PDP).

Example:

- Medicare Advantage Plans
- Part D Prescription Drug Plans
- Medicare Supplement Insurance (Medigap can then be used later in the document)



WEBSITE CHECKLIST



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Detail	Yes	No	N/A	Comments
Registration Information				
Is your URL Registered (if necessary)?				For certain Carriers, wesbsites of contracted agents/agencies must be registered. Regardless if it carries logos, branding, materials, or is meant for agents or consumers.
Does the URL Open/work?				
Logo Usage				
Appropriate Logo usage? Approved by Appropriate Carrier?				
Agent Title				
Appropriate use of Agent Title?				Cannot mislead consumers into thinking an agent is affiliated with Medicare in any way. Prohibited Titles: Medicare Sales Agent or Senior Advisor. Approved Titles: Sales Agent, Sales Representative, Licensed Sales Agent, Independent Sales Agent, etc.
Contact Page - BRC				
Appropriate Scope of Product included?				You may post a generic electronic Business Reply Card (eBRC) on your website; however,
Appropriate Method of Contact included?				the following disclaimer must appear, "A sales agent may mail, call, or e-mail as a result of completing the information to discuss Medicare Advantage, Prescription Drug Plans, or
Free from REQUIRING Prohibited Consumer Contact information: I.E. phone/email?				Medicare Supplement Insurance". The same content regulations apply to an electronic BRC as to a paper BRC.
Free from Date of Birth? (Cannot ask for D.O.B - age or date of Medicare eligiblitly is ok)				
Free from Medical or RX History?				
Disclaimers				
Are appropriate Event Disclaimers in place (when applicable)?				If advertising a marketing/sales event where there's a possibility of enrolling members include the following disclaimers on all marketing materials: "A sales person will be present with information and applications." and "For accommodation of persons with special needs at sales meetings call <insert and="" number="" phone="" tty="">."</insert>
Are appropriate Nominal Gift Disclaimers in place?				When promoting drawings, prizes, or promise of free gifts include a Nominal Gift disclaimer on all marketing materials stating there's no obligation. For example: "Eligible for a free drawing and prizes with no obligation" or "Free drawing without obligation".
Content				
Appropriate use of "Free" ?				May not refer to any benefit, item or service as "free", as the costs are built into the plan. May not use the term "free" unless something truly is free, meaning there is no cost to the plan, Medicare/CMS, or the beneficiary in any way. ACTION: Use "at no additional cost" instead.
Appropriate use of "Senior"?				CMS considers the term "senior" (when used to describe enrollment eligibility) to be discriminatory toward those beneficiaries eligible for Medicare based on disability. ACTION: Revise "senior" to "Medicare beneficiaries" or "seniors and other Medicare beneficiaries"
Appropriate use of "Entitled"?				Beneficiaries are not entitled to any Medicare benefits, except Part A (if certain requirements are meant) therefore using the term entitled implies that the beneficiary is not receiving something they should be. This is a misleading/inaccurate statement. ACTION: Change to "eligible"
Appropriate and complete product Terms Medicare Advantage not MA.				Full titles should be used when first introduced. i.e. Medicare Advantage; Prescription Drug Plan; Medicare Supplement Insurance Plans.
Free from Benefit/Premiums/Copays info?				Agent web pages may not contain material, including product descriptions and benefits, unless express permission is given by the appropriate Carrier.
 Free from inappropriate use of CMS/ DHHS/Medicare Symbols or name in URL? 				Cannot use names, domain names, logos, symbols, colors, etc. that would mislead a consumer into thinking you are affiliated in any way with Medicare or the government in any way.
Free from inappropriate Private/ Proprietary Materials embedded?				Disclosing Proprietary Information, Media Requests, and Public Relations Materials is not to be disclosed to anyone outside of the company, including the media, under any circumstances without prior approval from the appriate Carrier's Compliance/Legal department.
Free from Inaccurate/Misleading/ Misrepresentation?				Website content must not: • Speak disparagingly of Medicare, CMS, or a Carrier. • Include contracts or appointment forms. • Include plan materials, enrollment kits, or benefit guides.
Free from inappropriate posting of events for next AEP Prior to October 1?				Marketing for an upcoming plan year may not occur prior to October 1. Plans/Part D Sponsors must cease current year marketing activities once they begin marketing benefits for the new contract year.

ACTIVITES IN A HEALTHCARE SETTING

CMS distinguishes between provider-initiated activities and plan-initiated activities in a healthcare setting.

Provider-Initiated Activities

Agents who have relationships with Providers may have a referral opportunity as Providers are permitted to refer patients to other sources of information, including to plan marketing representatives.

MARKETING TIP: Offer to be a presenter at an educational event in conjunction with a provider. Providers are often looking to fill up their community calendars and agents are permitted to provide business reply cards at educational events. Win Win.

Plan/Part D Sponsor Activities

Sales activities, including sales presentations, the distribution of marketing materials, and the distribution and collection of enrollment forms, may be conducted in common areas of a healthcare setting. Common areas include, but are not limited to common entryways, vestibules, waiting rooms, hospital or nursing home cafeterias, and community, recreational, or conference rooms.

Marketing activities cannot take place in restricted areas where care, treatment or Provider interaction occurs, such as: exam rooms, hospital patient rooms, and pharmacy counter areas.

Communication materials (advertising pieces free of specific plan information) may be distributed and displayed in all areas of the healthcare setting.



ACTIVITES IN A HEALTHCARE SETTING

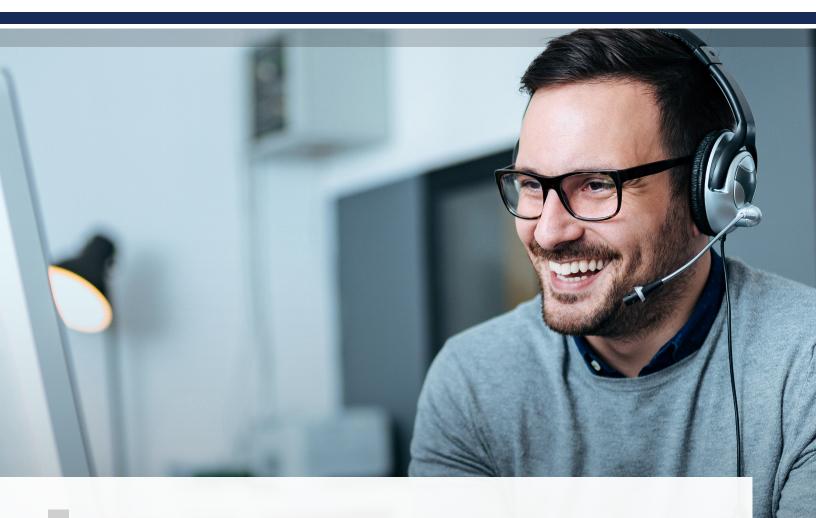
Communication About Providers

Agents must **not:**

- Hand out materials describing the provider's services or marketing the provider's practice
- Provide information about any free services or cost-sharing waivers offered by a provider unless they are part of a plan's benefit package (e.g. complementary transportation)
- Recommend a provider or share opinion about which provider is best (e.g. do not use superlatives when describing a particular provider)
- Offer or give anything to members or prospective members to persuade them to choose a particular provider
- Accept anything, directly or indirectly, from a provider in exchange for communicating about that particular provider (e.g. do not accept promises that provider's patients will use you for their insurance needs, charitable donations, sponsorships, gifts, cash, etc.)
- Engage with providers in a way that may influence the agent's interaction with a member or prospect regarding their choice of a Provider, including but not limited to, entering into any arrangements with Providers, or offering, receiving or agreeing to offer or receive anything of value from a Provider or a Provider's representative
- Engage with providers in a way that would influence the provider to steer patients toward a certain plan or set of plans (under the Medicare Communications and Marketing Guidelines, providers are prohibited from steering towards a particular plan)
- Any marketing material that mentions a provider must be submitted to the carrier for review prior to use (carrier specific requirement, so know each carrier's marketing rules)







SECTION 2:

READY TO SELL

Before you market or sell an MA/MAPD/PDP product, you must first become "Ready to Sell." What does that mean? This section will help explain what it takes to be "Ready to Sell" and offer some helpful tips to help you along the way.

READY TO SELL

READY TO SELL = LICENSED + APPOINTED + CERTIFIED

LICENSED

"Licensed" means you have an active Insurance License in each state where you market MA/PDP products (licensed in the state where the client resides).

APPOINTED

"Appointed" means being contracted with the applicable Carrier <u>and</u> appointed to sell each applicable product in each applicable state.

CERTIFIED

"Certified" means you have completed each of the required Carrier specific prerequisite modules (or AHIP equivalents) and the individual product modules for each product you market/sell.



Example: Agent John Smith resides in Nebraska and has clients both there and in Iowa. He wants to present MAPD products from Company XYZ to clients in both states. In order for him to be "Ready to Sell", he would need to:

- 1. Be actively licensed with the State DOI's of both NE (resident) and IA (non-resident).
- 2. Be contracted with Company XYZ and appointed to sell that particular MAPD in both NE and IA (have a NE and IA appointment with Company XYZ for the product being presented).
- 3. Complete the annual AHIP Certification or the Carrier specific pre-requisite modules, the product specific module for the product in question, as well as any other required trainings a Carrier may have.



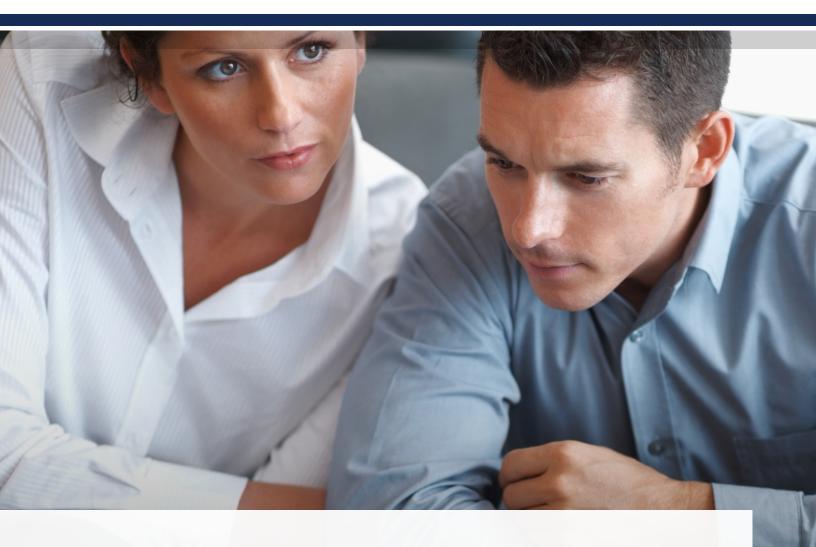
READY TO SELL

CHECKLIST

TIP	S:
	Confirm your State Licenses are Up-to-Date
	Verify you are Appointed in each State with each Carrier
	■ Make sure your state appointments are complete and accurate for each Carrier
	Verify your Product Certifications before Sales Appointments
	Full Portfolio Certification
	☐ Certify for all products not just the ones you "plan" on selling, especially PDP's
	Do NOT give out Applications to downline agents who aren't "Ready to Sell"
	L US or the Carrier if you are unsure about any of your pointments, certifications, or licenses.







SECTION 3:

COMPLIANT SALES

As you know, there are numerous rules and regulations to remember in terms of compliance when marketing and selling Medicare Advantage and Prescription Drug Plans. These regulations go beyond the sale itself, so we wanted to highlight areas that should help keep you compliant.

SCOPE OF APPOINTMENT

SCOPE OF APPOINTMENT (SOA):

When conducting marketing activities, in-person or telephonically, a Plan/Part D Sponsor may not market any health care related product during a marketing appointment beyond the scope that the beneficiary agreed upon before the meeting with that individual.



Things to Remember

- SOA's are required for ALL Sales Appointments or Personal/Individual Appointments with existing or new/potential members
- May only discuss products at an appointment that were agreed upon and documented in the SOA form
- Must be completed prior to the meeting/appointment
- Accepted forms of SOA Documentation
 - o CMS-Approved SOA form (either CMS model or a CMS approved Carrier version)
 - CMS-Approved oral recording of Sales Appointment Confirmation
 - o CMS-Approved BRC
- Attach a copy of the signed SOA form to all applications before you submit them (Carrier specific, know SOA guidelines for each of your Carriers)
- Make sure the client INITIALS are beside the products they wish to discuss
- Keep SOA's for at least 10 years and have them available upon request (even if you submit with the application)



SCOPE OF APPOINTMENT

FREQUENTLY ASKED QUESTIONS (FAQS):

1. If a beneficiary requests to discuss another health-related product during an appointment, what do I need to do?

A new SOA form is required if the beneficiary has requested to discuss another product type during the appointment. However, a new appointment is not required. The additional product can be discussed after a new SOA is filled out.

2. Is an SOA required for a Sales Event?

No. Beneficiaries are not required to complete and sign the Scope of Appointment form prior to participating at a sales event because they are not personal/individual appointments.

3. Can an SOA be collected at a Sales and/or Educational Event for a future appointment?

Yes. Beneficiaries may sign a Scope of Appointment form at a sales or educational presentation for a follow-up appointment. The follow-up appointment may be held at the venue immediately following the sales presentation, if the beneficiary so chooses.

- 4. If I'm selling for more than one carrier, can I use CMS's Model SOA or another CMS compliant generic SOA form for all carriers? Yes.
- 5. Can I market non-health care related products (such as Annuities or Life Ins) at an appointment?

No. You'd need to schedule a new appointment (at least 48 hrs. later if possible).

6. What should I do if my client brings an unexpected guest with them to a sales meeting?

You'll need to obtain a new SOA for the guest and provide an explanation in the appropriate field.



MAKING A COMPLIANT PRESENTATION

PRIOR TO THE APPOINTMENT

Con	plete a compliant Scope of Appointment form for ALL in attendance
	Only discuss products agreed upon in the Scope of Appointment
	Make sure the beneficiary initials the boxes next to products they want to discuss
Call	Your Prospect to Ask These Questions
	Does someone have a Power Of Attorney for making your financial decisions? If they will be signing your enrollment form, have them bring a copy of the POA document.
	Would you like to invite any friends, relatives, or other Medicare eligible individuals to hear the presentation?
	Is there any additional information that you think I should know?
	Tell them to bring a list of key service providers and any current prescriptions they would like to verify.
Mak	e sure you are "Ready to Sell" all products you could conceivably discuss
	Licensed, Appointed & Certified
	Unqualified Sales result in Loss of Compensation and possible termination



MAKING A COMPLIANT PRESENTATION

DURING THE PRESENTATION:

Show up on time, clearly introduce yourself, and stress that you do not work for MedicareStress that you do not work for Medicare
Only discuss products agreed upon in the SOA
☐ If the beneficiary requests to discuss other products not agreed upon in the original SOA, complete another SOA and then the appointment may continue
Use carrier's flipbook, agent guide, etc. if available
Confirm eligibility (Medicare A & B, Medicaid, LIS, other coverages, must live in service area, etc.)
Thoroughly Review the Provider Network and Drug Formulary
Confirm Provider Network and Provider Access
☐ Role of PCP / Specialist Referrals (if applicable)
Prescription Drug Tiers, Copays
Carefully Review Plan Benefits & Premiums
Part B Premium Requirement (must continue to pay)
Out-of-Pocket Costs (Office Visits/Urgent Care/Hospital/ER/Ambulance)
Thoroughly Review Copays and Coinsurance
Dental/Vision Benefits (if applicable)
Special Needs (DME, etc.)
Value-Added Services

Checklist continued on next page...



MAKING A COMPLIANT PRESENTATION

Explain what their new card will be used for
Review Statements of Understanding
Effective Date of Coverage
Customer Service Telephone Numbers
Make sure the application is filled out fully and accurately
Submit the applications the same day you receive them
NEVER help a consumer enroll via a Consumer Website if you are physically present (you can assist them over the phone)
 Only enroll clients online using an approved agent enrollment tool (ex. MedicareCenter, LEAN, Connecture, mProducer, Ascend, etc.)
Ask Yourself: Is this the best plan for my Client?
Give client your contact info and urge them to call you or the Plan with questions/issues - NOT Medicare



MAKING A COMPLIANT PRESENTATION

AFTER THE SALE

- ☐ See if they have any questions about the plan they enrolled in
- ☐ Make sure they fully understand the plan they chose
- Especially the Benefits/Coverages, Copays/Coinsurance, & Provider Network
- ☐ Make sure your client has your contact info so they can contact YOU for any further questions or information they may need.



DO'S AND DON'TS

DO	DON'T
Clearly Identify the Products to be discussed, and ONLY discuss those agreed upon in the Scope of Appointment (SOA)	Discriminate in any way including discouraging enrollment for disabled
Announce you don't work for Medicare and you could be compensated for this sale	Attempt to enroll someone with a diminished capacity to understand
Quote Accurate Plan Costs	Say that you or the plan is CMS-endorsed or recommended by the Federal Government
Hold meetings in handicapped-accessible facilities	Use misleading, conflicting, or confusing statements
Communicate to non-English speakers in a way they will understand	Engage in high-pressure sales or scare tactics
Advise the client how to use the Formulary	Collect financial info during pre-enrollment activities
Use only Materials that meet CMS requirements	Imply Medicare is only available to Seniors
Complete enrollment forms ONLY for those who are unable to do so them-selves	Ask to see a prospect's RX's unless they ask for help
	Offer Monetary or Promotional gifts to induce enrollment or to compensate based on use of services



COMPLIANCE METRICS

Below are some of the common metrics companies use to measure your overall compliance as it relates to the sales process.

- Cancelled Applications
- Rapid Disenrollments
- Late Applications
- Member Complaints
- PCP Auto-Assignments

CANCELED APPLICATIONS

A Cancelled App is defined as a submitted application that is cancelled by the consumer before the applications effective date.

Top Reasons for Cancelled Apps:

- Inaccurate Provider Network Information
- Inaccurate Drug Formulary Information
- Inaccurate Cost or Benefit Information
- Unsuitable Plan Enrollment
- Client Confusion with the Plan



COMPLIANCE METRICS

TIPS FOR REDUCING CANCELLED APPS:

- ☐ Verify the Provider Network and double-check to ensure the client's provider is still participating in the plan.
- ☐ Make sure all medications the client has are covered by the plan.
- Explain all costs associated with the plan accurately and thoroughly to make sure the client fully understands all costs involved.
- ☐ Discuss all benefits and make sure the client understands what benefits are covered and what is not covered. Ex. Dental, Vision, Gym Memberships, etc.
- ☐ Make sure the plan you are marketing/selling is the best option for the client. If it is, they should have no reason to cancel/switch plans.
- Over 1/2 of all Cancelled apps come from Dual SNP products. (Not surprising since they can switch plans any time). Take extra time with these clients to make sure they fully understand the plan and that the plan is the best fit for their needs.



COMPLIANCE METRICS

RAPID DISENROLLMENTS

A Rapid Disenrollment is the voluntary disenrollment of a member from an MA/PDP plan within the first 3 calendar months after their initial enrollment effective date.

Top Reasons for Rapid Disenrollments:

- **Inaccurate Provider Network Information**
- Inaccurate Benefit/Coverage Info (Ex. Copay/Coinsurance, Dental/Vision, etc.)
- Incorrect Drug Formulary Information
- Unsuitable Plan Enrollment
- Inaccurate Plan Description



COMPLIANCE METRICS

TIPS FOR REDUCING RAPID DISENROLLMENTS:

- ☐ Confirm enrollee's providers are participating.
- □ Provide and explain thoroughly (and multiple times, if needed) the plan's benefits and coverages (especially Dental/Vision benefits), its limitations and rules, including: copays, coinsurance, provider network, Coverage Gap, and Part D Penalty.
- ☐ Verify enrollee's medication coverage. Can use online search tools available to you or reference www.medicare.gov.
- Ensure that the chosen plan is the best option for your client and the correct plan is chosen on the enrollment form.
- Pay particular attention to your Dual SNP clients; majority of all Rapid Disenrollments come from this market segment.
- Explain enrollee is not joining a supplement plan.
- ☐ Review Next Steps at the time of enrollment.
- ☐ Urge them to attend Member Events in their area.
- Ensure the plan is the best fit for the client's needs.
- ☐ Send the member a Thank You Card.





COMPLIANCE METRICS

LATE APPLICATIONS

CMS requires enrollment forms to be submitted to them within seven (7) calendar days from the date the agent "receives" the application. Therefore, Carriers have their own timeliness requirements in order to give them ample time to get the enrollment form submitted to CMS within the 7 day timeframe. **Most Carriers require that the Completed Enrollment Form be submitted to them within 48 hours of the date the agent receives the application.**

TIPS FOR REDUCING LATE APPLICATIONS:



- ☐ Submit Apps the SAME DAY you receive them
- ☐ Submit the entire, completed app—no missing pages or information
- ☐ Use an Online Enrollment method if available for agents—**NOT via a consumer enrollment portal,** as agents cannot be present when

 consumers enroll through a consumer facing online portal
- ☐ Write Legibly in Black Ink (preferably) so processing isn't delayed
- ☐ Use the correct application (ex. 2020 application for 2020 product)
- □ Use Your FMO's Agent Portal to Upload your enrollment forms (you should get a confirmation of receipt immediately so you know the enrollments have been submitted and received) **Most Secure**Method!
- ☐ You may also be able to Email or Fax your applications to your FMO, contact them for preferred processes.
- ☐ If submitting apps directly to a Carrier, verify correct Fax #'s or Email addresses by calling your marketing team (if they aren't listed on the application itself)



COMPLIANCE METRICS

MEMBER COMPLAINTS

A member complaint happens when a beneficiary files a formal complaint against an agent. There are two types of complaints: Complaints to Medicare (CTM) or a Complaint to a Carrier. While it's important to avoid all complaints, it's more important to avoid a CTM. A complaint to a Carrier is better and less painful than one directly to CMS. Contact us for further guidance, we have job aids specific to the causes listed below.

Top Causes for Member Complaints:

- **Inaccurate Benefit/Coverage Information**
- Inaccurate Copay/Coinsurance (Cost) Information
- Inaccurate Provider Network
- Inaccurate Plan Description
- **Enrollment without Permission**



TIPS FOR AVOIDING COMPLAINTS:

- ☐ Complete a **thorough Needs Assessment** with the consumer to understand the consumer's medical, prescription, and financial needs.
- Recommend the best plan suited for the consumer based on those needs.
- Explain how the consumer's needs are being met by this plan.
- ☐ Review the Summary of Benefits page by page with the consumer.
 - Place additional emphasis on the copayment and coinsurance topics.
 - o Advise the consumer whether or not the particular benefit plan has an annual limit on the maximum out-of-pocket amount of cost sharing for in-network and out-of-network services (if applicable)



COMPLIANCE METRICS

- o Inform the consumer that a Medicare Advantage plan may limit the annual out-of-pocket maximum a member pay for cost sharing.
- Notify the consumer that there are no limits on the out-of-pocket spending for cost sharing in Medicare Part A and Part B.
- ☐ Thoroughly explain (multiple times, if needed) plan's **benefits**, coverages, limitations, and rules including copays, coinsurance, provider network, Coverage Gap, and Part D Penalty.
 - Explain the service area, prescription drug formulary, coverage gap, catastrophic coverage, and tiers.
- ☐ Confirm the enrollee's **providers** are participating in the plan.
 - Disclose how in-network and out-of-network differ and research whether the consumer's provider(s) would be in-network or out-ofnetwork.
 - Explain that Health Maintenance Organization (HMO), Health
 Maintenance Organization Point-of-Sale (HMO-POS), and Preferred
 Provider Organization (PPO) plans have a contracted network of
 doctors, specialists, hospitals, and pharmacies.
 - Ensure that the consumer is aware whether or not the plan requires a
 Primary Care Physician (PCP) referral for specialist visits.
 - Utilize the Plan Provider Directory and/or contact the provider directly to verify that they are in- network.
- □ Verify enrollee's <u>medication</u> coverage. Can use online search tools available to you or reference www.medicare.gov. Provide tier level and any restrictions (i.e., prior authorization, quantity limit, step therapy). Also, explain preferred vs. non-preferred pharmacy, if applicable.





COMPLIANCE METRICS

- o Be sure to inquire about any assistance they may require or receive for paying medical or prescription costs.
- o If a consumer receives Medicaid or Low Income Subsidy (LIS) costsharing help, do not guarantee a particular copayment or coinsurance cost to the consumer - advise them the State will determine the level of cost-sharing help.
- ☐ Thoroughly cover all **COSTS** involved with the plan (copay, deductible, premium, etc.).
- Ensure that the chosen plan is the best option for your client.
- ☐ Conduct a final review of the enrollment form and confirm all information is complete.
- ☐ Verify the enrollee understands all necessary components of the plan.
- ☐ Urge clients to contact YOU or the Plan (NOT CMS) with any questions or issues.
- ☐ FOLLOW-UP after the appointment to be sure they still understand the plan.



COMPLIANCE METRICS

PCP AUTO-ASSIGMENTS

Some Carriers require a valid Primary Care Physician (PCP) to be listed on the enrollment form. If a valid PCP # and Name are not listed, a PCP will be auto-assigned to the beneficiary. Some carriers monitor this number because they have found through research the autogeneration of a PCP leads to dissatisfaction with the plan in general; which in turn leads to complaints, app cancellations, and rapid disenrollments.

*Remember this is Carrier specific requirement so all Carriers may not monitor this element.



TIPS TO AVOID PCP AUTO-ASSIGNMENTS:

- ☐ List the PCP Name and Number EXACTLY as they are listed in the Provider Directory.
- ☐ Use the most accurate, up-to-date provider look-up source (generally an online provider directory).
- Don't use a physician offices or web searches (not affiliated with the Plan) for a source
- Ensure the Provider or Facility is In-Network for the plan the consumer is enrolling in.
- Always list a PCP when required on the enrollment form—DO NOT leave blank or put N/A
- Ask consumers what types of doctors and facilities are important to them, including specialists they only see occasionally.
- $\hfill \Box$ Take the time to look up all physicians (even specialists) and facilities.
- ☐ If a consumer doesn't have a PCP, help them find one that's In-Network and list one. They can switch at any time.



PRE-AEP

MARKETING DURING PRE-AEP AND PRIOR TO OCTOBER 1:

There are many interpretations of the marketing regulations during Pre-AEP. Knowing what you can and can't do during this period (Oct. 1 - Oct. 14) can be very confusing. Here are a few tips to help keep you compliant.

Prior to Oct. 1, Agents MAY:

- Contact existing members to schedule a plan review prior to Oct. 1.
- Schedule an appointment for Oct. 1 or later.
- Hold and promote member-only educational meetings or sales meetings on current year plan benefits at anytime
- Promote member-only educational meetings to discuss changes to plan benefits for the upcoming plan year prior to Oct. 1, for meetings scheduled Oct. 1 and beyond. Invitations to members may be sent via mail, telephone, and email.

Prior to Oct. 1, Agents may NOT:

- Conduct <u>marketing</u> activities for an upcoming plan year. To be clear, agents may not market upcoming plan year benefits prior to October 1.
- Solicit or accept enrollment applications for a January 1 effective date prior to the start of the Annual Election Period (AEP), unless the client is entitled to another enrollment period (i.e. Special Election Period).



PRE-AEP

During Pre-AEP (Oct 1 - Oct 14) You CAN:

- Educate consumers by providing plan and benefit information
- Conduct marketing activities as long as you don't "receive" or "solicit" an application
- Leave an application with the client for them to fill out and submit on/after Oct 15th (don't write your name or agent # on the app)
- Host Marketing/Sales Events

During Pre-AEP (Oct 1 - Oct 14) You CANNOT:

- Receive/Accept/Solicit enrollment forms prior to Oct 15th
- Write your name or writing # on an Application (prior to Oct 15th)
 Remember any enrollment form received before Oct 15th with any indication of agent involvement (i.e. Agent name or writing #) will be investigated by the respective Carrier.
- Strongly urge or pressure a client to fill out an application NOW



MISCELLANEOUS

NOMINAL GIFTS

Agents may offer nominal gifts (\$15 or less, or \$75 aggregate, per person, per year) to beneficiaries for marketing purposes, provided the gift is not contingent on enrollment and without discrimination.

The following rules apply to nominal gifts:

- If a nominal gift is a chance to receive one large gift or a communal experience (e.g., a concert, raffle, drawing), the total fair market value must not exceed the nominal per person value based on anticipated attendance. For example, if 10 people are expected to attend an event, the nominal gift may not be worth more than \$150 (\$15 for each of the 10 anticipated attendance). Anticipated attendance must be based on venue size, response rate, and/or advertisement circulation.
- Nominal gifts may not be in the form of cash or other monetary rebates even if their worth is \$15 or less.

NOTE: Agents can refer to the Office of Inspector General's website for advisory opinions and guidance on gifts and gift cards.

Exclusion of Meals as a Nominal Gift:

Agents <u>may not</u> provide or subsidize meals at **sales/marketing events.** Refreshments and light snacks may be provided. Plans/Part D sponsors should ensure that items provided could not be reasonably considered a meal and/or that multiple items are not being "bundled" and provided as if a meal.

Meals <u>may</u> be provided at **educational events** and other events that would fall under the definition of communications.



MISCELLANEOUS

VIRTUAL SALES

There may be times when an in-person appointment is not feasible or safe and, thus, a virtual appointment is needed. Virtual appointments/sales are allowable and a good option for agents when meeting in person isn't an option. There are many carrier-specific tools and resources available to help you through this process including enrollment tools, electronic scope of appointments, job aids, guides, etc. Just remember, that virtual appointments must follow CMS guidelines just like in-person appointments.



FREQUENTLY ASKED QUESTIONS (FAQS):

1. Do I need to capture a Scope of Appointment for virtual appointments sales?

Yes, you still need an SOA.

2. How do I capture a Scope of Appointment for virtual appointments?

You can capture SOAs for virtual appointments using the same methods you do for regular in-person appointments. Options include paper, electronic, and voice recording. Carriers may have other options as well and should have various tools available for you to capture SOAs. Contact your applicable carriers for further guidance.

3. What are best practices for remaining compliant?

Follow all CMS regulations as you would for a normal in-person appointment. Check with your carrier reps or carrier's agent portals as most have guides and job aids available for virtual marketing and selling.

4. What is the best way to submit enrollments online?

We suggest either using a carrier-specific online enrollment tool or using MedicareCenter, which our exclusive multi-carrier online enrollment tool.



MISCELLANEOUS

AGENT OVERSIGHT

CMS states that Plans/Part D sponsors (i.e. MA/PDP carriers) must oversee downstream entities to ensure agents/brokers abide by all applicable state and federal laws, regulations, and requirements. Carriers, in turn, funnel this requirement down to agents and agencies in their downline.

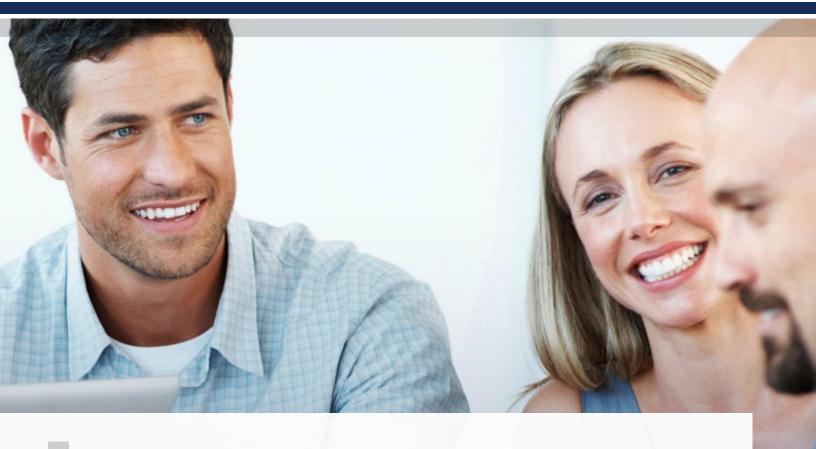
What does that mean for you?

If you have agents contracted under you, it means you are responsible for their compliance. It is your duty to assist carriers with the following compliance requirements:

- Ensure agents/brokers are properly licensed and appointed, per individual state requirements;
- Ensure agent/broker marketing materials and communication materials are compliant per CMS standards, and are properly approved by CMS when required;
- Ensure agents are not charging beneficiaries marketing fees;
- Ensure SOAs are completed for all marketing appointments (including telephonic and walk-ins).
- Provide training and coaching on compliance requirements including but not limited to:
 - o contact rules.
 - o compliant and thorough sales presentations,
 - o avoiding member complaints,
 - o sales and educational events,
 - o identification of proper enrollment periods,
 - o privacy/security,
 - o compliant enrollment methods, etc.







SECTION 4:

EVENT COMPLIANCE

Hosting Sales/Marketing events can be a good way to attract new clients and educate them on Medicare and the choices they have when choosing a Medicare plan. However, there are many compliance risks in hosting events, so we've highlighted some of the most important things you should remember when hosting an event.



FIRST OF ALL, LET'S LOOK AT THE TWO TYPES OF EVENTS: **EDUCATIONAL EVENTS AND SALES EVENTS.**

EDUCATIONAL EVENTS:

An event designed to **inform** or **educate** Medicare beneficiaries about Medicare Advantage, Prescription Drug, or other Medicare programs and does not include marketing activities (i.e. the event sponsor does not steer, or attempt to steer, potential enrollees toward a specific plan or limited number of plans).

SALES EVENT:

A **Sales Event,** or **Marketing Event** as they are sometimes called, is a marketing event where all allowable types of Marketing Activities can occur, and is designed to steer, or attempt to steer, potential enrollees toward a plan or a limited set of plans. Agents may educate beneficiaries just like at an educational event, but they can also market specific plans, discuss plan specific benefits, along with other compliant marketing activities.

Keep in mind, there are two different types of Sales Events: Formal and Informal

- **Formal Sales Events** are a more structured event using an audience/presenter type format.
- <u>Informal Sales Events</u> utilize a less structured format; for example, a table, kiosk, etc. that is manned by a sales representative where consumers must initiate the conversations.



WHAT YOU CAN DO AT AN EDUCATIONAL EVENT:

- Educate consumers about Medicare, Medicare Advantage, Prescription Drug, or other Medicare Programs
- Offer Promotional Items as long as they are of nominal value and free of benefit info. These items can display the Plan Name, Logo, Toll-free Number, and/or Website
- Display a banner with the Plan Name and/or Logo (as long as it doesn't include any specific product information)
- Distribute Business Cards and Contact Information for beneficiaries to initiate contact
- Set up a future marketing appointment and collect Scope of Appointment Forms
- Answer questions asked by consumers (provided the response doesn't go beyond the scope of the question asked)
- Provide Meals, Snacks, or Gifts (as long as they meet the \$15 Nominal Value requirement)

WHAT YOU CAN'T DO AT AN EDUCATIONAL EVENT:

- Distribute plan specific materials
- Distribute plan specific premiums/benefits
- Distribute enrollment forms or mandatory sign-up sheets
- Discuss plans offered
- Collect or Distribute enrollment forms
- Cannot be held at in-home or one-on-one settings (must be held in a public venue and must be advertised as Educational)





THINGS TO REMEMBER ABOUT SALES EVENTS:

- Sales Events MUST be reported to each applicable Carrier you are representing.
 - Each Carrier has their own process and time-frame requirements Make sure you know how/ when to report your events.
- If an event must be cancelled, know each Carriers process and time-frame requirements.
- If cancelled within the minimum required time-frame, a representative should still be present to notify potential attendees of the cancellation (stay at least a half an hour past the scheduled start time).
- Gifts, Snacks, or any promotional items must not exceed the "Nominal Gift" limit of \$15.
- Sign-in Sheets must be optional.
- Cannot require attendees to provide contact information.
- Sales Events in Healthcare settings are permitted in common areas such as hospital or nursing home cafeterias or community, recreational, or conference rooms.
 - o In Pharmacies, you must be "outside" of the areas where individuals wait for services from or interact with pharmacy providers and/or obtain medications (typically at least 15 ft away from the counter)



EDUCATIONAL VS SALES EVENTS - DO'S AND DON'TS:

ACTIVITY	EDUCATIONAL	SALES
File With CMS (via the applicable Carrier/s)	No*	Required
Host Event at a Public Venue	Required	Required
Conduct Lead Generating Activities	Yes	Yes
Distribute/Collect Enrollment Applications	No	Yes
Distribute/Collect SOA Forms for a Later Meeting	Yes	Yes
Provide Business Cards	Yes	Yes
Distribute <i>Marketing</i> Materials	No	Yes
Discuss Plans Offered	No	Yes
Distribute Sales/Plan Materials	No	Yes
Provide Giveaways displaying agent Contact Info	Yes	Yes
Provide Gift Cards/Certs, Cash, etc. as giveaways	No	No
Meals Allowed	Yes	No
Snacks Allowed	Yes	Yes
Nominal Gifts Allowed	Yes	Yes
Nominal gift value of \$15 Retail Value Limit Applies	Yes	Yes
Restrict Event Admission	No	No
Provide educational materials on healthcare topics	Yes	Yes

*Even though Educational Events are not filed with CMS, some carriers require them to be reported with them. Be aware of carrier specific.



HOW TO REPORT A SALES EVENT:

It obviously depends on which carrier you're dealing with, as they each have their own process. For assistance reporting events compliantly, contact your Carrier or FMO. Outlined below is the process for some of our larger MA Carriers. For instructions with other carriers, please contact your sales representative.

Aetna/Coventry

- 1. Fill out the Seminar Reporting Template (contact your local Rep for the Template)
- 2. Where you send it depends if you are licensed within an Aetna/Coventry local market or not.
 - a. **Licensed agents within an Aetna or Coventry local market** submit their seminar events directly to their market representative. The local market then submits the events to Agent Oversight.
 - b. Licensed agents <u>not</u> licensed within an Aetna or Coventry local market submit the spreadsheet directly to Agent Oversight's MedicareSemi@aetna.com mailbox.

Anthem

- Log into the Anthem Medicare Certification Training Center https://anthem.cmpsystem.com/
- 2. Click on "Sales Event Tracker"
- 3. Click on "Create Event"
- 4. Fill out the Event, Venue, and Marketing Information boxes
- 5. Click "Submit Event" to submit it to Anthem or "Save Event" to save it for future submission



Cigna Medicare

- 1. Agents/Brokers use the **Sales Event Log Template** to document marketing/sales event information
 - a. Contact your Cigna Medicare Broker Sale Representative (BSR) for the form
- 2. Upon completion, email the Sales Event Log Template to Cigna Medicare Broker Sale Representative (BSR) at least ten (10) days prior to date of the event
- 3. **If utilizing a Cigna Formal Sales Presentation,** complete a Sales Event Form and email to <u>salesevents@healthspring.com</u> (remember only use this if a Cigna Formal Sales Presentation is being used)
 - a. Also, if using a Cigna Formal Sales Presentation, you need to complete the Sales Event Training Attestation module before conducting an event.

Humana

- 1. Fill in the needed information on their Excel Spreadsheet (contact us for the Excel Template)
- 2. Email the completed spreadsheet to the local MSS (Market Support Staff) in your area
- 3. The Market Support Staff enters the seminar information into their reporting system and will send back a schedule confirmation (Allow 2 weeks' notice during Rest of Year and 3 weeks during AEP)



UnitedHealthcare

- 1. Before scheduling and reporting a Sales Event, you must complete and pass the Events Basics module for the applicable plan year
- 2. Download the **NEW Event Request Form** from Jarvis
 - a. It is located under Sales & Marketing Tools Sales → Materials. Scroll to the bottom of the page under Compliance Documents. The first tab is events, under that you will see the NEW Event Request form along with other helpful resources.
- 3. Complete the Tab/Worksheet titled "New Events"
- 4. After you have entered your event information, you can submit your form by double-clicking the "Validate and Submit" button at the top of the page.

NOTE: You will need MACROS enabled for this to work. If it won't send, this is most likely the reason. If this method does not work, contact your local UHC Agent Manager for instruction on submitting the form.

5. Must be submitted at least 7 calendar days prior to the event (best practice is 14 days)

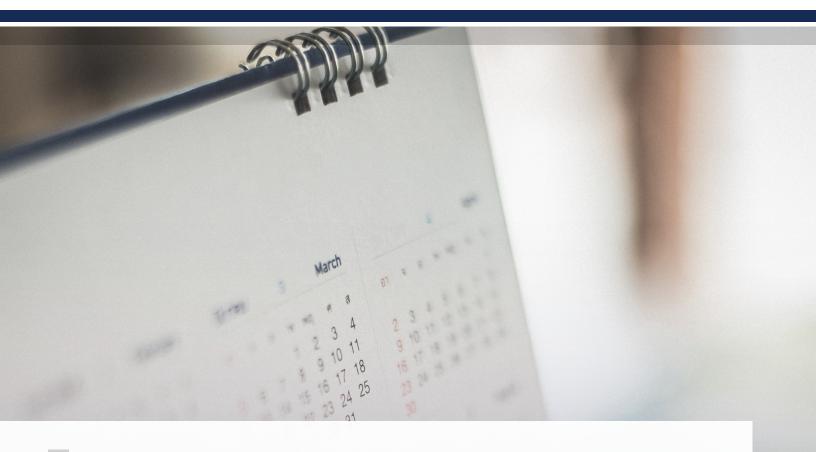


WellCare

- 1. Download the **Event Request Form** from the Agent Connect website.
 - a. Once Logged in, click on "Event Management" found within the scrollbar tool on the left of the page
 - b. You will see many tools/resources
 - c. Click on the Event Request Form to download it
- 2. Fill out the **Event Request Form**
- 3. Once completed, email the form to your local District Sales Manager
 - a. Remember, events generally must be submitted 7-10 business days prior to the date of the event







SECTION 5:

ENROLLMENT PERIODS

You can only enroll a client in a Medicare Advantage or Prescription Drug Plan during certain times. These "Enrollment Periods" determine when beneficiaries are eligible to enroll or make changes to current coverage. You need to be familiar with these enrollment periods so you are marketing and selling compliantly.

INITIAL ENROLLMENT PERIOD

The **Initial Enrollment Period (IEP)** is unique to each individual and is the timeframe when they are first eligible for Medicare, based on age. Also known as Age-In or T-65, this enrollment period is a seven-month window when an individual becomes eligible for Medicare, and thus, may enroll in an MA/MAPD plan. A person's initial enrollment period includes the three months prior to the month of their 65th birthday, the month in which they turn 65, and three months following the month of their 65th birthday.

MARKETING TIP: Agents may market to people turning 65 year-round, and provide ongoing educational information and position themselves as a source of expertise. Building a relationship in the months leading up to client's IEP can be a great way to gain new clients and generate sales. Some carriers enroll more new members through their Age-In campaigns than they do during AEP.

ANNUAL ENROLLMENT PERIOD

The **Annual Enrollment Period (AEP)** is the timeframe each year where a client can enroll in, change coverage, or drop coverage for a Medicare Advantage or Prescription Drug Plan. The AEP runs from October 15th to December 7th each year. This means you cannot enroll clients in MA/PDP plans outside of this.

You cannot "market" for an upcoming plan year prior to October 1, but keep in mind the actual definition of "marketing", as marketing includes specific plan benefit information. You can still conduct lead generation activities that don't include "marketing".

You are permitted to simultaneously market the current and prospective years starting on October 1, provided marketing materials clearly indicate what plan year is being discussed.

Enrollments in the new plan year may not be taken prior to October 15.

MARKETING TIP: Fueled by planners and procrastinators, most new enrollments and plan switches happen in the first and last weeks of AEP.



OPEN ENROLLMENT PERIOD

During the Medicare **Open Enrollment Period (OEP)** which runs from January 1 to March 31 each year, beneficiaries can switch from one Medicare Advantage plan to another or go back to Original Medicare. However, during OEP agents may not knowingly target or send unsolicited marketing materials to any MA or Part D enrollee. "Knowingly" takes into account the intended recipient as well as the content of the message.

During OEP, agents may:

- Conduct marketing activities based on other enrollment opportunities, such as:
 - Marketing to age-ins (who have not yet made an enrollment decision),
 - o Marketing for a 5-star plan, and
 - o Marketing to dual-eligible and LIS beneficiaries who, in general, may make changes once per calendar quarter during the first nine months of the year.
- · Send marketing materials when a beneficiary makes a proactive request; and
- Have one-on-one meetings at the beneficiary's request.



During OEP, agents may not:

- Conduct activities or send unsolicited materials advertising the ability/opportunity to make an additional enrollment change or referencing the OEP;
- Specifically target individuals who are in the OEP because they made a choice during Annual Enrollment Period (AEP) by purchase of mailing lists or other means of identification;
- Call or otherwise contact former enrollees who have selected a new plan during the AEP.

MARKETING TIP: OEP is a great time to shift to Age-In or other SEP activities. We also suggest using this time to reach out to your clients who enrolled in a plan during AEP to check in to confirm they know how to use their benefits or if they have any question. Doing so will go a long way with customer retention and satisfaction, will help reduce member complaints, and can spark a request for permissible marketing information.



SPECIAL ENROLLMENT PERIOD

In addition to the regular enrollment periods described previously, beneficiaries can make changes in their health or drug plan coverage if they qualify for a **Special Election Period (SEP)**. A beneficiary is eligible for an SEP when certain events happen in their lives, including, but not limited to:

- Being diagnosed with a severe or chronic condition and there's a Medicare chronic care
 Special Needs Plan (SNP) available that serves people with that condition. For example:
 - Diabetes
 - Cardiovascular disorders
 - o Chronic heart failure
 - Lung disease
- Moving into a different county that's not in their plan's service area
- Losing their current MA/PDP Plan in their area
- Qualifying for Extra Help with the cost of their prescription medicine
- Losing their retiree health coverage
- Receiving Medicaid assistance

MARKETING TIP: Purchased leads, targeted mailing lists, and provider-initiated activities can help connect you with prospective new clients.







SECTION 5:

PRIVACY/SECURITY

When it comes to privacy and security incidents, it is important to remember that members and consumers can easily be affected. They are trusting you with their sensitive information. It is your responsibility to keep the sensitive information of your clients secure!

YOU ARE THE FIRST LINE OF DEFENSE!

PRIVACY/SECURITY

All employees, contracted workers, and business associates (including agents) have a responsibility to protect the sensitive information of clients/members. Protecting this sensitive information can reduce the risk of identity theft and the negative impact it will have on your clients.

There are two types of sensitive information you need to be aware of and protect:

- PHI—Protected Health Information
- PII—Personally Identifiable Information

Both can be classified as any "non-public" personal information that can individually identify someone (i.e. SSN, DOB, medical info, etc.). All consumer and member information, including demographics, should be considered protected and confidential.



THINGS TO KNOW

- All employees, contracted workers, and business associates (including agents) are required to report any potential or actual inappropriate disclosures or uses of consumer/ member PHI/PII.
- All privacy breaches (even potential breaches) must be reported to either the:
 - o Compliance Department of the affected Carrier/s or
 - o Your FMO's Compliance Department:
- You must Encrypt all portable storage devices housing sensitive information, including flash drives, CD's, cell phones, laptops, tablets, etc.



PRIVACY/SECURITY

EXAMPLES OF INAPPROPRIATE DISCLOSURE OR PRIVACY BREACHES

- Emails or Faxes containing PHI/PII sent to the wrong person/address
- Lost or Stolen unencrypted electronic storage devices housing consumer PHI/PII
 - *If fully encrypted this would not be considered a breach of privacy
- Lost or Stolen hard copies of consumer PHI/PII
- Discussing member/customer information in public settings



TIPS FOR PROTECTING SENSITIVE INFORMATION:

- Use Secure/Encrypted Email and include a Privacy Disclaimer when emailing sensitive info
- Recheck Email Addresses and Fax #'s before sending
- When Faxing use a cover page with the HIPAA disclaimer
 - Acceptable HIPAA Disclaimer language:

CONFIDENTIALITY NOTICE: Information accompanying this facsimile is considered to be confidential and/or proprietary business information. Consequently, this information may be used only by the person or entity to which it is addressed. Such recipient shall be liable for using and protecting the information from further disclosure or misuse, consistent with applicable contract and/or law. The information you have received may contain protected health information (PHI) and must be handled according to applicable state and federal laws, including, but not limited to HIPAA. Individuals who misuse such information may be subject to both civil and criminal penalties. If you believe you received this information in error, please contact the sender immediately.

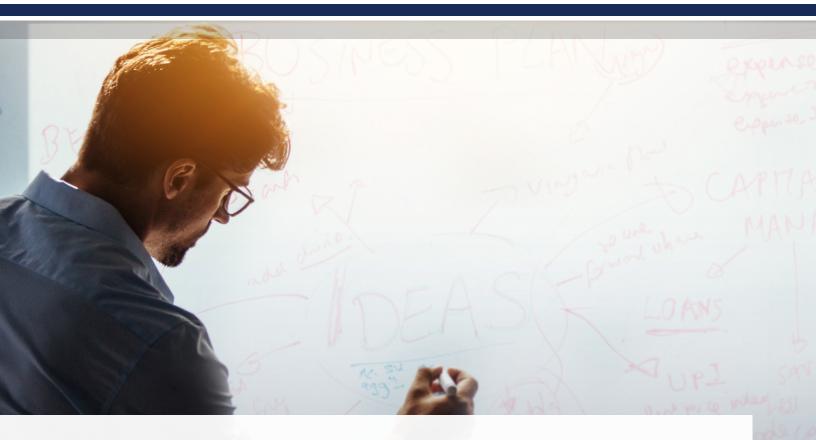


PRIVACY/SECURITY

- Encrypt all portable storage devices housing sensitive info
- Remember, Password Protecting is NOT the same as Encrypting. Ask your IT lead about acceptable means of encryption.
- Do not leave laptops, tablets, enrollment forms, etc. (anything housing sensitive client information) unattended in a non-secure place (i.e. your car, sales event kiosk/booth, etc.) where they could be stolen or lost
- NEVER connect to a public Wi-Fi (coffee shop, airport, etc.) without using VPN
- Properly dispose of all sensitive information (i.e. shred it)
- Do not discuss sensitive info in public places where others could overhear your conversation
- Don't bring unauthorized guests with you to appointments (ex. spouse, other agent, friend, etc.)
- Immediately report any suspected breach to the affected Carriers or your FMO!







SECTION 8:

BUILDING YOUR OWN COMPLIANCE PROGRAM

Do you have downline agents and/or employees working for you? If so, there are certain regulations that you must follow. These regulations deal with the oversight you have over your agents and/or employees, and what you do to keep them and your business operations running compliantly.

BUILDING YOUR OWN COMPLIANCE PROGRAM

FDR stands for <u>First-Tier</u>, <u>Downstream</u>, and <u>Related Entity</u>. If you have non-agent employees working for you or have downline agents who contract through you, you are considered a downstream entity. Thus, you are subject to carrier FDR requirements.

Carriers require all FDR's to have proper oversight over their non-agent employees and downline agents. In order to meet this requirement, carriers expect each FDR to implement and maintain an effective compliance program. **CMS and Plan Sponsors now have the authority to come directly to YOU and conduct Compliance Audits**. Having an effective compliance program in place will help you adhere to the FDR requirements highlighted below and keep your organization/agency compliant.



SEVEN CORE ELEMENTS OF AN EFFECTIVE COMPLIANCE PROGRAM

- 1. Written Policies and Procedures
- 2. Compliance Officer & Committee
- 3. Training & Education
- 4. Effective Lines of Communication
- 5. Well-Publicized Disciplinary Standards
- 6. Routine Monitoring and Identification of Risk
- 7. System for Prompt Response to Issues (without Retaliation)



BUILDING YOUR OWN COMPLIANCE PROGRAM

GETTING STARTED:

1. Designate a **Compliance Officer**

• It can be anyone you deem competent enough to oversee all aspects of the program and make sure your organization and all downline agents contracted with you are remaining compliant. They will be responsible for developing, operating, and monitoring the compliance program as a whole. They will need to train and educate employees on compliance as well as monitor and track agent performance in regard to compliance. Furthermore, they will need to independently investigate compliance matters and ensure that any necessary corrective action is taken.

2. Draft a set of Policies & Procedures

 Your P&P's will serve as a framework for all actions and conduct within your organization and serve as a guide for the day-to-day operations of your business. They should cover the rules and regulations that your employees and business partners are to adhere to; as well as lay out the fundamental principles and values expected of your employees and business partners.

3. Draft of Code of Conduct

A Code of Conduct is designed to promote honest, ethical, and lawful conduct by all
employees, officers, and directors within your organization. Remember, the actions of
all people affiliated with your organization affect the reputation and integrity of your
Company. You can draft your own or use your Carriers' Codes of Conduct. If you're
contracted with multiple Carriers you'd need to distribute each Code of Conduct. We've
found it easier to draft your own that meets all the requirements.



BUILDING YOUR OWN COMPLIANCE PROGRAM

TASKS TO COMPLETE TO MAINTAIN COMPLIANCE:

- 1. Distribute your Code of Conduct and Policies & Procedures to all Non-Agent Employees and/or Contractors
- Complete within 90 days of Hire and Annually thereafter
- <u>Proof of Completion</u> should be kept for a minimum of 10 years (ex. attestation page employees sign stating they've read and will adhere to the Code of Conduct and P&P's)
- 2. Deliver the CMS Medicare Parts C & D Fraud, Waste, & Abuse and General Compliance Training to all Non-Agent Employees and/or Contractors
- Complete <u>within 90 days of Hire and Annually</u> thereafter
- Must be the CMS version—can be found at www.cms.gov and type "Fraud waste and abuse training" in the search box
- <u>Proof of Completion</u> should be kept for a minimum of 10 years (ex. attestation page, attendance logs, certificates of completion, etc.)
- 3. Check each Non-Agent Employee/Contractor against the OIG and GSA excluded parties' lists
- Complete PRIOR to Hire and MONTHLY thereafter
- If any of your employees is on either list, they must be removed from all duties related to Medicare Advantage and/or Part D
- Recommend using <u>VerifyComply</u> and creating a free account. You can screen against all applicable exclusion lists in one search and print your results.
- <u>Proof of Completion</u> should be kept for a minimum of 10 years (ex. screenshots, print outs, saved PDFs for GSA checks, etc. - must include a Date/Time stamp of when search took place)



BUILDING YOUR OWN COMPLIANCE PROGRAM

4. Maintain Proper Oversight of your Downline Agents

- How do you monitor your agents' sales practices, the marketing materials they use, their lead generation practices, etc.?
- What type of Training/Support do you offer them to ensure they are selling compliantly?
- What communication methods do you use to keep them abreast of all compliance issues?
- What types of compliance related information do you communicate to them?



RESOURCES & CONTACTS

CMS updates their Marketing and Communications Guidelines annually but at the time this Guide was produced, the MCMGs had not been updated or released.

It's a good practice to check the links below and stay familiar with the Medicare Marketing Guidelines and Managed Care Manuals.

If you have questions, reach out to your Compliance team. We're here to help with any questions you may have.



Medicare Marketing Guidelines for MA and Part D

Medicare Managed Care Manual

COMPLIANCE CONTACT	Matt Fry
EMAIL TO CONTACT OUR COMPLIANCE DEPARTMENT	compliance@cornerstoneseniormarketing.com

