SAVERS MARKETING

AN INTEGRITY COMPANY

PINNACLE BENEFITS GROUP

AN INTEGRITY COMPANY

AGENT MEDICARE COMPLIANCE GUIDE

BEST PRACTICES IN MEDICARE COMPLIANCE & MARKETING

2025

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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).

LEAD GENERATION

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 or "Door Knocking" (Remember, even if you have a Business Reply Card or Permission to Contact form with the consumer's address listed, you cannot go to their residence without a pre-scheduled appointment)
- Leaving Flyers, Leaflets, door hangers, 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?

- 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)

- 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 is valid for 12 months

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 lines of business as a means of generating leads for Medicare plans)
- Referrals from current clients do not give you “permission to contact” that referral
- 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

LEAD GENERATION

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, and do not list benefits, premiums, copays, and cost sharing).

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 must have content with information about plan benefits, cost sharing, measuring, or ranking standards.**

LEAD GENERATION

MARKETING AND ADVERTISING MATERIALS

On May 10, 2023, CMS expanded the regulatory definition of "marketing" to include content that mentions **any type of benefit** covered by the plan (Effective July 10, 2023). Remember any material meeting the definition of "marketing" requires HPMS filing, for example:

- Advertisements intended to draw a beneficiary's attention to an MA plan or plans that include or address content regarding:
  - Plan premiums,
  - Cost sharing, or
  - Benefit information (as of May 10, CMS considers any mention of a benefit to be "marketing").

If your advertising materials (or ones you purchase from a lead vendor) include any language similar to the examples below, they should be submitted to CMS for review and approval (this includes Websites and Social media):

- "Medicare Advantage Plans may contain additional benefits such **Dental, Vision, Hearing, and Prescription Drugs**"
- "Medicare Advantage Plans may come with **OTC** and **Transportation benefits**"
- "Some Medicare Advantage Plans may have a **$0 Monthly Plan Premium**"
- "**Copays as low as $0**"
- "you may be eligible to get your **Part B premium paid back**"

Basically, any advertisement or mailer that mentions a premium, a benefit, a copay, or getting your Part B paid for (even if in a general fashion) needs to be submitted to HPMS for approval.

NOTE: CMS excludes material that might meet the definition of marketing based on content, but does not meet the intent requirements of marketing. So if there is no "call to action" on the part of the consumer, CMS still views those pieces as a "communication."

LEAD GENERATION
MARKETING AND ADVERTISING MATERIALS

CMS SUBMISSION

How do you submit materials for review and approval to CMS?

Materials are now submitted to HPMS by direct downstream agency partners of carriers (Top of Hierarchy contracts). Agents should reach out to their immediate upline agency for escalation of materials for submission. Prior to submission, materials will need to be compliant per CMS regulations, so be sure to thoroughly review this guide to ensure your materials are compliant. Also, carriers are required to approve materials prior to submitting multi-plan materials to HPMS. This review could take several weeks so be sure to allow time for this important step. We are here for guidance, so please reach out with any questions.

GENERAL GUIDANCE

- MA Organizations and TPMOs may not use the Medicare name, CMS logo, and products or information issued by the Federal Government, including the Medicare card, **in a misleading way**.
  - Interpretations on this will most likely vary from carrier to carrier, so a conservative approach is suggested. So take steps to make it very clear you are a Licensed Insurance Agent and not affiliated with Medicare.
  - ***Best Practice for now:*** *Include "qualifying language" in conjunction with disclaimers and other language on materials that appear "governmental" or prominently use the word "Medicare" to make it clear you are a licensed insurance agent and not affiliated with Medicare.*
- Use of the Medicare card image is now only permitted with prior authorization from CMS.
  - For approval, place the following disclaimer directly below/above the card image: "Not affiliated with or endorsed by CMS, HHS, or the Federal Medicare Program."
- 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).
- Marketing of benefits in a service area where those benefits are not available is prohibited, unless unavoidable because of the use of local or regional media that covers the service area.

LEAD GENERATION

MARKETING AND ADVERTISING MATERIALS

- Cannot market any products, plans, benefits, or costs, unless the company names of the entities offering the referenced products, plans, benefits, or costs are identified in the marketing material.
- All text on materials, including footnotes and disclaimers, should be printed with a font size equivalent to or larger than **Times New Roman 12pt font.**
  - 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
  - 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.*
- 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:
  - *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.**

PROHIBITED TERMS AND LANGUAGE

- **DO NOT use the word "Entitled"** when referring to plan benefits. Use "Eligible" instead.
  - Can only use "Entitled" in relation to Part A for Federal Medicare Products.
- Use caution when using the word **"Senior".**
  - 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.
  - 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.
  - 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:
  - "Customized" or "personalized" when describing Medicare plans or benefit as plans cannot be customized for an individual's needs.
  - "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:
  - 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)
- Avoid use of any language that might imply a consumer must call, reply, or contact the agent/agency to implement or qualify for benefits.
  - **Negative example:** “Call Now to find out what benefits you are missing out on!” or “Fill out the information below to receive benefits you are entitled to!”
  - **Positive Example:** “To learn more about Medicare Advantage Plans available in your area, call to speak with a licensed sales agent.” or “Fill out the information below to have a licensed insurance agent contact you regarding Medicare Advantage Plans available in your area.”

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 for yourself, remember if sharing beneficiary data with another TPMO, one-to-one consent must be captured): **BY PROVIDING THE INFORMATION ABOVE, I GRANT PERMISSION FOR A LICENSED INSURANCE AGENT TO CALL OR EMAIL ME REGARDING MY MEDICARE OPTIONS INCLUDING MEDICARE SUPPLEMENT, MEDICARE ADVANTAGE, AND PRESCRIPTION DRUG PLANS.**
- (best practice for all materials, but required for materials that are tied to Medicare Supplement): **THIS IS A SOLICITATION FOR INSURANCE.**

If you are promoting a <u>specific carrier's product(s)</u> 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.

REQUIRED DISCLAIMERS:

DISCLAIMER	EXAMPLE OR REQUIRED TEXT	APPLICABLE DOCUMENTS
Federal Contracting Statement (marketing materials)	**Example Text:** "[carrier's legal or marketing name] is a [plan type] with a Medicare contract. Enrollment in [carrier's legal or marketing name] depends on contract renewal." **Example Text** (Carrier Specific)**:** "[Carrier's legal or marketing name] is a [plan type] with a Medicare contract. Enrollment in [carrier's legal or marketing name] depends on contract renewal." **Example Text** (Generic)**:** "Plans are insured or covered by a Medicare Advantage organization with a Medicare contract and/or a Medicare-approved Part D sponsor. Enrollment in the plan depends on the plan's contract renewal with Medicare."	Required on all materials where specific carriers and plans are mentioned, except those specifically excluded by CMS Required elements in statement (see Note below).

LEAD GENERATION

MARKETING AND ADVERTISING MATERIALS

DISCLAIMER	EXAMPLE OR REQUIRED TEXT	APPLICABLE DOCUMENTS
Materials Developed by a TPMO	"We do not offer every plan available in your area. Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. Please contact Medicare.gov, 1-800-MEDICARE, or your local State Health Insurance Program (SHIP) to get information on all of your options."	Required on: • All TPMO marketing materials, including all print materials, TV ads, that are used, created, or distributed by a TPMO and that meet the definition of "marketing" • All TPMO websites (prominently displayed) • Provided verbally within the first minute of a sales call • Provided electronically when communicating with a beneficiary through email, online chat, or other electronic means of communication *Note: A different disclaimer is required for TPMOs that truly offer every option in a service area.*
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 (marketing)	**Example Text:** "Eligible for a free drawing, gift, or prizes with no obligation to enroll." Example Text: "Free gift without 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.
SEP Disclaimer	**Required Text:** "Enrollment in a plan may be limited to certain times of the year unless you qualify for a Special Enrollment Period or you are in your Medicare Initial Enrollment Period."	Materials used outside of AEP/OEP and/or are targeting a specific SEP, should include the following disclaimer.

LEAD GENERATION

MARKETING AND ADVERTISING MATERIALS

DISCLAIMER	EXAMPLE OR REQUIRED TEXT	APPLICABLE DOCUMENTS
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.
Benefits	**Example Text:** "Not all plans offer all of these benefits. Benefits may vary by carrier and location. Limitations, exclusions, copays, deductibles, and coinsurance may apply."	Required if a "marketing" material contains plan benefits (i.e. Dental, Vision, Hearing, OTC, Transportation, Fitness, etc).
Part B Giveback	**Required Text:** "Part B Premium giveback is not available with all plans. Availability varies by carrier and location. Actual Part B premium reduction varies."	Required on all materials when Part B giveback info is included.
VBID/SSBCI Benefit Disclaimer	**Required Text:** *Benefit(s) mentioned may be part of a special supplemental program for chronically ill members with one of the following conditions: Diabetes mellitus, Cardiovascular disorders, Chronic and disabling mental health conditions, Chronic lung disorders, Chronic heart failure. This is not a complete list of qualifying conditions. Having a qualifying condition alone does not mean you will receive the benefit(s). Other requirements may apply.	Required on all materials where VBID/SSBCI benefits are listed. Materials with SSBCI benefits should be indicated with an asterisk to identify the benefit that this disclaimer may apply to.

NOTE: Some disclaimers are not required on the following material types: banners and banner-like ads, envelopes, outdoor advertising, text messages, and social media. Certain statements are required in call scripts and must to be read to clients during enrollment calls.

LEAD GENERATION

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.

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 call or email 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

Things to Remember Continued:

- **MUST be retained for documentation purposes** and available upon request for the remainder of the selling year plus 10 additional years
- May not request spouse information. Permission to contact may only be granted by the individual; not conferred on another without being a legal authorized representative.
- Some carriers require submission of all BRC/PTC forms prior to use (regardless if they meet the definition of "marketing")

BENEFICIARY DATA DISTRIBUTION

When personal data of a beneficiary will be shared with another TPMO (this includes agents, agencies, lead lendors, etc.) for purposes of marketing and enrollment, prior express written consent must be obtained through clear and conspicuous language that lists each entity/individual that will receive said data (i.e. one-to-one consent).

What does this mean?

- TPMOs must capture Prior Express Written Consent to share beneficiary data (i.e. Leads) with other TPMOs
    - Remember: Agents, Agencies, Marketing Organizations, and Lead Companies are all TPMOs
- Creates "One-to-one" consent model meaning the individual/entity receiving the beneficiary data must be listed in the consent language

Best Practices

- Make sure you can access the lead source data of leads you receive – the ad, mailer, post, etc. (this includes the actual PTC form/language as well)
- When dealing with lead vendors, review pieces/mailers prior to purchasing – we can help with that review
- When purchasing leads, ensure your name is listed in the consent language

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.

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.

- 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.

- 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.

MATERIAL REVIEW CHECKLIST

GENERAL GUIDANCE
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 Name • Benefit Information • STAR Ratings
Marketing During OEP – Messages aimed at generating interest or leads during the OEP are generally prohibited unless targeting allowable segments (i.e. IEP, SEP, Dual Eligible, 5-STAR Plans). **Additional OEP Guidance:** • Marketing messages aimed at generating interest or leads during the OEP are generally prohibited. For example, a generic marketing line of "not happy with your plan, change now" would be considered inappropriate marketing. • Any lead/advertising piece that meets the definition of "marketing" sent or displayed during OEP must clearly show who it is targeting. Remember, only certain marketing is allowed during OEP. You can target Age-ins, Dual Eligibles, market 5-Star Plans, or other SEP's. • Carriers will also look for audience crossing, as that "muddies the waters". For example, if a piece makes references to veterans and DSNP on the same piece that begs the question, "are they marketing to veterans, are they marketing to dual eligible, or are they marketing to everyone and hoping someone lands in those categories?" The answer to that question would determine if its allowable marketing during OEP.
Rest of Year Marketing (4/1-9/30) • AEP cannot be marketed • IEP & SEP can be marketed • Communications are allowed, including general communications that promote a business as well as educational pieces about the upcoming AEP • It's strongly recommended that marketing materials be written in a way that the reviewer can easily identify them as IEP or SEP. If there is any mention of AEP, or information that leads the reviewer to believe the intent is to market AEP, the material is prohibited

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 Expert
- Mediare Agent
- Medicare Benefit Specialist
- Medicare Solutions Advisor
- i.e. Anything containing "Medicare" in the title

Recommended Titles:

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

SECTION 1
DETERMINE IF THE MATERIAL IS CONSIDERED "MARKETING" OR A "COMMUNICATION"

Definitions:

Communications – activities and use of materials created or administered by a Plan or any downstream entity to provide information to current and prospective enrollees. Basically, all activities and materials aimed at prospective and current enrollees, including their caregivers, are considered "communications".

Marketing – a subset of communications that must meet both **intent** and **content** standards to be defined as "marketing" and thus, require submission to CMS via the HPMS portal.

Intent – material or activities that are intended to:

- Draw a beneficiary's attention to a plan or plans,
- Influence a beneficiary's decision-making process when making a plan selection, or
- Influence a beneficiary's decision to stay enrolled in a plan.

Content – Materials or activities that include or address content regarding:

- Plan benefits, benefits structure, premiums, or cost sharing
- Measuring or ranking standards (for example, Star Ratings or plan comparisons), or
- Rewards and incentives

Example: An agency commercial or mailer states: "Call us to hear about plans that can provide hearing and dental benefits, zero-dollar monthly premiums, and can even lower your Medicare Part B costs."

Marketing or Communication? Marketing. While a specific plan is not mentioned by name, the commercial's **intent** is to draw the beneficiary to a MA plan or plans and the **content** addresses plan premium, cost-sharing, and benefit information for plans being represented and sold by the third party."

CHECKLIST CONT.

❑ **Yes** ❑ **No**	**1)** Is the material **intended** to draw attention to a Medicare Advantage Plan or Plans or influence a consumer's decision making process when making a plan selection? *If yes, it meets the "Intent" requirement for marketing. If no, it is not marketing, as there is no "intent" present.*
❑ **Yes** ❑ **No**	**2)** Does the material meet the **content** requirement for "marketing"? *If any of the below can be checked, it is marketing content.* ❑ Plan benefits listed, even if in a general fashion (ex. Dental, Vision, Hearing, etc.) ❑ Plan specific benefits are listed (ex. Hearing Aids, Dentures, etc.) ❑ Plan premiums, even if $0, low cost, or no cost (ex. Medicare Advantage Plans can have monthly plan premiums as low as $0) ❑ Copays, Coinsurance, Deductibles, etc. (ex. Copays as low as $0) ❑ Part B giveback or buydown
*** If #1 and #2 are answered Yes, then it is "marketing" and needs submitted to HPMS**	
❑ **Communication Only** ❑ **Marketing**	
SECTION 2 ENSURE THE MATERIAL IS ALIGNED WITH CMS AND CARRIER GUIDELINES NOTE: If you answer "No" to any of the questions below, it isn't compliant.	
❑ **Yes** ❑ **No** ❑ **N/A**	**Is all font legible and sized appropriately (including disclaimers)?** Suggested size: At least 12pt Times New Roman or equivalent.
❑ **Yes** ❑ **No** ❑ **N/A**	**Is Agency/Broker name or logo visible, so it is clear who the sender is?**

CHECKLIST CONT.

❑ Yes ❑ No ❑ N/A	**If the piece is being sent/distributed during OEP (Jan 1 – Mar 31), is it compliant with the guidance below?** • Unsolicited ""marketing"" material is prohibited during this time unless it specifically targets IEP or an SEP. (Ex. Age-ins, Dual Eligibles, 5-Star Plans, etc.) **Note:** Messages aimed at generating interest or leads during the OEP are generally prohibited unless the piece specifically calls out the IEP or SEP being targeted. Therefore, if the message is not clear that it is marketing IEP and/or SEP during this time, it is prohibited.
❑ Yes ❑ No ❑ N/A	**Are full plan names used when first mentioned?** Ex. Medicare Advantage Plan, Medicare Supplement Plan, Prescription Drug Plan
❑ Yes ❑ No ❑ N/A	**If the piece is asking the consumer to call, is it clear that by calling the number they will reach a licensed insurance agent?** *Example Text:* CALLING THE NUMBER ABOVE WILL DIRECT YOU TO A LICENSED INSURANCE AGENT. *Example Text:* CALL NOW TO SPEAK WITH A LICENSED INSURANCE AGENT
❑ Yes ❑ No ❑ N/A	**Is it clear that the agent is not affiliated with or endorsed by the government of Federal Medicare Program?** *Suggested Text (required on Lead Vendor / BRC Mailers):* NOT AFFILIATED WITH OR ENDORSED BY THE GOVERNMENT OR FEDERAL MEDICARE PROGRAM.
❑ Yes ❑ No ❑ N/A	**Is the piece free of any prohibited terms or language?** See examples of prohibited language below: • **"Entitled"** – when referencing plan benefits. Can only use "entitled" in reference to Part A. • **"Senior"** – should be careful not to limit your audience only to "seniors" as some Medicare beneficiaries are under 65 • **Absolute Superlatives** – "the best", "highest rated", "the most" doctors, "all" plans, insurance "expert"

CHECKLIST CONT.

	• **"Free"** – when referencing plan premiums or benefits, suggested language "no additional cost" • **Exaggerative Phrases** – words/phrases such as "all", "full", "complete", "unlimited" to describe benefits/plans (these are only examples) • **Customized or Personalized** – when describing Medicare plans or benefit as plans cannot be customized for an individual's needs • **"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". • **High-Pressure Sales tactics (scare tactics)** – language that may cause undue fear, anxiety, or confusion. Examples: "Beware", "Act Now", "Missing out", "You may lose your benefits", "URGENT", etc. • **"Medicare"** – when used in an agent title, ex. "Medicare Specialist", "Medicare Agent", "Medicare Advisor", etc. (carriers don't like Benefit Advior, Benfit Specialist, etc. either – advise using Licensed Insurance Agent or something very similar to make it very clear who they are)
❑ **Yes** ❑ **No** ❑ **N/A**	**If discussing benefits, is it clear to consumers that the piece is advertising a Medicare Plan, and not advertising additional benefits that can be added to current coverage?** For example: **Negative example:** "You may be eligible for additional beneifts, call to see if you qualify." **Positive example:** "There may be Medicare Advantage Plans in your area that include additional benefits. Call to speak with a licensed insurance agent to learn more."

CHECKLIST CONT.

❑ Yes ❑ No ❑ N/A	**Is the piece free of any language that might imply a consumer must call, reply, or contact the agent/agency to implement or qualify for benefits?** **Negative example:** "Call Now to find out what benefits you are missing out on!" or "Fill out the information below to receive benefits you are entitled to!" **Postitive example:** "To learn more about Medicare Advantage Plans available in your area, call to speak with a licensed sales agent." or "Fill out the information below to have a licensed insurance agent contact you regarding Medicare Advantage Plans available in your area."
BRC Lead Pieces / Permission to Contact Forms:	
❑ Yes ❑ No ❑ N/A	**If the piece is a Business Reply Card (BRC) or intended to gain permission to contact the consumer, does it contain the necessary permission to contact language?** ***Example Text:*** "By providing the information above, I grant permission for licensed insurance agent, <agent/agency name>, to call me regarding my Medicare options including Medicare Supplement, Medicare Advantage, and Prescription Drug Plans."
❑ Yes ❑ No ❑ N/A	**Does the material align with the following guidance?** **BRC/PTC forms should not ask for Date of Birth.** (Note: can ask for age or date of Medicare eligibility) Select Yes if material meets this requirement. ***Exception:*** *May include fields or ask questions related Medicare beneficiary's date of birth (DOB), gender, and tobacco use only if the lead generation mechanism includes Medicare Supplement Insurance in addition to Medicare Advantage and/or Prescription Drug plans.* ***All field(s) must be optional and there must be a note clearly indicating that information related to DOB, gender, and tobacco use questions is not needed for MA and Part D plans.***

CHECKLIST CONT.

❑ Yes ❑ No ❑ N/A	**Does the material align with the following guidance?** **BRC lead pieces should not include a place for consent to contact a spouse.** (Note: some carriers do not support the use of a single BRC for multiple consumer consents) Select Yes if material meets this requirement.
❑ Yes ❑ No ❑ N/A	**If Permission to Contact can be linked to Medicare Supplement products, does the piece include the following disclaimer?** **Example Text:** "This is a solicitation for insurance."
❑ Yes ❑ No ❑ N/A	**Does the piece contain the Agent/Agency name or logo?** For lead pieces that appear "governmental" (i.e. lead vendor mailers and BRC forms), agent/agency name and/or logo should be present to make it clear it isn't from the government.
Disclaimers:	
❑ Yes ❑ No ❑ N/A	**Federal Contracting Statement:** Required on all ""marketing"" materials, except those specifically excluded by CMS. ***Example Text (Carrier Specific):*** "[Carrier's legal or marketing name] is a [plan type] with a Medicare contract. Enrollment in [carrier's legal or marketing name] depends on contract renewal." ***Example Text (Generic):*** "Plans are insured or covered by a Medicare Advantage organization with a Medicare contract and/or a Medicare-approved Part D sponsor. Enrollment in the plan depends on the plan's contract renewal with Medicare."
❑ Yes ❑ No ❑ N/A	**Is the Third-Party Marketing Disclaimer included when required?** Required on all third-party websites, and on marketing materials, advertisements, television ads, etc. that meet the definition of "marketing". (Note: Different disclaimer is required for TPMOs that truly offer every option in a service area.) ***Example Text:*** "We do not offer every plan available in your area. Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. Please contact Medicare.gov, 1-800-MEDICARE, or your local State Health Insurance Program (SHIP) to get information on all of your options."

CHECKLIST CONT.

❑ Yes ❑ No ❑ N/A	**If plan benefits are marketed, is the following disclaimer included?** ***Example Text:*** "Not all plans offer all of these benefits. Availability of benefits and plans varies by carrier and location. Limitations and exclusions may apply."
❑ Yes ❑ No ❑ N/A	**If Part B giveback is referenced, is the following disclaimer included?** ***Example Text:*** "Part B Premium give-back is not available with all plans. Availability varies by carrier and location. Actual Part B premium reduction varies. Limitations and exclusions may apply."
❑ Yes ❑ No ❑ N/A	**If "Medicare" is mentioned in a name, heading, title, etc., does it include clear and prominent qualifier to make it clear there is no government affiliation?** Such as: ***Example Text:*** "<Agency name> is an insurance agency not affiliated with the government." or "Advertisement – no government affiliation."
❑ Yes ❑ No ❑ N/A	**If the piece appears "governmental" (most BRC mailers do), does it include a disclaimer separating it from the Government and Medicare?** ***Required Text:*** NOT AFFILIATED WITH OR ENDORSED BY THE GOVERNMENT OR FEDERAL MEDICARE PROGRAM. ***Best Practice*** is to include this on all/most advertisements and mailers to make it clear there is no affiliation. **Note:** Carrier guidance states that Lead Vendor pieces tend to ""appear governmental"" so would need this disclaimer prominently displayed, along with a qualifying statement and Agency/Agent name or logo. The disclaimer alone is not considered sufficient in delineating these pieces from the Government and Medicare.

CHECKLIST CONT.

Events:	
❑ Yes ❑ No ❑ N/A	**If the piece is an invitation to an event (educational or sales), is the following disclaimer included?** ***Example Text:*** "For accommodation of persons with special needs call <insert phone and TTY number>."
❑ Yes ❑ No ❑ N/A	**If a drawing or prize is advertised with the event, is the following disclaimer included?** ***Example Text:*** "Eligible for a free drawing and prizes with no obligation." or "Free drawing without obligation?
Note: Disclaimer Exceptions – Banners, Banner-like ads, outdoor ads, text messages, social media, and envelopes	

GENERIC MARKETING CHECKLIST – CARRIER EXAMPLES

ISSUE DESCRIPTION	NEGATIVE EXAMPLE (THESE ARE EXAMPLES OF PHRASES THAT MAY BE MISLEADING AND/OR CONFUSING AND MAY IMPLICATE CMS CONCERNS).	POSITIVE EXAMPLE (THESE ARE EXAMPLES OF HOW SUCH PHRASES CAN BE CORRECTED SO THAT INFORMATION ABOUT THE BENEFITS CAN STILL BE ADVERTISED AND COMMUNICATED IN A WAY THAT IS UNLIKELY TO BE MISLEADING OR CONFUSING).
a) Promoting benefits that are not generally included in most Medicare Advantage plans (e.g., dentures, free eyeglasses).	"And coverage for dental work with extractions, fillings, even dentures, all at no additional cost!"	"And plans may be available in some areas that include coverage for dental work with extractions, fillings, even dentures"
b) Advertising benefits that are limited to certain enrollees or where the amount varies per enrollee, like Part B Giveback.	"Included in your plan up to $144 added back to your Social Security check every month"	"Some plans in certain areas may include the Part B Giveback Benefit, which can allow you to get a partial or full Part B premium reduction."
c) Promoting an SSBCI or VBID benefit (these materials must comply with additional marketing requirements and may require special filing with CMS). Examples include grocery cards (VBID) and payment of utility bills (SSBCI).	"You may qualify for dental, vision, hearing, and even help paying for groceries and utility bills."	"There may be plans in your area with dental, vision, and hearing coverage, and some may include benefits for certain qualifying members that help pay for groceries and special supplemental benefits, including help paying utility bills, for chronically ill members who meet qualifying criteria." Note: If VBID or SSBCI benefits are mentioned, then the material must be filed with CMS with VBID and SSBCI benefits indicated.
d) Promoting cost savings that are not typical or limited to certain enrollees.	"The agent said I'm eligible to eliminate copays"	"The licensed sales agent said there may be plans available in my area that may help me save money"
e) Promoting very specific amounts related to benefits where most MA members would not receive that level of benefits (i.e. "$1500 back in my social security check").	"Get $1700 a year back in your pocket"	"You may be able to find a plan in your area with the Part B Giveback benefit, which may allow you to get a partial or full Part B premium reduction."
f) Describing benefits in a misleading way (e.g. "elimination of copays").	"You may be able to get significant extra benefits, all at no additional cost"	"You may be able to find a plan in your area with extra benefits, and $0 monthly plan premium"
g) Implying benefits can be added to existing coverage or tied to a zip code, as opposed to enrolling in a new plan available in their area with the described benefits.	"You can update your benefits, call the eight hundred number on your screen to check your zipcode"	"You can switch to a different plan, call the 800 number on your screen to speak with a licensed sales agent and check which plans are available in your zipcode"
h) Using the U.S. flag.	Flags displayed in the ad are very similar to images seen of government offices or the same way they are displayed behind the press secretary during a press conference, implying that the message is coming from a government agency.	Flag imagery may be used only to invoke more of a home-town, Americana sense rather than an official, governmental sense. I.e. a flag flowing from a flag pole in a person's yard rather than multiple flags on a stand in an office-like setting, similar to how they are displayed in govt. buildings.
i) Utilizing a red, white and blue color scheme.	Red, white and blue imagery that dominates piece, is combined with a U.S. flag/Medicare card/ company name that could appear to be associated with the government.	Red, white and blue color scheme may be permissible if other risky elements are omitted and arrangement of colors does not follow American flag.

CHECKLIST CONT.

j) Including a company name that is similar to or includes "Medicare" or may confuse consumers into believing the company is or is affiliated with Medicare.	Name – Medicare Help; Medicare Hotline; Medicare Benefits HotlineLanguage – "IMPORTANT NOTICE"; "ACTION REQUIRED"; "Notice Date" or other language that suggests that Medicare is providing an official document.	Any name or language that does not imply or give the impression that the agency is a government agency or the material is coming from a government agency. If "Medicare" is mentioned in a name, include clear and prominent qualifier such as, "a non-government entity" or "a health insurance agency", directly below the name.
k) Not incorporating disclaimers, or disclaimers are hidden or very small, not in a legible font/color, or not present long enough for an average viewer to see, read and interpret them and therefore fail to clarify that company is a sales agency and not the government or endorsed by the government.	"Extra benefits require enrollment in a MA plan."	"Extra benefits require enrollment in a MA plan and depend on whether you are eligible to enroll in a MA plan in your area. Benefits are available only in select areas." Note: Disclaimers must be large enough to be legible. If media is television, disclaimers must be clearly seen and remains on screen enough time for someone to read it and understand it.
l) Using scare tactics.	"Millions of Americans may not have all available benefits.""Take Action now to get the benefits you are entitled to."	"Depending on your area, you may be able to enroll in a plan with additional benefits." Note: The key is removing language that causes undue anxiety or fear which scares the consumer into calling because they think they are at risk of losing Medicare coverage or not receiving certain benefits. Avoid font that is in all caps, oversized and red.
m) Promoting a false sense of urgency to act now, in either words, imagery or tone.	"Attention: Anyone on Medicare""URGENT""Act now, or you may lose your benefits!"	"Medicare Advantage Plan Options for 2022""Information for Medicare Recipients"
n) Stressing a deadline for enrolling that could be misleading or unduly pressure beneficiaries into calling.	During AEP: "AEP is ending soon" (if used at the beginning of AEP)Outside AEP: Any language that implies the beneficiary is required to meet a deadline when they really are not (i.e. – "Attention: Important Medicare Deadline"; "Don't Miss the Deadline")	During AEP: "Enroll Now; AEP Ends on 12/7"; "The Time is Now"Outside AEP: "Learn more about your MA plan options"; "Call to speak with a licensed sales agent to see if you are eligible to enroll"
o) Implying that beneficiary must call the sales agency to implement their Medicare plan/ benefits.	"Call Now to Find out what benefits you are missing out on!""Call to receive benefits you are entitled to!"	"To learn more about Medicare Advantage plans available in your area, call to speak with a licensed sales agent."
p) Making it unclear whether it is referring to the Medicare Advantage and Prescription Drug Plan Annual Enrollment Period and/or dates of this enrollment period.	"Enrollment open now!"; "Open Enrollment Begins Now"; "Call before December 7th" (with no explanation of what this is referring to); "Annual Open Enrollment Period" (combining AEP and OEP)	"Medicare Advantage & Prescription Drug Plan Annual Enrollment Period"; "Medicare Annual Election Period;Medicare Annual Enrollment Period"Note: AEP may be acceptable if there is limited space and it clear from the context of the piece that the enrollment period referred to is that in which a person can enroll in a Medicare Advantage and/or Prescription Drug Plan.
q) Otherwise including misleading, confusing, or materially inaccurate information.	"Get money added back to your social security check!""See if your eligible for these benefits at no additional cost!""Eliminate your copays!""Call to check your zip code."	"Depending on your zip code, there may be a Medicare Advantage plan available that includes a Medicare Part B premium giveback which can reduce the amount deducted from your social security check each month.""Call to see if there are plans with $0 monthly plan premium available in your area.""Call to learn about plans in your area with affordable co-pays.""Call to see if you are eligible for plans that may include additional benefits like vision, hearing, and transportation."

LEAD GENERATION

MARKETING AND ADVERTISING MATERIALS

WEBSITE CHECKLIST

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, the following disclaimer must appear, "By providing the information above, I grant permission for a licensed insurance agent, <agent/agency name>, to call me regarding my Medicare options, including Medicare Supplement, Medicare Advantage, and Prescription Drug Plans." The same content regulations apply to an electronic BRC as to a paper BRC. **Note:** Some carriers require submission of websites if it contains a BRC or Contact form regardless if it meets the definition of "marketing" or not.
• Appropriate Method of Contact included?				
• Free from REQUIRING Prohibited Consumer Contact information: I.E. phone/email?				
• Free from Date of Birth? (Cannot ask for D.O.B – age or date of Medicare eligiblity is ok)				
• Free from Medical or RX History?				
Disclaimers				
• Required on all TPMO websites				"We do not offer every plan available in your area. Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. Please contact Medicare. gov, 1-800-MEDICARE, or your local State Health Insurance Program (SHIP) to get information on all of your options."
• Required on all TPMO websites that meet the definition of "marketing				Plans are insured or covered by a Medicare Advantage organization with a Medicare contract and/or a Medicare-approved Part D sponsor. Enrollment in the plan depends on the plan's contract renewal with Medicare.
• Required on all TPMO websites that include Plan benefit information				Not all plans offer all of these benefits. Benefits may vary by carrier and location. Limitations, exclusions, copays, deductibles, and coinsurance may apply.
• Required on all materials when Part B giveback info is included or referenced				Part B Premium give-back is not available with all plans. Availability varies by carrier and location. Actual Part B premium reduction varies.
• If STAR Ratings are mentioned in marketing materials, you need to convey that plans are evaluated yearly by Medicare and that ratings are based on a 5-star rating system				Every year, Medicare evaluates plans based on a 5-star rating system.
• Suggested to include on all websites so it's clear they aren't affiliated with the government				Not affiliated with or endorsed by the government or Federal Medicare Program. Agent Name or Agency Logo should be prominently displayed and it is suggested to include a qualifying statement like: "<Agency name> is an insurance agency not affiliated with the government."
Content (In addition to below, all guidelines that apply to other marketing materials also apply to websites)				
• 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.
• 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".

LEAD GENERATION

ACTIVITIES 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.

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 and 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:

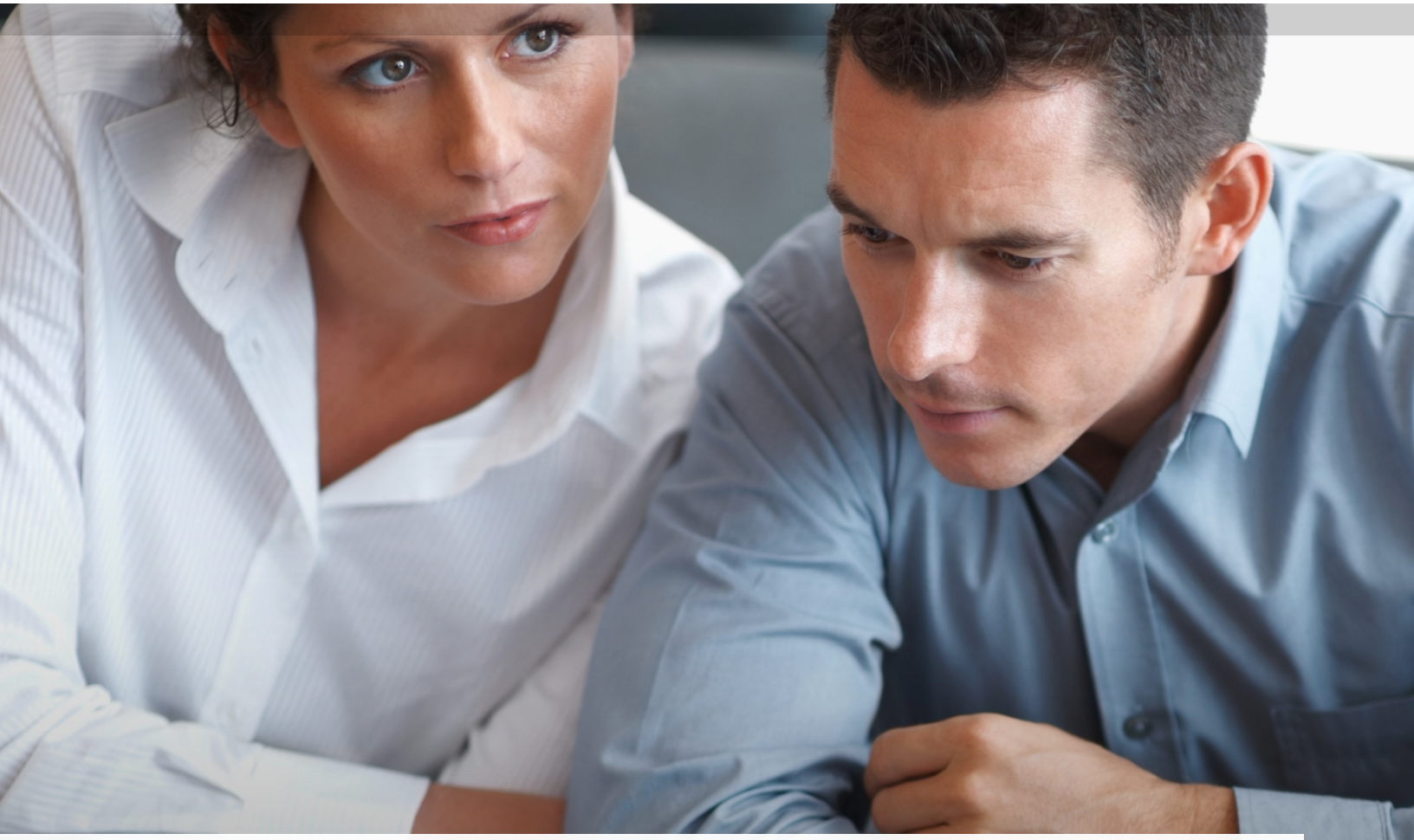
1. Be actively licensed with the State DOI's of both NE (resident) and IA (non-resident).
2. Be contracted with Company XYZ and appointed to sell that particular MAPD in both NE and IA (have a NE and IA appointment with Company XYZ for the product being presented).
3. Complete the annual AHIP Certification 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

TIPS:

- ❑ **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"**

CALL US or the Carrier if you are unsure about any of your appointments, 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 (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. **A Scope of Appointment must be obtained at least 48 hours prior to a personal marketing appointment.**

Exceptions to the 48-hour rule:

- SOAs that are completed during the last four days of a valid election period for the beneficiary
- Unscheduled, in-person meetings (walk-ins) initiated by the beneficiary (this includes in-bound phone calls)

Things to Remember

- TPMOs must record all sales, marketing, and enrollment calls (including the audio portion of virtual appointments) with beneficiaries in their entirety. Call recordings must be retained for 10 years.
- 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
- SOAs must be completed 48 hours prior to the meeting/appointment (unless an approved exception is applicable)

- Accepted forms of SOA Documentation
  - CMS-Approved SOA form (either CMS model or a CMS approved Carrier version)
  - CMS-Approved oral recording of Sales Appointment Confirmation
  - CMS-Approved Electronic Methods
- 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)

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 an Educational Event for a future appointment?**
   No, you may no longer make SOAs available or collect SOAs at educational events. Additionally, you may no longer set up future marketing appointments at educational events.

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.

COMPLIANT SALES

MAKING A COMPLIANT PRESENTATION

PRIOR TO THE APPOINTMENT

- ❑ **Complete a compliant Scope of Appointment form for ALL in attendance at least 48 hrs prior to the scheduled meeting (unless an exception applies)**
  - ❑ 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 (call should be recorded if it will contain any pertinent information affecting the sales/enrollment process, including: plan presentations, needs analysis, initial contact, medications, providers, enrollment, etc.)**
  - ❑ 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.
- ❑ **Make 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

DURING THE PRESENTATION

- ❑ **If meeting over the phone, remember to record the call and state the TPMO disclaimer within the first minute of the call**
- ❑ **Show up on time, clearly introduce yourself, and stress 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 (including the Pre-Enrollment Checklist – be sure to note the affect on current coverage)**
- ❑ **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)**

Checklist continued on next page...

- ❑ **Special Needs (DME, etc.)**
- ❑ **Value-Added Services**
- ❑ **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**

AFTER THE SALE

- ❑ **Call the beneficiary to Follow-Up**
  - ❑ 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.

COMPLIANT SALES

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
Ensure the client has the Pre-Enrollment Checklist (PECL), and understands all elements of the plan contained in the PECL – including the affect on coverage.	Offer Monetary or Promotional gifts to induce enrollment or to compensate based on use of services

COMPLIANT SALES

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**

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.

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**

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.

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)

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.
  - 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)

- 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-of-network.
  - 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 **medication** 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.

- Be sure to inquire about any assistance they may require or receive for paying medical or prescription costs.
- If a consumer receives Medicaid or Low Income Subsidy (LIS) cost-sharing 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.
- ❑ If the beneficiary must qualify or elect a certain benefit, ensure that is clear.
- ❑ Conduct a final review of the enrollment form and confirm all information is complete.
- ❑ Verify the enrollee understands all necessary components of the plan.
- ❑ Thoroughly review the pre-enrollment checklist (PECL), including effect on current coverage.
- ❑ Urge clients to contact YOU or the Plan (NOT CMS) with any questions or issues.
- ❑ **FOLLOW-UP** after the appointment to be sure they don't have questions and still understand crucial elements of the plan.

PCP AUTO-ASSIGNMENTS

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 auto-generation 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.
- ❑ 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.

COMPLIANT SALES

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 marketing 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).

COMPLIANT SALES

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

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 attendees). Anticipated attendance must be based on venue size, response rate, and/or advertisement circulation.
- Nominal gifts must be offered to similarly situated beneficiaries without discrimination and without regard to whether the beneficiary enrolls in a plan.
- Nominal gifts may not be in the form of cash, including cash-equivalents, or other monetary rebates.
- CMS is adopting OIG's interpretation of cash equivalents. OIG has interpreted the term"cash equivalents" to encompass items convertible to cash (such as a check) or items that can be used like cash (such as a general-purpose debit card, but not a gift card that can be redeemed only for certain categories of items or services, like a fuel-only gift card redeemable at gas stations).
- CMS's interpretation of "cash equivalents" for the purposes of this regulation mirrors OIG's interpretation subject to the following,additional guidance.

- A general gift card that is not restricted to specific retail chains or to specific items and categories would fall under those types that would be considered a cash equivalent (e.g. Visa gift card). Gift cards for retailers or online vendors that sell a wide variety of consumer products would also fall under this prohibition (e.g., Walmart and Amazon).
- A gift card that can be used for a more limited selection of items or food, would not be considered a cash equivalent (e.g. Starbucks or a Shell Gas giftcard).

Exclusion of Meals as a Nominal Gift:

Agents may not 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 may be provided at **educational events** and other events that would fall under the definition of communications.

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.

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:
  - contact rules,
  - compliant and thorough sales presentations,
  - avoiding member complaints,
  - sales and educational events,
  - identification of proper enrollment periods,
  - privacy/security,
  - 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.

EVENT COMPLIANCE

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 EVENTS

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.
- **Informal Sales Events** utilize a less structured format; for example, a table, kiosk, etc. that is staffed by a sales representative where consumers must initiate the conversations.

EVENT COMPLIANCE

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
- 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)
- Make available and collect Permission to Contact forms, such as BRCs, for attendees to request contact from the agent

WHAT YOU CAN'T DO AT AN EDUCATIONAL EVENT:

- Schedule future marketing appointments (individual sales appointments)
- Collect Scope of Appointment forms
- 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)

EVENT COMPLIANCE

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).
- Cannot host a sales/marketing event within 12 hrs of an educational event at the same location – "same location" means in the same building or any adjacent buildings.
- 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.
  - 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)

EVENT COMPLIANCE

EDUCATIONAL VS. SALES EVENTS – DO'S AND DON'TS

DO'S AND DON'TS AT AGENT HOSTED EVENTS		
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	No	Yes
Distribute/Collect Enrollment Applications	No	Yes
Distribute/Collect SOA Forms for a Later Meeting	No	Yes
Provide Business Cards	Yes	Yes
Distribute *Marketing* Materials	No	Yes
Discuss Plans Offered	No	Yes
Distribute Sales/Plan Materials	No	Yes
Provide Giveaways displaying agent Contact Info	Yes	Yes
Provide Cash or Cash Equivalents 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 guidance.**		

EVENT COMPLIANCE

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 not licensed within an Aetna or Coventry local market** submit the spreadsheet directly to Agent Oversight's MedicareSemi@aetna.com mailbox.

Anthem

1. 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

EVENT COMPLIANCE

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 salesevents@healthspring.com (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)

EVENT COMPLIANCE

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)

EVENT COMPLIANCE

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.

ENROLLMENT PERIODS

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.

ENROLLMENT PERIODS

OPEN ENROLLMENT PERIOD

During the Medicare Advantage **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),
  - Marketing for a 5-star plan, and
  - 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.

ENROLLMENT PERIODS

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.

ENROLLMENT PERIODS

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
  - 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 6:

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:
  - Compliance Department of the affected Carrier/s or
  - 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 7:

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 **First-Tier**, **Downstream**, and **Related Entity**. 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
- Proof of Completion 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 within 90 days of Hire and Annually thereafter
- Must be the CMS version—can be found at www.cms.gov and type "Fraud waste and abuse training" in the search box
- Proof of Completion 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 VerifyComply and creating a free account. You can screen against all applicable exclusion lists in one search and print your results.
- Proof of Completion 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)

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 provides updates to their Marketing and Communications Guidelines as needed. 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