yourmedicare℠
A non-government site powered by YourMedicare.com, LLC

Agent Compliance Guide

STAYING COMPLIANT BEFORE THE SALE

Making a Compliant MA/PDP Presentation

Prior to the Appointment

- [ ] **Complete a compliant Scope of Appointment form for ALL in attendance**
  - [ ] Only discuss products agreed upon in the Scope of Appointment
  - [ ] Make sure the beneficiary **initials** the boxes next to products they want to discuss
  - [ ] Make sure to use the SOA tools on YourMedicareEnrollmentCenter.com
- [ ] **Call Your Prospect to Ask These Questions**
  - [ ] **Does someone have a Power Of Attorney for making your financial decisions?** If they will be signing your enrollment form, have them bring a copy of the POA document
  - [ ] **Would you like to invite any friends, relatives, or other Medicare eligible individuals to hear the presentation?**
  - [ ] **Is there any additional information that you think I should know?**
  - [ ] **Tell them to bring a list of key service providers and any current prescriptions they would like to verify.**
- [ ] **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**

STAYING COMPLIANT DURING THE SALE

Making a Compliant MA/PDP Presentation

During the Presentation

- [ ] **Show up on time and clearly introduce yourself, or be prompt to your virtual appointment**
- [ ] **Confirm that you do not work for Medicare**
- [ ] **Disclose you may be compensated for this sale**
  - [ ] **If the beneficiary requests to discuss other products not agreed upon in the original SOA, complete another SOA and then the appointment may continue**
- [ ] **Eligibility (Medicare A & B, must live in service area)**
- [ ] **Lock-in / Disenrollment / Enrollment Periods**
- [ ] **Value-Added Services**

STAYING COMPLIANT DURING THE SALE, CONTINUED

- [ ] Thoroughly Review the Provider Network and Drug Formulary
- [ ] Healthcare Delivery Models (IPA, IPOD's - if applicable)
- [ ] Confirm Provider Network and Provider Access (You can use the YourMedicareEnrollmentCenter.com to look up and confirm providers)
- [ ] Role of PCP/ Specialist Referrals (if applicable)
- [ ] Carefully Review Plan Benefits & Premiums
- [ ] Dental/Vision Benefits (if applicable)
- [ ] Part B Premium Requirement (must continue to pay)
- [ ] Out-of-Pocket Costs (Office Visits/Urgent Care/Hospital/ER/Ambulance)
- [ ] Thoroughly Review Copays and Coinsurance
- [ ] Prescription Drug Tiers, Copays
- [ ] Special Needs (DME, etc.)
- [ ] Explain what their new card will be used for
- [ ] Use flipbook, agent guide, etc.
- [ ] Review Statements of Understanding
- [ ] Effective Date of Coverage
- [ ] Customer Service Telephone Numbers
- [ ] Give them your Contact Info
- [ ] 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 agent enrollment tool such as, YourMedicareEnrollmentCenter.com, LEAN, Ascend, etc.
- [ ] Ask Yourself: Is this the best plan for my Client?
- [ ] Urge the client to call you or the Plan with questions/issues - NOT Medicare

STAYING COMPLIANT AFTER THE SALE

Making a Compliant MA/PDP Presentation

After the Appointment

- [ ] 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

STAYING COMPLIANT: THINGS TO KNOW

Do's	Don'ts:
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 Rates	Say that you or the plan is CMS-endorsed or recommended by the Federal Government
Hold meetings in handicapped-accessible facilities	Engage in high-pressure sales or scare tactics or use misleading, conflicting, confusing statements
Communicate to non-English speakers in a way they will understand	Collect financial info during pre-enrollment activities
Advise the client how to use the Formulary	Imply Medicare is only available to Seniors
Use only Materials that meet CMS requirements	Ask to see a prospect's RX's unless they ask for help
Complete enrollment forms ONLY for those who are unable to do so themselves	Offer Monetary or Promotional gifts to induce enrollment or to compensate based on use of services

Compliance Metrics:

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

- **Cancelled Applications**
- **Rapid Disenrollment's**
- **Late Applications**
- **Member Complaints**
- **PCP Auto-Assignments**

STAYING COMPLIANT: THINGS TO KNOW, CONTINUED

Cancelled 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 half** of all Cancelled apps **come from Dual SNP product.** (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 three 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

STAYING COMPLIANT: THINGS TO KNOW, CONTINUED

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; **over 60%** of all Rapid Disenrollment's 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.
- 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.**

Top Reasons for Rapid Disenrollments:

- Submit Apps the **SAME DAY** you receive them
- Submit the **whole, completed app**-no missing pages or information
- Use an Online Enrollment method if available for agents - **NOT via a consumer enrollment portal** (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. 2021 application for 2021 product)
- Use **YourMedicareEnrollmentCenter.com** to submit your enrollments (you should get a confirmation of receipt immediately so you know the app has been submitted and received) **- Most Secure Method!**
- 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)

STAYING COMPLIANT: THINGS TO KNOW, CONTINUED

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 Information
- Inaccurate Provider Network
- Inaccurate Plan Description
- Unsuitable Plan Enrollment

TIPS for Avoiding Complaints:

- **Confirm** the enrollee's **providers are participating** in the plan
- **Thoroughly explain** (multiple times, if needed) plan's **benefits, coverages,** 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. Provide tier level and any restrictions (i.e., prior authorization, quantity limit, step therapy). Also, explain preferred vs. non-preferred pharmacy, if applicable.
- If you **quote a cost** (copay, deductible, premium, etc.) **make sure it's correct.**
- **Ensure** that the chosen plan is the **best option** for your client.
- **Conduct** a final review of the enrollment form and confirm all information is complete.
- **Verify** the **enrollee understands** all necessary components of the plan.
- **Urge clients to contact YOU or the Plan (NOT CMS) with any questions or issues.**
- **FOLLOW-UP after the appointment** to be sure they still understand the plan.
- Ensure you are **not present** with a client enrolling on a **consumer facing website/portal.**

Avoiding Member Complaints

- [ ] Complete a thorough Needs Assessment with the consumer to understand the consumer's medical, prescription, and financial need
- [ ] 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 pays 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.
- [ ] Review all benefits, including customized features, cost sharing (deductibles, copayments, and coinsurance); and all plan terms, conditions, and limitations.
  - 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.
- [ ] Explain the service area, prescription drug formulary, coverage gap, catastrophic coverage, and tiers.
- [ ] Identify what services and medications the consumer is currently using and clearly inform the consumer whether or not those services or medications are covered by 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.
- [ ] Utilize additional probing questions and seek consumer feedback to confirm the consumer understands the plan and agrees the plan is the right fit for them.

STAYING COMPLIANT: COMPLIANCE METRIC, CONTINUED

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 disenrollment's among other things.

****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 contact the physician's offices or use web searches 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.

STAYING COMPLIANT: 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.

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

- Educate consumers by providing plan 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

STAYING COMPLIANT: PRE-AEP, CONTINUED

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:

- **Obtain a Scope of Appointment (SOA)** form for the upcoming plan year prior to Oct. 1.
- **Discuss** any **plan options or benefits** for the upcoming plan year on phone calls or appointments prior to Oct. 1
- **Hold or promote sales/marketing meetings prior to Oct. 1** (regardless of when the meeting takes place) **- sales meetings may not be promoted or advertised prior to Oct. 1.**

EVENT COMPLIANCE

DO'S AND DON'TS

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

**Even though not filed with CMS, certain Carriers may require educational events to be filed with them.*