1. Module 4: Communications and Marketing Rules for Medicare Advantage and Part D Plans

2. Navigation Instructions

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4. Learning Objectives

- After reviewing "Module 4: Communications and Marketing Rules for Medicare Advantage and Part D Plans" you will be able to explain:
  - What are communications
  - What activities constitute marketing and what materials are marketing materials
  - The special rules for marketing Medicare health plans and Part D plans
  - Rules for making marketing appointments
  - Prohibited marketing and communications practices
  - Permitted promotional and marketing activities
  - The difference between educational and marketing events
  - Rules regarding agent compensation
  - Plan enforcement of the marketing rules and potential penalties

5. Training Roadmap: Module 4

- New rules for agent compensation and sharing of contact information
- New rules concerning incentives to agents and other TPMOs
- Applicability of rules concerning marketing and communications
- Marketing Representatives: agents/brokers and third-party marketing organizations
- Key terms and general background information
- Regulation of communications activities and materials
- Marketing communications – contacting beneficiaries
- Rules related to sales and educational events
- Marketing at individual appointments
- Use of social media to market
- Required practices
- Accessing and using certain plan materials
- Plan ratings and call recordings
- Prohibited activities
- Marketing during the open enrollment period
- Marketing in healthcare settings
- Plan oversight and enforcement of marketing requirements
- Prohibition on incentives, referral fees, and agent/broker compensation

6. New for Marketing of 2025 Products

- Compensation to independent agents/brokers will include amounts for administrative services. All Plan Sponsors that pay compensation to independent agents/brokers must pay the specified fair market value amount. No additional payments may be made to independent agents/brokers tied to enrollment, related to enrollment in a Medicare or Part D plan or product, or for services conducted as a part of the relationship associated with the enrollment.
- Beneficiary information collected by a third-party marketing organization (TPMO), including an agent/broker for purposes of marketing or enrolling the beneficiary into a Medicare health plan or Part D plan may only be shared with another TPMO when prior written consent is given by the beneficiary. The consent must list each entity receiving the data.
- Plan sponsors must ensure that no provision of a contract with an agent or other TPMO has a direct or indirect effect of creating an incentive that would reasonably be expected to inhibit an agent's ability to objectively assess and recommend which plan best fits the health care needs of a beneficiary.

7. Title Page – Applicability of Rules Concerning Marketing and Communications

8. Medicare Marketing and Communications Rules

The Medicare marketing and communications rules apply to the following types of Medicare health plans and Part D plans:

- Medicare Advantage (MA) only plans
- Medicare Advantage Prescription Drug (MA-PD) plans
- Prescription Drug Plans (PDPs)
- Section 1876 Cost plans
- Medicare-Medicaid Plans (MMPs)
    - For MMPs, marketing requirements may be modified by state-specific requirements. Each state in which MMPs are offered has state-specific marketing guidelines and CMS-approved model documents. Those guidelines and documents can be accessed at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPMarketingInformationandResources.html

9. Applicability of Medicare Communications and Marketing Rules to Marketing Representatives

Plan marketing representatives are subject to the same requirements related to marketing and communications as the plans. Plans are responsible for ensuring compliance with Medicare rules by their marketing representatives, such as the need for annual training.

Plan marketing representatives include:

- individuals employed by a plan
- individuals or entities under contract to the plan through a direct or downstream contract.
    - This would include brokers and agents (contracting directly with the plan or through an agency or other entity), Field marketing organizations (FMOs), agencies, general agents (GAs), or other Third-Party Marketing Organizations (TPMO).

10. Applicability of Medicare Communications and Marketing Rules when Marketing to Employer/Union Groups

Marketing representatives and Plans must follow all marketing rules and guidelines when marketing employer group health plans except the following:

- the prohibition against unsolicited contacts
- the prohibition against cross-selling other products
- the requirement to obtain prior documentation of the scope of an appointment
- the prohibition against providing meals at marketing events
- the pre-enrollment checklist requirement
- marketing representative compensation requirements

- the requirement that a marketing representative must pass an annual test, although the requirement for annual training does apply

Plans offering employer group health plans are not required to submit marketing materials specific only to those employer plans to CMS at the time of use. However, CMS may request and review copies if employee complaints occur or for any other reason to ensure the information accurately and adequately informs beneficiaries about their rights and obligations under the plan.

11. Title Page – Marketing Representatives: Agents/Brokers and Third-Party Marketing Organizations

12. Third-Party Marketing Organizations and "Marketing Representatives"

- Third-Party Marketing Organizations (TPMOs) are organizations and individuals, including independent agents and brokers, who are compensated to perform lead generation, marketing, sales, and enrollment related functions as a part of the chain of enrollment (the steps taken by a beneficiary from becoming aware of an MA or Part D plan or plans to making an enrollment decision). TPMOs may directly contract with the Plan Sponsor, may be a downstream contractor of a Plan Sponsor, or may be a related entity of the Plan Sponsor (referred to as first tier, downstream, or related entities or FDRs). However, they may also be entities that are not FDRs but provide services to a Plan Sponsor or a Plan Sponsor's FDR.
    - Independent agents and brokers are those that are not directly employed by a plan and those that market for more than one plan.
    - Agents and brokers employed by the plan are not TPMOs.
- In this training, we refer to TPMOs and employed agents and brokers as "Marketing Representatives."

TPMOs: Example
Amazing Agency contracts through an FMO to market and enroll members in 10 different Medicare Advantage organizations. Amazing Agency has contracted with Internet Innovations to advertise the agency, its products, and provide sales leads to the agency. The FMO, Amazing Agency, and Internet Innovations are all TPMOs.

13. Requirements to Act as Agents and Brokers

- Plan Sponsors must contract with or employ agents and brokers that are licensed by the state if they conduct the relevant activities in that state.
- Agents and brokers must be appointed by the plan if required under State law.
- MA and Part D plans are required by law to ensure that all employed and contracted agents and brokers complete training at least annually that includes all content specified by CMS.

- They also must pass a written test each year that demonstrates thorough familiarity with both the Medicare program and the products they are selling.
- Agents/brokers marketing only employer/union group plans are not required to be tested. However, plans may choose to require testing.

14. Title Page – Key Terms and General Background Information

15. Marketing and Communication – In General

- ***Communications*** are materials and activities that provide information to current and prospective enrollees on Medicare Health Plans and Part D Plans.
- ***Marketing*** is a subset of communications. Marketing is distinguished from communications-only material and activity based on intent and content.
- Marketing activities and materials are generally subject to a higher degree of regulation and oversight.

16. What is Marketing?

To be considered marketing, the material or activity must include both marketing intent and marketing content.

- **Marketing Intent** – the purpose of marketing activities and materials is to draw a prospective or current enrollee's attention to a plan or group of plans to influence a beneficiary's plan choice, including a decision to remain enrolled in their current plan.
- **Marketing Content** – Marketing activities and materials include or address content regarding any of the following:
  - Information about benefits or benefit structure
  - Information about premiums or cost-sharing
  - Rankings, such as comparisons to other Plan(s)/Part D sponsor(s)
  - Measurement standards, such as Star Ratings
  - Plan rewards and incentives programs (programs offered by Medicare health plans to qualifying individuals to voluntarily perform specified target activities in exchange for reward items)
  - Mentioning a broad category of widely available benefits, such as dental, vision, hearing or premium reduction is marketing content.

17. What are Communication-Only Materials and Activities?

Communication-only activities and material provide information to current and prospective enrollees that:

- contains no marketing content; or
- includes marketing content but does not have marketing intent. For example,
    - CMS designates certain materials that have marketing content, such as the Evidence of Coverage, as a communication-only material, while the summary of benefits and an annual notice of change are designated by CMS as marketing materials.
    - A targeted letter sent to a plan's members may be intended to encourage those members to receive certain preventive services they have not yet received and refer to the cost-sharing for those services. While it contains marketing content, it would not meet the marketing intent standard.

18. Title Page – Regulation of Communications Activities and Materials

19. Regulation of Communications-Only Materials

- **Material Content** -- While CMS does not generally require communications-only materials to be submitted to CMS for review and approval; it may review such materials and does require certain disclaimers to be used in those materials. CMS also prohibits the use of certain claims or language in communications materials.
    - CMS does require certain designated communication materials critical to beneficiaries' understanding or accessing their benefits to be reviewed (e.g., the Evidence of Coverage.
    - CMS may require prior review of communication materials that, based on feedback such as complaints or data gathered through reviews, warrant additional oversight to ensure accuracy.

What are Examples of Communication Only Materials

- A flyer that says, "Healthy Choice Medicare plan has been serving beneficiaries for 30 years, call to find out if we are right for you!"
- A newsletter sent to members of Healthy Choice Medicare plan reminding them that preventive health care services have a $0 copay and that it is important to get such services, such as flu shots, to stay healthy.
- A television advertisement from a large agency that announces, "We can connect you with a Medicare Advantage plan designed to meet your needs" (as discussed later in this training, such an ad would require the TPMO disclaimer).
- Materials specifically designated by CMS as communications because they do not meet the "intent" standard, such as the formulary, or provider directory.

20. Regulation of Communications-Only Activities

- **Contact** – CMS regulates how marketing representatives can contact potential enrollees. For example, agents may not make cold calls even if they limit their conversation to communications content.

- **Other Content** – CMS regulates what marketing representatives may say to enrollees and potential enrollees.

21. Regulation of Marketing Materials and Activities in General

CMS regulates marketing activities in a variety of ways, including:

- **Setting** – CMS has rules regarding marketing in a health care setting versus marketing in other settings and marketing at educational versus marketing events.
- **Who may market** – CMS requires marketing representatives to comply with state laws concerning licensure; CMS places strict limits on marketing by health care providers.
- **Timing** – CMS regulates when marketing representatives can begin marketing the next year's plans.
- **Contact**– CMS regulates how marketing representatives can contact potential enrollees.
- **Content** – CMS may require that certain disclaimers or other information be included in marketing materials. CMS also prohibits the use of certain claims or language.
- **Review and Approval** – CMS requires that all marketing materials be submitted to CMS for approval and/or review.
    - Materials developed for use with employer/union group members do not have to be submitted to CMS.

22. What are Examples of Marketing Activities?

Examples of marketing activities include:

- Talking to a Medicare beneficiary about how a particular plan offers a higher level of coverage for the services the beneficiary uses most often.
- Handing out health plan brochures and a summary of benefits at an event.
- Calling current clients who are Medicare beneficiaries to discuss upcoming premium and benefit changes to their plans and encourage them to remain enrolled in those plans.
- Passing out plan-specific benefits information and agent business cards after a health management seminar.
- Accepting enrollment forms and performing enrollment at marketing/sales events.

What are Examples of Marketing Materials?
Examples of marketing materials include the following if they contain marketing content:

- General audience materials such as direct mailings, newspaper ads, or websites that promote specific plans and discuss their star ratings.
- Marketing representative scripts or outlines for telemarketing, enrollment, or other presentations that discuss plan benefits.
- Brochures that promote enrollment in a plan and discuss the plan's reward programs for receiving preventive care services.
- Presentation materials such as slides and charts explaining the benefits of enrolling in a particular plan.
- Social media posts (e.g., Facebook, Twitter [now X], YouTube, etc.) that mention a plan's star rating, note its low premium, or promote its benefits.

23. Rules that apply to all Communications (including Marketing) Materials and Activities

Plans and their marketing representatives may not:

- mislead, confuse, or provide materially inaccurate information to beneficiaries.
- target enrollees based on income levels (except in the case of Dual Eligible SNPs).
- target enrollees based on health status (except in the case of a chronic care SNP).
- state or imply that the plans are only available to seniors, rather than all eligible Medicare beneficiaries (e.g., younger disabled individuals).

24. Title Page- Marketing and Communications – Contacting Beneficiaries

25. Unsolicited Contacts

- Marketing representatives are prohibited from making unsolicited contact with beneficiaries, including through:
  - door-to-door solicitation, including leaving leaflets, flyers, or door hangers at a residence or on someone's car. Contact is unsolicited door-to-door contact unless an appointment, at the beneficiary's home at the applicable date and time, was previously scheduled.
  - approaching beneficiaries in common areas such as parking lots, hallways, lobbies, sidewalks, stores, or parks.
  - telephone calls without a scope of appointment or not meeting the plan business exception.
  - text messages and other forms of electronic direct messaging (e.g., through social media platforms, like Facebook instant messaging).
  - voicemail messages after unplanned calls.
- The prohibition on making unsolicited contact does not extend to e-mail, conventional mail, and other print media such as advertisements.

26. Unsolicited Contacts

- Marketing representatives may not make unsolicited calls about other businesses as a means of generating leads for Medicare plans (e.g., bait and switch strategies).
- Marketing representatives may not make unsolicited contact based on referrals or leads provided by enrollees or other sources. However, they may leave business cards with beneficiaries for distribution to friends they are referring.
- Enrollees who are voluntarily disenrolling may not be contacted for sales purposes or be asked to consent to sales contacts.
- Marketing representatives may not make calls to beneficiaries who attended a marketing event unless the beneficiary gave express permission at the event for a follow-up call (there must be documentation of permission to be contacted).
- May not contact a lead provided by another TPMO unless the beneficiary gave explicit written consent to share their information with the agent and receive a marketing call.

Unsolicited Contacts Example

Example 1: Agent Jackson is involved in a health fair that offers a raffle. After the fair, Agent Jackson takes the telephone numbers on the raffle entries and calls each individual to see if they would be interested in discussing MA plans. Agent Jackson has violated the prohibition on unsolicited contacts.

Example 2: Agent Miller sells life insurance in addition to MA plans. Agent Miller calls a lead provided to him by another client to talk to her about life insurance. During the conversation, Agent Miller asked the beneficiary if she would like to learn more about Medicare Advantage plans. Agent Miller has violated the prohibition against making unsolicited calls about other business as a means of generating leads for Medicare plans.

Example 3: Agent Lopez's aunt tells him that her neighbor was recently telling her that she was having trouble understanding her Medicare choices and wanted to know if it made sense to enroll in an MA plan. His aunt offers the neighbor's telephone number, but Agent Lopez gives his aunt his card and says that the neighbor should call him. Agent Lopez has wisely avoided making an unsolicited call based on a referral.

27. Permitted Contacts

Marketing representatives may:

- initiate electronic contact through e-mail. However, they must provide an opt-out process to no longer receive electronic communications.
- return calls or messages from individuals who initiate contact and request information.
- call beneficiaries who have expressly given permission for the contact, for example by filling out a business reply card or asking a plan customer service representative to have an agent contact them. However, business reply cards and requests to contact are only valid for twelve months following the beneficiary's signature date or the date of the beneficiary's initial request for information.
- call beneficiaries to confirm an appointment that has already been agreed to by a beneficiary.
- call beneficiaries who submit enrollment applications to conduct business related to enrollment.

28. Permitted Contacts

Marketing representatives may:

- call current enrollees of the parent organization, including those in non-Medicare health plan products, to discuss plan business, for example, they may:
    - contact individuals enrolled in one of the MA organization's commercial health plans when the individual is aging into Medicare.
    - contact the MA organization's Medicaid plan enrollees to discuss Medicare products.
    - contact current MA enrollees to promote other Medicare plan types or to discuss plan options/benefits.
    - contact the MA organization's Medigap enrollees regarding MA, PDP, or cost plan options.
    - call current enrollees of a plan to discuss/inform them about general plan information such as Annual Enrollment Period dates, availability of flu shots, upcoming plan changes, educational events, and other important plan information.
    - call a beneficiary whom the marketing representative enrolled in a plan to discuss plan business, as well as discuss the availability of other plan options/types within the same parent organization.
- However, if the Plan Sponsor or its marketing representatives reach out to beneficiaries regarding plan business, the Plan Sponsor must provide notice to all beneficiaries whom the plan contacts at least once annually, in writing, of the individual's ability to opt out of future calls regarding plan business.

29. Title Page- Rules Related to Sales and Educational Events

30. Marketing/Sales and Educational Events

- Marketing/sales events are events designed to steer potential enrollees toward a plan or limited set of plans or to encourage current enrollees to remain in their plans.
- Educational events are events designed to inform potential enrollees about Medicare, including MA, Part D, or other Medicare programs, and do not include marketing materials or activities.
    - Educational events may be held in public venues.
    - Educational events may be put on by providers or other groups and/or sponsored by one or more health plans.
- Marketing events are prohibited from taking place within 12 hours of an educational event in the same location. The same location is defined as the entire building or adjacent buildings.
- Advertisements and invitations (in any form of media) that are used to invite beneficiaries to a marketing or educational event must include the following statement: "For accommodation of persons with special needs at meetings call <insert phone and TTY number>."

31. Marketing /Sales Events, Required and Permitted Activity

- Plans must submit presentations that include marketing content to CMS before use at a sales event.

- At marketing/sales events agents may:
  - discuss plan-specific information such as premiums and benefits.
  - discuss plan star ratings.
  - discuss the merits of a plan
  - distribute and collect enrollment applications.
  - distribute plan-specific advertisements, explanatory information, and general information about Medicare.
  - provide refreshments and light snacks of nominal value as long as they are not bundled and provided as if a meal.

32. Marketing/Sales Events, Prohibited Activity

At marketing/sales events agents may not:

- require beneficiaries to provide contact information as a prerequisite for attending the event.
  - This includes requiring an email address or other contact information as a condition to RSVP for an event online or through the mail.
  - Sign-in sheets must be labeled as optional.
- conduct health screenings or other activities that could give the impression of "cherry-picking."
- provide meals or multiple snacks/refreshments bundled and provided as if a meal, regardless of value.
- use information collected for raffles and drawings for other purposes.

33. Educational Events, Required and Permitted Activity

Educational events must be explicitly advertised as "educational." At educational events, marketing representatives may:

- engage in communications activities and distribute communication materials.
- use a banner with the plan sponsor name and/or logo displayed.
- distribute promotional items, including those with the plan name, logo, and toll-free number and/or website. These items must be free of marketing content and be provided consistently with gift/promotional item rules (e.g., provided to all without obligation and be under $15 retail value).
- provide an objective presentation to educate beneficiaries about the different ways they can get their Medicare benefits.
- have a health care provider make an educational presentation on wellness or another health care related topic.

Educational Events, Permitted Activities

At educational events, marketing representatives may:

- answer beneficiary-initiated questions about Medicare health or drug plans.
- make available opportunities to provide voluntarily and receive beneficiary contact information, including Business Reply Cards, but not including Scope of Appointment forms.

- distribute business cards and agent/agency or plan contact information so that beneficiaries can initiate contact.
- provide meals, refreshments, or snacks as long as they comply with the gift/promotional item requirements, including the nominal value requirement.

Educational Events, Prohibited Activities

When an event has been advertised as "educational," marketing representatives may NOT:

- conduct sales or marketing presentations.
- discuss, display, or distribute plan-specific premiums, benefits, or other marketing content or marketing materials.
- engage in marketing activities.
- distribute or collect enrollment applications.
- set up future personal marketing appointments.
- make available or obtain completed Scope of Appointment (SOA) forms.

34. Gifts and Promotional Items

Section 1128A (a) (5) of the Social Security Act prohibits offering or giving anything of value to a Medicare or Medicaid beneficiary that is likely to influence the beneficiary to order or receive from a particular provider, practitioner, or supplier any item or service covered under Medicare or Medicaid. There is a nominal value ($15) exception to this rule.

- Marketing representatives may provide gifts, prizes, or promotional items to beneficiaries as part of an event or for marketing purposes as long as the nominal value exception is met and the gift is provided regardless of enrollment and without discrimination.
- Gifts are of nominal value if an individual item is worth $15 or less based on the retail purchase price of the item (it does not matter if the plan or representative pays less for the item).
- When more than one gift is offered on one occasion, the combined value of all items must not exceed $15.
- Multiple gifts given to a beneficiary on different occasions may not exceed $75 aggregate, per person, per year.

35. Gifts and Promotional Items

Gifts or prizes must not be in the form of cash or cash equivalents or other monetary rewards or rebates even if their worth is less than $15.

- Cash equivalents include:
    - gift certificates or cards that can be readily converted to cash.
    - general gift cards that are not restricted to specific retail chains or to specific items and categories, such as VISA gift cards.
    - gift cards for retailers or online vendors that sell a wide variety of consumer products (e.g., Walmart, Target, and Amazon).

    - debit cards.
- 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 gift card).
- Rebates would include, for example, a discount on the first month's premium or on a copayment.
- Gifts or prizes may not be charitable contributions.

36. Promotional Activities: Drawings, Prizes, Giveaways

- Plan sponsors must include a disclaimer on all materials promoting a prize, drawing, communal experience (e.g., a concert), or any promise of a gift that there is no obligation to enroll in the plan.

37. Title Page –Marketing at Individual Appointments

38. Individual Marketing Appointments

- Personal/Individual marketing appointments are those tailored to an individual or small group (e.g., husband and wife). They are not defined by the location.
- During a personal/individual appointment, representatives may market only health care related products identified in a scope of appointment.
    - Health care related products include Medicare health plans, Medigap plans, and dental plans, but not accident-only plans.
    - Non-health care products (such as accident-only policies, life insurance policies, or annuities) may not be marketed during a Medicare health or drug plan appointment.

39. Required Practices: Scope of Appointment

- At least 48 hours before any marketing appointment, marketing representatives must coordinate with the beneficiary to identify the types of product(s) that will be discussed, obtain agreement from the beneficiary, and document that agreement (known as a "scope of appointment" or "SOA").
    - Types of products include MA, PDP, Cost plans, and Medicare-Medicaid Plans.
- There are two exceptions to the 48-hour rule:
    - Where the SOA is completed during the last 4 days of the relevant election period.
    - Where there is an unscheduled, in-person meeting initiated by a beneficiary. This includes when a beneficiary unexpectedly walks into a marketing representative's office or unexpectedly attends a sales appointment properly set up for another individual.
- A new SOA is required if the beneficiary requests information regarding a different plan type than previously agreed upon.
- An SOA is valid for twelve (12) months from the date of the beneficiary's signature.

40. Required Practices: Scope of Appointment

- A scope of appointment may be in writing, in the form of a signed agreement (including electronic signature) by the beneficiary, or a recorded oral agreement. Any technology (e.g., conference calls, fax machines, designated recording lines, pre-paid envelopes, and e-mail) can be used to document the scope of appointment.
- A Plan Sponsor or agent may not agree to the scope of appointment on behalf of the beneficiary.

Scope of Appointment: Documentation

Plan Sponsors and their TPMOs are expected to include the following documentation in the SOA:

- Product type (e.g., MA, MMP, cost plan, or PDP) that the beneficiary has agreed to discuss during the appointment,
- Date of appointment,
- Beneficiary and agent contact information (e.g., name, address, telephone number),
- Written or recorded verbal documentation of beneficiary or appointed/authorized representative agreement,
- A statement that beneficiaries are not obligated to enroll in a plan; their current or future Medicare enrollment status will not be impacted and clearly explaining that the beneficiary will not be automatically enrolled in any plan.

41. Individual Marketing Appointments, Permitted Activities

During individual appointments, marketing representatives may:

- distribute plan materials such as an enrollment kit or marketing materials.
- provide educational information.
- discuss benefits, premiums, and cost-sharing.
- distribute and accept plan applications.
- review the individual needs of the beneficiary including, but not limited to, health care needs and history, commonly used medications, and financial concerns.
- talk about plan rewards and incentives programs.
- provide and collect enrollment forms, provided that prior to enrollment all issues required to be discussed have been discussed.

Individual Marketing Appointments, Prohibited Activities

During individual appointments, marketing representatives may not:

- discuss plan options that were not agreed upon by the beneficiary and documented in a scope of appointment, business reply card, or request to receive additional information (which are only valid for twelve months following the date of the beneficiary's signature date or the date of the beneficiary's initial request for information).
- market non-health care related products.

- solicit/accept an enrollment request for a January 1st effective date before the start of the Annual Election Period on October 15 unless the beneficiary is entitled to another enrollment period (for example, an initial enrollment period or special enrollment period).

42. Use of Social Media to Market

- Plan Sponsors and their TPMOs must submit to CMS any social media (e.g., Facebook, Twitter [now X], YouTube, LinkedIn, TikTok, Scan Code, or QR Code) posts that meet the definition of marketing, specifically those that contain marketing content such as benefits, premiums, cost-sharing, or Star Ratings. This includes such posts by agents.
- Social media posts are generally subject to marketing/communications content requirements, such as prohibitions on using certain language and any requirements to include disclaimers.
- Re-publication (or re-post) of an individual's post, content or comment that promotes a Plan's/Part D Sponsor's product from social media sites is considered a product endorsement/testimonial and must adhere to the guidance on testimonials.

43. Title Page-Required Practices

44. Required Practices: Marketing and Discussion Topics

Marketing representatives must:

- provide to prospective enrollees only CMS-approved/submitted marketing materials or CMS created marketing materials.
- use only CMS-approved/submitted talking points and presentations if they are marketing.
- ensure that, before an enrollment, CMS' required questions and topics regarding beneficiary needs in a health plan choice are fully discussed. Topics include information regarding primary care providers and specialists (that is, whether the beneficiary's current providers are in the plan's network), prescription drug coverage and costs (including whether the beneficiary's current prescriptions are covered), costs of health care services, premiums, benefits, and specific health care needs.

45. Required Practices: HIPAA and Confidentiality of Beneficiary Information

Marketing representatives are business associates of the health plans they sell. As such, they must comply with Federal and state law regarding the confidentiality of individually identifiable health information (known as protected health information or PHI) and any confidentiality obligations in their business associate contracts with plans.

- PHI includes any information about an individual's health care coverage, payment for health care, or health care condition.
- HIPAA regulates both the use and disclosure of PHI. Marketing representatives may only use and disclose PHI on behalf of the plans they represent.

- If a marketing representative subcontracts with another individual or entity that may obtain, use, or disclose PHI on their behalf, they must enter into a business associate agreement with the individual or entity requiring the same protections to the PHI.
- Plan Sponsors must obtain a HIPAA compliant authorization from an enrollee before the Plan Sponsor may use (or may request a marketing representative to use on their behalf) information about the enrollee to market non-health related items or services. The authorization must explicitly allow marketing uses.

46. Required Practices: Consent to Share Beneficiary Information

Beginning October 1, 2024:

- Personal beneficiary information collected by a TPMO (including agents/brokers) for marketing or enrolling them into an MA, Cost, or Part D plan may only be shared with another TPMO when prior written consent to share the information and be contacted for marketing or enrollment purposes is given by the beneficiary.
- The beneficiary's prior written consent must be obtained through a clear and conspicuous disclosure that lists each entity that would receive the data and allows the beneficiary to consent or reject to the sharing of their data with each individual TPMO.

47. Required Practices: Use of TPMO Marketing Disclaimer

- Independent agents/brokers and other third-party marketing organizations must use the TPMO marketing disclaimer if they sell plans on behalf of more than one Plan Sponsor.
- If the TPMO does not sell for all Plan Sponsors available in the service area, the disclaimer consists of the following statement: "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 or 1–800–MEDICARE, or your local State Health Insurance Program to get information on all your options.''
- If the TPMO sells for all Plan Sponsors in the service area, the disclaimer consists of the statement: "Currently, we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. You can always contact Medicare.gov, 1–800–MEDICARE, or your local State Health Insurance Program for help with plan choices.''
- The disclaimer must be:
    a. verbally conveyed within the first minute of a sales call.
    b. electronically conveyed when communicating with a beneficiary through email, online chat, or other electronic means of communication.
    c. prominently displayed on TPMO websites.
    d. included in any TPMO marketing materials, including print materials and television advertising.

48. Required Practices: Special Rules Related to Lead Generation

- TPMOs conducting lead generating activities, either directly or indirectly for a Plan Sponsor, must, when applicable, disclose to the beneficiary that their information will be provided to a licensed agent for future contact. This disclosure must be provided:
  - verbally when communicating with a beneficiary through telephone;
  - in writing when communicating with a beneficiary through mail or other paper; or
  - electronically when communicating with a beneficiary through email, online chat, or other electronic messaging platform.
- If the lead generating TPMO transfers a beneficiary to an agent, the TPMO must disclose to the beneficiary that they are being transferred to a licensed agent who can enroll them into a new plan.
- Plan Sponsors, Agents/Brokers, FMOs, or agencies that obtain leads from such entities should ensure that these requirements have been met in generating the leads and include this obligation in any contracts with the lead generating TPMO.
- As previously noted in this module, beginning October 1, 2024, beneficiary information collected by a TPMO for marketing or enrolling may only be shared with another TPMO when prior written consent is given by the beneficiary.

49. Title Page- Accessing and Using Certain Plan Materials

50. Certain Plan Materials: Accessing and Using

Plans are required to post certain documents in a downloadable format on their website. Beneficiaries and marketing representatives may access the following materials, as applicable to the plan, through each plan's website:

- Evidence of Coverage
- Summary of Benefits
- Annual Notice of Change
- Provider Directory, searchable by specified elements such as name, location, cultural and linguistic capabilities, and specialty
- Pharmacy Directory
- Formulary

Such documents are important tools to be used by marketing representatives in determining issues such as:

- Whether a beneficiary's providers or pharmacies are in the plan network
- Whether the drugs a beneficiary takes are on the plan's formulary
- Whether the plan covers other benefits that are important to a beneficiary
- Whether or the extent to which the plan covers out-of-network services

Many plans provide their provider/pharmacy directories and formularies in a searchable format. Plans will also provide these materials to beneficiaries after they enroll.

51. Required Materials with an Enrollment Form

- When a beneficiary is provided with enrollment instructions/form, they must also receive:
    - plan ratings information
    - the summary of benefits
    - the pre-enrollment checklist
    - the multi-language insert (or at the plan option after September 30, 2024, the Notice of Availability)
- The beneficiary must also receive the multi-language insert when provided with any other CMS required material (for example, Evidence of Coverage, Annual Notice of Change, or Summary of Benefits).
- For Dual Eligible Special Needs Plans, if Medicaid benefits are not included in the summary of benefits, a separate document including the Medicaid benefits must be included with the enrollment form.
- When a beneficiary enrolls in a plan online, the plan sponsor must make these materials available electronically, (e.g., via website links) to the potential enrollee before the completion and submission of the enrollment request.
- For telephonic enrollments, the contents of the pre-enrollment checklist must be reviewed with the prospective enrollee before the completion of the enrollment. In addition, the beneficiary must be told verbally where the summary of benefits and star rating documents may be accessed.

52. Title Page- Plan Ratings and Call Recordings

53. Plan Ratings: Background

- CMS releases star ratings that allow beneficiaries to compare MA plans and Part D plans. These ratings include topics such as whether members got various screening tests, vaccines, and other check-ups to help them stay healthy, and how members rate the plan on topics such as access to care and customer service.
- Marketing representatives and beneficiaries who have access to the Internet may obtain plan rating information at http://www.medicare.gov.
    - Click on the “Find Health & Drug Plans” button.
- The Star Ratings information document must also be prominently posted on each plan’s website.

54. Plan Ratings – Required Practices

- Plan Sponsors must provide the plan’s overall performance ratings to beneficiaries in the standard Plan Ratings information document.
- New Plans/Part D Sponsors that do not have any Star Ratings information are not required to provide Star Ratings information until the next contract year.
- Plan Sponsors and their marketing representatives may only reference or mention a plan’s rating on an individual measure in conjunction with the plan’s overall performance rating (MA-PD), the contract’s highest rating, Part C summary rating (MA-only), or Part D summary rating (PDPs), with equal or greater prominence.

- Plan Sponsors and their marketing representatives may only market the Star Ratings in the service area in which the Star Rating is applicable.

55. Required Practices: Plan Ratings - Prohibitions

Plan Sponsors and their marketing representatives may not:

- use a plan's star rating in an individual category or measure to imply a higher overall plan rating than is actually the case.
    - For example, a plan that received a 5-star rating in customer service promotes itself as "rated 5 stars by our enrollees," when its overall plan rating is only 4 -stars.
- use the plan's star ratings in a manner that misleads beneficiaries into enrolling in plans based on inaccurate information.
- use updated star ratings until CMS releases star ratings on the Medicare Plan Finder.
- continue to use an old star rating after **21** days from the release of a new star rating.

56. Required Practices: Recording Calls with Beneficiaries

Independent agents/brokers and other third-party marketing organizations must record all sales, marketing, and enrollment calls with beneficiaries in their entirety. This includes recording the audio portion of calls occurring via web-based technology.

57. Title Page- Prohibited Activities

58. Prohibited Practices: Marketing and Communications

Marketing representatives must NOT:

- market any non-healthcare-related products (such as annuities and life insurance) during any MA or Part D sales activity or any other marketing activity for existing enrollees. This is considered cross-selling.
- use or disclose the enrollee's protected health information (PHI) for marketing purposes, including sending any non-plan or non-health related information or otherwise contacting them for purposes unrelated to plan benefits administration or CMS contract execution, without first obtaining HIPAA required authorization from the enrollee.
- market that the Plan Sponsor will not disenroll individuals due to failure to pay premiums.
- display the names or logos or both of provider co-branding partners on marketing materials, unless the materials indicate via a disclaimer or in the body that "Other providers are available in the network.
- fail to record all sales and enrollment related telephonic contact.

59. Prohibited Practices: Marketing and Communications

Marketing representatives must NOT:

- use a Medicare beneficiary to endorse a plan unless the beneficiary was an enrollee of the plan when the endorsement was created.
- solicit enrollment applications for the following contract year before the start of the annual election period on October 15.
- use marketing materials that have not been submitted by the plan for review and/or approval by CMS.
- charge beneficiaries marketing fees.
- engage in bait and switch strategies such as making unsolicited outbound calls to beneficiaries about other lines of business (e.g., calling Medicare beneficiaries about Affordable Care Act plans) as a means of generating leads for Medicare plans.

60. Prohibited Practices: Discriminatory Activity, Superlatives, and Comparisons

Marketing representatives must NOT:

- engage in any discriminatory activity such as attempting to recruit Medicare beneficiaries from higher-income areas without making comparable efforts to enroll Medicare beneficiaries from lower-income areas.
- encourage individuals to enroll based on their health status unless the plan is a special needs plan that focuses on the beneficiary's particular condition.
- conduct health screening or other activities that could give an impression of "cherry-picking".
- use unsubstantiated superlatives e.g., best, highest rated, best value, etc. Superlatives may only be used if the sources of documentation or data supportive of the superlative are also referenced in the material. Such supportive documentation or data must reflect data, reports, studies, or other documentation that applies to the current or prior contract year. (Including data older than the prior contract year is permitted provided the current and prior contract year data are specifically identified).
- make explicit comparisons between plans, unless they can support them, such comparisons are factually based, and the comparisons are not misleading.

61. Prohibited Practices: Misleading Marketing Practices

Marketing representatives must NOT engage in marketing practices that may mislead or confuse beneficiaries, such as:

- providing false or misleading information about the plan, including benefits, provider rules, and other plan information, such as claiming that a PFFS plan is the same as Original Medicare or a Medigap plan.
- claiming that Medicare, CMS, or any government agency endorses or recommends the plan.
- using the Medicare name, CMS logo, and products or information issued by the Federal Government, including the Medicare card in a misleading way. (Use of the Medicare card image is permitted only with authorization from CMS).

- advertising benefits that are not available to beneficiaries in the service area where the marketing appears, unless the advertisement is in local media that serves the service area(s) where the benefits are available and reaching beneficiaries who reside in other service areas is unavoidable.
- marketing products or plans, benefits, or costs, unless the Plan Sponsor's(s') name or marketing name(s) of the Plan Sponsor(s) offering the products or plans, benefits, or costs are identified in the marketing material.
- including information about savings to beneficiaries that are based on a comparison of typical expenses borne by uninsured individuals, unpaid costs of dually eligible beneficiaries, or other unrealized costs of a Medicare beneficiary.

62. Prohibited Practices: Misleading Marketing Practices

Marketing representatives must <u>NOT</u>:

- use the term "free" to describe a zero-dollar premium.
- use the term "free" in conjunction with any reduction in premiums, deductibles, or cost-share, including Part B premium buy-down, low-income subsidy, or dual eligibility.
- lead beneficiaries to believe that the broker or agent works for Medicare, CMS, or any government agency.
- imply that a plan operates as a supplement to Medicare.

63. Prohibited Practices: Targeting Dual Eligibles

Unless they are promoting a D-SNP, Marketing representatives must <u>NOT</u>:

- imply that the plan is available only to or designed for dual eligible individuals (unless the plan is comparable to a D-SNP plan, such as an MMP, as determined by the Secretary).
- claim that the Plan has a relationship with the state Medicaid agency, unless the MA plan (or its parent organization) has contracted with the state to coordinate Medicaid services, and the contract is specific to that MA plan (not for a separate D-SNP or MMP).
- market a non-dual eligible special needs plan as if it were a dual-eligible special needs plan.
- target their marketing efforts for the Plan exclusively to dual eligible individuals (unless the plan is comparable to a D-SNP plan, such as an MMP, as determined by the Secretary).

64. Open Enrollment Period – Marketing Prohibitions

The Medicare Advantage Open Enrollment Period (MA-OEP) is a period during which an individual enrolled in an MA or MA-PD plan can make a one-time change to another MA plan, elect Original Medicare, or can change Part D coverage. For individuals enrolled in an MA plan on January 1, the MA-OEP is the first 3 months of the calendar year. For individuals enrolling during their initial coverage election coverage period (ICEP), the MA-OEP is the first three months after they enroll in an MA or MA-PD plan. The MA-OEP is further described in Module 5.

During the MA Open Enrollment Period (OEP), marketing representatives may **not**:

- send unsolicited materials advertising the ability/opportunity to make an additional enrollment change or referencing the OEP.
- specifically target beneficiaries who are in the OEP because they chose an MA or MA-PD plan during the Annual Enrollment Period (AEP) by the purchase of mailing lists or other means of identification.
- engage in or promote activities that intend to target the OEP as an opportunity to make further sales.
- call or otherwise contact former enrollees who have selected a new plan during the AEP.

65. Promoting Health Plans During the Open Enrollment Period

However, during the OEP, marketing representatives may conduct marketing activities that focus on other enrollment opportunities, including but not limited to:

- marketing to individuals turning 65 (who have not yet made an enrollment decision).
- marketing by 5-star plans regarding their continuous enrollment SEP.
- marketing aligned D-SNPs (such as FIDE-SNPs and HIDE SNPs) to full-benefit dual-eligible beneficiaries who have a once-per month SEP to enroll in an aligned D-SNP.

In addition, during the OEP marketing representatives may:

- send marketing materials when a beneficiary makes a proactive request.
- at the beneficiary's request, have one-on-one meetings with a sales agent.
- at the beneficiary's request, provide information on the OEP through the Plan's call center.

MAOs may also include information about the OEP on their websites.

66. Soliciting Referrals from Beneficiaries

Inducements (such as gifts) for referrals are regulated under fraud and abuse laws (such as the anti-kickback statute or beneficiary inducement statute). However, typically there are nominal value exceptions under those laws. Marketing representatives should consult with their plans to determine whether the plans impose requirements around gifts in exchange for beneficiary referrals.

67. Title Page-Marketing in Healthcare Settings

68. Marketing Activities: Marketing in a Healthcare Setting

Marketing representatives must NOT:

- engage in marketing activities or provide marketing materials in areas where patients receive healthcare services, for example:
    - Exam rooms, dialysis center treatment areas, hospital patient rooms, pharmacy counter areas, and other treatment areas where patients interact with a provider and their clinical team and receive treatment.

Marketing representatives may:

- engage in marketing activities (i.e., conduct sales presentations and distribute and accept enrollment applications) in common areas of healthcare settings, for example:
  - In a cafeteria, community or recreational room, waiting room, common entryway, vestibule, or conference room
  - At a retail pharmacy, in areas away from the pharmacy counter
- provide communication materials to be distributed and displayed in the healthcare setting.

69. Marketing Activities: Marketing in a Long-term Care Facility

- Long-term care facilities include, for example, nursing homes, assisted living facilities, and board and care homes.
- Plan Sponsors/marketing representatives may schedule an appointment with a beneficiary in a long-term care facility ONLY upon request of the beneficiary (or authorized representative).
- Plan Sponsors/marketing representatives may not visit individuals in a long-term care facility without an appointment.
- MA institutional special needs plans (I-SNPs) may use staff operating in a social worker capacity to provide information, including marketing materials concerning I-SNPs, to residents. Such information must not include an enrollment form and the social worker may not accept or collect a scope of appointment or enrollment form on behalf of the plan sponsor.
- Marketing representatives may set up in common areas of a long-term care facility and allow residents to approach them.

70. Title Page- Plan Oversight and Enforcement

71. Oversight and Corrective Action

- Plan Sponsors must establish and implement an oversight plan that monitors agent and broker activities, identifies non-compliance with CMS requirements, and reports non-compliance to CMS.
- Plans are required to implement a strategy to prevent prohibited marketing practices from occurring, detect prohibited marketing tactics at their early stages, and take immediate corrective action to respond to non-compliant marketing activities.
- Plans must take disciplinary and/or corrective action in the event of verified misconduct. Examples of such disciplinary action include:
  - Withholding or withdrawing commissions
  - Retraining
  - Suspension of marketing
  - Termination
  - Other consequences outlined in the contract with the plan

72. Reporting to, and Cooperating with, States and CMS

- Plans must comply with requests from a State insurance or other department in connection with investigations of plan marketing representatives who are licensed by the department.
- Plans must report to States the termination of any agent or broker, including the reasons for the termination if required under State law. Plans must also report to CMS any for-cause agent/broker terminations.
- Plans must report to CMS all enrollments made by unlicensed agents or brokers.
- Upon CMS' request, the plan must provide CMS with information necessary for it to conduct oversight of marketing activities.

73. Reporting and Disclosure Obligations of Marketing Representatives

Plan Sponsors must require third-party marketing organizations, including independent agents and brokers, to:

- Disclose to the Plan Sponsor any subcontracted relationships used for marketing, lead generation, and enrollment.
- Report to plan sponsors monthly any staff disciplinary actions or violations of any requirements that apply to the Plan Sponsor associated with beneficiary interaction with the plan.

74. Title Page-Prohibitions on Incentives, Referral Fees, and Agent/Broker Compensation

75. Prohibitions on Incentives

Beginning with contract year 2025, Plan Sponsors must ensure that no provision of a contract with an agent, broker, or other TPMO has a direct or indirect effect of creating an incentive that would reasonably be expected to inhibit an agent or broker's ability to objectively assess and recommend which plan best fits the health care needs of a beneficiary.

This obligation would apply not only to direct contracts with Plan Sponsors but also to contracts between TPMOs.

76. Referral Fees

- Plan Sponsors and their subcontractors may pay individuals or entities for referrals (including recommendations, provision of information, or other means of referring beneficiaries) for potential enrollment into a plan. The payment may not exceed $100 for a referral into an MA or MA-PD, MMP, or 1876 Cost plan and $25 for a referral into a PDP plan.
- The limitations on referral fees for potential enrollment into a plan apply to all agents and brokers (including employed and captive agents) as well as any other individual or entities.

77. Agent/Broker Compensation: Compensation Defined

Compensation includes monetary or non-monetary compensation of any kind relating to the sale, renewal, or services related to a plan or product offered by a Plan Sponsor, including but not limited to:

- Commissions
- Bonuses
- Gifts
- Prizes or awards

Beginning with sales of 2025 plans, compensation also includes:

- payment of fees to comply with State appointment laws, training, certification, and testing costs.
- reimbursement for mileage for appointments with beneficiaries.
- reimbursement for actual costs associated with beneficiary sales appointments such as venue rent, snacks, and materials.
- any other payments made to an agent or broker that are tied to enrollment, related to an enrollment in a MA, Medicare Cost or Part D plan or product, or for services conducted as a part of the relationship associated with the enrollment into an MA, Medicare Cost or Part D plan or product.

78. Agent/Broker Compensation: Applicability of Rules

- Compensation structures for independent agents must comply with CMS guidance.
  - Independent agents are those who sell for multiple plans and are not employed by the plan sponsor.
  - Compensation rules do not generally apply to marketing representatives who are plan employees, to "captive" agents who market for only one plan, or when independent agents are marketing only to employer/union groups.
  - Compensation to independent agents who market to and enroll beneficiaries is covered by the rules whether it is paid directly by a plan or paid by an agency, Field Marketing Organization (FMO), or other Third-Party Marketing Organization (TPMO).
- The limitations on referral fees for potential enrollment into a plan apply to all agents and brokers (including employed and captive agents) as well as any other individual or entities.

79. Agent/Broker Compensation: When Compensation May Not Be Paid

Plan Sponsors may not pay agents:

  - when they have not been trained and tested.
  - when they do not meet state licensure/appointment requirements.

- When a Plan Sponsor and/or a contracted independent agent terminates an agent contract, any future payment for an existing business will be governed by the terms of the contract that specify the agent's payment, subject to the limits in the CMS regulation.

- However, to continue receiving renewal fees, agents must remain trained, tested, licensed, and appointed (to the extent required under state law), regardless of whether they are actively selling.

80. Agent/Broker Compensation: Applicable Amounts

- Applicable compensation amounts depend on whether enrollment is an initial year enrollment or a renewal year enrollment.
    - CMS provides reports to the plan that specify whether enrollment is initial or renewal.
- Renewal year enrollments include plan changes between "like plans."
    - A "like plan type" enrollment includes:
        - A PDP to another PDP
        - An MA, MA-PD, or MMP to another MA, MA-PD, or MMP
        - A Section 1876 Cost Plan to another Section 1876 Cost Plan
    - An "unlike plan type" enrollment includes:
        - An MA or MA-PD plan to a PDP or Section 1876 Cost Plan
        - A PDP to a Section 1876 Cost Plan or an MA (or MA-PD) plan
        - A Section 1876 Cost Plan to an MA (or MA-PD) plan or PDP

81. Agent/Broker Compensation: Applicable Amounts

- For enrollments in two plans at once (for example, enrollment in an MA-only plan like a MSA and a stand-alone PDP or a cost plan and a PDP), the compensation rules apply independently to each plan. This is known as "dual plan" enrollment.
- However, when dual plans are replaced by an enrollment in a single plan, compensation is paid based on the MA or cost plan movement (e.g., movement from an MA-only PFFS plan and PDP to an MA-PD plan would be compensated at the renewal compensation amount for the MA to MA-PD "like plan type" move).

82. Agent/Broker Compensation: Compensation Amounts

- Plan Sponsors are not required to pay compensation for enrollments. However, if they do, they must follow these rules.
- Beginning with sales of 2025 plans, compensation for initial year enrollments must be the fair market value (FMV) published annually by CMS.
- Beginning with sales of 2025 plans, compensation for renewal year enrollments must be 50 percent of the FMV cut-off.
- Referral or finders' fees paid to independent, captive, or employed agents/brokers may not exceed $25 for PDPs or $100 for all other types of plans.
- Payments for administrative services are included in the compensation amount. Thus, agents may not receive additional compensation for such services.

83. Agent/Broker Compensation: Rules

- Compensation is paid on a calendar year basis. Thus, regardless of the month of a beneficiary's initial year enrollment, the renewal year begins on January 1 of the subsequent year, NOT on the beneficiary's enrollment anniversary date.
- Plan Sponsors have the flexibility to make compensation payments annually, quarterly, monthly, or by a different schedule. However, they must pay compensation payments during the year of enrollment.
- Compensation (with some limited exceptions) may only be paid for the months the beneficiary is enrolled in the plan.
    - If a plan pays compensation in advance, it must recoup amounts paid for months a beneficiary is not enrolled.
    - If a beneficiary enrolls mid-year, compensation must be prorated.

84. Agent/Broker Compensation: Exception to Pro Rata Payment Rule

- A plan may choose to pay for an entire initial enrollment year, despite less than 12 months of enrollment, for a beneficiary who has never been enrolled in a plan before or where a beneficiary moves from an employer group plan to a non-employer group plan.
- However, if the plan pays a full initial compensation and the enrollee disenrolls during the contract year, the plan must recoup a pro-rated amount for all months the enrollee is not enrolled.

Example: Ms. Franklin turns 65 in June and is eligible for Medicare for the first time. An agent helped her enroll in an MAPD with a June 1 effective date. The contract between the plan and the agent specifies that the plan will pay the agent for the entire year at the initial rate for a beneficiary who has never been enrolled in a plan before. The plan makes the full year payment to the agent. However, Ms. Franklin disenrolls from the plan effective October 1. The plan must recoup payment for the eight months of the year in which Ms. Franklin was not enrolled.

85. Agent/Broker Compensation: Rapid Disenrollment

- If a beneficiary disenrolls within the first 3 months of enrollment (referred to as "rapid disenrollment"), the entire compensation amount paid for the enrollment must be recouped, except under certain circumstances.
    - plans do not have to recoup any compensation paid including when a beneficiary disenrolls in the first 3 months because the beneficiary:
        - Enrolls effective October 1, November 1, or December 1 and subsequently uses the Annual Election Period to change plans for an effective date of January 1.
        - Became dually eligible for both Medicare and Medicaid
        - Qualified for another plan based on special needs
        - Became LIS eligible
        - Lost Medicare entitlement
        - Moved out of the service area
        - Failed to pay the plan premium
        - Changed enrollment to a plan with a 5-star rating or disenrolled from a LPI (low performing) plan to move into a plan with three or more stars

- Moved into or out of an institution
- Gained/dropped employer/union sponsored coverage
- Changed plans due to an auto, facilitated, or passive enrollment
- Died.
- Was enrolled in a plan that terminated, non-renewed, or CMS imposed sanctions on the plan.

86. Compensation: Rapid Disenrollment, continued

Rapid disenrollment applies when an enrollee moves from one parent organization to another parent organization, (e.g., from Superior Health Plan to Healthy Living Plan) or when an enrollee moves from one plan to another plan within the same parent organization (e.g., from Superior Health Plan's gold plan to its silver plan).

Example of rapid disenrollment: An Agent assisted Ms. Howard in enrolling in a Medicare Advantage HMO plan during the Annual Enrollment Period. After enrolling, she realized her podiatrist was not in the network. In February she switched to a PPO offered by the same organization so that she would have coverage for out-of-network services. The plan must recoup all compensation payments paid to the Agent for Ms. Howard's enrollment.

87. For More Information

- Medicare Marketing Guidelines: http://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.html
- CMS Marketing Website: http://www.cms.gov/ManagedCareMarketing/
- Medicare Beneficiary Website: www.medicare.gov