2026 Medicare Basics Training

Annual Training Requirement for Medicare Agents and Brokers

Training Instructions

- Each year, the Centers for Medicare & Medicaid Services (CMS) provides Medicare Advantage Organizations (MAOs)/Part D sponsors training and testing requirements for their agents and brokers.
- The 2026 Medicare Basics Training will train and test on Medicare rules and regulations.
- There is no audio, and you can advance each slide on your own.
- A knowledge check will be provided at the end of the training program.
  - Completion of the knowledge check is required.
  - A score of 85% or above is required.

Agenda

- Overview of Medicare
- Eligibility Requirements and Premiums
- Coordinated Care Plans
- Options for Receiving Medicare
- Benefits and Beneficiary Protections
- Part D
- Enrollment and Disenrollment
- Communication and Marketing Requirements and Other Regulations
- Agent and Broker Compensation
- Marketing and Sale of an MA Plan

Section 1: Overview of Medicare

The Four Parts of Medicare

Medicare and its benefits can be broken into four parts:

- **Part A -** Hospital Insurance
- **Part B –** Medical Insurance
- **Part C –**Medicare Advantage (MA)
- **Part D –**Prescription Drug Coverage

Note: often, private insurers will offer both the Part C and Part D plans in one combined plan.

These plans are known as MA-PD plans (Medicare Advantage-Prescription Drug plans).

Medicare Parts and Covered Services

Part A

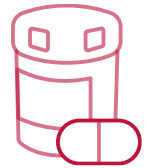
Covers hospital stays and inpatient services

Part B

Covers doctor visits, outpatient care, and preventive services

Part C

Refers to Medicare Advantage plans—and includes Part A and B,
and often Part D



Part D

Provides prescription drug coverage

Original Medicare

Medicare Advantage

Prescription Drug Coverage

MVP HEALTH CARE

Medicare Part A

Medicare Part A is also known as **Hospital Insurance**.

Part A covers:

- Inpatient hospital
- Skilled Nursing Facility (SNF)
- Nursing home care
- Home health services
- Hospice care

Medicare Part B

Medicare Part B is also known as **Medical Insurance.**

Part B covers:

- Doctor services
- Mental Health services
- Lab work
- X-rays
- Durable medical equipment (DME)
- Other medical services not covered under Part A
- Certain drugs not covered under Part D

Medicare Part C

- Medicare Part C is also known as **Medicare Advantage (MA).**
- MA plans are approved by Medicare and run by private insurance companies as an alternative to Original Medicare.
- CMS pays these private insurers to administer benefits and pay claims on behalf of CMS.
- Must have the same or better benefits than Original Medicare.
- May include additional coverage such as wellness education, eye care, or dental coverage.
- MA plan members **do not show** their Medicare card for coverage. They show the MA plan's benefit card to obtain services.

Medicare Part D

- Medicare Part D is **prescription drug coverage.**
- Part D provides coverage for basic and catastrophic non-Part B prescription drug costs.
- Administered by private insurance companies contracted through CMS.
- Beneficiaries can receive Part D coverage from a stand-alone Prescription Drug Plan (PDP) **or** as prescription drug coverage included in the benefits of an MA plan (MA-PD).
- Beneficiaries **cannot** purchase a Part C plan with one company and a Part D plan from another company.

If a beneficiary has a Part C plan with one company and elects a Part D plan from another company, they will be automatically disenrolled from the Part C plan and enrolled in Original Medicare.

Part D – Cost Sharing Subsidies for Low-Income Individuals

- There are both **state funded programs** and **Medicare funded programs** that may be available to help beneficiaries with their prescription drug costs.

- State funded assistance programs are known as State Prescription Assistance Plans or SPAPs.

SPAPs help pay for Part D:

- Premiums
- Deductibles
- Copayments & coinsurance

New York: Elderly Pharmaceutical Insurance Coverage (EPIC)

Not all states have a SPAP.

Part D – Cost Sharing Subsidies for Low-Income Individuals

LIS (Low-Income Subsidy) or "Extra Help"

- Medicare program to help people with limited income and resources pay for Medicare prescription drug costs:
  - Premiums
  - Deductibles
  - Coinsurance, and copayments

- The LIS program is available to anyone who meets Medicare's income requirements.
- If a person would like to know if they qualify, they should call the Social Security Administration (SSA) Office.

Note: If a person qualifies for LIS with their Medicare prescription drug coverage costs, Medicare will pay part of their plan's premium. The person will be billed for the amount that Medicare does not cover.

Section 2: Eligibility Requirements and Premiums

Medicare Part A – Eligibility

To be eligible for Part A:

- be a U.S. citizen and 65 years old or older **OR**;
- be a permanent U.S. resident for five or more continuous years and be 65 years old or older

If you are not 65 or older, you can still qualify for Part A if:

- you are a U.S. citizen or legal resident under age 65 but have a qualifying disability, such as blindness, or a qualifying medical condition, such as Lou Gehrig's Disease
- you have received disability benefits from Social Security or the Railroad Retirement Board for 24 months

Medicare Part A – Premium Information

- Most people don't have to pay a monthly premium for Part A if:
    - *You (or a spouse) paid Medicare taxes for **at least 40 quarters (10 years)** while you were working.*
- Additional ways to qualify for premium-free Part A include:
    - You already get retirement benefits from Social Security or the Railroad Retirement Board.
    - You're eligible to get Social Security or Railroad benefits but haven't filed for them yet.
    - You or your spouse had Medicare-covered government employment.
- If you're under 65, you can get premium-free Part A if:
    - You got Social Security or Railroad Retirement Board disability benefits for 24 months.

Medicare Part B – Eligibility & Premiums

- Anyone receiving ***or*** entitled to Part A is eligible for Part B.
- Unlike Part A, signing up for Part B is voluntary and **everyone must pay a monthly premium** based on their income.
  - **Monthly premiums** are set each year by the Federal government and can be deducted directly from your Social Security check.

Medicare Part C- Eligibility and Premiums

Eligibility:

- Be currently enrolled in and continue to pay applicable premiums for both Medicare Parts A and B.
- Be permanent residents in the MA plan's service area.
- Pay an MA plan's premium, if needed.

Premiums:

- Each MA Plan has different premium amounts.
- Premiums are paid directly to the private insurer.
- MA plan premiums are in addition to Part A and Part B premiums.

Medicare Part D – Eligibility and Premiums

- To be eligible for Part D, individuals can be enrolled in Part A ***or*** Part B.
- Part D plans are provided through private insurance companies.
    - Monthly premiums vary between plans
- PDPs and MA-PDs can only offer equivalent or better coverage than the CMS Standard Medicare Part D benefit.
- **Creditable Coverage** is prescription drug coverage that is at least equal to the benefits provided by the CMS Standard Medicare Part D benefit.

If a member delays enrollment into a Part D plan, or switches from prescription drug coverage that is not creditable to a Part D plan, a Part D Late Enrollment Penalty (LEP) may be added to the beneficiary's monthly Part D premium, and will remain for as long as the member is enrolled in Part D.

Section 3: Coordinated Care Plans

Coordinated Care Plans

Coordinated Care Plans are Medicare Advantage plans that offer health care through an established provider network and are approved by CMS.

Coordinated Care Plans include:

- **HMO/HMO-POS** Health Maintenance Organizations with or without a Point of Service option
- **PPO**: Preferred Provider Organizations
- **SNP**: Special Needs Plans

Health Maintenance Organization (HMO)

- An HMO is a type of health plan that limits beneficiaries to coverage from participating providers.
  - They generally won't cover out-of-network care except in an emergency.
- Some HMOs offer a point-of-service (POS) option, which allows beneficiaries to go out of network for certain services.
  - In these cases, beneficiaries will be covered but usually at a higher cost.

Preferred Provider Organizations (PPO)

- In a PPO plan, all services that are covered for participating providers are also covered for non-participating providers.
  - The cost-share for non-participating providers is generally higher for the beneficiary.
- There are two types of Medicare PPO plans:
  - Regional PPOs (RPPO), which serve a single state or multi-state areas determined by Medicare.
  - Local PPOs, which serve a single county or group of counties chosen by the plan and approved by Medicare.

Special Needs Plans (SNPs)

- SNPs are a coordinated care plan that specifically targets enrollment to beneficiaries who are:
  - Institutionalized
  - Dually eligible
  - Individuals with severe or disabling chronic conditions
- All SNPs are designed to meet specific care needs, and you can only join a SNP if you fit the special needs category the plan serves.
- SNPs may provide care and coverage coordination services not offered by other types of Medicare Advantage Plan.

Section 4: Options for Receiving Medicare

Options for Receiving Medicare

- Original Medicare
- Original Medicare w/ a stand alone PDP
- Medicare Advantage-Prescription Drug Plan (MA-PD)
- Medicare Advantage without a PDP
- Medigap
- Employer Group Waiver Plans (EGWP)
- Private Fee-for-Service
- Cost Plan with a stand-alone PDP
- Cost Plan without a stand-alone PDP
- PACE
- MSA
- Special Needs Plans (SNPs)

Original Medicare

- Medicare Part A and Part B only.
- **May be responsible for a deductible and 20% co-insurance** for some covered medical services.
- See any doctor in the U.S. that accepts Medicare.
- **Does not cover** benefits such as dental care, vision exams, hearing aids, or international travel.
- Prescription drugs are **not** covered.
  - A separate Part D plan or creditable coverage is needed to avoid penalties
- Has **no maximum out-of-pocket costs.**

Medicare Advantage (MA) Plans

- **Combines Parts A, B, C, and may include Part D**, in one plan
- Must have the **same or better benefits** than Original Medicare
- Many plans include **extra benefits** not covered by Original Medicare-Vision, Dental, Gym
- Medicare Advantage plans are **rated annually by Medicare**

"All in One"

EXTRA BENEFITS

Offered by private insurance companies

Medicare Supplement (Medigap)

- **Covers Part A and Part B services**, as well as some of the remaining costs not paid for by Original Medicare
- **Coverage may be subject to a deductible** and other out of pocket costs, which vary by plan
- **Does not cover** prescription drugs
- Helps pay for "**gaps"** that Original Medicare doesn't cover
- Must have **Part A and Part B**

Do not work with MA plans

Enhances Original Medicare

Offered by private insurance companies

Employer Group Plans

- Known as Employer Group Waiver Plans **(EGWPs)**
- Employer Groups can elect to offer their retirees Medicare plans **administered by private insurers** for medical coverage.
- In most cases, the Employer Group **is billed by the plan**
- They can choose to **offer retirees several options** for Medicare Coverage, including MA plans, Part D PDP plans, Medigap plans, or Cost plans.

Member pays the group

Enrollment typically through a broker

Can have different enrollment periods

Private Fee-for-Service Plans (PFFS)

- A Private Fee-For-Service (PFFS) plan is a Medicare Advantage (MA) health plan.
- Provide Medicare benefits, plus any additional benefits the company decides to provide.
- Can see a specialist without referrals, and they do not need to select a primary care physician (PCP).
- Beneficiaries can see any provider who is eligible to receive payment from Medicare and agrees to accept payment from the PFFS Medicare Advantage Organization.

Section 1876 Cost Plans

- Section 1876 Cost Plans are Medicare plans offered by private insurers that contract with the federal government.

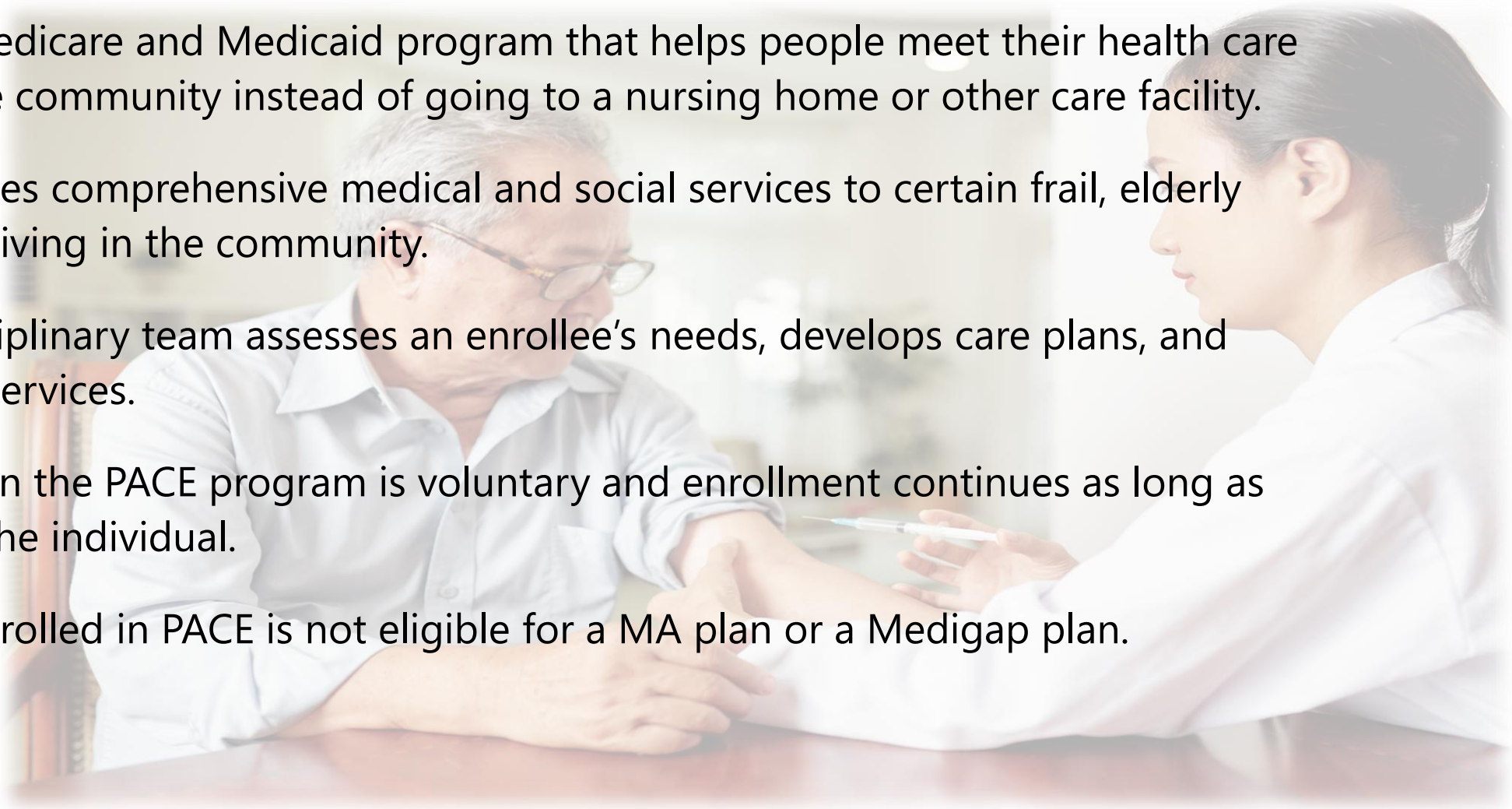
- These plans are **not** Medicare Advantage plans.

- May provide additional coverage and benefits to Original Medicare:
    - Dental
    - Vision
    - Hearing

- Beneficiaries keep their Medicare Part A and/or Part B coverage, but also have access to a network of providers through the Cost plan.

- Cost plans pay for services outside their service area **only** if there is an emergency or urgently needed services.
    - Routine services outside the plan's network area will get their Medicare covered services paid by Original Medicare

Program of All-inclusive Care for the Elderly (PACE)



- PACE is a Medicare and Medicaid program that helps people meet their health care needs in the community instead of going to a nursing home or other care facility.
- PACE provides comprehensive medical and social services to certain frail, elderly people still living in the community.
- An interdisciplinary team assesses an enrollee's needs, develops care plans, and delivers all services.
- Enrollment in the PACE program is voluntary and enrollment continues as long as desired by the individual.
- A person enrolled in PACE is not eligible for a MA plan or a Medigap plan.

Medical Savings Account - MSA

- Medicare MSA is a type of Medicare Advantage plan that combines a high-deductible health plan with a medical savings account.
- Medicare MSA plans provide Medicare beneficiaries with more control over health care utilization, while still providing coverage against catastrophic health care expenses.
- Medicare gives the plan an amount of money each year that is deposited into a MSA account to be used for Medicare covered costs.
- No monthly plan premium.
- Do not offer Part D coverage.
- Generally, do not have a network of health care providers.

Special Needs Plans

- A Special Needs Plan (SNP) provides benefits and services to people with specific conditions, certain health care needs, or who also have Medicaid.
- SNPs include care coordination services and tailor their benefits, provider choices, and list of covered drugs to best meet the specific needs of the groups they serve.

Dual-Eligible Special Needs Plans (D-SNPs)

Institutional Special Needs Plans (I-SNPs)

Chronic Condition Special Needs Plans (C-SNPs)

Dual-Eligible Special Needs Plans (D-SNPs)

Individuals who are entitled to both Medicare and Medicaid.

Include:

- Coordination-only D-SNPs (CO)
- Fully Integrated D-SNPs (FIDE)
- Highly Integrated D-SNPs (HIDE)
- Applicable Integrated Plans (AIPs)

Coordination-only D-SNPs (CO)

- These plans provide Medicare-covered services.
  - Members will receive their Medicaid from another insurance carrier.
- The plans are required to coordinate the delivery of benefits with the Medicaid program.
- Plans must notify states when enrollees are admitted to inpatient facilities.

Fully Integrated D-SNP (FIDE)

- These plan provide coverage of Medicare and Medicaid benefits.
  - Under a single legal entity that holds both:
    - an Medicare Advantage contract with CMS;
    - and a contract with the state Medicaid agency that meets the requirements of a managed care organization.

Highly Integrated D-SNPs (HIDE)

- These plans provide coverage of Medicaid benefits (through the D-SNP or an affiliated Medicaid managed care plan).
- They also include coverage of:
  - Long-Term Support Services (LTSS)
  - Behavioral health benefits
  - Or both

Applicable Integrated Plans (AIPs)

- A designation that can apply to a CO, FIDE, and a HIDE.
- Must have a unified appeals and grievances process that takes into consideration both Medicare and Medicaid.
- Must have exclusively aligned enrollment.
  - When a D-SNP's enrollment is limited to only allow individuals who receive their Medicaid benefits through the D-SNP or the D-SNP's affiliated MMCO.

Institutional Special Needs Plans (I-SNPs)

- I-SNPs are for individuals who live in long-term care settings:
  - Long-term care nursing facility
  - Long-term care skilled nursing facility
  - Inpatient psychiatric facility
  - Intermediate care facility for individuals with developmental delays
- Eligibility:
  - Need institutional setting services for 90 days or more
  - Expected to need to the level of services provided in a LTC, SNF, inpatient psychiatric setting or intermediate care facility.

Chronic Condition Special Needs Plans (C-SNPs)

- Enrollment restricted to special needs individuals with severe or disabling chronic conditions.
- The individual's doctor must verify the individual has a qualifying health condition.
- Designed for people who need extra support due to an eligible chronic or disabling condition.
- Plans are designed to tailor benefits to the individual’s chronic condition and are customized to fit their health care needs.

Section 5: Benefits and Beneficiary Protections

Beneficiary Protections

- All Medicare beneficiaries have the same rights and protections, **no matter how they get their Medicare**.
- These protections cover all parts of Medicare.
- Universal Protections Include:
  - Appeal Rights
  - Filing a Complaint
  - Be Protected from Discrimination
  - Have Personal Information Kept Private
  - Have Questions about Medicare Answered
  - Get Emergency Care when Needed

Benefits and Beneficiary Protections

- MA plans must cover all services that Original Medicare cover and not impose any limitations.
  - However, plans do not cover all services.
- There are benefit limitations in place, which are plan specific.
  - Protects the MA plan and enrollees from catastrophic medical expenses.
  - To assure that the right treatment is being used.
- Some services require prior approval from the MA plan.

Prior Authorization

- Requirement that a health care provider obtain approval from the MA plan to provide a given service.
- The provider must show that the requested service is medically necessary.
- MA plans often require prior authorization to see specialists, get out-of-network care, get non-emergency hospital care, and more.
- Each MA plan has different requirements, so MA enrollees should contact their plan to ask when prior authorization is needed.

Step Therapy

- A type of prior authorization for drugs that begins medication for a medical condition with the most preferred drug therapy and progresses to other therapies only if necessary, promoting better clinical decisions.
- For example, by using step therapy, plans could ensure that an enrollee who is newly diagnosed with a condition, begin treatment with a cost-effective drug, before progressing to a more costly drug, should the initial treatment prove ineffective.
- By implementing step therapy along with care coordination and drug adherence programs, it will lower costs and improve the quality of care for Medicare beneficiaries.

Appeals

- Medicare beneficiaries have the right to file an appeal for any coverage or payment decision by Medicare, the Medicare Health Plan or the Medicare Prescription Drug Plan.
- Appeal is the action a beneficiary can take if they disagree with a coverage or payment decision.
- Filing an appeal is a right of all Medicare beneficiaries.
- Appeals start at the plan level – meaning the beneficiary starts the process by contacting the plan.

Grievance

- Grievance is a complaint about the way a Medicare health plan or Medicare drug plan is giving care.
- Filing a grievance is a right of all Medicare beneficiaries.
- A grievance may be filed if the beneficiary feels they have been mistreated in any way.
  - If the complaint is about a plan's refusal to cover a service, supply, or prescription, an appeal needs to be filed, not a grievance.
- A grievance can also be filed on the quality of care received from a provider or hospital.
- A grievance must be filed within 60 days of the incident. Grievances can be filed by contacting the plan or by calling 1-800-MEDICARE.

Out of Pocket Costs

Premium - The amount paid for health insurance every month.

Coinsurance - amount required to pay for the share of the cost for services. Coinsurance is usually a percentage.

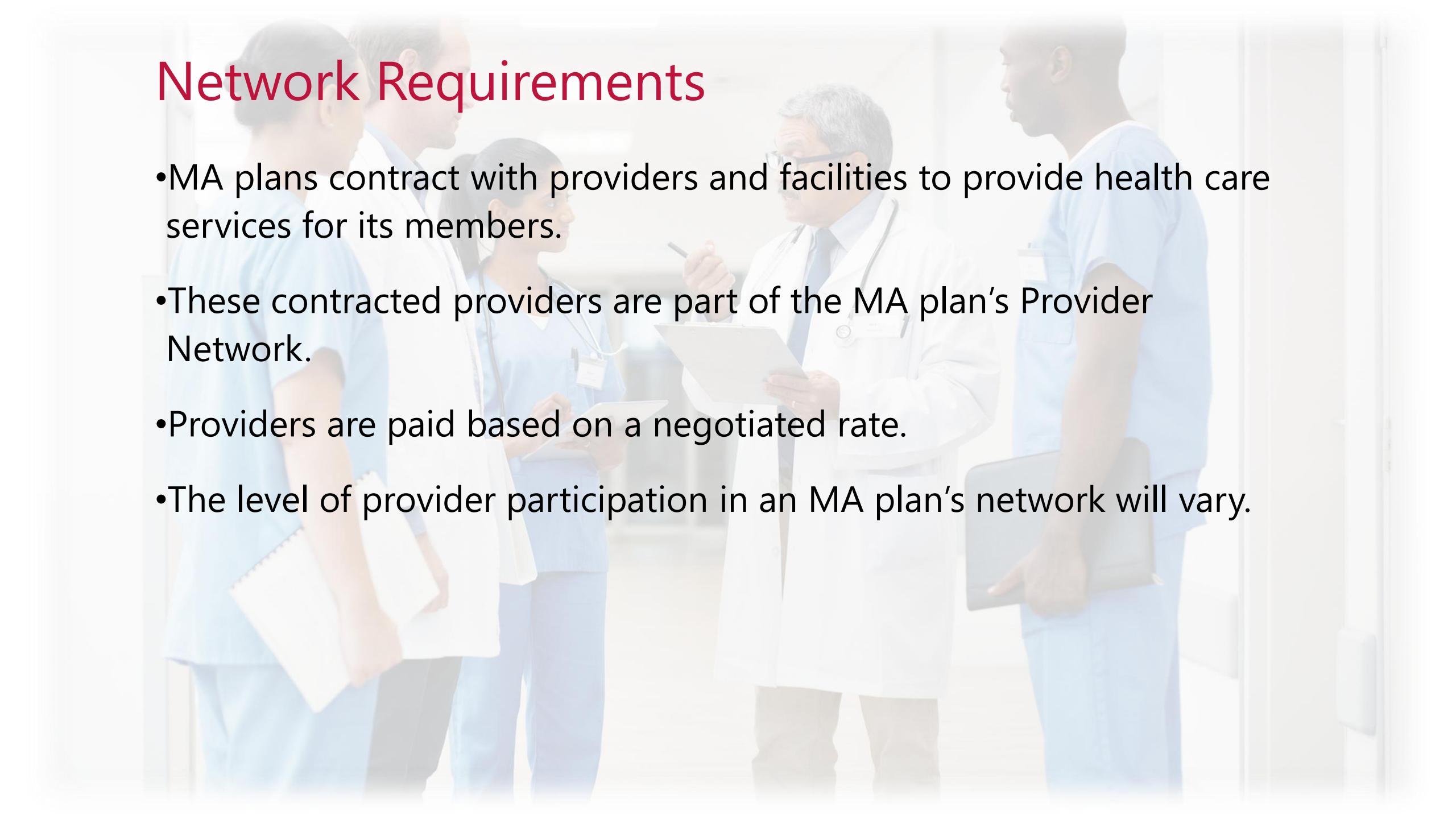
Copayment - amount required to pay as the share of the cost for services. A copayment is usually a set amount, rather than a percentage.

Deductible –the amount a beneficiary must pay out of pocket for prescription drug costs before a Part D plan's benefits "kick in". Some Part D plans have deductibles, some do not.

Maximum Out of Pocket (MOOP) Limits

- MA plans have an MOOP limit to help protect members from catastrophic medical expenses.
- The MOOP max limits how much a member must pay in copays, coinsurance, and deductibles before the plan will pick up 100% of covered expenses.
- Non-medical expenses, such as Part D copays and eyewear allowances, do not count towards a member's MOOP max.

Network Requirements



- MA plans contract with providers and facilities to provide health care services for its members.
- These contracted providers are part of the MA plan's Provider Network.
- Providers are paid based on a negotiated rate.
- The level of provider participation in an MA plan's network will vary.

In and Out of Network Providers

- **In-Network** providers are contracted to administer health care services to an MA plan's members.
- Par providers can be found in an MA plan's Provider Directory.
- **Out-Of-Network** providers are not contracted to administer health care services to an MA plan's members.
- Depending on the type of MA plan, a member's out of pocket costs may be higher.
- The provider network for an MA plan may be different than that of Original Medicare.
- **Medicare members are required to see providers who accept Medicare.**

Medicare Provider Reimbursement

- Under original Medicare rules, a Medicare participating provider is a provider that signs an agreement with Medicare to always accept assignment.
- Participating providers may never balance bill because they have agreed to always accept the Medicare allowed amount as payment in full.
- Medicare members are still responsible for paying any copayments, coinsurances and deductibles indicated in the plan.

Section 6: Part D

Medicare Part D – Plan Types

1) Medicare Drug Plans

- "Stand-alone" prescription plan
- Must have Part A and/or Part B
- Add drug coverage to Original Medicare, Medigap Plans, Cost Plans, Fee-for-Service Plans, and Medical Savings Account plans.

2) Medicare Advantage Plans (Part C)

- Must have Part A and Part B.
- Includes prescription drug coverage in the plan.
  - Not included in all Part C plans
- Cannot enroll in a stand-alone plan and a Part C plan

TrOOP

- True out-of-pocket
  - Represents the member's out-of-pocket costs.
- For 2026, when a member's TrOOP reaches $2,100, they will no longer have any costs for Part D formulary drugs for the rest of the year.
- True out-of-pocket (TrOOP) is a combination of:
  - Member costs in the Deductible Stage.
  - Member costs in the Initial Coverage Stage.
  - Amounts paid by SPAPs, AIDS Drug Assistance Programs, and the Indian Health Service.

Pharmacy Networks

- **In-Network Pharmacies** are pharmacies that an MA plan has contracted with to provide its members with prescription drugs.
- **Out-of-Network Pharmacies** are pharmacies that are not contracted by the MA plan.
    - Plans may only pay for prescriptions filled through an out-of-network pharmacy on a limited, non-routine, or an emergency situation when an in-network pharmacy is not available.

Medicare Prescription Payment Plan

- Beginning in 2025, as part of the Inflation Reduction Act, the Medicare Prescription Payment Plan will be in effect.
- Required for all Medicare prescription drug plans, standalone drug plans and MA plans with prescription drug coverage
- Offers enrollees the option to pay out-of-pocket prescription drug costs in the form of capped monthly installment payments instead of all at once at the pharmacy.

Inflation Reduction Act Changes

Catastrophic Coverage - cost-sharing for Part D drugs will be eliminated for beneficiaries in the catastrophic phase of coverage.

Vaccines - Part D plans must not apply the deductible to an adult vaccine recommended by the Advisory Committee on Immunization Practices and must charge no cost-sharing at any point in the benefit for such vaccines.

Insulin - Part D plans must not apply the deductible to any Part D covered insulin product and must charge no more than $35 per month's supply of a covered insulin.

Low-Income Subsidy -will be expanded so that beneficiaries who earn between 135 and 150 percent of the federal poverty level, and meet statutory resource limit requirements, will receive the full LIS subsidies that were prior to 2024, only available to beneficiaries earning less than 135 percent of the federal poverty level.

Part D Manufacturer Discount Program

- Beginning in 2025, as part of the Inflation Reduction Act, the Part D Manufacture Discount Program will be in effect.
- This program will replace the existing Coverage Gap Discount Program (this program ended in 2025).
- Program requires participating manufacturers to provide “discounted prices” on their “applicable drugs” dispensed to “applicable beneficiaries.”
- Manufacturers will cover around 10% in the Initial Coverage Phase and 20% in the Catastrophic Phase.

2026 Standard Benefit

- **Deductible**
  - $615. The enrollee pays 100% of their prescription costs
- **Initial Coverage**
  - Enrollee pays 25%
  - Plan pays 65% or applicable drugs and 75% of all other Part D drugs
  - Manufacturer covers 10% of applicable drugs.
- **Catastrophic**
  - Enrollee pays $0 for Part D drugs.
  - Plans pay around 60%
  - Manufacturer pays a discount around 20%
  - CMS pays a reinsurance subsidy between 20%-40%

Section 7: Enrollment and Disenrollment

Recording Enrollments

Agents and brokers will need to record all marketing/sales and enrollment calls with beneficiaries in their entirety

Non-Discrimination Requirements for Enrollment

An MA organization may not impose any additional eligibility requirements as a condition of enrollment other than those established by CMS.

MA organizations cannot deny enrollment based on current health, race, sex, age, or medical history.

Pre-Enrollment Checklist

Plans must include the Standardized Pre-Enrollment Checklist:

Understanding the Benefits:

- Review full list of benefits found in the Evidence of Coverage (EOC)
- Review Provider Directory
- Review Pharmacy Directory
- Review Part D Formulary

Approved Enrollment Mechanisms

- The MA organization must use an enrollment mechanism that complies with CMS' guidelines in format and content.
- Enrollment mechanism must include information indicating that the applicant acknowledges:
    - The requirement to keep Part A and B;
    - That they will abide by the rules of the MA plan;
    - The release of information to Medicare and other plans. Information may be used to track enrollment and for other purposes, as allowed under federal law;
    - That enrollment in the MA plan automatically disenrolls him or her from any other Medicare health plan and prescription drug plan.
    - The right to appeal service and payment denials made by the organization.

Effective Date of Coverage

- The MA organization must determine the effective date of coverage for all enrollment requests.
- If the individual fills out an enrollment form with a MA organization representative:
  - Representative may advise the individual of the proposed effective date
  - Must also stress to the individual that it is only a proposed effective date and that the individual will hear directly from the MA organization to confirm the actual effective date.
- With the exception of some SEPs and when election periods overlap, beneficiaries may not choose their effective date.

Processing Enrollment Requests – Notifications

Once CMS approves the enrollment request, a new member packet and ID card are sent to the beneficiary.

The packet includes important materials like:

- Formulary (if the plan sends it)
- Member Handbook
- Evidence of Coverage, also known as the member's contract (if the plan sends it)

Upon the member's effective date with the plan, the member should use their plan ID card to access all services.

Enrollment Notifications

- The MA organization must notify the member of the effective date of coverage prior to the effective date.
- If a beneficiary completes an enrollment request with an unallowable effective date, or if the MA organization allowed the beneficiary to choose an unallowable effective date:
  - The MA organization must notify the beneficiary in a timely manner and explain that the enrollment must be processed with a different effective date.
- MA organizations must ensure enrollees have access to plan benefits as of the effective date.

Enrollment Notifications

- In some instances, the MA organization will be unable to provide the materials and required notifications to new enrollees prior to the effective date.
  - These cases will generally occur when an enrollment request is received late in a month with an effective date of the first of the next month.
- In these cases, the MA organization still must provide the member all materials no later than 10 calendar days after receipt of the completed enrollment request.
- The member's coverage will be active on the effective date regardless of whether or not the member has received all the information by the effective date.

Initial Enrollment Period (IEP)

You can sign up for Medicare Parts A and B and enroll in a Medicare plan during a seven-month window, starting as early as three months before you turn 65.

– 3 MONTHS

Three months before your birthday month

Your plan coverage will start the first day of your birthday month.

The month in which you turn 65

Your plan coverage will start the first day after your birthday month.

+ 3 MONTHS

Three months after your birthday month

Your plan coverage will start the first of the month after the month of enrollment

Annual Election Period

The Annual Election Period (AEP) is available each calendar year to all Medicare beneficiaries.

Annual Election Period is October 15th through December 7th.

- Benefits selected during the AEP are effective on January 1st of the following year.
- A beneficiary's last completed choice made during the AEP will be the election that takes effect.
- MA, MA-PD, or PDP plans can submit enrollment requests to CMS from October 15th - December 7th.
- MA plans may not solicit enrollment applications prior to the start of the AEP.

MA Open Enrollment Periods (MA-OP)

Newly Eligible MA-OP

- Available for three months following the MA plan start date
- Switch to a different MA Plan
- Drop to Original Medicare and join a Part D plan
- Can use **once** during the three-month timeframe

Annual MA-OP

- January 1st-March 31st
- Switch to a different MA Plan
- Drop to Original Medicare and join a Part D plan
- Can use **once** during the three-month timeframe

Open Enrollment Period for Institutionalized Individuals (OEPI)

- The Open Enrollment Period for Institutionalized Individuals (OEPI) is for individuals who move into, reside in, or move out of an institution.
- The OEPI is continuous for eligible individuals residing in an institution.
- The OEPI ends two months after the month the individual moves out of the institution.
- The effective date of coverage will begin on the first of the month following the election.

Special Enrollment Period (SEP)

Medicare provides a Special Enrollment Period (SEP) for enrolling when certain events happen in your life.

SEPs can happen throughout the year, outside of the Annual Enrollment Period.

Examples include:

Moving

Leaving employer group coverage

Having a state pharmaceutical plan, **Low Income Subsidy**, or **being enrolled in both Medicare and Medicaid**

Switching into a 5-star plan

Limitation of Dual-Eligible/LIS SEP

- **For "At-Risk" and "Potential At-Risk" Beneficiaries**
- An individual can be identified by an MA-PD plan as a "potential at-risk" or "at-risk" beneficiary for prescription drug overutilization and can be barred from using the SEP for Dual-Eligible Individuals and Other LIS-Eligible Individuals.
- The plan must send a written notice to the individual stating that the individual cannot use this SEP to change plans while this designation is in place.
- The plan can evaluate and remove the designation of "potential at-risk" or "at-risk" if the plan determines that the beneficiary no longer meets the criteria.

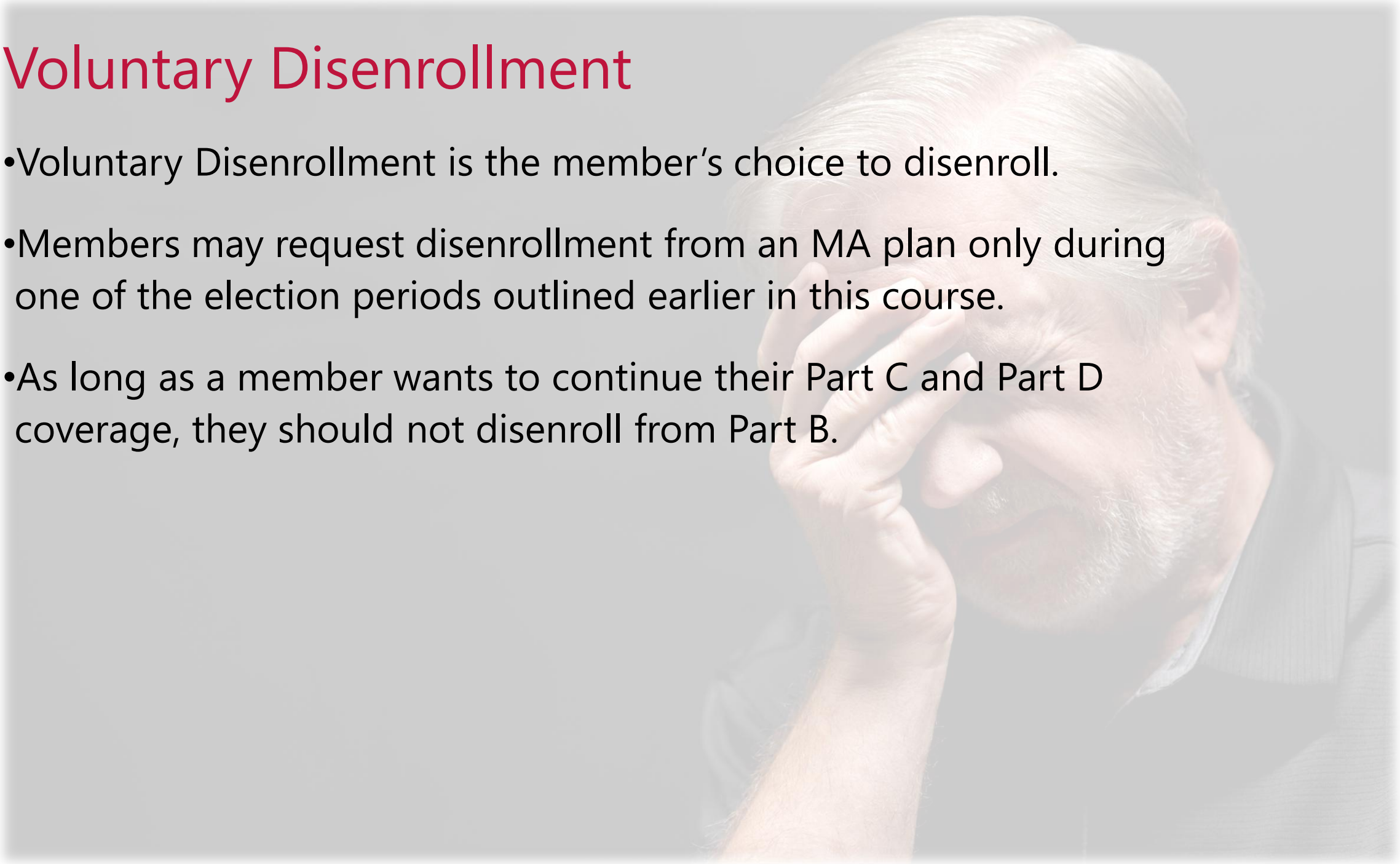
Section 1876 Cost Plan Open Enrollment

The general requirements for open enrollment are that the cost plan:

- Hold an annual open enrollment period of at least 30 or more consecutive days for Medicare beneficiaries.
- Publicize its upcoming enrollment period in appropriate media throughout the service area
  - (this requirement does not apply for Cost Plans that are continuously open for enrollment).
- Enroll Medicare beneficiaries on a first come, first serve basis.

Voluntary Disenrollment

- Voluntary Disenrollment is the member's choice to disenroll.
- Members may request disenrollment from an MA plan only during one of the election periods outlined earlier in this course.
- As long as a member wants to continue their Part C and Part D coverage, they should not disenroll from Part B.



Voluntary Disenrollment

MA, MA-PD, or PDP Plans:

- When a member is enrolled in a Part C or D plan, and enrolls in another plan, the individual is automatically disenrolled from the first plan upon CMS's approval of the enrollment.
- The beneficiary does not need to contact their first MA plan to notify them of their disenrollment.

Non-MA plans:

- Beneficiaries with a Medigap plan should not disenroll from their current plan until they have received the confirmation letter from the Part C or Part D plan.
- Waiting until the approval is official ensures the beneficiary will not be without coverage.

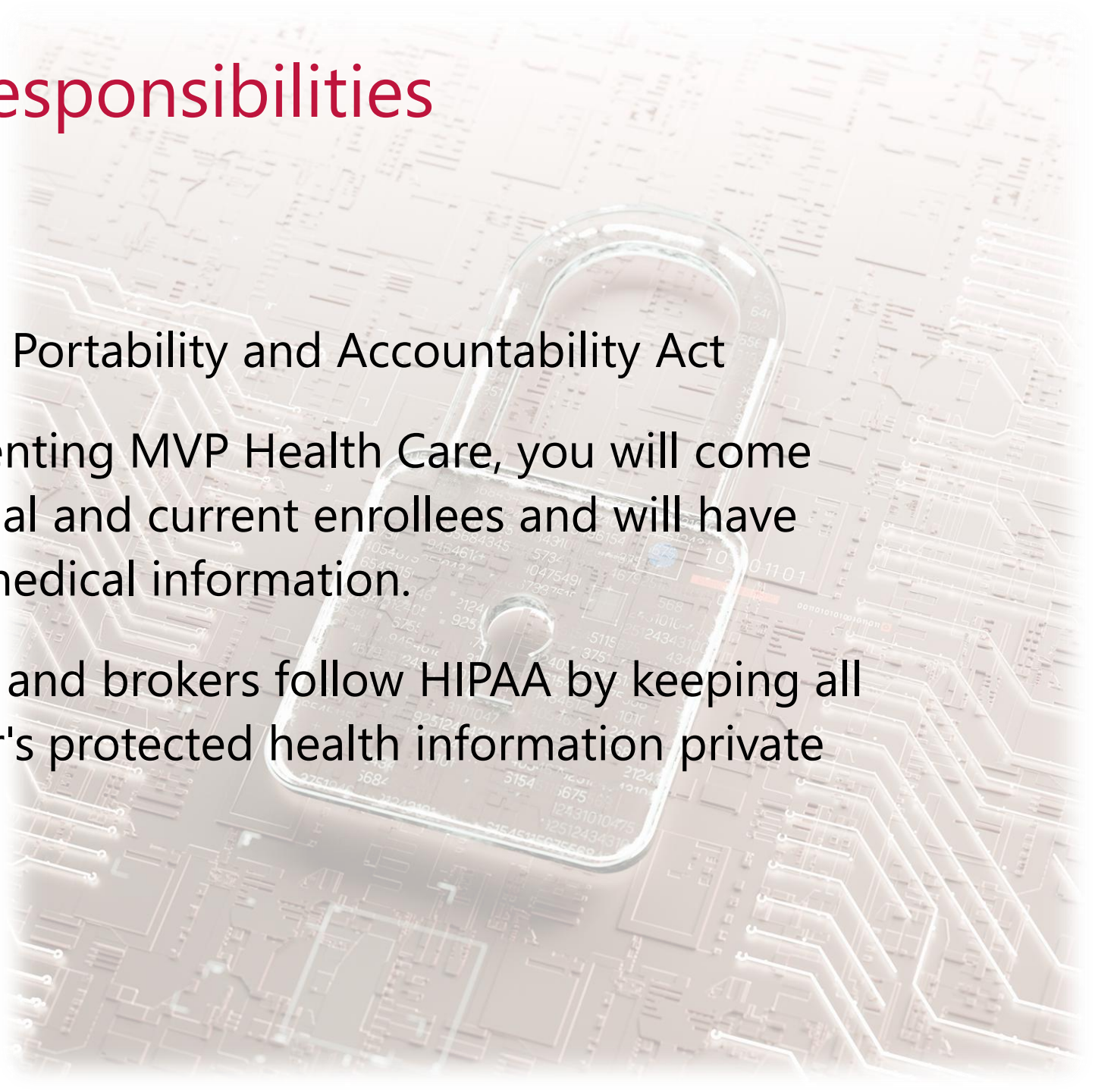
Involuntary Disenrollment

Involuntary Disenrollment occurs when a member does not choose to disenroll, but they are disenrolled for various reasons, including:

- A change in residence which makes the individual ineligible to remain enrolled
- The member loses entitlement to either Medicare Part A or Part B
- Premiums are not paid on a timely basis
- The member engages in disruptive behavior
- The member provides fraudulent information on an enrollment request

Section 8: Communication and Marketing Requirements and Other Regulations

Agent and Broker Responsibilities



HIPAA Privacy

- HIPAA – The Health Insurance Portability and Accountability Act
- As an Agent or Broker representing MVP Health Care, you will come into contact with both potential and current enrollees and will have access to their personal and medical information.
- It is imperative that all agents and brokers follow HIPAA by keeping all potential and current member's protected health information private and confidential.

TPMO Oversight

- Some TPMOs have been selling and reselling personal beneficiary data.
  - Can undermine existing rules that prohibit cold calling people with Medicare and result in other aggressive marketing tactics for Medicare Advantage and Part D plans.
- CMS is codifying the requirement that personal beneficiary data collected by a TPMO for marketing or enrolling the individual into an MA or Part D plan may only be shared with another TPMO when prior express written consent is given by the individual.
- Further, the TPMO must obtain this written consent through a transparent and prominently placed disclosure from the individual to share the information and be contacted for marketing or enrollment purposes, separately for each TPMO that receives the data.

Responsibilities Required by MVP

- MVP Health Care requires agents to frame its MA plans in a manner that is complete, fair and accurate.
- All people representing MVP Health Care to the community must abide by all Federal laws, rules, and regulations governing the Medicare program.
- In addition, they must also abide by New York State and Vermont's insurance laws, rules and regulations.
- Agents and Brokers are to follow Medicare's marketing guidelines, not New York and/or Vermont's marketing guidelines.

Communications

- Activities and use of materials to provide information to current and prospective enrollees.
- This means that all activities and materials aimed at prospective and current enrollees, including their caregivers and other decision makers associated with a prospective or current enrollee, are “communications”.
- Communications are to advise of the plan’s benefits, **not to convince them to enroll into the health plan.**

Marketing Definition

- Includes activities and use of materials that are conducted by the Plan with **the intent to draw a beneficiary's attention to a MA plan or plans.**
  - To influence a beneficiary's decision-making process when selecting a MA plan for enrollment or deciding to stay enrolled in a plan.
- Marketing contains information about the **plan's benefit structure, cost sharing, measuring or ranking standards, and rewards and incentives.**
- Marketing activities may take place face-to-face, via telephone, mailings, electronic communications, or through various media channels such as TV, websites, or social media.

Communication vs Marketing Examples

Communication

- A flyer reads *"Swell Health is now offering Medicare Advantage coverage in Nowhere County. Call us at 1-800-BE-SWELL for more information."*
- While the intent is to draw a beneficiary's attention to Swell Health, there is no marketing content.

Marketing

- A billboard reads *"Swell Health Offers $0 Premium Plans in Nowhere County"*
- The intent to draw the viewer's attention to the plan and has content that mentions zero-dollar premiums being available.

Marketing Rules and Requirements

- Plans/Part D sponsors cannot market for an upcoming plan year prior to October 1st.
- Plans/Part D Sponsors are permitted to concurrently market the current year with the prospective year starting on October 1st, provided marketing materials make it clear what plan year is being discussed.
- Plans/Part D sponsors may compare their Plan to another Plan/Part D sponsor, provided the information is accurate, not misleading, and can be supported by the MA organization making the comparison.
- Plans/Part D Sponsors may use the term "free" in conjunction with mandatory, supplemental, and preventative benefits provided at a zero-cost share for all enrollees.
- Plans/Part D Sponsors cannot use the term "free" to describe a $0 premium, any type of reduction in premium, reduction in deductibles or cost sharing, low-income subsidy, or cost sharing pertaining to dual eligible individuals.

Star Ratings

- CMS rates MA plans based on "Star Ratings" that range from 1-5 stars.
- Stars for each plan show how well the plan performs in their service areas:
  - Detecting and preventing illness
  - Ratings from patients
  - Patient safety
  - Customer service.
- Plan sponsors must display their plans' ratings information to current and prospective enrollees by referring them to http://www.medicare.gov or by including it in their enrollment kits, making it available on websites, and upon request.

Rules when Referring to Star Ratings

- References to individual Star Ratings measures must also include references to the contract's overall rating, with equal or greater prominence.
- Must not use an individual underlying category or measure to imply higher overall or summary Star Ratings.
- Any reference to a contract's Star Rating must make it clear that the rating is "___ out of 5 stars".
- Must clearly identify which Star Ratings contract year applies.
- May only market the Star Ratings in the service area in which the Star Rating is applicable.

Marketing Materials

CMS requires MA Organizations to disclose certain plan information, this information is available on mvphealthcare.com

Summary of Benefits is a document that outlines the benefits from each plan from an MA Organization and is used for the beneficiary to compare different plan offerings. Plans must include the Summary of Benefits when providing an enrollment form and upon request.

Provider and Pharmacy Directories are directories of providers and pharmacies that participate in a MA plan's network and must be made available at the time of enrollment and annually afterward.

Evidence of Coverage is the member's contract with the Medicare Advantage plan. It gives details about the plan they are enrolled in and is made available at the time of enrollment and annually afterward.

Part D Formulary is a reference guide for a member's Part D plan and lists drugs covered by the Part D plan and is made available annually.

Annual Notice of Change (ANOC) is a document that highlights premium and benefit changes for a current MA enrollee's plan for the coming plan year. The ANOC must be provided to current plan enrollees no later than September 30th of each year.

Communication and Marketing Activities

Inappropriate and Prohibited Activities

- Conducting health screenings at marketing events
- Providing cash or monetary rebates
- Unsolicited contact with beneficiaries
- Comparing plan to other plans (requirement and restriction)
  - Unless the information is accurate and not misleading
- Displaying names or logos or both of provider co-branding partners (requirement and restrictions)
- Failure to record all sales and enrollment-related telephonic contact

Potential Consequences

Potential Consequences of Engaging in Inappropriate or Prohibited Communication and Marketing Activities

- All people marketing for MVP are contractually obligated to conform to all federal laws, rules, and regulations.
- This obedience guarantees beneficiaries do not receive misleading information. CMS or other federal agencies can impose criminal, civil, and/or monetary damages on specific individuals and/or MVP.
- Plans/Part D sponsors must report the termination of any agents/brokers to the State and CMS, and the reasons for the termination, if State law requires the reasons to be reported.

Examples of Consequences

- Termination of enrollment and/or marketing activities
- Termination of agent found to be engaging in inappropriate activities
- Suspension of payment to MVP
- Punitive damages to MVP and/or agent
- Forfeiture of agent's future commission

If any of the above penalties are directly attributed to the agent's actions, MVP could be found harmless, and **all penalties could be directed to the individual** agent. Any sanctions would remain in effect until CMS is satisfied that the deficiencies have been corrected and safeguards have been implemented to avoid future reoccurrences.

Marketing/Sales Events

Marketing/Sales Events are designed to steer or attempt to steer potential enrollees, or the retention of current enrollees, toward a plan or limited set of plans.

The following requirements apply to all marketing/sales events:

- Plans/Part D sponsors must submit talking points, if applicable, and presentations to CMS prior to use, including those to be used by agents/brokers
- Sign in sheets must clearly be labeled as optional
- Health screenings or other activities that may be perceived as, or used for, "cherry picking" are not permitted
- Plans/Part D sponsors may not require attendees to provide contact information as a prerequisite for attending an event
- Contact information provided for raffles or drawings may only be used for that purpose

Marketing in a Health Care Setting

Plans **may not conduct** marketing activities in healthcare settings **except in common areas.**

- Hospital or Nursing Home Cafeterias
- Community or Recreational Rooms
- Conference Rooms
- Common Entryways
- Vestibules
- Waiting Rooms
    - Can only interact if an individual approaches the agent.
    - The agent cannot approach individuals in a waiting room.

Activities in Health Care Settings - Dos

Examples Include:

- Hospitals
- Skilled nursing facilities
- Doctor's offices

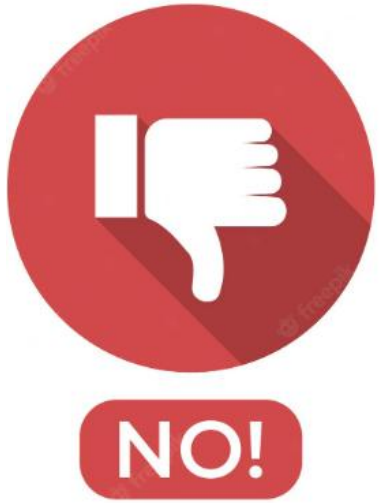
Agents May:

- Interact with prospects while onsite in common areas (cafeterias, conference rooms, common entryways, and waiting rooms)
- Participate in facility events
- Leave plan materials in common areas
- Conduct sales presentations or obtain SOAs in common areas
- Schedule an appointment with a prospect residing in LTC facility (Resident must have requested an appointment)

Marketing in a Health Care Setting

Plans are prohibited from marketing to Medicare beneficiaries in areas where **patients primarily receive health care services or are waiting to receive health care services.**

- Waiting Rooms
- Exam Rooms
- Hospital Patient Rooms
- Dialysis Center Treatment Areas
- Pharmacy Counter Areas



Sales Events – Dos

At sales events plan sponsors may:

- Accept and perform enrollments
- Provide a nominal gift to attendees with no obligation
- Give a sales presentation
- Distribute applications
- Collect applications

At sales events plan sponsors must:

- Announce all plan and product types that will be covered during the presentation at the beginning of that presentation
- Submit all sales scripts and presentations for approval to CMS prior to their use during the marketing/sales event
- Give appropriate notice for all cancelled events

Sales Events – Don’ts

At sales events plan sponsors may not :

- Provide or subsidize meals. Plan Sponsors **may provide refreshments and light snacks**
- Solicit enrollment applications prior to the start of the Annual Election Period (Oct 15th)
- Require potential enrollees to submit personal information, such as contact information, as a prerequisite to attend plan marketing events
- Provide gifts over the $15 limit
- Give away items that are considered a health benefit, such as a free checkup
- Structuring marketing events to steer enrollees to particular providers, practitioners, or suppliers

Personal/Individual Marketing Appointments

- Personal/individual marketing appointments typically take place in the beneficiary's home.
- However, these appointments can also take place in other venues such as a library or coffee shop.
- Appointments must follow the Scope of Appointment guidance.
- All one-on-one appointments with beneficiaries are considered sales/marketing events.
- *Note: phone consultations can be considered a 1-1 appointment.*

TPMO Disclaimer

TPMO (third-party marketing organization) Disclaimer.

CMS now requires the following disclaimer from TPMOs:

"We do not offer every plan available in your area. Any information we provide is limited to those plans we do offer in your area. Please contact Medicare.gov or 1-800-MEDICARE to get information on all of your options."

TPMOs will be required to include this disclaimer:

- Verbally provided within the first minute of a phone call
- Electronically when communicating with a beneficiary through email, online chat, or other electronic means of communication
- Prominently display the disclaimer on their website and marketing materials, including all print materials and television advertisements

Scope of Appointment

- When conducting marketing activities, a plan representative **may not market** any health care related product during a marketing appointment **beyond the scope that the beneficiary agreed to.**
- The plan representative must document the scope of the agreement before the appointment.
- If a beneficiary requests to discuss other products, the plan representative **must document a second scope of appointment** for the additional product type to continue the marketing appointment.
- The documentation may be in writing, in the form of a signed agreement by the beneficiary, or a recorded oral agreement.

Scope of Appointment

48-Hour Rule

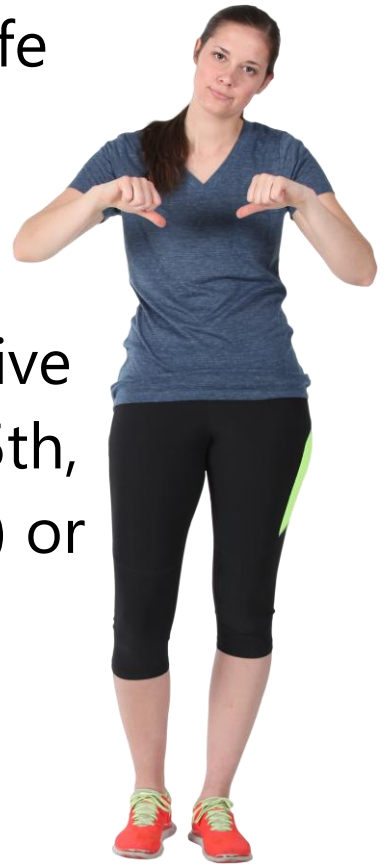
Agents must obtain a signed Scope of Appointment form 48 hours **prior** to the appointment with the beneficiary

Exceptions:

- Beneficiary is within four days of the end of an election period
- Unscheduled in-person visits initiated by the beneficiary

Personal/Individual Marketing Appointments-Don'ts

- **The Plan representatives may not do the following:**
  - Discuss plan options that were NOT agreed to by the beneficiary.
  - Market non-health care related products, such as annuities or life insurance.
  - Ask a beneficiary for referrals.
  - Solicit/accept an enrollment application for a January 1st effective date prior to the start of the Annual Election Period, October 15th, unless the beneficiary is entitled to Special Election Period (SEP) or within their initial enrollment period.



Individual Sales Appointments – Do's

- Comply with Medicare marketing guidelines.
- Submit talking points and presentation to CMS prior to use.
- Complete and execute a Scope of Appointment prior to presenting the product.

Educational Events

Educational events are designed to **inform beneficiaries** about Medicare Advantage, Prescription Drug, or other Medicare programs

- Must be advertised as educational and hosted in a public venue by the Plan/Part D sponsor or an outside entity.
- May include communication activities and distribution of communication materials.
- May answer beneficiary-initiated questions.
- May set up a future marketing appointment and distribute business cards and contact information for beneficiaries to initiate contact.
- **Must not include** marketing or sales activities or distribution of marketing materials or enrollment forms – no materials or discussion about plan specific premiums or benefits.
- **Meals, snacks, or refreshments** may be provided at educational events.

Promotional Activities and Nominal Gifts

Promotional activities and nominal gifts are designed to attract the attention of prospective enrollees and encourage retention of current enrollees

- Must be offered to all people regardless of enrollment and without discrimination.
- Must have only nominal value of no more than $15 and have an aggregate cap of $75 per year.
- Must not be in the form of cash or other monetary rebates, even if their worth is $15 or less.
  - Cash gifts include charitable contributions made on behalf of potential enrollees, and those gift certificates and gift cards that can be readily converted to cash, regardless of dollar amount.
- Must not be in the form of meals at marketing events.
  - Snacks and light refreshments are permitted. Snacks cannot be bundled to create a “meal”. Meals are permitted at educational events.

Cross-Selling

- **Cross-selling** is defined as marketing non-health related products, such as life insurance and annuities, during a marketing event.
- It is also considered cross-selling to include enrollment applications for competing health-care related products:
  - MA-PD or MA plans
  - Medigap products
  - Other non-Medicare health plans, in mailings that combine Medicare plan information with other product information.
- **CMS strictly prohibits cross-selling.**

Plan Representatives – Do's

Plan representatives **may make unsolicited** direct contact with potential enrollees using the following methods:

- Conventional mail and other print media (e.g., advertisements, direct mail).
- Email provided all emails contain an opt-out function.

Unsolicited Contact-Don'ts

Plan representatives may not:

- Use door-to-door solicitation, including leaving information such as a leaflet or flyer at a residence.
- Approach potential enrollees in common areas (e.g., parking lots, hallways, lobbies, sidewalks, etc).
- Use telephonic solicitation, including leaving electronic voicemail messages.
- Send direct messages from social media platforms.

Note: when agents/brokers pre-schedule appointments with a potential enrollee and are a "no-show" they **may leave information** at potential enrollee's residence. If a potential enrollee provides permission to be contacted, the contact must be event-specific, and not treated as open-ended permission for future contacts.

Prohibited Telephonic Activities

Plan Representatives may not conduct telephonic activities that include, but are not limited to, the following:

- Unsolicited calls about other business as a means of generating leads for Medicare plans.
- Calls based on referrals.
  - If an individual would like to refer a friend or relative to an agent or Plan/Part D sponsor, the agent or Plan/Part D sponsor may provide contact information such as a business card that the individual could provide to a friend or relative.
- Calls to market plans or products to former enrollees who have disenrolled, or to current enrollees who are in the process of voluntarily disenrolling.
- Calls to beneficiaries who attended a sales event, unless the beneficiary gave express permission at the event for a follow-up call (there must be documentation of permission to be contacted).
- Calls to prospective enrollees to confirm receipt of mailed information.

Referrals and Soliciting Leads

The following guidelines apply to referral programs under which a plan sponsor solicits leads from new members for new enrollees:

- A plan sponsor can ask for referrals from active members, including names and addresses, but cannot request phone numbers.
- Plan sponsors may use member provided referral names and mailing addresses to solicit potential new members by mail only.
- Any solicitation for leads, including letters sent from plan sponsors to members cannot announce that a gift will be offered for a referral.
- Plan sponsors may not use cash promotions as part of a referral program.
- Plan sponsors may offer thank you gifts provided that they’re each individually worth $15 or less.

Activities in the Community

Examples Include:

- Shopping center, public library, community center
- Parked MVP vehicle in an approved location

Agents May:

- Set up a table or kiosk and provide information.
- Serve meals, snacks, or refreshments.
- Leave plan communication material and Business Reply Cards (BRCs) and SOAs
- Provide giveaways with the plan name/number but no benefit information.
- Answer questions and obtain SOAs for future appointments.
- Include communication activities and distribute communication materials.
- Perform sales activities immediately following the event (beneficiary must be made aware of transition).

Section 9: Agent and Broker Compensation

Broker Compensation

Compensation Eligibility

- All compensation requirements contained in this section apply to independent agents/brokers.
- Agents/brokers employed by a Plan/Part D Sponsor are exempt from compensation requirements.
- Referral fees, however, apply to everyone.
- All other marketing and sales requirements must be met.

Compensation Eligibility

- Plans must ensure that all agents and brokers selling Medicare products are trained and tested annually on Medicare rules, regulations, and on details specific to the plan products that they sell.
- Training and testing must take place **prior** to the agent or broker selling the product.
- Agents and brokers must obtain a passing score of at least **85%** on the test.
- Agents and Brokers are not eligible for compensation unless they complete and pass the required training and testing.
- Plans may not pay compensation to agents and brokers not meeting licensure and appointment requirements or those that have been terminated for cause.

Definition of Compensation

- Compensation includes monetary or non-monetary remuneration of any kind relating to the sale or renewal of a policy including, but not limited to:
  - Commissions
  - Bonuses
  - Gifts
  - Prizes
  - Awards
  - Referral/finder's fees
- Annually, CMS releases its Fair Market Value (FMV) cut-offs for Agent/Broker compensation.
- These cut-offs are the maximum a plan can pay for initial and renewal compensation.

Broker Compensation

Compensation **does not include:**

- The payment of fees to comply with State appointment laws
- Training
- Certification
- Testing costs
- Reimbursement for mileage to, and from, appointments with beneficiaries
- Reimbursement for actual costs associated with beneficiary sales appointments such as venue rent, snacks, and materials

Compensation Types

Initial Compensation is paid for the beneficiary's first year of enrollment and when a beneficiary enrolls in an "unlike plan type," like from an MA-PD to a Cost plan, if the beneficiary is currently in a renewal year. Initial compensation may be paid at or below the fair market value (FMV) cut-off amounts published by CMS annually.

Renewal Compensation is paid following the initial year compensation, or when a beneficiary enrollees in a new, "like plan type." (MA-PD to MA-PD). A new "like plan type" may be a change from one plan to another plan within the same Parent Organization or between different Parent Organizations. Renewal compensation may be paid up to fifty (50) percent of the current FMV.

Referral/Finder's Fees are paid to all agents and brokers and may not exceed $100 ($25 for PDPs) for an agent or broker to recommend or enroll a beneficiary into a Plan/Part D Sponsor that meets beneficiaries' healthcare needs. Referral/finder's fees paid to all agents and brokers must be part of total compensation not to exceed FMV for that contract year.

“Like Plan Type”

The beneficiary remains enrolled in the same plan or enrolls in a new same type of plan.

Examples include:

- PDP replaced with another PDP.
- MA or MA-PD replaced with another MA or MA-PD.

“Unlike Plan Type”

The beneficiary enrolls in a new different type of plan.

Examples include:

- 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.

Guidance on Compensation Payments

- The compensation year is January 1st through December 31st, regardless of the month the beneficiary enrolls in their plan.
- Initial compensation is paid either the full amount, or is pro-rated, depending on the beneficiary enrollment date.
- Payment must be pro-rated for mid-year renewals.
- Recoupment of compensation must occur for the months a member is not in a plan.

Rapid Disenrollment

- Rapid disenrollment means the member disenrolled from the plan **within the first three months of enrollment.**
- Additionally, rapid disenrollment compensation recovery applies when a beneficiary **uses OEP to make an enrollment change.**
- Rapid disenrollment compensation recovery does not apply when a beneficiary enrolls in a plan effective October 1, November 1, or December 1, and uses the Annual Election Period to make changes to their current plan for an effective date of January 1 of the following year.
- If a beneficiary enrolls for October 1, November 1 or December 1 and disenrolls from the plan unrelated to the AEP, the Plan/Part D Sponsor should recover compensation based on the rapid disenrollment. Rapid disenrollment compensation recovery does not apply when CMS determines that recoupment is not in the best interests of the Medicare program.

Section 10: Marketing and Sale of an MA Plan

Pre-enrollment Requirements

- CMS requires that all agents and brokers who are selling Medicare Advantage plans discuss certain topics with beneficiaries **prior** to the enrollment.
- CMS has developed a list of items that agents and brokers are required to follow and discuss with beneficiaries.
- The upcoming slides provide the list of required topics agents and brokers must follow.

Pre-enrollment Requirements

- What kind of health plan does the beneficiary wish to enroll in?
  - Low premium and higher copay, or vice versa?
- Are the beneficiary's current providers (primary care and specialists) in-network?
- Is the beneficiary's current pharmacy in-network?
  - If not, explain that they will need to choose a new pharmacy.
- Are the beneficiary's prescriptions on the formulary?
  - If not, explain that they may have to pay the full price of the prescription.

Pre-enrollment Requirements

- Does the beneficiary require hearing, dental, and/or vision coverage?
- Does the beneficiary have any other healthcare needs, such as durable medical equipment or physical therapy?
- Is the beneficiary's preferred hospital in-network?
  - If not, explain that they will need to pick a new one.
- Are there other preferred facilities that need to be in-network?
- Does the beneficiary have any other specific healthcare needs?

Pre-enrollment Requirements

- Review premiums, including Part B premium, {insert dollar amount}
  - If applicable, review current premium vs. another plan premium.
- Review beneficiary cost sharing such as deductibles, copays, and coinsurances.
- Go over deductible cost, PCP copay, Specialist copay, inpatient hospital copay, and any other copays for services/items the beneficiary needs.
- Discuss the costs/limitations on dental, vision, and hearing.

Pre-enrollment Requirements

- Review coverage for out-of-network providers and services
  - (e.g., except in emergency or urgent situations, plan does not cover services by out-of-network providers (i.e., doctors who are not listed in the provider directory)).
- Review coverage outside the United States.
- Explain the potential effect that enrolling in this plan will have on other, current coverage, which may in some cases mean that the beneficiary is disenrolled from their current health coverage (e.g., another MA plan, Medigap).

Pre-enrollment Requirements

- Explain that the plan operates on a calendar year basis, so benefits may change on January 1 of the following year.
- Explain that the Evidence of Coverage provides all of the costs, benefits, and rules for the plan.
- Review how to file a complaint.
- Review needs to have Medicaid to qualify for a D-SNP.
- Inform beneficiary of their right to cancel this enrollment as well as the specific date on which cancellation may occur.

Test Your Knowledge

- Congratulations – you've completed MVP's 2026 Medicare Basics Training for Agents/Brokers.
- You must take the knowledge check and score an 85% or better to pass - you will be allowed multiple attempts to pass.
- You will receive a score upon completion of the exam. MVP Health Care will also receive a copy of your score upon your completion.