Tools for Compliant Selling

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Introduction

Welcome to the Tools for Compliant Selling course.

The overall goal of this course is to help you learn how to use the various tools and online systems available to our agents to assist you in quoting benefits accurately to a beneficiary. Clear communication with the beneficiary will aid you in selling in a compliant manner and help to avoid misunderstandings or agent allegations.

For this module, you will be required to achieve a score of 100% on the assessment to earn a passing grade. This module will be updated annually or as needed to reflect changes in consumer and sales trends.

You will be required to re-take this module, and possibly other modules if a complaint is received regarding your sales practices. Additional modules may be assigned as a method of re-training depending upon the nature of the inquiry, if one should be received at the plan.

Learning Objectives

- List the requirements for an agent to be considered qualified to sell on behalf of a plan sponsor
- Identify the resource to verify drug formulary status and how to use it
- List “best practices” of successful, compliant agents
- Identify how Medicare Supplement plans differ from Medicare Advantage plans

Understanding “Ready to Sell”

In order to sell our Medicare Advantage and Prescription Drug Plans, an agent must complete the necessary requirements to be considered qualified, or “ready to sell.”

What is needed to become “ready to sell” (RTS)?

- A current **license** in the state in which you plan to sell (resident and/or non-resident – as applicable)
- **Appointment** with the insurance carrier (in all markets) whose plans you intend to sell
- Successful completion of the carrier’s annual **certification** training program for Medicare Advantage and Prescription Drug Plans, including any required Product, Compliance or Fraud, Waste & Abuse training

Understanding “Ready to Sell” (cont.)

Agents must have an active “qualified/ready to sell” status in order to:

- Market our Medicare Advantage and Prescription Drug Plans
- Receive initial or renewal commissions on plans sold (remember, in order to receive commissions on any MA-PD products, you are required to complete the PDP training module in addition to the MA product training to be considered ready to sell)

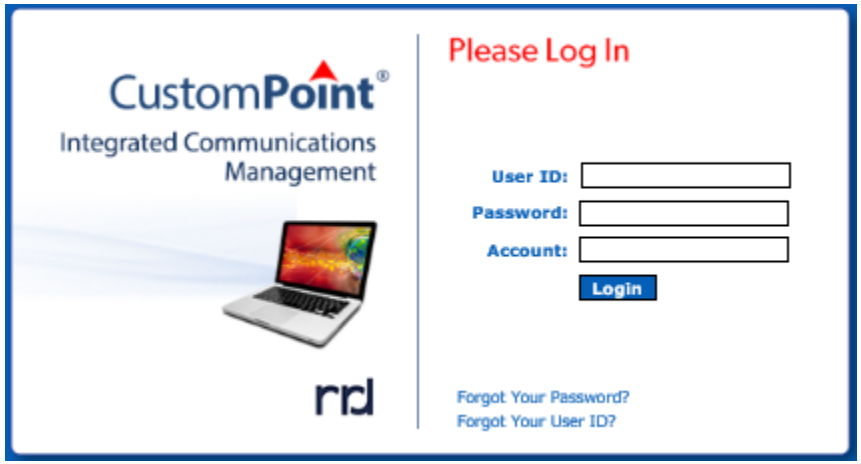
Plans sold before an agent has completed the necessary licensing, appointment and certification will not be eligible for commission payments.

The date on which the **last** of all the required elements has been completed will be the date the agent is considered ready to sell.

Sales and Marketing Materials

Once an agent is considered “ready to sell” by the carrier, access will be granted to the sales and marketing materials.

Only those Medicare Advantage and Prescription Drug plans in which the agent is ready to sell will be displayed. **Be sure to select the correct plan year when ordering materials.**



Summary of Benefits

The Summary of Benefits (SB) document is a very important piece of your presentation to the beneficiary.

It is your tool to answer coverage questions and provide beneficiaries with specific, accurate information. The typical Summary of Benefits may be set up in the following manner:

Introduction

- Plan name and where it is available
- Who is eligible
- Prescription drug information, including Rx Extra Help
- Contact information for Customer Service, Medicare and our web site

MA-only vs. MA-PD Plans

Medicare Advantage (MA) only plans do not include Part D prescription coverage.

For a beneficiary who enrolled in an MA-only plan during the Annual Election Period, the beneficiary **will not be able to enroll in a plan that offers prescription drug coverage until the following Annual Election Period.**

EXCEPTION: The beneficiary chooses to use their one-time election during the Open Enrollment Period or qualifies for a Special Election Period.

Formulary Tiers

On plans that cover Part D, covered drugs fall into particular categories, known as **formulary tiers**, to determine the member cost-share of prescriptions.

We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much the member pays for a drug.

If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made.

Formulary Finder

Verify current medications are covered under the plan's formulary, and if so, at what level or tier.

Different formulary tiers require different copayments or may be subject to deductible or even coinsurance. Member cost sharing amounts may differ depending upon eligibility for Low Income Subsidy.

Reminder: *Formularies may change from year to year, so it is important to confirm coverage and copayments each plan year.*

What should be on my “Best Practices” checklist?

- Follow required procedures, including Scope of Appointment, and maintain other documentation as required
- Be sure to schedule enough time for the appointment so the beneficiary does not feel rushed – you should allow ample time to explain the plans and answer any questions the beneficiary may have
- Explain your role as an agent, that you represent an insurance carrier or agency, not Medicare

What should be on my “Best Practices” checklist? (cont.)

Be familiar with the components of the marketing materials or “sales kit.”

The kit may contain the following items to assist you with your presentation during the appointment:

- Sales brochure
- Plan Star Ratings information
- Summary of Benefits
- Pre-Enrollment Checklist
- Enrollment application

Suggested Steps for the Plan Discussion

- Explain the differences between Medicare Supplement and Medicare Advantage plans – this is a common area of confusion
- Discussions regarding Medicare Supplement plans should be separate from any discussion regarding Medicare Advantage and/or Part D plans
- Explain the Late Enrollment Penalty for Part D if applicable

Suggested Steps for the Plan Discussion (cont.)

Be sure to cover the following:

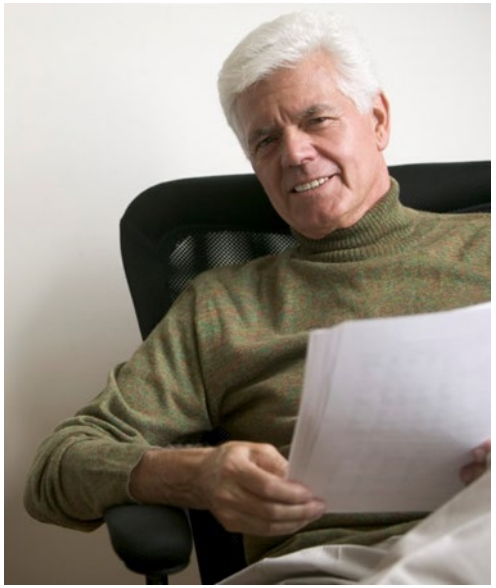
- Coverage for prescription drugs
- Service area
- Any network requirements; what happens if a provider is out-of-network
- Member rights and protections
- Contact numbers
- Premium/plan cost
- General benefit information, such as:
  - Inpatient/Outpatient Care
  - Preventive Services
  - Over-the-Counter (OTC) benefits
  - Optional Supplemental Benefits

Listen to your Customer

During your presentation, always pause along the way to ask if the beneficiary has questions, or ask “How does that sound?”

They may hesitate to stop you with a question. Watch for non-verbal clues that they may be getting upset or confused.

Be sure to offer assistance in completing the application form.



Working with Existing Members

When working with existing members, you may need to assist them in understanding the Annual Notice of Changes (ANOC) and Evidence of Coverage (EOC) booklet sent to them for review prior to the annual election period.

The ANOC will highlight changes to the plan, including premium, benefits, out of pocket costs or the plan's network. It gives a side-by-side view of each item for the current year and what it will be the next year if the member chooses to remain in the plan.

Be sure they know what their premium will be for the upcoming year and where they can find it.

A few notes about Medicare Supplement Plans…

Medicare Supplement

A common area of confusion are the differences between Medicare Supplement and Medicare Advantage plans.

Medicare Supplement (or Medigap) plans:

- Fill in the gaps of Original Medicare Plan coverage
- Are sold by private insurance companies and must be clearly labeled as “Medicare Supplement Insurance”
- Allow members to visit any Medicare-approved doctor, specialist or hospital with no referrals required
- Have all the rights and protections available under Original Medicare

Medicare Supplement (cont.)

- Members pay their monthly Medicare Part B premium and a separate premium for the Medicare Supplement plan
- Medicare Supplement insurance providers offer a choice of “standardized” plans in all states (except for Wisconsin, Minnesota, and Massachusetts)
- Standardized Plans of the same type (A, B, F, G, N, etc.) have the same benefits and every company must make Plan A available if they offer Medicare Supplement Plans

Medicare Supplement Changes as of 2020

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) made changes to Medigap plans effective in 2020. Specifically, for individuals newly eligible to Medicare, the Part B deductible cannot be covered.

Therefore, Plans C and F are no longer an option for **newly eligible** individuals starting January 1, 2020.

However, individuals who already have Plans C and F will be able to keep their current versions of the plans; and individuals eligible for Medicare prior to January 1, 2020 can purchase the current version of Plans C and F on or after January 1, 2020, if offered by the insurance company.

In non-standard states (like Wisconsin), this would impact availability of the Part B rider.

Medicare Supplement Eligibility

Applicants must:

- Have Medicare Parts A and B*
- Be a permanent resident of the state in which the application is taken

Please keep in mind:

- Enrollment into a Medicare Supplement plan will not cause an automatic disenrollment from a Medicare Advantage Plan and vice versa
- Applicants should be advised they will need to notify their current Medicare Advantage plan in writing of their intention to enroll into a Medicare Supplement plan and disenroll from their Medicare Advantage Plan (or vice versa) so they do not carry both plans at the same time

* Note: In Virginia, applicants can be eligible for Medicare Part A and/or Medicare Part B.

Medicare Supplement Enrollment

General Information

The Medigap open enrollment period lasts for six months and starts on the first day of the month in which the Medicare beneficiary is:

- Age 65 or older, and
- Enrolled in Medicare Part B

Individuals that do not enroll during the open enrollment period may be required to pass medical underwriting to enroll in a Medicare Supplement plan.

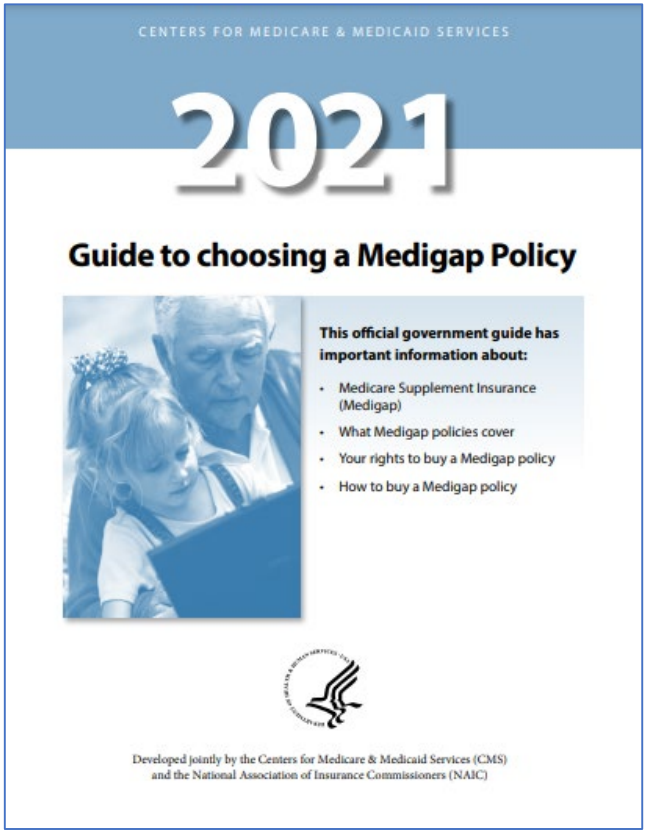
Individuals may have Medicare before age 65 due to a Medicare qualifying disability or End Stage Renal Disease (ESRD). Depending on state requirements, insurance companies may not be required to offer Medicare Supplement policies to beneficiaries under the age of 65. Please verify the Medicare Supplement rules for the state(s) in which you are licensed to sell.

Medicare Supplement Waiting Periods

Pre-Existing Waiting Periods may be enforced on Medicare Supplement plans if the beneficiary did not enroll at initial eligibility.

A pre-existing condition is a health problem that existed prior to the start date of a new insurance policy (whether actually seen for the health problem or should have been seen for it). The waiting period may be waived when enrolling immediately from another plan.

See the *"Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare"* publication from the Medicare.gov web site for more information.



What do I do when I have questions or issues?

If you have questions or concerns with the Medicare Advantage or Part D plan, **please contact the plan directly for assistance, including:**

- Sales support
- Sales director or regional sales manager

Also, be sure to take advantage of the guides in the Resources section of this certification site and the "Producer Online News."

Tools for Compliant Selling Assessment

An assessment will be given to test your knowledge on the information presented. A score of **100%** on the assessment is required to successfully pass this module. If a score of 100% is not obtained, the assessment can be attempted again immediately.

Please click the link to access the assessment.

After completing the assessment for this course, refer to your online training summary for your certification progress.

CLICK HERE FOR ASSESSMENT