



Medicare Beneficiary Sales Presentation and Enrollment

Broker Training

Module Description

This module is designed to review:

- The Sales Presentation Process
- Scope of Appointment
- How to Conduct a Sales Presentation
- Virtual Sales Presentation
- Medicare Beneficiary Enrollment
- Expectations After Submitting the Signed Application
- Broker Responsibilities



Sales Presentation Process

The sales presentation process can be broken down into four main steps:

1. Beneficiary initiates contact
2. Broker completes Scope of Appointment
3. Broker conducts sales presentation
4. Broker enrolls Medicare beneficiary and submits a signed application

Sales Presentation Process

It is necessary that Brokers follow all compliance measures when conducting a MAPD Sales Presentation. We have prepared a checklist to guide you through this process. As you meet with prospective members, it is important to cover each step.

The MAPD Sales Presentation Compliance Checklist can be obtained from the public website [Brokers](#) page under Medicare Flyers.

Health First Health Plans
Advent Health
Advantage Plans

MAPD Sales Presentation
Compliance Measures

SCOPE

- Obtain a scope-of-appointment prior to discussing any MA/MAPD products during 1:1 Sales Presentations

MATERIALS

- Use only current year approved materials
- Plan materials must contain the current CMS approval ID
- Provide an Enrollment Kit to each consumer
- Do not modify consumer materials in any way (e.g., add sticker or content, or business card, remove pages, write on)

PLAN PRESENTATION

- State your name, the plan sponsor you represent, the plan you are presenting, and provide your contact information and that you do not work for Medicare/CMS
- Conduct the CMS-approved plan presentation provided by the plan

CLEARLY STATE AND EXPLAIN:

- A Medicare Advantage plan is not a Medicare Supplement plan and describe the differences between them to ensure understanding
- Members must continue to pay their Part B premium
- Members must use their Member ID card when obtaining plan-covered services
- How other coverage might be affected if the consumer enrolls in the plan
- How to cancel or withdraw an enrollment application and dis-enroll from the plan
- For HMO plans, that in-network providers must be used to receive benefits except in emergencies
- For HMO-POS plans that use in-network providers, you will likely experience less costs than using out-of-network providers

FOR PLANS WITH PRESCRIPTION DRUG COVERAGE:

- Low-Income Subsidy or Extra Help
- Late enrollment penalty – explain what it is and process for attesting to creditable coverage
- Cost-sharing: Copayments, coinsurance, and pricing
- Formulary, drug tiers, quantity limits, step therapy, prior authorization, and where to find additional information
- Initial coverage, coverage gap, and catastrophic coverage
- Pharmacy network and preferred pharmacies and cost-sharing impacts – Show member where to locate formulary lists

REVIEW WITH THE BENEFICIARY:

- Enrollment election periods / OEP opportunity
- Enrollment eligibility requirements
- Appeals and grievance processes

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Sales Presentation Process

Step 1: Beneficiary Initiates Contact

In order for brokers to reach out and conduct a sales appointment with a Medicare beneficiary, it is a requirement that the beneficiary initiates the contact.

Brokers must receive from the Medicare beneficiary:

- An inbound call, or
- A written request, or
- An electronic request

Brokers may send out business reply cards or flyers to collect permission to contact. Ultimately, the beneficiary must initiate the communication. Examples of consent may begin with a business reply card response, inbound call inquiry or online form.

Scope of Appointment

Step 2: Broker Completes Scope of Appointment (SOA)

The Centers for Medicare & Medicaid Services (CMS) requires brokers to document the scope of a marketing appointment prior to any sales meeting to ensure understanding of what will be discussed between the broker and the Medicare beneficiary (or their authorized representative). Brokers may discuss only those products that were agreed upon in advance. **The SOA should be signed and gathered by the prospective member before the appointment.**

Only CMS-approved SOA forms can be used. Prospects must initial the product(s) they agree to discuss at the appointment, sign and return the SOA to the broker. An SOA is valid until used or until the end of the applicable election period. If a second meeting takes place, a new scope is required.

Scope of Appointment

How to Complete a Scope of Appointment (SOA)

Brokers may obtain an SOA form from the public website [Brokers](#) page.

- Log in to either myHFHP.org or myAHplan.com
- Select *Brokers* from the top navigation bar
- From the Forms section, locate “Scope of Appointment”
Note: You may also obtain and complete the SOA through the Medicare Enrollment Portal electronically

Medicare beneficiaries complete the top section of the SOA. Brokers complete all lines of the “To be completed by Agent” box. A completed SOA should be submitted with each enrollment application.

Health First Health Plans

Scope of Sales Appointment Confirmation Form

The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment prior to any face-to-face sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative.

Please initial below beside the type of product(s) you want the agent to discuss.

Stand-alone Medicare Prescription Drug Plans (Part D)
Medicare Prescription Drug Plan (PDP) — A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans.
Medicare Supplemental Health Insurance (Medigap Policy)
Medigap Policy — A Medicare supplement insurance policy sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage. Medigap policies help pay some of the health care costs that the Original Medicare Plan doesn't cover. Medigap policies sold after January 1, 2006, do not include prescription drug coverage.
Medicare Advantage Plans (Part C) and Cost Plans
Medicare Health Maintenance Organization (HMO) — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).
Medicare Preferred Provider Organization (PPO) Plan — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors and hospitals but you can also use out-of-network providers, usually at a higher cost.
Medicare Private Fee-For-Service (PFFS) Plan — A Medicare Advantage Plan in which you may go to any Medicare-approved doctor, hospital and provider that accepts the plan's payment, terms and conditions and agrees to treat you — not all providers will. If you join a PFFS Plan that has a network, you can see any of the network providers who have agreed to always treat plan members. You will usually pay more to see out-of-network providers.
Medicare Special Needs Plan (SNP) — A Medicare Advantage Plan that has a benefit package designed for people with special health care needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who reside in nursing homes, and people who have certain chronic medical conditions.
Medicare Medical Savings Account (MSA) Plan — MSA Plans combine a high deductible health plan with a bank account. The plan deposits money from Medicare into the account. You can use it to pay your medical expenses until your deductible is met.
Medicare Cost Plan — In a Medicare Cost Plan, you can go to providers both in and out of network. If you get services outside of the plan's network, your Medicare-covered services will be paid for under Original Medicare but you will be responsible for Medicare coinsurance and deductibles.

Health First Health Plans is an HMO plan with a Medicare contract. Enrollment in Health First Health Plans depends on contract renewal.
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Sales Presentation Process

Step 3: Broker Conducts Sales Presentation

During a sales presentation, the broker must:

- Review Medicare basics, parts A, B, C and D
- Review enrollment periods
- Review benefit comparison
- Review summary of benefits, formulary and directory
- Answer questions
- Complete enrollment, either electronically or via paper application

Sales presentations may be conducted:

- In person
- Virtually
- Telephonically

Virtual Sales Presentation

Telephonic or Virtual MAPD Sales Presentations Are Acceptable

Here are some steps to follow to help you stay compliant while conducting business virtually:

- 1. Get consent.** It is still a requirement that brokers receive consent from the Medicare beneficiary to conduct a sales call or proceed to a virtual sales presentation.
- 2. Collect a Scope of Appointment.**
- 3. Send a marketing kit.** Provide the Medicare beneficiary appropriate sales kit information ahead of time via email or postal service. This could include a benefit summary, star rating, formulary, etc. Give the beneficiary a chance to review prior to and be sure to reference during your virtual appointment.
- 4. Set an appointment.** When conducting a virtual or telephonic sales presentation, conduct as you would in person.
 - Warm up with the prospect
 - Provide full disclosure
 - Complete needs analysis, drug search and provider lookup
 - Provide a complete benefits review
 - Answer questions

IMPORTANT: When conducting virtual or telephonic MAPD Sales Presentations, all current CMS Medicare marketing guidelines must be followed. It is good practice to record your call, showing your presentation has included all compliance measures.

Does the Beneficiary Have Other Insurance?



If the Beneficiary currently has health coverage from an employer or union, joining a plan could:

- Affect their employer or union health benefits, including prescription drug coverage
- Cause loss of the employer or union coverage

Important: The Beneficiary should read the communications their employer or union sends. If they have questions, they should visit their website or contact the office listed in their communications. If there isn't any information on whom to contact, their benefits administrator or the office that answers questions about the coverage can help.

Medicare Beneficiary Enrollment

Step 4: Broker Enrolls Medicare Beneficiary and Submits a Signed Application

Health First Health Plans and AdventHealth Advantage Plans offer two options for submitting a Medicare application.

- **Electronic Enrollments**
Submitted through the Broker Portal
- **Paper Applications**
Fax to 833-582-2838 within 24 hours of signature

Expectations After Submitting the Signed Application

After submission by the Broker:

- Health First Health Plans submits all enrollment applications to CMS.
- If the prospective member is eligible, they are enrolled.
- The member's Evidence of Coverage (EOC) document, also known as their contract, is available upon request through customer service.

Within 10 calendar days, a member will receive:

- An acknowledgment letter showing their member number, plan name and effective date. This can be used as proof of coverage until he/she receives their ID card.

Within 15 calendar days, a member will receive:

- An enrollment verification letter. This letter verifies their enrollment request into our plan.
- A member ID card that will be used for all medical and prescription needs in place of the red, white and blue Medicare card.

Within 90 calendar days, a member will receive:

- A welcome call from the Member Engagement Department.

Premium Payment Options

Premium payment options for plans that require payment or late enrollment penalties:

Health First Health Plans (Classic, Value or LEPs):

- Monthly invoices
- Electronic funds transfer (EFT)
- Social Security withholding (**preferred option**)

AdventHealth Advantage Plans (LEPs)

- Monthly invoices
- Electronic funds transfer (EFT)
- Social Security withholding (**preferred option**)

Broker Responsibilities

DO's

- Follow Scope of Appointment guidelines.
- Use the authorized Health First Health Plans'/AdventHealth Advantage Plans' presentation – **Digital presentation will be emailed upon request.**
- Submit the completed enrollment form within 24 hours of beneficiary signing.
- Always use marketing materials that have been approved by Health First Health Plans, AdventHealth Advantage Plans and CMS. All marketing materials are required to be approved annually.

DON'Ts

- Don't promote non-healthcare-related products.
- Don't solicit/accept an enrollment request for a January 1 effective date prior to the start of the Annual Election Period (AEP) on October 15.
- Don't discuss plan options that were not agreed to in the SOA.

Consequences

Potential Consequences of Engaging in Inappropriate or Prohibited Marketing/Sales Activities:

- Disciplinary action
- Appointment termination
- Forfeiture of future compensation

Complaints received by members or prospective members in reference to a Broker with any aspect of the Health Plan's operations, activities or behavior are addressed via the Complaints Tracking Module (CTM).

For additional information, review the Broker Training Module: Broker Services Partner Integrity Program.

Helpful Contacts

Broker Services

321.434.5265

HFBroker@HF.org

Commissions

Commissions@HF.org

For plan year 2021 and prior questions

HF-brokercommissions@plusoscar.com

For plan year 2022 and beyond questions

Customer Service

Broker Support

Local: 321.434.4945

Toll Free: 877.693.6489

HFHPInfo@HF.org

HF-brokers@plusoscar.com

Thank You!