2009 Fall National Meeting
Washington, DC

Senior Issues (B) Task Force

Tuesday, September 22, 2009
3:30 – 5:30 p.m.
Gaylord Convention Center—National Harbor 2-3

ROLL CALL

Kevin McCarty, Chair	Florida	John Huff	Missouri
Sean Dilweg, Vice Chair	Wisconsin	Ann Frohman	Nebraska
Jim L. Ridling	Alabama	Scott Kipper	Nevada
Jay Bradford	Arkansas	James J. Wrynn	New York
Steve Poizner	California	Adam Hamm	North Dakota
Thomas R. Sullivan	Connecticut	Mary Jo Hudson	Ohio
Karen Weldin-Stewart	Delaware	Kim Holland	Oklahoma
J.P. Schmidt	Hawaii	Teresa Miller	Oregon
William W. Deal	Idaho	Joel Ario	Pennsylvania
Michael T. McRaith	Illinois	Ramón Cruz-Colón	Puerto Rico
Carol Cutter	Indiana	Merle D. Scheiber	South Dakota
Susan E. Voss	Iowa	Mike Geeslin	Texas
James J. Donelon	Louisiana	Kent Michie	Utah
Mila Kofman	Maine	Paulette Thabault	Vermont
Ralph S. Tyler, III	Maryland	Alfred W. Gross	Virginia
Glenn Wilson	Minnesota	Mike Kreidler	Washington
Mike Chaney	Mississippi	Jane L. Cline	West Virginia

AGENDA

1. **Discussion and Adoption of 2010 Charges** – *[Mary Beth Senkewicz (FL)]* [Attachment #1]

2. **Discussion of Charges 11 and 12 to Monitor and Maintain Record of Medicare Supplement New or Innovative Benefits** – *[Mary Beth Senkewicz (FL)]* [Attachment #2]

3. **Federal Issues Update** – *[Brian Webb (NAIC Staff)]*

4. **Long-Term Care Issues**

   a. **Report from Appendix E Subgroup on Revisions to the Long-Term Care Insurance Model Regulation** – *[Randy Moses (SD)]* [Attachment #3]

   b. **Update on Long-Term Care Partnership Program** – *[Hunter McKay (U.S. Department of Health and Human Services)]* [Attachment #4]

5. **Medicare Supplement Insurance Issues**

   a. **Implementation of Revisions to the Medigap Model Regulation** – *[Mary Beth Senkewicz (FL)]*

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1) **SERFF Update from Speed to Market Task Force –** *[Julie Fritz (NAIC Staff)]*

2) **Advance Marketing –** *[Mary Beth Senkewicz (FL)]*

3) **2010 Choosing a Medigap Policy Guide –** *[Mary Beth Senkewicz (FL)]*

b. **Report from Accident and Health Working Group –** *[Steve Ostlund (AL)*]

c. **Update from CMS on Medicare Supplement Issues** – *[Jay Dobbs (CMS)*]

6. **Medicare Private Plan Issues**

a. **Creation of NAIC-CMS Policy Group –** *[Mary Beth Senkewicz (FL)*]

b. **Update from CMS on Medicare Advantage Issues** – *[Deanna DiVenanzio (CMS)]*

1) **Update on Joint Collaboration on Outreach to Facility Directors** [Attachment #5]

2) **Other Items**

7. **Any Other Matters Brought Before the Committee**

SENIOR ISSUES (B) TASK FORCE

The mission of the Senior Issues (B) Task Force is to consider policy issues, develop appropriate regulatory standards and revise the NAIC models, consumer guides and training material, as necessary, on Medicare supplement insurance, senior counseling programs and other insurance issues which affect older Americans.

Ongoing Maintenance of NAIC Programs, Products and Services

1. Review model laws adopted in 2004 and recommend whether they be retained, revised or deleted. Report by 2009 Winter National Meeting; *Essential*

2. Continue to monitor and work with federal agencies to advance appropriate regulatory standards for Medicare Supplement and other forms of health insurance applicable to older Americans. Report quarterly; *Essential*

3. Review the Medicare Supplement Insurance Minimum Standards Model Act and Regulation to determine if amendments are required based on changes to federal law and revise if necessary. Report by 2009 Winter National Meeting; *Essential*

4. Monitor the Medicare Advantage and Medicare Part D marketplace, assist the states as necessary with regulatory issues, and maintain a dialogue and coordinate with CMS on regulatory issues, including solvency oversight of waived plans and agent misconduct. Report quarterly. *Essential*

5. Monitor and assist states in the implementation of changes to the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act to modernize the Medicare supplement market, as approved by the NAIC in March 2007 as required by the Medicare Improvement for Patients and Providers Act of 2008 and the Genetic Information Nondiscrimination Act of 2008. Report quarterly; *Essential*

6. Continue to monitor the changes in the Medicare Supplement insurance market and assist states with implementation of Medicare Supplement Model amendments due to federal statutory changes. Report quarterly; *Essential*

7. Provide the perspective of state insurance commissioners to the U.S. Congress, as appropriate, and the Centers for Medicare & Medicaid Services of the U.S. Department of Health and Human Services on insurance issues, including concerning the effect and result of federal activity on the senior citizen health insurance marketplace and regulatory scheme; *Essential*

8. Work with the Centers for Medicare & Medicaid Services to revise the annual joint publication, *Guide to Health Insurance for People with Medicare*; *Essential*

~~9. Amend the NAIC Long-Term Care Insurance Model Act and Regulation for independent external review for claim denials based upon failure to meet the ADL, cognitive impairment or medical necessity test. Report on progress quarterly and complete by December, 2009; *Essential*~~

~~10~~9. Monitor information on legislation impacting the funding of State Health Insurance Assistance Programs (SHIP). Report quarterly; *Important*

1~~1~~0. Assist the states and serve as clearinghouse for information on Medicare Advantage plan activity. Report quarterly; *Important*

1~~2~~1. In accordance with changes to the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act approved by the NAIC in March 2007, monitor and maintain a record of state approvals of all Medicare supplement insurance new or innovative benefits for use by regulators and others. *Important*

1~~3~~2. In accordance with changes to the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act approved by the NAIC in March 2007, periodically review state-approved new or innovative benefits and consider whether to recommend that they be made part of standard benefit plan designs in the model regulation. *Important*

1~~4~~3. Review preferred provider arrangements with Medicare supplement policies and determine their legality and their effect on Medicare supplement standardization. Take appropriate action, as necessary. *Important*

New or Innovative Benefits language:

Language from Medigap Model Regulation – Model 651

Section 9.1 Standard Medicare Supplement Benefit Plans for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery on or After June 1, 2010

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F. New or Innovative Benefits: An issuer may, with the prior approval of the [commissioner], offer policies or certificates with new or innovative benefits, in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits shall include only benefits that are appropriate to Medicare supplement insurance, are new or innovative, are not otherwise available, and are cost-effective. Approval of new or innovative benefits must not adversely impact the goal of Medicare supplement simplification. New or innovative benefits shall not include an outpatient prescription drug benefit. New or innovative benefits shall not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

Drafting Note: Recognizing the challenge in maintaining standardization while ensuring availability of new or innovative benefits, the drafters have included additional guidance to states in the NAIC Medicare Supplement Insurance Model Regulation Compliance Manual.. This guidance includes a recommendation that states consider making publicly available all approved new or innovative benefits, and requests states to report the approval of all new or innovative benefits to the NAIC Senior Issues Task Force, who will maintain a record of these benefits for use by regulators and others. The Senior Issues Task Force will periodically review state approved benefits and consider whether to recommend that they be made part of standard benefit plan designs in this regulation.

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Language from Medigap Compliance Manual:

SECTION II: ISSUES AND COMMENTS

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INNOVATIVE BENEFIT ISSUES

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Availability of new or innovative benefits in the marketplace

In order to maintain standardization and simplification in the Medicare supplement marketplace, States who approve new or innovative benefits should report each such approval to the NAIC Senior Issues (B) Task force. The NAIC Senior Issues (B) Task Force will maintain a record of all new or innovative benefits approved throughout the country. States and insurers will have access to these records in order to evaluate their possible use in their market. The Task Force will periodically review the new or innovative benefits approved in the states and will determine, in collaboration with CMS and other interested parties, whether any of the new or innovative benefits approved for use in the states should be made part of the standard benefit designs and benefit plan designs contained in the Medicare Supplement Model Regulation.

In addition, each state should consider publishing all the new or innovative benefits it has approved in order for the benefits to be available to all insurers in the marketplace. An expeditious review and approval process might be considered for those Medicare supplement carriers that wish to provide already approved new or innovative benefits and that certify the benefit they are filing for approval is exactly as a previously approved new or innovative benefit.

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LONG-TERM CARE INSURANCE MODEL REGULATION

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Section 15. Reporting Requirements

A. Every insurer shall maintain records for each agent of that agent's amount of replacement sales as a percent of the agent's total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a percent of the agent's total annual sales.

B. Every insurer shall report annually by June 30 the ten percent (10%) of its agents with the greatest percentages of lapses and replacements as measured by Subsection A above. (Appendix G)

C. Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely agent activities regarding the sale of long-term care insurance.

D. Every insurer shall report annually by June 30 the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year. (Appendix G)

E. Every insurer shall report annually by June 30 the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year. (Appendix G)

F. Every insurer shall report annually by June 30, for qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied. (Appendix E)

~~**Drafting Note:** The definition of claim denied used in this reporting form is for HIPAA reporting purposes only, and is not intended to be applied to any other regulatory issues, such as market conduct examinations.~~

G. For purposes of this section:

(1) "Policy" means only long-term care insurance;

(2) Subject to Paragraph (3), "claim" means a request for payment of benefits under an in force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met;

(3) "Denied" means the insurer refuses to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition; and

(4) "Report" means on a statewide basis.

H. Reports required under this section shall be filed with the commissioner.

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APPENDIX E

Claims Denial Reporting Form
Long-Term Care Insurance

For the State of ______________________
For the Reporting Year of ______________

Company Name:____ Due: June 30 annually
Company Address:____
____
Company NAIC Number:____
Contact Person: ________________________________Phone Number: _____________________

Line of Business: Individual Group

Instructions

The purpose of this form is to report all long-term care claim denials under in force long-term care insurance policies. Indicate the manner of reporting by checking one of the boxes below:

☐ **Per Claimant** – counts each individual who makes one or a series of claim requests.

☐ **Per Transaction** – counts each claim payment request.

"Denied" means a claim that is not paid for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition. It does not include a request for payment that is in excess of the applicable contractual limits.

Inforce Data

	State Data	**Nationwide Data**[1]
Total Number of Inforce Policies [Certificates] as of December 31st		

Claims & Denial Data

		State Data	**Nationwide Data**[1]
1	Total Number of Long-Term Care Claims Reported		
2	Total Number of Long-Term Care Claims Denied/Not Paid		
3	Number of Claims Not Paid due to Preexisting Condition Exclusion		
4	Number of Claims Not Paid due to Waiting (Elimination) Period Not Met		
5	Net Number of Long-Term Care Claims Denied for Reporting Purposes (Line 2 Minus Line 3 Minus Line 4)		
6	Percentage of Long-Term Care Claims Denied of Those Reported (Line 5 Divided By Line 1)		
7	Number of Long-Term Care Claim Denied due to:		

8	• Long-Term Care Services Not Covered under the Policy[2]		
9	• Provider/Facility Not Qualified under the Policy[3]		
10	• Benefit Eligibility Criteria Not Met[4]		
11	• Other		

1. The nationwide data may be viewed as a more representative and credible indicator where the data for claims reported and denied for your state are small in number.
2. Example—home health care claim filed under a nursing home only policy.
3. Example—a facility that does not meet the minimum level of care requirements or the licensing requirements as outlined in the policy.
4. Examples—a benefit trigger not met, certification by a licensed health care practitioner not provided, no plan of care.

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U.S. Department of Health and Human Services

Partnership
For Long Term Care

Implementation Status Report

National Association of Insurance Commissioners
Senior Issues (B) Task Force
September 22, 2009

Hunter McKay
Office of the Assistant Secretary
for Planning and Evaluation

Partnership Timeline

- **February 1, 2006:** Deficit Reduction Act of 2005
- **July 26, 2006:** HHS guidance to Medicaid Directors
- **September 2, 2008:** HHS Reciprocity Notice
- **December 18, 2008:** HHS Insurer Reporting Regulation
- **December 18, 2008:** HHS Policy Data Privacy Notice
- **August 1, 2009:** First Deadline: Registry Data:
- **November 1, 2009:** First Deadline: Claims Data

Implementation Status 9/09

- Partnership Policies for Sale (31): 77% 45-64 US pop
  - CA, CT, IN, NY
  - AL, AR, CO, FL, GA, ID, KS, KY, MD,
  - MN, MO, ND, NE, NJ, NV, OH, OK, OR, PA, RI, SC, SD, TN, TX, VA, WI, WY

- Approved State Plan Amendments (3): 3% 45-64 US pop
  - AZ, IA*, NH

- Pending State Plan Amendments (1): >1% 45-64 US pop
  - ME

  - Partnership policies available to <u>:80% 45-64 US pop</u>

Implementation Issues

- Group Partnership
  - No uniform approach for multi-state filings
- Tiered Inflation Protection
  - Filing turning up in a handful of states
  - Uneven state regulation and reception
  - New ASPE report on type of inflation protection and lapse **FPO policies more likely to lapse**
- Notice of Asset Protection
  - No uniform notice provisions in place
  - Opportunities for state and insurer coordination
- State level Partnership education/awareness

Reciprocity Status

- DRA States Participating (26):
  - AL, AR, CO, FL, GA, ID, KS, KY, MD,
  - MN, MO, ND, NE, NJ, NV, OH, OK, OR, PA, RI, SC, SD, TN, TX, VA,

- DRA Not Participating (1):
  - WI

- RWJF State Participating (2):
  - CT, IN

- RWJF States Not Participating (2):
  - NY, CA

Reporting Overview

- Registry File:
  - Snapshot of all PQ policies
  - Jan – June deadline: August 1
  - July – December deadline: February 1
- Claims File:
  - History of claims paid for PQ policies
  - Deadlines: Feb 1, May 1, Aug1, Nov1
- State Access:
  - Summary reports on web site
  - Individual records for identified state contact

Reporting Highlights

- **27** insurers submitted data
- **130,000** PQ policies
- **65%** PQ policies are new sales vs. exchanges.
- **65%** PQ policies in-force from FL, MN, VA, and WI
- **$252,000**: average lifetime maximum
- **$168**: average daily benefit amount
- **86%** of buyers under age 61 have 5% compound IP
-
- **$1,861** Average premium for all insureds

Reporting Issues

- Several insurers reported Partnership policies with inflation features not allowed by DRA
- Data quality process still developing
  - DQR process to assist states and insurers in making the data better
  - What to do when data errors are discovered
- Companies with closed blocks and very small numbers of Partnership policies
- Data for 2 RWJF states with Reciprocity

http://www.dehpg.net/LTCPartnership

Long Term Care Partnership Program

- Home
- What's New
- Background
- State Reciprocity
- Federal Documents
- Reporting Requirements
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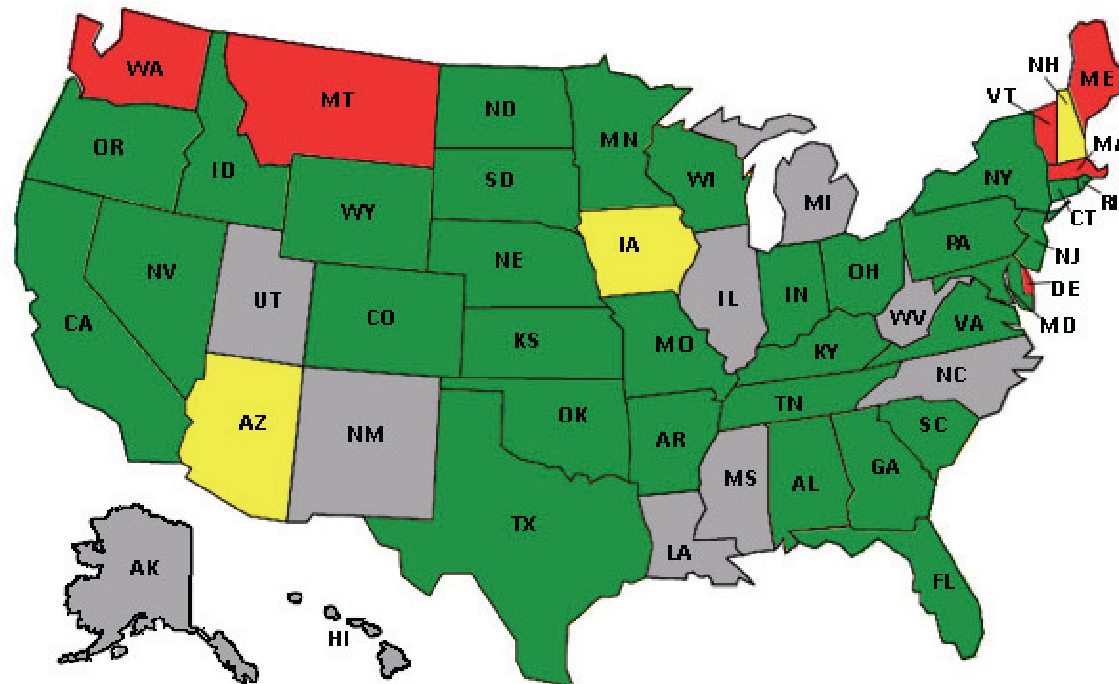
- Implementation Issues
- Reports

Long Term Care Partnership State Tracking Map

To see a list of available documents for a state, either choose a state from the dropdown list below and click on GO, or click directly on a state in the map below.

ALABAMA GO



Conclusion

- Total population of covered lives with Partnership policies continues to grow
  - DRA states: 130,000
  - RWJF states: 242,833
  - All state: 372,833
- Rapid implementation by states and insurers continues
- Maturing of program brings new issues

Long Term Care Partnership Data Reporting System

Registry File 1 – Initial Submission on 8-1-09

Initial Data Summary – all records U.S. (update 8-31-09)

OVERVIEW:

- Data received from 27 insurers with over 130,000 PQ policies.
- The three largest insurers account for 76% of all PQ policies in force. Eight insurers have between 1,000 and 5,000 PQ policies and the remaining carriers have < 1,000.
- Almost two-thirds (65%) of the PQ policies are new sales vs. exchanges.
- Based on state of issue, FL, MN, VA and WI lead with the largest number of PQ policies in-force, accounting for about 65% of the total.
- The NTO and lapse rates respectively are 1.3% and 1.0%. Given that nearly half of the PQ policies are derived from exchanges it makes sense that these numbers would be low.
- Less than 1% of policies starting the reporting period as PQ lost that status (mostly as a result of dropping inflation protection).
- Just over two-thirds are individual policies and the rest are group.

DEMOGRAPHICS:

- Over half (56%) of new sales are to females.
- Insureds under age 61 account for 66% of the PQ policies.
- The specific age breakdowns are as follows:
  - Under age 41 11%
  - Age 41-45 6%
  - Age 46-50 10%
  - Age 51-55 17%
  - Age 56-60 22%
  - Age 61-65 21%
  - Age 66-70 9%
  - Age 71-75 2%
  - Age 76+ 2%

COVERAGE FEATURES:

- Almost all policies are comprehensive with a single lifetime maximum design, expressed in dollars, not days.
- Only 3% and 2% of policies are facility only or home care only respectively.
- The average lifetime maximum is about $252,000, with the following specific breakdown:
  - $36,599 or less 1%
  - $36,600 - $73,099 2%
  - $73,100 - $109,599 6%
  - $109,600 - $146,099 6%
  - $146,100-$182,599 11%
  - $182,600 and above 64%
  - Unlimited 7%
- The average daily benefit amount for facility care is $168 with roughly equivalent amounts for other levels of care.

INFLATION PROTECTION:

- Almost all buyers under age 61 (86%) have 5% compound Inflation Protection (IP).
- The rest have either 3% compound (2%), some other compound percentage (2%) or a CPI-based IP, graded IP or some other compound percentage (8%).
- For buyers ages 61-75, just over half have 5% compound IP and one-third have 5% simple.
- Over age 76, close to 61% of insureds have no IP.

PREMIUMS:

- The average premium for all insureds is $1,861.
- For insureds under age 61, the average premium is $1,545.
- For those ages 61-75, the average is $2,444 and it is $2,898 for those ages 76 and over.
- The average premium distribution across all ages is as follows:
  - Under $500 13%
  - $500-$999 24%
  - $1,000-$1,499 13%
  - $1,500-$1,999 13%
  - $2,000-$2,499 10%
  - $2,500-$2,999 8%
  - $3,000-$3,499 6%
  - $3,500-$3,999 4%
  - Over $4,000 9%

Final Draft: Updated 07-31-09

To Facility Director:

The Centers for Medicare & Medicaid Services (CMS) and the ______Department of Insurance wanted to share with you some important information regarding the rights and protections of your Medicare and Medicaid residents, including those who are entitled to both programs ("dual eligibles".)

We are soliciting the assistance of facility directors who serve vulnerable Medicare beneficiaries in alerting us to instances of inappropriate and overly aggressive behavior by insurance agents selling Medicare Advantage and Prescription Drug Plans.

As you are aware, prescription drug coverage through the Medicare Prescription Drug Program began in 2006. This included a change in drug coverage for dual eligibles. All Medicare beneficiaries, including dual eligibles, can choose to enroll in a Medicare Prescription Drug Plan (PDP). PDPs are private insurance plans, offered as Medicare Part D, that have been approved by CMS as meeting all of CMS rules and requirements. Traditional Medicare coverage (Medicare Part A and Medicare Part B) does not change when a beneficiary enrolls in a PDP. Dual eligibles are also eligible to receive extra assistance from the government to help pay for premiums and copayments for their medications.

In addition to PDPs, Medicare beneficiaries also have the choice to obtain Medicare prescription drug coverage through Medicare Advantage plans with prescription drug coverage (MA-PDs), if they decide to enroll in such a plan. MA-PDs are private managed care plan options for beneficiaries that provide health benefits covered by traditional Medicare (Medicare Parts A & B), in addition to providing prescription drug coverage. However, some Medicare beneficiaries may be confused about MA-PDs. If a beneficiary currently has traditional Medicare and decides to enroll in an MA-PD, that beneficiary will no longer receive services through traditional Medicare. In addition, since MA-PDs are a private managed care option, the plan may have certain network restrictions and may limit the health care providers that the beneficiary can utilize.

Both PDPs and MA-PDs can be sold through insurance agents and brokers. While most insurance agents and brokers are honestly providing a valuable service to their clients, there have been troublesome reports of inappropriate and aggressive insurance agent and broker activity regarding enrollment of dual-eligibles into PDPs or MA-PDs. Unlike other Medicare beneficiaries, dual eligible individuals may switch PDPs or MA-PDs at any time during the year and are not limited to the set annual and open-enrollment periods established for the general Medicare-eligible population. This ability to switch plans year-round has caused some insurance agents to target the dual eligible population in order to gain commissions they may

generate by switching a dually-eligible individual from one plan to another. Unfortunately, CMS and the ____ DOI have become aware of incidents where certain agents have taken advantage of this situation, causing problems for vulnerable, dual-eligible individuals.

You and your residents should also be aware of a new federal law and existing state rules designed to protect individuals from inappropriate and illegal marketing practices. The Medicare Improvements for Patients and Providers Act (MIPPA) (Pub. L. 110-275), enacted in the fall of 2008, provides new protections for beneficiaries through increased oversight of such agent behavior. MIPPA provides very specific guidelines for marketing behavior, which include agent and broker activities. Because agents and brokers who sell PDPs and MA-PDs must be licensed by the states in which the agent or broker is doing business, State DOIs have the ability to take enforcement action against an agent or broker who is engaged in inappropriate marketing and sales activity. Together, MIPPA and state laws provide comprehensive rules for overseeing agent behavior.

CMS and ______ have been working together to ensure that PDP and MA-PD plans, along with their agents and brokers follow these rules by sharing information concerning the actions of the plans and agents. In addition, CMS instituted a comprehensive surveillance and enforcement strategy of these plans to ensure that they are in compliance with both federal and state rules. However, we know we cannot reach every beneficiary.

We need your help in monitoring for any inappropriate behavior of agents or plans. We also recognize that your residents would benefit from additional information from us. In return, we want to be a resource for you if you have concerns or specific agent complaints you would like to report. The CMS __ Regional Office may be contacted at _____. The (State) Department of Insurance may be contacted at _____. Please be assured that we take all complaints very seriously and can serve as a resource for your questions. As an additional resource, the (State) Health Insurance Assistance Program (SHIP) can provide unbiased information for you and your residents.

Because insurance agents are directly compensated by the plans they represent they generally do not offer eligible Medicare beneficiaries comprehensive benefit comparisons of all products that are available. The (State) SHIP can serve as resource in helping Medicare beneficiaries obtain the information needed in order to make an informed decision about their healthcare options. The SHIP can be reached at _________.

Enclosed are specifics of prohibited and inappropriate behavior of agents selling PDP or MA-PD products. We hope that you find this helpful. We have also included in this letter a document that we hope you will find helpful for your residents. Please feel free to post in common areas or use at your discretion.

Thank you for this opportunity to partner with you concerning this very important initiative.

CMS Signature State DOI Signature

Prohibited Agent Behavior

- Agents cannot state that they are from Medicare or use "Medicare" in a misleading manner. For example, an agent cannot state that they are endorsed by Medicare, are calling on behalf of Medicare, or Medicare asked them to call or see the beneficiary.
- Agents are prohibited from soliciting potential enrollees door-to-door.
- Agents are prohibited from sending unsolicited emails
- Agents may not conduct outbound marketing calls, unless the beneficiary requested the call or the beneficiary is an existing client. (Agents are allowed to call their existing clients to discuss new plan options.)
- Agents may not approach beneficiaries in common areas (i.e. parking lots, hallways, lobbies)
- Agents may not call or visit a beneficiary who attended a sales event, unless the beneficiary gave express permission.
- Agents may not market non-health related products (such as annuities and life insurance) to prospective enrollees during MA or PDP sales activities or presentations. This is considered cross-selling and is prohibited.
- Agents may not contact friends or family of clients under the premise that they had been "referred." Agents may leave cards behind for clients to provide to friend or family. The "referred" beneficiary has to contact the agent directly.
- Agents cannot offer gifts to potential enrollees of more than $15. The value is based on the retail purchase price of the product.
- Agents must clearly identify the types of products that will be discussed before marketing to a potential enrollee. They must initially meet with a beneficiary to discuss specific lines of business.
- Prior to any marketing appointment, the beneficiary must agree to the "scope of the appointment" and that the agreement must be documented. For example, if a beneficiary attends a sales presentation and schedules an appointment, the agent must obtain written documentation that is signed by the beneficiary agreeing to the products that will be discussed during the appointment.
    - Additional products may not be discussed unless the beneficiary requests the information.

  - In addition, any additional lines of plan business that are not identified prior to the in-home appointment will require a separate appointment.
  - Appointments may not be re-scheduled until 48 hours after the initial appointment.
- Agents may not make unsolicited contacts to beneficiaries under the guise of selling a non-MA or non-PDP product where the conversation turns to MA or PDP. For example, an agent may not begin by selling a Medicare Supplement plan and then turning the conversation to MA or PDP products.
- Agents may not conduct sales activities in healthcare settings except in common areas. Appropriate common areas include hospital or nursing home cafeterias, community or recreational rooms, and conference rooms. Agents are prohibited from conducting sales presentation and distributing or accepting enrollment applications in areas where patients primarily intend to receive health care services. Improper areas include waiting rooms, exam rooms, hospital patient rooms, dialysis centers and pharmacy counter areas.
- Agents are only permitted to schedule appointments with beneficiaries residing in long term care facilities upon request.
- Agents may not provide meals to potential enrollees at sales presentations.
- Agents may not engage in marketing or sales activities at an educational event.

Appropriate Agent Behavior

- Agents or brokers who enrolled a beneficiary in a plan may call that beneficiary while they are a member of that organization.
- Agents may call beneficiaries who have expressly given them permission for a plan or a sales agent to contact them, for example by filling out a business reply card or asking a Customer Service Representative (CSR) to have an agent call them. The permission applies only to the entity from whom the beneficiary requested contact, for the duration of that transaction, or as indicated by the beneficiary.
- Agents may initiate a phone call to confirm the appointment that has already been agreed to by a beneficiary, but may not change the scope of the appointment without appropriate documentation.
- Sales presentations to groups of beneficiaries do not require documentation of the beneficiary agreement because they are not personal/individual sales events.
- While agents are no longer permitted to provide meals, they may provide refreshments and light snacks to prospective enrollees at sales presentations.