Sales Agent Educational Guide

Sales Agents must:

- **Obtain a Scope of Appointment**
  - CMS requires sales agents to obtain a Scope of Appointment (SOA) prior to beginning a sales appointment in any format (e.g. telephonic, in-person, etc.). A compliant SOA includes the following: 1) product types to be discussed; 2) date of appointment; 3) beneficiary and sales agent contact information; 4) statement indicating the beneficiary is not obligated to enroll, current or future Medicare enrollment status will not be impacted, and the beneficiary will not be automatically enrolled.
  - Remember that you must obtain a new SOA if the beneficiary requests information about a different plan type than what you previously agreed to discuss.
  - Never cross sell any non-health related products during an appointment regarding Medicare Advantage or Prescription Drug Plans. If a beneficiary would like to discuss non-health related products, schedule an appointment at a later date/time to discuss.

- **Always conduct a NEADS Analysis** This will help you assess the beneficiary's coverage needs and only recommend plans that would be in the best interest of the beneficiary based on those needs.
  - A NEADS Analysis includes assessing the following:
    - **N**ow - What's your current coverage for health, RX, dental, and vision? What do you pay for each? Do you have coverage through an employer, VA, Tricare or ChampsVA?
    - **E**njoy - What do you enjoy about your current coverage? Any benefits, doctors, hospitals, cost, or other feature preferences?
    - **A**dd / **A**lter - What would you add or alter to have coverage you'd like even more? What are you hoping to gain by changing your coverage arrangement? Is anything more important to you – like medical vs Rx benefits? Any preference for plan types, like HMO or PPO? Is travel or living elsewhere at times part of your lifestyle?
    - **D**ecision - Will you make your own enrollment decision today?
    - **S**ummary – Provide a summary of the beneficiary's needs back to the beneficiary to ensure you have a complete understanding of what they are looking for.
  - If a beneficiary has medical and/or prescription drug coverage through other means outside of Medicare/Medicaid, such as an employer, VA, Tricare For Life, or ChampsVA, enrolling in a Medicare Advantage and/or Prescription Drug Plan (MA/MAPD) may alter that existing coverage. It is crucial that you determine whether a beneficiary has other medical and/or prescription drug coverage to determine if an MA, MAPD, or PDP plan is in their best interest.
  - Medicare Advantage may not be in the beneficiary's best interest if they also have TRICARE For Life (TFL) or CHAMPVA. You must ensure that beneficiaries consider and understand how their existing benefits would change if they enroll in a Medicare Advantage plan.

- **Only use a valid enrollment period that is based on the beneficiary's particular circumstances**
  - It is important that a valid election period is listed on a beneficiary's enrollment application and the beneficiary has the right eligibility to enroll to avoid their application being pended or denied by CMS.
  - Never coach, suggest, or lead beneficiaries into improperly using of a special enrollment period (SEP).
  - Always engage in conversation with the beneficiary to determine the proper election period to use and ensure the beneficiary is aware of its use.
  - If a beneficiary is unsure of their Medicaid or Low Income Subsidy (LIS) status, take the necessary steps to validate their level of eligibility. Do not enroll a beneficiary into a Dual Eligible Special Needs plan without confirming they have the right level of eligibility to enroll in the plan.

- **Fully inform the beneficiary about all plan benefits, limitations, and cost sharing**
  - Use only CMS approved Humana sales materials and call scripting.
  - Remember to review the Summary of Benefits in its entirely – don't skip or omit anything. Take your time and actively listen to the beneficiary's reactions to gauge if they understand. Ask if the beneficiary understands and/or has any questions several times as you review and discuss.
  - Don't use tactics that may confuse or mislead beneficiaries into choosing a plan that is not in their best interest. As a licensed sales agent, you are responsible for ensuring beneficiaries are enrolled in the right plan that fits their circumstances and needs.

- Keep in mind that Medicaid and (LIS) eligibility can change monthly. Changes in eligibility can affect a beneficiary's cost share. Be transparent and fully explain cost sharing details.
- Never use the term "free" to describe a $0 premium, reduction in premiums, deductibles, cost sharing, and/or low-income subsidy.
- Use only CMS approved Humana Sales Presentation materials and call scripting and ensure that the presentation is complete and compliant with CMS requirements and Humana guidance.
- Never suggest that a provider can "just ask" a plan to add a new medication to their formulary.

❖ **Provide clear, thorough, and accurate information regarding all Humana plans or products, including the network status of providers or pharmacies**

- Always use Humana and CarePlus approved sources to verify provider participation status, such as the Find a Doctor tool. Be aware that Humana and CarePlus have different provider networks and a provider may not be in both networks. Ensure you use the correct tool depending on which plan you are discussing.
- Remember to offer to look up all primary care physicians (PCP) and specialists to determine if they are in network with the beneficiary's plan of choice. If a beneficiary does not want to provide the names of any providers, clearly explain the importance of verifying provider network status. While beneficiaries are not required to provide the names of their providers, it is crucial they understand the consequences of selecting a plan that does not include their providers in network.
- Keep in mind that just because a facility or physicians group/practice is in network, it does not mean all providers within the facility or group/practice are in the network as well. Always check the network participation status of every individual PCP and specialist that the beneficiary mentions.
- Do not assign a specialist as a PCP. This will result in the beneficiary being assigned a random PCP in their area.
- Do not suggest or imply to a beneficiary that a provider may join a plan's network or that a beneficiary can ask a provider to join a plan's network.

❖ **Only enroll beneficiaries who appear to be competent and affirmatively agree to enroll**

- Be aware that you are responsible for ensuring beneficiaries have a full understanding of the implications of signing up for a plan. Actively listen to the beneficiary and look for signs of hesitation, confusion and/or lack of understanding.
- As part of your NEADS analysis, ask if the beneficiary makes their own healthcare decisions and/or has an authorized representative like a power of attorney (POA), guardian, or someone else who helps them make decisions. Be clear when asking this question and listen closely to the beneficiary's response. The beneficiary may say no or not clearly start they have a POA but listen for clues that they do. For example, a beneficiary may say their family member lives in another state but "takes care of everything for me" or say their family members "holds their Medicare card for them". Ask the beneficiary if there is someone they would like to have on the line with them or if they would like to call you back with that person on the call. Only continue with the sale if you are confident the beneficiary fully understands the implications of signing up for a plan and can make their own healthcare decisions.
- Required disclosures can be difficult to follow or understand. Read the disclosures slowly pausing to ensure the beneficiary understands and does not have any questions. If a recording is used to play disclosures, take the time to ask the beneficiary if they understood or have any questions.
- Agreeing to enroll in a plan is about more than providing a signature. Beneficiaries must fully understand the plan they are enrolling in and how it coordinates with any other coverage they may have.
- Always confirm and obtain the beneficiary's clear agreement to complete an enrollment. Clearly state the name of the new plan they are enrolling in and that this will change their current plan and/or coverage, as applicable.

❖ **Ensure that all information on the enrollment form is complete and accurate**

- Always review all the information you entered into the application with the beneficiary before you submit it.

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Please note the above is not exhaustive. For a complete list of all applicable CMS regulations, refer to 42 CFR § 422.2260 - § 422.2274, 42 CFR § 423.2260 - 42 CFR §423.2276, Chapter 2 of the Medicare Managed Care Manual, and Chapter 3 of the Medicare Prescription Drug Benefit Manual. In addition, please refer to Humana's Code of Ethics. Humana also has a wide range of training materials and job aids, available through Vantage at www.humana.com, to assist you in maintaining compliance with state and federal regulations and Humana policies regarding the sale of Humana products.

This information is provided to you by Humana's Agent Investigation Unit (AIU).