

# Agent and Broker Training & Testing Guidelines

## Introduction

Content for the Agent/Broker training guidelines is based on information from CMS' Medicare Managed Care Manual (MMC), CMS' Medicare Prescription Drug Benefit Manual (MPDBM), and regulations (i.e., Title 42 of the Code of Federal Regulations, Parts 417, 422, and 423).

Each year, CMS provides annually agent and Broker requirements for training and testing. Plans/Part D sponsors should use at a minimum the high-level Agent/Broker training and testing criteria below to develop individual training and testing for Agents and Brokers. Plans/Part D sponsors may organize their training at their discretion, provided the training meets the minimum requirements below. Plans/Part D sponsors (including 3<sup>rd</sup> party vendors, if applicable) are responsible for ensuring:

- All agents and brokers (including employed) that sell Medicare products are trained and tested annually on Medicare rules and regulations, and details specific to the plan products they are selling. This includes employees, subcontractors, downstream entities, and/or delegated entities.
- That training and testing procedures are put in place to ensure each individual is taking the test independently, maintaining the integrity of the training and testing program.
- That information on training and testing programs can be provided to CMS upon request. CMS may request information that includes, but is not limited to, training tools, training exams, policies and procedures, and documentation demonstrating evidence of completion.

When applicable, each of the items below must address Part C plans (including all types of plans), Part D plans, and 1876 Cost plans.

### 1. Medicare Basics

- a. Overview of Medicare
  - i. Medicare Parts and covered services
    - 1. Medicare Part A: Original Medicare - Hospital Insurance
    - 2. Medicare Part B: Original Medicare - Medical Insurance
    - 3. Medicare Part C: Medicare Advantage
    - 4. Medicare Part D: Prescription Drug Coverage – Stand-alone PDP and MA-PD
  - b. Eligibility requirements and applicable premiums
    - i. Original Medicare (Part A and Part B)
      - 1. General provisions (including eligibility requirements and applicable premiums)
    - ii. Part C
      - 1. General provisions (including eligibility requirements and applicable premiums)

- iii. Part D
  - 1. General provisions (including eligibility requirements and applicable premiums, such as but not limited to Cost-Sharing Subsidies for Low-Income Individuals)
- iv. Section 1876 Cost Plans
  - 1. General provisions (including eligibility requirements and applicable premiums)
- c. Description of Medigap
  - i. Medicare supplemental policies – general provisions
- d. Options for receiving Medicare
  - i. Original Medicare only
  - ii. Original Medicare + PDP
  - iii. MA-PD
  - iv. MA or Cost Plan without stand-alone PDP
  - v. Private Fee-for-Service MA or Cost Plan with stand-alone PDP
- e. A high level description for each of the Plan Types and Coverage listed below. The Plan/Part D sponsor should also provide information regarding the following topics (as applicable) for the products the agent/broker will be selling: types of plans (MA-PDP, DSNP, PDP, etc.), premiums, premium assistance (LIS), maximum out-of-pocket limits, cost sharing, coinsurance, provider/pharmacy networks, in-network vs out-of-network, Preferred and Standard cost sharing pharmacies, prior authorization, and benefit limitations.
  - i. Original Medicare (Part A and B)
    - 1. Benefits and beneficiary protections
    - 2. Individual enrollment and entitlement for supplementary medical insurance (SMI)
  - ii. Part C
    - 1. Description of coordinated care plans (e.g., HMO, PPO, RPPO, SNP)
    - 2. Description of Private Fee-for-Service Plans
    - 3. Benefits and beneficiary protections (beneficiary grievance and appeal rights)
    - 4. Network requirements
    - 5. Treatment plan
    - 6. Knowledge of how doctors are paid
    - 7. Description of Medicare Medical and Savings Accounts (MSA)
    - 8. Description of Maximum Out-of-Pocket (MOOP) Limits
  - iii. Part D
    - 1. Description of plan types (MA-PD, Prescription Drug Plan)
    - 2. Benefits and beneficiary protections (beneficiary grievance and appeal rights)
    - 3. Standard benefit
      - a. TrOOP, coverage gap, catastrophic coverage
      - b. Medicare Coverage Gap Discount Program

- 4. Pharmacy Networks
      - a. In-network versus out-of-network coverage
      - b. Preferred and standard cost-sharing for network pharmacies
    - iv. Other Plan Types
      - 1. Employer Group Plans
      - 2. Medicare Cost Plans
      - 3. Optional: Programs of All-Inclusive Care for the Elderly (PACE)
- 2. **Enrollment and Disenrollment (Part C, Part D, and Section 1876 Cost Plans – where applicable)**
  - a. Enrollment Procedures
    - i. Format of enrollment requests (use of approved enrollment mechanisms)
    - ii. Appropriate use of short enrollment forms or model plan selection forms (Part C and D)
    - iii. Enrollment mechanism used to require beneficiary to acknowledge and consent to required key elements
  - b. Processing Enrollment Request
    - i. Enrollment effective dates
    - ii. Notifications
  - c. Non-discrimination requirements for enrollment
  - d. Enrollment periods and processing Part C and D enrollments
    - i. Clarify that there are very limited circumstances under which a beneficiary may make a mid-year change in enrollment
    - ii. Initial Coverage Election Period
    - iii. Annual Election Period (AEP)
    - iv. Initial Enrollment Period for Part D (IEP for Part D)
    - v. Open Enrollment Period for institutionalized individuals (OEPI)
    - vi. Special Election Periods (SEP)
      - 1. 5-Star Special Enrollment Period (SEP)
      - 2. Provide other examples of SEPs (e.g., moving to a different service area, change in dual eligibility, etc.)
      - 3. Medicare Advantage Disenrollment Period (MAPD)
    - vii. Section 1876 Cost Plan open enrollment
  - e. Disenrollment
    - i. Voluntary disenrollment
    - ii. Involuntary disenrollment-provide examples of when a member must be disenrolled (e.g., move out of service area, loss of dual eligibility, etc.)
- 3. **Marketing Requirements and Other Regulations (Part C, Part D, and Section 1876 Cost Plans – where applicable)**
  - a. Agent and Broker Responsibilities
    - i. HIPAA privacy
    - ii. Other responsibilities required by plan

- b. Marketing Overview
  - i. Description of marketing activities
  - ii. Provision of Star Ratings information, including instructions on how to access and use the information
  - iii. Information on how to access and use the Summary of Benefits, current Provider/Pharmacy Directory, Evidence of Coverage, and formulary, as applicable
- c. Standards for Marketing- Inappropriate/Prohibited Marketing Activities
  - i. Conducting health screenings
  - ii. Providing cash or monetary rebates
  - iii. Making unsolicited contact
- d. Potential Consequences of Engaging in Inappropriate or Prohibited Marketing Activities (Prohibited activities, include but are not limited to: conducting health screenings, providing cash or monetary rebates and making unsolicited contact)
  - i. Report requirements
  - ii. Disciplinary actions
  - iii. Termination
  - iv. Forfeiture of future compensation
- e. Sales Events
  - i. Definition of sales events (formal vs. informal)
  - ii. Appropriate promotion of sales events
  - iii. Examples of dos and don'ts, including but not limited to:
    - 1. Provision of refreshments, snacks, and meals
    - 2. Solicit enrollment applications prior to the start of the AEP
    - 3. Requiring information as a prerequisite for events (e.g., contact information)
  - iv. Notification requirements for sales events
- f. Personal/Individual Marketing Appointments
  - i. Scope of appointment
  - ii. Examples of dos and don'ts, including but not limited to:
    - 1. Discussion/marketing of non-health care products
    - 2. Solicitation of referrals
    - 3. Discuss products not agreed upon by the beneficiary
- g. Educational Events
  - i. Appropriate promotion of educational events
  - ii. Sponsorship, promotion
  - iii. Example of dos and don'ts, including but not limited to:
    - 1. Topics (Medicare, plan-specific premiums and/or benefits, etc.)
    - 2. Display and/or distribution of advertising, Summary of Benefits, Provider and Pharmacy Directory
    - 3. Sales activities
    - 4. Provision of refreshments, snacks, and meals

- h. Nominal Gifts
  - i. Examples of Dos and Don'ts, including but not limited to:
    1. Eligibility (e.g., all potential enrollees, regardless of enrollment in specific plan(s))
    2. Value (e.g., \$15 or less)
    3. Refreshments, snacks, and meals
    4. Cash, charitable contributions, and gift certificates/cards that can be readily converted to cash
  - i. Cross-selling – definition
    - i. Health care related products – definition and “dos and don'ts”
    - ii. Non-health care related products – definition and “dos and don'ts”
  - j. Unsolicited contact, outside of advertised sales or educational events or mailings
  - k. Referrals – solicitation of leads from members for new enrollees
    - i. Any solicitation for leads – all communication types (requirements and restrictions)
    - ii. Gifts for referrals (requirements and restrictions)
  - l. Marketing in Health Care Setting
    - i. Examples of dos and don'ts, including but not limited to:
      1. Conducting sales activities in common areas
      2. Conducting activities where patients get care
    - ii. Conducting activities in long term care facilities
  - m. Agent/Broker Compensation
    - i. Changes made by 42 CFR 422.2274 and 423.2274
      1. Effective date of change
      2. Compensation cycle
      3. Compensation amounts
      4. Referral/finder's Fees
    - ii. Definition of compensation
    - iii. Compensation types
    - iv. Regulations for employed agents
    - v. Guidance on compensation payments
      1. Compensation year is Jan. 1 through Dec. 31, regardless of beneficiary enrollee date
      2. Initial members are paid either a pro-rated amount or the full compensation
      3. Payment must be pro-rated for mid-year renewals
      4. Recoupment must occur for months a member is not in the plan

## Appendix: Associated References

Content	Reference(s)
Original Medicare Basics	42 CFR- Subpart B, General Provisions
Medicare Advantage Basics	42 CFR Part 422 <ul style="list-style-type: none"> <li>• Subpart A—General Provisions</li> <li>• Subpart B—Eligibility, Election, and Enrollment</li> <li>• Subpart C—Benefits and Beneficiary Protections</li> </ul> Medicare Managed Care Manual(MMCM) Ch. 1 & 2
Part D Basics	42 CFR Part 423 <ul style="list-style-type: none"> <li>• Subpart A—General Provisions</li> <li>• Subpart B—Eligibility and Enrollment</li> </ul> Medicare Prescription Drug Benefit Manual (PDBM) Ch. 1 & 3
1876 Cost Plans and Other Plan Types	42 CFR Part 422: Subpart A—General Provisions 42 CFR Part 423: Subpart A—General Provisions MMCM Ch. 1 & 2; PDBM Ch. 1 & 2
Extra Help	42 CFR Part 423 <ul style="list-style-type: none"> <li>• Subpart P—Premiums and Cost-sharing Subsidies for Low Income Individuals</li> <li>• Subpart S—Special Rules for States-Eligibility Determinations for Subsidies and General Payment Provisions</li> </ul> PDBM Ch. 13
Election Periods	42 CFR §422.62- Election of coverage under an MA plan 42 CFR §423.38- Enrollment periods MMCM Ch.2 Section 30; PDBM Ch. 3 Section 30
Enrollment and Disenrollment Process	42 CFR Part 422; Subpart B—Eligibility, Election, and Enrollment 42 CFR Part 423; Subpart B—Eligibility and Enrollment MMCM Ch.2; PDBM Ch. 3
Beneficiary Protections	42 CFR Part 422; Subpart C—Benefits and Beneficiary Protections MMCM Ch. 17f; PDBM Ch. 5
Part C Organizational Determinations and Appeals, Part D Coverage Determinations and Redeterminations, and Grievances	42 CFR Part 422; Subpart M—Grievances, Organization Determinations, and Appeals 42 CFR Part 423; Subpart M—Grievances, Coverage Determinations, Redeterminations, and Reconsiderations MMCM Ch. 13; PDBM Ch. 18
Overview of Marketing	42 CFR Part 422; Subpart V—Medicare Advantage Marketing Requirements 42 CFR Part 423; Subpart V—Marketing Requirements MMCM Ch. 3; PDBM Ch. 2
Overview of Marketing Materials Requirements	42 CFR §422.2260 - 422.2266 42 CFR §423.2260 - 423.2266 MMCM Ch. 3; PDBM Ch. 2

Content	Reference(s)
Agent/Broker Compensation	42 CFR §422.2274- Broker and agent requirements 42 CFR §423.2274- Broker and agent requirements MMCM Ch.3 Section 120.4; PDBM Ch. 2 Section 120.4
Marketing Event Requirements	42 CFR Part 422; Subpart V—Medicare Advantage Marketing Requirements 42 CFR Part 423; Subpart V—Marketing Requirements MMCM Ch. 3 Section 70; PDBM Ch. 2 Section 70
Marketing Event Type	42 CFR Part 422; Subpart V—Medicare Advantage Marketing Requirements 42 CFR Part 423; Subpart V—Marketing Requirements MMCM Ch. 3 Section 70.9-70.10; PDBM Ch. 2 Section 709-70.10

## Agent and Broker Training & Testing

### Sample Test

This section provides sample test questions illustrating some of the topics presented in the previous sections of the guidelines. These sample test questions are neither comprehensive of the topics that should be included in an Agent and Broker training, nor are they meant to serve as a template for testing. These questions are solely intended to provide illustrative examples of test questions that might be used to ensure Agents and Brokers have been properly trained and that they possess the necessary knowledge to accurately and appropriately help beneficiaries choose from their health care options.

#### Part I: Medicare Basics

- 1) If a beneficiary who is enrolled in an HMO tells you that she wants to see a specialist, you should tell her:
  - A. You will likely need a referral from your primary care physician (PCP) to see a specialist. If you see your specialist without this referral, the plan may not pay for your visit.
  - B. Call and make the appointment
  - C. You do not need to see a specialist
  - D. All of the above
  
- 2) True or False? Once a beneficiary is enrolled in an MA plan and has paid his plan-specific monthly premium, he no longer needs to pay his Part B premium.
  - A. True
  - B. False
  
- 3) Match the Medicare Part in the first column with the correct description in the second.

Medicare Part	Description
A. Part A	1. Physician services, outpatient hospital care, lab tests, mental health services, some preventative services, and medical equipment considered medically necessary to treat a disease or condition 2. Prescription Drug Benefit 3. Hospital inpatient care, some SNF care, and home health and hospice care 4. An option for beneficiaries to receive private health plan coverage in lieu of Original Medicare (i.e., Parts A and B) through MA Plans
B. Part B	
C. Part C	
D. Part D	

#### Part II: Enrollment and Disenrollment

- 4) Mrs. Doe will turn 65 at the end of March and signed up for an MA plan in January during her Initial Coverage Election Period (ICEP). When will her coverage begin?
  - A. On February 1
  - B. On March 1
  - C. On April 1
  - D. On May 1

- 5) Which of the following periods provide an opportunity for a beneficiary to move from Original Medicare to an MA plan?
- A. October 15 through December 7
  - B. January 1 through April 15
  - C. January 1 through February 14
  - D. The month when the beneficiary turns 65 years of age
  - E. All of the above
- 6) Which of the following conditions would qualify an MA plan member to switch plans during a Special Enrollment Period (SEP)? (more than one may be correct)
- A. The member recently moved into a nursing home
  - B. The member's plan was terminated
  - C. The member does not like his/her doctor
  - D. The member is not satisfied with the plan
  - E. The member has moved to another state
  - F. The member was recently admitted into the hospital
- 7) During a formal sales event held on October 5, an agent tells attendees, "You can enroll in Acme's Traditional Medicare Advantage HMO plan between October 15 and December 7, but the plan won't take effect until January 1. However, if you don't like the plan after you enroll, you have until March 1 to switch back to Original Medicare." Following the presentation, the agent assists a couple in filling out an enrollment form for Acme's Traditional HMO plan, and tells the couple that she will "hold on to it" until the October 15 enrollment date. Which of the following statements are true? (more than one may be true)
- A. The agent is not allowed to assist beneficiaries in completing their enrollment form
  - B. The presenter provided incorrect Annual Election Period (AEP) information
  - C. The agent is not allowed to accept an enrollment prior to October 15
  - D. The presenter provided incorrect Medicare Advantage Disenrollment Period (MADP) information

### **Part III: Beneficiary Protections**

- 8) Mrs. Doe has decided to file a grievance because she feels that she was treated with disrespect while communicating with a plan's customer services representative (CSR). What is the first step Mrs. Doe should take to file a grievance?
- A. File an appeal with the plan
  - B. File an appeal with an Administrative Law Judge
  - C. Contact the plan in writing or by telephone to file a grievance
  - D. Contact her lawyer

- 9) For **all** MA plans, an enrollee that chooses to join a PDP will be automatically disenrolled from his/her current plan.
- A. True
  - B. False
- 10) A plan may end an enrollee's membership if:
- A. The enrollee is away from the service area for more than 6 months
  - B. The enrollee does not stay continuously enrolled in Medicare Part A or Part B
  - C. The enrollee is no longer eligible for the plan's SNP category
  - D. All of the above

#### **Part IV: Marketing Regulations and Materials for Sales Agents/Brokers**

- 11) True or False: A state insurance department would like to investigate a sales agent that they suspect is violating Medicare marketing regulations. The plan does not need to allow the investigation because the agent is licensed and has followed the guidelines to date.
- A. True
  - B. False
- 12) Which of the following is NOT considered a plan sales agent?
- A. A marketing entity
  - B. An independent plan agent
  - C. A member of the plan who speaks highly of the plan
  - D. A plan broker
- 13) True or False: CMS requires plans to record the names of all attendees attending their plan-sponsored marketing/sales events.
- A. True
  - B. False
- 14) At a formal marketing event that occurred on December 1st, an agent provided information on the MA/MA-PD plans available from Acme Health Plan, and noted that compared to all other plans in the area, Acme has the largest network of doctors available and is also the most well liked. At the end of the presentation, the agent told the beneficiaries that if they do not sign up for coverage today, they will likely lose their opportunity to do so. Are these actions appropriate?
- A. Yes. The agent highlighted a key aspect of the plan as well as informed beneficiaries that they could miss their chance to enroll.
  - B. Partially. While the agent provided a great comparison of other plans networks, the beneficiaries could have felt pressured into enrolling.
  - C. Partially. The agent did not qualify their statement regarding the provider network but rightfully informed that beneficiaries the AEP deadline was approaching.
  - D. No. The agent made unsubstantiated absolute statements and also inappropriately pressured beneficiaries into enrolling.

## Part V: Agent/Broker Compensation

- 15) A beneficiary enrolled into Acme Health Plan in 2012 as an initial enrollment and has remained in the plan since. How much should Acme pay in CY2015 to the agent that facilitated the enrollment?
- A. 50% of CY2012 fair market value
  - B. 60% of CY2012 fair market value
  - C. Up to 50% of CY2015 fair market value
  - D. Up to 60% of CY2015 fair market value
- 16) A beneficiary enrolls into Acme Health Plan in November 2014 as an initial enrollment. Assuming the beneficiary remains enrolled in the plan in 2015, in what month does their first renewal cycle begin?
- A. December, 2014
  - B. January 2015
  - C. November 2015
  - D. December 2015
- 17) If a beneficiary makes a plan change to a plan offered by another organization, and the new organization doesn't use agent and brokers, what happens to the payment?
- A. The new organization would continue to make payments to the enrolling agent from the previous organization
  - B. The initial organization would continue to pay the enrolling agent for one full renewal cycle
  - C. The new organization would not make payments and the initial plan would have to recoup for the number of months the member was not in the plan.
  - D. None of the above

## Part VI: Medicare Marketing Activities

- 18) Mr. Smith, an agent with ACME Health Plan, is giving a sales presentation and wants to provide some food for his guests. What can Mr. Smith provide?
- A. A sit down meal offered in a separate room, before or after the promotional portion of the event
  - B. A buffet dinner
  - C. Snacks such as cheese and crackers
  - D. None of the above
- 19) In which of the following settings is a Scope of Appointment form NOT required to be collected?
- A. A formal marketing event that a beneficiary did not pre-register to attend
  - B. A one-on-one appointment occurring in the beneficiary's home
  - C. An unscheduled meeting with a beneficiary who arrives at an agent's office without an appointment and requests information
  - D. All of the above scenarios require a Scope of Appointment form be collected

Agent and Broker Training & Testing  
Sample Test: Answer Key

Question	Topic	Answer	Explanation
1	Medicare Basics	<b>A</b>	Because the beneficiary is enrolled in an HMO, she should work with her PCP prior to seeing a specialist (except in an emergency).
2	Medicare Basics	<b>B</b>	The answer is false. Beneficiaries are required to continue paying their Part B premium (unless they receive Extra Help) in addition to any plan-specific premium.
3	Medicare Basics		<p><b>Option A = 3.</b> Part A of Medicare covers hospital inpatient care, some SNF care, and home health and hospice care</p> <p><b>Option B = 1.</b> Part B of Medicare covers physician services, outpatient hospital care, lab tests, mental health services, some preventative services, and medical equipment considered medically necessary to treat a disease or condition</p> <p><b>Option C = 4.</b> Part C of Medicare provides an option for beneficiaries to receive private health plan coverage in lieu of Original Medicare</p> <p><b>Option D = 2.</b> Part D of Medicare provides prescription drug benefit</p>
4	Enrollment and Disenrollment	<b>B</b>	The ICEP coverage begins the first day of the month of entitlement to Medicare Part A and Part B, OR the first of the month following the month the enrollment request was made (if after entitlement has occurred).
5	Enrollment and Disenrollment	<b>A</b>	The Annual Election Period (AEP) for enrolling in an MA Plan is October 15 through December 7. Answer B is incorrect because there is no enrollment period during these dates. Answer C is the enrollment period for enrolling in an MADP, but this period only allows a beneficiary to change from an MA plan to Original Medicare (with/without a stand-alone PDP). Answer D is incorrect because the beneficiary is already enrolled in Original Medicare, so there is no Initial Coverage Election Period (ICEP) that is applicable.
6	Enrollment and Disenrollment	<b>A, B and E</b>	If an individual moves into, resides in, or moves out of a long-term care facility (such as a nursing home) he or she is eligible for a SEP. He/She would also be eligible for an SEP as a result of moving out of the plan's service area or if his/her current plan is terminated.

Question	Topic	Answer	Explanation
7	Enrollment and Disenrollment	<b>C and D</b>	Although agents may assist beneficiaries in completing their forms, an agent may not accept, collect, or take possession of completed enrollment forms before October 15 and may not encourage beneficiaries to mail the enrollment form to the plan prior to October 15. Further, although the agent provided the correct dates for the AEP (October 15 – December 7), she misstated the window for which a beneficiary may disenroll and revert back to Original Medicare. In 2015, the MADP is January 1 – February 14.
8	Beneficiary Protections	<b>C</b>	The first step in the process for filing a grievance is to contact the health plan by telephone or in writing. An appeal is intended to handle different circumstances involving coverage decisions or organizational determinations.
9	Beneficiary Protections	<b>B</b>	The statement is false. A person who is enrolled in an MSA or an MA-PFFS plan without drug coverage and is joining a PDP will not be automatically disenrolled from the MSA or MA-PFFS plan. To disenroll, the beneficiary must call 1-800-MEDICARE or submit a written disenrollment request to the plan. A person enrolled in any MA coordinated care plan (HMO, PPO), or an MA-PFFS plan that includes drug coverage, who is joining a PDP will be automatically disenrolled from their current plan upon enrolling in a PDP.
10	Beneficiary Protections	<b>D</b>	A plan may end an enrollee's membership for any of the reasons listed (involuntary disenrollment), so long as the enrollee is part of a plan for which the rule applies.
11	Marketing Regulations and Materials for Sales Agents/Brokers	<b>B</b>	The statement is false. Plans must comply with requests from state insurance departments or other state agencies investigating sales agents licensed by that agency.
12	Marketing Regulations and Materials for Sales Agents/Brokers	<b>C</b>	Plan sales agents include those employed by the plan itself and those who are contracted with the plan through direct or downstream contracts. They do not necessarily have to be an employee of the plan but they must be contracted with the plan.

Question	Topic	Answer	Explanation
13	Marketing Regulations and Materials for Sales Agents/Brokers	<b>B</b>	The statement is false. There is no such requirement. On the contrary, any sign-in or attendance sheet distributed during an event must clearly indicate that providing personal information is optional. Similarly, agents are prohibited from insisting that attendees provide additional information (or implying that they are required to provide information) as a requirement for attending an event. Agents are also prohibited from requiring attendees to pre-register.
14	Marketing Regulations and Materials for Sales Agents/Brokers	<b>D</b>	Plans may not use absolute superlatives (e.g., we are the best), unless they are substantiated with supporting data provided to CMS as part of the marketing review process or they are used in logos/taglines. Additionally, plans are prohibited from using “scare tactics” or pressuring beneficiaries into enrolling.
15	Agent/Broker Compensation	<b>C</b>	Renewal compensation should be paid up to 50% of the current fair market value (FMV), regardless of whether the member is new to the organization or not. The initial rate when the member first entered the plan will no longer be utilized to determine the renewal rate.
16	Agent/Broker Compensation	<b>B</b>	The compensation year is January through December. “Rolling years” are not permitted. In this example, the beneficiaries first initial year ends December 31, 2014 and their first renewal year would be January 1, 2015 through December 31, 2015.
17	Agent/Broker Compensation	<b>C</b>	When a switch happens across organizations, and the new organization doesn’t use agents and brokers, the new MA organization would not make payments. The initial plan would have to recoup for the number of months the member was not in the plan.
18	Medicare Marketing Activities	<b>C</b>	Meals (either provided or subsidized) are prohibited at marketing events where plan-specific benefits are discussed and plan materials are distributed.  Refreshments and light snacks are permitted, however agents and brokers should use their best judgment on the appropriateness of food products provided and should ensure that items provided could not be reasonably considered a meal and/or that multiple items are not being “bundled” and provided as if a meal.

Question	Topic	Answer	Explanation
19	Medicare Marketing Activities	<b>A</b>	<p>Regardless if an agent or broker requests that beneficiaries pre-register for a public marketing event, collection of a Scope of Appointment would not be appropriate in this setting.</p> <p>Collection of a Scope of Appointment form is required in all personal or individual, face-to-face marketing appointments where MA, MA-PD, PDP and Cost Plan products are to be discussed with Medicare beneficiaries including walk-ins and for unexpected beneficiaries who wishes to attend a pre-scheduled, one-on-one meeting with another beneficiary</p>