

Medicare Sales and Marketing Do's and Don'ts Guide

Calendar Year 2025



The Centers for Medicare and Medicaid Services (CMS) holds the Plan Sponsor/Carrier responsible for the actions of all agents representing them. It is important to know these regulations and guidelines and to understand how they govern all business and conduct.

This document is an overview of the CMS MA Communication requirements as well as Cigna Healthcare's policies. It highlights specific areas of the CFR related to agent oversight. It is not all-inclusive, we recommend referring to this document and the CFR to remain compliant.

Please remember, failure to follow CMS guidelines and Cigna Healthcare policies may result in an agent being referred to the Sales Development Action Program (SDAP) team where remediation may include counseling, training and/or termination.





Table of Contents



Click below to jump to a section.

3	Activities with Healthcare Providers or in the Healthcare Setting	14	Prohibited Terminology
6	General Communication/Marketing Requirements	16	Unsolicited Contact
7	Star Ratings State Licensure and Appointments Laws: Agents/Brokers	19	Websites and Social Media
8	Training and Testing Agents/ Brokers Open Enrollment Period (OEP)	21	Third-Party Marketing Organization (TPMO)
9	Educational Events	25	Related Laws, Regulations and Links Resources
10	Marketing/Sales Events		



Activities with Healthcare Providers or in the Healthcare Setting

**CFR §422.2266. Cigna Healthcare Policy: MCARE-MCMG-01-012.
Marketing with Health Care Providers and in Health Care Settings.**

CMS distinguishes between provider-initiated activities and plan-initiated activities in healthcare settings to maintain safeguards while not impeding the provider/patient relationship.

Provider-initiated activities

Provider-initiated activities are those conducted by a healthcare professional, at the request of the patient. Or, as a matter of a course of treatment when meeting with the patient as part of the professional relationship between healthcare provider and patient. Provider-initiated activities do not include those conducted at the request of the Carrier or pursuant to network participation agreement between Carrier and provider. Provider-initiated activities fall outside of the CMS definition of marketing and, therefore, not subject to the regulation.

Plan-initiated activities

Plan-initiated activities are defined by CMS as activities where either the Carrier requests contracted providers to perform a task, or provider is acting on behalf of the Carrier.

MA organization activities in the health care setting

MA organization activities in the health care setting are those activities, including marketing activities that are conducted by MA organization staff or on behalf of the MA organization, or by any downstream entity, but not by a provider.

- Carrier requests for providers to discuss benefits and cost sharing fall under marketing definition and are PROHIBITED from taking place where care is being delivered. Contracted providers MUST remain neutral when assisting with enrollment decisions; but MAY engage in discussions w/beneficiaries should a beneficiary seek advice.
- Provider agreements held w/ Cigna Healthcare MUST ensure compliance; agreements MUST address marketing activity consistent with Medicare regulations. Providers/ facilities are PERMITTED to make available and/or distribute plan-marketing materials as long as the provider/facility distributes or makes available marketing materials for all plans with which they participate – CMS does not expect providers to proactively contact all participating plans.



Permissible provider-initiated activities include

- Distributing unaltered, printed materials created by CMS, such as reports from Medicare Plan Finder, the “Medicare and You” handbook, or “Medicare Options Compare” (from <https://www.medicare.gov>), including in areas where care is delivered.
- Providing the names of MA organizations with which they contract or participate or both, as long as any provider affiliation announcements sent by the provider **DO NOT** include marketing content.
- Answering questions or discussing the merits of a MA plan or plans, including cost sharing and benefit information, including in areas where care is delivered.
- Referring patients to other sources of information, such as State Health Insurance Assistance Program (SHIP) representatives, plan marketing representatives, State Medicaid Office, local Social Security Offices, CMS' website at <https://www.medicare.gov>, or 1-800-MEDICARE.
- Referring patients to MA plan marketing materials available in common areas.
- Providing information and assistance in applying for LIS.
- Announcing new or continuing affiliations with MA organizations, once a contractual agreement is signed. Announcements may be made through any means of distribution.



Providers may not

- Accept or collect Scope of Appointment (SOA) forms.
- Accept Medicare enrollment applications.
- Make phone calls or direct, urge, or attempt to persuade their patients to enroll in a specific plan based on financial or any other interests of the provider.
- Mail marketing materials on behalf of the MA organization.
- Offer inducements to persuade patients to enroll in a particular MA plan or organization.
- Conduct health screenings as a marketing activity.
- Distribute marketing materials or enrollment forms in areas where care is being delivered.
- Accept compensation from the MA organization for any marketing or enrollment activities performed on behalf of the MA organization.

During plan initiated activities in a healthcare setting providers may

- Make available, distribute, and display communications materials, including in areas where care is being delivered.
- Provide or make available marketing materials and enrollment forms in common areas.



Common areas in healthcare setting include but not limited to

- Common entryways, vestibules, waiting rooms.
- Hospital or nursing home cafeterias.
- Community, recreational or conference rooms.
- Pharmacy counter area - space outside (approx. 20 ft.) of where one waits for services or interacts w/pharmacy provider and/or obtains medications.



Restricted areas in healthcare setting include but not limited to

- Exam rooms.
- Hospital patient rooms.
- Treatment areas where patients interact with provider or clinical team and receive treatment (including dialysis treatment facilities).
- Pharmacy counter areas (where patients interact with pharmacy providers/obtain medications).

Activities of Institutional Special Needs (I-SNPs) Serving Long-Term Care Facility Residents

- Depending on the context of a given situation, I-SNP contracted with a long term care facility can be viewed as both a provider and a plan.
- I-SNPs may use staff operating in a social worker capacity to provide information, including marketing materials (excluding enrollment forms), to residents of a long term care facility.
- Social workers of the I-SNP (whether employees, agents, or contracted providers) may not accept or collect a scope of appointment or enrollment form on behalf of the I-SNP.
- Unless the beneficiary or the beneficiary's authorized representative initiates additional contact with or by the plan, all other marketing and outreach activities in the beneficiary's room must follow the requirements for beneficiary contact under §422.2264.

All other activities with healthcare providers or in the healthcare setting must comply with section §§422.2266 of the CFR and the Medicare Communications and Marketing Guidelines.



General Communications Materials and Marketing Requirements

CFR §422.2262, §422.2263

Cigna Healthcare Policy: MCARE-MCMG-01-015 General Communications and Marketing Requirements and Restrictions

Carrier's are responsible for ensuring all marketing materials used by any agent selling their Medicare plans are consistent with the CFR and all other relevant guidance (MCMG).

Do

- **USE** only marketing materials and scripts previously reviewed and approved by Carrier(s)
- **COMPLY** w/your obligations under other anti-discrimination rules and requirements
- **BEGIN** marketing Medicare plans and marketing/sales events for upcoming plan year no sooner than Oct. 1 – this includes advertising for events scheduled in early October
- **BEGIN** soliciting/accepting enrollment applications for a Jan. 1 effective date no sooner than start of Annual Enrollment Period (AEP) -Oct. 15 -unless a beneficiary is entitled to another enrollment period
- **MARKET** current and prospective years starting Oct. 1, provided marketing materials clearly indicate plan year being discussed

Don't

- **SUBMIT** marketing materials directly to CMS yourself. Materials must be submitted to the HPMS Marketing Module by the Carrier. Materials that have been developed by a Third Party Marketing Organization (TPMO) for multiple Carriers, must receive prior approval by each Carrier prior to submission to CMS.
- **TARGET** beneficiaries from higher income areas or state or imply plans are available only to seniors rather than to all Medicare beneficiaries (referred to as cherry picking)
- **TARGET** potential enrollees based on health status, unless it is a special needs plan or comparable plan as determined by the HHS Secretary
- **MARKET** benefits in a service area where those benefits are not available unless unavoidable due to use of local or regional media



Star Ratings

CFR §422.2263

Do

- **PROVIDE** overall Star Ratings info from the standardized Star Ratings document; this **MUST** be included when the enrollment form is provided
Note: New Plans that have no Star Ratings are not required to provide until following contract year.
- **MAKE** it clear that rating is “X out of five (5) stars”
- **DIRECT** customers to <http://www.medicare.gov> for additional rating information.

Don't

- **DISPLAY** or release Star Rating info until CMS releases the Star Rating on Medicare Plan Finder (MPF) – issued in Oct. of each year.
- **ENCOURAGE** enrollment based on argument that if enrollee is dissatisfied with a plan, s/he can later request an SEP and change to a higher-rated plan.
- **ATTEMPT** to discredit or refute a Low Performing Icon (LPI) assigned by CMS by only showcasing a higher overall Star Rating.
- **USE** an individual underlying category or measure to imply higher overall or summary Star Ratings.
- **MARKET** the 5-star SEP, after November 30 of each year if the contract has not received an overall 5 star for the next contract year.



State Licensure and Appointments Laws: Agents/ Brokers

CFR §422.2272

**Cigna Healthcare Policy:
MCARE-MCMG-01-005
Agent/Broker Training,
Testing, Onboarding and
Termination**

Agents **MUST** be licensed and
appointed (if applicable) per
State law to sell Medicare
products.



Training and Testing Agents/Brokers

CFR §422.2274

Agents/Brokers **MUST** complete Carrier training and testing prior to selling Medicare products to satisfy annual CMS certification requirements.

- **DO NOT** cheat, obtain, request help for any test; it is a violation of Code of Conduct and can result in corrective action, including, but not limited to loss of compensation and termination
- If you **DO NOT** obtain a passing score of 85% or better within three attempts of taking a test, you are locked out and unable to proceed with certification

Open Enrollment Period (OEP)

CFR §422.2263

OEP is an enrollment period when enrollees can switch from one MA Plan to another, or switch from an MA Plan to Original Medicare with or without a Part D plan. The MA OEP occurs each year from January 1 through March 31, and changes take effect on the first of the month following the month you enroll.

Do

- **SEND** marketing materials, have one-on-one meetings, and provide information on the OEP, at the beneficiaries request.
- **MARKET** to age-ins who have not yet made an enrollment decision, however materials should not include references to OEP.
- **MARKET** to dual-eligible and LIS beneficiaries who, in general, may make changes once per calendar quarter during the first nine months of the year.
- **INCLUDE** general information on website about enrollment periods, including the OEP, but **DO NOT** include marketing information.
- **MARKET** 5-star plans regarding their continuous enrollment.

Don't

- **TARGET** beneficiaries who made a choice during AEP; includes purchasing mailing lists or other means of identification.
- **SEND** unsolicited materials advertising opportunity/ability to make additional enrollment change or reference the OEP.
- **ENGAGE** or promote agent/broker activities with intent to target OEP as an opportunity to make further sales.

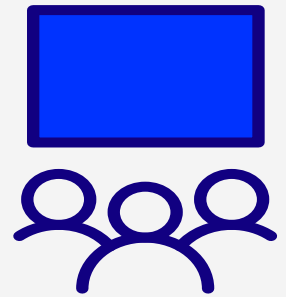


Educational Events

CFR §422.2264 (c)(1)

Do

- **KEEP** events free of materials w/plan-specific/benefit info, including premiums and copayments data
- **PROVIDE** promotional items, including those w/plan name, logo and toll-free customer service number and/or website
- Give-away items **MUST** be free of benefit information and consistent w/CMS definition of nominal gift requirements
- **PROVIDE** meals in accordance with Cigna Healthcare and CMS requirements
- **DISPLAY** a banner w/plan name and/or logo and Business Reply Cards (BRC)
- **ANSWER** beneficiary initiated questions; responses will not render event as marketing/sales, provided scope of your response does not go beyond question asked
- **EVENTS MAY** be hosted in a public venue by the Carrier or outside entity.
- **REPORT** all educational sales events to Cigna Healthcare according to policies and procedures, prior to advertising the event or 10 calendar days prior to event's scheduled date, whichever is earlier.



Don't

- **INCLUDE** marketing (do not steer, or attempt to steer potential enrollee towards specific plan or limited number of plans).
- **INCLUDE** sales activities, distribution of marketing materials, or distribution/collection of plan applications. This includes distribution of material with plan-specific information (i.e., premiums, co-payments, or contact information)
- **HOLD** Marketing/Sales events at the same location (e.g., entire building or adjacent buildings) within 12 hours of an educational event.
- **DEMONSTRATE** any bias toward one plan type over another or hold in-home or in one-on-one settings
- **ACCEPT** or have available Enrollment or SOA forms; includes collecting forms or helping beneficiaries complete one and placing it in an envelope for the beneficiary to mail later
- **SOLICIT** beneficiaries for individual appointments during an educational event;
- **YOU MAY NOT** schedule future appointments.



Marketing and Sales Events

CFR §422.2264



Definition: An event designed to steer, or attempt to steer, potential enrollees toward plan or limited set of plans.

Agents may discuss plan-specific information (i.e., premiums, cost sharing, benefits, etc.), distribute health plan brochures and enrollment materials, distribute/collect applications and perform enrollments.

Marketing of non-health care related products (i.e., annuities and life insurance) to beneficiaries during MA/MAPD/PDP/CSB marketing/sales events is cross selling and **PROHIBITED**.



There are three types of marketing/sales events:

- Informal
- Formal
- Retail Program Events

An informal presentation does not require completion of a training module.

A formal presentation is provided typically in audience/presenter style layout w/agent formally providing specific plan/product information.

- If only one person attends the marketing sales event, you can discuss MA/MAPD/PDP/CSB products.
- If attendee requests full presentation, you must do one. In this situation, SOA is not required as meeting falls under the marketing sales event already reported.



Marketing and Sales Events- continued

CFR §422.2264

Do

- **REPORT** all marketing/sales events to Cigna Healthcare according to policies and procedures, prior to advertising the event or 10 calendar days prior to event's scheduled date, whichever is earlier.
- **ANNOUNCE** all products/plan types to be covered during marketing/sales event at beginning of event (i.e., HMO, PPO, PDP, etc.).
- **USE** only CMS-approved, sales presentations and/or talking points during the event.
- If applicable, **YOU MUST** use CMS-approved sales presentations/talking points from beginning to end when discussing MA/MAPD/PDP products; read all sales presentation notes; if available, use MAPD/PDP sales presentation video, **MUST** use in conjunction with CMS-approved sales presentation.
- **YOU MAY** obtain signed SOA form at marketing/sales event for future personal appointment.
- **YOU MAY** provide light snacks and refreshments only.
- **YOU MAY** provide nominal gifts to attendees with no obligation; **MUST** be of nominal gift value – refer to “Nominal Gift” section for more info.
- **PROVIDE** attendees with an enrollment form including the current Star Ratings sheet; Summary of Benefits; and the Pre-Enrollment Checklist.
- **SAVE** documentation related to sales events, cancellations, revisions; documentation as this **MUST** be available upon request by CMS or any Carrier at least for 10 years.
- **MAY** provide marketing materials and distribute and accept plan applications.



Marketing and Sales Events- continued

CFR §422.2264

Don't

- **DO NOT** schedule or conduct a marketing event within 12 hours of an educational event at the same location.
- **DO NOT** solicit enrollment applications prior to start of AEP – Oct. 15 unless beneficiary is entitled to another enrollment period.
- **DO NOT** require beneficiaries to provide any contact information as prerequisite for attending formal/informal event; this includes requiring an email address or other contact info as a condition to RSVP for an event online or through the mail.
- **DO NOT** require SOA form to be filled out for beneficiary to attend marketing sales event.
- **DO NOT** use raffle or drawing contact information for any other purpose.
- **DO NOT** provide meals.
- **DO NOT** ask for referrals.
- **DO NOT** use absolute or qualified superlatives; see details listed under Prohibited Terminology/Statements heading.
- **DO NOT** claim you or any Carrier is recommended or endorsed by CMS, Medicare, or the Department of Health and Human Services.
- **DO NOT** require sign-in sheets or require attendees to provide contact information as a prerequisite for attending an event.
- **DO NOT** conduct activities, including health screenings, health surveys, or other activities that are used for or could be viewed as being used to target a subset of beneficiaries.



Cancellations and Changes of Marketing/Educational Sales Events

DO immediately report to Cigna Healthcare all cancellations/revisions to marketing/educational sales events **at least 48 hours prior to the event's originally scheduled date and time**, whenever possible.

Marketing/Educational Sales Events canceled **LESS** than 48 hours before originally scheduled date and time

- **MUST** notify venue, if applicable.
- **DO** have plan representative present on site at scheduled start time of canceled event to inform attendees of cancellation and distribute info about plan; the plan representative **MUST** remain at least 15 minutes (our standard) after the scheduled start time – follow Carrier's process unless advised otherwise.
- **DO** as a courtesy to anyone arriving after you leave, try posting signage stating that the event has been canceled (this includes cancellations for non-attendance); if appropriate, list alternate events; some venues may not permit a sign, check before posting one; confirm venue will remove.
- **NOT REQUIRED** to have representative present at an event site if the event is canceled due to inclement weather; the agent/broker or plan representative informs their local BSR/Field Sales Manager who then notifies Compliance via phone or email.

Marketing/Educational Sales Events canceled **MORE** than 48 hours before originally scheduled date and time

- **MUST** notify venue, if applicable.
- **DO** notify beneficiaries of canceled event using same means used to advertise event.
- A representative is **NOT** required to be present at event site when event canceled w/Carrier more than 48 hours before event's originally scheduled date/time.



Prohibited Terminology/ Statements

CFR §422.2262

CMS **PROHIBITS** distribution of communications/marketing materials that are materially inaccurate, misleading, or otherwise make material misrepresentations or could confuse beneficiaries

- **MAY** use term “Medicare-approved” to describe benefits and services within marketing materials- this is allowed but is not required.
- **MAY** state that the Plan/Part D sponsor is approved to participate in Medicare programs and/ or is contracted to administer Medicare benefits
- **MAY** use the term “free” in conjunction with mandatory, supplemental, and preventive benefits provided at a zero-dollar cost sharing for all enrollees.

Don't

- **DO NOT** use words, symbols, or state you or products mentioned are recommended or endorsed by CMS, Medicare, or Department of Health and Human Services (DHHS).
- **DO NOT** use absolute superlatives (i.e., “the best,” “highest ranked,” “rated number 1”) unless substantiated w/supporting data provided during CMS marketing review process.
- **DO NOT** state enrollees will not be disenrolled due to failure to pay premiums
- **DO NOT** use term “free” to describe zero-dollar premium, reduction in premiums (including Part B buy-down), reduction in deductibles or cost sharing, low-income subsidy (LIS), and cost sharing for those with dual eligibility.
- **DO NOT** intimidate, use high-pressure tactics (aggressive marketing behavior), or scare tactics to enroll beneficiary into a plan or to acquire an in-home appointment; if told they are not interested, end visit/conversation immediately.



Prohibited Terminology/ Statements- Continued

CFR §422.2262

Don't

- **DO NOT** state or imply plans are only available to seniors rather than to all Medicare beneficiaries.
- **DO NOT** imply that the plan operates as a supplement to Medicare or claim a relationship with the state Medicaid agency, unless a contract to coordinate Medicaid services for enrollees in that plan is in place.
- **DO NOT** state or imply a plan is available only to or is designed for beneficiaries who are dually eligible for Medicare and Medicaid unless it is a dual-eligible special needs plan or comparable plan as determined by the HHS Secretary.



Unsolicited Contact

CFR §422.2264

CMS has strict guidelines around contacting Medicare beneficiaries. In general, you **CAN'T** market through unsolicited direct contact (referred to as cold calling, including going door-to-door). Referred beneficiaries **MUST** contact you or the plan directly.

- **NO** marketing can be conducted prior to the start of AEP (Oct. 1) each year. This includes any contact with a prospective client to offer your services or schedule a meeting if it is targeted to the new plan year's benefit options.
- You **MUST** adhere to TCPA (Telephone Consumer Protection Act) restrictions on calls, texts and faxes, in addition to consent and do not call requirements.
- **NO** calls can be made between 9pm and 8am, local time of the patient, customer, plan member or provider. State laws may further restrict hours.
- Agents/brokers **MUST** follow FCC (Federal Communication Commission) rules and applicable State laws, Federal Trade Commission's Requirement for Sellers and Telemarketers, National/State Do-Not-Call Registry, "Do not call again" requests and Federal/State calling hours.

Electronic Communication (emails)

- **MAY** initiate contact via email to prospects and to retain enrollment of current enrollees.
- **MUST** provide opt-out process on each communication to no longer receive emails.
- **CANNOT** text message or use other forms of electronic direct messaging (e.g., social media platforms).
- **DO NOT** send emails on your own to prospects without referring to CAN- SPAM Act; these types of communications are highly regulated, require opt out features and many other federal requirements (see CAN-SPAM law).





Unsolicited Contact- continued

CFR §422.2264

Marketing Contacts

Do

- **DO** use conventional mail and other print media (i.e., advertisements, direct mail) to contact beneficiaries.
- **DO** use emails to contact beneficiaries provided all emails contain an opt-out function.
- **MAY** leave info at beneficiary's residence if pre-scheduled appointment at beneficiary's residence becomes a "no-show".
- **DO** provide contact information (ex: business card) when an individual wants to refer a friend/relative to you.

Don't

- **DO NOT** use telephone solicitation (that is, cold calling), robocalls, text messages, or voicemail messages.
- **DO NOT** leave info such as leaflet or flyer at a residence or on a car.
- **NO** door-to-door solicitation is permitted.
- **DO NOT** approach beneficiaries in common areas (i.e., parking lots, hallways, lobbies, sidewalks, etc.).
- **DO NOT** send direct messages from social media platforms.
- **DO NOT** call beneficiaries who attended a sales event unless the beneficiary gave express written permission to be contacted.

Telephonic Contacts

- **MAY** contact your own current enrollees to discuss plan business, but cannot market prior to Oct. 1 under the pretense of plan business.
- **MAY** call beneficiaries who submit enrollment applications to conduct business related to enrollment.
- **MAY** call your current enrollees, including those in non-Medicare products, to discuss plan business (ex: includes calls to enrollees aging-in to Medicare from commercial products offered by same organization, calls to organization's existing Medicaid/MMP enrollees to talk about its Medicare products, and calls to current MA enrollees promoting other Medicare plan types, or to discuss plan benefits).
- **MUST** follow Medicaid rules when discussing Medicaid.



Unsolicited Contact- continued

CFR §422.2264

Telephonic Contacts- continued

Do

- **DO** return phone calls or messages; not considered unsolicited contact.
- **DO** call individuals who gave permission for agent/plan to contact them (ex: filling out a BRC/ permission to contact form or asking a Customer Service Rep to have agent contact them); permission applies **ONLY** to entity from which the individual requested contact and for the duration and topic of that transaction.
- **MAY** call your current clients to discuss/inform them about general plan information (i.e., AEP dates, flu shot availability, upcoming plan changes, educational events and other important plan information).

Don't

- **DO NOT** make unsolicited calls to prospective enrollees.
- **DO NOT** use bait-and-switch strategies – making unsolicited calls about other business as a means of generating leads for Medicare plans.
- **DO NOT** place calls based on referrals – if an individual wants to refer someone, agent may provide contact information and the “referred” individual must contact the agent or plan.
- **DO NOT** call former customers who have disenrolled, or current customers in the process of voluntarily dis-enrolling for sales purposes, to market plans or products, or ask for consent in any format to further sales contacts.
- **DO NOT** call beneficiaries who attended a marketing/educational sales event, unless the beneficiary gave permission at the event for a follow-up call (completed Permission to Contact forms) or SOA form; documentation of permission must be saved and be reproducible.
- **DO NOT** call prospective enrollees to confirm receipt of mailed information.





Websites and Social/Electronic Media

CMS has many rules and regulations around website marketing; be sure you check with and obtain necessary approvals from the Carrier before you proceed.

- If you direct a beneficiary to call a phone number, you **MUST** clearly indicate that “calling the phone number will direct the individual to a licensed agent/broker” (when applicable).
- **MUST** ensure any sites used for the purpose of generating leads **MUST** also comply with Carrier and CMS requirements.
- **MUST** ensure if you purchase leads from any lead generation websites, those websites **MUST** comply with CMS requirements.
- **MUST** use required marketing disclaimers on websites containing information specific to Carrier MA, MAPD, PDP products.
- **MUST** have written approval from Carrier before using/creating a website listing their products and their name/brand/logo.



- **MUST** be a certified (licensed, appointed, trained) to sell the Carrier MA, MA- PD, and/or PDP plans described on your page; this does not apply to lead generation sites.



Websites and Social/Electronic Media-continued

- **MAY NOT** ask for any health information, including (but not limited to): pre-existing medical conditions, weight, whether beneficiary smokes, their age, etc.
- **MAY NOT** ask for any beneficiary identification numbers, including (but not limited to): Social Security, Health Insurance Claim Number (HICN), and Medicaid ID.
- **MAY NOT** ask for beneficiary financial details, including credit card numbers, income and resource limits, etc.
- **MAY NOT** require any information, other than a zip code, county, and/or state for access to non-beneficiary specific website content.
- **MAY NOT** ask for referrals from beneficiaries via your website or offer enrollment into Carrier MA/MAPD/PDP plans on your website.
- **MAY NOT** use the word “free” when referring to Medicare plan benefits.
- **MAY NOT** identify/refer to a Medicare Supplement plan as an MA/MAPD/PDP plan.
- **MAY NOT** use absolute and/or qualified superlatives when referring to Carrier plans (e.g., “the best,” “the lowest”/ “one of the best”).
- **MAY NOT** claim you or Carrier are recommended or endorsed by CMS, Medicare, or the Department of Health and Human Services.
- **MAY NOT** charge any fee for providing information about carrier MA/MAPD/ PDP plans.





Third Party Marketing Organization (TPMO)

As Cigna Healthcare’s TPMO, it is critical that you understand and support the requirements related to the chain of enrollment. You are also required to have oversight of any TPMOs that you contract with directly who support Cigna Healthcare lead generation, marketing, sales and enrollment.

A “**TPMO**” is defined as organizations and individuals, including independent agents and brokers, who are compensated to perform lead generation, marketing, sales, and enrollment related functions as a part of the chain of enrollment (the steps taken by a beneficiary from becoming aware of an MA plan or plans to making an enrollment decision). TPMOs may be a first tier, downstream or related entity (FDRs), as defined under [§ 422.2](#), but may also be entities that are not FDRs but provide services to an MA plan or an MA plan's FDR.

Sub-contracted TPMOs

As Cigna Healthcare’s TPMO, you are required to update contracts or other agreements with the TPMOs that you contract with directly to include all applicable requirements as outlined in §422.2267, §422.274, §423.2267 and §423.274.

TPMO’s contracted directly with Cigna Healthcare, as well as those contracted through a Cigna Healthcare FDR must adhere to all CMS, State Government and Cigna Healthcare requirements. This includes, but is not limited to, the following guidance:

Reporting to the Plan

As Cigna Healthcare’s TPMO, you are required to report the following to us.

Requirements	When to Report
Disclose any subcontracted relationships used for marketing, lead generation, and enrollment.	New TPMO relationships to be reported immediately upon entering into a contract.
Report staff disciplinary actions associated with beneficiary interaction to the plan.	Report monthly.
Report violations of any requirements that apply to MA plans associated with beneficiary interaction to the plan.	Report monthly.



Third Party Marketing Organization (TPMO)- continued

Sales Telephonic Recordings

TPMOs are required to record all marketing/sales and enrollment calls with beneficiaries **in their entirety**. The requirement to record calls between TPMOs and beneficiaries includes virtual connections such as Zoom and Facetime, however, only the audio portion only must be recorded.

Marketing/Communications Materials Disclaimers and Disclosures

CMS has issued a new disclaimer which reads:

"We do not offer every plan available in your area. Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. Please contact Medicare.gov, 1-800-MEDICARE, or your local State Health Insurance Program (SHIP) to get information on all of your options."

OR

If the TPMO sells for all MA organizations in the service area the disclaimer consists of the statement:

"Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. You can always contact Medicare.gov, 1-800-MEDICARE, or your local State Health Insurance Program (SHIP) for help with plan choices."

The new disclaimer must be:

- ✓ Included on all marketing materials
 - All materials that meet the definition of "marketing" including website, print, and television.
- ✓ Conveyed to a beneficiary during interactions
 - Any verbal, electronic or written interactions with a beneficiary, depending on how the TPMO is interacting with the beneficiary.

NOTE: If the TPMO is providing information to the customer verbally, the disclaimer must be stated within the first minute of the call.

CMS prohibits the use the Medicare name, CMS logo, and products or information issued by the Federal Government, including the Medicare card, in a misleading way. Use of the Medicare card image is permitted only with authorization from CMS.



Third Party Marketing Organization (TPMO)- continued

Conducting Enrollments Telephonically

- **MUST** use the Agency's approved technology and call system.
- **MUST** perform a comprehensive needs assessment and review of health plan benefits in order for the potential customer to make an educated decision on enrollment into the plan.
- **MUST** follow CMS-approved scripts for both pre-enrollment and enrollment portions of the call.
- **MUST** only accept enrollment requests during an inbound telephone call from a potential customer, **UNLESS**:
 - i. You are making an outbound call to an existing Cigna Healthcare customer regarding plan business and the customer expresses a desire to enroll in a different or additional plan.
 - ii. You are making an outbound call to a customer who is not currently a member, in response to receipt of a business reply card or in order to return a message left by the customer and the customer expresses a desire to enroll in a Cigna Healthcare plan.

Conducting Compliant Enrollments

Agents are required to explain the effect of an enrollee's enrollment choice on their current coverage.

- **YOU MUST** review the Pre Enrollment Checklist (PECL) in its entirety with the customer.
- **DO** review the full CMS list of required elements prior to enrollment with the customer including PCPs and Specialist information, prescription drug coverage and costs, costs of health care services, premiums, benefits and specific health care needs.

REMINDER: All portions of the call (needs assessment, pre-enrollment, enrollment, and any transfers between agents or non-licensed reps) must be recorded and stored for 10 years per CMS guidelines.

Upon completing a telephonic enrollment request, an agent must provide a confirmation number to the customer for tracking purposes.



Third Party Marketing Organization (TPMO)-continued

Scope of Appointment (SOA) Forms

The SOA must be completed for each personal marketing appointment you conduct. At least 48 hours must have passed between a customer completing the SOA and the actual appointment occurring.

- **YOU MAY** conduct an appointment when less than 48 hours have elapsed when a beneficiary initiated walk-in to an agent/broker's office occurs.
- **YOU MAY** conduct an appointment during last 4 days before the end of an enrollment period.
NOTE: Inbound unscheduled calls do not need to have a 48-hour time-frame waiting period prior to discussing products.

TPMO sharing of personal beneficiary data

TPMOs must obtain prior express written consent from the beneficiary to share their data and to be contacted for marketing or enrollment purposes. Permission to contact must be obtained through a clear and conspicuous disclosure that lists each entity receiving the data and allows the beneficiary to consent or reject to the sharing of their data for each individual TPMO.



Related Laws, Regulations, and Links

- **MUST** provide reasonable accommodations for beneficiaries with disabilities -Americans with Disabilities Act of 1990.
- **MUST** ensure effective communication with individuals with disabilities and provide auxiliary aids/services, such as alternate formats - Section 504 of Rehabilitation Act.
- **MUST** prohibit discrimination on basis of race, color, national origin, sex, age or disability in certain health programs or activities – Section 1557 of Patient Protection and Affordable Care Act.
- **MUST** write all Medicare publications, documents and forms in a clear, concise, well-organized manner - Plain Writing Act of 2010.
- **MUST** adhere to the Telephone Consumer Protection Act 47 U.S.C. § 227.
- **MUST** follow all Federal and State laws regarding confidentiality and disclosure of patient information; this includes compliance w/provisions of HIPAA Privacy Rule and its specific rules pertaining to disclosures of beneficiary information; additional information on HIPAA Privacy Rule can be found at <http://www.hhs.gov/ocr/privacy>.

Resources



1. [Code of Federal Regulations: CFR Part 422](#)
2. [Medicare Communications and Marketing Guidelines \(MCMG\)](#)
3. [Cigna Healthcare's Producer University](#)

