

(ii) Verbally conveyed within the first minute of a sales call.

(iii) Electronically conveyed when communicating with a beneficiary through email, online chat, or other electronic means of communication.

(iv) Prominently displayed on TPMO websites.

(v) Included in any marketing materials, including print materials and television advertisements, developed, used or distributed by the TPMO.

(42) *Mid-year supplemental benefits notice.* This is a model communications material through which plans must inform each enrollee of the availability of any item or service covered as a supplemental benefit that the enrollee has not begun to use by June 30 of the plan year.

(i) The notice must be sent on an annual basis, no earlier than June 30 of the plan year, and no later than July 31 of the plan year.

(ii) The notice must include the following content:

(A) *Mandatory supplemental benefits.* For each mandatory supplemental benefit an enrollee has not used, the MA organization must include the same information about the benefit that is provided in the Evidence of Coverage.

(B) *Optional supplemental benefits.* For each optional supplemental benefit an enrollee has not used, the MA organization must include the same information about the benefit that is provided in the Evidence of Coverage.

(C) *SSBCI.* For plans that include SSBCI—

(1) The MA organization must include an explanation of SSBCI available under the plan (including eligibility criteria and limitations and scope of the covered items and services) and must include point-of-contact information for eligibility assessments, including providing point-of-contact information (which can be the customer service line or a separate dedicated line), with trained staff that enrollees can contact to inquire about or begin the SSBCI eligibility determination process and to address any other questions the enrollee may have about the availability of SSBCI under their plan;

(2) When an enrollee has been determined eligible for SSBCI but has not

used SSBCI, the MA organization must include a description of the unused SSBCI for which the enrollee is eligible, and must include a description of any limitations on the benefit; and

(3) The disclaimer specified at paragraph (e)(34) of this section.

(D) The information about all supplemental benefits listed in the notice must include all of the following:

(1) Scope of benefit.

(2) Applicable cost-sharing.

(3) Instructions on how to access the benefit.

(4) Any applicable network information.

(E) Supplemental benefits listed consistent with the format of the EOC.

(F) A customer service number, and required TTY number, to call for additional help.

[86 FR 6108, Jan. 19, 2021, as amended at 87 FR 27898, May 9, 2022; 88 FR 22336, Apr. 12, 2023; 88 FR 34780, May 31, 2023; 89 FR 30827, Apr. 23, 2024; 89 FR 63827, Aug. 6, 2024]

§ 422.2272 Licensing of marketing representatives and confirmation of marketing resources.

In its marketing, the MA organization must:

(a) Demonstrate to CMS' satisfaction that marketing resources are allocated to marketing to the disabled Medicare population as well as beneficiaries age 65 and over.

(b) Establish and maintain a system for confirming that enrolled beneficiaries have, in fact, enrolled in the MA plan, and understand the rules applicable under the plan.

(c) Employ as marketing representatives only individuals who are licensed by the State to conduct marketing activities (as defined in the Medicare Marketing Guidelines) in that State, and whom the organization has informed that State it has appointed, consistent with the appointment process provided for under State law.

(d) Report to the State in which the MAO appoints an agent or broker, the termination of any such agent or broker, including the reasons for such termination if State law requires that the reasons for the termination be reported.

(e) Establish and implement an oversight plan that monitors agent and

broker activities, identifies non-compliance with CMS requirements, and reports non-compliance to CMS.

[73 FR 54220, Sept. 18, 2008, as amended at 73 FR 54250, Sept. 18, 2008; 76 FR 21569, Apr. 15, 2011; 83 FR 16735, Apr. 16, 2018; 88 FR 22337, Apr. 12, 2023]

§ 422.2274 Agent, broker, and other third-party requirements.

If an MA organization uses agents and brokers to sell its Medicare plans, the requirements in paragraphs (a) through (e) of this section are applicable. If an MA organization makes payments to third parties, the requirements in paragraph (f) of this section are applicable.

(a) *Definitions.* For purposes of this section, the following definitions are applicable:

Compensation. (i) Includes monetary or non-monetary remuneration of any kind relating to the sale, renewal, or services related to a plan or product offered by an MA organization including, but not limited to the following:

- (A) Commissions.
- (B) Bonuses.
- (C) Gifts.
- (D) Prizes or awards.
- (E) Beginning with contract year 2025, payment of fees to comply with state appointment laws, training, certification, and testing costs.
- (F) Beginning with contract year 2025, reimbursement for mileage to, and from, appointments with beneficiaries.
- (G) Beginning with contract year 2025, reimbursement for actual costs associated with beneficiary sales appointments such as venue rent, snacks, and materials.
- (H) Beginning with contract year 2025, any other payments made to an agent or broker that are tied to enrollment, related to an enrollment in an MA plan or product, or for services conducted as a part of the relationship associated with the enrollment into an MA plan or product.

Fair market value (FMV) means, for purposes of evaluating agent or broker compensation under the requirements of this section only, the amount that CMS determines could reasonably be expected to be paid for an enrollment or continued enrollment into an MA

plan. Beginning January 1, 2021, the national FMV is \$539, the FMV for Connecticut, Pennsylvania, and the District of Columbia is \$607, the FMV for California and New Jersey is \$672, and the FMV for Puerto Rico and the U.S. Virgin Islands is \$370. For contract year 2025, there will be a one-time increase of \$100 to the FMV to account for administrative payments included under the compensation rate. For subsequent years, FMV is calculated by adding the current year FMV and the product of the current year FMV and MA growth percentage for aged and disabled beneficiaries, which is published for each year in the rate announcement issued under § 422.312.

Initial enrollment year means the first year that a beneficiary is enrolled in a plan versus subsequent years (c.f., *renewal year*) that a beneficiary remains enrolled in a plan.

Like plan type means one of the following:

- (i) PDP replaced with another PDP.
- (ii) MA or MA-PD replaced with another MA or MA-PD.
- (iii) Cost plan replaced with another cost plan.

Plan year and *enrollment year* mean the year beginning January 1 and ending December 31.

Renewal year means all years following the initial enrollment year in the same plan or in different plan that is a like plan type.

Unlike plan type means one of the following:

- (i) An MA or, MA-PD plan to a PDP or Section 1876 Cost Plan.
- (ii) A PDP to a Section 1876 Cost Plan or an MA or MA-PD plan.
- (iii) A Section 1876 Cost Plan to an MA or MA-PD plan or PDP.

(b) *Agent/broker requirements.* Agents and brokers who represent MA organizations must follow the requirements in paragraphs (b)(1) through (3) of this section. Representation includes selling products (including Medicare Advantage plans, Medicare Advantage-Prescription Drug plans, Medicare Prescription Drug plans, and section 1876 Cost plans) as well as outreach to existing or potential beneficiaries and answering or potentially answering questions from existing or potential beneficiaries.

(1) Be licensed and appointed under State law (if required under applicable State law).

(2) Be trained and tested annually as required under paragraph (c)(4) of this section, and achieve an 85 percent or higher on all forms of testing.

(3) Secure and document a Scope of Appointment prior to meeting with potential enrollees.

(c) *MA organization oversight.* MA organizations must oversee first tier, downstream, and related entities that represent the MA organization to ensure agents and brokers abide by all applicable State and Federal laws, regulations, and requirements. MA organizations must do all of the following:

(1) As required under applicable State law, employ as marketing representatives only individuals who are licensed by the State to conduct marketing (as defined in this subpart) of health insurance in that State, and whom the MA organization has informed that State it has appointed, consistent with the appointment process for agents and brokers provided for under State law.

(2) As required under applicable State law, report the termination of an agent or broker to the State and the reason for termination.

(3) Report to CMS all enrollments made by unlicensed agents or brokers and for-cause terminations of agents or brokers.

(4) On an annual basis, provide training and testing to agents and brokers on Medicare rules and regulations, the plan products that agents and brokers will sell, including any details specific to each plan product, and relevant State and Federal requirements.

(5) On an annual basis for plan years through 2024, by the last Friday in July, report to CMS whether the MA organization intends to use employed, captive, or independent agents or brokers in the upcoming plan year and the specific rates or range of rates the plan will pay independent agents and brokers. Following the reporting deadline, MA organizations may not change their decisions related to agent or broker type, or their compensation rates and ranges, until the next plan year.

(6) On an annual basis by October 1, have in place full compensation struc-

tures for the following plan year. The structure must include details on compensation dissemination, including specifying payment amounts for initial enrollment year and renewal year compensation.

(7) Submit agent or broker marketing materials to CMS through HPMS prior to use, following the requirements for marketing materials in this subpart.

(8) Ensure beneficiaries are not charged marketing consulting fees when considering enrollment in MA plans.

(9) Establish and maintain a system for confirming that:

(i) Beneficiaries enrolled by agents or brokers understand the product, including the rules applicable under the plan.

(ii) Agents and brokers appropriately complete Scope of Appointment records for all marketing appointments (including telephonic and walk-in).

(10) Demonstrate that marketing resources are allocated to marketing to the disabled Medicare population as well as to Medicare beneficiaries age 65 and over.

(11) Must comply with State requests for information about the performance of a licensed agent or broker as part of a state investigation into the individual's conduct. CMS will establish and maintain a memorandum of understanding (MOU) to share compliance and oversight information with States that agree to the MOU.

(12) Ensure that, prior to an enrollment, CMS' required questions and topics regarding beneficiary needs in a health plan choice are fully discussed. Topics include information regarding primary care providers and specialists (that is, whether or not the beneficiary's current providers are in the plan's network), regarding pharmacies (that is, whether or not the beneficiary's current pharmacy is in the plan's network), prescription drug coverage and costs (including whether or not the beneficiary's current prescriptions are covered), costs of health care services, premiums, benefits, and specific health care needs.

(13) Beginning with contract year 2025, ensure that no provision of a contract with an agent, broker, or other

TPMO has a direct or indirect effect of creating an incentive that would reasonably be expected to inhibit an agent or broker's ability to objectively assess and recommend which plan best fits the health care needs of a beneficiary.

(d) *Compensation requirements.* MA organizations must ensure they meet the requirements in paragraphs (d)(1) through (5) of this section in order to pay compensation. These compensation requirements only apply to independent agents and brokers.

(1) *General rules.* (i) MA organizations may only pay agents or brokers who meet the requirements in paragraph (b) of this section.

(ii) For contract years through contract year 2024, MA organizations may determine, through their contracts, the amount of compensation to be paid, provided it does not exceed limitations outlined in this section. Beginning with contract year 2025, MA organizations are limited to the compensation amounts outlined in this section.

(iii) MA organizations may determine their payment schedule (for example, monthly or quarterly). Payments (including payments for AEP enrollments) must be made during the year of the beneficiary's enrollment.

(iv) MA organizations may only pay compensation for the number of months a member is enrolled.

(2) *Initial enrollment year compensation.* For each enrollment in an initial enrollment year for contract years through contract year 2024, MA organizations may pay compensation at or below FMV.

(i) MA organizations may pay either a full or pro-rated initial enrollment year compensation for:

(A) A beneficiary's first year of enrollment in any plan; or

(B) A beneficiary's move from an employer group plan to a non-employer group plan (either within the same parent organization or between parent organizations).

(ii) MA organizations must pay pro-rated initial enrollment year compensation for:

(A) A beneficiary's plan change(s) during their initial enrollment year.

(B) A beneficiary's selection of an "unlike plan type" change. In that case, the new plan would only pay the

months that the beneficiary is enrolled, and the previous plan would recoup the months that the beneficiary was not in the plan.

(3) *Renewal compensation.* For each enrollment in a renewal year for contract years through contract year 2024, MA plans may pay compensation at a rate of up to 50 percent of FMV. For contract years beginning with contract year 2025, for each enrollment in a renewal year, MA organizations may pay compensation at 50 percent of FMV.

(i) MA plans may pay compensation for a renewal year:

(A) In any year following the initial enrollment year the beneficiary remains in the same plan; or

(B) When a beneficiary enrolls in a new "like plan type".

(ii) [Reserved]

(4) *Other compensation scenarios.* (i) When a beneficiary enrolls in an MA-PD, MA organizations may pay only the MA compensation (and not compensation for Part D enrollment under § 423.2274 of this chapter).

(ii) When a beneficiary enrolls in both a section 1876 Cost Plan and a stand-alone PDP, the 1876 Cost Plan sponsor may pay compensation for the cost plan enrollment and the Part D sponsor must pay compensation for the Part D enrollment.

(iii) When a beneficiary enrolls in a MA-only plan and a PDP plan, the MA plan sponsor may pay for the MA plan enrollment and the Part D plan may pay for the PDP plan enrollment.

(iv) When a beneficiary changes from two plans (for example, a MA plan and a stand-alone PDP) (dual enrollments) to one plan (MA-PD), the MA organization may only pay compensation at the renewal rate for the MA-PD product.

(5) *Additional compensation, payment, and compensation recovery requirements (Charge-backs).* (i) MA organizations must retroactively pay or recoup funds for retroactive beneficiary changes for the current and previous calendar years. MA organizations may choose to recoup or pay compensation for years prior to the previous calendar year, but they must do both (recoup amounts owed and pay amounts due) during the same year.

(ii) Compensation recovery is required when:

(A) A beneficiary makes any plan change (regardless of the parent organization) within the first three months of enrollment (known as rapid disenrollment), except as provided in paragraph (d)(5)(iii) of this section.

(B) Any other time period a beneficiary is not enrolled in a plan, but the plan paid compensation based on that time period.

(iii) Rapid disenrollment compensation recovery does not apply when:

(A) A beneficiary enrolls effective October 1, November 1, or December 1 and subsequently uses the Annual Election Period to change plans for an effective date of January 1.

(B) A beneficiary's enrollment change is not in the best interests of the Medicare program, including for the following reasons:

(1) Other creditable coverage (for example, an employer plan).

(2) Moving into or out of an institution.

(3) Gain or loss of employer/union sponsored coverage.

(4) Plan termination, non-renewal, or CMS imposed sanction.

(5) To coordinate with Part D enrollment periods or the State Pharmaceutical Assistance Program.

(6) Becoming LIS or dually eligible for Medicare and Medicaid.

(7) Qualifying for another plan based on special needs.

(8) Due to an auto, facilitated, or passive enrollment.

(9) Death.

(10) Moving out of the service area.

(11) Non-payment of premium.

(12) Loss of entitlement or retroactive notice of entitlement.

(13) Moving into a 5-star plan.

(14) Moving from an LPI plan into a plan with three or more stars.

(iv)(A) When rapid disenrollment compensation recovery applies, the entire compensation must be recovered.

(B) For other compensation recovery, plans must recover a pro-rated amount of compensation (whether paid for an initial enrollment year or renewal year) from an agent or broker equal to the number of months not enrolled.

(1) If a plan has paid full initial compensation, and the enrollee disenrolls prior to the end of the enrollment year, the total number of months not en-

rolled (including months prior to the effective date of enrollment) must be recovered from the agent or broker.

(2) Example: A beneficiary enrolls upon turning 65 effective April 1 and disenrolls September 30 of the same year. The plan paid full initial enrollment year compensation. Recovery is equal to 6/12ths of the initial enrollment year compensation (for January through March and October through December).

(e) *Payments other than compensation (administrative payments).* (1) For contract years through contract year 2024, payments made for services other than enrollment of beneficiaries (for example, training, customer service, agent recruitment, operational overhead, or assistance with completion of health risk assessments) must not exceed the value of those services in the marketplace.

(2) Beginning with contract year 2025, administrative payments are included in the calculation of enrollment-based compensation.

(f) *Payments for referrals.* Payments may be made to individuals for the referral (including a recommendation, provision, or other means of referring beneficiaries) to an agent, broker or other entity for potential enrollment into a plan. The payment may not exceed \$100 for a referral into an MA or MA-PD plan and \$25 for a referral into a PDP plan.

(g) *TPMO oversight.* In addition to any applicable FDR requirements under § 422.504(i), when doing business with a TPMP, either directly or indirectly through a downstream entity, MA plans must implement the following as a part of their oversight of TPMPs:

(1) When a TPMP is not otherwise an FDR, the MA organization is responsible for ensuring that the TPMP adheres to any requirements that apply to the MA plan.

(2) Contracts, written arrangements, and agreements between the TPMP and an MA plan, or between the TPMP and an MA plan's FDR, must ensure the TPMP:

(i) Discloses to the MA organization any subcontracted relationships used for marketing, lead generation, and enrollment.