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Government Focuses On Medicare Marketing In New Regulations

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Introduction

In September, the Centers for Medicare and Medicaid Services (CMS) released its final regulations regarding marketing practices utilized by Medicare Plans, Medicare Advantage Plans, and Prescription Drug Plans (referred to as Plans). These regulations were promulgated in part to implement provisions of the Medicare Improvements for Patients and Providers Act (MIPPA) passed in July 2008 and also “based on lessons we have learned since 2006, the initial year of the prescription drug program and the revised MA program.”² CMS’ goal in issuing these regulations is to protect Medicare beneficiaries from what it perceives to be deceptive or high-pressure marketing tactics by insurance companies and their agents during the Plans’ annual election period.

Additionally, it should be noted that the Department of Health and Human Services Office of Inspector General (OIG) announced in its annual work plan its intentions to more closely monitor and scrutinize Plans and their marketing practices. Therefore, Plans should expect significant interaction with the government in the coming months and years with regard to their marketing practices. Specifically, CMS and OIG will look to these new regulations as benchmarks to guide full compliance in this program. What

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² See Medicare Advantage and Prescription Drug Benefit Programs: Final Marketing Provisions: Final Rule, 73 Fed. Reg. 54208-52223.

follows is a summary of the newly enacted marketing regulations. Many of these regulations are a codification of the practices, guidance, and limitations found in the Medicare Marketing Guidelines (Marketing Guidelines). Others are new regulations promulgated as CMS attempts to better standardize marketing practices amongst the Plans.

Agent and Broker Compensation³

One of the most significant changes brought about under the new regulations is the establishment of limits on agent and broker compensation. CMS initially issued these changes and the rest of the regulations in September. However, because of concerns over Plan misinterpretation of the proposed rule, CMS issued a second interim final rule on November 10, 2008 (published on November 14, 2008).⁴ Note that while CMS has stated that it will accept comments on this interim rule through December 15, 2008, Plans must incorporate these latest requirements into their compensation structures in time for open enrollment, November 15, 2008.

CMS has been concerned that agents and brokers, earning commissions based on enrollments, were inappropriately incentivized to encourage beneficiaries to select new enrollment opportunities each year. Under this new structure, agents receive compensation based on the length of time beneficiaries stay enrolled in their Plans. The goal is to encourage beneficiaries to enroll in appropriate Plans at the outset, thus ensuring appropriate compensation to the agents and brokers. This approach therefore disincentivizes agents and brokers to 'churn' beneficiaries to re-enroll in a different plan each year. The shift in the basis for agent and broker compensation from enrollment to the length of time beneficiaries are enrolled in plans, as a practical matter, will likely cause Plans to reduce commission payment amounts and possibly eliminate them altogether.

³ 42 C.F.R. §§ 422.2274(a) and 423.2274(a).

⁴ See Revisions to the Medicare Advantage and Prescription Drug Benefit Programs: Clarification of Compensation Plans, 73 Fed. Reg. 67406-67414.

CMS expects that compensation for brokers and agents will be set at levels that are reasonable and reflect fair market value for services provided. This is a change from the September rule that was intended only to limit Plans' compensation to agents and brokers for initial enrollments, and then pay a fixed amount for each of the next five renewal years. In the September rule, CMS estimated that initial-year enrollment would exceed renewal-year enrollments and set a cap so that initial-year enrollments shall not exceed 200% of what Plans pay in renewal-year compensation for each of the next five years. According to CMS, Plans interpreted the September 18 rule in ways the agency believes were inconsistent with the rule's intent, potentially causing significant front loading of commissions to agents and brokers into the first year of compensation. Therefore, CMS changed the 200% cap so that in the aggregate, compensation to agents and brokers for each of the five renewal years must be at fair market value for the services provided and be no more or less than 50% of the aggregate compensation paid for the initial year of the six-year cycle. Additionally, Plans must pay agents and brokers at renewal rates for the 2009 year. CMS will determine later whether or not initial-year compensation should be paid retrospectively for 2009.

There are five basic global requirements to the compensation structures:

- Compensation is to be defined as pecuniary or non pecuniary remuneration of any kind relating to the sale or renewal of policies. Salary or other benefits related to employment are excluded from this definition. Covering a broker's or agent's fees to comply with state laws, costs of training and testing, mileage reimbursement, venue rent, and snacks while interacting with potential beneficiaries also are not included in compensation;
- An agent's aggregate first-year compensation cannot exceed 50% of the aggregate compensation in each individual's subsequent renewal year, as described above. There also must be a total of five renewal years, thus creating a six-year cycle;
- Compensation is earned in months four through twelve of the enrollment year, as long as the member is active with the plan. If an enrollee leaves the plan prior to the fourth month, there is no compensation. If an enrollee leaves a plan after the

third month, but before the end of the fourth month is complete, compensation is paid on a pro-rated basis for the actual month the enrollee was a member of the plan;

- After the 2009 base year, no compensation may be provided that is greater than the renewal compensation payable by the replacing plan on renewal policies if an existing policy is replaced during the first and five renewal years;
- Plans must establish compensation structures for new and replacement enrollments, and renewals effective in a given plan year. The compensation may not be altered during the given plan year and compensation structures must be in place by the beginning of the marketing period, October 1 of each year.

In its November 10 memorandum, CMS attempts to provide further clarification regarding agent/broker compensation. CMS indicates that Plans should establish an initial and renewal compensation structure for the 2009 year. CMS indicates that Plans will be required to certify and submit to CMS their compensation structures paid from 2006 – 2008 and the structures that they will use in 2009. As part of this data submission and certification process, Plans will be required to submit a certification that their compensation structures meet CMS' requirements for 2009. Plans have two options for calculating their compensation structures. If using the first option provided by CMS, certification must have been submitted by November 13, 2008. If using the second option, certification must have been submitted no later than November 17, 2008. Plans also must submit agent information sheets and agent compensation data. CMS has stated that it will consider an organization that does not submit compensation structures for the appropriate years by the compliance date to be out of compliance with marketing requirements. Those entities will face potential sanctions and other penalties.

Other Highlights from the Marketing Regulations

Many of these regulations' origins can be found in the Marketing Guidelines. CMS' goal in codifying these regulations is to simplify and clarify the beneficiary's experience during the enrollment process. CMS has been concerned that beneficiaries are bombarded with information and sales tactics that can be overwhelming during a

complex process. These regulations clearly intend to make this process as user friendly to the beneficiary as possible.

*Disclosure of Plan Information*⁵

Plans must disclose plan information to beneficiaries at the time of enrollment or by each October 31 for existing members. For existing members, the information provided now must include the annual notice of coverage that describes plan changes for the coming year and the evidence of coverage (EOC), which includes comprehensive information about coverage plan policies including, but not limited to, information regarding the Plan's P & T Committee, member transition to nursing facilities, and enrollment/disenrollment procedures. Previously, the EOC was not required to be provided to the beneficiaries until January of each plan year. With this change, both the annual notice and the EOC must be provided by October 31. The goal appears to be to ensure that beneficiaries receive all Plan information at one time, thus eliminating the constant barrage and hopefully reducing beneficiary confusion.

*Elimination of File and Use Eligibility*⁶

As of October 1, 2008, Plans may no longer submit marketing materials through the file and use *eligibility* process. Organizations may use the file and use *certification* process. Materials under this process must be submitted five business days prior to use. Plans are required to submit at least 90% of qualifying materials for the file and use certification process. If there are model documents available, they must be used without any modification to be submitted through file and use certification. Further, any Plans that modify model documents already in existence will need to submit those documents for the standard review. The standard review process, unlike the file and use certification process, can involve up to a forty-five-day review period before the materials can be used in marketing. The effects of this regulation are greater uniformity among the plans' written materials and lower risk that "creative" marketing materials will provide less than useful information to prospective enrollees.

⁵ 42 C.F.R. §§ 422.111(a)(3) and 423.111(a)(3).

⁶ 42 C.F.R. §§ 422.2262 and 423.2262.

*Nominal Gifts*⁷

This regulation states that Plans may offer gifts to potential enrollees if the gifts are of nominal value (\$15) and are provided regardless of whether the beneficiaries enroll in the plan. This regulation, like many of the new regulations, codifies guidance that has previously been provided in the Marketing Guidelines. CMS has stated that it will monitor the \$15 nominal amount and modify it for inflation and other market factors.

*Unsolicited Contacts*⁸

The Marketing Guidelines prohibited door-to-door solicitations and several other types of unsolicited encounters with potential beneficiaries. The new regulations extend this prohibition to the following activities:

- Outbound marketing calls, unless the beneficiary requests the call beforehand;
- Calls to former members to market plans or products;
- Calls to confirm receipt of materials mailed to beneficiaries or acceptance of an appointment made by a third party or independent insurance agent;
- Calls or visits after beneficiary-attended sales events unless the beneficiary explicitly provides permission to do so;
- Unsolicited emails; and
- Approaching beneficiaries in common areas, such as parking lots, hallways, lobbies, etc.

The new regulations permit the following:

- Outbound calls to existing members that are related to enrollment;
- Calls to former members after disenrollment to conduct the disenrollment survey for quality-improvement purposes;

⁷ 42 C.F.R. §§ 422.2268(b) and 423.2268(b).

⁸ 42 C.F.R. §§ 422.2268(d) and 423.2268(d).

- Under specific circumstances, subject to advance approval by CMS, calling members a Plan may lose due to reassignment;
- Agents and brokers calling beneficiaries they have enrolled while the beneficiary is a member of the organization;
- Calling beneficiaries who have expressly given permission for a sales agent to contact them.

For outbound calls, scripts for those call processes must be submitted to CMS for review and approval prior to use in the marketplace. In addition, note that while calls are permitted for disenrollment surveys, they may only be made after an affected disenrollment date and if no sales or marketing information is discussed in the call.

Cross-selling⁹

In codifying the Marketing Guidelines, the new regulations prohibit marketing by Plans of non-healthcare-related products to prospective enrollees during sales activity or presentation. CMS cites examples of beneficiaries faced with the cross-selling of annuities, life insurance, and other non-healthcare-related items. CMS believes that beneficiaries already face a complex process in determining coverage and should be afforded an environment for making their decisions without confusion about available packages that include non-healthcare-related products. When a beneficiary calls a Plan and requests information on other non-healthcare-related products, Plans may sell these products. Please note that CMS has expressed concern about the marketing of non-healthcare-related products while beneficiaries are on hold or with interactive voice response systems that Plans utilize. CMS may issue guidance in the future prohibiting or limiting cross-selling during these types of messages.

Scope of Appointments¹⁰

⁹ 42 C.F.R. §§ 422.2268(f) and 423.2268(f)).

¹⁰ 42 C.F.R. §§ 422.2268(g), (h) and 423.2268(g), (h).

Under the Marketing Guidelines, representatives must clearly identify the types of products that will be discussed before marketing to a beneficiary. Under the new regulations, prior to any marketing appointment, the Plan must ensure that the beneficiary has agreed to the scope of the appointment and that agreement must be documented by the Plan. Plans may document the scope in writing or may record the documentation through beneficiary telephone conversations. Additional products may not be discussed unless the beneficiary requests the information. The regulations further encourage Plans to use existing systems to monitor and track calls whenever there is beneficiary interaction. If an appointment must be rescheduled or if follow up is desired, it may not be booked until forty-eight hours after the initial appointment—a cool-off period. At appointments, marketing representatives may leave plan materials (not enrollment applications) related to other product lines, but cannot discuss them.

CMS notes in its October 17, 2008 memorandum that this regulation does not have an impact where Plans receive enrollment forms from prospective enrollees or where requests are initiated by enrollees through inbound calls. The regulation also does not affect beneficiary walk-ins to a Plan or broker because this is considered a beneficiary-initiated, face-to-face event. CMS acknowledges that Plans will continue to return beneficiary phone calls because these are in response to beneficiary-initiated events. Lastly, in the November 10, 2008 memorandum, CMS includes an updated model Sales Appointment Confirmation Form (the original having been released with CMS' October 8, 2008 memorandum) that, when submitted to CMS without modification, will be approved for use under the file and use certification process referenced earlier.

*Sales and Marketing in Healthcare Settings*¹¹

Codifying the Marketing Guidelines, Plans may not conduct sales activities in areas where individuals receive and/or wait to receive healthcare services, including, but not limited to, waiting rooms, examination rooms, hospital/patient rooms, dialysis centers, and pharmacy counter areas where patients wait for services or interact with pharmacy providers. Plans may conduct sales activities in common areas—which allow public

¹¹ 42 C.F.R. §§ 422.2268(k) and 423.2268(k).

access—but are not areas in which individuals receive and/or wait to receive healthcare services. These areas include, but are not limited to, hospital or nursing home cafeterias, community or recreational rooms, and conference rooms. In a pharmacy, a common area would be the area outside of where patients wait for services or interact with the pharmacy providers. Just like if a beneficiary resides in a private residence, Plans may only schedule appointments for a beneficiary residing in long-term care facilities upon request by the beneficiary. Lastly, providers are allowed to make available a plan’s marketing materials, as long as the provider is distributing materials for all plans in which he/she participates.

In its October 17, 2008 memorandum, CMS clarifies the Medicare Marketing Guidelines statement regarding marketing activities by healthcare providers. CMS continues to encourage providers to remain neutral in assisting Plans and beneficiaries with enrollment decisions. It is therefore inappropriate for providers to be involved in offering sales and appointment forms, mailing marketing materials on behalf of Plans, making phone calls, or steering beneficiaries in any way to a limited number of Plans.

*Sales and Marketing and Educational Events*¹²

Under the regulations, Plans are prohibited from marketing at educational events. Educational events include, but are not limited to, health information fairs, conference expositions, and state or community sponsored healthcare events. Plans may distribute Medicare and other health educational materials. Agents and brokers may only give out their business cards when a beneficiary requests it. Any organization that sponsors or participates in any of these educational events is required to include a disclaimer on all advertising materials that states, “This event is only for educational purposes and no plan specific benefits or details will be shared.” Pursuant to further guidance dated October 17, 2008, CMS states, “the disclaimer is not required on Plan materials when a Plan is invited to an educational event sponsored by an entity other than the plan.” However, Plans must use this disclaimer during Plan-sponsored educational events.

¹² 42 C.F.R. §§ 422.2268(l) and 423.2268(l).

CMS also notes in its October 17, 2008 guidance that the rules regarding cross-selling in the regulations do not currently extend to educational events.

*Co-Branding*¹³

Through this regulation, CMS has attempted to eliminate confusion and ensure that beneficiaries understand that there are multiple network providers available to them. This provision also codifies existing guidance found at the Marketing Guidelines and prohibits Plans from putting the names or logos of their network partners on beneficiaries' plan I.D. cards. For example, some member I.D. cards have contained pharmacy chain logos that caused beneficiaries to believe that they could only purchase their medications at that particular pharmacy. There are two exceptions to this rule. First, Plans that have a network exclusive to a co-branded provider can provide that logo on the I.D. cards. Second, Plans may include on the I.D. card the names and logos of providers that have been selected by the member. Also, in the October 17, 2008 memorandum, CMS indicates that PBMs may continue to co-brand on plan I.D. cards.

*Prohibition on the Provision of Meals*¹⁴

This new regulation applies to Plans when their agents or brokers are discussing plan benefits or handing out plan materials. At those events, meals may not be served. Agents and brokers are allowed to provide to prospective enrollees what are referred to as "refreshments" and "light snacks." While CMS does not define the term "meal," it provides some guidance stating that the following are acceptable: fruit, raw vegetables, pastries, cookies and other small dessert items, crackers, muffins, cheese, chips, yogurt, and nuts. However, Plans must take care to ensure that multiple items are not being "bundled" or eaten together like a meal. This regulation has caused a major revamping of how Plans market to their target populations. Meals, unsurprisingly, can be a significant draw to the senior citizen population. Plans are concerned that there will be a significant drop in attendance at marketing opportunities without the draw of a

¹³ 42 C.F.R. §§ 422.2268(n) and 423.2268(n).

¹⁴ 42 C.F.R. §§ 422.2268(p) and 423.2268(p).

complimentary meal. CMS has held firm on this matter and it will be interesting to observe how Plans change the marketing strategy.

State Appointment of Agents and Brokers¹⁵

When Plans conduct marketing through independent agents, they must use state-licensed, certified, or registered individuals. Moreover, both independent agents and internal sales staff that perform marketing must be licensed by the states in which they operate. In addition to these requirements, the final regulation clarifies that some Plan activities, generally related to provision of customer service, do not require the use of licensed marketing representatives. These activities include providing factual information, fulfilling a request for materials, and taking demographic information to complete an enrollment application that was initiated by the enrollee. If other activities that are considered marketing activities are involved in these examples where an agent or salesperson does not need to be licensed to interact with patients, Plans must monitor these potential enrollee interactions to ensure that all marketing-related activities are conducted by individuals who are appropriately licensed.

Plan Reporting of Terminated Agents¹⁶

Simply put, where state appointment law requires it, the new regulation requires Plans to report to the appropriate state agencies the termination of any brokers or agents, and the reasons for termination. Many states already require licensure of sales personnel, and this new regulation creates a national standard.

Broker/Agent Training and Testing¹⁷

This new regulation requires Plans to ensure that, starting with plan year 2009, agents and brokers selling Plan products are trained on Medicare rules and regulations, and on Plan details specific to products being sold. This training must occur annually. Moreover, brokers and agents must receive a passing score of at least 85% for tests administered on or after September 18, 2008 to qualify to sell the products.

¹⁵ 42 C.F.R. §§ 422.2272(c) and 423.2272(c).

¹⁶ 42 C.F.R. §§ 422.2272(d) and 423.2272(d).

¹⁷ 42 C.F.R. §§ 422.2274(b) and 423.2274(b).

Conclusion

CMS has set up a mailbox for questions that are specific to these new provisions. The email address is regulationquestions@CMS.hhs.gov. CMS continues to collect the questions and answer them in cumulative summaries. These new regulations, and both CMS and the OIG's more concerted focus on plan marketing activities, marks a brave new world for Plans participating in Medicare Advantage and the Prescription Drug Program. In the coming weeks and months, Plans will scramble to incorporate these regulatory requirements into their marketing activities.

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