

CENTER FOR DRUG AND HEALTH PLAN CHOICE

MEMORANDUM

DATE: October 8, 2008

TO: Medicare Advantage Organizations
Medicare Advantage-Prescription Drug Organizations
Cost-Based Contractors
Prescription Drug Plan Sponsors
Employer/Union-Sponsored Group Health Plans

FROM: Abby L. Block /s/
Director, Center for Drug and Health Plan Choice

SUBJECT: Clarification of guidance for regulations in CMS 4131-F and CMS 4138-IFC

On September 15, 2008, we released guidance to help the industry implement the new Medicare regulations, CMS 4131-F and CMS 4138-IFC. The guidance addressed important changes for Medicare Advantage, Medicare Prescription Drug Plans and Cost-based plans. Subsequently, we conducted briefings and answered questions related to implementation of the rules. In response to the many questions we have received, this document provides additional clarification.

- **Marketing through unsolicited contacts** – Sections 422.2268(d) and 423.2268(d) prohibit plans and their representatives from engaging in direct unsolicited contact with potential enrollees, including outbound calls. CMS has become aware of third-party organizations contacting plans and/or agents, providing incorrect interpretations of our regulation/guidance, and offering services that would, if accepted, put the plan out of compliance with our requirements.
 - Third-parties may not make unsolicited MA or PDP marketing calls to beneficiaries (other than to current plan members if contracted by a plan, as described below) to set up appointments with potential enrollees.
 - Third-parties may not make unsolicited calls to beneficiaries for non-MA and PDP products (for example, a “benefits compare” meeting) and provide those contacts to plans for ultimate use as an MA or PDP sales appointment.
 - Sales of MA and PDP products are subject to our scope of appointment guidance, even if conducted during a sales appointment for a Medicare Supplement plan. This includes the requirement for a beneficiary-completed agreement form prior to the appointment and a 48-hour waiting period.

Any plan or its representative that accepts an appointment to sell an MA or PDP product that resulted from an unsolicited contact with a beneficiary regardless of who made the contact will be in violation of the prohibition against unsolicited contacts. Once we become aware of the violation through our surveillance activities or other mechanisms, we will begin the

appropriate compliance actions against the plan. Please see the attached Q&A document for more details.

- **Contacting existing members** – On page 16 of the September 15, 2008, guidance document, we broadly stated that the prohibition against outbound calls included calls by plans to existing members. We would like to clarify that plans continue to be allowed to call their current members to discuss normal plan business, including discussions about other products offered by the same sponsoring organization. On page 17, we stated that an agent/broker who enrolled a beneficiary into a plan may call that beneficiary while the beneficiary is a member of that organization. We want to reiterate that agents/brokers can make calls only to the beneficiaries they enrolled into the plan.
- **Payment of appointment fees** – On page 21 of the September 15, 2008, guidance document, we stated that organizations are required to pay any fees associated with appointment laws. It was not our intention to specify who should be responsible for payment of appointment fees. Rather, our intention was to make clear the following: if an agent or broker sells MA and PDP products, that agent or broker must be appointed in accordance with the State appointment law and if there are any fees required as part of the appointment law, those fees must be paid.
- **Agent testing (85% passing score)** – On page 23 of the September 15, 2008, guidance document, we indicated that brokers and agents selling Medicare products starting with plan year 2009 must be trained and tested on the Medicare rules and the specifics of the plans they are selling. We indicated that a passing score was now 85% or greater. To clarify, any broker or agent tested after September 18, 2008, must pass with at least a score of 85%.
- **Employer/Union group plans** – We received a number of questions asking us to clarify which marketing provisions apply to employer/union group plans. The attached table identifies the provisions that do/do not apply to employer/union group plans. Please note that the agent/broker requirements apply to the transactions between the agent/broker selling the plan to the employer/union. All activities conducted by the employer/union or its designees to enroll individual employees in the plan(s) selected by the employer/union are excluded from these provisions.
- **Scope of appointments** – On page 18 of the September 15, 2008, guidance document, we indicated that agents and brokers must document the scope of an individual marketing appointment in writing or by recording a phone call in advance of the appointment. Because CMS received numerous requests surrounding the format or elements necessary in this form, we have created a model Sales Appointment Confirmation Form (attached). When used without modification, this model form may be submitted through File & Use. (Category 4000, Code 4010). We strongly encourage all plans to use this model form for consistency and to allow beneficiaries to become familiar with the format and content.
- **Agent/Broker compensation** – On page 22 of the September 15, 2008, guidance document, we established a process for transitioning to the new compensation structure in the first year in which any movement of a beneficiary in 2009 would result in the agent/broker receiving an initial compensation amount. In 2009, CMS and the plans have insufficient information to reliably designate a beneficiary for an initial or renewal enrollment until our systems can be programmed to provide this information. Since we have become increasingly concerned about the potential incentives for agents/brokers to “churn” beneficiaries in order to receive

the initial compensation amount, we have decided to transition to the new compensation structure by requiring that renewal compensation amounts be paid for all beneficiary enrollments in CY2009. We will consider this the first renewal year for all enrollment changes. Plans that pay the renewal compensation amount for enrollments in 2009 will still be required to pay renewal compensation for four additional renewal years if the agent/broker is still in good standing with the plan and the State, and the beneficiary is still enrolled in the plan. Plans should establish a first year and renewal/replacement compensation structure for 2009 using our rules for calculating the compensation. The plans would not be paying the first year amount and would only pay the renewal/replacement amount. Due to the recent HPMS email that delayed the date on which plans' compensation structures would be set, and the new guidance provided in this memo, plans are now expected to have their compensation structures in place no later than October 15, 2008. This includes the actual compensation amounts as well as the structure.

- **Compensation of employed agents** - Based on public comments and discussions with the industry, we realize that while our current regulations are relevant to the way independent agents are compensated, the relationship and compensation arrangements between organizations/sponsors and employed agents is very different. We anticipate receiving comments on this issue during the 60-day public comment period. Until the final regulation is published, we will not enforce the provisions of 422 and 423 (.2274(a) (1 – 3)) for employed agents.

In order to be responsive to your questions about the implementation of these new requirements, we have created a mailbox for questions specific to the Medicare Advantage and Prescription Drug provisions of the Medicare Improvements for Patients and Providers Act (MIPPA) and our new regulations. The email address is: regulationquestions@cms.hhs.gov. CMS will develop answers and distribute the questions and answers to the industry, generally in the form of a cumulative summary. **We will also host another special Part C and D User Group call to discuss this updated guidance and answer industry questions on Thursday, October 9, 2008, from 3:00 pm to 4:30 pm EDT.** Organizations that participate on the user group call must use the usual conference number and pass code that has been distributed to all registered participants.

Additionally, we remind MA organizations and Part D sponsors (CMS Contractors) that they are responsible for the actions of plan representatives including subcontractors and downstream entities like brokers and agents. CMS Contractors cannot delegate the responsibility for ensuring that subcontractors and downstream entities are in compliance with Medicare rules, regulations, and other guidance.

Attached are the following enclosures:

Questions & Answers Related to Marketing Questions
Table Describing the Applicability of Marketing Provisions to Employer / Union Plans
Model Sales Appointment Confirmation Form