

Summary of Marketing Questions

October 8, 2008

Marketing of 2008 Plans

Several plans inquired about the marketing rules for 2008 plans sold with the effective dates of October-December 2008.

The new marketing rules are in effect for the marketing of products available in benefit year 2009. Once plans begin marketing their 2009 products, marketing for 2008 must stop. Marketing for the 2009 benefit year began on October 1, 2008, and all plans that begin marketing their 2009 products after that date must be compliant with the marketing requirements in the regulations published on September 18, 2008.

Educational Events

Several plans asked for additional definition regarding educational vs. marketing events, as well as clarification regarding what activities are allowed at educational events. For example, several plans asked if they could display business reply cards/sign-up sheets and/or distribute promotional items at educational events and whether they could discuss plan benefits if asked by an individual. They also asked for clarification on how our guidelines apply to events hosted by outside entities.

As stated in the Regulation and accompanying Guidance Document, educational events may not include sales activities such as the distribution of marketing materials or the distribution or collection of plan applications. An event hosted by an outside entity is considered an educational event if the event is advertised to beneficiaries as “educational.” If the event is not advertised as “educational,” then plans are allowed to conduct sales activities, however all CMS marketing rules/guidance apply.

The following are examples of acceptable materials for distribution and activities at an educational event:

- Materials provided that meet our definition of education in the CMS Marketing Guidelines: “Informing a potential enrollee about MA or other Medicare Programs, generally or specifically, but not steering, or attempting to steer, a potential enrollee towards a specific plan or limited number of plans.” Specifically, any material distributed or made available to beneficiaries at an educational event must be free of plan-specific information (this includes plan-specific premiums, co-payments, or contact information), and any bias toward one plan type over another.
- A banner with the plan name and/or logo displayed.
- Promotional items, including those with plan name, logo, and toll-free customer service number and/or website. Promotional items must be free of benefit information.
- A business card if the beneficiary requests information on how to contact the agent for additional information, as long as the business card is free of plan marketing or benefit information.

Plans may not:

- Discuss plan-specific premiums and/or benefits.
- Distribute or display business reply cards, scope of appointment forms, or sign-up sheets.
- Set-up personal sales appointments or get permission for an outbound call to the beneficiary.
- Attach business cards or plan/agent contact information to educational materials.

The following are examples of events that are considered marketing events, and all rules regarding marketing events apply:

- A plan advertises a presentation as educational, but after the presentation the agent asks if anyone would like to hear more about any specific options available to them. In this situation, the entire event would be considered marketing. Similarly, a plan may not advertise an educational event and then have a marketing event immediately following in the same general location (same hotel, for example).
- A plan conducts events where beneficiaries can get educational materials, a blood pressure check and enroll in the plan.
- An agent goes into a senior housing complex and talks about Original Medicare and/or Medicare supplemental policies, but then discusses an MA or PDP plan.
- An agent attends a community-sponsored health fair, and hands out plan-specific benefits information including premium and/or copayment amounts; or the agent hands out only educational materials but gives a brief presentation that mentions plan-specific premiums and/or copayment amounts.
- A SHIP hosts an event that is not advertised to beneficiaries as “educational.” A plan may be invited to discuss plan-specific benefits.

Marketing through Unsolicited Contacts

Several plans requested clarification on outbound calls to members. Plans asked if they could conduct outbound calls to existing membership to discuss other benefits. Plans also asked if they could contract with a third party to conduct outbound calls to members regarding plan benefits. Several plans asked if the prohibition on unsolicited contacts extended to follow-up calls on appointments already made by a contracted entity or third party to remind the beneficiary of an appointment or sales/educational event. All of these activities are permitted under our rules.

Third-party entities selling beneficiary leads that claim they are not subject to the unsolicited contact provisions are providing misinformation. CMS reminds plans that they will be held accountable for all actions of agents/brokers selling their products, and plans/agents/brokers should be wary of any company selling beneficiary contacts they claim to be permissible under our guidance. In addition, permission given by a beneficiary to be called or otherwise contacted is to be considered short-term, event-specific basis, and may not be treated as open-ended permission for future contacts. All

business reply cards used for documenting beneficiary agreement for a contact must be submitted to CMS for review/approval (Category 4000, Code 4010).

The following are examples of acceptable plan activities:

- Organizations may contact their members or use third parties to contact their current plan members to discuss other products and services that may be available through the organization.
- Agents may contact members that they enrolled in a plan to discuss plan issues and market other plan options, but cannot conduct unsolicited phone calls to other beneficiaries or plan members. During an agent's outbound call to a current member, the agent is not required to set up an appointment to discuss other available plans/products with the beneficiary.
- Agents may initiate a phone call to confirm an appointment that has already been agreed to by a beneficiary.
- Plan/agent mailings are allowed.

Plans may not:

- Conduct or allow unsolicited contacts, including unsolicited outbound calls, to beneficiaries to offer a non-MA or non-PDP product if the unsolicited contact also discusses MA or PDP. (Examples of non-MA or non-PDP products include, but are not limited to: a discount prescription drug card, a Medicare Supplement plan, a needs assessment, an educational event, a review of Medicare coverage options, or any other service or product that is not MA or PDP.)
- Accept an MA or PDP appointment that resulted from an unsolicited contact with a beneficiary (including if the call started based on a non-MA or non-PDP product). We reiterate that any agent/broker who is a producer for a MA or PDP contractor is subject to the CMS marketing requirements at any point that an MA or PDP product becomes part of a discussion with a beneficiary, even if during a sale of an unrelated product, such as Medicare Supplement or long-term care insurance. (See Scope of Appointment, below)
 - Exception for Medicare Supplement policy outbound telephone calls: Due to the nature and relation of Medicare Supplement and MA/PDP product options, if during the course of an outbound call for a Medicare Supplement product the beneficiary initiates interest in an MA or PDP product, then that MA or PDP product may be discussed, as long as the call is recorded, including the beneficiary-initiated request for MA or PDP information.

Scope of Appointments

Several plans requested clarification on documentation for the scope of appointment and on what types of sales activities require the form. Several plans asked if CMS intends to produce a model scope of appointment documentation form and/or if the documentation forms required CMS approval. We have also received reports of third-party entities

misinterpreting our scope of appointment regulation and incorrectly informing plans/agents that the requirement does not apply during a meeting arranged to discuss a non-MA or non-PDP product.

The preamble and regulation at 422.2268(g) state that in conducting marketing activities, an MA or Part D plan may not market any health care related product during a marketing appointment beyond the scope agreed upon by the beneficiary, and documented by the plan, prior to the appointment, (and that distinct lines of plan business include Medicare Supplement, MA, and PDP). For example, if a beneficiary has agreed to an in-home appointment to discuss a PDP product, an agent cannot discuss an HMO product with them during that same meeting, even upon beneficiary request. The agent may leave plan information and have the beneficiary sign a scope of appointment agreement to discuss an HMO product at a separate appointment that must be rescheduled at least 48 hours later. Further clarifying the requirements around written documentation:

- Outside entities are misinterpreting this regulatory scope of appointment requirement, and incorrectly stating that if a beneficiary agrees to a Medicare supplement meeting and during the meeting asks about a MA or PDP product, that those products can be discussed without the documented prior agreement or the 48-hour waiting period. This interpretation is not accurate, as CMS authority applies at any point during an educational or sales meeting/call when an MA or PDP product is discussed, whether initiated by an agent or by the beneficiary.
- As stated in the September 15, 2008, guidance memo, marketing representatives must clearly identify the types of products that will be discussed before marketing to a potential enrollee. This includes all sales presentations, events, appointments, and outbound calls (that are permissible under our unsolicited contacts guidance). The Scope of Appointment form is required for any face-to-face personal/individual marketing appointment with a beneficiary. Sales presentations do not require documentation of beneficiary agreement because the scope of products that will be discussed should be indicated on all event advertising materials.
- Plans must secure Scope of Appointment documentation prior to the appointment. A beneficiary cannot agree to the scope over the phone and then sign the documentation form at the beginning of the sales event. If a plan/agent does not have phone recording capability, a form may be mailed to the beneficiary that can be returned as written documentation. Any Scope of Appointment form must be completed by the beneficiary and returned prior to the appointment.
- The documentation must be in writing, in the form of a signed agreement by the beneficiary, or a recorded oral agreement. A plan or agent documenting the agreement is not acceptable, whether done in writing or using an electronic contact documenting system.
- A beneficiary may sign a Scope of Appointment form at a marketing presentation for a follow-up appointment.

- CMS has developed a model Scope of Appointment form, released as an attachment to this October 7, 2008, guidance. Written Scope of Appointment forms must be submitted for CMS approval (Category 4000, Code 4010). We encourage plans to use our model Scope of Appointment form, and use of the model without modification may be submitted under File&Use. A modified form must be submitted for 45-day review.

Marketing in Health Care Settings

Several plans requested clarification on the display and distribution of marketing materials in health care settings. Specifically, plans have asked if it is acceptable for providers to distribute/display materials only for those plans that respond with materials.

Plans have been advised that providers should attempt to display plan materials for all plans with which they participate. If a particular plan fails to provide materials, the provider may display the materials for only those plans that have provided them.

Meals

Several plans requested clarification on the prohibition of meals provided to current enrollees at marketing events. Plans have also requested clarification on meals provided at educational events.

Meals may be provided at educational events only. Meals may not be provided to current enrollees at a marketing event, as meals at marketing events are prohibited and in that context the current members would be considered potential enrollees for the plan(s) being marketed at that event.

State Appointment of Agents/Brokers

Several plans requested clarification on fees associated with appointment laws. On page 21 of the September 15, 2008, guidance document, CMS stated that organizations are required to pay any fees associated with appointment laws.

CMS is clarifying that in the new regulation in 42 CR 422.2272(c) and 423.2272(c) our intention was to make clear that for an agent or broker to sell our Medicare products, that agent or broker must be appointed in accordance with the state appointment law and that if there are any fees required as part of the appointment law, the fees must be paid. CMS did not intend to dictate who should pay the fees.

Broker/agent training and testing

Several plans requested clarification on the training and testing requirements for plan year 2009. Specifically, plans asked if agents are required to have a passing score of 85% or greater prior to the 2009 marketing season.

CMS is clarifying that in order to market plans after October 1, 2008, any broker or agent tested after September 18, 2008, must pass with at least a score of 85%, but those agents or brokers tested prior to September 18, 2008, must have passed with an 80% score.

Broker/Agent Use of Marketing Materials

Several plans and brokers/agents requested clarification on whether brokers/agents are allowed to create their own marketing materials.

CMS wants to remind all parties that our current Guidelines clearly state that Medicare organizations are responsible for all marketing materials used by their subcontractors to market their plan. All marketing materials used by plans or their subcontractors must be submitted by the organization to CMS for review and approval prior to use. Marketing materials cannot be submitted directly by a third party to CMS.

Additionally, agent/brokers who wish to use materials containing plan information from multiple organizations can either have one organization submit the material on behalf of all the other organizations, or have the piece submitted and approved by CMS for each organization mentioned prior to use.

Compensation

We have received a number of questions regarding compensation. These questions include: whether the rules apply when agents/brokers are providing additional services like scrubbing applications and performing delegated functions; which rules apply to the sale of plans to employers/unions; what happens after the 6-year cycle ends; and does a chargeback apply in the case of an involuntary disenrollment.

Any additional services that an agent/broker is contracted to perform outside of the selling of MA and PDP products would be excluded from the compensation requirements in sections 422.2274 and 423.2274. However, we caution plans to look carefully at arrangements with umbrella marketing organizations of any type to ensure that administrative services fees are paid only for actual services performed and are not used to circumvent the compensation provisions of the rule.

Employer/union group plans are responsible for ensuring that the agents/brokers selling their plans to the employer/union are in compliance with the marketing provisions. The activities conducted by employers/unions or their designees to sign-up members into the plan(s) that the employer/union has selected are not subject these regulations.

Once the 6-year cycle ends, the plan is not required to initiate a new cycle. The first plan change after a cycle ends would initiate a new cycle.

Currently the regulations prohibit payment to agents if the beneficiary disenrolls in the first three months for any reason. Based on anticipated comments to the rule, we expect to clarify in the final regulation the types of disenrollment that would not result in charge back.