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HEALTH LAW ALERT
August 10, 2009

CMS Issues Final Marketing Guidelines

Outbound Verification Calls and Marketing Attestations Among New Requirements

The Centers for Medicare and Medicaid Services ("CMS") issued final Medicare Marketing Guidelines for Medicare Part D plan sponsors and Medicare Advantage organizations (collectively, "Plan Sponsors") on August 7. The new guidelines, published as Chapter 3 of the Medicare Managed Care Manual ("Guidelines"), implement the marketing provisions of the Medicare Improvements for Patients and Providers Act of 2008 ("MIPPA"), the CMS marketing rules that went into effect earlier this year, and CMS's "latest provisions and clarifications" on marketing issues.

The most significant changes from previous marketing guidance include requirements that all Plan Sponsors:

- Conduct outbound education and verification calls "to ensure beneficiaries requesting enrollment understand the plan rules";
- Submit with each piece of marketing material the attestation of two employees that the marketing material meets the requirements of the Guidelines, as delineated in a CMS-provided checklist;
- Implement new requirements for marketing-material disclaimers, including a new statement that must go on the envelope (or the mailing itself if no envelope);
- Make CMS ratings on plan quality, customer satisfaction, and other measures available to current and prospective enrollees;
- Implement additional restrictions on promotional activities and items; and
- Provide appropriate notice of marketing event cancellations.

The Guidelines incorporate guidance previously published in other formats as well as modifying and clarifying a variety of requirements. The Guidelines—including the outbound verification call and other new requirements—were effective immediately upon publication on August 7.

Outbound Verification Calls

Under the Guidelines, Plan Sponsors will be required to conduct outbound verification calls to most new enrollees. Within 10 calendar days of receiving an application, a Plan Sponsor must make "three documented attempts to contact the applicant by telephone"; the calls cannot be made at the point of sale. If the first attempted telephone contact is unsuccessful, the Plan Sponsor must send the individual a "model education letter," to be furnished by CMS. The Guidance also indicates that CMS will provide for the verification calls a "model script," which "has been developed for all plan sponsors for this purpose."

Although Private Fee for Service ("PFFS") plans have been required to make such verification calls in the past, the requirement is new for other types of plans.[1] The requirement goes into effect immediately and applies to all individuals enrolling in a Medicare Advantage or Part D plan, except those (a) enrolling in employer/union PFFS plans and (b) switching from one plan offered by a Plan Sponsor to another plan offered by the same Plan Sponsor.

Marketing Attestations

The Guidelines now require Plan Sponsors to have two employees evaluate any marketing materials that are to be submitted for CMS review and, prior to submission, attest that the material meets the requirements outlined in a CMS-created checklist. The Guidelines claim that "CMS will eventually utilize a number of checklists that will correspond to all required materials." In the interim, CMS will develop a "standard checklist" for materials for which CMS has not created a specific checklist. The checklists will list relevant requirements and disclaimers. CMS reviewers will use the same checklists to help "eliminate discrepancies and confusion."

New Disclaimer Requirements

The Guidelines require Plan Sponsors to print one of three statements on the envelope of every mailing—or the mailing itself, if there is no envelope:

- For advertising material, the Plan Sponsor must print on the envelope (or mailing) "This is an advertisement";
- For plan information, the Plan Sponsor must print "Important plan information about your enrollment"; and
- For care management and similar programs, the Plan Sponsor must print "Health or wellness prevention information."

[1] Indeed, links provided in the Guidance for the model letter and model script lead to PFFS-specific documents (as of 8/10/2009).

In addition, a three-sentence (43-word) disclaimer must go on advertising material that provides benefit information. The Guidelines specify that these and all other disclaimers on advertising, enrollment, pre-enrollment, and post-enrollment materials "must be prominently displayed at the bottom center of the first page of the [marketing] material," unless the Guidelines explicitly require a different location.

CMS Ratings

The Guidance explains that CMS "rates how well plan sponsors perform in different categories[, such as] detecting and preventing illness, ratings from patients, patient safety and customer service," and imposes a new requirement on Plan Sponsors to make this information available to current and prospective enrollees. Plan Sponsors must include the information in enrollment kits, make it available on request, and refer individuals to the information on the Medicare website. The Guidelines indicate that additional information on this requirement will be forthcoming from CMS.

Restrictions on Promotional Activities and Items

CMS imposes new restrictions on promotional activities and items. Plan Sponsors may not offer as promotional activities or items health benefits, such as checkups, or the waiver (or lowering) of co-pays or deductibles. Promotional activities and items cannot be mentioned in advertising or pre-enrollment materials or marketing of a plan. A Plan Sponsor must track and document the provision of promotional activities and items, make them subject to its grievance process, and "explicitly advise enrollees of the right to grieve and the process for filing a grievance." Plan Sponsors may offer promotional items only to promote health-related activities, such as colorectal cancer screening, mammography screening, and smoking cessation.

Notice of Marketing Event Cancellations

Under the Guidelines, a Plan Sponsor is required to notify beneficiaries when it cancels a marketing or sales event, using the same means it used to advertise the event in the first place. Notice of cancellation should be provided to CMS via HPMS as soon as possible. If the event is cancelled less than 48 hours in advance, the Plan Sponsor must send a representative to the event to inform people the event has been cancelled; the representative must remain there for at least 15 minutes and leave a sign notifying people that the event has been cancelled. The Plan Sponsor must "attest that the event was cancelled and that beneficiaries were notified," and retain documentation of a list of beneficiaries contacted about the cancellation, including the date and time of notification.

Other Modifications and Clarifications

Broker Compensation. The Guidance clarifies that brokers who enroll individuals in two plans, such as a Cost plan and a standalone Prescription Drug Plan, should receive compensation for each enrollment, but that brokers are entitled only to the Medicare

Advantage rate for enrolling an individual in a Medicare Advantage-Prescription Drug ("MA-PD") plan. Plan Sponsors are also required to recover payments made to brokers when a beneficiary disenrolls within three months of enrolling (rapid disenrollment) or is otherwise not enrolled for the entire period of time for which the broker received compensation.

Standardization of Plan Name Type. The Guidelines implement the MIPPA requirement that Plan Sponsors include in the name of each plan they offer a standardized description of the type of the plan, *e.g.*, HMO, PPO, PDP, etc. The Guidelines include a few exceptions to the previously described requirement. Under the exception, Plan Sponsors are not required to include the plan type when verbally providing information to current or prospective enrollees; nor must Plan Sponsors add the plan type to names of plans that already end with the type of plan, such as "Gold Plan PFFS."

Other Clarifications. The Guidelines provide clarification on a number of other issues. For example, Plan Sponsors:

- May, but are not required to, indicate in provider directories which providers participate in e-prescribing;
- May not discriminate based on sexual orientation; and
- Are not required to submit materials about Value Added Items and Services ("VAIS") to CMS for review.

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