

Group & Individual Marketing News Bulletin



South Carolina

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ARCHIVES

You may access marketing bulletins from 2001 to present in the “I Am An Agent” portion of our Web site, www.SouthCarolinaBlues.com.

NEW ADDRESS?

If your contact information changes, including e-mail address or fax number, please e-mail us your updated information to grpandindv@bcssc.com.

ORDER SUPPLIES

To order BlueCross supplies on COIN, visit our Web site at www.SouthCarolinaBlues.com, and select *I Am An Agent*. Then, select “Order Supplies” under *Resources*.

QUESTIONS?

Contact your marketing representative at 1-800-288-2227 ext. 42328 if you have questions.

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Important information regarding Medicare Advantage plan marketing

The Centers for Medicare & Medicaid (CMS) release final marketing regulations and important tips about submitting applications

New CMS Marketing Regulations

The open enrollment period for our Medicare Advantage (MA) and prescription drug plan (PDP) is underway. We have listed several changes made to the marketing regulations below so that you can continue to be in compliance with all CMS regulations. Continued compliance with all CMS regulations is a top priority for BlueCross.

In July, Congress passed marketing restrictions in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). These restrictions prohibit:

- Providing meals to beneficiaries as part of marketing activities
- Telemarketing, door-to-door solicitation, and other sales contacts made without a beneficiary’s express invitation
- Cross-selling of non-health care related products during any sales, marketing, or presentation for an MA plan or PDP
- Conducting sales presentations or distributing and accepting health plan applications in provider offices or other places where health care is delivered
- Conducting sales activities, distributing, or collecting applications at education and health fair events

Additionally, prior to any marketing appointment, the beneficiary must agree to the scope of the appointment and that agreement must be documented in writing, signed or through a call recorded by the agent.

This is a brief recap of the CMS regulations. Please see attached document for full details. To learn more about these new regulations, please visit the CMS Web site, www.cms.hhs.gov.

Please contact your marketing rep with any questions.

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Important Information on Submitting Medicare Advantage or Part D applications

Incorrectly submitted applications may cause your customer unnecessary coverage delays.

- CMS requires certified Medicare Advantage agents to sign and date the application with the date *the completed application is received from the customer*.
 - Applications must be received at BlueCross within 48 hours of the agent's signature.
 - To expedite receipt of applications, agents may scan and e-mail applications to MedAdv.Apps@bcbssc.com.
 - Agents may also fax applications to 803-264-9581.
 - Application can be delivered in person to BlueCross at:
4101 Percival Road
Columbia, SC 29229
Clearly mark the package "Medicare Advantage Applications, AX-G07."
 - **DO NOT** submit applications for the same member through multiple delivery methods; i.e. do not fax and mail the same application.
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CENTER FOR DRUG AND HEALTH PLAN CHOICE

MEMORANDUM

DATE: October 17, 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

RE: 2nd Group of Marketing Questions for regulations in CMS 4131-F and CMS 4138-IFC

On September 15, 2008, CMS released guidance to help the industry implement the new Medicare regulations, CMS 4131-F and CMS 4138-IFC. On October 9, 2008, CMS released additional implementation guidance. Attached below are clarifications based on questions received in the regulationquestions@cms.hhs.gov mailbox. Please be sure to read and review all CMS guidance documents including the questions and answers.

Educational vs. Marketing Events

CMS is now requiring a new disclaimer when an educational event is organized, sponsored or promoted by a plan.

"This event is only for educational purposes and no plan specific benefits or details will be shared."

This disclaimer is not required when a plan is invited to be a participant in an educational event sponsored, organized or promoted by an entity other than the plan.

Further, plans that intend to market at events should not refer to the event as an “educational event”. Plans may provide education at a sales or marketing event, but may not market or sell at an education only event.

CMS would like to clarify our guidance regarding educational and/or marketing events:

- Generally we will not categorize State Fairs, Expos, Senior Events, etc., as either educational or marketing events. Our guidance memos clearly define what is and what is not an educational event.
- MIPPA rules regarding cross-selling do not currently extend to educational events.
- CMS has not established requirements for a minimum number of participants at an educational event. However, educational events should not be used to make unsolicited contacts or allow an agent / broker to violate the scope of appointment rules.

- As long as any Medicare beneficiaries are there, all applicable rules are in effect (even if the event is geared towards providers or other non-Medicare eligible beneficiaries).
- CMS does not have any problem with plan sales staff or agents participating in educational events so long as they do not engage in any prohibited activities during the educational event. Their title of “sales agent” is immaterial so long as they conduct themselves in accordance with the rules.

Marketing through Unsolicited Contacts

For purposes of the new MIPPA guidance regarding unsolicited contacts, CMS clarifies:

- Not all third-party leads are prohibited. Leads may still be generated through mailings, websites, advertising and public sales events. Unsolicited third-party leads are prohibited per the guidance memo.
- One of the bullet points regarding Outbound Calls in the previous guidance reads: "plans are prohibited from requesting beneficiary identification numbers (e.g. Social Security Numbers, bank account numbers, credit card numbers, HICN)". However, if a potential beneficiary initiates contact and asks the plan contact to verify eligibility for a SNP plan, it is permissible in this limited case for plans to ask for the HICN number for the purpose of verifying Medicaid status.
- CMS marketing guidelines and regulations apply to Medicare age-ins as well as existing beneficiaries.
- Plans may contact beneficiaries who submit enrollment applications to conduct quality control and agent/broker oversight activities. Scripts for this purpose, like all other call scripts, must be submitted to CMS for review and approval.

CMS considers the following to be unsolicited contacts and in violation of MIPPA:

- Generally, use of old lists or consents to satisfy the new MIPPA rules regarding unsolicited contacts. While CMS understands plans might have previously received beneficiary consent to contact them for sales activities, we view that previous consent as limited in scope, and per our Oct. 9, 2008 MIPPA guidance, short-term, event-specific consent may not be treated as open-ended permission for future contacts. The exceptions are for agents contacting their own clients and also plans / agents contacting their current members.
- Referrals of beneficiaries and/or their contact information resulting in an unsolicited contact are prohibited by the new guidance. The purpose of this policy is to avoid unsolicited contacts based on a claim by an agent / broker that they have a “referral” from a friend or other third-party. Plans or agents/brokers are permitted to leave contact information such as business cards with beneficiaries for them to give to friends they are referring to the agent or plan. However, in all cases, a referred beneficiary needs to contact the plan or agent/broker directly. A call from an agent to a beneficiary who was referred would be considered an unsolicited contact.
- Members who are voluntarily disenrolling from a plan should not be contacted for sales purposes or be asked to consent in any format to further sales contacts. However, members who are being involuntarily disenrolled may be contacted while they are still a member to determine whether they would agree to future sales contacts.

Scope of Appointments

MIPPA scope of appointment rules were put in place to protect beneficiaries from being sold Medicare plans that were not within the agreed upon scope of the sales appointment. Plans are reminded that this does not have any impact on:

- Plan receipt of enrollment forms from prospective enrollees, or requests to enroll initiated by beneficiaries through means such as in-bound calls to plans asking to enroll telephonically.
- Beneficiary walk-ins to a plan or agent/broker office or similar beneficiary-initiated face-to-face sales event. The plan or agent/broker should complete a scope of appointment form and secure the beneficiaries signature prior to discussing Medicare Advantage or Prescription Drug Benefit plans. Plans and agents/brokers should note on the scope of appointment form that the beneficiary was a walk-in.
- Plans and agents/brokers continue to be able to return beneficiary phone calls or messages as these are not unsolicited.

CMS is clarifying that if and when agents unexpectedly find other beneficiaries present for a properly solicited appointment that details the agreed upon scope of appointment, the agent should have the additional beneficiaries complete the scope of appointment form prior to conducting the sales discussion. This is viewed by CMS as a beneficiary-initiated contact.

Lastly, the record retention requirements for all documentation related to MIPPA implementation are the same as those that pertain to other similar Medicare areas (i.e. enrollment) - current contract period, including ten (10) prior periods (see 42 CFR 422.504(e)(4) ; 42 CFR 423.505(d)).

Provider Marketing

CMS would like to restate our current Medicare Marketing Guidelines (“MMG”) as they pertain to provider marketing. "Plans shall prohibit providers from steering, or attempting to steer an undecided potential enrollee toward a plan, or limited number of plans, offered either by the plan sponsor or another plan sponsor, based on the financial interest of the provider or agent, (or their subcontractors). Providers that have entered into co-branding relationships with plan sponsors must also follow this guidance. CMS is concerned about provider activities for the following reasons: Providers may not be fully aware of all plan benefits and costs; and Providers may confuse the beneficiary if the provider is perceived as acting as an agent of the plan vs. acting as the beneficiary’s provider." (MMG p.122-123)

Providers should remain neutral parties in assisting plans to market to beneficiaries or assisting enrollment decisions. Therefore, it would be inappropriate for providers to be involved in any of the following actions:

- offering sales / appointment forms,
- mailing marketing materials on behalf of plans,
- making phone calls or steering beneficiaries, in any way, to a limited number of plans.

This type of action by providers can cause undue confusion regarding the financial motivations of providers.

CMS would not condone a medical group or other health service provider (though they do not sell insurance) conducting parties, dances or other events not related to the medical care of their patients if the intention of the event is to steer beneficiaries to a plan. Additionally, health plans are not allowed to co-sponsor meals or otherwise engage in restricted activity under our Marketing Guidelines or regulations, even if providers are involved.

Meals

CMS guidance prohibits the provision of meals during a sales event, even if the meal is not sponsored by the plan and is a normal activity in that location (soup kitchen, senior center, etc.). Our new MIPPA guidance clearly states that *"Medicare Advantage and Medicare Prescription Drug Plans may not allow prospective enrollees to be provided meals, or have meals subsidized, at any event or meeting at which plan benefits are being discussed and/or plan materials are being distributed."* There are at least two concerns CMS has with allowing plans or agents to conduct marketing at a soup kitchen, shelter or senior center. Many of those beneficiaries are there simply for the meal and may be unwilling to participate in a sales event, and the presence of a plan's sales agents could result in confusion about whether the plan sponsored the meal.

In addition, this guidance clarifies that meals may not be provided to beneficiaries at any event, that does not meet the definition of an "educational event", even if the setting is a State Fair, Expos, etc. where "educational events" are sometimes held.

Cross-selling

For the purposes of the prohibition on "cross-selling", CMS defines "non-health care related products" as any insurance product not involving medical / health coverage (for example, annuities and life insurance). Dental coverage is considered medical / health coverage.

Compensation

CMS would like to clarify these points regarding the MIPPA Agent / Broker compensation guidance:

- It applies only to agents / brokers who make the sale and not to administrative or management staff who might be paid an administrative fee for scheduling, processing or managing the sale.
- "Like plan type" is not defined by the organization that offers the plan. Therefore, an enrollment change from an MA-PD to another MA-PD is considered to be within a "like plan type", regardless of whether the plans were offered by the same or different organizations.
- CMS defines "year" as a plan year, January 1, through December 31.
- For the purpose of calculating compensation, the movement by a beneficiary from an employer group plan to an individual plan (either within the same organization or between different organizations) counts as an initial enrollment.
- Plans should pay compensation in accordance with the structure in place when the enrollment occurred so long as the agent is in good standing and the member is still enrolled. Further, the commission structure of the receiving health plan (rather than the losing health plan) applies to any replacement enrollment.
- CMS does not differentiate between agents, brokers, general agents, general agencies, distribution partners, employees, etc. It is the Medicare plan's responsibility to ensure

that all of their contracted sales staff's compensation levels abide by the new MIPPA guidance.

- While CMS does not dictate how plans should pay compensation, i.e. , monthly, quarterly, annually, we prohibit plans from paying compensation in advance, e.g. paying 5 years' residuals up front).
- While we have not banned bonuses based on the sale of Medicare products, bonuses (announced or unannounced prior to payment) must be calculated into the compensation structure and fall within the new MIPPA guidance. A bonus does not fall outside of the MIPPA guidance because it was not announced to agents or brokers in advance.
- In 2009, when a beneficiary enrolls in a new plan with or without the assistance of an agent, that enrollment triggers year 1 of the 5 year renewal cycle. Whether or not compensation is paid depends on whether an agent assisted in the enrollment.
- If a contracted agent receives a base salary and sells exclusively for one organization, that agent may be considered employed for purposes of applying CMS agent / broker compensation requirements.

Cobranding

The new MIPPA guidance does not change the ability of Pharmacy Benefits Management ("PBMs") to cobrand on the plan ID card.

Marketing Violations

CMS reminds plans that they should forward any allegations of marketing violations directly to their Regional Office Account Manager. Beneficiary marketing complaints should continue to be reported in the Complaints Tracking Module in HPMS.

Use of the Medicare Name

CMS reminds all MA contractors and Part D sponsors that under the Social Security Act, 42 U.S.C. 1320b-10, Section 1140, it is forbidden for any person to use words or symbols, including "Medicare", "Centers for Medicare and Medicaid Services", "Department of Health and Human Services", "Health and Human Services", in a manner that would convey the false impression that the business or product is approved, endorsed, or authorized by Medicare or any other government organization. This rule extends to down stream contractors who may be directly or indirectly involved in marketing Medicare plans. MA contractors and Part D sponsors should assure that their subcontractors are not using the Medicare name in a misleading manner.