DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
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MEDICARE DRUG & HEALTH PLAN CONTRACT ADMINISTRATION GROUP

DATE: August 14, 2013

TO: Medicare Advantage Organizations, Medicare Advantage-Prescription Drug Organizations, Section 1876 Cost Plans, Prescription Drug Plan Sponsors, Employer/Union-Sponsored Group Health Plans, Medicare-Medicaid Plans

FROM: Danielle R. Moon, J.D., M.P.A.
Director

SUBJECT: Additional Clarification of Contract Year 2014 Medicare Marketing Guidelines and Agent/Broker Compensation Structure

This memorandum provides Medicare Advantage Organizations, Medicare Advantage-Prescription Drug Organizations, Section 1876 Cost Plans, Prescription Drug Plan Sponsors, Employer/Union-Sponsored Group Health Plans, and Medicare-Medicaid Plans with additional clarification regarding the Contract Year (CY) 2014 Medicare Marketing Guidelines (MMG) and agent/broker compensation structure.

Additional Contract Year 2014 Medicare Marketing Guidelines Clarifications

On July 19, 2013, CMS held a webinar discussing the CY 2014 MMG. After releasing the MMG and presenting the webinar, we received a variety of requests for clarifications from Plans/Part D Sponsors regarding the CY 2014 MMG. Below, please find information regarding the location of Questions and Answers from the webinar and clarification of several topics.

1. Questions and Answers

We have compiled a set of Questions and Answers responding to inquiries related to the MMG received either through the webinar training or submitted to our marketing policy mailbox. The Questions and Answers will be available shortly on the Outreach and Education webpage under the CMS Final Contract Year 2014 Medicare Marketing Guidelines event at the following link: http://www.cms.gov/Outreach-and-Education/Training/CTEO/Event_Archives.html.

2. Section 40.1 Marketing Material Identification – Approved and Accepted Status on Marketing Materials

CMS is clarifying the guidance in section 40.1 whereby Plans/Part D Sponsors should include approved or accepted status only after the material is approved or accepted and

not when submitting the material for review. The requirements for this guidance will only apply to materials that are prospectively reviewed. Marketing materials submitted as File & Use may include the "accepted" status since these materials are not reviewed prospectively.

3. Section 50.1 Federal Contracting Disclaimer

Section 50.1 of the MMG requires all marketing materials to include a Federal contracting disclaimer. For CY 2014, CMS further refined the contracting disclaimer based on our regulatory requirements in §§ 422.2264(c) and 423.2264(c), which require written materials to include a statement that continued enrollment depends on the contract between CMS and the Plan/Part D Sponsor remaining in effect, i.e., being renewed and not terminated.

In section 50.1 of the MMG, CMS has included an example of a disclaimer that meets these requirements. Plans/Part D Sponsors must develop disclaimer language understandable to the enrollee (i.e., plain language) that meets our regulatory requirements at §§ 422.2264(c) and 423.2264(c). When developing the disclaimer, Plans/Part D Sponsors may combine plan types such as PPO, HMO, PFFS or Medicare Advantage, as applicable.

It has come to CMS' attention that some Plans/Part D Sponsors thought that, because the disclaimer was provided as an example, it was optional. As a result, they were not including the disclaimer on their materials. CMS is now clarifying that such a disclaimer has been and continues to be required. We expect Plans/Part D Sponsors to revise the contracting disclaimer as quickly as possible, but we are granting a grace period for compliance until January 1, 2014. Plans/Part D sponsors may use their existing stock until December 31, 2013, but must have systems in place to print materials with the revised disclaimer beginning January 1, 2014.

Furthermore, we advise Plans/Part D Sponsors to work closely with their account manager to ensure that the requirements are met.

4. Section 60.7 Annual Notice of Change/Evidence of Coverage (ANOC/EOC) – Additional Materials

CMS is clarifying that the revised guidance in section 60.7 is not a change in policy. Rather, the statement, "Additional materials may not be included in the ANOC/EOC mailing unless otherwise specified," was moved from section 40.10 in the CY 2013 MMG to section 60.7 in our effort to streamline the CY 2014 MMG. When using the terms "otherwise specified," we mean specified in the form instructions. The documents that can be included with the ANOC/EOC mailing are provided in the instructions released with the CY 2014 ANOC/EOC templates. Please refer to the instructions posted with the ANOC/EOC templates, available at: http://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/MarketngModelsStandardDocumentsandEducationalMaterial.html.

Please also note that this section correctly states that "Plans/Part D Sponsors that mail in waves should enter the actual date for each wave." The mailing instruction in 4.v. on page 3 of the 2014 ANOC/EOC incorrectly states that the date of the last wave should be entered.

5. Regulatory Requirements

In revising the MMG, CMS further aligned the marketing guidance with regulatory requirements. In instances where "must" has been changed to "should" or "expected," CMS policy has not changed. Plans/Part D Sponsors must continue to meet the requirements in Title 42 of the Code of Federal Regulations, Parts 422, 423, and 417. In the CY2014 MMG, CMS provides guidance as to how Plans/Part D Sponsors are expected to meet these requirements.

We advise that Plans/Part D Sponsors direct any additional questions on the MMG to their account manager or marketing reviewer.

Agent/Broker Compensation Structure

In its review of agent/broker compensation (compensation), CMS has determined that some Plans/Part D Sponsors (organizations) are inappropriately paying agent commissions. This memo addresses specific areas of concern based on CMS' recent review and clarifies how organizations should pay compensation to independent agents and brokers. Requirements relating to compensation may be found at 42 C.F.R. §§ 422.2274 and 423.2274, as well as section 120 of the MMG.

CMS defines a plan year as January 1 through December 31 and requires compensation to be determined and paid based on this time period. Initial compensation, regardless of the enrollment effective date, should always be calculated and paid through the end of the initial plan year (i.e., December 31of year 1). Renewal compensation, regardless of the enrollment effective date, should also be calculated and paid through December 31 of the applicable renewal year. CMS has determined that some organizations are basing initial and/or renewal compensation on the enrollment effective date, resulting in compensation extending from one plan year into another plan year. For example, consider an initial enrollee with an effective date of September 1, 2013. Some organizations incorrectly determined initial payment as covering September 1, 2013 through August 31, 2014 instead of basing it on the plan year. The correct compensation should have the initial payment (either full or pro-rated payment) covering September 1, 2013 through December 31, 2013, with a renewal payment covering January 1, 2014 through December 31, 2014.

In addition, CMS requirements state that compensation may only be paid for the beneficiary's months of enrollment. CMS has identified instances where organizations are not recouping compensation payments for mid-year disenrollments. Organizations must recover compensation for all disenrollments that are not effective at the end of the plan year (i.e., December 31). The recovery amount must be a pro-rated amount equal to the number of months that the beneficiary was not enrolled in the plan, unless it requires a full recovery, as in the case of a rapid

disenrollment. For example, a third year renewal member disenrolls effective August 31. The organization must recover four-twelfths (4/12^{ths}) of the renewal amount since the member was not enrolled from September through December, accounting for four of the twelve months within the plan year.

Finally, since payment may only be made for the months a member is enrolled in a plan, mid-year enrollments equate to a pro-rated payment, with the exception of an initial payment, which may be made at the full initial amount. CMS has determined that some organizations are either paying a full renewal amount regardless of the enrollment date, or are paying an improperly calculated pro-rated renewal amount. Similar to mid-year disenrollments, the pro-rated amount must correlate with the number of months the member is enrolled. For instance, if a renewal member's enrollment is effective March 1 the organization's compensation payment would be ten-twelfths (10/12^{ths}), representing the months March through December, of the yearly renewal amount.

Please direct any questions regarding the compensation issues addressed in this memo to Christine Reinhard (christine.reinhard@cms.hhs.gov or 410-786-2987).