Marketing Guidelines: Provider Promotional Activities
“To the extent that a provider can assist a beneficiary in an objective assessment of the beneficiary’s needs and potential plan options that may meet those needs, providers are encouraged to do so.”
Potential Concerns

- May not be fully aware of all Plan benefits and costs
- The beneficiary's provider should not want to be perceived as an agent of the Plan
- May face conflicting incentives
Background Information
The Medicare Marketing Guidelines Are For:

- Medicare Advantage Plans (MA)
- Medicare Advantage Prescription Drug Plans (MA-PDs)
- Prescription Drug Plans (PDPs)
- 1876 Cost Plans
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<td>• Overview and Definitions</td>
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Definitions

- Assisting in Enrollment
- Education
- Marketing
Employees, Brokers, and Agents

A Plan may directly employ or contract with a person to market a Plan, if the Plan Sponsor:

- Complies with all applicable laws and CMS policies and guidelines
- Conducts monitoring activities to ensure compliance
- Uses a state licensed, certified, or registered individual to perform marketing, if a state has such a marketing requirement
Provider Promotional Activities
1. Provider Activities

- “...objective assessment of the beneficiary’s needs and potential plan options...”
- Inform prospective enrollees where they may obtain information on the full range of Plan options
2. Plan Activities

- Common areas (e.g., cafeterias, community rooms, area outside of where patients wait for and interact with pharmacy providers and obtain medications)

- Restricted areas (e.g., waiting rooms, exam rooms, pharmacy counter area)
Provider Promotional Activities

3. Provider Affiliation Information

4. Comparative and Descriptive Plan Information

5. Non-Benefit/Service Providing Third-Party

6. Providers/Provider Group Web Sites

7. Health Fairs

8. Leads from Providers
Providers Can:

• Provide names of plans with which they contract and/or participate

• Provide information and assistance in applying for LIS

• Provide objective information on specific Plan formularies, based on a patient’s medications and health care needs
Providers Can:

- Provide objective information regarding Plans (e.g., benefits, cost sharing, utilization management tools)
- Distribute PDP marketing materials, including enrollment forms
- Distribute MA and MA-PD marketing materials, excluding enrollment forms
Sample Can and Cannot List

Providers Can:

- Refer patients to other sources of information (e.g., SHIPs, Plans, State Medicaid Office, SSA, CMS Web Site, 1-800-MEDI CARE)
Sample Can and Cannot List

Providers Cannot:

• Direct, urge, or attempt to persuade, any prospective enrollee to enroll in a particular Plan or to insure with a particular company

• Collect enrollment applications

• Offer inducements to persuade beneficiaries to enroll in a particular plan or organization
Providers Cannot:

• Offer anything of value to induce Plan enrollees to select them as their provider

• Health screen when distributing information to patients, as health screening is a prohibited marketing activity

• Expect compensation in consideration for the enrollment of a beneficiary
Some Considerations

• Marketing Guidelines
• State Laws
• Federal Laws
• Contractual Relationships
• Corporate Structure
Staying Inside the Lines:
Marketing the Medicare Prescription Drug Program

Rebecca Shanahan, Aetna Specialty Pharmacy LLC

Robert E. Slavkin, Foley & Lardner LLP
MMA - A New Market for Drug Management

- Drug management for private plans under Medicare regulators
- Pressure on price and performance
  - Plan Sponsor premium competition
  - Expanded out of pocket costs for beneficiaries
  - Rebates and price transparency
  - Cost effectiveness of drugs
  - Pay for performance and risk sharing
- Informatics and monitoring
  - Comparative drug analysis
  - Evidence based decisions
  - Outcomes and standards of measurements
Part D Overview

- Largest expansion of Medicare program since its inception in 1965
- Medicare Beneficiaries will represent:
  - 43 million in 2006; 13% of population
  - 2011 “Baby Boomer” waves enter system
  - 34% of Rx dispensed
  - 42% of the US drug spend
  - $35 billion new market opportunity; 90% of beneficiaries Rx spend $2,322 a year
Part D Plans

Drug Benefit Delivered to Beneficiaries Through

- Private Prescription Drug Plans “PDPs” OR Medicare Advantage Prescription Drug Plans “MA-PDs” OR Other Prescription Drug Plans
The Government Moves to

- Regulate the Drug Benefit Market
  - Help MA-PD and PDP survive
  - Encourage beneficiary movement to integrated managed care plans
  - Spend considerable dollars on marketing and allow greater plan sponsor marketing freedoms (lessons learned from the DDC)
  - Move seniors to managed consumerism

- Move Plan Sponsors Towards “Value Based Purchasing”
  - Support plan influence on provider decision and treatment decision making
  - Extract data on quality and outcomes
  - Pay-for-performance and quality indicators
  - Disease management and integrated MTM
MMA Drug Benefit Implementation Timeline

- **Start of Part D**: Jan 2005
- **Final Rule**: Jan 2005
- **Regions**: Jan – March 2005
- **Plan Application Period**: April – May 2005
- **Review of Plan Formularies**: June – August 2005
- **Evaluation of Plan Bids**: Oct – Dec 2005
- **Contracts**: Jan 2006
- **Evaluation of Plan Choices**: If Needed, Fallback Plans Activated
- **Start of LIS Outreach**: Start of Plan Enrollment

Events:
- **Start of LIS Outreach**: June – August 2005
- **Start of Plan Enrollment**: Jan 2005
- **Regions**: Jan 2005
- **Final Rule**: Jan 2005
- **Plan Application Period**: Jan – March 2005
- **Review of Plan Formularies**: April – May 2005
- **Evaluation of Plan Bids**: June – August 2005
- **Contracts**: Oct – Dec 2005
- **Evaluation of Plan Choices**: Jan 2006
- **Start of LIS Outreach**: Start of Plan Enrollment

Timeline:
- **Dec 2004**: Regions
- **Jan 2005**: Final Rule
- **Jan – March 2005**: Plan Application Period
- **April – May 2005**: Review of Plan Formularies
- **June – August 2005**: Evaluation of Plan Bids
- **Oct – Dec 2005**: Contracts
- **Jan 2006**: Evaluation of Plan Choices
Beneficiaries Can Voluntarily Enroll or Switch Plans

- **Initial Enrollment Period (IEP)**
  - November 15, 2005 through May 15, 2006 for those eligible for Medicare by February 28, 2006

- **Annual Coordinated Election Period (AEP)**
  - November 15th through December 31st of every year for benefits starting January 1st of the following year
  - Enrollment is for the calendar year

- **Certain circumstances may qualify a member for a Special Enrollment Period (SEP) when they may disenroll or switch plans.**
Pharmaceutical Management 2005

Increasing Patient Populations

Costs

Treatment Complexity

$54b Biopharmaceuticals

Specialty Pharmacy

OPC & Providers

Home Infusion

Mail Order Rx $20b

Retail Rx $180b
Drug Benefit Management

**CMS**

**Medicare**
- Prescription Drug Programs PDP
  - Nat’l PDP (10)
  - Reg. PDPs (34)
- Medicare Advantage MA-PD
  - MA/ PDPs (143)
- Competitive Acquisition Programs (CAPs)
  - Nat’l CAP (5+)
  - Reg. CAP (?)

**Medicaid**
- State Programs (50)

**340B Programs**
- 4,000 Programs
Medicare Beneficiaries PDP Trusted Information Sources

- Doctor
- CMS
- State Medicaid
- Insurance Agent
- Pharmacist
Medicare Beneficiaries
Trusted Sources for PDP Information

- CMS (Medicare & Medicaid)
- Doctors (Healthcare Professionals)
- Pharmacists
- Newspapers & Periodicals
- Insurance Agents
- Family Member
CMS Part D Standard Benefit

- **Beneficiary**
  - Pays Deductible $250
  - Pays 25% up to $2,250
  - Pays 100% in the "Donut Hole" $2,850 gap

- **CMS**
  - Pays 75% of Total Drug Costs

- **Donut Hole**
  - $2,850 gap
  - Beneficiary pays 100%

- **Total Drug Costs**
  - Beneficiary and CMS pay until hitting $5,100
  - Beneficiary pays $250 deductible

- **Beneficiary**
  - Has NO COVERAGE in the "Donut Hole"
CMS Covered Drug Classes

- USP Formulary Model
  - 146 classes
  - At least 2 covered drugs per class minimum
- Last minute additionally all PDP formularies must include “all or substantially all” drugs in these six categories:
  - Antidepressants
  - Antipsychotics
  - Anticonvulsants
  - Anticancer
  - Immunosuppressants
  - HIV/AIDS
Closed Formulary Specifics

- Limited number of products available
- Prescriptions must be from the formulary list to be paid for
- Non-formulary drugs:
  - Patient pays out of pocket, OR
  - In some situations, the plan will cover the cost with prior authorization
Marketing Guidelines

- How do Plans Communicate the Part D Message?
- Part D Marketing Guidelines
  - Published 53,000 words August 15, 2005
    - Address do’s and don’ts for all potential marketers within the D arena.
    - Leave open communications issues arising out of coverage confusion with Parts A, B, CAP B and potential “E”
Healthcare Professionals CAN

- Objectively provide the names of PDP plans in the region
- Provide information and assistance in applying for the Extra Help
- Provide objective information on specific Plan formularies, based on a particular patient’s medications and health care needs
- Provide objective information regarding specific plans, such as covered benefits, cost sharing, and utilization management tools
- Distribute PDP marketing materials, including enrollment application forms
- Refer patients to other sources of information
- (CMS website) Triple AAA
- Distribute comparative marketing materials
HealthCare Professionals CAN’T

– Direct, urge, or attempt to persuade, any prospective enrollee to enroll in a particular Plan or to insure with a particular company based on financial or any other interest of the provider (or subcontractor) STARK

– Provide plan to plan comparison unless part of an overall third party comparison

– Collect enrollment applications for submission to PDP

– Offer inducements to persuade beneficiaries to enroll in a particular plan or organization

– Health screen when distributing information to patients

– Offer anything of value to induce Plan enrollees to select them as their PDP provider

– Expect compensation in consideration for the enrollment of a beneficiary

– Expect compensation directly or indirectly from the Plan for beneficiary enrollment activities
### PDP Benchmark Bids by Region

#### Median Premium Bids Closest to, but Below Regional Benchmark Sorted By Benchmark Price

<table>
<thead>
<tr>
<th>Region</th>
<th>State(s)</th>
<th>Benchmark</th>
<th>Region</th>
<th>State(s)</th>
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Source: CMS Conf Call – Lehman Brothers Managed Care Benchmark announced 08/10/05
Actuarial Equivalency creates opportunity for confusion

- Patients selecting a plan with cheaper premiums may open up Pandora’s box:
  - Drug Restrictions (Closed Formulary)
  - Potential for higher brand Tiers and non-preferred co-pays
  - Prior authorization for services, need to switch drugs, etc…
  - Out of pocket costs for non-covered brand preferred drugs through the PDP or MA-PD plan that does not go toward their TrOOP (“True Out-of-Pocket Costs”)
  - Specialty injectables and biologics on 4th Tiers with high copays
## PDP Comparative Analysis

<table>
<thead>
<tr>
<th>Company</th>
<th>Product Name</th>
<th>Range of Premiums</th>
<th>Ded.</th>
<th>Tiered Copays</th>
<th># of Top 100 Drugs in Formulary</th>
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<tr>
<td>CIGNA</td>
<td>Value Plan</td>
<td>$30.37 - $37.27</td>
<td>$250</td>
<td>3 tiers</td>
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<td>Plus Plan</td>
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<td>Complete Plan</td>
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<td>AARP</td>
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<td>WellPoint</td>
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<td>(Unicare)</td>
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</tbody>
</table>
Practical Implementation of Marketing Plans

- Potential Enrollee Encounters
  - Kiosks
  - Individuals/Plan Reps/Enrollment Staff
  - Public Service Announcements
  - Mailers
  - Websites
  - Billboards
  - Printed advertisements
  - Event signage
  - Post Stands and Freestanding inserts in Print materials
  - Counter Tents & Stickers
  - Promotional Buttons
  - Banners
Practical Implementation of Marketing Plans

- **Web Site Guidelines**
  - Must have a dedicated Prescription Drug Benefit web site or page, including name of Part D plan
  - Must have font size 12 coded into its site
  - Part D Plan toll-free customer service number, TTY/TDD number, physical or Post Office Box address & hours of operation
  - Description of services, benefits, applicable terms and conditions, premiums, cost sharing, conditions associated with receipt or use of benefits 60 day notice regarding formulary changes, pharmacy access information, out of network coverage, grievance, appeals & exceptions policies
  - Links for Summary of Benefits, Enrollment Instructions & Forms, Evidence of Coverage & Privacy Notice
Practical Implementation of Marketing Plans

- Information Content
  - Plan Names must not convey:
    - Exclusion of disabled, non-senior beneficiaries,
    - religious or ethnic affiliation, or
    - Medicare “endorsed”
  - Plan service area(s)
  - Plan contracted with the Federal Government for 1 year with not guarantee of continuity of coverage
  - Hours of Operation & Customer Service phone numbers
  - Enrollee obligation to continue Part B premium payment
  - Summary of Benefits
  - Pharmacy Directory
  - Comprehensive Formulary
  - Enrollment Information
  - Member ID Card
  - Evidence of Coverage
  - Explanation of Benefits
  - Notice of Availability of alternative formats, e.g. braille, foreign languages, audio tapes, large print
Practical Implementation of Marketing Plans

- Evidence of Coverage must include
  - Plan Service Area
  - Annual Deductible amount; initial coverage limit; cost sharing under initial coverage limit and the cost sharing between initial coverage limit and annual out of pocket threshold.
  - Major exclusions and limitations, including UM, generic substitution and any other formulary restrictions; emergency and urgent care
  - All monetary limits as well as restrictive policies that might impact access to drugs or services
  - Quality assurance policies & procedures, including UM and DTM
  - Part D Plan’s contract is renewable annually so coverage beyond 1 year not guaranteed
  - Define & explain formulary & how to obtain exceptions to formulary or tiered cost structures; EOBs for prescription drug benefits used
  - Availability of Limited Income Subsidies and Rights of Appeal
Practical Implementation of Marketing Plans

- **Prizes & Incentives**
  - Plans may not use free gifts or prizes as inducements to enroll...any gratuity provided must be made available to all participants regardless of enrollment and may not exceed $15 value.
  - Cash gifts are prohibited, including charitable contributions made on behalf of individuals and gift certificates, readily converted to cash. Prizes greater than $15 can be offered to the general public in any amount.

- **Radio & Television advertisements must:**
  - must include the Plan’s toll free number
  - Television display number in a crawl or banner fashion and show TTY/TDD numbers.
  - Have received CMS final script approval

- **Printed Materials must meet CMS prior review**
Practical Implementation of Marketing Plans

- **Insurance Brokers**
  - >100 Complaints to CMS as of 11/26
  - Cross-selling other types of insurance, discounts on hearing aids, eyeglasses, healthclub memberships & other financial services
  - No door-to-door selling without beneficiary invitation; no repeated outreach for 6 months after beneficiary refuses assistance or doesn’t respond

- **Retail Pharmacies**
  - Matching verbal communication with written communication regarding plan design, formulary coverage and/or changing enrollment (compliance issue)

- **Physician Offices**
  - Nurses
  - Office Staff
  - Physician

- **Health Plan Call Centers**
Practical Implementation of Marketing Plans

- MMA allows MA organizations to offer plans to serve special needs individuals
- Dual Eligible Special Needs Plans
  - Materials must be targeted to the specific dual eligible individuals and must clearly state eligibility requirements for that plan
  - All eligible individuals must be contacted
- Institutional SNP
  - May have limited enrollment options (limited beds in limited facilities)
- State Pharmaceutical Assistance Programs
  - State provided drug coverage to limited income or disease specific populations
  - May require additional promotion to assure that benefits are as generous as existing coverage
- Significant requirements regarding financial information about potential beneficiary eligibility
Practical Implementation of Marketing Plans

- Potential Compliance Issues
  - Matching verbal with written communication regarding plan design, formulary coverage and/or changing enrollment
  - Training staff regarding Plan Design & Options, Fraud & Abuse Avoidance and Appeals opportunities
  - Work Force Education/Competency & Qualifications
  - Brokerage Activities
  - Call Center Environment
    - Training Materials
    - TSF/ASA Requirements
    - Performance Standards
    - Documentation/Risk Management
Plan Sponsor Sales Force

- CMS Training Requirements

- Plans to be marketed by licensed insurance salespersons
  - Florida licensure requirements:
    - Pre-licensing course completion
    - Pass a Licensure Exam
    - Submit Application that Includes:
      - Applicant’s full name, address, age, ss #
      - Proof of completion or about to complete prelicensing course
      - Information on whether the applicant has had an insurance sales license revoked
      - Whether the applicant is indebted under an agency contract
      - Proof applicant meets requirements for type of license sought
      - Additional information regarding experience, education, ability
    - FINGERPRINTING
Plan Sponsor Sales Force

- Issues of bait & switch, even when not intended
- Cross Selling
- Disclosure & rescission options
- Other
Compliance Training Plan

- Questions to ask in creation of a plan:
  - What would be included in the training?
  - How would competency be documented?
  - How would competency be reviewed?
  - What updates?
    - What intervals?
  - Silent Shoppers; Call Monitoring; “Ride Along” training of sales force & follow up Quality/Customer Satisfaction surveys
  - If cross-selling other products, look at statistical data around how many cross-sold products, any patterns? Demographic profiles of sales accounts
Compliance Training Plan

Additional Issues
- Quality Check with Enrollees?
- Silent Monitoring?
- Stupid Call Center Tricks
- Hand offs of information between entities, including HIPAA confidentiality
 Covered entities, health plans included, may use patient protected information for:
  – Treatment
  – Payment, or
  – Health care operations
  – Certain public interest or benefit purposes

 Health plans may use their members’ information to provide those members with information regarding the plan’s Part D benefit packages.
HIPAA and Part D Marketing

- Advantage for MA-PDs -- Challenge for PDPs
  - Where do they get their contact information?
  - Blanket advertising
    - Bowling for beneficiaries!

- HIPAA a one way street, so to speak
  - Entities sub-contracted with MA-PDs must execute Business Associate or Data Use Agreements
Questions
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