

## MARKETING

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## OVERVIEW

The Centers for Medicare & Medicaid Services (CMS) *Medicare Managed Care Manual* (CMS Pub. No. 100-16) contains Marketing Guidelines for Prescription Drug Plans (PDPs) and Medicare Advantage Prescription Drug Plans (MA-PDs), available online at <http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/Chapter%202%20Medicare%20Marketing%20Guidelines.pdf>. Providers, such as pharmacies and all other entities that contract with MA plans, must also follow a set of Marketing Guidelines. Congress took steps in the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 to address several problematic marketing activities. MIPPA and related CMS rules and guidance deal with unsolicited contacts with Medicare beneficiaries, providing meals to prospective enrollees, and the use of unlicensed sales agents. CMS also issued new guidance on co-branding, appointments to market MA plans to prospective enrollees, and agent and broker compensation.



If a SHIP counselor or a beneficiary believes that a plan or provider is not following the guidelines, he can report such activities to the following places:

- CMS encourages counselors to submit cases to the Regional Office for tracking and follow up through a central process.
- Counselors who help beneficiaries file grievances with their plans should contact the plan or 1-800-MEDICARE to do so.
- Counselors should not usually report issues directly to the plan.

The materials and methods Medicare Advantage (MA) organizations use to promote and sell MA plans to eligible beneficiaries must follow standards established by CMS. Unless otherwise specified, this section of the guide addresses all MA plans, including MA-only and MA-PD plans, and Cost plans. This section does not focus on the marketing of PACE plans, which are subject to a different set of rules.

It is important for SHIP counselors and Medicare beneficiaries to recognize and report to CMS activities or behaviors that do not meet the Marketing Guidelines. Please refer to HAP's *MA and PDP Plan Marketing Fact Sheet* (Appendix C) for a summary of the Marketing Guidelines.

Marketing for the next plan year may not begin until an MA organization receives notice from CMS that the plan has an approved contract to offer in the coming year, but not before October 1 of the current year. Prior to this marketing period, plans may only provide educational material or presentations to eligible Medicare beneficiaries, that is, with no intent to enroll potential members.

MA organizations may not market an MA plan outside of the plan's service area unless it is unavoidable. In unavoidable situations, the organization must disclose the plan's service area in a clear manner.

**EXAMPLE** *One example of an unavoidable situation is television advertising. A commercial for an MA plan may be broadcast from a television station that broadcasts across state lines and MA regions. The MA plan may be available in one of the MA regions and not the other. In this case, the MA plan cannot avoid marketing to those who live outside the MA plan's service area.*

## Plan Names

CMS has specific rules about names for MA plans. MA organizations may not use a plan name that discourages certain beneficiaries to enroll in the plan. For example, an MA organization cannot use the words "senior" or "seniors," because they may mislead Medicare beneficiaries under age 65 to think they are not eligible to enroll in the plan. Also, MA plans generally may not suggest an ethnic or religious group in their names. The exception to this rule is for plans that are affiliated with a group named as such. Finally, while MA plan names may not include the words "Medicare endorsed" they may contain the word "Medicare."

## Co-Branding

MA organizations may coordinate with a separate entity in a business arrangement to offer an MA plan. Because of this relationship, the MA plan may use the name of the co-branded entity in the plan's marketing materials. CMS prohibits, however, the use of the co-branded entity's name on enrollees' membership cards.

Because of confusion in past years, marketing materials that include the name of the co-branded entity now must clarify that the plan has a larger provider network than those of the co-branded entity alone. CMS requires that these materials include the following language, "Other (Pharmacies/Physicians/Providers) are Available in Our Network."

The co-branded entity may also only market the MA plan during appropriate marketing and enrollment periods.

**EXAMPLE** *Humana offers MA plans that are co-branded with Wal-Mart. Humana may not use the name, Wal-Mart, on their membership cards. Humana's marketing materials may include the name, Wal-Mart, but they also must say, "Other pharmacies are available in our network."*

## Cross-Selling

Starting on September 18, 2008, a CMS rule prohibits MA and Part D drug plans and their representatives from marketing non-health care related products (such as annuities and life insurance) to prospective plan enrollees during sales activities or presentations. The rule's purpose is to prevent confusion that Medicare health plans and non-health related financial products are part of the same package. Plans may, however, sell non-health related products on inbound calls when a beneficiary asks for information about them.

**Note:** *State insurance departments typically approve marketing materials for health insurance policies sold in their states. With the Medicare Advantage program, federal law preempts state regulation of MA plan marketing materials. The states, however, still license and regulate the agents and brokers who work for, and contract with, MA plans.*

## MARKETING MATERIALS

All materials used in promoting and selling an MA plan and for enrollment are subject to CMS rules and restrictions on marketing. Separate CMS rules govern the materials that plans use for different phases of the marketing process.

### Advertising

Advertising, as governed by CMS rules, includes the following methods:

- Television ads
- Radio ads
- Banner ads
- Outdoor advertising
- Print ads
- Internet advertising
- Direct mail (including enrollment forms or materials)

There are specific rules about certain aspects of MA plan advertising, including the following features:

- **Disclaimer:** Except for banner ads and outdoor advertising, all ads must state that the organization contracts with the Federal government.
- **Claim Forms and Paperwork:** Materials addressing claim forms and paperwork may not state the plan has “no paperwork” or “no claim forms,” but the materials may say, “virtually no paperwork” or “hardly any paperwork.”
- **Hours of Operation:** When ads include phone numbers, they must also include the hours of operation of the customer service department.
- **TTY/TDD Numbers:** Generally, when ads include plan phone numbers, they must also include TTY/TDD numbers in the same font size and style.
- **Pharmacies:** MA plans may advertise the number of network pharmacies but must distinguish between preferred and non-preferred pharmacies, if applicable.
- **Formatting Requirements:** Footnotes must be the same size font as the majority of text in a piece of written advertisement. Brochures and direct mail may not use a font size smaller than Times New Roman 12-point font. Information or advertising on the MA plan’s website must be written in a minimum of 12-point Times New Roman font, or the same point size in another font.
- **Logos/Tag Lines:** MA organizations may use unproven claims about their plans in advertising, but may not make superlative remarks about an MA plan. That is, ads may not state that a plan is better than all other plans in delivering services or care.
- **Drawings/Prizes/Giveaways:** Free gifts and prizes offered by an MA plan during marketing must be made available to all those at an enrollment event and may not be used to obligate a beneficiary to enroll. The value of any gift or prize must be less than \$15 retail. The gift or prize may not be cash or a cash equivalent, like a gift card.

## Pre-Enrollment Materials

CMS has a specific set of rules to govern the marketing materials that MA organizations use prior to enrollment. These are called “pre-enrollment materials.”

- **Language Requirements**

MA plans must include certain statements in all pre-enrollment materials. These language requirements fall into the following specific categories:

- **Lock-In Statement/ Access Information:** This statement must be used by MA plans that limit access to providers (i.e., a coordinated care plan’s provider network). Pre-enrollment materials must indicate that enrollees must use plan providers for routine care. These materials must state that neither Medicare nor the MA plan will cover routine care received outside of the plan’s network.

- **Benefit and Plan Premium Information:** Pre-enrollment materials must include the specifics of coverage and cost information, including:
  - Part B premium payment
  - Annual limits on benefits
  - Annual monetary limits
  - Major exclusions and limitations
  - Reference to the plan’s customer service phone number
- **Alternative Formats:** Pre-enrollment materials must indicate when an MA plan has beneficiary materials in alternative formats (e.g., Braille, languages other than English, audio, or large print).
- **Claim Forms and Paperwork:** Materials addressing claim forms and paperwork may not state the plan has “no paperwork” or “no claim forms,” but the materials may say, “virtually no paperwork” or “hardly any paperwork.”

- **Formatting Requirements**

All pre-enrollment materials for MA plans must follow specific formatting requirements to ensure their readability. These formatting requirements fall into the following specific categories:

- **Member Materials:** Printed pre-enrollment materials must use 12-point or larger font.
- **Materials on the Internet:** Information on the MA plan’s website must be written in a minimum of 12-point Times New Roman font, or the same point size in another font.
- **Footnotes and Subscripts:** Footnotes and subscripts on notices must be written in a minimum of 12-point Times New Roman font, or the same point size in another font.

- **Eligibility Requirements**

Pre-enrollment materials must describe the eligibility requirements for enrollment into an MA plan. The materials must include the following specific eligibility information:

- An individual must have both Medicare Part A and Part B to enroll in an MA plan
- An individual must reside in the service area of an MA plan
- An enrollee in an MA-PD plan must receive his Medicare prescription drug coverage through the MA-PD plan

- **Other Requirements**

CMS has established other requirements for pre-enrollment materials that include:

- **Premiums:** The pre-enrollment materials of all MA plans must contain the statement, “You must continue to pay your Medicare Part B premium, if not otherwise paid for under Medicaid or by another third-party.”

- **Logos/Tag Lines:** MA organizations may use unproven claims about their plan in pre-enrollment materials, but may not make superlative remarks to promote the MA plan. That is, ads may not state that a plan is better than all other plans in delivering services or care.
- **Online Enrollment Center:** MA organizations may choose to allow enrollment into MA plans through CMS's Online Enrollment Center (Health Plan Finder).
- **Low-Income Subsidy:** All MA organizations offering MA-PD plans must include the following language, "You may be able to get extra help to pay for prescription drug premiums and costs." The statement must include contact information for 1-800-MEDICARE, the Social Security hotline, and a reference to the state Medicaid office.
- **Summary of Benefits**

The Summary of Benefits (SB) is the main means that an MA organization uses to provide current enrollees and eligible individuals wide-ranging information about an MA plan's structure, coverage, benefits, and costs.

The SB is a standardized document with four sections:

- **An introduction and beneficiary information:** This section includes standard language that applies to all MA organizations (as well as organizations offering PDP plans) and must be included verbatim in the SB.
- **A benefit comparison matrix:** This section of the SB includes a chart of benefits offered by the MA plan. The benefits included on the chart are pulled from a list of commonly available benefits.
- **An optional free-form text area:** This section includes information about the plan's benefits not included elsewhere in the SB.
- **Beginning in January 2010, Special Needs Plans (SNPs) for dual-eligible beneficiaries must provide each prospective enrollee a written statement describing**
  - Benefits the individual is entitled to under Medicaid
  - Cost-sharing protections the individual is entitled to under Medicaid
  - Which of these benefits and cost-sharing protections are covered under the SNP

## Post-Enrollment Materials

CMS has a specific set of rules to govern the marketing materials an MA organization uses after enrollment. These are called "post-enrollment materials."

- **Language Requirements**

All post-enrollment materials must include certain language when used to market MA plans. These language requirements fall into the following specific categories:

- **Lock-In Statement/ Access Information:** MA plans with limits on access to providers (i.e., coordinated care plans with provider networks) must use this statement. Post-enrollment materials – including the Summary of Benefits (SB), Evidence of Coverage (EOC), and Member Handbook – must indicate that enrollees must use plan providers for routine care. These materials must state that neither Medicare nor the MA plan will cover routine care received outside the plan’s provider network.
- **Alternative Formats:** The EOC must indicate when an MA plan has beneficiary materials in alternative formats (e.g., Braille, languages other than English, audio, or large print).
- **Claim Forms and Paperwork:** Materials addressing claim forms and paperwork may not state the plan has “no paperwork” or “no claim forms,” but the materials may say, “virtually no paperwork” or “hardly any paperwork.”
- **Formatting Requirements**  
All post-enrollment materials for MA plans must follow the same formatting requirements that apply to pre-enrollment materials, described above.
- **Other Requirements**  
CMS has established other requirements for post-enrollment materials. Post-enrollment marketing materials must meet the following requirements:
  - **Logos/Tag Lines:** MA organizations may use unproven claims about their plan in post-enrollment materials, but may not make superlative remarks to promote the MA plan. That is, ads may not state that a plan is better than all other plans in delivering services or care.
  - **Media Type:** MA organizations may offer post-enrollment materials, including the SB, EOC, and Provider/Pharmacy Directory, in different formats (e.g., hard copy, CD-ROM) provided the alternative formats are available in the required time frame.
- **Specific Guidance**  
CMS has established guidance to govern certain post-enrollment materials. Plans must provide the following documents to enrollees at the time of enrollment and annually thereafter:
  - **Annual Notice of Change (ANOC):** This document describes MA plan changes for the following plan year. The ANOC must be delivered to enrollees by October 31 each year. Current plan enrollees receive the ANOC and EOC in one envelope each fall.
  - **Summary of Benefits**
  - **Evidence of Coverage (EOC):** MA plans must mail this document to MA plan enrollees by January 31 of the plan year. The EOC must describe rules for accessing health services, emergency and urgent care rules, appeal rights, benefits and plan premiums, and low-income subsidy information (if applicable).

- Comprehensive or Abridged Formulary
- ID Card
- Provider/Pharmacy Directory

## Low-Income Subsidy (LIS) Issues

All MA plans that offer Medicare drug coverage (i.e., MA-PDs) must provide information to all enrollees about the low-income subsidy (LIS) program that provides Extra Help to beneficiaries with limited income and resources. Each of the following marketing materials must include information about LIS program eligibility:

- Member Letters
- Direct Mail
- Telephone Scripts
- Pre-Enrollment Packet
- Websites

While CMS does not require it, these plans may conduct outreach to a portion of, or all, enrollees about the LIS program. For those who do not respond to this outreach, plans may follow up to provide information and assistance in applying for LIS. MA-PD plans' marketing materials may provide alternatives for LIS application, including referring enrollees to SHIPs to receive help with the application process.

Medicare rules prohibit MA-PD plans from storing and sharing financial information about enrollees with any entity not involved in the LIS outreach. These plans also may not imply to enrollees that the plan has the right to screen enrollees for eligibility.

## Dual-Eligible Outreach

MA organizations have the option to conduct outreach to enrollees about the Medicaid and Medicare Savings Programs (MSPs) which assist Medicare beneficiaries who qualify for the programs with some health care costs. MA organizations providing such outreach programs must submit plans to CMS for approval.

If an MA organization chooses to provide such outreach to enrollees, it must follow CMS-established guidance to be effective and to protect enrollees. MA plans must:

- Provide outreach for all levels of assistance
- Clarify that providing financial information is optional
- Clarify that MSPs are part of the Medicaid program
- Confirm the plan will protect the privacy of information provided to the plan
- Explain that the plan's initial assessment of eligibility is not final; the State Medicaid Agency makes the final determination

- Provide follow up information for enrollees that the MA plan determines are not eligible for assistance
- Adequately train staff to conduct outreach
- Provide alternate sources of information for assistance
- Ensure privacy guidelines are followed
- Coordinate with CMS's regional offices

MA plans providing such outreach may:

- Conduct outreach to a portion of enrollees rather than the entire enrollee population
- Provide hands-on assistance to the enrollee in completing applications
- File an *Authorization of Representative* form to help enrollees apply for assistance with the state
- Follow up with enrollees who do not respond to initial attempts to contact for such outreach
- Assist enrollees to reapply for benefits when necessary
- Subcontract outreach to another entity

MA plans providing outreach to enrollees may not:

- Solicit potential enrollees door-to-door or through other means of direct contact including cold calls, without an enrollee initiating the contact
- Share private financial information with other entities not involved in the outreach process
- Use enrollees' financial information for any purpose other than to provide an initial screening for assistance programs
- Continue to contact enrollees who have refused outreach assistance
- Imply to enrollees that the plan has final authority to decide eligibility for such programs

## MARKETING REVIEW

With few exceptions, MA plans must submit all of their marketing materials to CMS for review and approval prior to use. Most marketing materials and enrollment forms are submitted to CMS for a 45-day review. When MA organizations submit model language for materials without modification, CMS has 10 days to review the materials. One of these four outcomes may result from submission of such materials: approval, disapproval, deemed, or withdrawn. A status of "deemed" occurs when CMS neither approves nor disapproves materials within the appropriate time frame.

## SPECIAL GUIDELINES

### Requirements for Marketing to Populations with Special Needs

Organizations offering MA plans must make marketing materials available in any language spoken as a primary language by more than ten percent of residents within a plan's service area. MA plans also must provide a service through their toll-free call centers to assist beneficiaries who speak a language other than English.

MA plans must accommodate enrollees with visual impairment by providing appropriate basic enrollee information materials. Any Medicare beneficiary eligible to enroll in an MA plan, including those with disabilities, must have appropriate assistance from the MA plan to access information.

Plans must submit materials in languages other than English (including Braille) with an English translation as well as a signed and certified letter to demonstrate that the translation is suitable.

### Anti-Discrimination

The law prohibits Medicare Advantage organizations from discriminating on the basis of:

- Race
- Ethnicity
- Religion
- Gender
- Sexual Orientation
- Health Status
- Geographic Location

With a few exceptions, an MA plan's services must be offered to all enrollees in the plan. A few examples of these exceptions include gender-specific services and certain services for those with specific diagnoses.

## PROMOTIONAL ACTIVITIES

CMS has established specific rules about many aspects of MA plan promotion. It is important to note that CMS guidance issued in September 2008 clarified a distinction between "educational events" and "marketing (or sales) events." Several important restrictions on sales activities apply to MA plans involved in educational events. CMS's marketing rules, designed to protect beneficiaries from undue sales pressure and misleading information, apply to the following activities:

## Nominal Gifts

MA plans may provide small gifts of nominal value (\$15 retail) to potential enrollees who attend a marketing or sales presentation. Plans must provide any nominal gift to any eligible beneficiary and cannot make the gift conditional on enrollment in the plan. Plans advertising any free gifts must include disclaimers that there is no obligation to enroll in the plan. Medicare rules prohibit plans from using cash, charitable contributions, gift certificates, and gift cards as nominal gifts.

## Drawings/Prizes/Giveaways

Any prize offered to potential enrollees at marketing or sales presentations may not be used to coerce beneficiaries to enroll in a specific MA plan. An MA plan may offer a larger drawing, prize, or giveaway with a value greater than \$15, but any attendee of the function (not only beneficiaries) must be eligible to win.

## Hold Time Messages

An MA plan may use health-related information as part of the messages played while on hold with the MA plan's toll-free call center. Information may not be presented during these messages about non-health related services, for example, other lines of insurance.

## Referral Programs

MA plans may offer small, nominal gifts to plan members who refer potential enrollees to the plan. The rules limit these gifts to one per year for any plan member, and are subject to the same limitations as other nominal gifts (e.g., retail value less than \$15). MA plans may solicit such referrals from their enrollees during the year.

## Educational Events

Starting on September 18, 2008, MA plans cannot engage in sales activities, including the distribution of marketing materials or the collection of plan applications, at educational events. Typically, educational events include health information fairs and other state or community-sponsored events that the event sponsors promote as being educational in nature. MA plans and other organizations may sponsor educational events. According to CMS, the purpose of an educational event is to provide objective information about the Medicare program and issues such as wellness and prevention. CMS guidance says that the plans should not use educational events to steer or attempt to steer beneficiaries "to a specific or limited number of plans." (See the CMS Managed Care Marketing Regulatory Resources web page at [http://www.cms.hhs.gov/ManagedCareMarketing/02\\_RegulatoryResources.asp](http://www.cms.hhs.gov/ManagedCareMarketing/02_RegulatoryResources.asp).)

Organizations that sponsor or participate in educational events must add a notice on advertising materials saying that the event is “educational only and information regarding the (MA) plan will not be available.” In contrast to educational events, sales events are those that have the purpose of marketing to potential members or steering potential members to a specific or limited number of plans.

## Health Fairs and Health Promotion Events

MA organizations may take part in health fairs either as a sole-sponsor or as a co-sponsor. At sole-sponsor events, such plans may offer door prizes, or similar items, with a value less than \$15. At multiple-sponsor events, MA plans may exceed the \$15 limit if they contribute to a larger prize offered by multiple contributors. CMS prohibits sales presentations and enrollment at health fairs and health promotion events.

## CMS-Sponsored Health Information Fairs

CMS is required to sponsor informational events about MA and Part D plans. The agency permits MA plans (as well as Part D plans) to participate. At these health fairs, MA plans may assist in planning, distribute information and applications, have a booth, distribute nominal gifts, contribute funding to the costs of the fair, and market multiple lines of business. CMS does not, however, permit MA plans to make sales presentations, collect enrollment forms, collect names or addresses of beneficiaries, compare benefits to other plans, use third-party materials, or provide gifts larger than \$15.

## Meals and Light Snacks

Starting on September 18, 2008, CMS rules prohibit MA and Part D prescription drug plans from providing or subsidizing meals for potential enrollees and current enrollees at marketing events, that is events at which someone discusses plan benefits or distributes plan materials. The prohibition on subsidizing meals means that plans cannot give restaurant gift cards or gift certificates to beneficiaries, regardless of the gift’s value.

Plans and their representatives may, however, provide refreshments and light snacks at marketing events. CMS guidance suggests that foods such fruit, nuts, cookies, crackers, and cheese, are acceptable as light snacks. In addition, the rules allow plans to provide meals to beneficiaries at educational events.

## Provider Promotional Activities

Providers may be involved in some activities to promote MA plans. This section refers to providers, including pharmacists, pharmacies, physicians, hospitals, and long-term care facilities.

- **Providers in the Health Care Setting**
  - Providers may have general discussions with beneficiaries about potential plan options.
  - Providers may make available marketing materials to their patients as long as they make them available for all MA plans with which a provider participates.
  - Providers cannot accept enrollment applications.
  - Providers may not persuade beneficiaries to join an MA plan.
  - Providers may not offer anything to a beneficiary in return for enrolling in an MA plan.
  - Providers may refer their patients to other sources of information, including the SHIP.
- **Plans in the Health Care Setting**
  - MA plans may not conduct sales activities in health care settings, except in common areas such as hospital and nursing home cafeterias, community or recreational rooms, or conference rooms.
  - Plans cannot conduct sales presentations and distribute or accept enrollment applications in areas where patients primarily receive health care services, including waiting rooms, exam rooms, hospital patient rooms, dialysis center, and pharmacy counter areas.
  - Plans may not mislead or pressure beneficiaries into participating in the presentation.
  - Plans may only schedule marketing appointments with long-term care nursing facility residents when a beneficiary requests it.
- **Provider Affiliations**
  - Providers may announce new affiliations for specific MA plans through general advertising.
  - Any materials found within the provider's location that list a provider's MA plan affiliations must include all such plans.
- **Health Fairs**
  - Providers may distribute marketing materials (not including MA enrollment applications) at health fairs.
  - Providers may present general education about MA plans at health fairs.

## Agent and Broker Guidance

People employed by or contracting with a Medicare Advantage organization are governed by a set of rules concerning their behavior and activities. The MA organization employing or contracting such sales agents is responsible for the activities of these agents. State insurance departments also regulate agents and brokers. This means that agents are subject both to plan and state oversight. One variable in this arrangement is that the effectiveness of oversight often depends on the strength of a state's insurance department.

No person marketing an MA plan may choose to market to or selectively enroll healthier beneficiaries. This discriminatory practice is called “cherry picking” and is not allowed in the marketing of MA or PDP plans.

- **Licensed and Trained Marketing Representatives**

CMS requires MA plans to use only those agents, brokers, and sales representatives who are licensed, certified, or registered under state law to market their MA products. CMS further expects plan sponsors to follow a state’s appointment process to inform the state insurance regulators of the representatives they have appointed to market MA plans on their behalf, as well as to report the termination of any agents or brokers. In addition, starting with plan year 2009, MA plan sponsors must ensure each year that brokers and agents who sell Medicare products are trained on Medicare rules, regulations, specific plan details, and that they pass a test with a score of at least 85 percent.

- **Agent and Broker Compensation**

CMS is aware that MA plans offer compensation to agents and brokers who market these plans to beneficiaries, and that some plans’ compensation structures have led to “churning,” a prohibited sales practice in which an agent or broker enrolls a beneficiary in a new MA plan each year to take advantage of higher first year commissions. While compensation structures may differ among types of plans (e.g., MA versus MA-PD), Medicare law now requires plans to create compensation systems that create incentives for agents and brokers to enroll beneficiaries in the MA plan that best meets their health care needs. In short, compensation systems that create incentives for agents or brokers to move beneficiaries between different MA (and/or PDP) plans are prohibited. CMS rules that took effect with the 2009 plan year limit agent or broker compensation for a beneficiary’s annual renewal in an MA plan to half the compensation paid for the beneficiary’s first year as an MA plan member. The rule also requires that compensation paid to agents and brokers reflect fair market value based on commissions paid in past years (with inflation adjustments allowed). CMS will review the plans’ compensation structures annually, and plans cannot change their commission rates or compensation structures without CMS approval.

- **Scope of Appointments (Sales Meetings) with Beneficiaries**

MA and Part D drug plans’ sales representatives, including agents and brokers, may not market any health care related product during an individual marketing appointment beyond the scope of topics that the beneficiary agrees to discuss. This rule, in effect with the 2009 plan year, requires plans and their sales representatives to document, in advance of a personal sales meeting, the scope of the beneficiary’s interest in discussing different MA plan options (see Appendix D for CMS’s *Model Scope of Sales Appointment Confirmation Form*). The rule applies to marketing appointments with both current and prospective MA plan members. CMS expects plans to confirm that a beneficiary wants to talk about

stand-alone Part D prescription drug plans or Medicare Advantage plans, or both. MA plans may document a beneficiary's consent through a signed appointment form, a recording, and other verifiable means.

**Note:** SHIPs continue to report to CMS that MA and PDP plan sales agents market their products improperly. Some agents receive an invitation from one resident of a senior housing facility and then go door-to-door within the facility. SHIPs also report agents who offer rides to visit family and friends to encourage them to enroll in MA or PDP plans. Counselors should report all of these "bad agent" behaviors to 1-800-MEDICARE (The SHIP Medicare hotline is 1-888-647-6701.)

1-800-MEDICARE (or the SHIP hotline) will enter information into the Complaints Tracking Module (CTM). CMS uses the CTM to track the number and type of complaints made about MA and PDP plans. CMS also uses the CTM when they must use corrective action against plans..

## Marketing through Unsolicited Contacts

Starting on September 18, 2008, CMS rules prohibit MA plans from making unsolicited contact with prospective enrollees outside of advertised educational or marketing events. The rules apply to both door-to-door and telephone marketing activities.

- **Door-to-Door Solicitation**

MA organizations cannot market their MA plans door-to-door without a beneficiary's invitation to do so. Similarly, agents and brokers cannot visit or call beneficiaries who attended an event unless the beneficiary gave permission for the follow-up contact at the event.

- **Unsolicited Email Policy**

Generally, MA organizations may not send unsolicited emails to beneficiaries. If beneficiaries request email from an MA plan, the MA organization is permitted to do so.

- **Outbound Marketing Calls**

Rules that took effect for the 2009 plan year prohibit MA plans and their sales representatives from making outbound calls to potential enrollees, without the beneficiary first initiating the contact. MA plans may not conduct or allow unsolicited contacts under the guise of selling another product such as Medicare Supplements, a needs assessment, or a review of Medicare coverage options to which CMS's unsolicited contact rules do not directly apply. The prohibition on outbound calls does not apply, however, to Medicare Supplement marketing. Thus, the MA plan sponsors must walk a fine line because the rules allow sales representatives to make outbound calls specifically to market Medicare Supplement policies and to discuss MA products if the beneficiary expresses an interest in them.

CMS, however, allows plans to contact beneficiaries **who are already plan members** to discuss other products. In the same way, agents and brokers may contact beneficiaries who they previously enrolled in an MA plan to discuss plan issues and to market other MA plan options. Agents also can initiate phone calls to confirm an appointment to which a beneficiary has already agreed. Otherwise, agents cannot make unsolicited phone calls to other beneficiaries or plan members, and plans cannot make unsolicited contacts with former plan members who have disenrolled or with current members who are in the process of disenrolling voluntarily.

## Informational Inbound Telephone Scripts

MA plans must have scripts for customer service representatives who answer the toll-free hotlines. An MA plan must have prepared a minimum set of topics for such calls:

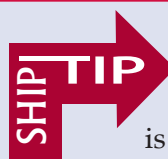
- Pre-enrollment information
- Post-enrollment information
- Benefits
- Service area
- Cost-sharing
- Formulary (MA-PDs)
- Network pharmacies (MA-PDs)
- Out-of-network coverage
- Claims submission
- Formulary transition process (MA-PDs)
- Grievances, coverage determinations, and appeals
- Claims processing
- Benefit coverage
- Extra Help or LIS (MA-PDs)
- Claims payment
- TrOOP status (MA-PDs)
- Obtaining forms
- Replacing membership cards

During inbound pre-enrollment calls, plans may not request beneficiary identification numbers or payment information. During post-enrollment calls, plans may request a member ID number. Plans may not direct the caller to their enrollment call center unless requested to do so.

## Enrollment via Inbound Telephone

MA organizations may not enroll beneficiaries during outbound calls (telemarketing). Furthermore, they cannot transfer outbound calls to inbound lines to proceed with enrollment. During an appropriate enrollment call, the MA plan may not collect (or request) credit card or bank account numbers.

Beneficiaries who would like to enroll in an MA plan during an appropriate enrollment period may call the plan directly to do so.



If a SHIP counselor or a beneficiary believes that a plan or provider is not following the guidelines, he can report such activities to the following places:

- CMS encourages counselors to submit cases to the Regional Office for tracking and follow up through a central process.
- Counselors who help beneficiaries file grievances with their plans should contact the plan or 1-800-MEDICARE to do so. More information about grievances is available in the section on Grievances and Appeals.

Counselors should not usually report issues directly to the plan.

## EMPLOYER/UNION SPONSORED GROUP PLANS FOR RETIREES

Medicare law allows plan sponsors to offer MA plans (including HMO, PPO, and PFFS plans) exclusively for employer and union retiree groups. Because a group plan sponsor typically is dealing directly with a plan administrator – not beneficiaries – to market plan options, some of the marketing rules for these plans differ from those in effect for MA plans sold on an individual basis.

The marketing rules (starting on page 67) that also apply to employer and union sponsored group plans include those for:

- Nominal gifts
- Marketing in health care settings
- Marketing at educational events
- Co-branding
- State licensing, appointment, and reporting
- Training

The marketing rules that do not apply to employer and union sponsored group plans include those for:

- Unsolicited contacts
- Cross-selling
- Scope of marketing appointments
- Providing meals
- Agent and broker compensation
- Testing

