Draft Medicare Marketing Guidelines
External Comment/Response Form

Plan/Non-health Plan Entity: The Medicare Rights Center and Center for Medicare Advocacy
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MMG Comments

Section #	*Page #*	*Description of Issue or Comment*	Suggested Revision or Comment
All	All	Thank you for allowing an extra week for comments on the MMG.	In future years, we would hope CMS might be able to coordinate comments on Medicare & You, the Advance Notice/Call Letter and the MMG. We appreciate the time-sensitive nature of each of these critically important documents, yet would like to have sufficient time to provide CMS with thoughtful comments to your proposed changes.
Throughout		Relationship of marketing rules to duals demos	We note that there is no discussion in the draft marketing rules about what plans may or may not say to beneficiaries who also may be part of the target population of a dual eligible demonstration. We recognize that many issues, including how the demonstration plans will themselves be marketed, are still being worked out. Because of the potential for beneficiary confusion, we ask CMS to consider appropriate and coordinated rules for both demo and non-demo plans that will ensure that beneficiaries receive accurate information about their choices and protect them from aggressive marketing of inappropriate products.
30.4 : Use of Medigap data to Market MA/PDP/Cost Plans	12	Allows plan sponsors who also sell Medigaps to Market its MA PDP or cost plan products to Medigap customers.	Plans should not be able to Market MA or Cost plans to people with Medigaps without fully explaining that, to enroll in the MA/Cost plan they will need to disenroll from their Medigap Plan; whether and under which circumstances they will be able to return to their Medigap; and a comprehensive and comprehendible comparison of their costs and coverage under the MA or Cost Plan and the Medigap. Because individuals cannot enroll in Medigap plans at any time or under any circumstance, it is imperative that individuals understand the reprocussions of disenrolling and their limited abillity to re-enroll at a later date.
30.7	13	Permitting multi-language insert in more mailings	We are very appreciative of the addition of the insert.We ask that CMS make it clear to plans that they are permitted to include the insert in other mailings besides the Summary of Benefits and EOC and that the agency encourages them to do so.
30.7	13	Expanding required use of inserts	We ask CMS to consider expanding the requirement to include multi-language inserts to notices related to denial of coverage determination and redetermination requests. These are critical documents and individuals need to know what they say.

30.7	13	Translations and inserts with corrective action plans	Although perhaps outside of marketing guidelines, we ask that whenever CMS requires a plan to undertake an outreach effort as part of a corrective action plan, e.g. because a plan charged members incorrectly, plans should be required to translate documents in accordance with the requirements of 30.7 and also include the multi-lingual insert in any required mailings. With corrective action plans, plans have already done something to injure the consumer. Often the explanation is complex and the consumer has choices to make. In such situations there is a particularly strong duty to make sure that beneficiarires understand the communications sent to them. We have seen this problem recently where a plan sent letters to beneficiaries in English explaining complex options. Several Spanish speakers who usually received marketing documents in Spanish but received CAP messages in English, had particular difficulty in understanding their rights and their choices.
30.8: Required Materials for Enrollment form	14	Must receive plan ratings information; an Explanation of benefits and a multi language insert with enrollment form	We support this requirement, and encourage CMS to further require provision of easy-to understand explanations of the ratings system along with the ratings information. However, we agreee with CMS' determination in the draft 2013 Call Letter that plans should not be able to market themselves as a "five star plan" unless there overall rating is five stars.
30.8	14	Required Materials with an Enrollment Form	We concur with CMS that ratings information should be provided to potential members as they contemplate enrollment. For 2012, plan ratings information was generally not available at the start of the enrollment period. We appreciate the challenges CMS faced in preparing for an earlier 2012 Annual Enrollment Period and yet hope that the plan ratings can be made available by Oct. 15, 2012, in time for the start of the 2013 enrollment season. This would enable more beneficiaries to make use of the quality ratings as they compare and select a 2013 plan. As they shop for the best plan for each individidual, the plan ratings would better enable each one to make rational economic decisions in their own best interest.
30.12 Plan rating information	15	Plan Sponsors must provide overall plan rating information to beneficiaries through the standardized plan ratings information document	CMS should include explanations of the ratings system in the standardized document, and plans should be required to include subject area breakdowns as well as the overall rating. However, again, we agreee with CMS' determination in the draft 2013 Call Letter that plans should not be able to market themselves as a "five star plan" unless there overall rating is five stars.
30.12.1 Referencing plan ratings in Marketing Materials	16	Plans may only reference the overall performance rating in marketing materials	We agree that plans should only be able to advertise the overall rating, beneficiaries should have access to information regarding individual measures, either on the plan's website or through a referral to Medicare.gov
40.13 Standardization of Plan Names	24	Plan Sponsors must include the plan type in each plan's name using standard terminology	Plan Sponsors should be required to include the full name of the plan, including the plan type, in every reference to the plan, as the names of different plans can be confusingly similar.

50.2	27	Disclaimers When Benefits are Mentioned	We suggest adding to the statement that "limitations, copayments and restrictions may apply", a requirement that plans inform beneficiaries about where they may find out what specific limitations, copayments and restrictions may be applied to the services they need.
50.3 Disclaimers where plan premiums are mentioned	27	"Fully integrated dual-eligible SNP's where the state pays the Part B premium should indicate that the Part B premium is covered for full-dual members"	This is confusing, as it implies that the D-SNP is paying the Part B premium where this is not the case. Plans should not be able to imply that state- or federal- low income benefits are provided as a result of membership or participation in the plan. If improperly advertised or marketed, it could encourage enrollment into a specific plan even if this same cost-sharing protection, provided by MSPs, would exist under other plans and Original Medicare.
50. 5 SNP Materials Disclaimer	28	"This plan is available to anyone who has both Medical Assistance from the State and Medicare"	Because many different kinds of "Medical Assistance from the State" are offered, including but not limited to Medicaid programs, this disclaimer should specifically identify the name of the relevant State's Medicaid program, as well as the Medicare Savings Programs
50.6 Dual Eligible SNP Materials	28-29	"[premiums], [co pays], [coinsurance] and [deductibles] may vary based on the level of Extra Help that beneficiaries may receive and that the beneficiary should contact the plan for further details"	People in D-SNPs should always have Full Extra Help. They may have different co-pays depending on their income level but premiums and deductibles should not apply. D-SNPs should not be allowed to charge more than the benchmark for Part D plan for the relevant area.It may be more helpful to just indicate that individuals have copays no more than than the relevant year's full Extra Help co-pay amount for people who do not live in nursing homes or get home and community based services. Also, Dual SNP marketing materials should also include disclaimers about relevant Part B cost-sharing as well. For example, if the dual SNP includes individuals enrolled only in Medicare Savings Programs other than QMB and allows providers to charge copays to these individuals, the plan materials should indicate that cost-sharing may apply to certain enrollees, Finally, if the SNP network includes providers who do not accept Medicaid and Medicare-only providers can bill beneficiaries (for example, in a situation where someone may be fully Medicaid elgible due to spend-down rules but not elgible for QMB, the materials should clarify that they may need to pay a co-pay if they see providers who do not accept both Medicare and Medicaid. Furthermore, We suggest adding language here and elsewhere within Section 50 informing beneficiaries that they may also contact their State Health Insurance Assistance Program and that the applicable state-wide 1-800 number is on the inside back cover of Medicare & You 2013.
50.11 Disclaimer on Promoting a Nominal Gift	30	"free drawing without obligation"	this disclaimer should be strengthened to clarify that there is no obligation to enroll in the plan or to sign up for additional marketing
50.12	30	Disclaimer for Plans Accepting Online Enrollment	The 2013 draft Advance Notice/Call Letter provides that plans with quality ratings under 3 stars will not be permitted to accept enrollments via the Medicare Plan Finder. We suggest adding that new policy here and/or elsewhere in Section 50.

50.13	30-31	Disclaimer When Using Third Party Marketing Materials	We have commented in previouis years and continue to believe that CMS should review ALL marketing materials promoting Part C and D plans and developed with the intent of steering beneficiaries towards enrollment. The caveat that CMS has not reviewed materials is confusing to beneficiaries and opens a serious potential for misleading, abusive and fraudulent marketing materials to reach beneficiaries who may not be able to understand the distinction between materials reviewed by CMS from those not-reviewed. We are very pleased with the change making plan sponsors responsible for ensuring that non-benefit/service providing third-party entities comply with all MMG requirements. In previous years we have brought to CMS' attention very serious instances of such entities providing beneficiaries with erroneous and misleading marketing materials while alleging such materials are not subject to CMS review. We suggest cleary cross-referencing the new requirement with Section 40.11.3 on page 23.
60.1 Summary of Benefits	32-33	SB Requirements	We have found most dual eligible SNP Summaries of Benefits to be confusing and difficult to decipher. Most SBs fail to clearly compare benefits under the SNP and vs. Medicaid AND FFS Medicare and persons cannot make "apples to apples" comparisons. In order to fufufill the statutory requirement, it is not enough for plans to simply state what benefits Medicaid offers versus the SNP. We strongly urge CMS to require plans to compare the benefits under the SNP plan to the benefits offered under Medicaid PLUS FFS Medicare. Plans must be required to do this in chart form (rather than narrative) so that the differences and similarities are easily apparent. If plans enroll persons enrolled in the MSPs, the comparison chart must also include SNP benefits vs. Medicare FFS and a Medicare Savings Program. Also, if SNP plan cost-sharing differs based on whether the provider accepts Medicaid or not, the comparison should clearly state this. We understand that in some states, some persons with full Medicaid but not QMB could conceivably need to pay Medicare cost-sharing if they see Medicare-only providers. (Although beyond the scope of these comments, we reiterate our previous requests that CMS require D-SNPs to include only providers who accept both Medicare and Medicaid. Alternatively, we request that CMS prohibit plans from allowing Medicare-only providers to charge full duals without QMB cost-sharing. We would welcome the opportunity to work with CMS on improvements to the the dual eligible SNP summary of benefits. For the reasons atated above, we also urge CMS to make SNP models of care publicly
60.2 & 60.3 ID Card Requirements	33-34		In addition to the CMS contract number and PBP number, PDP cards should clearly state "Medicare PDP" and Medicare Advantage plans should include "MA" or "MA-PD" and a plan-type identifier. Furthermore, while we support the requirement to include "Medicare Limiting Charges Apply" to PPO and PFFS plan cards, we urge CMS to also require all MA plans to issue, upon request, a card to QMB recipients which includes a similar statement regarding QMB balance billing protections.

60.4	35-38	Directories	We urge CMS to consider requiring plans to provide a 30 day prior notice when providers or pharmacies are terminated. Mandating only that plans make a "good faith" effort is insufficient when the consequences of losing an in-network provider or pharmacy may be dire. Moreover, plans should be required to offer affirmative assistance to members in need of new, contracted providers. This assistance would seem to us to be inherent to the care coordination obligations of networked plans. We also believe that CMS should not leave to the plan sponsors definition of "significant changes" that require special mailings. We urge CMS to establish minimum threshholds for "significant changes," rather than merely reserving the option of directing plans to conduct such mailings at its discretion.
60.4.2 Provider Directories	36	"Note that for D-SNPs, the Medicaid indicator in the provider directory is a required element for those plans that have a contract with the State Medicaid Agency. "	We fully support this requirement, and urge CMS to require that D-SNPs include information about cost-sharing protections for full-dual eligibles and for QMBs with this directory. This should include examples demonstrating the different protections for Medicaid indicated providers and other providers, for dual-eligibles with and without QMB.
60.5 Provision of Notice to Beneficiaires regarding Formulary Changes	42	Requires a notice to beneficiaries when there are mid-year formulary changs	The guidance should clarify which mid-year formulary changes trigger this notice (i.,e changes that affect the beneficiary during the plan year (i.e, safety concern, generic subsitution) and/or changes that do not take effect for current members during the calendar year). The applicable regulation (42 CFR Section 423.100 (b)(5)) does not specify when notice is required and Section 30.3.4 of the Medicare Prescription Drug Manual indicates that the beneficiary notice is not required when beneficiaries are exempt from the changes (non-maintenance changes).
60.7	43-44	Annual Notice of Change (ANOC) and Evidence of Coverage (EOC)	As in previous comments, we continue to urge CMS to de-couple delivery of the EOC and ANOC. Both are lengthy documents with extensive content that is critical for beneficiaries to understand. Yet each has its own distinct purpose and we continue to believe clarity would best be served by separate mailing of the two required documents. We commend CMS for including FIDE SNPs in the mandate to provide ANOCs and EOCs to members no later than September 30th. Dually entitled beneficiaries have no less need and indeed often have greater and deeper need for education about their options for the following year and this need is likely to be even more compelling for 2013 with so many states pursuing various forms of Medicaid-Medicare fiscal and delivery alignment innovations. We agree with CMS that new members joining plans with October, November and December start dates should receive both current as well as next year EOCs and the plan's ANOC describing changes being implemented in the followinbg year. This information can help beneficiaries arrive at the decisions that make the most rational, economic and coverage-related sense.
70.10.1 Dual Eligible Outreach Programs	59	Lists conditions for outreach to dual-eligibles by plan sponsors	We support increased oversight and clarity in materials sent by D-SNPs. The listed requirements are a good start, but it should be made clear that the benefits of enrolling in Medicaid or and MSP are not contingent upon joining a particular SNP and that individuals can apply directly with the State.

80.1.2	68	Call center policies and emergency drug needs	We are concerned that the staffing requirements for calll centers do not address the needs of individuals calling who need expedited coverage determinations. Plans should be required to have systems in place so that those calls can be returned immediately, no matter the time of day or season of year.
90.6-.9: File and Use Program	78-80		We urge CMS to increase randomized oversight with regard to file-and-use materials, as we have received reports from beneficiaries regarding misleading, inaccurate and confusing materials that were sent under 'file and use.' These materials included letters that implied that the beneficiary would lose his/her Medicare benefits if they disenrolled from a plan, a letter that implied that MSP benefits, including payment of the Part B premium, were plan benefits, and a letter, without plan identification or letterhead (except on the outside of the envelope), that urged recipients to call to "get the most out of your Medicare benefits"
100: Websites and Social/Electronic Media	84-91		We support the requirements listed in this section for plan websites and use of electronic media. In particular, we feel that it is important the plans (100.1) have a section or page devoted to each product offered, with separate and distinct sections for Medicare information. We have often seen beneficiaries confused about the benefits of their particular plan, and unable to find information about the plan they are enrolled in where sponsors offer several different plans with similar names. Information on other pages that applies to some, or all of the plans offered by the sponsor should clearly indicate which plans and plan types are covered by the information provided.
100.2.2	88	Required Documents for Part D Sponsors	We commend CMS for requiring posting of the plan's prescription drug transition policy and suggest CMS require plans to add a method for those aggrieved of electronically filed transition complaints, as these are urgent matters and plan members, as well as pharmacists should be able to communicate directly with plans about problems they encounter.
100.3	88	Online Enrollment	We thank CMS for reiterating that enrollment may not be accomplished through an agent or broker Website. If CMS finalizes the proposal in the draft 2013 Advance Notice/Call Letter to preclude plans with less that a 3-star ranking to enroll new members through the Medicare Plan Finder it will be important to conform this section of the MMG. We also appreciate that CMS has clarified that a searchable formulary database may not substitute for a downloadable version and that the formulary must indicate timely updates. Finally, for all of the bulleted caveats on pp 89-90, we suggest that CMS require plans to inform members that they may obtain more information from their own call centers, from the SHIP and also from 1-800-MEDICARE.
110. 5 Online Formulary and Utilization Management Requirements	89-90	Requires that online formularies include a statement indicating that formularies can change during the year and describes the notice provided when formularies change.	The disclaimer should be clarified to reflect that changes cannot apply to persons during the calendar year unless they involve safety concerns or generic substitutions.