2011 Draft Medicare Marketing Guidelines- Revised			
External Comment/Response Form			
Plan/Non-health Plan Entity:	National Senior Citizens Law Center, Center for Medicare Advocacy, Medicare Rights Center, California Health Advocates, Health Assistance Partnership, Families USA		
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Special Instructions on Completing the Form			
* Please do not use the merge -cell function of excel.			
* Please use only one row and the four columns per comment.			
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MMG Comments			
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Passim			We thank CMS for adding language throughout the marketing guidelines that reinforces CMS's commitment to oversight and enforcement of marketing rules.
Introduction	7		We think the new paragraph will help clarify the breadth of activities that are considered marketing activities, including activities for which the individual/entity expects indirect compensation.
§20	9 to 15	Definitions	The new definitions codify CMS interpretations and add necessary guidance to ensure that beneficiaries are not subject to marketing abuses. We acknowledge improvements in clarifying and defining marketing materials and activities. We hope these changes lead to a reduction in misconduct.

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§30.2.2	17	Concerns that co-branding provisions will add to confusion SPAP enrollees already face	1) The guidance suggests that SPAPs should offer co-branding of materials, including identification cards, to all plan sponsors. Some SPAPs, such as ConnPACE in Connecticut, require SPAP beneficiaries to enroll only in LIS-eligible plans. If ConnPACE were to offer to co-brand with a non-LIS plan sponsor, and the plan sponsor accepted, this would create the erroneous perception that ConnPACE eligible individuals could enroll in a non-LIS plan and still retain their SPAP eligibility. SPAPs with such limitation should only be required to co-brand with all plans that offer LIS plans. 2) We are concerned about the practicality of including all plan sponsors on an identification card. Many SPAP ID cards are already cluttered. The addition of multiple plan sponsor names may make the cards unreadable.
§30.4	18	Use of Medigap Data	We reiterate our objections outlined in joint comments submitted to the 2010 Guidelines by CHA, NSCLC, CMA, HAP and MRC. Medigap issuers who also offer MA and Part D products should not be permitted to use enrollee data to market such products to their Medigap enrollees. In addition, the allowance of MA and PDP sales to occur during outbound cold calls involving Medigaps amounts to an end-run around the prohibition on unsolicited contacts and cold calling. Given the different nature of Medigaps vs. MA and Part D products, the potential loss of rights to reacquire a Medigap policy once it is dropped, and the anticipated confusion surrounding the upcoming change in Medigap benefit structures for plans effective June 2010 and thereafter, Medigap plan sponsors that also offer MA and Part D products should be given no allowances to circumnavigate rules applicable to MA and PDP sales.

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§30.6	19 to 20	Anti-discrimination	Thank you for a adding the language prohibiting targeting of beneficiaries.
§30.7	20	Translated marketing materials	We suggest: 1) adding a sentence that encourages plans to voluntarily translate documents for populations that do not meet the CMS threshold; 2)stating specifically in the call letter that plans must routinely send translated materials to beneficiaries who request it (CMS includes a box in the model application form where beneficiaries can indicate their preference) so beneficiaries should expect that checking a box means something); 3)changing “translation services” to “interpreter services” when referencing call center requirements; 4)adding a link to the HPMS memo from January 2, 2007 entitled Best Practices for Addressing the Needs of Non-English Speaking and Limited English Proficient (LEP) Beneficiaries.
§30.7 (cont'd)	20	Translated marketing materials (cont'd)	We also reiterate NSCLC's continued objection to CMS’s use of a 10% threshold for mandatory translation. This threshold is so high that it keeps millions of beneficiaries from receiving information in their preferred language, a result inconsistent with the requirements of Title VI. Instead, a threshold of 5% or 1,000 persons affected, whichever is lower, would be more appropriate and consistent with statutory intent. See Executive Order 13166, 65 Fed. Reg. 50121 (Aug. 16, 2000) and our more extensive comments on language access at www.nsclc.org/areas/medicare-part-d/nsclc-comments-on-c-and-d-regulations/at_download/attachment.

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§30.9	21 to 22	Materials in enrollment package	Plans should include the LIS information in the enrollment kit, even if they have included the information in the pre-enrollment package, because the information cannot be presented too many times. We appreciate the additional language reminding beneficiaries that plan benefits and cost-sharing may change from year to year.
§30.9 (cont'd)	21	Required information on cover letter	Add that the cover letter should include prominently on the top or bottom of the first page an offer, written in the appropriate language, to provide documents in any language into which they have been translated. In addition, the cover letter should include a statement on the top or bottom of the first page, written in English and in multiple languages, saying: "if you need help in [a language other than English], call xxx-xxx-xxxx and an interpreter will assist you."
§30.9 (cont'd)	22	Provider directory provided upon request	A common barrier enrollees face concerning access to care is the issue of how and when they find out if the providers they currently use are contracted with a plan. There should be some notice when people are reviewing a plan that they need to check to see if the providers they use are contracted with that plan. There should also be a similar notice as part of the application process, and any sub-directories that exist need to be part of this disclosure during a solicitation and application.
§30.9 (cont'd)	22	LIS notice	Suggest adding a parenthetical ("doughnut hole") after "coverage gap, since many beneficiaries are more familiar with that term.

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§30.10, §60.7	22, 65	Time frame for sending materials to new and renewing	We thank CMS for establishing different time frames to send D-SNP enrollees the ANOC and EOC. We believe that this is a good first step. As stated elsewhere, we continue to believe that the ANOC and EOC should be sent separately to all beneficiaries. We have asked CMS in the past to require that the ANOC/EOC be sent separately for all MA-plan enrollees, and we renew that request. The ANOC should be used by beneficiaries to determine whether, given the changes, the plan benefits continue to meet their needs. A beneficiary who decides to change plans does not need the entire EOC for the following year.
§30.12	23	Hold Time Messages	We appreciate the reminders that CMS will review hold time messages & that hold time messages cannot include information on non-health related services.
§30.14	24	Referral program	We reiterate our objections outlined in joint comments submitted to the 2010 Guidelines by CHA, NSCLC, CMA, HAP and MRC. We object to permitting plan sponsors to solicit leads for new enrollees from their members, as well as allowing plans to provide rewards for such leads. Any effort to market to individuals based upon enrollee referrals should be treated as prohibited unsolicited contacts.
§40.8	29	Identification of all plans in materials	We appreciate the clarification that plan sponsors may mention more than one plan in a single marketing piece as long as there is a distinction made between plan types and benefits offered.

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§40.9	29 to 30	Marketing to Beneficiaries of Non-Renewing Medicare Plans	We object to the provision that allows plan sponsors to market directly to beneficiaries in nonrenewing plan as long as after date required to receive non-renewal letter. We believe that this will allow plans to target beneficiaries at a vulnerable time. Some of the marketing materials we have seen give the impression that a beneficiary in a non-renewing plan must choose another MA plan, when, in fact, for some beneficiaries, returning to traditional Medicare may be a better option. Additionally, beneficiaries in non-renewing plans already get information from their terminating plan about their options. They do not need additional mail on top of the multiple mailings they get about their rights upon plan termination.
§40.9	29 to 30	Marketing to Beneficiaries of Non-Renewing Medicare Plans	We suggest deleting this provision because there does not appear to be an operational justification for giving sponsors such exclusive marketing leads for their other products.
§40.10	30	Product endorsements/testimonials	We thank you for the additional clarifying language about the requirements for plans to use product endorsements/ testimonials.
§40.11	30	Customer service	We continue to request that customer service departments be required to operate 24/7, at least during enrollment periods.
§40.14	32	Marketing Multiple Lines of Business	We reiterate our strong objection in prior joint comments to plan sponsors being allowed to market multiple lines of business, both health and non-health related, to both prospective and current plan enrollees. Part D and Medicare Advantage products are complex and easily subject to misrepresentation. Accordingly, we urge against allowing plan sponsors to market both health and non-health lines of business to both plan members and prospects. If such marketing is permitted, it should only be on an opt-in basis.

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§40.14.1	32	Multiple Lines of Business – General Information	As stated above, we reiterate our objection to plan sponsors being allowed to market multiple lines of business to current and prospective enrollees. We also reiterate our prior joint comments stating that, at the very least, prior written authorization from an enrollee should be required for the marketing of any other product – either health-related or non-health related -- by the same plan sponsor (in other words, enrollees should affirmatively "opt in" instead of opting out of receiving such solicitations). Nor should plan sponsors be allowed to market Medicare and non-Medicare related products in the same document; there is too much chance for confusion (e.g. beneficiary believing that all products are Medicare-related and/or necessary for full coverage).
§40.14.2	32	Multiple Lines of Business – Exceptions	We reiterate prior joint comments stating that plan sponsors should not be allowed to market non-plan lines of business, even if in a separate envelope/enclosure. In addition, plan sponsors should not be able to combine marketing for non-competing lines of business (e.g. PDP and Medigap) as these are distinct and very different types of products that generally require a good deal of explanation about how they work and work together (if at all).

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§40.14.2 (cont'd)	32 to 33	Inclusion of non-health related products in a plan non-renewal notice.	We appreciate the addition of language saying that plan sponsors cannot include enrollment applications for competing lines of business or for non-Medicare lines of business in mailings that combine plan information with other product information. However, we have no confidence that merely separately folding documents in the same envelope is a successful strategy for protecting beneficiaries from confusion. A CMS subsidized mailing should only discuss the CMS subsidized product, namely the Part D plan. Folding documents differently and prorating costs are not appropriate or adequate.
§40.14.4	33	Multiple lines of business – Internet	Many beneficiaries and their family members do not understand that the Medicare Advantage plans offered by a plan sponsor are different from the health plans offered by the same company in the private market. Requiring plan sponsors to keep a separate and distinct section of their website for MA plan information only will help reduce confusion.
§40.14.4 (cont'd)	33	Multiple lines of business – Internet (cont'd)	We ask that here or somewhere in the call letter, CMS require that the websites that plans provide to CMS as links for the plan finder and for other parts of Medicare.gov be sites specifically for the plan that the beneficiary is seeing on the plan finder. Some current links from Medicare.gov take beneficiaries to websites covering multiple Medicare products and even some non-Medicare products and require multiple, often confusing, clicks to get to the specific plan.

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§40.14.5	34 to 35	Method of transmittal-addressing limited English proficient individuals	We have concerns about how the proposed procedures would work with people who are limited English proficient and with those with some cognitive impairment. We propose 1) if a beneficiary has stated a preference for a language in which the plan prints materials, any outgoing communication, written or oral, about an electronic alternative should be in the language designated by the beneficiary; 2) that any outgoing written communication to beneficiaries about electronic options include a tag line in any language into which translations are required under 30.4 stating that the letter is available in the non-English language and also include taglines in other languages, and in English, telling beneficiaries that they can call the plan 800 number if they need language assistance in understanding the notice; 3) that as a final check, beneficiaries be required to send a reply email confirming that they wish to receive information electronically.
§40.14.6	34	Plan Responsibility for Marketing Activities of Third Parties	We are concerned with the new language included in this draft that allows third parties to market Part D and Medicare Advantage plans absent any CMS review. Plan Sponsors have learned that they can entirely evade CMS oversight by hiring third parties to generate leads for them. As CMS is aware, these third parties have engaged in practices prohibited by CMS, causing harm to beneficiaries who have relied to their detriment on misleading and fraudulent marketing practices and messages. This side-stepping of the careful rules and regulations that have evolved through CMS with input from consumer advocates since the beginning of the Part D program should be prohibited by bringing all promotion of Part D and Medicare Advantage plans under the strict purview of CMS marketing review.

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§40.14.6	34	Plan Responsibility for Marketing Activities of Third Parties	Merely requiring third parties to place a disclaimer on materials that would otherwise be construed as marketing does not help people with Medicare to be informed consumers. Consumers are not likely to understand the meaning of the required disclaimer "Medicare has neither reviewed, nor endorses, this information." At best they will understand the claims being made in the marketing documents, not the fine print caveat at the end. They are not likely to understand that because CMS has not reviewed the content those assertions could be misleading or incorrect.
§40.14.6 (cont'd)	34	Plan Responsibility for Marketing Activities of Third Parties (cont'd)	Merely requiring third parties to place a disclaimer on materials that would otherwise be construed as marketing does not help people with Medicare to be informed consumers. Consumers are not likely to understand the meaning of the required disclaimer "Medicare has neither reviewed, nor endorses, this information." At best they will understand the claims being made in the marketing documents, not the fine print caveat at the end. They are not likely to understand that because CMS has not reviewed the content those assertions could be misleading or incorrect. Because of the history of misleading and abusive marketing materials put forth by these third parties, plan sponsors should be held responsible for what is being said to promote their products. Accordingly, we strongly believe that all marketing materials, whether prepared by the Plan sponsor or a third party organization must be compliant with all CMS rules and regulations. This is necessary to protect the consumer.

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§40.14.6 (cont'd)	34	Plan Responsibility for Marketing Activities of Third Parties (cont'd)	We urge emphasizing in this section that plans are held responsible for the actions of any third party that meets the definition of marketing, e.g., that tend to steer Medicare beneficiaries to a plan or subgroup of plans. We make this recommendation because of past practices of plans to deny responsibility for the marketing activities of non-contracted third parties, such as trade associations.
§40.16	35	Standardization of plan name type	We renew our concern that plan sponsors should not be allowed to give all of their plans of a certain type the same name, for example “Gold HMO” or “Silver PPO.” This creates too much confusion for beneficiaries, particularly where the differences among the Gold HMO offerings are very small. Plan sponsors should be required to differentiate among each plan they offer of a similar type, for ex., “Gold HMO 1, Gold HMO 2, Gold HMO 3.” This will help ensure that beneficiaries are enrolled in the plan that meets their needs. It will also help SHIPs and other counselors know the precise plan in which a beneficiary who seeks their assistance is enrolled.
§40.16	35	Standardization of plan name type	We also have concerns that designations such as HMO-POS-SNP after a plan name are not user friendly and will mean little to most beneficiaries. We urge CMS to develop terms that will be more meaningful to beneficiaries. Also we propose that whenever such terms are used, plans be required to have footnotes explaining the meaning of the acronyms.
§50, et seq.	37	Marketing Material Types and Applicable Disclaimers	We appreciate CMS’ overall effort to assist beneficiaries in reviewing and understanding plan materials by requiring additional labeling and disclaimer information.
§50.1.1	39	Guidance and Disclaimers	We suggest adding language to the disclaimer in the last bullet to clarify that no sales are to take place at Education Events.

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§50.1.1 (cont'd)	40	Guidance and Disclaimers	In the next to last bullet on PFFS plans, there is a typo and grammatical problems. Replace (i.g.. Medigap plan) with (i.e., Medigap plan). In the second sentence, the pronoun “it” is not consistent with the subject “doctor.”
§50.1.1 (cont'd)	41	SNP eligibility statement	Please add a sentence stating that if the eligibility requirements for a DE SNP are based on a state Medicaid subset, plans must state clearly that only members of that subset are eligible for membership in the SNP.
§50.1.2	41	Federal Contracting Statement	The introduction to this section indicates that the federal contracting statement must state that the plan sponsor contracts with the federal government. Yet five of the seven examples say nothing about Medicare being a federal program. Some readers may not realize that a federal agency administers Medicare. We suggest adding text such as, “A Health plan contracting with CMS, the federal Medicare agency,” or “A Medicare Advantage organization with a contract with the federal Medicare agency.”
§50.1.2 (cont'd)	41	Permissible statements describing MA plans	We are concerned that the varying descriptors permitted can be confusing to beneficiaries. In particular, the last descriptor, “a coordinated care plan with a Medicare Advantage contract” could suggest that a plan is unique compared to other MA plans while the term is, in fact, generic.

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§50.1.3	42	Disclaimer language	On the first disclaimer, change “herein” to “here”. Change “contact the plan” to “Contact us at 1-800-xxx-xxxx.” On the second disclaimer change “formulary” to “list of covered drugs” The benefit information disclaimer at the top of the page could be simplified to make it more accessible to a general reader and to avoid the appearance of legalese. We suggest an alternative such as, “The benefit information that this material contains is only a brief summary and does not fully describe the benefits. For more complete information about the benefits, contact the plan.”
§50.1.4	42	Explanatory Materials that Mention Plan Benefit and Premium Information	We are very pleased that CMS states that “Full benefits DE SNPs for whose members the State pays the Part B premium should indicate that the Part B premium is covered for full dual members.” We think that language should be mandatory and suggest changing “should” to “must.” We also believe that that language should be required for all MA plans, since full benefit dual eligibles may be enrolled in any MA plan other than an MSA. We suggest that CMS require, rather than encourage, plans to insert the paragraph about Extra Help in all pre-enrollment materials that contain Part D benefit and premium information.
§50.1.5	43	Enrollment Limitations	We suggest that the enrollment limitation example note that SEPs may apply in certain circumstances. An alternative would be, “Generally, members may enroll in the plan only during specific times of the year. Special Enrollment Periods are available, however, in limited situations. Contact [plan] or 1-800-MEDICARE for more information.”

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§50.1.6	43	Location of availability statements	Require that the disclosures be prominent on the front of the document, either on the top or the bottom.
§50.1.7	44	Disclaimer language	We suggest strengthening the educational event disclaimer to indicate that no sales activity will take place at the event. Here is an alternative: “This event is only for educational purposes. Though plan representatives may be present, they cannot share plan specific benefits or details, or attempt to sell Medicare health plans or other insurance products”
§50.1.8	44	Disclaimer language	We suggest this alternative to the disclaimer on invitations to marketing events: “A sales person will be present with detailed information and enrollment applications for [plan].”
§50.1.9	44	Disclaimer language	For the nominal gift disclaimer, we encourage you to say a few more words about the nature of the “obligation” that some people may feel. The second example would read: “Free drawing without obligation to speak with a sales person or enroll in a plan.”
§50.1.11	45	Disclaimers	In second bullet, change “emergent” to “emergency”; change “be responsible” to “pay for.”

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§50.1.16	47	Disclaimer language	We suggest modifying the PFFS disclaimer to make clear that a provider's non-acceptance of a plan's payment terms has one more important implication for beneficiaries. The suggested modifications are in bold. A Private Fee-for-Service plan works differently than Original Medicare with a Medicare Supplement plan (i.e., Medigap plan). If you have a doctor, hospital, or other health care provider, they may continue to treat you if they agree to accept our terms and conditions of payment. If they do not agree to accept our terms and conditions of payment, they may choose not to provide health care services to you, except in emergencies. In that case, you would have to find health care providers who accept our terms and conditions of payment in order to make use of your Medicare coverage."
§50.1.16	47	Language Use	In the directive to marketing representatives to read or state the disclaimer, please consider substituting "orally" for "verbally." Verbal can be ambiguous because it refers to both the written and spoken word. Oral specifically refers to the spoken word, thus it conveys your meaning more clearly.
§50.1.17	46	Additional Guidance Applicable to All PFFS Plan Materials	The language in the disclaimer concerning providers' option to continue treating an individual should only be required to be used by PFFS plans offered in service areas that are not subject to network requirements pursuant to §162 of MIPPA (in other words, these disclaimers should only apply in non-network areas wherein providers will still be free to accept or refuse a plan's terms and conditions; such language used in network areas will be confusing to individuals and inaccurate). Note that this comment is also applicable to the PFFS disclaimer discussed in connection with marketing events at §70.8 on page 82.

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§50.1.17 (cont'd)	47 to 48	Additional Guidance for D-SNPs	We think it is crucial that plan sponsors provide accurate information about actual cost-sharing for beneficiaries who are also eligible for full or partial Medicaid benefits. This disclaimer is a good first step in that direction. However, dual eligible individuals who are enrolled in other MA plans need the same information. Particularly in light of the CMS memo which found that some SNPs do not offer benefit packages that are any different from other MA plans, some duals who are interested in enrolling in a private plan may prefer enrollment in another type of plan. Additionally, many individuals who are eligible for enrollment in I-SNPs and C-SNPs may also be eligible for full or partial Medicaid benefits. These individuals also need clear information about how the benefit packages and cost sharing for those plans interact with their Medicaid.

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§50.2	50	Support for Plan Sponsor Mailing Statements	We would like to offer our strong support for this change to the marketing rules for MA and Part D plans. Since the implementation of Part D, we have heard from countless SHIP programs and counselors working with beneficiaries who are bombarded with marketing materials throughout the year. Much of this mail arrives prior to and during the Annual Enrollment Period. As you know, this is also the timeframe for plans to send required information to their current enrollees ahead of the new plan year. It is virtually impossible for many beneficiaries to sort through the hundreds of mailings they receive each fall. Each year SHIP counselors spend many hours helping beneficiaries sort through their mail. Counselors will ask beneficiaries to bring in the mail that "looks important" as a means to help the counselors find what they need. This change to the guidelines would assist beneficiaries to figure out what information is vital and what is not.

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§50.2	50	Suggested Improvements to Plan Sponsor Mailing Statements	First, we ask for clarification on what type of information might be "non-plan" and "non-health." An example or some additional guidance would be very helpful to ensure plans do not take advantage of this exception. Second, we strongly encourage CMS to require plan sponsors also to include the plan's logo or plan name on the outside of all mailings as well. We continue to hear reports from SHIPs of mailings with an address only. Finally, the way the language of this section reads, plans can seemingly label other (e.g., political) mailings as “Important Plan Information” if they can show it is not an advertisement or health and wellness mailing. Alternatively, plans might argue that such mailings are “non-plan” and “non-health related” information therefore not subject to this guidance. We believe that such propaganda mailings be labeled as “advertising” or some additional category like “political opinion.”
§60.1	51	Summary Of Benefits	We thank you for the specific statements concerning Medicaid with regard to D-SNPs and renew our request that this information be provided by all MA plans, or at least by all SNPs.
§60.4.2	56	Provider directories	We appreciate that the Medicaid indicator is a required element for the provider directory for D SNPs. Again, this information should be required for all MA plans, or at least all SNPs. We also question why a D-SNP would have any providers who do not accept Medicaid.
§60.4.3	56 to 57	Subnetworks	Allowing plans to have subnetworks makes plans unduly complicated for beneficiaries to navigate and almost impossible to compare. The requirement for subdirectories of providers does not remedy this fundamental structural problem. We urge CMS to reconsider allowing plans to use subnetworks.

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§60.4.6	58	Notification of changes to provider networks	The requirement in the call letter for plans to notify patients who see a provider “regularly” when that provider is terminating a relationship with the plan is too vague. Instead, CMS should set a more precise requirement, for example, that a plan must notify any patient who has seen the provider within one year.
§60.5.1	60	Utilization management	Require that there be a note on the utilization management column directing the reader to the website where beneficiaries and providers can find the specific UM requirements for a drug.
§60.5.2	61	Comprehensive formulary	We do not understand the last two sentences of this section. What are drugs “adjudicated at the point of sale as formulary drugs that are not found on the CMS approved HPMS formulary?”
§70.4	70	Marketing Through Unsolicited Contacts	While we appreciate and support the additional clarifications concerning unsolicited contacts (e.g., leaflets, flyers, door hangers, social networking sites, telephonic, text and email messages), we reiterate prior joint comments stating that we believe that CMS has failed to implement adequate safeguards against unsolicited contacts and other consumer protections pursuant to section 103(a) of MIPPA. For example, although unsolicited door-to-door contacts are prohibited, there are no effective oversight and enforcement methods outlined to prevent them. In addition, CMS has written in loopholes to some of these protections through guidance issued in the Fall of 2008 and re-stated here (e.g., scope of appointment requirements, as discussed below). In addition, neither MIPPA nor its implementing regulations spell out exceptions for plan sponsors to market other products to their current enrollees.

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§70.5	71	Specific Guidance on Telephonic Contact	As expressed in prior joint comments, we strongly object to plans/agents being allowed to market to their own members/clients and note that neither statutory nor regulatory language reserves this right for plan sponsors and agents. There should be no exceptions to the prohibition on cold calling for plans or agents trying to sell other products. Also see comments re: unsolicited calls concerning Medigap products discussed above re: §30.4. CMS should expand its marketing guidelines to prohibit cold calls involving the sale of Medigap products. In addition, any MA and PDP discussions resulting from such calls re: Medigap plans is an end run around the general prohibition on unsolicited contacts, and should also be prohibited.
§70.5	73	Outbound calls by losing plan	Although we appreciate that CMS requires advance approval of outbound calls by plans losing beneficiaries because of reassignment, we urge CMS to prohibit such calls entirely.
§70.6	75	Outbound education and verification calls to new enrollees	We agree with the proposed changes. We ask that beneficiaries who learn as a result of the outbound education and verification process that they are enrolled in a plan that does not meet their needs be entitled to a SEP to enroll in a different PDP/MA plan or to return to traditional Medicare and a PDP. CMS should clarify that outbound verification calls are required for any enrollments that result from in-home sales or enrollments taken at marketing events. Only enrollment requests via in-bound telephone calls initiated by the beneficiary that do not feature steering toward particular product lines should be exempted from the requirement that all enrollments effectuated by brokers or agents be followed by an outbound verification call.

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§70.7	78	Educational Events	We reiterate prior comments stating that we believe that, in addition to marketing events, all educational events should be reported to CMS ahead of time so that such events can be monitored to ensure that plans sponsors and agents are adhering to the rules separating educational from marketing events.
§70.7 (cont'd)	79	Responding to questions at an educational event	The exception allowing plans to respond to questions at an educational event guts the marketing prohibition entirely.
§70.9.1	90	Scope of Appointments – Failure to Implement Adequate Protections	We are disappointed that CMS has failed to adequately protect consumers concerning individual marketing appointments. As noted, for example, in prior joint comments, CMS has apparently abandoned the requirement that a discussion of any lines of business not agreed upon prior to an in-person appointment is subject to a 48-hour cooling off period (see 42 CFR sec. 422.2268(h)). Moreover, as discussed below, the scope of appointment process has been rendered all but meaningless. In short, we continue to believe that CMS' interpretation and implementation of these rules unnecessarily accommodate plan sponsors and agents at the expense of beneficiaries.

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§70.9.1 (cont'd)	90	Scope of Appointments – Failure to Require "Advance" Agreement	We believe that CMS has failed to follow the statutory requirements related to scope of appointments. Section 103(b) of MIPPA requires "advance agreement with a prospective enrollee on the scope of the marketing appointment and documentation of such agreement ..." With respect to "advance agreement" CMS has, through guidance, effectively ignored this requirement by: 1) allowing agents to have the beneficiary sign the form at the beginning of the appointment "if it is not feasible for [the form] to be executed prior to the appointment"; and 2) by allowing a new form to be completed at the time of the appointment if the beneficiary "request[s]" information about a type of plan not previously agreed to be discussed. CMS proposes to add the following language: “CMS expects plans to record and maintain documentation on why it was not feasible to obtain the scope of appointment prior to the appointment.” Without further articulation of what may “pass” a CMS inspection of such documentation, it is difficult to surmise whether this new language will provide any additional meaningful protection for beneficiaries.
§70.9.1 (cont'd)	90	Scope of Appointments – Failure to Require Agreement in "Writing" for In-Person Appointments	Section 103(b) of MIPPA requires "documentation" of scope of appointment agreements, and provides even more specificity with respect to high-risk in-person sales appointments: "In the case where the marketing appointment is in person, such documentation shall be writing." CMS has abandoned this requirement by allowing beneficiaries to give consent during recorded phone calls instead of keeping a written record, reviewed and signed by the beneficiary.

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§70.10	91	Specific Guidance to Outreach	We recommend that CMS strongly encourage plans to conduct inreach to identify plan members who may be eligible for LIS or an MSP and to offer enrollment assistance to these members. We further recommend that authorizations for plans to represent members should be specifically limited to assistance with applying for LIS and/or MSPs and should expire upon submission of the application(s). Assistance with redeterminations of eligibility should be permitted only upon the express request of the member. Plans should be required to provide specific referral information to members about SHIPs and other MIPPA grantees in their areas.
§70.10.2	94 to 95	Dual eligible outreach	We appreciate the addition of a bullet encouraging plans to work closely with SHIPs and state agencies to enroll duals. The role of plans in enrolling people eligible for Medicaid can be important and coordination with advocates and states can only enhance their effectiveness.
§70.10.2 (cont'd)	94 to 95	Dual eligible outreach (cont'd)	We appreciate CMS' effort to ensure that plan sponsor's efforts in informing dual eligibles about potential assistance programs is done in a way to protect the individual. We believe that all requirements under this section should be required to be both printed in the materials and included in the discussion between the plan sponsor and the individual. This will help to ensure that individuals receive and understand all the information being presented to them, as some beneficiaries have better understanding when things are in writing and others better understand things orally.

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§70.10.2 (cont'd)	94 to 95	Dual eligible outreach (cont'd)	We appreciate the new language that CMS will consult with stakeholders (e.g., SHIPs, state agency) when working with the plan sponsors. We advise that this consultation begin early and continue through the process of approving plan materials. Stakeholders are the best source of information about the dual eligible population and can help to ensure that this process is successful.
§80.1	100	Call center operating standards	We renew our request that call centers be required to operate 24/7 during enrollment periods. We also suggest that "(Other than Coverage Determinations and Appeals Call Centers)" be added to the title of this section to emphasize that the hourly requirements are different for Coverage Determinations and Appeals Call Centers.
§80.1 (cont'd)	100	Call center operating standards (cont'd)	Having operators available 24/7 is of particular importance to limited English proficient callers who cannot navigate automatic prompts in English. Also, if CMS continues to permit limited hours for live operators, require that there be a mechanism so that, when live operators are not available to handle or redirect calls, individuals calling to request expedited coverage determinations can be redirected to a number or mailbox where their request can be immediately addressed. This should be in addition to the separate line for providers discussed at 80.1.1.
§80.1 (cont'd)	100	Call center operating standards (cont'd)	We advise that the agent/broker phone numbers on advertisements should be in a separate section and should include mandatory language stating that the phone number is for a licensed broker who will attempt to sell an insurance product. We further urge requiring call centers to be operational 24/7 during generally available enrollment periods.

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§80.1.2	101	Coverage Determinations and Appeals Call Centers	We renew our request that call centers be staffed 24/7. We have assisted beneficiaries who have been prescribed non-formulary medications at other than standard business hours and who have had a great deal of difficulty in reaching a coverage and appeals center. For some of these beneficiaries, the inability to get needed medications, particularly antibiotics in exceptional situations, has caused a deterioration of their medical conditions and physical harm.
§§80.1.3 - 80.1.9	102 to 108	Scripts/ Calls	We believe these sections are necessary improvements to the marketing guidelines. We ask that CMS work to develop mandatory language to ensure that the information provided to beneficiaries is accurate and understandable. We also ask that CMS monitor compliance with these sections closely to ensure that beneficiaries are protected.
§80.1.4	104	Greeting	Particularly to accommodate limited English proficient speakers, require that plans set IVR systems to default to a live CSR if the caller does not push any buttons or make a verbal selection from an options menu. See CMS 12/19/09 memo to plans recommending this action. www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/MemoCallCenterMonitoring_12.19.08.pdf
§§90.7.1 – 90.7.3	116 to 117	Standardized vs. Model Language	We appreciate the additional clarification and renew our request that CMS move to more standardized language.
§90.11	119	Review of alternate format material	Please clarify that all non-English versions of marketing pieces, not just those that are mandated because a population reaches threshold requirements, must be submitted.

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§102.0	127	Organization Website Content	Plans must post all prescription drug utilization management information at the time they post their formularies. Utilization management information should be easy to find, clearly marked, and understandable.
§102.1	128	Pharmacy access disclosures	We question the value of a statement saying that a plan has contracts with pharmacies that equal or exceed CMS requirements. Such a statement does not provide beneficiaries with any information that they can use.
§110.1	133 to 134	VAIS	The additional language should help avoid the confusion caused when plans attempt to provide information about VAIS in required marketing materials. We ask CMS to continue to monitor compliance with this section. However, the language of this disclaimer can be read to imply that a grievance process may exist for value added items or services when the plan might not offer one. Suggest changing the language to “may or may not”.
§110.1	133 to 134	VAIS	The concept of VAIS requires definition and illustrative examples would be very helpful in distinguishing VAIS from benefits. In order to minimize misunderstandings and misuse of the VAIS concept, we recommend including a clearer definition and distinction of VAIS from health and drug coverage on page 15. Moreover, illustrative examples and explanations would be helpful to plan sponsors, beneficiaries and their advocates. For example, VAIS should not be construed, as happened in 2008, to include transportation to medical providers’ offices (which may be a Medicaid-covered benefit) offered by Dual Special Needs Plan.

Section #	*Page #*	*Description of Issue or Comment*	*Suggested Revision or Comment*
§120	134 to 142	Guidance on Marketing	We urge CMS to incorporate the recent findings and recommendations from the HHS Office of Inspector General in its marketing oversight and enforcement strategy, particularly in regards to agent licensing, training and compensation. We note with concern the OIG finding of a continued high incidence in 2009 of marketing related complaints generally, and regarding marketing misrepresentation in particular. We urge CMS to use all the tools at its disposal—regulatory and subregulatory guidance, targeted audits and civil and monetary penalties, including prohibitions on marketing and enrollment, to prevent reoccurrence of the serious marketing violations uncovered by OIG, including: • Use of unlicensed and untrained agents; • Inability to identify whether enrollments were effected by licensed or trained agents; • Failure to conduct outbound enrollment verification calls; • Use of cost reimbursement, payments to Field Marketing Organizations and other means to skirt limits on agent compensation.
§120 (cont'd)	134 to 142	Guidance on Marketing	Finally, the OIG report also calls into question CMS' ability, given current resources and staffing, to adequately police marketing conduct by Medicare Advantage plans. We urge CMS to work with Congress, the National Association of Insurance Commissioners and state insurance departments to develop an approach that would give state insurance departments an active role in enforcement of market conduct by Medicare Advantage plans.

Section #	*Page #*	*Description of Issue or Comment*	*Suggested Revision or Comment*
§120.1	134	Compliance with State Appointment Laws	It is unclear whether the appointment requirement referenced in this section applies to solicitation or only an actual sale. We are aware of instances in which people are solicited but only the actual application is signed by the licensed agent. We ask CMS to clarify.
§120.2	134 to 135	Plan Reporting of Terminated Agents	We urge CMS to follow the OIG's recommendation and require plans to report incidences of unlicensed agents to relevant state authorities. We note OIG's finding that some MA plans are unable to identify whether the agent submitting an enrollment application is properly licensed. We reiterate our longstanding recommendation to include on the MA application a place for the agent to include his or her National Insurance Producer Registry number This will enable plans to readily identify the agent responsible for the enrollment and whether or not the agent is licensed in the relevant state.
§120.3	135	Agent Training and Testing	We agree with CMS on the importance of annual agent training both on Medicare rules and on the products they sale. We note OIG's finding that plans continue to use untrained agents and urge CMS to fully enforce this requirement. We continue to hear reports that plans have one designated person to take tests for all agents and brokers in an office or area. Our reports have come from SHIPs and directly from plans themselves.
§120.4	135	Agent Use of Materials	We do not object to allowing agents to create and distribute business cards that indicate which products they sell without CMS approval. We are concerned that the lack of specificity in this guidance may encourage agents to produce materials, such as brochures, to describe the plans they sell that does not meet CMS approval.

Section #	*Page #*	*Description of Issue or Comment*	*Suggested Revision or Comment*
§120.5	135 to 141	Compensation	Excessive agent compensation creates incentives for aggressive, fraudulent and deceptive marketing, which the OIG found continues to plague the Medicare Advantage program. In addition, marketing commissions are a drain on plan resources that could otherwise be used to improving plan benefits. We urge CMS to use its authority to lower the limits on per-enrollment commissions, including by incorporating within those limits the cost based reimbursement and FMO payments that plans are using to skirt compensation limits and gain competitive advantage. Such competitive advantage is to the detriment of Medicare consumers since it creates incentives for aggressive marketing of plans that use comparatively more of their Medicare and beneficiary premium revenue for marketing and comparatively less for plan benefits.
§120.5.1	136	Definition of Compensation	We urge CMS to incorporate any payments to agents for fees for state appointment and reimbursement for costs related to sales appointments and for mileage within the definition of compensation, and subject to said limit. The OIG found that these cost-related reimbursements were used by plans to skirt limits on compensation.
§120.5.4	137 to 138	Good Standing	It is not sufficient merely to allow plans not to pay compensation to agents who fail to complete annual testing. CMS should prohibit plans from compensating agents who are not properly trained or licensed and appointed. We agree with CMS' proposal to include referral fees and all bonuses within compensation limits.
§120.5.4.1	139	Additional Fees	CMS should require plans to terminate any agent who charges the beneficiary a marketing fee and identify the agent to the state department of insurance for possible disciplinary action.

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§120.5.6	139	Chargebacks	We disagree that plans should not recover commissions paid for disenrollments within three months during the Medigap trial period or for non-payment of premium. In our experience, rapid disenrollments during the Medigap trial period are likely due to marketing misrepresentation. Commissions should not be paid for rapid disenrollments made during the Medigap trial period. Disenrollments for nonpayment of premiums during the first three months also likely indicate that the beneficiary did not adequately understand their premium or other cost-sharing obligations. Commissions should be recouped by plans if they enrollee is disenrolled for nonpayment of premiums. We urge CMS to engage in greater scrutiny over whether MA plans are properly recouping commissions paid after rapid disenrollments and taking appropriate actions to track and discipline or terminate the responsible agents.
§120.5.8	141	Third Party Marketing Entities	The OIG report found that plan payments to FMOs were used to skirt CMS' compensation limits and that CMS' fair market value standard allowed plans to gain a competitive advantage by paying FMOs much larger fees than competing plans. Such fees drive enrollment to the plans that pay them, rather than plans that provide higher quality care or better benefits. We urge CMS to incorporate all FMO fees within the total per enrollment commission structure. Alternatively, we urge CMS to establish an appropriate ceiling across all plans for FMO compensation. Finally, we urge CMS to work with plans to identify FMOs associated with a pattern marketing violation issue appropriate guidance barring plans from employing these FMOs.

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§160	152	Use of Federal Funds	This new section adds important protections for beneficiaries. We heard from many beneficiaries who were confused by mailings and phone calls, including robo-calls, asking them to take actions designed to influence legislation or appropriations pending before Congress. If anything, we would strengthen this section by mentioning written and oral communications, including communications designed to facilitate such activity by connecting a plan enrollee directly with his/her elected official.
§170	152 to 156	Allowable Use	We object to the exception for previous commercial relationships. This exception opens the door to confusing marketing actions, because many beneficiaries have trouble distinguishing Medigap policies from Medicare Advantage plans.
§170.1	153	When Prior Authorization Is Not Required	We don't want plans to send their Medigap or PDP enrollees MA information that says how much better the MA plan is. Information about another product is very different from information on disease management programs, or why benefits have changes, or on Medicaid.
§170.3	154	Obtaining prior authorization	Plans should not be allowed to get prior authorization at marketing events. Prior authorization should be limited to enrollees, not the general public. This opens wide the ability of plans to use sign-in sheets that grant authorization to contact people who come for information purposes about any of their products.