April 26, 2018

COMMENTS SUBMITTED ELECTRONICALLY

Re: 2019 Medicare Advantage Marketing Materials

1. **Section: Other: Miscellaneous**

Thank you for the opportunity to comment on these proposed changes to the 2019 Medicare Marketing Guidelines (MMG). We are disappointed that this process allows us such limited scope for comment and lacks even rudimentary draft language.

The absence of clear draft language means that we are unable to comment directly in many cases. Rules surrounding marketing to and communicating with beneficiaries depend greatly on the details of specific permissions and prohibitions. Small changes to language can be quite significant in terms of beneficiary understanding. In particular, the absence of draft language around definitions, such as proposed changes to Appendix 1, makes it impossible to judge the sufficiency and accuracy of the new definitions. But other changes also hinge on precise wording that ensures that all parties can see the scope of—and potential ambiguities in—textual changes. By denying commenters a glimpse of the text, CMS is rejecting valuable insights, clarifications, and feedback about how the text will be interpreted, used, or even misused.

In addition, the lack of draft language makes identifying the exact location of changes difficult. This commenting form expects commenters to assign comments to particular sections of the MMG, yet the list provided by CMS does not identify the precise sections that are being modified. This requires commenters to guess exactly what changes are being made where, which can cause misunderstanding and frustration for all parties involved.

The missing draft language also requires commenters to guess regarding other changes CMS may consider more minor and not warranting a bullet in the short list. This means that commenters are forced to make assumptions about unmentioned changes, either to assume they are not being made or to assume they are.

1. **Section: 40.3 and 40.5**

The proposed changes include changes to the "General Marketing Requirements (current MMG sections 40.3 - 40.5) that enhance plans' ability to market competitively and foster fair comparisons, while making sure beneficiaries have clear and reliable information with which to base their choices. This could include eliminating or revising current requirements and/or restrictions."

The sections identified limit the use of non-Medicare data and the use of testimonials or endorsements. While there is no detail as to what changes will be made, we object to any changes that may loosen or remove consumer protections. These protections allow people who are joining or are already enrolled in Medicare to be free from harmful, misleading, or coercive advertising that may induce them to make decisions that do not best suit their personal circumstances. At a time when Medicare Advantage (MA) plan choice is becoming increasingly complex, especially when combined with new CMS policies to allow insurers the freedom to put forth plans that appear duplicative or that have never-before-seen benefit flexibilities, it is vital that beneficiaries be able to trust, understand, and utilize the materials they receive.[1] This requires firm oversight from CMS, not a relaxation of standards and restrictions.

2. **Section: Other: Miscellaneous**

Recent legislation (the Bipartisan Budget Act of 2018) in conjunction with decisions by CMS grant more flexibility to plans to create new supplemental benefits that are not directly related to health care. While we support providing needed benefits to people with Medicare, the availability of such benefits must not become merely or primarily a sales tool. Plans must not be permitted to use supplemental benefits to persuade beneficiaries into their plans. We are especially concerned that agents and other sales personnel will ask individuals about their conditions and steer them toward specific plans in violation of antidiscrimination rules. Seemingly innocuous conversations about what a beneficiary wants from a plan could lead to pernicious steering and rate manipulation through cherry picking.

We urge CMS to establish strict rules against such targeting and suggest that all shareable information about every plan be divulged to potential enrollees, empowering them to choose the appropriate plans for themselves. This may require plans to categorize benefits in a standard way to allow beneficiaries to understand all of the options in the benefits catalog as a whole. Both CMS and plan sponsors must be vigilant for unusual spikes in enrollment or enrollment patterns that might reveal inappropriate steering of enrollees.

3. **Section: Other: Miscellaneous**

We object to several of the proposals that remove restrictions on methods of contact and allow for marketing of gifts and giveaways as part of the advertising process. For example, the proposals to allow referring enrollees to provide email addresses for referees and to allow plans to mention gifts to these referrers, to allow agents to disseminate contact information at educational events, and eliminating from review certain business reply cards will allow plans to intrude more fully into beneficiaries' lives without permission or request.

Educational events do not require the same CMS oversight specifically because they are not marketing / sales events. To allow agents to provide their contact information at these events blurs the line and raises the risk of pitches being presented as educational events.

In addition to inserting sales materials into education events, removing the restriction on requesting email addresses when asking for referrals from enrollees will result in unwanted emails joining the current deluge of mail that beneficiaries currently receive, whether they have agreed to be contacted or

[1] Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program, FR 16440.

not. Like phone calls or house visits, electronic communication with plans should be something that beneficiaries themselves must opt into, rather than allowing a referrer to provide their address. Similarly, plans and sponsors should not be able to encourage enrollees to offer up their friends and relatives, regardless of interest, by announcing that gifts are available.

The decision to choose a particular plan is a complicated one—made only more complicated by CMS's recent expansion of plan flexibilities[2]—that should not depend on the enrollment of friends or be swayed by biased sales events under the guise of "education." Instead, people must carefully consider their own health needs and the real benefit structure offered by various plans. Loosening these marketing requirements makes it harder for beneficiaries to form independent decisions based on their own interests.

4. **Section: Other: Miscellaneous**

We object to the proposal to update the font size in required documents only. Marketing materials of any type should be in a font that is readable. Providing information in smaller font sizes has no purpose other than to decrease the likelihood that the information will be read.

We also object to the proposal to consolidate many disclaimers into one pre-enrollment checklist instead of requiring the disclaimers on multiple marketing materials. It is unreasonable to expect a beneficiary to recall the disclaimers sent previously. Relevant disclaimers to clarify beneficiary rights and responsibilities must be included in all applicable documents.

5. **Section: 30.5**

Currently translation for marketing documents is required for languages spoken by five percent or more of the population in the plan service area. We ask that CMS adopt regulations which provide that translation requirements are triggered if a non-English language is spoken either by a percentage or by an absolute number of people in the service area. We further propose that, for purposes of counting absolute numbers, the service area be determined by combining all service areas served by the plan sponsor. These changes would address two major anomalies created by the current regulations. First, though Medicare Prescription Drug Plans (PDPs) in states like New York or California with large populations may serve tens of thousands of limited English proficient (LEP) individuals speaking a non-English language, the five percent threshold is not triggered because the population base against which the threshold is calculated is so large. Second, the current threshold does not take into account the reality that both the PDP market and the MA market are dominated by large national plan sponsors. These plans easily serve many thousands of speakers of Chinese, Vietnamese, Korean and other common languages yet may have no obligation to translate model documents in these languages. By any balancing of equities, the burden on plans is minimal compared to the benefits of access and transparency for plan members.

[2] *Id.*

6. **Section: 30.10.1, 30.10.2**

Star Ratings serve multiple purposes—dictating payments, plan renewals, enrollment periods and more. But one primary purpose is to accurately and understandably communicate plan quality to consumers. CMS's marketing rules should not allow plans to manipulatively describe or obscure their Star Ratings . We also encourage CMS to include language in the revised MMG which prevents plan sponsors from marketing plans as having received 4 or 5 stars in previous years (i.e., "2 of the last 3 years") or from marketing sub-category, rather than overall, scores. As CMS reviews the MMG sections on Star Ratings, we strongly urge CMS to retain important consumer protections set forth by these guidelines, and to engage with a diverse set of stakeholders on any proposed revisions.

CMS also plans to address the impact of contract consolidations through averaging Star Ratings for consolidated contracts. We support this policy change.