August 10, 2018

COMMENTS SUBMITTED ELECTRONICALLY

Re: 2019 Final Medicare Communications and Marketing Guidelines (MCMG)

Thank you for this opportunity to comment on the 2019 Medicare Communications and Marketing Guidelines (MCMG).

General Comments

This finalized guidance for Medicare communications and marketing guidelines has undergone a complete revision from previous years, including a major reorganization. This reorganization improves the readability and logical progression of the guidelines and is much appreciated.

However, it is greatly disappointing that the guidelines do not mention the new flexibilities in Medicare Advantage (MA) and Part D and do not offer guidance for how MA sponsors should market plans with new supplemental benefits. Guidance on supplemental benefits is absolutely vital, as the risk of such benefits is that they will enable sponsors to cherry-pick beneficiaries and inappropriately steer potential enrollees. CMS has lost a valuable opportunity to establish firm guardrails to protect people with Medicare.

As we stated in our comments on the proposed changes,[1] we are appreciative of efforts to provide support for Medicare beneficiaries that may enable them to stay longer in their homes and to cope with Social Determinants of Health that create barriers to well-being. But the availability of supplemental benefits must not become merely or primarily a sales tool and sponsors must not be permitted to use supplemental benefits as a marketing device 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 anti-discrimination rules, and this guidance does nothing to assuage our concerns. Cherry-picking and lemon-dropping must not be permitted through lax oversight.

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 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.

In addition, we are concerned that at various points throughout the guidance, CMS seems to be easing marketing restrictions that were put in place to protect beneficiaries, and in response to persistent,

[1] Medicare Rights Center, "Comments on 2019 Medicare Communications and Marketing Guidelines (MCMG)" (April 2018).

documented abuses. We object to any changes that may loosen or remove consumer protections. We also object to gaps in the guidance that do not protect people who are joining or are already enrolled in Medicare from harmful, misleading, or coercive marketing that may induce them to make decisions that do not best suit their personal circumstances. It is exceptionally important now, when MA plan choice is increasing in complexity and confusion, that beneficiaries be able to trust, understand, and utilize the materials they receive. We need robust oversight from CMS at this important juncture.

20—Communications and Marketing Definitions; 20.1—Factors for Activity and Material Determination

In the new definition of marketing, CMS identifies an exclusion of "materials that might meet the definition of marketing based on content, but do not meet the intent requirements of marketing." Later, the guidelines provide an example (the flyer, page 3) of materials that meet the definition of marketing based on intent, but apparently lack the necessary content. This seemingly means the new marketing definition excludes some types of blatant advertising.

The definition of marketing is also confusing in that it specifically mentions MA plans twice and could be read to only apply to Medicare Advantage, although we understand that the intent is to include PDPs. We also ask that the sentence: "Additionally, marketing contains information about the plan's benefit structure, cost sharing, and measuring or ranking standards," to "Additionally, marketing **may** contain information about the plan's benefit structure, cost sharing, **or** measuring or ranking standards." The change clarifies that any of the items listed are relevant to a determination that a document is marketing and all need not be present.

We appreciate that, in this definition, CMS expressly includes retention-based marketing, which is an important element in plans' marketing strategies.

20.2—Activity and Material Designation

CMS flags communication activities that have the potential to become marketing activities as a risk and requires sponsors or downstream entities to adhere to all marketing requirements when such activities transition. We support this admonition and appreciate its clarity.

While we appreciate the effort to distinguish between marketing and other communications, we continue to urge CMS to closely monitor materials they have designated "non-marketing communications" to ensure they genuinely do not have a marketing intent.

30.1—Anti-Discrimination

We appreciate and share CMS's concern about potential discrimination in marketing. In particular, we note that CMS has included another category of potential discrimination in its anti-discrimination prohibition—"receipt of health care." We support this inclusion as it covers both people who are high utilizers of health care and people who may have untreated medical needs, such as new beneficiaries who lacked coverage before becoming Medicare eligible.

In addition to the issues mentioned in the guidance, we urge CMS to closely monitor D-SNP look-alikes, which can be discriminatory in both marketing and design.

We also ask that CMS be more specific in its reference to other federal anti-discrimination rules and requirements and cite, as an example, HHS regulations found at 45 C.F.R. Part 92 since this set of regulations is directly applicable to the marketing and communications activities of plans and plan sponsors.

30.2—Standardized Plan Name

We urge that CMS clarify that this requirement includes stating that the plan is a D-SNP or C-SNP or I-SNP if applicable.

30.6—Electronic Communications Policy

We object to permitting unsolicited email communication with prospective enrollees who do not have other relationships with the plan sponsor. Emails are only slightly less intrusive than phone calls. Allowing mailing is quite enough of an intrusion on older adults and persons with disabilities who need time and space to make optimal decisions about their health care.

30.7—Prohibited Terminology/Statements

CMS restricts the use of the word "free" and forbids its use "to describe a zero-dollar premium, reduction in premiums (including Part B buy-down), reduction in deductibles or cost sharing, low-income subsidy (LIS), or cost sharing for individuals with dual eligibility." Sponsors may use "free" "in conjunction with mandatory supplemental and preventive benefits provided at a zero-dollar cost sharing for all enrollees." There is potential ambiguity around plans using "free" to describe optional supplemental benefits that are only available to enrollees with specific conditions, as such benefits are not covered under either the explicit prohibition or the specific permission.

Additionally, we are concerned about the allowable use of unsubstantiated absolute or qualified superlatives in logos or taglines, often the most powerful portions of advertising campaigns. CMS has provided no explanation of why these items should be exempt from the general prohibition. We ask the agency to reconsider this policy.

We are also confused by the statement that non-D-SNP plans cannot claim that they have a relationship with the state Medicaid agency unless the plan has contracted with the state to coordinate Medicaid services. How would such a contract exist outside of a D-SNP on an MMP context? Is this section talking about MMPs? If so, it should be more explicit.

Further, we are concerned about the requirement that MA plans not "target their marketing efforts exclusively to dual eligible individuals." While we applaud this restriction, we are concerned about the term "exclusively." It is easy for D-SNP look-alike plans to make perfunctory efforts to recruit non-duals in order to avoid a charge of "exclusive" recruiting. Targeting "primarily" at dual eligibles would be a more appropriate standard. We also note that much of the inappropriate targeting of non-D-SNPs to dual eligibles begins with a plan deductible and co-insurance structure that would only make sense for dual eligible. (See discussion in June 2018 MedPac Report to Congress at p. 273). To curtail inappropriate marketing to dual eligibles, we encourage CMS to look at both plan design and marketing practices.

30.8—Product Endorsements/Testimonials

In its list of requirements for endorsements or testimonials, CMS has removed several previous rules:

- An endorsement or testimonial by an individual cannot use any quotes by physicians or other health care providers.
- A contracted or employed physician or health care provider cannot provide an endorsement or testimonial.
- An endorsement or testimonial cannot use negative testimonials about other Plans/Part D Sponsors.[2]

We do not support the removal of these prohibitions, which are in place to ensure beneficiaries have accurate, unbiased information. Allowing physicians or other providers to provide testimonials or offer endorsements could unduly impact beneficiaries, given the unique aspects of the patient-provider relationship.

40.1—Plan Comparisons

CMS allows comparisons to another plan or sponsor, provided the comparison can be supported and is factually based. This removes the requirements that there be information about and disclaimers for the studies. It is important, however, that potential enrollees know about the limitations and source of studies and statistical information. Thus, we object to this change.

40.2—Marketing Through Unsolicited Contacts

We are concerned about allowing unsolicited emails, which are only slightly less intrusive than telephone calls. Since we assume that CMS does not provide email addresses of beneficiaries to plans, this encourages buying email lists. It will be difficult if not impossible for CMS to monitor whether emails (and the email lists that plans purchase) are targeted to particular subgroups of beneficiaries in violation of CMS's anti-discrimination requirements. Further, it is cheap and easy for plans to barrage beneficiaries with emails, a practice that does not aid informed choice.

40.3—Marketing Through Telephonic Contact

We object to allowing unsolicited calls to Medicaid/MMP enrollees about other Medicare products. Plan sponsors that participate in MMP demonstrations should be required to make a commitment to those demonstrations and should not be allowed to poach members away from their own MMP products.

We also have concerns about allowing limited marketing calls to LIS-eligible individuals who are being reassigned to another Part D plan. If such outreach is permitted, it must be done in a way that supports informed beneficiary choice. At the very least, scripts should direct beneficiaries to SHIP counseling and provide them with specific information on how to contact the local SHIP.

40.6—Marketing Star Ratings

We encourage CMS to include language in future years to prevent 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.

50.1—Educational Events

[2] 2018 Medicare Marketing Guidelines, "40.5—Product Endorsements/Testimonials," p. 20.

CMS is relaxing rules against distributing business cards at educational events. We object to this change. Educational events should not provide opportunities for marketing as this blurs the line between the event types and may lead to beneficiary confusion and steering. We cannot risk sales pitches being disguised as educational information.

50.2—Marketing/Sales Events

There is an apparent error in this section. It reads "The following requirements apply to all marketing/sales events: Health screenings or other activities that may be perceived as, or used for, 'cherry picking'." It appears that this is requiring such health screenings when the likely intent is to prohibit them.

60.5—Provider Affiliation Announcement

We ask CMS to clarify that provider affiliation announcements may not be made by telephone or email to anyone not a member of a plan or otherwise connected with a plan sponsor. Calling an individual who is not enrolled in a plan to report a new affiliation has no other purpose than marketing, either directly or indirectly, regardless of whether the call also discussed benefits or costs. Telephone calls are intrusive and many beneficiaries, once connected, may feel an obligation to engage in conversation with the caller and undue pressure to enroll. We urge CMS to consistently protect beneficiaries from such calls as it does from unsolicited marketing calls more generally. Further, as noted in our comments to Section 40.2, we urge CMS to also protect beneficiaries from unsolicited emails with such announcements.

70.1.3—Required Content

CMS is removing the requirements that plan websites include information on out-of-network coverage rules, service area, premiums and cost-sharing. We strongly encourage CMS to reinstate requirements for this content. This information is critical to evaluating and selecting coverage. Beneficiaries must have the opportunity to access this data via as many access points as possible.

We also ask that CMS consider requiring Part C plans to include information on QMB billing protections and/or links to CMS information on those protections.

80.3—Informational Scripts

We suggest deleting "ideally" from the second sentence in this suggestion. We believe that, for transfers to a marketing department, use of a yes/no question is generally most appropriate.

We suggest adding scripts on the following topics:

- QMB status of a member or billing protections for a member who is a QMB and how to obtain assistance from the plan in instances of improper billing
- If the plan has delegated networks or other limitations on an individual's access to all the providers in the network, information on such limitations.
- If a plan has taken advantage of the new flexibilities with respect to limitations of certain supplemental benefits to members with particular diagnoses or to those in specific geographical areas, information about those limitations.

- Continuity of care and the plan's process to transfer members to in-network providers.

90.3—Non-English Language and Alternate Format Materials

With respect to the requirement that plans submit English translations of materials that were created in a non-English language, we ask that CMS stress to plans that the requirement encompasses broker-created materials; that plans have an obligation to affirmatively ensure that broker materials are submitted; and, further, that the English language versions submitted must accurately reflect the non-English originals.

We also ask CMS to reconsider its decision not to require submission of non-English translations of English-language documents. While we recognize that CMS may not have the capacity to review all translations, there is value in having the translations on file as a resource. Further, even if CMS cannot undertake systematic review of all non-English language documents, the agency could do some spot checking with the goal of developing best practices for plans.

100—Required Materials

We appreciate the clarification that required materials be in a readable format, specifically 12-point Times New Roman font or equivalent. We ask that this policy be expanded to include all marketing materials, so that beneficiaries can best read, understand, and absorb the information.

In addition, we request that CMS adopt new rules that trigger translation requirements if a non-English language is spoken either by a percentage or by an absolute number of people in the service area and that 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.

100.2—Electronic Delivery of Materials; 100.2.1—Notification of Availability of Electronic Materials

CMS is now permitting electronic delivery of certain materials without enrollee opt-in. We oppose this change as it may lead to beneficiaries lacking access to all of their plans' materials. Not every Medicare beneficiary has access to the internet, and no opt-out process can ensure that every person who would choose to opt out sees and responds to notification about their right to do so. CMS should instead require that beneficiaries opt in to receive materials electronically.

110.1—Agent Requirements

In light of the new flexibilities CMS is permitting in plan design, we urge the agency to thoroughly review broker training and testing materials, as well as plan design materials, to ensure broker compliance. It is particularly important that brokers understand any limits based on diagnosis or geography for

supplemental benefits and that they are trained in how to present those details in an objective, informational way that beneficiaries can easily understand.

110.2—Permitted Agent Activities

CMS is now allowing agents to provide business reply cards at educational events. As we stated above, in section 50.1, we object to any blurring of the lines between educational and marketing events. Choosing between plans is a very personal, complicated decision and beneficiaries must not be inappropriately influenced by biased sales events that masquerade as "educational." Instead, people with Medicare must have the opportunity to carefully consider their own health needs and the real benefit structure offered by various plans. Loosening these marketing requirements will make it harder for beneficiaries to form and execute independent decisions.

110.3—Plan/Part D oversight

We are concerned that the Guidance does not sufficiently emphasize the need for proactive oversight of brokers by plans. We urge CMS to require that plans have protocols in place to respond to complaints of questionable broker conduct and that those protocols be followed. We also ask that CMS work with plans to develop best practices in broker monitoring, with particular attention to monitoring marketing in non-English languages and marketing to vulnerable communities.

120—Use of Medicare Beneficiary Information Obtained from CMS

To the extent that CMS has email addresses for beneficiaries, we ask that information not be shared with plans. At the very, least plans should not be allowed to use such information for any marketing or communications activities for individuals who are not plan members.

Appendix 1—Definitions

CMS has changed the definition of "Marketing" to include only materials that include "information about the plan's benefit structure, cost sharing, and measuring or ranking standards." We object to this too-narrow definition that excludes obvious advertising for plans or plan sponsors.