CMS Manual System

Pub. 100-16 Medicare Managed Care

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

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I. SUMMARY OF CHANGES:

Section 20 – Marketing Review Process - Added information contained in the Director of the Health Plan Benefits Group's August 29, 2003, memorandum regarding submission of marketing materials by mail, e-mail, or fax.

Section 20.2 – Employer Group Marketing Review Process - Clarified that the waiver on review of employer group materials applies not only to members of employer group plans, but also to members of individual plans who have joined the individual plan through their employer (i.e., the employer has contracted with the M+C organization for its employees/retirees to join the individual plan).

Section 30.1 – Guidelines for Advertising Materials - Added a requirement for font size rule for Internet materials.

Section 30.2 – Guidelines for Pre-enrollment Materials - Added a requirement for font size rule for Internet materials.

Section 40.1 – General Guidance for Post Enrollment Materials - Added requirement for PPO Demonstrations only. This requirement relates to including a description of post-stabilization requirements in the Evidence of Coverage and in Section 3 of the Summary of Benefits (SB). Also, added a requirement for font size rule for Internet materials.

Section 40.1.2 – Use of Standardized Post-Enrollment Materials - Clarified that all employer group members and members of individual plans who have joined the individual plan through their employer must receive an SB, but that the SB does not need to follow the format of the standardized SB.

Section 40.5.1 - Summary of Benefits for Medicare+Choice Organizations

Section 40.5.1.C- Summary of Benefits for Medicare+Choice Organizations, Section 2 - Benefit Comparison Matrix - Added statement clarifying that the CMS reviewer reviews Section 2 of the SB when the M+C organization has chosen Option 1 of the streamlined review process.

Section 40.5.1.E - Summary of Benefits for Medicare+Choice Organizations, Permitted Changes to SB Language and Format - Added reference to see section 40.5.3 for further detail on request for hard copy change.

Section 40.5.1.F- Summary of Benefits for Medicare+Choice Organizations, Footnotes - Clarified that required footnotes are for the benefit column for Original Medicare and that they must be included if they apply to the benefit. Also clarified that Footnote 1 does not need to be referenced for mammograms, pap smears/pelvic exams and prostate cancer screening exams.

Section 40.5.3- Requests to Change Hard Copy Summary of Benefits - Added new section on how to request hard copy changes.

Section 50.2 – Specific Guidance About Provider Promotional Activities - Eliminated the prohibition of M+C organizations/health plans and provider representatives from giving out and accepting applications in health care settings, as long as the activity takes place in the common areas of the setting, and as long as patients are not misled or pressured into participating in such activities.

Section 50.4 - Answers to Frequently Asked Questions About Promotional Activities - Deleted Q&A 13. This information is now covered in §50.2.

Section 60 – Other Marketing Activities - Added an introduction for this section.

Section 60.2 – Marketing of Multiple Lines of Business - For direct mailing, clarified that the description of the opt-out provision need not be included on every piece included in the direct mailing, but must be included on at least one piece in each direct mailing conducted by the organization.

NEW/REVISED MATERIAL - EFFECTIVE DATE: January 9, 2004

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged.

II. CHANGES IN MANUAL INSTRUCTIONS: (R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	Chapter 3 / Section 20 / Marketing Review Process
R	Chapter 3 / Section 20.2 / Employer Group Marketing Review Process
R	Chapter 3 / Section 30.1 / Guidelines for Advertising Materials
R	Chapter 3 / Section 30.2 /Guidelines for Pre-enrollment Materials
R	Chapter 3 / Section 40.1 / General Guidance for Post Enrollment Materials
R	Chapter 3 / Section 40.1.2 / Use of Standardized Post-Enrollment Materials
R	Chapter 3 / Section 40.5.1 / Summary of Benefits for Medicare+Choice Organizations
N	Chapter 3 / Section 40.5.3 / Requests to Change Hard Copy Summary of Benefits
R	Chapter 3 / Section 50.2 / Specific Guidance About Provider Promotional Activities

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	Chapter 3 / Section 50.4 / Answers to Frequently Asked Questions About Promotional Activities
R	Chapter 3 / Section 60 / Other Marketing Activities
R	Chapter 3 / Section 60.2 / Marketing of Multiple Lines of Business.

III. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
	One-Time Special Notification

Medicare Managed Care Manual

Chapter 3 - Marketing

(Rev. 42, 01-09-04)

Table of Contents

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20 - Marketing Review Process

(Rev. 42, 01-09-04)

Marketing review consists of:

- Pre-approval of marketing materials before they are used by the health plan/M+C organization;
- Review of on-site marketing facilities, products, and activities during regularly scheduled contract compliance monitoring visits;
- Random review of actual marketing pieces as they are used in/by the media;
- Retrospective review of marketing materials approved under the streamlined marketing review process; and
- "For-cause" review of materials and activities when complaints are made by any source.

Marketing materials, once approved, remain approved until either the material is altered by the organization or conditions change such that the material is no longer accurate. The CMS may, at any time, require an organization to change any previously approved marketing materials if found to be inaccurate, even if the original submission was accurate at the time.

The CMS reviews marketing materials according to 42 CFR 422.80(c)(4), to ensure that the marketing materials "are not materially inaccurate or misleading or otherwise make material misrepresentations." This means that CMS does not disapprove marketing materials based on typographical or grammatical errors. It is the organization's decision to maintain professional excellence by producing marketing materials that do not contain typographical or grammatical errors.

Submission of Marketing Materials to Regional Offices

All CMS Regional Offices accept marketing material submissions by mail, fax, and e-mail.

When sending materials by e-mail, if the material is over 5 pages long you must also mail the material to the Regional Office. The 5-page requirement refers to the length of the marketing material and does not include the Marketing Material Transmittal Sheet that you may be submitting with the marketing material. The mailing requirement also applies to materials that are of large size, such as draft posters or full-page ads. These materials should be sent by overnight or priority mail. ***NOTE****: Some Regional Offices may be equipped to accept e-mail submissions of greater than 5-pages in length without*

requiring that a hardcopy submission also be mailed. Your Regional Office will notify you if this is the case.

All Regions will accept e-mail submissions in Microsoft® Word or portable document format (pdf) format. If you have a document in a different format, you should contact the Region to determine whether it can accept that format by e-mail.

When faxing materials to the Regional Office, please call your Regional Office Managed Care Specialist/Plan Manager prior to sending the fax. Under normal circumstances a submission of over 5 pages long should not be faxed to the Regional Office. However, if you need to fax a long piece of marketing material to the Region, you should notify the Regional Office Managed Care Specialist/Plan Manager to let them know that the material is over 5 pages long, prior to sending the fax.

If you send in marketing material in multiple formats (e.g., mail and e-mail), you should indicate on the marketing material that it is being submitted in multiple formats.

Review of marketing materials in non-English language or Braille:

For marketing with materials that contain non-English or Braille information (in whole or in part), the health plan/M+C organization must submit the non-English or Braille version of the marketing piece, an English version (translation) of the piece, and a letter of attestation from the organization that both pieces convey the same information. Health plans/M+C organizations will be subject to verification monitoring review and associated penalties for violation of this CMS policy. In addition to verifying the accuracy of non-English marketing materials through monitoring review, CMS will also periodically conduct marketing review of non-English materials on an "as needed" basis. If materials are found inaccurate, health plans/M+C organizations may not distribute materials until revised materials have been approved. If national health plans/M+C organizations have submitted materials in English to the lead RO and these have been approved, the same materials in other languages or Braille may be used in other regions provided that organizations submit attestation letters to each region vouching that the non-English or Braille version contains the same information as the English language version.

Marketing Material Identification Systems:

The following requirement applies to all marketing pieces **except** television and radio ads, outdoor advertisements, and banner/banner-like ads.

Health plans/M+C organizations must use the system mandated by the reviewing RO for identifying marketing materials submitted to CMS. If the reviewing RO does not have a system, health plans/M+C organizations may use their own system for identifying marketing materials. The health plan identifier should appear on the lower left or right side of the marketing piece. After the RO approves the marketing piece, the approval date (month/year) should always be posted to the marketing piece. The approval date is the date on the CMS approval notice.

20.2 - Employer Group Marketing Review Process

(Rev. 42, 01-09-04)

Under the authority granted in §617 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000, CMS has waived all M+C organizations from having to follow the requirements under 42 CFR 422.80(a) for employer group members. *This waiver applies to members of employer-group only plans and to members of individual plans who have joined the individual plan through their employer (i.e., the employer has contracted with the M+C organization for its employees/retirees to join the individual plan).* This means that M+C organizations need not have CMS pre-approve marketing materials prepared by M+C organizations designed for members of employer groups. The waiver does not include waiving the disclosure requirements at 42 CFR 422.111, which outline what information must be provided to members annually and at the time of enrollment. While M+C organizations do not need to have employer group materials pre-approved under this waiver, they still must disclose the information at 42 CFR 422.111(b) to all members (e.g., plan benefits, prior authorization rules, grievance and appeals procedures, etc.).

The CMS will assume that M+C organizations have chosen to use this waiver unless we hear otherwise from the M+C organization. All M+C organizations will be required to send informational copies of employer group-specific marketing materials to the Regional Office/lead region within 14 days of their release/use. (Regional Offices will not be reviewing these materials; instead, they will keep them on file in the event any inquiries are received about them.)

The M+C organization assumes responsibility for the accuracy of the employer group marketing materials, including making any corrections to those materials when necessary. The M+C organization is expected to continue to follow the guidelines within this chapter when preparing its marketing materials. In the unusual circumstance of an organization knowingly releasing/distributing incorrect or false marketing materials, sanctions, and or/fines may be imposed on that organization.

30.1 - Guidelines for Advertising Materials

(Rev. 42, 01-09-04)

Advertising materials can be defined as materials that are primarily intended to attract or appeal to a potential enrollee. They are intended to be viewed quickly by a potential enrollee and are short in length/duration. Specifically, these advertisements are:

- Television ads;

- Radio ads;
- Banner/banner-like ads;
- Outdoor advertising;
- Direct mail;
- Print ads (newspaper, magazine, flyers, etc.); and
- Internet advertising.

This section outlines requirements for these types of advertisements.

The following definitions apply to some of the ads addressed in this section:

- **Outdoor Advertising (ODA):** ODA is marketing material intended to capture the quick attention of a mobile audience passing the outdoor display (e.g., billboards, signs attached to transportation vehicles, etc.). ODA is designed to catch the attention of a person and influence them to call for detailed information on the product being advertised.
- **Banner Advertisements:** "Banner" advertisements are typically used in television ads, and flash information quickly across a screen with the sole purpose of enticing a prospective enrollee to call the organization for more information. This type of ad does not contain benefit or cost sharing information.
- **Banner-like Advertisements:** A "banner-like" advertisement can be ODA and is usually in some media other than television, is intended to very brief and to entice someone to call the organization or to alert someone that information is forthcoming and, like a banner ad, does not contain benefit or cost sharing information.

The following guidelines apply to advertisements:

A. Language Requirements

1. **Disclaimers/Disclosures:**

    a. For banner ads, banner-like ads and ODA, health plans/M+C organizations are not required to include **any** disclaimers or disclosures (e.g., lock-in and premium information) on the ads.

    b. For all other advertising materials not listed in a. above, health plans/M+C organizations must include the statement that the organization contracts with the Federal government. Refer to the Must Use/Can't Use/Can Use chart in §30.4 for statements the organization may use.

If the material references benefits/cost sharing, and is being used under the streamlined review process addressed in §20.3, then the material must also include the disclaimer that the benefits/cost sharing is "pending Federal approval." With one exception for certain materials (see c. below), no other disclaimers or disclosures (e.g., lock-in and premium information) are required for these advertising materials.

c. In addition to the disclaimers required in b. above, flyers and invitations to sales presentations that are used to invite beneficiaries to attend a group session with the intent of enrolling those individuals attending must also include the following two statements:

- "A sales representative will be present with information and applications."
- "For accommodation of persons with special needs at sales meetings, call [insert phone number]."

2. **Hours of Operation:** Health plans/M+C organizations must list the hours of operation for customer services and other health plan services anywhere that these phone numbers are provided. This requirement does not apply to any numbers included on advertising materials for persons to call for more information.

3. **TTY Numbers:** With the exceptions listed below, TTY numbers must appear in conjunction with any other phone numbers in the same font size and style as the other phone numbers. Health plans/M+C organizations can use either their own or State relay services, as long as the number included is accessible from TTY equipment.

   Exceptions:

   - TTY numbers need not be included on ODA and banner/banner-like ads or in radio ads that include a telephone number.
   - With respect to television ads, the TTY number need not be the same font size/style as other phone numbers since it may result in confusion and cause some prospective enrollees to call the wrong phone number. Instead, health plans/M+C organizations are allowed to use various techniques to sharpen the differences between TTY and other phone numbers on a television ad (such as using a smaller font size for the TTY number than for the other phone numbers).

4. **Reference to Studies or Statistical Data:** Health plans/M+C organizations may refer to results of studies or statistical data in relation to customer satisfaction, quality, cost, etc. as long as specific study details are given. At a minimum, study details that need to be included are the source and dates. (**NOTE**: When

submitting the material to CMS for review, the organization must provide the study sample size and number of plans surveyed for review purposes). M+C organizations may not use study or statistical data to directly compare their plan to another. If M+C organizations use study data that includes information on several other M+C organizations, they will not be required to include data on all of the organizations included in the study. However, study details, such as the number of plans included, must be disclosed. Qualified superlatives (e.g., among the best, one of the highest ranked, etc.) may be used. Superlatives (e.g., ranked number one, etc.) may only be used if they are substantiated with supporting data.

5. Physicians and Other Health Care Providers:

a. If the number of physicians and other health care providers is used in an ad, the ad must include only those physicians and providers available to Medicare beneficiaries. (Medicare cost plans may annotate in materials that members may obtain services from any Medicare provider).

b. For print ads and direct mail materials:

1. If a total number of physicians and providers is used in the ad, it must separately delineate the number of primary care providers and specialists included.

2. If the M+C organization uses the name and/or picture of providers and/or facilities to market itself, the provider information may only be used within the context of informing beneficiaries of providers that are associated with the M+C organization's delivery system.

6. Preferred Provider Organizations (including PPO Demonstrations) Only:

The following requirements only apply to Internet ads, brochures, and direct mail pieces. They do not apply to television and radio ads, ODA, and banner/banner-like ads.

- **Mandatory Supplemental Benefits:** If a PPO offers benefits, including mandatory supplemental benefits (such as prescription drugs or dental services) that are limited to in-network providers and facilities, marketing materials that mention these benefits must state that not all benefits are available from non-preferred providers.

- **Cost Savings Described in Marketing Materials:** If a PPO states in marketing materials that prospective enrollees may save money if they join the plan, it must acknowledge the added cost of accessing services out-of-network and/or that using services in-network can cost less than using services out-of-network.

B. Formatting Requirements

1. **Font Size Rule:** With the exception listed below, for all written advertising materials footnotes and any text appearing in the advertisement must be the same size font as the commercial message. The term "commercial message" refers to the material which is designed to capture the reader's attention regarding the health plan/M+C organization. The term does not refer to the commercial membership (i.e., non-Medicare/Medicaid members) of the organization. The text size is left to the discretion of the organization and can be smaller than size 12-point font, but the commercial message and footnotes must be the same size font.

   Exception:

   - Information contained in brochures and direct mail pieces must be no smaller than Times New Roman 12-point or equivalent font. More detail on this requirement is contained in §30.2.

   - If an organization publishes a notice to close enrollment (as required in Chapter 2) in the Public Notices section of a newspaper, the organization need not use 12-point font and can instead use the font normally used by the newspaper for its Public Notices section.

2. ***Font Size Rule for Internet Advertising:*** *Unless an exception regarding font size is noted in #1 above, any advertising materials that a M+C organization places on its Web site need to be in a minimum 12-point Times New Roman-equivalent font. Neither CMS nor the M+C organizations has any control over the actual screen size shown on individuals' computer screens that can be adjusted by the user. Therefore, the 12-point font requirement refers to how the M+C organization codes the font for the Web page, not how it actually looks on the user's screen.*

30.2 - Guidelines for Pre-Enrollment Materials

(Rev. 42, 01-09-04)

"Pre-enrollment" materials are materials that health plans/M+C organizations use to promote the plan and to increase plan membership. These materials provide more detail on the plan (e.g., plan rules, plan benefits, etc.) than what is provided in an advertisement. Pre-enrollment materials include both sales and enrollment materials, including the following types of materials:

- Product descriptions used in the sales/enrollment process -- enrollment booklets, sales kits, etc.

- Sales scripts, sales presentations, etc.

NOTE: There are other enrollment-related documents that are usually included in sales packages -- such as enrollment applications and the Statement of Understanding. Requirements and models for these documents are addressed in Chapter 2.

NOTE: While the SB and could be viewed as both a pre- and post-enrollment material, we have placed instructions regarding these documents in the post-enrollment section since, at a minimum, it must be sent to current enrollees. Instructions on the SB can be found at §40.5.

The following guidelines apply to pre-enrollment materials:

A. Language Requirements

1. **Lock-In Statement:** The concept of "lock-in" must be clearly explained in all pre-enrollment materials. For marketing pieces that tend to be of short duration we suggest: "You must receive all routine care from plan providers" or "You must use plan providers except in emergent care situations or for out-of-area urgent care/renal dialysis." However, in all written materials used to make a sale, a more expanded version is suggested: "If you obtain routine care from out-of-plan providers neither Medicare nor [name of M+C organization] will be responsible for the costs." Modify materials if the health plan has a Point-of-Service (POS) or Visitors' Program benefit or is a Private Fee-For-Service Plan (PFFS) or PPO.

   For Medicare cost plans, all pre-enrollment materials must clearly explain that members may use plan and non-plan providers, and also explain the benefit/cost sharing differentials between use of plan and non-plan providers.

2. **Networks and Sub-networks:** All pre-enrollment marketing materials must clearly explain the concept of networks and sub-networks and the process for obtaining services, including referral requirements.

3. **Hours of Operation:** Health plans/M+C organizations must list the hours of operation for customer services and other health plan services anywhere that these phone numbers are provided.

4. **Identification of All Plans in Materials:** Where M+C organizations may file separate/distinct Adjusted Community Rate (ACR) Proposals and the Plan Benefit Package (PBPs) cover the same service area (or portions of the same service area), there is no requirement that all plans be identified in all of the health plan's/M+C organization's marketing materials, although health plans/M+C organizations may identify or mention more than one plan in a single marketing piece at their discretion.

5. **Contracting Statement:** All pre-enrollment materials (and some other materials, as mentioned in §§30.1 and 40) must include a statement that the health

plan/M+C organization contracts with the Federal government. Refer to the Must Use/Can't Use/Can Use chart in §30.4 for statements the organization may use.

6. **TTY Numbers:** TTY numbers must appear in conjunction with any other phone numbers in the same font size and style as the other phone numbers. The TTY number must also include the hours of operation, if they are for customer or health plan services. Health plans/M+C organizations can use either their own or State relay services, as long as the number is accessible from TTY equipment.

7. **Availability of Alternative Formats:** To ensure that beneficiaries have access to beneficiary education materials in alternative formats (e.g. Braille, foreign languages, audio tapes, large print), Health plans/M+C organizations must provide a disclosure on pre-enrollment materials indicating the document is available in alternative formats.

8. **Marketing plans to beneficiaries of non-renewing Medicare plans:** As stated in §30, health plans/M+C organizations may market plans directly to beneficiaries of former Medicare plans that have chosen not to renew their contracts as long as the marketing does not begin until after the date the beneficiary has received the plan termination letter. In addition to the targeted message, any pre-enrollment marketing pieces must contain a statement indicating that the health plan/M+C plan is open to all Medicare beneficiaries eligible by age or disability in the plan's service area.

9. **Preferred Provider Organizations (including PPO Demonstrations) Only:**

    - **Cost Savings Described in Marketing Materials:** If a PPO states in marketing materials that prospective enrollees may save money if they join the plan, it must also acknowledge the added cost of accessing services out-of-network and/or that using services in-network can cost less than using services out-of-network.

    - **Preferred and Non-Preferred Benefits:** If a PPO offers benefits for which the coinsurance is the same percentage both in and out of network, the PPO must make it clear in all pre-enrollment material that member responsibility may be greater out of network since the coinsurance is based on the Medicare allowed amount and not on the potentially lower contracted amount.

    - **Mandatory Supplemental Benefits:** If a PPO offers benefits, including mandatory supplemental benefits (such as prescription drugs or dental services) that are limited to in-network providers and facilities, marketing materials that mention these benefits must state that not all benefits are available from non-preferred providers.

B. Formatting Requirements

1. **Font Size Rule for Member Materials:** Readability of written materials is crucial to informed choice for Medicare beneficiaries. All pre-enrollment materials that convey the rights and responsibilities of the health plan/M+C organization and the member must be printed with a 12-point font size or larger. Materials subject to this requirement include, but are not limited to enrollment and disenrollment forms and notices. The CMS is cognizant of the fact that, when actually measured, 12-point font size may vary among different fonts with the result that some font types may be smaller than others. Times New Roman font type is the standard by which font size is measured. Therefore, if health plans/*M+C* organizations choose to use a different font type, it is their responsibility to ensure that the font used is equivalent to or larger than Times New Roman 12-point.

2. ***Font Size Rule for Materials on the Internet:*** *Any pre-enrollment materials that a M+C organization places on its Web site need to be in a minimum 12-point Times New Roman-equivalent font. Neither CMS nor the M+C organization has any control over the actual screen size shown on individuals' computer screens that can be adjusted by the user. Therefore, the 12-point font requirement refers to how the M+C organization codes the font for the Web page, not how it actually looks on the user's screen.*

3. **Font Size Rule for Footnotes and Subscripts:** The 12-point font size or larger rule described above also applies to any footnotes or subscript annotations in notices.

4. **Footnote Placement:** Health plans/M+C organizations must adopt a standard procedure for footnote placement. Footnotes should appear either at the end of the document or the bottom of each page and in the same place throughout the document. For example, the health plan/M+C organization cannot include a footnote at the bottom of page 2 and then reference this footnote on page 8; the footnote has to also appear at the bottom of page 8.

5. **Reference to Studies or Statistical Data:** Health plans/M+C organizations may refer to results of studies or statistical data in relation to customer satisfaction, quality, cost, etc. as long as specific study details are given. At a minimum, study details that need to be included are: source, dates, sample size, and number of plans surveyed. Health plans/M+C organizations may not use study or statistical data to directly compare their plan to another. If health plans/M+C organizations use study data that includes information on several other health plans/M+C organizations, they will not be required to include data on all of the organizations included in the study. However, study details, such as the number of plans included, must be disclosed. Qualified superlatives (e.g., among the best, one of the highest ranked, etc.) may be used. Superlatives (e.g., ranked number one, etc.) may only be used if they are substantiated with supporting data.

6. **Medicare Cost Plans Only**

- In all pre-enrollment marketing materials the health plan must indicate that it meets Medicare regulatory requirements for providing enrollment opportunity and benefit packages for both Part A and B and Part B-only eligible beneficiaries.[4]

- Cost-contracting health plans must market a low option or basic benefit package that is identical to the Medicare fee-for-service benefit package (except for any additional benefits the health plan may offer at no charge, for which the health plan claims no reimbursement). Information on the availability of this package must appear in all of the health plan's pre-enrollment marketing materials.

C. Submission and Review Requirements

1. **Sales Scripts:** Sales scripts, both for in-home and telephone sales use, must be reviewed by the CMS prior to use. However, health plans/M+C organizations are not required to adhere to a specific format for submission (i.e. verbatim text or bullet points).

D. Other Requirements

1. **Logos/Tag Lines:** The CMS recognizes the difference of purpose and intent between company logos/product tag lines and other advertising or marketing materials. The guidelines regarding the use of unsubstantiated statements that apply to advertising materials do not apply to logos/taglines. Contracting health plans may use unsubstantiated statements in their logos and in their product tag lines (e.g., "Your health is our major concern," "Quality care is our pledge to you," "First Care means quality care," etc.). This latitude is allowed only in logo/product tag line language. Such unsubstantiated claims cannot be used in general advertising text regardless of the communication media employed to distribute the message. Not withstanding the ability to use unsubstantiated statements as indicated above, the use of superlatives is not permitted in logos/product tag lines (e.g., "First Care means the first in quality care" or "Senior's Plus means the best in managed care"). Refer to the Must Use/Can't Use/Can Use chart in §30.4 of this Chapter for more information on restrictions associated with the use of superlatives.

40.1 - General Guidance for Post-Enrollment Materials

(Rev. 42, 01-09-04)

In many cases, the requirements for pre-enrollment notices (in §30) are the same for post-enrollment materials. The following are guidelines for post-enrollment materials:

A. Language Requirements

1. **Lock-In Statement:** The concept of "lock-in" must be clearly explained in the SB, the EOC, and Member Handbooks.

   For Medicare cost plans, all pre-enrollment materials must clearly explain that members may use plan and non-plan providers, and also explain the benefit/cost sharing differentials between use of plan and non-plan providers.

2. **Networks and Sub-networks:** The SB, the EOC, Provider Directories and Member Handbooks must clearly explain the concept of networks and sub-networks and the process for obtaining services including referral requirements.

3. **Hours of Operation:** Health plans/M+C organizations must list the hours of operation for customer services and other health plan services anywhere that these phone numbers are provided.

4. **Contracting Statement:** The SB, Member Handbooks, and the EOC must include a statement that the organization contracts with the Federal government. Refer to the Must Use/Can't Use/Can Use chart in §30.4 for statements the organization may use.

5. **TTY Numbers:** TTY numbers must appear in conjunction with any other phone numbers in the same font size and style as the other phone numbers. The TTY number must also include the hours of operation, if they are for customer or health plan services. Health plans/M+C organizations can use either their own or State relay services, as long as the number included is accessible from TTY equipment.

6. **Availability of Alternative Formats (EOC only):** To ensure that beneficiaries have access to beneficiary education materials in alternative formats (e.g. Braille, foreign languages, audio tapes, large print), health plans/M+C organizations must provide a disclosure on the EOC indicating the document is available in alternative formats.

7. **Reference to Studies or Statistical Data:** Health plans/M+C organizations may refer to results of studies or statistical data in relation to customer satisfaction, quality, cost, etc. as long as specific study details are given. At a minimum, study details that need to be included are: source, dates, sample size, and number of plans surveyed. Health plans/M+C organizations may not use study or statistical data to directly compare their plan to another. If health plans/M+C organizations use study data that includes information on several other health plans/M+C organizations, they will not be required to include data on all of the organizations included in the study. However, study details, such as the number of plans included, must be disclosed. Qualified superlatives (e.g., among the best, one of

the highest ranked, etc.) may be used. Superlatives (e.g., ranked number one, etc.) may only be used if they are substantiated with supporting data.

8. **Member ID Cards:** CMS recommends that all health plans/M+C organizations, especially PPOs and PFFS Plans, include the phrase "Medicare limiting charges apply" on Member ID cards. However, use of this phrase is optional. The CMS believes that use of this phrase on a card that most providers will see is a reliable method of informing providers of the billing rules for the plan, and thus could reduce the chance for incorrect or inappropriate balance billing.

   The CMS also recommends that PPOs and PFFS Plans include the statement that the provider should bill the PPO or PFFS organization and not Original Medicare. The CMS believes this statement will help prevent claim processing errors. However, use of this statement is optional.

9. **Minimum Information Requirements (EOC Only):** The minimum information requirements outlined in §30.3 apply to the EOC.

10. **Preferred Provider Organizations (including PPO Demonstrations) Only:**

    - **Mandatory Supplemental Benefits:** If a PPO offers benefits, including mandatory supplemental benefits (such as prescription drugs or dental services) that are limited to in-network providers and facilities, marketing materials that mention these benefits must state that not all benefits are available from non-preferred providers. The EOC must specifically explain which benefits are offered at the non-preferred benefit level and any limitations that may apply.

    - **Prior Notification/Authorization Requirements:** Some PPOs may require or request that members notify them prior to receiving certain services. In these cases, the organization must clearly define the requirement in marketing materials. It must also include the information in the PBP Notes section so that the appropriate language regarding the penalty may be used in marketing materials. If there is a penalty for not receiving prior referral/notification/authorization, marketing materials that mention these services must clearly describe the penalty.

    - ***Post-Stabilization (PPO Demonstrations Only):*** *In the EOC and the SB (Section 3), PPO Demonstrations must specify all cost sharing requirements with regard to emergency hospital admissions, including whether the in-network or out-of-network cost sharing is required for enrollees who are stabilized and receive post-stabilization care in a non-preferred (out-of-network) hospital following an emergency situation. If the Demo includes a cap on enrollee out-of-pocket costs for such services, state the out-of pocket maximum amount. In the EOC, clearly state any other requirements associated with an out-of-network emergency hospital*

admission, e.g., enrollee notification upon stabilization, policies with regard to transfers to network hospitals, etc.

B. Formatting Requirements

1. **Font Size Rule for Member Materials:** Readability of written materials is crucial to informed choice for Medicare beneficiaries. All member materials that convey the rights and responsibilities of the health plan/M+C organization and the member must be printed with a 12-point font size or larger. Materials subject to this requirement include, but are not limited to, the EOC or member brochure and contract, letters confirming enrollment and disenrollment, notices of non-coverage and notices informing members of their right to an appeals process. The CMS is cognizant of the fact that, when actually measured, 12-point font size may vary among different fonts with the result that some font types may be smaller than others. Times New Roman font type is the standard by which font size is measured. Therefore, if health plans/M+C organizations choose to use a different font type, it is their responsibility to ensure that the font used is equivalent to or larger than Times New Roman 12-point.

   Exception:

   - Due to the size of the member ID card, the member ID card need not have all information in a 12-point font size or larger.

2. **Font Size Rule for Internet Materials:** *Unless an exception for font size is noted in #1 above, any post-enrollment materials that a M+C organization places on its Web site need to be in a minimum 12-point Times New Roman-equivalent font. Neither CMS nor M+C organization has any control over the actual screen size shown on individuals' computer screens that can be adjusted by the user. Therefore, the 12-point font requirement refers to how the M+C organization codes the font for the Web page, not how it actually looks on the user's screen.*

3. **Font Size Rule for Footnotes and Subscripts:** The 12-point font size or larger rule also applies to any footnotes or subscript annotations in post-enrollment notices.

4. **Footnote Placement:** Health plans/M+C organizations must adopt a standard procedure for footnote placement. Footnotes should appear either at the end of the document or the bottom of each page and in the same place throughout the document. For example, the health plan/M+C organization cannot include a footnote at the bottom of page 2 and then reference this footnote on page 8; the footnote has to also appear at the bottom of page 8.

C. Other Requirements

1. **Option to Choose Media Type:** With respect to the SB, the EOC, and the Provider Directory, health plans/M+C organizations have the option of contacting

members to determine in what format they would like to receive the materials (e.g., hardcopy, CD ROM, Internet Web pages, etc.). Health plans/M+C organizations that choose this option must contact members in writing (e.g., by letter, postcard, newsletter article, etc.) to determine whether they would like to receive the SB, EOC, and/or the Provider Directory in another format. If the organization does not receive a response from the member, then the organization must assume that the member wants to receive the information in hardcopy.

If the organization sends one provider directory to an address where up to four members reside (as allowed in §40.2), then it may send one written notice regarding choice of media type to that address (if it is notifying members by letter), rather than one notice to each individual member at that address. A reply from one member at that address constitutes a reply for the entire address.

The following would also apply:

- The member must receive the materials in the required time frames, regardless of the format.

- For the EOC and the SB, if the organization will be providing any of these marketing materials via an Internet Web page, then it must establish a process for informing members when that Web page has been updated. For example, the organization could notify members by newsletter article, by e-mail, by postcard, etc. Often any change in the EOC or SB is communicated to all members by newsletter and notification that the change has been made on the Web page could be made at the same time. This requirement does not apply to provider directories since provider directory updates can occur far more frequently than updates to the EOC or SB.

- The non-hardcopy format should match the approved hardcopy format, and if it does, it will not need additional CMS approval. If anything is added or deleted, the non-hardcopy format must receive separate CMS approval.

NOTE: Some health plans/M+C organizations use a database/search function for their provider directory on the Internet. In this case, as long as the information that comes up on a specific provider is the same information as what is contained in the hardcopy format, then the Internet provider directory would be considered to be the same as the hardcopy format and would not need additional CMS approval.

40.1.2 - Use of Standardized Post-Enrollment Materials

(Rev. 42, 01-09-04)

The CMS has implemented certain standardized beneficiary notification marketing materials for health plan participants in Medicare managed care. In particular, all M+C organizations are required to use a standardized Summary of Benefits (SB). Use of standardized materials by M+C organizations is mandatory. Guidelines for the standard SB can be found in §40.4.

The M+C organizations must send an SB to members of employer group plans and to members of individual plans who have joined the individual plan through their employer, or it must arrange to have the employer send one to these members. However, M+C organizations are exempt from using the **standardized** SB *for employer group members and members of individual plans who have joined the individual plan through their employer, and may instead develop a different format for the SB*.

40.5.1 – Summary of Benefits for Medicare+Choice Organizations

(Rev. 42, 01-09-04)

Medicare+Choice organizations and Demonstration projects are required to use a standardized SB.

A. General Instructions

1. M+C organizations must adhere to the language and format of the standardized SB and are only permitted to make changes if approved by CMS. Changes in the language and format of the SB template will result in the disapproval or delayed approval of the SB.

2. The title "Summary of Benefits" must appear on the cover page of the document.

3. All three sections of the SB must be provided together as one document and may not be bound separately or placed in a folder in separate sections. M+C organizations may also describe several plans in the same SB package by displaying them in separate columns in the comparison matrix section of the SB.

4. Front and back cover pages are acceptable.

5. Printing font size of 12-point or larger must be used for the SB (including footnotes). **NOTE:** Since sections 1 and 2 will not be generated from the PBP in

12-point font, the M+C organization should change the font to ensure that the font size is 12 point. M+C organizations may enlarge the font size and also use bold or capitalized text to aid in readability, provided that these changes do not steer beneficiaries to, or away from any benefit items or interfere with the legibility of the document.

6. Colors and shading techniques, while permitted, must not direct a beneficiary to or away from any benefit items and must not interfere with the legibility of the document. There is no requirement regarding the type of paper used.

7. It is acceptable to print the SB in either portrait or landscape page format.

8. It is acceptable for M+C organizations with multiple plans and PBPs (separate ACRPs) to include more than one plan in the benefit comparison matrix (section 2). However, since the PBP will only print section 1 and 2 reports for one plan, the M+C organizations will have to create a side-by-side comparison matrix for two (or more) plans by manually combining the information into a chart format.

9. It is acceptable for M+C organizations to display more than one plan together in the same columns of the benefit comparison matrix, provided all of the benefits are the same and only the service areas are different. Plans may identify the service areas at the top of the plan column of section 2. **NOTE:** If anything beyond the service area is different, the plans must be displayed separately.

10. If the SB includes only one of several plans offered, the availability of other plans must be noted in the Annual Notice of Change (ANOC). If the M+C organization lists more than one plan offering, it is required to identify the specific plan in which the member is currently enrolled on the cover letter transmitting the SB.

11. If an M+C organization wants to include mandatory supplemental benefits beyond those benefits found in the benefit comparison matrix, the M+C organization must place the information in section 3 of the SB. The M+C organization must include a brief description of the benefits and any copay requirements.

12. If an M+C organization includes additional information about covered benefits in section 3, the M+C organization may include a page reference to this information in the appropriate box in the benefit comparison matrix using the following sentence: “See page___ for additional information about (Enter the benefit category exactly as it appears in the left column).”

13. M+C organizations may include additional information about covered benefits in a separate flyer or other material and mail this with the standardized SB and the Annual Notice of Change Letter.

14. Enrollees whose source of enrollment is through an employer-sponsored group are not currently included in the mandated use of the standardized SB for either annual notification or initial marketing purposes.

B. Section 1 - *Beneficiary* Information Section

1. This section is incorporated into your SB exactly as it is generated by the PBP. **NOTE:** M+C organizations have the option of indicating at the top of this section a geographic name, for example, "Southern Florida." If used, the geographic name must match the geographic label indicated in the Health Plan Management System (HPMS).

2. Section 1, as generated by the PBP, will include the applicable H number and plan number at the top of the document. M+C organizations must delete this information.

3. The fourth paragraph (How can I compare my options?) contains a sentence "We also offer additional benefits, which may change from year to year." If this is not applicable to your plan, you must remove this sentence.

4. The second question and answer in section 1 includes the plan's service area; the PBP will generate a list of counties, with an * indicating those counties that are partial counties. The M+C organization may list the zip codes of these counties in this section or provide a cross-reference in section 3 and list the zip codes here. The M+C organization must also explain in section 1 that the * indicates a partial county.

5. The second question and answer in section 1 lists the plan's service area, but does not indicate that the information listed represents counties. Therefore, the M+C organization must amend the SB so that the answer reads, "The service area for this plan includes the following counties: [list of counties automatically generated by the PBP]."

6. The last sentence in section 1 on page 2 states, "If you have special needs, this document may be available in other formats." M+C organizations contracting with CMS are obligated to follow the regulatory requirements of the American with Disabilities Act and the Civil Rights Act of 1964. Compliance with these requirements satisfies the intent of the above referenced SB sentence. No additional requirements are imposed by the above referenced SB sentence.

C. Section 2 - Benefit Comparison Matrix

The SB benefit comparison matrix will be generated by the PBP in chart format with the required language. Therefore, the information included in the PBP must first be correct in order for the SB comparison matrix to be correct. M+C organizations should review the comparison matrix to ensure that all of the information presented is correct. Information presented in the benefit comparison matrix must match the information presented in the

PBP, with the exception of the permitted and/or necessary changes discussed below. If any changes are required, the M+C organization must make these changes in the PBP prior to the deadline date for submission of the ACRP, generate a revised SB benefit comparison matrix, and include this matrix in its SB.

If the M+C organization follows Option 1 of the streamlined marketing review process (as addressed in §20.3), then the CMS reviewer will have the benefit comparison matrix that is generated by the PBP and will compare this with the matrix provided as part of the plan's SB. Any discrepancies between the matrix generated by CMS and that provided by the plan (with the exception of those permitted below) will result in disapproval of the SB. *If the M+C organization follows Option 2 of the streamlined marketing review process, this comparison will not occur during the review since CMS is not reviewing Section 2 of the SB.*

D. Section 3 - Plan Specific Features

This section is limited to a maximum of six pages of promotional text and graphics and is not standardized with regard to format or content. The 6-page limit means that the information is limited to six single-sided pages or 3 double-sided pages. However, there is one exception to this limit:

- When an M+C organization is translating the SB to a foreign language, it may add pages as necessary to ensure the translation conveys the same information as the English language version.

Section 3 is used by the M+C organization to describe special features of the M+C organization beyond information contained in sections 1 and 2 of the SB. Section 3 may contain non-standardized language, graphics, pictures, maps, etc.

M+C organizations may use this section to further describe mandatory and optional supplemental benefits that appear in the benefit comparison matrix. If an M+C organization chooses to do this, they may reference the information in the relevant section of the benefit comparison matrix using the following sentence: "See page___ for additional information about (Enter the benefit category exactly as it appears in the left column.)"

E. Permitted Changes To SB Language and Format

M+C organizations are only permitted to make changes to the benefit matrix or Hard Copy Summary of Benefits on a limited basis. **Any changes** must be approved by CMS. *Please refer to §40.5.3 for further detail.*

F. Footnotes

The comparison matrix generated by the PBP will *contain* the required footnotes *in the benefit column for Original Medicare (OM)*. Therefore, the M+C organization must include the following footnotes provided below *if they apply to the benefit*. Please note

that the footnote number must appear in the text of the column and the footnote must appear at the bottom of each page.

NOTE: For review purposes, the M+C organization can list all of the footnotes at the end of section 2, but the final proof copy must include the footnotes at the appropriate points in the text. If the M+C organization chooses this option, the M+C organization must notify the CMS Regional Office conducting the review and must indicate in the SB where the footnotes will actually appear in the final printed version.

1. Each year, you pay a total of one $100 deductible.

   This footnote must be referenced after every statement in the Original Medicare column that describes the required Medicare coinsurance, e.g., "You pay 20% of Medicare approved amounts." *The only exception where footnote (1) does not need to be referenced is mammograms, pap smears/pelvic exams and prostate cancer screening exams*. *If* the footnote is applicable to the plan it must also be referenced in the Plan column. This footnote must also appear at the bottom of each page.

2. If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you pay more.

   This footnote must be referenced after every statement in the OM column that describes the following benefits and after footnote (1), where applicable. The text of this footnote must appear at the bottom of each page.

3. A benefit period begins the day you go to the hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

   This footnote must be referenced after the words "benefit period" in the OM column describing Inpatient Hospital Care and Skilled Nursing Facility and the text of this footnote must appear at the bottom of the page on which these benefits are described. Additionally, if the footnote is applicable to the plan it must also be referenced in the Plan column.

4. Lifetime reserve days can only be used once.

   This footnote must be referenced after the statement, "Days 91-150: $ (The Medicare amount may change each year) each lifetime reserve days" in the OM column describing Inpatient Hospital Care. Additionally, if the footnote is applicable to the plan it must also be referenced in the Plan column. The text of this footnote must appear at the bottom of the page on which these benefits are described.

40.5.3 - Requests to Change Hard Copy Summary of Benefits

(Rev. 42, 01-09-04)

The CMS may allow, on a very limited basis, changes to hard copy SBs. Any approved changes will NOT result in changes in Medicare Personal Plan Finder, nor will they result in changes to the Plan Benefit Package. However, requests may be considered for future changes to the Plan Benefit Package

What types of Changes will be Permitted?

*The only changes that will be permitted are those that would correct inaccurate or misleading information presented to beneficiaries in the hard copy SB. For example, if a plan does not have a network, a change **may** be permitted to remove a sentence referring to the requirement that members see doctors within the plan's network.*

What types of Changes will NOT be Permitted?

*Requests for changes in which the existing sentences are accurate will not be permitted. MCOs will **NOT** be permitted to add additional sentences in Section 2 of the Summary of Benefits in order to further explain their benefits. The CMS will not allow changes in wording, based on individual preferences.*

How to request a change?

To request a change to the hard copy SB, e-mail your request to sb2004@cms.hhs.gov. The subject line in the request must read: "Hard Copy SB Change Request." In the request, provide:

1. *The H number and Plan ID—each H number and Plan ID should be in a separate e-mail;*

2. *The Regional Office and Contact who review the MCO marketing material;*

3. *The existing standardized Summary of Benefits language;*

4. *An explanation of why the existing standardized language is inaccurate; and*

5. *A modified sentence.*

How will CMS review the requests?

A cross-functional workgroup reviews each request. The workgroup will determine if the current standardized wording is inaccurate or misleading. If the workgroup denies the request, CMS will notify the MCO and the MCO must adhere to the standardized language. If the workgroup permits a change, CMS will notify the MCO with the approved language. Note that the approved language will be decided by CMS and will be considered "standardized." The CMS will also notify the Regional Office of the approved language. If the request is based on a preferred wording, the request will not be approved.

50.2 - Specific Guidance About Provider Promotional Activities

(Rev. 42, 01-09-04)

Some health plans/M+C organizations use their providers to help them market their Medicare product. As used in this chapter, the term "provider" means all Medicare health plan/M+C organization contracting health care delivery network members; e.g., physicians, hospitals, etc. The purpose of this section is to specify what marketing practices in this area meet both CMS requirements and the needs of the health plans/M+C organizations with respect to entities considered providers by health plans/M+C organizations.

In general, providers should only market in their capacity as a member of the plan's network and only in coordination with the health plan/M+C organization (for example, providers/provider groups could co-sponsor an open house or a health fair with a health plan/M+C organization, or could cooperatively advertise on TV).

Marketing by a plan provider shall be deemed to be marketing by the health plan/M+C organization. Therefore, health plans/M+C organizations should stipulate in their contracts with providers that any coordinated marketing to be carried out by the provider must be done in accordance with all applicable CMS marketing guidelines. All marketing materials describing the health plan/M+C organization in any way must get prior approval, have the health plan/M+C organization's name or logo as well as the provider's/provider group's name or logo, adhere to the guidelines in this chapter, and have prior approval by CMS.

The CMS is concerned with provider marketing for the following reasons:

- Providers are usually not fully aware of all health plan/M+C organization benefits and costs; and

- A provider may confuse the beneficiary if the provider is perceived as acting as an agent of the health plan/M+C organization vs. acting as the beneficiary's provider.

Providers may face conflicting incentives when acting as a health plan/M+C organization representative since they know their patients' health status. Desires to either reduce out-of-pocket costs for their sickest patients, or to financially gain by enrolling their healthy patients may result in recommendations that do not address all of the concerns or needs of a potential health plan/M+C organization enrollee.

There are some permissible delegated provider marketing activities, however. Listed below are some requirements for these, and the reasons they are permitted:

1. **Health Fairs** - At health fairs, provider groups and individual providers can give out health plan/M+C organization brochures including enrollment applications. Because they may not be fully aware of all benefits and costs of the various health plans/M+C organizations, providers or their representatives cannot compare benefits among health plans/M+C organizations in this setting. In addition, applications may not be taken at health fairs. (See the discussion of health fairs and health promotion events in §50.1.3 above.)

2. **Provider Office Activities and Materials** - In their own offices, *physicians and other health care* providers can give out health plan/M+C organization brochures, and posters announcing health plan/M+C organization affiliation. *However, they cannot give out or accept applications*. Providers cannot offer inducements to persuade beneficiaries to join health plans/M+C organizations or to steer beneficiaries to a specific health plan/M+C organization.

   While providers are prohibited from giving and accepting applications in the health care setting, the M+C organizations/Health plans and provider representatives may conduct sales presentations and give and accept applications in health care settings as long as the activity takes place in the common areas of the setting, and as long as patients are not misled or pressured into participating in such activities. Common areas, where marketing activities are allowed, would be areas such as hospital cafeterias, community or recreational rooms, and conference rooms.

   Regulations prohibit sales presentations and the acceptance of applications in areas where patients primarily intend to receive health care services. These restricted areas would include, but not be limited to, waiting rooms, exam rooms, nursing resident rooms, and hospital (patient) rooms.

   In addition, providers cannot offer anything of value to induce health plan/M+C organization enrollees to select them as their provider. When patients seek information or advice from their own physician regarding their Medicare options, physicians may engage in this discussion. Because physicians are usually not fully

aware of all health plan/M+C organization or original Medicare benefits and costs, they are advised to additionally refer their patient to other sources of information, such as 1-800-MEDICARE, the State Health Insurance Assistance Program, and/or specific health plan/M+C organization marketing representatives. Additional information can also be found on CMS' Web site, http://www.medicare.gov/. Physicians are permitted to printout and share information with patients from CMS' Web site.

3. **Providers/Provider Group Affiliation Information**- Providers/provider groups can announce a new affiliation with a health plan/M+C organization to their patients. An announcement to patients of a new affiliation which names only one health plan/M+C organization may occur only once. Additional contacts from providers to their patients regarding affiliation must include all the Medicare health plans/M+C organizations with which the provider contracts. This includes, for example, annual affiliation announcements, announcements that certain affiliations have terminated, and the display of health plan/M+C organization brochures/posters. If these communications describe health plans/M+C organizations in any way (as opposed to just listing them), they must be prior approved by CMS (see below).

4. **Providers/Provider Group Comparative/Descriptive Information** - Providers/provider groups may provide printed information to their patients comparing the benefits of different health plans/M+C organizations with which they contract. Such materials must have the concurrence of all health plans/M+C organizations involved and must be prior approved by CMS. The health plans/M+C organizations may want to determine a lead health plan/M+C organization to coordinate submission of these materials. CMS continues to hold the health plans/M+C organizations responsible for any comparative/descriptive material developed and distributed on their behalf by their contracting medical groups and other health care providers. The providers/provider groups may not health screen when sending out such information to their patients. The reason for this is that any material sent to beneficiaries that talks about health plans/M+C organizations is marketing and health screening is a prohibited marketing activity.

5. **Providers/Provider Group Web Sites** - Providers/provider groups may provide links to health plan/M+C organization enrollment applications and/or provide downloadable enrollment applications as long as the site provides the links/downloadable formats to enrollment applications for all health plans/M+C organizations with which the provider/provider group participates.

The **"Medicare and You" Handbook** or "**Medicare Compare Information"** (from CMS' Web site, www.medicare.gov), may be distributed by providers/provider groups without additional approvals. There may be other documents that provide comparative/descriptive material about health plans, are of a broad nature, and are written by CMS or have been prior approved by CMS. These materials may be distributed by health plans/M+C organizations and providers without further CMS approval. Please

advise your health plan/M+C organization providers and provider groups of the provisions of these rules.

50.4 - Answers to Frequently Asked Questions About Promotional Activities

(Rev. 42, 01-09-04)

1. **Q** - We purchased books on health maintenance that we plan to give away to anyone attending one of our marketing presentations, regardless of whether or not they enroll in our health plan/M+C organization. Because we purchased a large number of these books, we were able to buy them at a cost of $14.99 per book. However, on the inside jacket, the retail price is shown as $19.99. May we give these books away at our marketing presentation?

   A - No. The retail purchase price of the book is $19.99, which exceeds CMS' definition of nominal value.

2. **Q** - We are participating in a health fair during which we will have marketing staff present. During the fair, we will offer a number of free health screening tests to people who attend. The value of these tests, if purchased, would be considerably more than $15. Is this permissible?

   A - No. You may not offer these tests for free because their value exceeds CMS' definition of **nominal** value.

3. **Q** - At our health plan/M+C organization, we offer gifts of nominal value to people who call for more information. We then offer additional gifts if they come to marketing events. Each of the gifts meets CMS' definition of nominal value, but taken together, the gifts are more than nominal value. Is this permissible?

   A - Yes.

4. **Q** - Listed below are some possible promotional items to encourage people to attend marketing presentations. Are these types of promotions permissible?

   - Meals
   - Day trips
   - Magazine subscriptions
   - Event tickets
   - Coupon book (total value of discounts is less than $15)

A - Yes. All these promotional items are permissible as long as they are offered to everyone who attends the event regardless of whether or not they enroll and as long as the gifts are $15 or less. Cash gifts are prohibited including charitable contributions made on behalf of people attending a marketing presentation, and including gift certificates that can be readily converted to cash, regardless of dollar amount.

5. **Q** - Can a health plan/M+C organization advertise eligibility for a raffle or door prize of more than nominal value for those who attend a marketing presentation if the total value of the item is less than $15 per person attending?

   A - No. You cannot have a door prize of more than nominal value. Such gifts or prizes are prohibited by CMS. However, the raffle or door prize can exceed the $15 limit if the M+C organization is jointly sponsoring the prize with other health plans/M+C organizations at a health fair. See §50.1 for a discussion of rules pertaining to health fairs.

6. **Q** - What about post-enrollment promotional activities? Are there any rules prohibiting such items or activities as coupon books, discounts, event tickets, day trips, or free meals to retain enrollees?

   A - Currently, the Medicare Managed Care Manual states that health plans/M+C organizations may not offer post-enrollment promotional items that in any way compensate beneficiaries for lower utilization of services. Any promotional activities or items offered by health plans/M+C organizations, including those that will be used to encourage retention of members, must be of nominal value, must be offered to all eligible members without discrimination, and must not be in the form of cash or other monetary rebates. The same rules that apply to pre-enrollment promotional activities apply to post-enrollment promotional activities.

7. **Q** - Can health plans/M+C organizations provide incentives to current members to receive preventive care and comply with disease management protocols?

   A - Yes, as long as the incentives are:

   - Offered to current members only;
   - Not used in advertising, marketing, or promotion of the health plan/M+C organization;
   - Provided to promote the delivery of preventive care; and
   - Are not cash or monetary rebates.

   NOTE: If these products are in the CMS approved contracted health plan/M+C organization benefit package (ACR and PBP) under “Preventive Services,” the

provision of such incentives are within the purview of the medical management philosophy of the M+C organization and do not require additional review by CMS for marketing accuracy/compliance. The nominal value rule **does not** apply.

8. **Q** - Can a health plan/M+C organization offer reductions in premiums or enhanced benefits based on the length of a Medicare beneficiary's membership in the health plan/M+C organization?

   A - No. Longevity of enrollment is not a basis for reductions in premium or enhanced benefits. [18]

9. **Q** - Can a health plan/M+C organization provide discounts to beneficiaries who prepay premiums for periods in excess of 1 month?

   A - No. Health plans/M+C organizations cannot provide any discounts to Medicare beneficiaries for prepayment of premiums in excess of 1 month.

10. **Q** - Can a health plan/M+C organization take people to a casino or sponsor a bingo night at which the member's earnings may exceed the $15 nominal value fee?

    A - No. The total value of the winnings may not exceed $15 and the winnings **cannot be in cash or an item that may be readily converted to cash**.

11. **Q** - Can M+C organizations send a $1 lottery ticket as a gift to prospective members who request more information?

    A - Offering a $1 lottery ticket to prospective members violates the "no cash or equivalent" rule discussed above, whether or not the person actually wins since, generally, the "unscratched" ticket has a cash value of $1.

12. **Q** - Can health plans/M+C organizations pay beneficiaries that sign up to be "ambassadors" a flat fee for transportation?

    A - The health plan/M+C organization may reimburse the beneficiary for any actual, reasonable transportation costs but must not pay the beneficiary a flat fee for transportation. If the health plan/M+C organization employs a beneficiary to be an "ambassador" and travel reimbursement is part of the employment compensation, then CMS has no oversight over this issue.

13. **Q** - Can health plans/M+C organizations that own nursing homes conduct health fairs and distribute enrollment forms to nursing home residents?

    A - Yes, organizations that own nursing homes may conduct health fairs and distribute enrollment forms if the sales presentations are confined to a common area (i.e., community or recreational rooms) or if a member volunteered for an individual presentation. Promotional activities and sales presentations cannot be

made in individual resident rooms without a prior appointment for a "home" visit. Such activities would be considered door-to-door solicitation and are prohibited. The organization is required to meet all health fair/sales presentation and enrollment requirements as currently outlined in this chapter and regulations.

14. **Q** - What information should an active member be asked to release to a health plan/M+C organization concerning a potential member lead?

    A - The health plan/M+C organization can ask for referrals from active members, including names and addresses, but cannot request phone numbers. Health plans/M+C organizations can then use this information for soliciting by mail.

15. **Q** - Can physician groups that contract with health plans/M+C organizations hire marketing firms to cold call from non-health plan/M+C organization member listings?

    A - Yes, as long as the marketing guidelines for provider marketing are followed.

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60 - Other Marketing Activities

(Rev. 42, 01-09-04)

This section outlines requirements for a variety of marketing activities. In particular, this section is divided into four sub-sections:

60.1 – Provides requirements for value-added items and services;

60.2 – Provides requirements for marketing multiple lines of business;

60.3 – Provides requirements for review of third party marketing materials, and

60.4 – Provides requirements for marketing to non-English speaking populations.

60.2 - Marketing of Multiple Lines of Business

(Rev. 42, 01-09-04)

M+C organizations may market multiple lines of business in accordance with the following.

Direct mail: Direct mail health plan/M+C organization marketing materials sent to current members describing other lines of business should contain instructions describing how individuals may opt out of receiving such communications. Health plan/M+C

organizations *need not describe this opt-out provision in every piece included in the direct mailing, but they must include it on at least one piece in each direct mailing they conduct.* Health plan/M+C organizations should make reasonable efforts to ensure that all individuals (including non-members) who ask to opt out of receiving future marketing communications, are not sent such communications.

NOTE: These instructions regarding "opting out" of receipt of direct mail apply only to information that does not require prior authorization, as discussed in §60.2.1.

With one exception (mentioned below), health plans/M+C organizations may advertise multiple lines of business in direct mail marketing materials within the same document as the one that is advertising the plan product, as long as the non-plan lines of business are clearly and understandably distinct from the plan product. For example, the document might highlight the name of the plan product in bold and underlined font and then include a paragraph to describe the product in "regular" font, then it would go on to highlight the name of a Medigap product in bold and underlined font followed by a paragraph describing the Medigap product in "regular" font. Please keep in mind that the direct mail materials advertising multiple lines of business still should allow the beneficiary the choice of opting out of receiving future notices about non-M+C products. Also, if a health plan/M+C organization advertises non-plan products with a plan product, it must pro-rate any costs so that costs of marketing non-plan products are not included as "plan-related" costs on Adjusted Community Rate (ACR) proposal submissions.

Organizations that offer more than one type of Medicare+Choice products (HMOs, PPOs) may market all of the products as a "family of products." In this case, the marketing materials must clearly distinguish between the type of product, eligibility requirements, how to obtain services (lock-in, preferred vs. non-preferred benefits), and any out-of-pocket maximums, and specify the benefits to which they apply. Furthermore, multiple product advertising may only be conducted in areas where those products share service areas. We recognize that service areas may not perfectly align. When this occurs, the M+C organization should make a reasonable effort to market the "family of products" only in counties that all products share.

Direct Mail Exception

While health plans/M+C organizations may mention non-plan lines of business at the time they send a plan nonrenewal notice, they may only do so using separate enclosures in the same envelope. Health plans/M+C organizations must not include mention of the non-plan lines of business within the actual nonrenewal notice. The purpose of this exception is to ensure that the nonrenewal notice gives beneficiaries focused information only about the plan nonrenewal.

Health plans/M+C organizations must not include enrollment applications for non-plan lines of business in any package marketing its M+C products, as beneficiaries might mistakenly enroll in the other option thinking they are enrolling in a health plan/M+C organization. Also, if information regarding cost/M+C products and non-plan lines of business are included in the same package, postage costs must be prorated so that costs of

marketing non-plan products are not included as "plan-related" costs on ACR proposal submissions.

Television: Health plans/M+C organizations may market other lines of business concurrently with plan products on television advertisements, as long as those products are separate and distinct from the plan product.

Internet: Health plan/M+C organizations may market other lines of business concurrently with plan products on the Internet, though to avoid beneficiary confusion, the health plan/M+C organization must continue to maintain a separate and distinct section of their Web site for plan information only.

The CMS will review the M+C organization's Web pages to ensure that M+C organizations are maintaining the separation between M+C plan information and information on other lines of business.
