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CHAPTERS	REVISED SECTIONS	NEW SECTIONS	DELETED SECTIONS
3	Table of Contents		60.1.5
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	20	40.1.3	
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NEW/REVISED MATERIAL - EFFECTIVE DATE: April 4, 2003
IMPLEMENTATION DATE: April 4, 2003

Table of Contents - Added several line items for new sections listed above.

Section 10 – Introduction. Added a sentence introducing the information provided in Section 60. Where applicable, clarified that instructions apply not only to M+C organizations, but also to cost plans.

Section 10.1 – HIPAA Considerations. Added new section to address how the new HIPAA Privacy rules affect marketing.

Section 20 - Marketing Review Process. Modified the third and fourth paragraph to provide for 10-day marketing review for cost contractors when they follow a CMS model without modification. Where applicable, clarified that instructions apply not only to M+C organizations, but also to cost plans.

Section 30.1 - Guidelines for Advertising (Pre-enrollment) Materials.

- Under “operational items,” #5 – Added billboards as an exception for marketing materials needing an approval date.
- Under “operational items” added new #10.
- Under “operational items” added new #11.
- Under “operational items” added new #12.
- Under “editorial items,” #1, clarified that member identification cards do not have to have text in 12-point font or larger.
- Under “editorial items,” #2, did not establish any new policy but made some changes to clarify that two types of materials are being addressed in this section (notices and non-notices).
- Where applicable, clarified that instructions apply not only to M+C organizations, but also to cost plans.

Section 40.1.3 - Model Annual Notice of Change. Added new section to include model Annual Notice of Change for Medicare +Choice organizations and Cost plans.

Section 40.2 - Specific Guidance About Provider Directories. Added a new paragraph at the end of this section. This change allows organizations to send one directory to addresses with multiple (i.e., up to four) members. Where applicable, clarified that instructions apply not only to M+C organizations, but also to cost plans. In particular, clarified that cost plans must send a provider directory to all members at the time of enrollment and annually thereafter. **Since not all cost plans have been required to follow this procedure in the past, cost plans have until January 1, 2004 to begin to comply with this requirement (i.e., annual provider directory mailings must begin in 2004).**

Section 40.5 - Specific Guidance for the Standardized Summary of Benefits (SB). Added new section to include those standardized Summary of Benefits (SB) instructions that generally do not change from year to year.

Section 40.5.1 - Summary of Benefits for Medicare+Choice Organizations. Added new section to outline SB instructions specific to M+C organizations and Demonstration projects.

Section 40.5.2 - Summary of Benefits for Cost Plans. Added new section to outline SB instructions specific to Cost plans.

Section 50.1.2 – Specific Guidance About the Use of Independent Insurance Agents. The previous section "50.1.2 - Referral Programs" was deleted, and material formerly in section 60.1.5 has been moved to this section, 50.1.2. No policy changes were made to the use of independent insurance agents. Where applicable, clarified that instructions apply not only to M+C organizations, but also to cost plans.

Section 50.2 - Specific Guidance About Provider Promotional Activities. Noted that providers/provider groups may post enrollment applications on their Web sites. Re-

numbered some of the bullets. Clarified that the permissible activities outlined in this section are delegated activities. Where applicable, clarified that instructions apply not only to M+C organizations, but also to cost plans. Also, reference to section 1128 of the Social Security Act was deleted – while the reference is correct, it is related to the authority of the Office of the Inspector General and therefore inappropriate for this agency to cite as if it were its own authority.

Section 50.3 - Frequently Asked Questions About Promotional Activities. Q&A #12 is clarified to state that a Medicare health plan can reimburse an ambassador for actual, reasonable transportation costs. Where applicable, clarified that instructions apply not only to M+C organizations, but also to cost plans.

Section 60.1.2 - Relationship of Value-Added Items and Services (VAIS) to Benefits and Other Operational Considerations. Revised the third paragraph to clarify that organizations may include VAIS along with their Annual Notice of Change (ANOC) and/or Summary of Benefits (SB) in one bound brochure as long as the value-added services are clearly distinct from the ANOC and/or SB.

Section 60.1.5 - Specific Guidance About the Use of Independent Insurance Agents. Material in this section was moved to section 50.1.2 and this section number deleted.

Section 60.2 - Marketing of Multiple Lines of Business. Made changes to language in this section to allow for marketing of multiple lines of business on television ads, as long as the products are separate and distinct. Where applicable, clarified that instructions apply not only to M+C organizations, but also to cost plans.

Section 60.2.1 – HIPAA and the Marketing of Multiple Lines of Business. Added new section to address how HIPAA affects marketing of multiple lines of business.

Section 60.3 - Third Party Marketing Materials. Renamed this section from " Non-Benefit Providing Third Party Marketing Materials" and added text to better define third party marketing materials.

Section 60.3.1 - Benefit/Service Providing Third Party Marketing Materials. New section added to reflect policy on review of benefit/service providing third party marketing materials.

Section 60.3.2 - Non-Benefit/Service Providing Third Party Marketing Materials. Previously listed as section 60.3. This section reflects revised policy on review of non-benefit/service providing third party marketing materials.

Endnotes. Modified endnotes #1, 9, 11 and 13 to change any reference from the National Marketing Guidelines to chapter 3. Also modified endnote #1 to apply to both M+C organizations and cost plans. Also modified contact information in #15.

Medicare Managed Care Manual

Chapter 3 - Marketing

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10 - Introduction - (Rev. 20, 04-04-03)

This chapter explains requirements for marketing.¹ The intent of this chapter is to:

- Expedite the process for CMS's review of marketing materials;
- Conserve resources by avoiding multiple submissions/reviews of a document prior to final approval;
- Ensure consistent marketing review across the nation; and
- Enable *Medicare+Choice organizations (M+C organizations) and cost-contracting health plans (cost plans)* to develop accurate, consumer friendly, marketing information that will assist beneficiaries in making informed health care choices.

Marketing materials, in general, *are* informational materials targeted to Medicare beneficiaries that promote the *health plan/M+C organization* or any plan offered by *the health plan/M+C organization*, or communicate or explain an M+C *or cost* plan.² (See 42 CFR 422.80(b).) The definition of marketing materials extends beyond the public's general concept of advertising materials to include notification forms and letters used to enroll, disenroll, and communicate with the member on many different membership scenarios. General guidance regarding the marketing review process, including the process for review of materials submitted by national organizations, is provided in §20. In addition, this chapter contains two separate sections devoted to the discussion of guidelines for marketing materials. Section 30 addresses requirements for advertising or

"pre-enrollment" materials, and §40 addresses requirements for beneficiary notification materials that are provided for beneficiary currently enrolled in the plan. Materials relating to promotional activities, including health fairs and sales presentations, are also included in the general definition of marketing materials and are discussed in §50.

Guidelines for other marketing activities, including marketing value added items and services and marketing multiple lines of business, are addressed in §60.

10.1 - HIPAA Considerations - (Rev. 20, 04-04-03)

On April 14, 2003, new Federal rules governing the privacy of health data become enforceable. The rule "Standards for Privacy of Individually Identifiable Health Information" is found at 45 CFR Part 164. Health plans/M+C organizations may use or disclose their members' protected health information as permitted by that rule. Specifically, they may use or disclose this information without beneficiary authorization for treatment, payment or health operations (as those terms are defined by the rule) and for a number of public policy purposes, such as public health and research, recognized in the rule. Health plans/M+C organizations are not required to obtain authorization from beneficiaries prior to marketing their plan benefit packages. For additional information regarding HIPAA, go to www.hhs.gov/ocr/hipaa/.

20 - Marketing Review Process - (Rev. 20, 04-04-03)

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; and
- "For cause" review of materials and activities when complaints are made by any source.

This chapter deals primarily with the pre-approval of marketing materials. As outlined in regulations at 42 CFR 422.80(a) *and 42 CFR 417.428(a)(3)*, *health plans/M+C organizations* may not distribute any marketing materials or election forms or make them available to individuals eligible to elect a *plan offered by a M+C organization/cost plan* unless such materials have been submitted to CMS at least 45 days prior to distribution and CMS has not disapproved the materials. A *health plan/M+C organization* may also distribute materials before 45 days have elapsed if prior approval has been granted by CMS. There is a limited exception to this requirement for model beneficiary notices, as outlined in §40 of this Chapter. Guidelines for CMS review are further described at 42 CFR 422.80(c) *for M+C organizations and 42 CFR 417.428(a) for cost plans*. Marketing materials, once approved, remain approved until either the material is altered by the *health plan/M+C organization* or conditions change such that the material is no longer accurate. The CMS may, at any time, require a *health plan/M+C organization* to change any previously approved marketing materials if found to be inaccurate, even if the original submission was accurate at the time.

Exception to the 45-day marketing review rule:

- **M+C Organization Exception:** *When an M+C organization follows CMS model language without modification, CMS must review the material within 10 days (as opposed to the usual 45 days). The CMS must make a determination on the material within 10 days or else the marketing material is deemed approved.*
- **Cost Plan Exception:** *While not required by law, CMS will review materials prepared by cost plans within 10 days if they have followed CMS cost plan model language without modification. However, while CMS intends to review the cost plan marketing materials within 10 days, the cost plan must not consider the material deemed approved if 10 days pass and it has not received approval or disapproval from CMS since, by law, 45 days must pass before the material may be deemed approved.*

To alert the CMS reviewer to the need for a 10-day review, the health plan/M+C organization must indicate on the submission that it has followed the CMS model without modification and is requesting a 10-day review.

The 10-day review period only applies when the health plan/M+C organization has followed the CMS model without modification. "Without modification" means the health plan/M+C organization used CMS model language verbatim and only used its own language in areas where we have given them license to include their own information (such as where they are asked to include their plan-specific benefits). It also means that the health plan/M+C organization has followed the sequence of information provided in the model in its own marketing material. In these cases, the regional office may only need to review the health plan's/M+C organization's language in order to make a determination on the marketing material within the 10-day time frame.

NOTE: Some of the CMS models cannot be approved until an M+C organization's *Adjusted Community Rate* (ACR) is approved. These include the *Summary of Benefits* (SB), *Annual Notice of Change* (ANOC), and the *Evidence of Coverage* (EOC) (if it is submitted early in the year). In these cases, the Regional Office will review and approve all non-ACR-related information within the 10-day review period, and will conduct a cursory review of all ACR-related information based on the M+C organization's ACR submission. However, the Regional Office will need to disapprove the release of ACR-related marketing material within the 10-day window, since there is no basis for approving it, and indicate that the material will be approved upon approval of the ACR. The Regional Office will need to promptly review and approve these marketing materials upon approval of the ACR.

30.1 - Guidelines for Advertising (Pre-enrollment) Materials – (Rev. 20, 04-04-03)

This section provides guidance to health plans/M+C organizations regarding sales packages and language that may be used in marketing materials. Advertising/pre-enrollment material may be defined as material that is intended primarily to attract or appeal to M+C eligible non-members and to promote membership retention by providing general information to enrollees about the health plan. This includes all ads (print as well as radio TV and Internet ads) and certain other material such as sales scripts, sales

presentation flyers, and direct mail pieces that contain information of interest to all potential and current enrollees of the plan. This chapter offers a general guide and a matrix describing marketing language that health plans/M+C organizations "Must Use/Can't Use/Can Use."

These guidelines were created by identifying required language frequently omitted by health plans/M+C organizations or revised by CMS. Acceptable language was created to meet both CMS requirements and the needs of the health plans/M+C organizations. Although use of suggested "Can Use" language is not required, its use will expedite the review process and achieve greater consistency among marketing materials. Please note that the specific language and format used in all standardized marketing materials like the standardized Summary of Benefits (SB) is required. Please also note that the language provided in the "Must Use" column of the "Must Use/Can't Use/Can Use Chart" (see §30.3 of this Chapter) is required for all the marketing materials as specified in the chart.

Some phrases in this document may not apply to your health plan's/M+C organization's benefit package or marketing strategy. We caution you to apply the information contained in this document with the understanding that it must be evaluated for applicability to your health plan/M+C organization.

Listed below are items that apply to the various pre-enrollment/member retention marketing scenarios experienced by Medicare managed care contracting entities:

Operational Items

1. ***Lock-In Statement:*** *The* concept of "lock-in" must be clearly explained in all materials. For marketing pieces which 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 health plan/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 cost *plan*, Private Fee-For-Service Plan (PFFS) *or PPO*.
2. All marketing materials must clearly explain the concept of networks and sub-networks and the process for obtaining services including referral requirements.
3. 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.
4. **Definition of 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. Due to the nature of ODA, CMS is

- willing to waive the disclaimer information required with other forms of marketing media (e.g., lock-in and premium information).³
5. **Marketing Material Identification Systems:** 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*. This requirement is *also* applicable to all approved internet pages and paper advertisements (e.g. brochures, newspaper ads). Approved radio, television, *and billboard* marketing materials need not include mention of the approval date/*ID number*.
 6. Where M+C organizations may file separate/distinct Adjusted Community Rate (ACR)s Proposals and the Plan Benefit Package (PBP)s covering 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 M+C organizations may do so at their discretion. M+C organizations must disclose whether other plans are available in their Annual Notice of Change letter.
 7. 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 following requirements are met:
 - No such marketing is permitted until after the date the beneficiary has received the plan termination letter; and
 - In addition to the targeted message, the marketing piece must contain a statement indicating that the plan is open to all Medicare beneficiaries eligible by age or disability in the plan's service area.
 8. Sales scripts, both for in-home and telephone sales use, must be reviewed by 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).
 9. Health plans/M+C organizations may not use Medicare member lists for non-plan-specific purposes. If a health plan/M+C organization has questions regarding specific material, which it wishes to send to its Medicare members, the material should be submitted to CMS for a decision.
 10. ***Banner and Banner-Like Advertisements:*** *Health plans/M+C organizations are not required to include the disclaimer information that is required with other forms of marketing media (e.g., lock-in and premium information) for banner or banner-like 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. A "banner-like" advertisement is usually in some media other than television, is*

intended to very briefly 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.

11. Member ID Cards: *The 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 PFFS Plans include the statement that the provider should bill the PFFS organization and not Original Medicare. The CMS believes this statement will help prevent claim processing errors. However, use of this statement is optional.

12. 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 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.*
- 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.*
- 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.*

Affiliation Acknowledgements

1. All marketing materials must include a statement that the health plan/M+C organization contracts with the Federal government. One possible statement is "A Federally Qualified HMO with a Medicare contract." Cost-contractors may use "An HMO with a Medicare contract" and/or "An M+C organization with a Medicare contract" if they are State licensed as HMOs. Medicare+Choice organizations may identify Medicare products as "An HMO with a Medicare+Choice contract" if they are Federally Qualified or State licensed as HMOs. M+C organizations may also identify their Medicare plans as "An M+C plan with a Medicare+Choice contract," or "A Coordinated Care Plan with a Medicare+Choice contract," if the health plan/M+C organization meets the requirements of §1851(a)(2)(A) of the *Social Security Act*. In addition, an M+C organization may describe its Medicare product as a "Medicare+Choice plan offered by [name of M+C organization], a Medicare+Choice Organization".
2. An M+C organization may only identify itself as an "M+C *Provider Sponsored Organization (PSO)*" or imply that it is one of the PSO options for Medicare beneficiaries under M+C if it has received a State licensure waiver from CMS in accordance with 42 CFR 422.370-.378. State licensed M+C organizations may identify themselves in marketing materials as a "Provider Sponsored Organization (PSO)," a "State licensed PSO with a M+C contract," or any other term generally applied to managed care organizations that are sponsored by health care providers as long as they do not use the specific term "M+C PSO" or imply that they are one of the specific PSO options for Medicare beneficiaries defined by the Balanced Budget Act of 1997 and implementing regulations at 42 CFR 422.350-.356.
3. M+C organizations are permitted to use ethnic and religious affiliation in their plan names, as long as the legal entity offering the plan has a similar proper name/affiliation. For instance, if a plan were affiliated with the Swedish Hospital of Minnesota, it would be permissible for the plan to use the tag line, "Swedish Plan, offered by Swedish Hospital System of Minnesota."

Special Situations

1. Beneficiaries with disabilities must be considered part of the audience that any marketing strategy is intended to reach. Specifically, and in light of the publication of the final M+C regulation, health plans/M+C organizations may not use plan names that suggest that a plan is available only to Medicare beneficiaries age 65 or over, rather than to all beneficiaries. This prohibition generally bars plan names involving terms such as "seniors," "65+," etc. In fairness to M+C organizations with an existing investment in a plan name, CMS will allow the "grandfathering" of existing M+C plan names; that is, plan names established before the final rule took effect.
2. TDD/TTY numbers must appear in conjunction with any other phone numbers in the same font size and style as the other phone numbers. The TDD/TTY number must also appear along with the hours of operation, if the inclusion of hours of operation are required (as outlined under ["Operational Items," item #3](#)). The font

- size/style rule is required for all media with the exception of television ads. The CMS recognizes that the requirement that the TTY/TDD number be the same font and style as other numbers can result in confusion on a television ad, resulting in some prospective enrollees calling the wrong phone number. Therefore, health plans/M+C organizations are allowed to use various techniques to sharpen the differences between TTY/TDD and other phone numbers on a television ad (such as using a smaller font size for the TTY/TDD number than for the other phone numbers). Health plans/M+C organizations can use either their own or State relay services, as long as the number is included. Health plans/M+C organizations can use either their own or State relay services, as long as the number is included.
3. Review of marketing materials in non-English language or Braille: For marketing with non-English or Braille materials 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 health plan/M+C 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. 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 provided that health plans/M+C organizations submit attestation letters vouching that the non-English or Braille version contains the same information as the English language version.

Section 1876 Cost Contracts Only

1. For §1876 of the Social Security Act, cost-contracting health plans only - In all marketing materials (e.g., brochure narratives and introductions to side-by-side comparisons) 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
2. 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 marketing materials. The health plan/M+C organization may also offer additional optional enriched benefit packages for an additional charge to the extent they wish.

Editorial Items

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, the enrollment and disenrollment applications, letters confirming enrollment and disenrollment, notices of non-coverage (NONC) and notices informing members of their right to an appeals process. *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. The CMS is cognizant of the fact that, when actually measured, font size 12 point 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 Notice and Non-Notice Materials: The 12-point font size or larger rule also applies to any footnotes or subscript annotations in notices. In all non-notice material (e.g., TV advertisements) the footnote and any text appearing in the material 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 health plan/M+C organization. All non-notice materials must have the same font size for both the commercial message and footnotes. The size is left to the discretion of the health plan/M+C organization and can be smaller than size 12 font, but the commercial message and footnotes must be the same size font.*
3. 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. In other words, 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.

Other

1. **Marketing through the Internet:** CMS considers the Internet as simply another vehicle for the distribution of marketing information. Therefore, all regulatory rules and requirements associated with all other marketing conveyances (e.g., newspaper, radio, TV, brochures, etc.) are applicable to health plan/M+C organization marketing activity on the Internet. The CMS marketing review authority extends to all marketing activity (both advertising and beneficiary notification activity) the health plan/M+C organization pursues via the Internet.
2. Health education materials are generally not under the purview of CMS marketing review. However, if such materials are used in any way to promote the M+C organization or explain benefits, then they are considered marketing materials and must be approved before use. If there is any "commercial message" (defined previously in this section) or beneficiary notification information in a health education piece, it must be reviewed by CMS.
3. M+C organizations may refer to results of studies or statistical data in relation to customer satisfaction, quality, etc. as long as specific study details are given (at a minimum source, dates, sample size, and number of plans surveyed). 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

organizations. 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.

4. CMS recognizes the difference of purpose and intent between company logos/product tag lines and other advertising marketing materials. The guidelines regarding specifically 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. Notwithstanding 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 [§30.3](#) of this Chapter for full information on restrictions associated with the use of superlatives.

40.1.3 - Model Annual Notice of Change - (Rev. 20, 04-04-03)

*All M+C organizations are required to give members notice of Medicare program and health plan changes taking place on January 1 of the upcoming year, by October 15 of the current year. Cost plans must give notice within 30 days of the effective date of the Medicare program and health plan changes (i.e., by December 1 for January 1 changes). "Give notice" means that members must have **received** the notice by the required date. This notice is known as the "Annual Notice of Change," or "ANOC."*

The ANOC must be member specific. This means that the notice must have the member's own name either on the envelope addressed to the member or on the ANOC itself. The following is a model ANOC for M+C organizations and cost plans.

MODEL ANNUAL NOTICE OF CHANGE

Dear [member name] - or - [Member]:

Beginning January 1, [insert upcoming year], there will be some changes to [insert plan name]. These changes are described in this letter.

How will my monthly premiums change?

Starting January 1, [insert upcoming year], the monthly premium that you pay to [insert plan name] will [increase/decrease] from \$ ___ to \$ ___ OR stay the same at \$ ___.

How will my benefits and costs change?

[Clearly describe all benefit changes, including changes in cost sharing, annual drug cap, drug coverage, and any new benefits that will be offered by the plan in the coming year or that will be covered by Medicare. Also describe any benefits offered in the current year that will no longer be offered by the plan in the upcoming year. When

describing benefit changes, do so by comparing the current year benefit with the upcoming year benefit.]

We have enclosed a summary of your benefits, premiums and copays that will be effective January 1, [insert upcoming year]. [M+C organizations: Insert whichever of the two following sentences is appropriate for your circumstance: (1) "Medicare has reviewed and approved the changes in benefits, premiums, and other costs included in this letter and on the enclosed Summary of Benefits" or, (2) "The changes in benefits, premiums, other costs included in this letter and on the enclosed Summary of Benefits are pending Federal approval."] [Cost plans insert the following sentence: Medicare has reviewed the changes in benefits, premiums, and other costs included in this letter and on the enclosed Summary of Benefits"] We will send you an [insert: "Evidence of Coverage" or whichever name is used by your MCO as the name for the EOC] [insert either "by [date]" or "at a later date"]. All changes begin January 1, [insert upcoming year], and will be in effect through December 31, [insert upcoming year]. Rest assured that you will be a member of [insert plan name] for the coming year if you do nothing to change your Medicare coverage.

[If the organization lists more than one plan offering on the enclosed SB, the organization must identify the specific plan in which the member will be enrolled. In addition, if the organization lists only one plan in the SB but offers multiple plans in the service area, the ANOC must notify beneficiaries that additional plans are available and include specific information on how beneficiaries can obtain more information.]

Are there other benefits I can get?

[Include this section if the plan offers optional supplemental benefits.]

[Clearly describe any optional supplemental benefits and the premiums for those benefits. A description of the process that the member must follow to elect optional supplemental benefits must also be included.]

Where can I get more information?

Please call our Member Services Department [insert days and hours of operation], at [insert phone number] if you have any questions. TTY users should call [insert TTY phone number].

You can contact us if you need additional information, including:

- Information about how we control the use of services and costs;*

[Cost plans do not need to include the remaining three bullets]

- Information on the number of appeals and grievances filed by our members;*
- A summary description of how we pay our doctors;*
- A description of our financial condition, including a summary of our most recently audited statement.*

You can also get information about the Medicare program and Medicare health plans from the www.medicare.gov Web site or by calling 1-800 MEDICARE (1-800-633-4227).

TTY users should call 1-877-486-2048. Medicare customer service representatives are available, 24 hours a day, including weekends, to answer questions about Medicare.

We look forward to serving you now and in the future.

Sincerely,

Plan Representative

ENCLOSURE - Summary of Benefits

40.2 - Specific Guidance About Provider Directories - (Rev. 20, 04-04-03)

Regulations at 42 CFR 422.111(b) require that M+C organizations disclose the following information to each enrollee electing an M+C plan offered by the M+C organization:

1. The number, mix, and distribution, including addresses of providers from whom enrollees may obtain services, as well as any out-of-network coverage or point-of-service option;
2. Information regarding out-of-area coverage and emergency coverage, including the process and procedures for obtaining emergency services, and the location where emergency care can be obtained, as well as other locations where contracting physicians and hospitals provide emergency services, and post-stabilization care included in the M+C plan;
3. Prior authorization rules and other review requirements that must be met in order to ensure payment for the services; and
4. Instructions to enrollees that, in cases where noncontracting providers submit a bill directly to the enrollee, the enrollee should not pay the bill, but submit it to the M+C organization for processing and determination of enrollee liability, if any.

Section 422.111(a) requires that this information be disclosed in clear, accurate, and standardized form at the time of enrollment and at least annually thereafter.⁹ M+C organizations generally include this information in their provider directory and distribute the directory to new members upon enrollment and existing members on an annual basis.¹⁰ In addition to the information provided above, provider directories should also contain the following:

1. Names, complete addresses, and phone numbers of the primary care physicians;
2. Names and addresses (city or town) of specialists, skilled nursing facilities, hospitals, outpatient mental health providers, and pharmacies, where outpatient prescription drugs are offered by the M+C plan;
3. General information regarding lock-in, including the role of the primary care physician (PCP) as well as the process for selecting a new PCP and any specific requirements for referrals to specialists and ancillary providers;
4. A description of the plan's service area, including a list of cities and towns;

5. Telephone numbers for customer service or appropriate contact information (including the hours of service) for members who have questions or require assistance in selecting a PCP; [u](#) and
6. A general disclaimer that indicates that the directory is current as of a particular date and that a provider's listing in the directory does not guarantee that the provider is still in the network or accepting new members.

The M+C organizations may publish separate PCP and Specialty directories provided that both directories must be given to enrollees at the time of enrollment and at least annually thereafter. M+C organizations that use sub-networks of providers must clearly delineate these sub-networks (preferably by listing the providers as a separate sub-network) and describe any restrictions imposed on members that use these sub-networks. This is particularly important since beneficiaries could choose their primary care physician without realizing that this choice restricts them to a specified group of specialists, ancillary providers, and hospitals. M+C organizations must also clearly describe the process for obtaining services in these networks and sub-networks, including any referral requirements, as well as any out-of-network coverage or point-of-service option.

The M+C organizations may find it more economical to print a separate directory for each sub-network and disseminate this information to members in a particular sub-network. This practice is permissible, provided that the directory clearly states that a directory that lists providers for other networks is available and provides this information to members upon request.

*With respect to the annual mailing of the directory, health plans/M+C organizations have the option to either mail one directory to every member, or to mail one directory to every address where **up to four members** reside. (Keep in mind that individuals in, for example, apartment buildings, are only considered to be at the "same address" if the apartment number is the same.) Please note that every member must still receive his or her own directory at the time of enrollment.*

If you choose to mail the directory to every address where up to four members reside, you must keep the following in mind:

- *If a member at that address subsequently requests that you mail another copy of the directory, you must mail them a directory.*
- *When mailing a directory to one address, you should include the name of at least one of those individuals in the mailing address (however, we prefer that you include the names of all individuals, to prevent any members mistakenly believing that you failed to mail them a directory).*

Please also refer to §30.1, "Operational Items #12," which contains more information regarding mailing of the Provider Directory.

40.5 - Specific Guidance for the Standardized Summary of Benefits (SB) – (Rev. 20, 04-04-03)

The standardized Summary of Benefits (SB) is a stand-alone marketing document that is generated from the Plan Benefit Package. It is the primary pre-enrollment document used by M+C organizations to inform potential Medicare beneficiaries of plan benefit packages offered by M+C organizations.

40.5.1 - Summary of Benefits for Medicare+Choice Organizations – (Rev. 20, 04-04-03)

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. The CMS reviewers 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.

D. Section 3 - Plan Specific Features

*This section is limited to a maximum of four pages of promotional text and graphics and is not standardized with regard to format or content. The 4-page limit means that the information is limited to four single-sided pages or 2 double-sided pages. **However, there are two exceptions to this limit:***

- 1. PPOs will be allowed to use up to two more pages (i.e., for a total of up to six pages) to describe out of network benefits or to describe out of network benefits with the in-network benefits that are described in section 3; and*
- 2. When an M+C organization is translating the SB to a foreign language, it may add pages as necessary to ensure the translation matches 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 the Requests to Change Hard Copy Summary of Benefits for further detail.*

F. Footnotes

The comparison matrix generated by the PBP will not contain the required footnotes. Therefore, the M+C organization must include the following footnotes provided below. 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 (OM) column that describes the required Medicare coinsurance, e.g., "You pay 20% of Medicare approved amounts." Additionally, 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.

40.5.2 -Summary of Benefits for Cost Plans - (Rev. 20, 04-04-03)

Cost plans are not required to use the standardized Summary of Benefits, however they are required to provide members with an SB. If a cost plan intends to have the plan appear in Medicare Health Plan Compare and Medicare Personal Plan Finder, it will need to complete the Plan Benefit Package (PBP) to create a standardized SB. Cost plans that create a standardized SB should follow all instructions below.

Cost plans should follow all instructions outlined in §40.5.1 for M+C organizations. In addition, the following instructions are specific to cost plans.

A. General Instructions

- 1. The benefit description column and Original Medicare column must remain unchanged.*
- 2. All sentences in the plan column of the matrix must be completed with applicable copays or coinsurance amounts.*
- 3. Additional instructions provided in italicized text and in parentheses should be removed from the Summary of Benefits prior to submitting the document to CMS for review.*
- 4. Unless otherwise indicated, cost plans should choose all of the applicable sentences in each category to describe their benefits.*

B. Section 1- Beneficiary Information Section

For cost plans that are "closed" to new enrollment, the pre-enrollment language in section 1 will not apply. Therefore, these cost plans should include the following disclaimer in their ANOC. Any additional information regarding the contractor's "closed status" should also be included in the cover letter.

The CMS requires the Summary of Benefits (SB) to be used in both pre-enrollment and annual notice of change (ANOC) functions. Plan member receiving the SB should disregard all pre-enrollment language.

C. Section 2 - Benefit Comparison Matrix

Cost plans may include the following footnote on each page of the benefit comparison matrix. The text of the footnote should appear at the bottom of every page.

If you go to a provider outside of [insert name of plan] who accepts Medicare patients, your coverage would be the same as Original Medicare. Original Medicare deductibles and coinsurance apply.

50.1.2 - Specific Guidance About the Use of Independent Insurance Agents - (Rev. 20, 04-04-03)

The CMS recognizes that independent insurance agents can provide a necessary service to Medicare beneficiaries and potential enrollees. They can also be a valuable resource in helping to reach low-income and rural populations, persons with disabilities, and other special populations. Therefore, CMS urges health plans/M+C organizations to consider requiring specific cost/M+C training for their contracted agents. This will ensure that appropriate information is being delivered to Medicare beneficiaries and potential enrollees.

Please note that CMS is aware that sales by independent insurance agents are typically tied to compensation, and that agents are often given incentives to steer enrollees towards the carrier offering the most compensation. Further, independent insurance agents may be in a unique position to "cherry pick," given their often longstanding relationships with clients. Additional operational guidelines to address these concerns will be forthcoming.

50.2 - Specific Guidance About Provider Promotional Activities – (Rev. 20, 04-04-03)

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 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/MCOs.

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 section 1 above.)

- 2. Provider Office Activities and Materials** - In their own offices, provider groups and individual providers can give out health plan/M+C organization brochures, and posters announcing health plan/M+C organization affiliation (all of which must be exclusive of applications). Providers, their representatives and qualified health plan/M+C organization (marketing) representatives are all prohibited from taking applications in the place where health care is delivered, such as provider offices or hospital wards. This is to prevent Medicare beneficiaries from experiencing inappropriate pressure to enroll at the time that health care is being delivered. 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.

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's Web site, <http://www.medicare.gov/>. Physicians are permitted to printout and share information with patients from CMS's Web site.

- 3. Health Plan/M+C organization and Provider Co-sponsorships** - Providers and provider groups can co-sponsor an event, e.g., an open house or a health fair with a health plan/M+C organization. Providers and provider groups and health plans/M+C organizations can cooperatively market and advertise by such means as TV, radio, direct mail, testimonials, posters, fliers and print ads. All marketing materials describing the health plan/M+C organization in any way must get prior approval, should have the health plan's/M+C organization's name or logo on them as well as the provider's/provider group's name or logo, and must follow all of the rules in Chapter 3 - Guidelines for Advertising Materials. All materials mentioning the health plan/M+C organization are considered marketing materials and must therefore adhere to this *chapter* and have prior approval by CMS.
- 4. 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).

5. ***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.
6. ***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's 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.

50.3 - Answers to Frequently Asked Questions About Promotional Activities (Rev. 20, 04-04-03)

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's 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's 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's 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+Cs* 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 M+C organizations hold marketing presentations in clinics or hospitals?

A - Yes, marketing presentations are allowed in clinics, hospitals or physicians offices (or other health care delivery locations) provided that the presentations are held in common areas (i.e., community or recreational rooms) and that patients being treated at the facility are not coerced in to attending.

14. **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.

15. **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.

16. **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

60.1.2 - Relationship of Value-Added Items and Services (VAIS) to Benefits and Other Operational Considerations - (Rev. 20, 04-04-03)

Health plans/M+C organizations can market, either through oral presentations or written materials, Value-Added Items and Services (VAIS). Organizations can also mention VAIS in their newsletters. VAIS may not appear in the Plan Benefit Package (PBP) or the Standardized Summary of Benefits (SB) (including in the M+C organization special features §30 at the end). However, organizations will be permitted to reference their pharmacy discount program in section 3 of their SB, provided they also include the disclaimers included in this section. In addition, the SB must clearly state (in the location that the program is described) that the discount drug program will be available for the entire contract year.

Any description of VAIS must be preceded by the following prominently displayed language:

1. The products and services described on this page are neither offered nor guaranteed under the M+C organization's contract with the Medicare program, but are made available to all enrollees who are members of [Name of *plan*].
2. These products and services are not subject to the Medicare appeals process. Any disputes regarding these products and services may be subject to the [Name of *plan*] grievance process.
3. Should a problem arise with any Value-Added Item or Service, call [Name of *plan*] for assistance at [*Customer service number*]. Our customer service hours are [Enter hours].

VAIS must not appear in the Plan Benefit Package (PBP) or the Standardized SB (including in the health plan/M+C organization special features in §30 at the end). However, organizations will be permitted to reference their pharmacy discount program in section 3 of their SB, provided they also include the disclaimers included in this section. In addition, the SB must clearly state (in the location that the program is described) that the discount drug program will be available for the entire contract year.

Organizations may include VAIS along with their ANOC and/or SB in one bound brochure as long as the value-added services are clearly distinct from the ANOC and/or SB (such as on a different color piece of paper), and the information on value-added services includes all the disclaimers required in this chapter.

Because VAIS does not meet the definition of a benefit under the M+C program, neither the actual costs of the VAIS nor associated administrative costs may appear in the ACR. Furthermore, because they are not contained within the contracted health benefits package, these services are not subject to the Medicare appeals process. VAIS may not be described in Medicare Compare or the "Medicare and You" handbook.

The CMS will not require prior approval of materials describing VAIS, since VAIS are not benefits as described within CMS regulations. The CMS will review these materials on monitoring visits to ensure compliance with these requirements. The CMS may initiate a monitoring visit if it becomes aware that materials have been distributed describing VAIS without the appropriate disclaimers or in violation of the requirements stated herein. CMS will also investigate complaints by beneficiaries regarding VAIS, just as it would other possible violations of CMS requirements.

60.2 - Marketing of Multiple Lines of Business - (Rev. 20, 04-04-03)

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

Direct mail: Direct mail *health plan/M+C0* 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* may

apply this opt-out provision on an annual basis. *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.

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.

60.2.1 - HIPAA and the Marketing of Multiple Lines of Business – (Rev. 20, 04-04-03)

In general, a health plan/M+C organization does not need to obtain authorization from beneficiaries to market its own health-related, value-added products. This includes other lines of business offered by the same covered entity and its subcontractors (business associates) doing business on behalf of the covered entity. However, a health plan/M+C organization must obtain authorization from beneficiaries under certain circumstances. For example, authorization is needed if the product is a pass-through discount, a product offered by an entity other than the covered entity or outside of a business associate contract, an accident only policy, a life insurance policy, or is not in the plan of benefits because it is not a health related item or service. For additional information regarding HIPAA, go to www.hhs.gov/ocr/hipaa/.

60.3 - Third Party Marketing Materials - (Rev. 20, 04-04-03)

From time to time, a third party may prepare marketing materials for a health plan's/M+C organization's membership and/or supply those materials to the membership. These materials are known as "third party marketing materials," and can be prepared both by benefit/service providing and non-benefit/service providing third parties. Marketing review of these materials is dependent upon the type of third party, as outlined in the remainder of this section.

60.3.1 - Benefit Providing Third Party Marketing Materials – (Rev. 20, 04-04-03)

A benefit/service-providing third party is an entity that either administers or covers the health care benefits of the health plan's/M+C organization's Medicare membership or provides health care services to the health plan's/M+C organization's Medicare membership. Some examples of benefit/service-providing third party entities would be employer groups, drug companies, or nursing homes, etc.

Other than M+C employer group marketing materials, CMS reviews all marketing materials prepared by benefit/service-providing third party entities if they will be used by the health plan/M+C organization for its membership (as stated in §20.2, M+C organizations are waived from having marketing materials reviewed for employer group members). Marketing materials must be submitted to CMS via the health plan using the materials, and may not be submitted directly by the third party to CMS. The benefit/service-providing third party should submit the material via the health plan/M+C organization with the largest membership.

*In the event a benefit/service-providing third party works with multiple health plans to provide the **same** marketing material to each organization's membership, the material need only be approved by CMS once, as long as that material is not for use by health plans/M+C organizations with dual eligible members (since dual eligible marketing materials may need to vary by state). Once CMS has approved the material, it is considered approved for all other health plans/M+C organizations with which the third party works. The third party or the health plan/M+C organization may change the product name, telephone numbers, addresses, and/or tracking codes on the material and a new approval will not be necessary.*

Please note that as part of its business relationship with other health plans/M+C organizations the third party must inform the other health plan/M+C organization that it would like to use the CMS-approved material for its membership. Also, the health plan/M+C organization and the third party should work together to determine whether the material will be used for the health plan's membership or whether new materials need to be developed.

If a health plan/M+C organization intends to have the third party provide the pre-approved material to its membership, it must send an "FYI" copy of that material to the Regional Office (RO) for the RO's files.

60.3.2 - Non-Benefit/Service Providing Third Party Marketing Materials - (Rev. 20, 04-04-03)

A non-benefit/service providing third party is an entity that neither administers the health care benefit nor provides health care services to the health plan's/M+C organization's Medicare membership. For the purpose of marketing review, non-benefit/service providing third party entities are organizations or individuals that supply information to a health plan's/M+C organization's membership which is paid for by the health plan/M+C organization or by themselves. An example of a non-benefit/service providing third party could be a research firm that provides comparative data relating to managed care organizations.

The CMS does not review marketing materials originated by non-benefit providing third party entities.

If a non-benefit/*service*-providing third party wishes to market to *health plan/M+C organization* membership, they must submit their materials to the *health plan/M+C organization*, which in turn, can distribute the materials to their membership. It is the responsibility of the *health plan/M+C organization* to ensure that *these* marketing materials contain the disclaimer, "Medicare has neither reviewed, nor endorses this information." This disclaimer must be prominently displayed at the bottom center of the first page of the material and must be of the same font size and style as the commercial message.

Endnotes - (Rev. 20, 04-04-03)

¹ The primary CMS/health plan contractual frame of reference in *Chapter 3* is *of a Medicare+Choice organization offering a* coordinated care plan. Where applicable, alternative language is provided for cost *plans* as well as scenarios involving the point-of-service (POS) and Visitor Program features which may be applicable for M+C an/or cost *plans*. [Back to Text](#)

² The guidelines throughout this document apply to Medicare+Choice Organizations (M+C organizations) as well as Section 1876 of the Act cost contractors unless stated otherwise. Therefore, for ease of review and reference, the term "health plan" is used throughout the document to include requirements specific to both Medicare+Choice Organizations and §1876 cost contractors. [Back to Text](#)

³ See §30 of the chapter for specific application requirements for Outdoor Advertising (ODA.) [Back to Text](#).

⁴ Under M + C, individuals who are not already member - those that are grandfathered in - must have both Parts A and B of Medicare in order to eligible for enrollment. [Back to Text](#).

⁵ The health plan/M+C organization must be sure to offer adequate explanation of Medicare card use with out-of-plan utilization that is not an emergency or an urgently-needed service. [Back to Text](#)

⁶ Note to health plan/M+C organization - CMS has the discretion to disapprove language based on site visit reviews identifying substantial deficiencies in health plan/M+C organization operations. [Back to text](#).

⁷ Note to health plan/M+C organization - A member of the health plan/M+C organization may use a superlative in relating their personal experience with the health plan/M+C organization so long as the testimonial is preceded with the phrase "in my opinion" (e.g., "I have been with the health plan/M+C organization for 10 years and in my opinion they have given me the best care possible.") If the member does not preface the superlative statement with the "in my opinion" phrase, the member must substantiate the statement with an acceptable qualifying information source. [Back to text](#).

Note 8 has been deleted.

⁹ In accordance with *Chapter 3*, this information should be provided in at least 12-point font size. [Back to text](#).

¹⁰ M+C organizations may choose to disseminate an errata sheet or addendum during the year to update members with respect to changes in provider's addresses and phone numbers. However, in accordance with 42 CFR 422.111(c), M+C organizations must make a good faith effort to disclose any changes to the provider information upon request and, under 422.111(e), must make a good faith effort to provide written notice at least 30 calendar days before the termination effective date. M+C organizations should consult the M+C regulations for further information. [Back to Text](#).

¹¹ In accordance with *Chapter 3*, the applicable TDD/TTY number must also be provided, including the hours of operation. [Back to text](#).

¹² The CMS's monthly capitation rate to an M+C organization for an M+C member is higher for an enrollee who is a Medicaid recipient because, statistically, the Organization incurs higher medical costs due to higher utilization than that of a non-Medicaid recipient. However, CMS does not pay the Medicaid adjustment factor for QI-1s or QI-2s because CMS created those categories of Medicaid recipients after it established the standard monthly payment upon which it bases all capitation payments. [Back to text](#).

¹³ *Since health plans/M+C organizations are primarily responsible for conducting outreach, Chapter 3 has been written targeting that audience.* However, if the *health plan/M+C organization* contracts with another entity for any part of this outreach, the contracting entity must abide by *Chapter 3* as well. [Back to text](#).

¹⁴ The CMS considers the following to be examples of substantive changes to an outreach program that would make the proposal and/or attached member materials an "initial"

proposal: changes to the steps involved in the outreach process, changes to the language in the outreach letters, revisions to the telephone scripts, changes to the network of subcontractors participating in the outreach efforts, etc. CMS considers the following to be examples of changes allowable without designating the proposal as "initial": contact telephone numbers, letterhead, mailing dates and targeted member numbers, updates to income and resource criteria and benefit levels as updated by the State. [Back to text.](#)

¹⁵ *Outreach proposals should go to the PCT Lead, Ann Knievel, CMS San Francisco Regional Office, 75 Hawthorne Street, Suite 401, San Francisco, CA 94105; phone: 415-744-3625; fax: 415-744-3761; Aknievel@cms.hhs.gov, [Back to text.](#)*

¹⁶ Section 1851(e)(3) of the Act and 42 CFR 422.10(b). [Back to text.](#)

¹⁷ An Enrollment by Mail Forms (EBMF) may be either:

1. A specifically designed enrollment application form which is attached to health plan/M+C organization marketing materials; or
2. A standard health plan/M+C organization enrollment application form with instructions that the form must be mailed back to the health plan M+C organization.

The key feature of the EBMF is that it must be completed by the beneficiary in the absence of health plan/M+C organization marketing influences and returned to the health plan/M+C organization by mail. (Self-addressed, postage paid, return envelopes may be provided by the health plan/M+C organization.). [Back to text.](#)

¹⁸ This "no" statement also applies to "zero" premium plans that might want to award a nominal value gift as a reward for longevity of enrollment. [Back to text.](#)