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# CMS Manual System

## Pub. 100-16 Medicare Managed Care

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

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### I. SUMMARY OF CHANGES:

#### NEW/REVISED MATERIAL - EFFECTIVE DATE: August 08, 2004

**Table of Contents** - Added lines for new sections 20.5, 40.6, 60.4.1, and 60.4.2; changed title of section 30.3; and deleted section 30.4.

**Section 10 – Introduction** - Added language about health education materials that was inadvertently deleted in the October 2003 update. Added rules about using “Medicare Advantage” as a plan name based on the Acting Director, HPBG’s March 16, 2004 memorandum.

**Section 20.3 – Streamlined Marketing Review Process** - Clarified which sections of the Summary of Benefits must be sent to the RO according to which streamlined process the organization follows. Added requirement that organizations submitting templates for review notify the RO if those templates will vary in any way.

**Section 20.5 – Guidelines for File and Use** - New section added on the File and Use Program, based on the Acting Director, HPBG’s November 25, 2004 memorandum.

**Section 30 – Guidelines for Advertising and Pre-Enrollment Materials** - Added requirement on comparison of plans to each other in advertising and pre-enrollment materials. Technical changes to reflect deleted section.

**Section 30.1 – Guidelines for Advertising Materials** - Clarified that direct mail materials can be ads as long as they do not include the enrollment form. Deleted requirement that the plan provide study details to the RO if the study is a CMS study. Added requirement that press releases include the pending Federal approval disclaimer, when appropriate. Clarified font size requirements. Added new requirement that the organization must list the hours of operation for 1-800-MEDICARE any time the organization lists the 1-800-MEDICARE number.

**Section 30.2 – Guidelines for Pre-Enrollment Materials** - Clarified that if direct mail pieces include enrollment forms, then they are pre-enrollment materials. Defined minimum information requirements for prospective enrollees. Moved discussion of studies or statistical data from “Formatting Requirements” sub-section to “Language Requirements” sub-section. Moved some language requirements from old section 30.3 to this section (such as benefit and plan premium information requirements). Added new

requirement that the organization must list the hours of operation for 1-800-MEDICARE any time the organization lists the 1-800-MEDICARE number.

**Section 30.3:**

**Sales Package Minimum Information Requirements** - Deleted old section. All requirements from this section are now included in sections 30.2 and/or new section 40.6.

**Must Use/Can't Use/Can Use Chart.** Previously section 30.4 moved to section 30.3.

**Section 30.3 – Must Use/Can't Use/Can Use Chart** - Moved this material to Section 30.3

**Section 40 – Guidelines for Post-Enrollment Materials** - Technical change to reflect new section 40.6.

**Section 40.1 – General Guidance for Post-Enrollment Materials** - Technical change to reflect new section 40.6. Added new requirement that the organization must list the hours of operation for 1-800-MEDICARE any time the organization lists the 1-800-MEDICARE number.

**Section 40.2 – Specific Guidance About Provider Directories** - Inserted information from Acting Director, HPBG's May 2, 2003 memorandum on changed pages for the provider directory. Also re-organized the section slightly to clarify our requirements for annual notification of provider information. Moved some provider directory requirements to §40.6.

**Section 40.5.1 - Summary of Benefits for M+C Organizations** - Clarify that Section 3 of the Summary of Benefits is not intended to include a description of every plan benefit that is not listed in Section 2.”

**Section 40.5.3 – Requests to Change Hard Copy Summary of Benefits** - Updated with new SB E-mail address.

**Section 40.6 – Specific Guidance on the EOC** - New section in Chapter 3. This section addresses information requirements for the EOC, much of which come from old section 30.3. Changed requirements for when the EOC must be sent to new members (it must now be sent no later than when the organization notifies the member of acceptance (confirmation) of enrollment. (The time frame requirements for sending notice of acceptance of enrollment are contained in Chapter 2, §40.4.2).

**Section 50 – Guidelines for Promotional Activities** - Removed reference to the Office of the Inspector General.

**Section 50.1.2 – Referral Programs** - Moved information contained in old Q&A #14 in Section 50.4 to this section.

**Section 50.2 – Specific Guidance About Provider Promotional Activities** - Corrected reference to having marketing materials approved.

**Section 50.4 – Answers to Frequently Asked Questions About Promotional Activities** - Deleted Q&A #14 (this was moved to section 50.1.2). Added new Q&A #14 to explain that M+C organizations can obtain leads from providers.

**Section 60.1.2 – Relationship of Value-Added Items and Services to Benefits and Other Operational Considerations** - Added rule that VAIS may not appear in the ANOC or EOC (unless it is a drug discount program).

**Section 60.4.1 – Guidelines for Review of Non English Materials** - New section added to address situations when materials are in non-English or Braille is submitted.

**Section 60.4.2 – Model Attestation** - New section added for a model attestation form.

**Endnotes** – Endnote 4 was deleted because the section referring to this endnote was deleted. Endnote 5 was deleted and the requirement was placed into new section 40.6.

**CLARIFICATION – EFFECTIVE: Not Applicable.**

**Section 40.5.1 – Summary of Benefits for Medicare+Choice Organizations** - Clarified that Section 3 of the Summary of Benefits is not intended to include a description of every plan benefit not included in Section 2 that has cost sharing associated with it.

**Section 50.3 – Specific Guidance About the Use of Independent Insurance Agents** - Clarified that as with provider marketing, marketing by independent insurance agents is deemed to be marketing by the organization.

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

**II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual not updated.)**  
**(R = REVISED, N = NEW, D = DELETED – (Only One Per Row.)**

<b>R/N/D</b>	<b>CHAPTER/SECTION/SUBSECTION/TITLE</b>
R	3/10/Introduction
R	3/20/20.3/Streamlined Marketing Review Process
N	3/20/205/File and Use
R	3/30/Guidelines for Advertising and Pre-Enrollment Materials
R	3/30/30.1/Guidelines for Advertising Materials
R	3/30/30.2/Guidelines for Pre-Enrollment Materials

<b>R/N/D</b>	<b>CHAPTER/SECTION/SUBSECTION/TITLE</b>
D	3/30/30.3/Sales Package Minimum Information Requirements
R	3/30/30.3/Must Use/Can't Use/Can Use Chart
R	3/40/Guidelines for Post-Enrollment Materials
R	3/40/40.1/General Guidance for Post-Enrollment Materials
R	3/40/40.2/Specific Guidance About Provider Directories
R	3/40/40.5.1/Summary of Benefits for Medicare+Choice Organizations
R	3/40/40.5.3/Requests to Change Hard Copy Summary of Benefits
N	3/40/40.6/Specific Guidance on the Evidence of Coverage.
R	3/50/Guidelines for Promotional Activities
R	3/50/50.1.2/ Referral Programs
R	3/50/50.2/Specific Guidance About Provider Promotional Activities
R	3/50/50.3/Specific Guidance About the Use of Independent Insurance Agents
R	3/50/50.4/Answers to Frequently Asked Questions About Promotional Activities.
R	3/60/60.1.2/Relationship of Value-Added Items and Services (VAIS) to Benefits and Other Operational Considerations
N	3/60/60.4.1/Review of Marketing Materials in Non-English Language or Braille
N	3/60.4.2/Model Attestation
R	3/Endnotes

### III. ATTACHMENTS:

	<b>Business Requirements</b>
<b>X</b>	<b>Manual Instruction</b>
	<b>Confidential Requirements</b>
	<b>One-Time Special Notification</b>

# Medicare Managed Care Manual

## Chapter 3 - Marketing

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*(Rev. 60, 08-20-04)*

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## **10 - Introduction**

*(Rev. 60, Issued 08-20-04, Effective: August 08, 2004/Implementation: N/A)*

This chapter explains requirements for marketing.<sup>1</sup> The intent of this chapter is to:

- Expedite the process for CMS' 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 *health plans* to develop accurate, consumer friendly marketing information that will assist beneficiaries in making informed health care choices.

This chapter is organized as follows:

Section 20 -- guidance on the marketing review process

Section 30 -- guidelines for advertising and other pre-enrollment materials

Section 40 -- guidelines for post-enrollment (beneficiary notification) materials

Section 50 -- guidelines on promotional activities, including health fairs and sales presentations

Section 60 -- guidelines for other marketing activities, such as marketing value added items and services and multiple lines of business

Marketing materials, in general, are informational materials targeted to Medicare beneficiaries that promote the *Medicare* health plan or any plan offered by the *Medicare* health plan, or communicate or explain a *Medicare health plan*.<sup>2</sup> (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. *Press releases are not considered to be marketing material; however, the CMS does require that one disclaimer be used on press releases during certain times of the year. This requirement is discussed in §30.1.A, Item # 7.*

*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 organization or explain benefits, then they are considered marketing materials and must be approved before use. If there is any commercial message or beneficiary notification information in a health education piece, it must be reviewed by CMS.*

**NOTE:** The 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 *Medicare* health plan marketing activity on the Internet. The CMS marketing review authority extends to all marketing activity (both advertising, pre-enrollment, and post-enrollment activity) the *Medicare* health plan pursues via the Internet. The specific requirements that apply depend on the type of material. For

example, the advertising guidelines in [§30.1](#) would apply to postings on the Internet that fall within the definition of advertising.

The following are requirements regarding the establishment of a name for a M+C plan:

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, 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, the CMS will allow the “grandfathering” of M+C plan names established before the final rule took effect (i.e., before June 29, 2000).
2. 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.”
3. *M+C organizations can use the term “Medicare” or the term “Advantage” in their plan names. Furthermore, all plans in existence as of January 1, 2004, who had the name “Medicare Advantage” may continue to use that name indefinitely. However, new plans are not allowed to do business under the name “Medicare Advantage.”*

*If an organization chooses to retain the Medicare Advantage plan name it must insert the company name before “Medicare Advantage” (i.e., Acme Medicare Advantage plan) beginning with all 2005 plan year materials. This will help prevent any confusion with the national Medicare Advantage program.*

## **10.1 - HIPAA Considerations**

***(Rev. 60, Issued 08-08-04, Effective: August 08, 2004/Implementation: N/A)***

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 <http://www.hhs.gov/ocr/hipaa/>.



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## 20.3 – Streamlined Marketing Review Process

*(Rev. 60, Issued 08-08-04, Effective: August 08, 2004/Implementation: N/A)*

The CMS offers a streamlined marketing review process to M+C organizations and demonstrations for certain marketing materials in order to ensure that the materials can be available to Medicare beneficiaries in time to make decisions about their health insurance coverage. In particular, the streamlined marketing review process only applies to marketing materials developed for the Fall campaign (i.e., the Annual Notice of Change (ANOC), the Summary of Benefits (SB), and materials necessary to develop an annual enrollment period marketing package in the Fall to encourage members to join the plan) and marketing materials developed to notify members of any mid-year benefit enhancements.

An organization may choose one of two ways to have materials reviewed and approved under the streamlined process.

**Option 1: M+C organizations can obtain approval of their plan marketing materials based on submitted ACRPs.**

Under this option the CMS RO will review the materials based on the submitted (i.e., not yet approved) ACRP information. *The organization must submit all sections of the SB for review.*

*Under this option, if the organization resubmits an ACRP that includes changes/corrections that affect marketing materials that are still under review by CMS, the organization must re-submit the material to CMS containing the changes/corrections.*

**Option 2: An M+C organization can submit materials without cost sharing/benefit information contained in the “template” material.**

Under this option the RO will review the template and the organization will be responsible for inserting the accurate cost sharing/benefit information after approval is received. *Under this option, the organization need only submit section 3 of the SB for review and approval.*

*If the template the organization sends to the RO will vary in any way, it must describe those variations to the RO when submitting it for review (for example, if the provider directory template will be broken down into sub-versions for larger counties or will differ for plans with hospital tiering, the organization must alert the RO to this fact).*

Organizations can submit the *template* marketing materials for review before the date that M+C organizations may submit ACRPs to CMS, since these materials would not contain the ACRP information.

Regardless of which option is chosen, keep in mind the following:

- The organization must use the “pending Federal approval” disclaimer on the materials until the ACR is approved by CMS. Once the ACR is approved, the M+C organization must remove the disclaimer.
- If the organization resubmits an ACRP that includes changes/corrections that affect marketing materials already approved (*or under review, for organizations following option #2*), the organization is responsible for correcting all marketing materials to reflect these ACRP changes. The material does not need another approval by CMS.
- Any organization that uses marketing materials containing errors (e.g., the benefit or cost sharing information differs from that in the approved ACRP) will be required to correct those materials for prospective members and send errata sheets/addenda to current members before January 1. The CMS will conduct a retrospective review of a sample of M+C plan materials and will notify the organization if corrections are necessary. The M+C organization will be expected to conduct a self review of all other marketing materials for plans not included in the sample and to issue CMS-approved correction notices as necessary.

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## ***20.5 – File & Use***

***(Rev. 60, Issued 08-08-04, Effective: August 08, 2004/Implementation: N/A)***

*The File & Use program is designed to streamline the marketing review process. Under this process, organizations that can demonstrate to CMS that they can continually meet a particular standard of performance will be able to publish and distribute certain marketing materials without prior CMS approval.*

### ***File & Use Policies and Procedures***

*Either the parent company (which could be a multi-site organization but is not always a multi-site organization) or the contracting entity can request that the RO grant File & Use status to the contracting entity. File & Use status is given to and maintained by a contracting entity (i.e., also known as the “organization,” this is the entity that is granted a single H #). All plans (PBPs) within a single H # will be a part of the File & Use program once the single H # is on File & Use status. Individual contracting entities can maintain this status even if other entities in the parent company do not. For example, if a parent company operates in a number of different states (i.e., has several different H #s),*

*and File & Use status is given to only a subsidiary operating in one state, that subsidiary organization may maintain its File & Use status, even if the subsidiaries in other states do not.*

*The CMS RO that is the lead for that multi-region company maintains File & Use status for that multi-region company. If File & Use status is granted to a multi-region company, it means that the lead Regional Office (i.e., the “multi-region team lead”) has granted File & Use privileges to all **national** materials developed by the multi-region company. The local Regional Office must still review local materials, unless the local contracting entity has been granted File & Use status by the local Regional Office.*

*Some organizations use many non-English marketing materials. Once a contracting entity is granted File & Use status, both the English and the non-English materials are included within the File & Use program. See §60.4.1 for detail in review of marketing materials in non-English or Braille.*

- **Eligible Material:** *All advertising and pre-enrollment materials used to market the health plan to potential enrollees through a format of general circulation, all enrollment and disenrollment letters, and any post-enrollment materials that do **not** describe benefits and/or cost sharing and/or plan rules.*

*Materials that are **not** eligible for the File & Use program are materials that CMS believes pose greater risk to a Medicare beneficiary if they are inaccurate in any way. These are post-enrollment materials (beneficiary notification materials) that describe benefits and/or cost sharing and/or plan rules and enrollment and disenrollment forms. These include materials such as the Evidence of Coverage, Summary of Benefits, and other member notices (such as the Annual Notice of Change, provider termination notices, claims denial notices, etc.).*

- **Acceptable Material:** *All material that is not materially inaccurate or misleading or otherwise makes a material misrepresentation, which means that the material follows the guidelines delineated in Chapter 3 of the Medicare Managed Care Manual. It also means that, as submitted, the materials do not need to be changed to avoid adverse impact on a beneficiary’s decision to elect the plan or to disenroll and/or to avoid leading a member to believe that he/she could not get coverage for a covered service.*

*Examples of changes that would result in a material being **unacceptable** include failing to include a disclaimer that a particular benefit is not available to everyone or providing inaccurate premium or benefit information.*

*Example of changes that would not cause a material to be **unacceptable** (i.e., it would still be “acceptable”) might be to not adhere to font-size requirements for an ad or to provide incorrect dates or times for a sales presentation. Keep in mind that persistent errors in sales presentation dates or persistent failure to adhere to*

*font size requirements could cause CMS to begin considering an organization's materials to be unacceptable.*

### ***Eligibility for the File & Use Program***

*The File & Use status is only granted on a calendar quarter basis (i.e., January 1, April 1, July 1, or October 1).*

*Organizations that use the File & Use program are agreeing to retract and revise any materials that are later determined by CMS to be misleading or inaccurate, or do not follow the guidelines outlined in this chapter.*

*To become eligible for or to stay on the File & Use program, an organization must meet the following criteria.*

### ***How to Attain File & Use Status***

*The organization must request in writing to the Regional Office to be on File & Use no later than 30 days prior to each calendar quarter.*

*The CMS RO will select a random sample of eligible materials that the organization submitted to the RO for review over the prior 6 months. In the case where zero material is found during prior 6 months, the CMS RO will go back further to an additional 3 months to review the materials.*

*Ninety (90) percent of these materials must be "acceptable," according to File & Use criteria. This means that while the materials were pre-approved by the RO, they would have met the definition of "acceptable" even if the RO had not reviewed them.*

*The contracting entity (i.e., the H#) must have been in the Medicare program for at least the last 18 months. One exception to this 18-month rule is if the parent company has been in the program for over 18 months, and the parent company requests that the contracting entity be given File & Use status even though the H# has not been in the Medicare program for 18 months.*

*The CMS RO Branch Chief will notify the organization of the Region's decision in writing 7 days prior to next the calendar quarter.*

*If the organization disagrees with the RO's decision, it can notify the National File & Use Coordinator of its disagreement. The National File & Use Coordinator and the Marketing Product Consistency Team (PCT) will review the decision made by the Regional Office and notify the organization in writing if the decision is upheld or overturned.*

## ***How to Maintain File & Use Status***

*Once an organization is on the File & Use program, it must do the following to maintain that status:*

- The ninety (90) percent of eligible materials used under the File & Use program during the preceding calendar quarter must be "Acceptable" per File & Use criteria (as determined by the Regional Office). The RO will conduct quarterly reviews of random sample of materials filed under the File & Use program to determine whether the materials meet this performance standard. In markets where foreign language marketing materials are used, the CMS RO may select such pieces in the sample that will be reviewed;*
- The organization must follow the procedures outlined in the section below entitled "Procedures to Follow When using File & Use"; and*
- The organization must continue to submit to CMS materials that are not eligible for the File & Use program in accordance with the requirements outlined in this chapter. (For clarification, see the definition of "Eligible Material" above.)*

### ***Procedures to Follow When Using File & Use***

*The organization must provide CMS with copies of all final materials within **5 calendar days prior** to their distribution. The "final" materials are the copies that will be sent to the printer, or the comparable copies that are provided for reproduction.*

*All organizations must specify the expected date of initial distribution or publication when filing materials with CMS.*

*All organizations must clearly indicate on the front cover of the Marketing Material Transmittal sheet that the material is being filed as a "File & Use" material.*

*Upon receipt of the materials, CMS will log them into the Marketing Module of the Health Plan Management System.*

*Organizations that have File & Use privileges may still submit using the standard procedure for prior approval any eligible materials with respect to which they would like guidance from CMS. This may prevent an organization from losing File & Use privileges.*

*If the organization submits materials under the File & Use program, but later decides it does not want to use the materials, it must notify the RO in writing that it no longer intends to use them. This is to ensure that the RO does not review those materials as part of the random sample reviewed during the quarterly review.*

### ***Loss of File & Use Status***

*An organization may lose File & Use status if it uses materials that do not meet the definition of “Acceptable” and/or, fails to file two or more materials at least 5 calendar days prior to distribution or publication.*

*The RO will notify the organization in writing if it is in danger of losing File & Use status. This notice will indicate that the organization has been placed on a probationary review period and will delineate the length of the probationary period. The length of the probationary period will be determined by the RO on a case-by-case basis, depending on the type and impact of errors identified in marketing materials, but generally will last no less than 1 month and no more than one calendar quarter in length.*

*During the probationary period, the RO will conduct an increased level of spot checks of marketing materials used under the File & Use process. In the middle of the probationary period, the RO will provide written notice to the organization indicating whether it has seen improvement during the spot checks of marketing materials, or if the organization is still in danger of losing File & Use status. At the end of the probationary period, the RO will notify the organization in writing regarding whether or not the organization may continue with File & Use status. If the determination is to terminate File & Use status, this notice will provide the organization with a 10-day advance notice of the termination.*

*The termination of File & Use status does not mean that an organization may never again obtain File & Use status. If CMS terminates an organization’s File & Use status, the organization may request to get back on File & Use once at least two calendar quarters have passed since its status was terminated. If an organization loses File & Use status twice, it may not request to get back on File & Use status for at least 1 year after the status was terminated the second time.*

## **30 - Guidelines for Advertising and Pre-Enrollment Materials**

***(Rev. 60, Issued 08-08-04, Effective: August 08, 2004/Implementation: N/A)***

The guidelines in this section apply to all advertising and pre-enrollment materials. The section is divided into *three* subsections:

30.1 -- provides guidelines on advertising materials

30.2 -- provides guidelines on pre-enrollment materials

30.3 -- provides the “Must Use/Can’t Use” chart

Guidelines for post-enrollment materials (beneficiary notification materials -- member handbooks, member letters, etc.) are addressed in [§40.1](#).

*Medicare* health plans may market plans directly to beneficiaries of former Medicare plans that have chosen not to renew their contracts as long as the marketing does not begin until after the date the beneficiary has received the plan termination letter. Some disclosures are required on pre-enrollment materials – refer to [§30.2.A, Item #8](#).

*No Medicare health plan may compare itself to another Medicare health plan by name in either advertising or post-enrollment materials.*

### **30.1 - Guidelines for Advertising Materials**

*(Rev. 60, Issued 08-08-04, Effective: August 08, 2004/Implementation: N/A)*

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

- Television ads;
- Radio ads;
- Banner/banner-like ads;
- Outdoor advertising;
- Direct mail *(as long as it does not include the enrollment form)*;
- Print ads (newspaper, magazine, flyers, etc.); and
- Internet advertising.

This section outlines requirements for these types of advertisements.

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

- **Outdoor Advertising (ODA):** ODA is marketing material intended to capture the quick attention of a mobile audience passing the outdoor display (e.g., billboards, signs attached to transportation vehicles, etc.). ODA is designed to catch the attention of a person and influence them to call for detailed information on the product being advertised.
- **Banner Advertisements:** “Banner” advertisements are typically used in television ads, and flash information quickly across a screen with the sole purpose of enticing a prospective enrollee to call the organization for more information. This type of ad does not contain benefit or cost sharing information.

- **Banner-like Advertisements:** A “banner-like” advertisement can be ODA and is usually in some media other than television, is intended to very brief and to entice someone to call the organization or to alert someone that information is forthcoming and, like a banner ad, does not contain benefit or cost sharing information.

The following guidelines apply to advertisements:

## A. Language Requirements

### 1. Disclaimers/Disclosures:

- a. For banner ads, banner-like ads and ODA, *Medicare* health plans are not required to include **any** disclaimers or disclosures (e.g., lock-in and premium information) on the ads.
- b. For all other advertising materials not listed in a. above, *Medicare* health plans must include the statement that the organization contracts with the Federal government. Refer to the “Must Use/Can’t Use/Can Use” chart in [§30.3](#) for statements the organization may use.

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

- c. In addition to the disclaimers required in b. above, flyers and invitations to sales presentations that are used to invite beneficiaries to attend a group session with the intent of enrolling those individuals attending must also include the following two statements:
  - “A sales representative will be present with information and applications.”
  - “For accommodation of persons with special needs at sales meetings, call [insert phone number].”

2. **Hours of Operation:** *Medicare* health plans must list the hours of operation for customer services and other health plan services anywhere that these phone numbers are provided. *This includes listing the hours of operation for 1-800-MEDICARE any time the organization lists the 1-800-MEDICARE number (24 hours a day/7 days a week).* This requirement does not apply to any numbers included on advertising materials for persons to call for more information.



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

**Exceptions:**

- TTY numbers need not be included on ODA and banner/banner-like ads or in radio ads that include a telephone number.
  - With respect to television ads, the TTY number need not be the same font size/style as other phone numbers since it may result in confusion and cause some prospective enrollees to call the wrong phone number. Instead, *Medicare* health plans are allowed to use various techniques to sharpen the differences between TTY and other phone numbers on a television ad (such as using a smaller font size for the TTY number than for the other phone numbers).
4. **Reference to Studies or Statistical Data:** *Medicare* health plans may refer to results of studies or statistical data in relation to customer satisfaction, quality, cost, etc. as long as specific study details are given. At a minimum, study details that need to be included are the source and dates. (NOTE: When submitting the material to CMS for review, *unless the study that is referenced is a CMS study [such as CAHPS]*, the organization must provide the study sample size and number of plans surveyed for review purposes). *Medicare health plans* may not use study or statistical data to directly compare their plan to another. If *Medicare health plans* use study data that includes information on several other *Medicare health plans*, they will not be required to include data on all of the organizations included in the study. However, study details, such as the number of plans included, must be disclosed. Qualified superlatives (e.g., among the best, one of the highest ranked, etc.) may be used. Superlatives (e.g., ranked number one, etc.) may only be used if they are substantiated with supporting data.

5. **Physicians and Other Health Care Providers:**

- a. If the number of physicians and other health care providers is used in an ad, the ad must include only those physicians and providers available to Medicare beneficiaries. (Medicare cost plans may annotate in materials that members may obtain services from any Medicare provider).
- b. For print ads and direct mail materials:
  1. If a total number of physicians and providers is used in the ad, it must separately delineate the number of primary care providers and specialists included.

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

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

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

- **Mandatory Supplemental Benefits:** If a PPO offers benefits, including mandatory supplemental benefits (such as prescription drugs or dental services) that are limited to in-network providers and facilities, marketing materials that mention these benefits must state that not all benefits are available from non-preferred providers.
- **Cost Savings Described in Marketing Materials:** If a PPO states in marketing materials that prospective enrollees may save money if they join the plan, it must acknowledge the added cost of accessing services out-of-network and/or that using services in-network can cost less than using services out-of-network.

7. *Press Releases: As stated in §10, press releases are not marketing material. However, if an organization chooses to address any benefit, cost sharing or service area information in a press release before CMS has approved the benefits, cost sharing or service area, it must include the "pending Federal approval" disclaimer in the press release.*

## B. Formatting Requirements

1. **Font Size Rule:** With the exception listed below, for all written advertising materials footnotes must be the same size font as the *majority of the text of the advertisement*. The text size is left to the discretion of the organization and can be smaller than size 12-point font, but the *majority of the text of the advertisement* and footnotes must be the same size font.

### Exception:

- Information contained in brochures and direct mail pieces must be no smaller than Times New Roman 12-point or equivalent font. More detail on this requirement is contained in [§30.2](#).
- If an organization publishes a notice to close enrollment (as required in [Chapter 2](#)) in the Public Notices section of a newspaper, the organization

need not use 12-point font and can instead use the font normally used by the newspaper for its Public Notices section.

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

## 30.2 - Guidelines for Pre-Enrollment Materials

*(Rev. 60, Issued 08-08-04, Effective: August 08, 2004/Implementation: N/A)*

“Pre-enrollment” materials provide more detail on the plan (e.g., plan rules, plan benefits, etc.) than what is provided in an advertisement, *and generally are used by prospective enrollees to decide whether or not to enroll in a plan.* Pre-enrollment materials include both sales and enrollment materials, including the following types of materials:

- Product descriptions used in the sales/enrollment process -- enrollment booklets, sales kits, etc.;
- Sales scripts, sales presentations, etc.; and
- *Direct mail that includes an enrollment form.*

*At a minimum, prior to enrollment, prospective enrollees should receive information on lock-in/access requirements and a summary of benefits. However, it is preferable to provide more information to help a prospective enrollee make the choice to enroll in a plan.*

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

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

The following guidelines apply to pre-enrollment materials:

## A. Language Requirements

1. **Lock-In Statement/Access information:** *When appropriate for the plan, the concept of “lock-in” must be clearly explained in all pre-enrollment materials. For marketing pieces that tend to be of short duration we suggest: “You must receive all routine care from plan providers” or “You must use plan providers except in emergent care situations or for out-of-area urgent care/renal dialysis.” However, in all written materials used to make a sale, a more expanded version is suggested: “If you obtain routine care from out-of-plan providers neither Medicare nor [name of M+C organization] will be responsible for the costs.”*

*For PPOs, POS plans and, if appropriate, Visitors Programs for any plan type, explain that use of non-plan or non-preferred providers is allowed, but may cost more to the beneficiary.*

*For Medicare cost plans, enrollees must be informed that after enrollment is effective, in order for them to receive the full coverage offered, services other than emergency and urgently-needed services must be obtained through the HMO or CMP. In the case of cost enrollees, however, they may receive services that are not provided or arranged by their HMO or CMP, but they would be responsible for payment of all Medicare deductibles and coinsurance as well as any additional charges as prescribed by the Medicare program. They also would be liable for any charges not covered by the Medicare program.*

2. **Networks and Sub-networks:** All pre-enrollment marketing materials must clearly explain the concept of networks and sub-networks and the process for obtaining services, including referral requirements.
3. **Hours of Operation:** *Medicare* health plans must list the hours of operation for customer services and other health plan services anywhere that these phone numbers are provided. *This includes listing the hours of operation for 1-800-MEDICARE any time the organization lists the 1-800-MEDICARE number (24 hours a day/7 days a week).*
4. **Identification of All Plans in Materials:** Where M+C organizations may file separate/distinct Adjusted Community Rate (ACR) Proposals and the Plan Benefit Package (PBPs) cover the same service area (or portions of the same service area), there is no requirement that all plans be identified in all of the M+C organization’s marketing materials, although M+C organizations may identify or mention more than one plan in a single marketing piece at their discretion.
5. **Contracting Statement:** All pre-enrollment materials (and some other materials, as mentioned in [§§30.1](#) and [40](#)) must include a statement that the health

plan/M+C organization contracts with the Federal government. Refer to the Must Use/Can't Use/Can Use chart in [§30.3](#) for statements the organization may use.

6. **TTY Numbers:** TTY numbers must appear in conjunction with any other phone numbers in the same font size and style as the other phone numbers. The TTY number must also include the hours of operation, if they are for customer or health plan services. *Medicare* health plans can use either their own or State relay services, as long as the number is accessible from TTY equipment.
7. **Availability of Alternative Formats:** To ensure that beneficiaries have access to beneficiary education materials in alternative formats (e.g. Braille, foreign languages, audio tapes, large print), *Medicare* health plans must provide a disclosure on pre-enrollment materials indicating the document is available in alternative formats.
8. **Marketing plans to beneficiaries of non-renewing Medicare plans:** As stated in [§30](#), *Medicare* health plans may market plans directly to beneficiaries of former Medicare plans that have chosen not to renew their contracts as long as the marketing does not begin until after the date the beneficiary has received the plan termination letter. In addition to the targeted message, any pre-enrollment marketing pieces must contain a statement indicating that the *Medicare* health plan is open to all Medicare beneficiaries eligible by age or disability in the plan's service area.
9. **Preferred Provider Organizations (including PPO Demonstrations) Only:**
  - **Cost Savings Described in Marketing Materials:** If a PPO states in marketing materials that prospective enrollees may save money if they join the plan, it must also acknowledge the added cost of accessing services out-of-network and/or that using services in-network can cost less than using services out-of-network.
  - **Preferred and Non-Preferred Benefits:** If a PPO offers benefits for which the coinsurance is the same percentage both in and out of network, the PPO must make it clear in all pre-enrollment material that member responsibility may be greater out of network since the coinsurance is based on the Medicare allowed amount and not on the potentially lower contracted amount.

*Also, explain in pre-enrollment materials that with the exception of emergency or urgent care, it may cost more to get care from non-plan or non-preferred providers.*
  - **Mandatory Supplemental Benefits:** If a PPO offers benefits, including mandatory supplemental benefits (such as prescription drugs or dental services) that are limited to in-network providers and facilities, marketing

materials that mention these benefits must state that not all benefits are available from non-preferred providers.

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

**11. Benefit and Plan Premium Information:** Pre-enrollment materials that describe benefit and plan premium information must:

- Include the statement: “You must continue to pay your Medicare Part B premium” with premium information, even if the premium is \$0.
- When specifying benefits, specify annual limits (e.g., \$1,000 annual maximum for prescription drugs), annual benefit payout (e.g., \$700 for eyeglasses every 2 years) and applicable copayments (e.g., \$5 copayment for a doctor visit).
- Clearly state major exclusions and limitations. For example, restriction of pharmacy benefits to a specific formulary or a restricted set of pharmacies must be explained.
- Clearly state all monetary limits, as well as any restrictive policies that might impact a beneficiary’s access to drugs or services.
- When annual dollar amounts or limits are provided, also mention the applicable quarterly or monthly limits, and whether any unused portion of that benefit can be carried over from one calendar quarter to the next.
- Include a closing statement such as: “For full information on [organization name] (e.g., drugs, routine physical exam, eyeglasses, dental, etc.) benefits, call our Customer Service Department at [phone number]. Our office hours are [insert hours].”
- Cost contractors must describe their premiums and cost-sharing for services received through the HMO or CMP, and any optional supplemental benefit packages they offer. They must also indicate that

*premiums, cost-sharing, and optional supplemental benefits may change each year.*

- *Make the statement that the Medicare health plan's contract with CMS is renewed annually, and that the availability of coverage beyond the end of the current contract year is not guaranteed.*

## **B. Formatting Requirements**

1. **Font Size Rule for Member Materials:** Readability of written materials is crucial to informed choice for Medicare beneficiaries. All pre-enrollment materials that convey the rights and responsibilities of the *Medicare* health plan and the member must be printed with a 12-point font size or larger. Materials subject to this requirement include, but are not limited to enrollment and disenrollment forms and notices. The CMS is cognizant of the fact that, when actually measured, 12-point font size may vary among different fonts with the result that some font types may be smaller than others. Times New Roman font type is the standard by which font size is measured. Therefore, if *Medicare* health plans choose to use a different font type, it is their responsibility to ensure that the font used is equivalent to or larger than Times New Roman 12-point.
2. **Font Size Rule for Materials on the Internet:** Any pre-enrollment materials that a M+C organization places on its Web site need to be in a minimum 12-point Times New Roman-equivalent font. Neither CMS nor the *Medicare health plan* has any control over the actual screen size shown on individuals' computer screens that can be adjusted by the user. Therefore, the 12-point font requirement refers to how the *Medicare health plan* codes the font for the Web page, not how it actually looks on the user's screen.
3. **Font Size Rule for Footnotes and Subscripts:** The 12-point font size or larger rule described above also applies to any footnotes or subscript annotations in notices.
4. **Footnote Placement:** Medicare health plans must adopt a standard procedure for footnote placement. Footnotes should appear either at the end of the document or the bottom of each page and in the same place throughout the document. For example, the *Medicare health plan* cannot include a footnote at the bottom of page 2 and then reference this footnote on page 8; the footnote has to also appear at the bottom of page 8.

## **C. Submission and Review Requirements**

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

## D. Other Requirements

1. **Logos/Tag Lines:** The CMS recognizes the difference of purpose and intent between company logos/product tag lines and other advertising or marketing materials. The guidelines regarding the use of unsubstantiated statements that apply to advertising materials do not apply to logos/taglines. Contracting health plans may use unsubstantiated statements in their logos and in their product tag lines (e.g., “Your health is our major concern,” “Quality care is our pledge to you,” “First Care means quality care,” etc.). This latitude is allowed only in logo/product tag line language. Such unsubstantiated claims cannot be used in general advertising text regardless of the communication media employed to distribute the message. 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 more information on restrictions associated with the use of superlatives.

### ***30.3 - “Must Use/Can’t Use/Can Use” Chart***

***(Rev. 60, Issued 08-08-04, Effective: August 08, 2004/Implementation: N/A)***

The “Must Use/Can’t Use/Can Use” Chart provides guidance on language that *Medicare* health plans must use, can’t use, and can use in pre-enrollment materials and in post-enrollment materials (as addressed in [§40.1](#)). With the exception of the “Contract with the Government” topic contained in the Chart, the “Must Use” column does **not** apply to advertisements (as defined in [§30.1](#)). Only the “Can’t Use” and “Can Use” column applies to advertisements.

The Chart does not indicate when a particular topic must be included in marketing materials. Instead, it provides guidance on language use when the topic is included on a particular marketing piece. If a topic is required to be included in a marketing material, the requirement for its inclusion can be found in [§30.2](#) for pre-enrollment materials and [§40.1](#) for post-enrollment materials.

Although use of suggested “Can Use” language is not required, its use will expedite the review process. Please note that the specific language and format used in all standardized marketing materials like the standardized Summary of Benefits is required. Please also note that the language provided in the “Must Use” column of the “Must Use/Can’t Use/Can Use Chart” is required if the particular topic is being addressed in a pre- or post-enrollment marketing material.

Some phrases in this document may not apply to your 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 organization.



## “Must Use/Can’t Use/Can Use” Chart

The following chart provides guidance on language that M+C organizations must use, can’t use, and can use in pre-enrollment materials and in post-enrollment materials. With the exception of the “Contract with the Government” topic contained in the Chart, the “Must Use” column does **not** apply to advertisements (as defined in [§30.1](#)). Only the “Can’t Use” and “Can Use” column applies to advertisements.

This Chart does not indicate when a particular topic must be included in marketing materials. Instead, it provides guidance on language use when the topic is included on a particular marketing piece. If a topic is required to be included in a marketing material, the requirement for its inclusion can be found in [§30.2](#) for pre-enrollment materials and [§40.1](#) for post-enrollment materials.

The use of any language found in the “Can Use” column is discretionary.

Subject	Must Use	Can’t Use	Can Use	Reason
Lock-In	<ul style="list-style-type: none"> <li>- Enrolled members “must use (name of plan/ organization) (contracting, <i>plan</i>, affiliated, or name of plan organization participating) providers for routine care”</li> <li>- “<i>A</i>vailable to all Medicare beneficiaries”</li> <li>- For Medicare cost plans, all pre-enrollment materials must clearly explain that members may use plan and non-plan providers, and also explain the benefit/cost sharing differentials between use of plan and non-plan providers.</li> </ul> <p>This information may be either in the text of the piece or in a disclaimer at the end/bottom of the piece</p>	<ul style="list-style-type: none"> <li>- The term “Participating Providers”</li> </ul>		

Subject	Must Use	Can't Use	Can Use	Reason
<p>Descriptions of the <i>Medicare health plan's</i> Quality <sup>6</sup></p>		<ul style="list-style-type: none"> <li>- Superlatives (e.g., highest, best)<sup>7</sup></li> <li>- Unsubstantiated comparisons with other <i>Medicare health plans</i></li> <li>- Direct negative statements about other <i>Medicare health plans</i> including individual statements from members or former members</li> </ul>	<ul style="list-style-type: none"> <li>- Qualified superlatives (e.g., among the best, some of the highest)</li> <li>- Superlatives (e.g., ranked number 1, if they can be substantiated by ratings, studies or statistics (Source must be identified in the advertising piece.) See §30 for more information.</li> <li>- “[<i>Name of plan/organization</i>] delivers (adjective) quality of care”</li> <li>- Can use satisfaction survey results, e.g., “The (name of specific study) indicated we rated highest in member satisfaction.” (Must disclose year and source.) See §30 for more information.</li> <li>- M+C organizations may use CAHPS survey data regarding their own organization but may not use it to make specific comparisons to other M+C organizations.</li> </ul>	
<p>Premium Costs</p>	<ul style="list-style-type: none"> <li>- If a <i>Medicare</i> health plan premium is mentioned, it must be accompanied by a statement that beneficiaries must continue to pay Part B premium or Medicare premium.</li> <li>- If an annual dollar amount/limit is mentioned, quarterly or monthly limits must also be mentioned as</li> </ul>	<ul style="list-style-type: none"> <li>- “No premium”</li> <li>- “No premium or deductible”</li> <li>- “Free”</li> </ul>	<p>The following may be used:</p> <ul style="list-style-type: none"> <li>- “No plan premium”</li> <li>- “<i>Plan</i> premium equals _____”</li> <li>- “\$0 plan premium”</li> <li>- “At no extra cost to you” but only if referring to a specific</li> </ul>	

Subject	Must Use	Can't Use	Can Use	Reason
	<p>well as any ability to carry over any remaining benefit from quarter to quarter.</p>		<p>benefit</p> <ul style="list-style-type: none"> <li>- “No <i>plan</i> premium or deductibles”</li> <li>- “No <i>plan</i> premium or deductibles (you must continue to pay the Medicare Part B premium”</li> <li>- “No <i>plan</i> premium beyond your monthly Medicare payment”</li> <li>- “No <i>plan</i> premium other than what you currently pay for Medicare”</li> </ul>	
<p>Testimonials</p>	<ul style="list-style-type: none"> <li>- Content must comply with CMS marketing guidelines, including statements by members.</li> <li>- Speaker must identify specific <i>Medicare</i> health plan membership.</li> </ul>	<ul style="list-style-type: none"> <li>- Cannot have non-members say he/she belongs. (Can use actors, but they cannot say they belong to the <i>Medicare</i> health plan.)</li> <li>- <i>Medicare health plans</i> cannot use negative testimonials about other plans from members or ex-members.</li> </ul>		

Subject	Must Use	Can't Use	Can Use	Reason
<p>Contract with the Government</p>	<p>With the exception of outdoor advertisements and banner/banner-like ads, <i>the SB, EOC, Member Handbook and</i> all other advertisements and all pre-enrollment materials <b>must</b> include this disclaimer.</p> <p>This information may be either in the text of the piece or in a disclosure paragraph at the end/bottom of the piece.</p> <ul style="list-style-type: none"> <li>- “A/An [insert plan type: HMO, PPO, POS plan, PSO, etc.] with a Medicare contract”</li> <li>- “An M+C organization with a Medicare contract”</li> <li>- “A Health Plan with a Medicare contract”</li> <li>- “A Federally Qualified HMO with a Medicare contract”</li> <li>- “A Federally Qualified Medicare contracting HMO”</li> <li>- “Medicare approved [insert plan type: HMO, PPO, POS plan, PSO etc.]”</li> <li>- “A Coordinated Care Plan with an Medicare+Choice contract”</li> </ul>	<ul style="list-style-type: none"> <li>- “Recommended or endorsed by Medicare”</li> <li>- Cannot imply that <i>Medicare</i> health plan has a unique or custom arrangement with the government, e.g.: <ul style="list-style-type: none"> <li>-- “Special contract with Medicare”</li> <li>--”Special <i>Medicare</i> health plan for Medicare beneficiaries”</li> </ul> </li> </ul>		
<p>Physicians and Other Health Care Providers</p>	<ul style="list-style-type: none"> <li>- If the number of physicians and other health care providers is used, it must include only providers available to Medicare beneficiaries.</li> <li>- If a total number of physicians and providers is used it must</li> </ul>	<ul style="list-style-type: none"> <li>- Implication that providers are available exclusively through the particular HMO unless such a statement is true</li> <li>- “Participating providers”</li> </ul>	<ul style="list-style-type: none"> <li>- “(<i>Medicare</i> health plan’s name) participating providers”</li> <li>- “Plan” providers</li> <li>- “Network” providers</li> </ul>	<p>Do not use the word “participating” when referring to <i>Medicare</i> health plan providers (unless you use <i>Medicare</i> health plan name), since it could be confused with a participation</p>

Subject	Must Use	Can't Use	Can Use	Reason
	<p>separately delineate the number of primary care providers and specialists included.</p> <p>- If the <i>Medicare health plan</i> uses the name and/or picture of providers and/or facilities to market itself, the provider information may only be used within the context of informing beneficiaries of providers that are associated with the organization's delivery system.</p>	<p>unless you use <i>Medicare</i> health plan name</p> <p>- The M+C organization may not identify itself by the name of a participating provider or provider group, with the exception of a PSO.</p>	<p>- "Contracting" providers</p> <p>- "Affiliated" providers</p> <p>- Number of providers should be same total number of Medicare providers</p>	<p>agreement with Medicare. Organizations should either use "contracting" or "<i>Medicare</i> health plan name" when referring to <i>Medicare</i> health plan providers.</p> <p>It must be clear to the beneficiary with whom the contract with CMS is held.</p>
Eligibility	<p>- Must indicate that beneficiaries must be entitled to Part A and enrolled in B</p> <p>For M+C plans-- Must indicate that all Medicare beneficiaries with Parts A and B of Medicare may apply</p> <p>For §1876 cost contracting health plans:</p> <p>-- Must indicate that all Medicare beneficiaries may apply</p> <p>This information may be either in the text of the piece or in a disclosure paragraph at the end/bottom of the piece.</p>	<p>"No health screening" unless specific mention is made of ESRD</p> <p>"Seniors" unless term appears with "and all other Medicare eligibles"</p> <p>"[Name of Medicare Health plan] designed especially for seniors"</p> <p>"Senior Medicare health plan" unless part of <i>Medicare</i> health plan name</p> <p>"Individuals age 65 and over"</p>	<p>- "Anyone with Medicare may apply"</p> <p>- "Medicare entitled by age or disability"</p> <p>- "Individuals eligible for Medicare by age or disability"</p> <p>- "Individuals on or entitled to Medicare by age or disability"</p> <p>- "Medicare beneficiaries"</p> <p>- "Medicare enrollees"</p> <p>- "People with or on Medicare"</p> <p>- "No physicals required"</p> <p>- "No health screening" if a caveat is included for ESRD</p> <p>- "Grandfathered enrollees"</p>	<p>Since all Medicare beneficiaries may enroll in Medicare-cost contracting HMOs, you may not refer to your <i>plan</i> as a "senior <i>Medicare</i> health plan" (unless you refer to it as part of the health plan name). The term "senior <i>Medicare</i> health plan" implies that disabled beneficiaries may not enroll.</p> <p>Medicare Part A is not a requirement for enrollment in Medicare-cost contracting HMOs. M+C organizations may only enroll individuals with both Parts A and B of Medicare, with the exception of "grandfathered" members.</p>

Subject	Must Use	Can't Use	Can Use	Reason
Claims Forms / Paperwork		<p>“No paperwork”</p> <p>“No claims or paperwork/complicated paperwork”</p> <p>No claims forms”</p>	<p>“Virtually no paperwork”</p> <p>“No paperwork when using <i>Medicare</i> health plan providers”</p> <p>“Hardly any paperwork”</p>	Members may be required to submit bills or claims documentation when using out-of-plan providers.
Benefits: a) Comparison	<p>- If premiums and benefits vary by geographic area, must clearly state this or must clearly state geographic area in which differing premiums and benefits are applicable.</p> <p>- If only benefits vary, clearly state geographic area in which benefits are applicable.</p>	<p>- Minimal co-pays may vary by county</p> <p>- Minimal co-pays may apply</p>	<p>- “Premiums and benefits may vary by county [and plan]” or “These benefits apply to the following counties”*</p> <p>- “Except for _____ county”*</p> <p>- <i>Medicare health plans</i> may compare benefits to Medigap plans as long as information is provided accurately and in detail.</p>	Premiums, benefits, and/or copayment amounts may vary by county within a given service area.
Benefits: b) Limitations		- “At no extra cost to you” or “free” if co-pays apply	<p>- State exact dollar amount limit on any benefit</p> <p>- “Limitations and restrictions may apply”</p> <p>- “Minimal copayments will apply”</p> <p>- “Minimal copayments vary by county”*</p> <p>- State which benefits are subject to limitations</p>	If benefits are specified within the piece, any applicable copayment should be stated or you may include the general statement as shown.

Subject	Must Use	Can't Use	Can Use	Reason
<p>Benefits:</p> <p>c) Prescription Drugs</p>	<ul style="list-style-type: none"> <li>- If prescription drugs are mentioned and have limitations, must say:</li> <li>- Limited outpatient drug coverage; or,</li> <li>- Drug coverage benefits subject to limitations; or</li> <li>- Up to xxx annual/ quarterly/ monthly limit or xxx limit per year/quarter/month and other limits and restrictions may apply.</li> <li>- Copayment amounts and indicate for a xx number of days supply</li> <li>- If benefits are restricted to a formulary, this must be clearly stated. - In addition, must state:</li> <li>- That formulary contents are subject to change within a contract year without advance notice</li> <li>- <i>Medicare health</i> plan should be contacted for additional details.</li> </ul>	<ul style="list-style-type: none"> <li>- “We cover prescription drugs” unless accompanied by reference to limitation</li> <li>- “Prescription drug coverage” unless accompanied by reference to limitation</li> </ul>	<ul style="list-style-type: none"> <li>- Fully disclose dollar amount of copayments and annual/quarterly/monthly limit</li> <li>- If limited, you must say so</li> <li>- Limited outpatient drug coverage with xx copayments for xx number of days supply and xxx annual/quarterly/monthly limit</li> <li>- “Prescriptions must be filled at contracting or <i>Medicare</i> health plan affiliated pharmacies.”</li> </ul>	<p>Prescription drugs are an important benefit that must be adequately described. Any dollar limits must be clearly conveyed.</p>

Subject	Must Use	Can't Use	Can Use	Reason
Benefits: d) Multi-Year Benefits	- Whenever multi-year benefits are discussed, M+C organizations are required to make appropriate disclosure that the benefit may not be available in subsequent years.		- “[benefit] may not be available in subsequent years” OR - “[name of M+C organization] contracts with Medicare each year, this benefit may not may not be available next year”  - “At the end of each year, [name of organization] may leave the Medicare program or change plan benefits. However, new plans or benefits may also become available.”	Potential applicants and members must be informed that multi-year benefits in current year benefit packages are not guaranteed in future contract years.
- Definitions - Emergency and Urgently Needed Care		- “Life threatening” - “True emergency”	- Emergency - definition as stated in current CMS policy. - Urgent - definition as stated in current CMS policy.	Emergency and urgent care criteria should be explained per Medicare guidelines rather than in the commercial context.
Drawings / Prizes		- “Eligible for free drawing and prizes”	- “Eligible for a free drawing and prizes with no obligation”  - “Free drawing without obligation”	It is a prohibited marketing practice to use free gifts and prizes as an inducement to enroll. Any gratuity must be made available to all participants regardless of enrollment. The value of any gift must be less than the nominal amount of \$15.



Subject	Must Use	Can't Use	Can Use	Reason
Sales presentations	<p>- Indicate that a telecommunication device for the deaf (TTY) is available to get additional information or to set up a meeting with a sales representative.</p> <p>If mentioned in a response card where the beneficiary's phone number is requested:</p> <p>- "A sales representative may call."</p>	<p>- "A health plan representative will be available to answer questions."</p>	<p>"A telecommunications device for the deaf (TTY) is available to get additional information or set up a meeting with a sales representative."</p>	
Medicare + Choice Provider Sponsored Organizations		<p>- State licensed M+C organizations may 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.</p>	<ul style="list-style-type: none"> <li>- 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.</li> <li>- State licensed M+C organizations may identify themselves 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</li> </ul>	

<sup>6</sup> Note - CMS has the discretion to disapprove language based on site visit reviews identifying substantial deficiencies in *Medicare* health plan operations.

<sup>7</sup> Note - A member of the *organization* may use a superlative in relating their personal experience with the organization so long as the testimonial is preceded with the phrase “in my opinion” (e.g., “I have been with the *plan*/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.

## 40 - Guidelines for Post-Enrollment Materials

*(Rev. 60, Issued 08-08-04, Effective: August 08, 2004/Implementation: N/A)*

“Post-enrollment” materials are those materials used by *Medicare* health plans to convey benefit or plan operational information to enrolled beneficiary health plan members. Post-enrollment marketing materials includes all notification forms and letters and sections of newsletters that are used to enroll, disenroll, and communicate with the member on many different membership operational policies, rules and procedures. Post-enrollment marketing materials include, but are not limited to, the Annual Notice of Change, the Evidence of Coverage, the Provider Directory, and the Summary of Benefits. These materials are also called beneficiary notification materials and subject to additional CMS requirements.

This section is organized in several sub-sections:

40.1 -- provides guidelines on beneficiary notification materials

40.2 -- provides guidelines on provider directories

40.3 -- provides guidance on drug formularies

40.4 -- provides guidelines on outreach to dual eligible membership

40.5 -- provides guidance on the SB

*40.6 – provides guidance on the EOC*

Please note that *Medicare* health plans may not use Medicare member lists for non-plan-specific purposes. If an 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.

**NOTE:** The requirements outlined in the “Must Use/Can’t Use/Can Use” Chart contained in [§30.3](#) also apply to post-enrollment materials.

## 40.1 - General Guidance for Post-Enrollment Materials

*(Rev. 60, Issued 08-08-04, Effective: August 08, 2004/Implementation: N/A)*

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

### A. Language Requirements

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

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

2. **Networks and Sub-networks:** The SB, the EOC, Provider Directories and Member Handbooks must clearly explain the concept of networks and sub-networks and the process for obtaining services including referral requirements.
3. **Hours of Operation:** *Medicare* health plans must list the hours of operation for customer services and other health plan services anywhere that these phone numbers are provided. *This includes listing the hours of operation for 1-800-MEDICARE any time the organization lists the 1-800-MEDICARE number (24 hours a day/7 days a week).*
4. **Contracting Statement:** The SB, Member Handbooks, and the EOC must include a statement that the organization contracts with the Federal government. Refer to the Must Use/Can't Use/Can Use chart in [§30](#). for statements the organization may use. *All other post enrollment materials are not required to have this statement (i.e., it is optional).*
5. **TTY Numbers:** TTY numbers must appear in conjunction with any other phone numbers in the same font size and style as the other phone numbers. The TTY number must also include the hours of operation, if they are for customer or health plan services. *Medicare* health plans can use either their own or State relay services, as long as the number included is accessible from TTY equipment.
6. **Availability of Alternative Formats (EOC only):** To ensure that beneficiaries have access to beneficiary education materials in alternative formats (e.g. Braille, foreign languages, audio tapes, large print), *Medicare* health plans must provide a disclosure on the EOC indicating the document is available in alternative formats.
7. **Reference to Studies or Statistical Data:** *Medicare* Health plans may refer to results of studies or statistical data in relation to customer satisfaction, quality, cost, etc. as long as specific study details are given. At a minimum, study details

that need to be included are: source, dates, sample size, and number of plans surveyed. Organizations may not use study or statistical data to directly compare their plan to another. If *Medicare* health plans use study data that includes information on several other *Medicare* health plans, they will not be required to include data on all of the organizations included in the study. However, study details, such as the number of plans included, must be disclosed. Qualified superlatives (e.g., among the best, one of the highest ranked, etc.) may be used. Superlatives (e.g., ranked number one, etc.) may only be used if they are substantiated with supporting data.

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

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

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

- **Mandatory Supplemental Benefits:** If a PPO offers benefits, including mandatory supplemental benefits (such as prescription drugs or dental services) that are limited to in-network providers and facilities, marketing materials that mention these benefits must state that not all benefits are available from non-preferred providers. The EOC must specifically explain which benefits are offered at the non-preferred benefit level and any limitations that may apply.
- **Prior Notification/Authorization Requirements:** Some PPOs may require or request that members notify them prior to receiving certain services. In these cases, the organization must clearly define the requirement in marketing materials. It must also include the information in the PBP Notes section so that the appropriate language regarding the penalty may be used in marketing materials. If there is a penalty for not receiving prior referral/notification/authorization, marketing materials that mention these services must clearly describe the penalty.
- **Post-Stabilization (PPO Demonstrations Only):** In the EOC and the SB (Section 3), PPO Demonstrations must specify all cost sharing requirements with regard to emergency hospital admissions, including whether the in-network or out-of-network cost sharing is required for enrollees who are stabilized and receive post-stabilization care in a non-

preferred (out-of-network) hospital following an emergency situation. If the Demo includes a cap on enrollee out-of-pocket costs for such services, state the out-of-pocket maximum amount. In the EOC, clearly state any other requirements associated with an out-of-network emergency hospital admission, e.g., enrollee notification upon stabilization, policies with regard to transfers to network hospitals, etc.

## B. Formatting Requirements

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

### **Exception:**

- Due to the size of the member ID card, the member ID card need not have all information in a 12-point font size or larger.
2. **Font Size Rule for Internet Materials:** Unless an exception for font size is noted in #1 above, any post-enrollment materials that a *Medicare health plan* places on its Web site need to be in a minimum 12-point Times New Roman-equivalent font. Neither CMS nor organization has any control over the actual screen size shown on individuals' computer screens that can be adjusted by the user. Therefore, the 12-point font requirement refers to how the organization codes the font for the Web page, not how it actually looks on the user's screen.
  3. **Font Size Rule for Footnotes and Subscripts:** The 12-point font size or larger rule also applies to any footnotes or subscript annotations in post-enrollment notices.
  4. **Footnote Placement:** *Medicare* health plans must adopt a standard procedure for footnote placement. Footnotes should appear either at the end of the document or the bottom of each page and in the same place throughout the document. For example, the organization cannot include a footnote at the bottom of page 2 and then reference this footnote on page 8; the footnote has to also appear at the bottom of page 8.

## C. Other Requirements

1. **Option to Choose Media Type:** With respect to the SB, the EOC, and the Provider Directory, *Medicare* health plans 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.). *Medicare* health plans that choose this option must contact members in writing (e.g., by letter, postcard, newsletter article, etc.) to determine whether they would like to receive the SB, EOC, and/or the Provider Directory in another format. If the organization does not receive a response from the member, then the organization must assume that the member wants to receive the information in hardcopy.

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

The following would also apply:

- The member must receive the materials in the required time frames, regardless of the format.
- For the EOC and the SB, if the organization will be providing any of these marketing materials via an Internet Web page, then it must establish a process for informing members when that Web page has been updated. For example, the organization could notify members by newsletter article, by e-mail, by postcard, etc. Often any change in the EOC or SB is communicated to all members by newsletter and notification that the change has been made on the Web page could be made at the same time. This requirement does not apply to provider directories since provider directory updates can occur far more frequently than updates to the EOC or SB.
- The non-hardcopy format should match the approved hardcopy format, and if it does, it will not need additional CMS approval. If anything is added or deleted, the non-hardcopy format must receive separate CMS approval.

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

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## 40.2 - Specific Guidance About Provider Directories

*(Rev. 60, Issued 08-08-04, Effective: August 08, 2004/Implementation: N/A)*

*Regulations at 42 CFR 422.111(a) and (b) require that M+C organizations disclose the following information to each enrollee in clear, accurate, and standardized form at the time of enrollment and at least annually thereafter.<sup>9</sup> M+C organizations usually include this information in their provider directory. The directory is then given to new members upon enrollment and existing members on an annual basis.<sup>10</sup> Regulations at 42 CFR 417.436(a)(2) and (b) also require that Medicare cost plans send a provider directory to members at the time of enrollment and annually.*

*The directory must include:*

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.

In addition, provider directories should also contain the following *(this is optional)*:

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; <sup>11</sup>
6. *Instructions to enrollees that, in cases where non-contracting 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.*
7. *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;*

8. *Prior authorization rules and other review requirements that must be met in order to ensure payment for the services; and*
9. 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.

***PCP and Specialty Directories: Medicare health plans*** 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. 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. 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.

***Medicare health plans*** may 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.

***Mailing the Provider Directory to Addresses with Multiple Members:*** With respect to the annual mailing of the directory, ***Medicare*** health plans 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).

***Provider Directory Change Pages:*** With respect to those members who choose to receive a hard copy directory as opposed to an electronic copy, Medicare health plans have the option to mail a complete directory to members, or to instead mail only change pages to members. (Note that the CMS still requires that every member receive a complete directory at the time of enrollment.) In addition, if at any time a member requests a complete directory, the organization must comply with the request.

If an organization chooses to send change pages to members, the following will also apply:

- *In instances where significant changes to the provider network occur, the organization must send a special mailing of change pages immediately. In general, the organization can define “significant changes” when determining whether a special mailing is necessary. However, the CMS may also determine a mailing is needed and may direct the organization to conduct such a mailing.*
- *A new, complete provider directory must be mailed to all members at least every 3 years.*
- *Change pages may consist of the actual page being changed or a list of changes with referenced pages. Change pages must be dated.*
- *When sending out change pages, the organization must include a cover letter that explains that the member can receive a complete directory upon request. The organization should also include information on how to obtain provider network information on the Internet and/or by telephone. In addition, the first time the organization sends change pages the cover letter should explain that the organization will now be sending change pages to members, as opposed to a complete directory.*

Please also refer to [§40.1.C, Item #1](#), which contains more information regarding mailing of the Provider Directory.

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## **40.5.1 – Summary of Benefits for Medicare+Choice Organizations**

***(Rev. 60, Issued 08-08-04, Effective: August 08, 2004/Implementation: N/A)***

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

### **A. General Instructions**

1. M+C organizations must adhere to the language and format of the standardized SB and are only permitted to make changes if approved by CMS. Changes in the

language and format of the SB template will result in the disapproval or delayed approval of the SB.

2. The title “Summary of Benefits” must appear on the cover page of the document.
3. All three sections of the SB must be provided together as one document and may not be bound separately or placed in a folder in separate sections. M+C organizations may also describe several plans in the same SB package by displaying them in separate columns in the comparison matrix section of the SB.
4. Front and back cover pages are acceptable.
5. Printing font size of 12-point or larger must be used for the SB (including footnotes). **NOTE:** Since sections 1 and 2 will not be generated from the PBP in 12-point font, the M+C organization should change the font to ensure that the font size is 12 point. M+C organizations may enlarge the font size and also use bold or capitalized text to aid in readability, provided that these changes do not steer beneficiaries to, or away from any benefit items or interfere with the legibility of the document.
6. Colors and shading techniques, while permitted, must not direct a beneficiary to or away from any benefit items and must not interfere with the legibility of the document. There is no requirement regarding the type of paper used.
7. It is acceptable to print the SB in either portrait or landscape page format.
8. It is acceptable for M+C organizations with multiple plans and PBPs (separate ACRPs) to include more than one plan in the benefit comparison matrix (section 2). However, since the PBP will only print section 1 and 2 reports for one plan, the M+C organizations will have to create a side-by-side comparison matrix for two (or more) plans by manually combining the information into a chart format.
9. It is acceptable for M+C organizations to display more than one plan together in the same columns of the benefit comparison matrix, provided all of the benefits are the same and only the service areas are different. Plans may identify the service areas at the top of the plan column of section 2. **NOTE:** If anything beyond the service area is different, the plans must be displayed separately.
10. If the SB includes only one of several plans offered, the availability of other plans must be noted in the Annual Notice of Change (ANOC). If the M+C organization lists more than one plan offering, it is required to identify the specific plan in which the member is currently enrolled on the cover letter transmitting the SB.
11. If an M+C organization wants to include mandatory supplemental benefits beyond those benefits found in the benefit comparison matrix, the M+C organization must

place the information in section 3 of the SB. The M+C organization must include a brief description of the benefits and any copay requirements.

12. If an M+C organization includes additional information about covered benefits in section 3, the M+C organization may include a page reference to this information in the appropriate box in the benefit comparison matrix using the following sentence: “See page\_\_\_ for additional information about (Enter the benefit category exactly as it appears in the left column).”
13. M+C organizations may include additional information about covered benefits in a separate flyer or other material and mail this with the standardized SB and the Annual Notice of Change Letter.
14. Enrollees whose source of enrollment is through an employer-sponsored group are not currently included in the mandated use of the standardized SB for either annual notification or initial marketing purposes.

## **B. Section 1 - Beneficiary Information Section**

1. This section is incorporated into your SB exactly as it is generated by the PBP.  
**NOTE:** M+C organizations have the option of indicating at the top of this section a geographic name, for example, “Southern Florida.” If used, the geographic name must match the geographic label indicated in the Health Plan Management System (HPMS).
2. Section 1, as generated by the PBP, will include the applicable H number and plan number at the top of the document. M+C organizations must delete this information.
3. The fourth paragraph (How can I compare my options?) contains a sentence “We also offer additional benefits, which may change from year to year.” If this is not applicable to your plan, you must remove this sentence.
4. The second question and answer in section 1 includes the plan’s service area; the PBP will generate a list of counties, with an \* indicating those counties that are partial counties. The M+C organization may list the zip codes of these counties in this section or provide a cross-reference in section 3 and list the zip codes here. The M+C organization must also explain in section 1 that the \* indicates a partial county.
5. The second question and answer in section 1 lists the plan’s service area, but does not indicate that the information listed represents counties. Therefore, the M+C organization must amend the SB so that the answer reads, “The service area for this plan includes the following counties: [list of counties automatically generated by the PBP].”

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

### **C. Section 2 - Benefit Comparison Matrix**

The SB benefit comparison matrix will be generated by the PBP in chart format with the required language. Therefore, the information included in the PBP must first be correct in order for the SB comparison matrix to be correct. M+C organizations should review the comparison matrix to ensure that all of the information presented is correct. Information presented in the benefit comparison matrix must match the information presented in the PBP, with the exception of the permitted and/or necessary changes discussed below. If any changes are required, the M+C organization must make these changes in the PBP prior to the deadline date for submission of the ACRP, generate a revised SB benefit comparison matrix, and include this matrix in its SB.

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

### **D. Section 3 - Plan Specific Features**

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

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

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

M+C organizations may use this section to further describe mandatory and optional supplemental benefits that appear in the benefit comparison matrix. If an M+C organization chooses to do this, they may reference the information in the relevant

section of the benefit comparison matrix using the following sentence: “See page\_\_\_ for additional information about (Enter the benefit category exactly as it appears in the left column.)” *Section 3 is not intended to include a description of every plan benefit not included in Section 2 that has cost sharing associated with it.*

### **E. Permitted Changes To SB Language and Format**

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

### **F. Footnotes**

The comparison matrix generated by the PBP will contain the required footnotes in the benefit column for Original Medicare (OM). Therefore, the M+C organization must include the following footnotes provided below if they apply to the benefit. Please note that the footnote number must appear in the text of the column and the footnote must appear at the bottom of each page.

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

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

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

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

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

3. A benefit period begins the day you go to the hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital

deductible for each benefit period. There is no limit to the number of benefit periods you can have.

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

4. Lifetime reserve days can only be used once.

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

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### **40.5.3 - Requests to Change Hard Copy Summary of Benefits**

*(Rev. 60, Issued 08-08-04, Effective: August 08, 2004/Implementation: N/A)*

The CMS *will* allow *an organization to make changes to hard copy SBs* on a very limited basis. *The organization must receive approval from the CMS Central Office prior to making any changes.* Any approved changes will NOT result in changes in Medicare Personal Plan Finder, nor will they result in changes to the Plan Benefit Package. However, requests may be considered for future changes to the Plan Benefit Package.

#### **What types of Changes will be Permitted?**

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

#### **What types of Changes will NOT be Permitted?**

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

## **How to request a change?**

To request a change to the hard copy SB, e-mail your request to [Summary of Benefits@cms.hhs.gov](mailto:Summary_of_Benefits@cms.hhs.gov). The subject line in the request must read: “Hard Copy SB Change Request.” In the request, provide:

1. The H number and Plan ID—each H number and Plan ID should be in a separate e-mail;
2. The Regional Office and Contact who review the MCO marketing material;
3. The existing standardized Summary of Benefits language;
4. An explanation of why the existing standardized language is inaccurate; and
5. A modified sentence.

## **How will CMS review the requests?**

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

## ***40.6 – Specific Guidance on the Evidence of Coverage***

***(Rev. 60, Issued 08-08-04, Effective: August 08, 2004/Implementation: N/A)***

*All organizations are required to give an EOC to all members annually. They must also send new members an EOC no later than when they notify the member of acceptance (confirmation) of enrollment (the time frame requirements for sending notice of acceptance of enrollment are contained in [Chapter 2, §40.4.2](#)). These requirements apply to all plan members, including employer group members. CMS provides a model EOC for HMOs, PPOs, and Medicare cost plans under separate cover.*

*In addition to the guidance provided in [§§40.1](#) and [40.3](#), the following information must be contained in the EOC:*



## ***Lock-In Requirements/Selecting a Primary Care Physician - How to Access Care in the Plan***

*Medicare health plans must describe rules for receipt of primary care, specialty care, hospital care, and other medical services in their EOC. The EOC must:*

- Disclose specific rules for referrals for follow-up specialty care;*
- HMOs: Explain that when a beneficiary enrolls in a plan, he/she agrees to use the network of physicians, hospitals, and providers that are affiliated with the plan for all health care services, except emergencies, urgently needed care, or out-of-area renal dialysis services;*
- Explain that use of non-plan or non-preferred providers is allowed, but may cost more to the beneficiary (this requirements applies to PPOs and POS plans and, if appropriate, Visitors Programs for any plan type);*
- Explain the impact of using the Medicare card for out-of-plan utilization that is not an emergency or urgent care;*
- Explain that a plan member selects a primary care physician (PCP) to coordinate all of the member's care. A PCP is usually a family practitioner, general practitioner, or internist. The PCP knows the plan's network and can guide the member to plan specialists when needed. The member always has the option to change to a different PCP. Changes in PCP will be effective according to the plan guidelines that, in some instances, could be the first or the 15th day of the following month as opposed to immediately. (This requirement does not apply to PPOs or PFFS plans that do not use PCPs.);*
- For HMOs, explain that neither the M+C organization nor Medicare will pay for medical services that the member receives outside of the network unless it was authorized, or it is an emergency, urgently needed care, or out-of-area dialysis service. The member may be responsible for paying the bill;*
- For PPOs, explain that with the exception of emergency or urgent care, it may cost more to get care from non-plan or non-preferred providers;*
- Explain prior authorization rules for any in or out-of-network services and describe other review requirements that must be met in order to ensure payment for the services; and*
- For Medicare cost plans, enrollees must be informed that after enrollment is effective, in order for them to receive the full coverage offered, services other than emergency and urgently needed services must be obtained through the HMO or CMP. In the case of cost enrollees, however, they may receive services that are not provided or arranged by their HMO or CMP, but they would be responsible*

*for payment of all Medicare deductibles and coinsurance as well as any additional charges as prescribed by the Medicare program. They also would be liable for any charges not covered by the Medicare program.*

### ***Emergency Care***

*EOCs must describe rules for emergency care and post-stabilization care. In particular, they must:*

- Explain that members are not required to go to health plan-affiliated hospitals and practitioners when they experience an emergency;*
- M+C organizations: Define the term “Emergency medical condition (this definition can be found in Chapter 4);*
- Define the term “Emergency services” (M+C organizations can find this definition in Chapter 4; Medicare cost plans can refer to 42 CFR 417.401.);*
- Describe rules and coverage for post-stabilization care. M+C organizations can refer to Chapter 4 and 42 CFR 422.113(b)(3), (c)(2)(i) through (iii) for more information on responsibility for emergency care and stabilization and post-stabilization requirements; and*
- Describe precisely where emergency coverage will be available under the organization (e.g., the United States and its Territories, worldwide, etc.).*

### ***Urgent Care***

*EOCs must describe rules for urgent care. In particular, they must:*

- Define “urgently needed services” (for M+C organizations, this definition can be found in Chapter 4, for Medicare cost plans, it is at 42 CFR 417.401).*
  - Explain that urgently needed care provided by non-plan providers is covered when a member is in the service area or M+C continuation area under the unusual circumstance that the organization’s provider network is temporarily unavailable or inaccessible. Normally, if a member needs urgent care and is in the organization’s service area or M+C continuation area, the member is expected to obtain care from the organization’s providers.*

### ***Appeal Rights***

*EOCs must describe the appeals process and rights to appeals. In particular, they must explain that members have a right to appeal any decision the organization makes regarding, but not limited to, a denial, termination, payment, or reduction of services. This includes denial of payment for a service after the service has been rendered (post-*

*service) or denial of service prior to the service being rendered (pre-service). For more information on appeals, M+C organizations can refer to [Chapter 13](#).*

*Optional supplemental benefits cannot be appealed for Medicare cost plans. Therefore, Medicare cost plans must explain that complaints about Optional supplemental benefits are handled through the grievance process.*

### ***Benefits, Plan Premium and Billing Information***

*EOCs must describe benefit and plan premium information. In particular, they must:*

- Include the statement: “You must continue to pay your Medicare Part B premium” with premium information, even if the plan premium is \$0;*
- When specifying benefits, specify annual limits (e.g., \$1,000 annual maximum for prescription drugs), annual benefit payout (e.g., \$700 for eyeglasses every 2 years) and applicable copayments (e.g., \$5 copayment for a doctor visit);*
- Clearly state major exclusions and limitations. For example, restriction of pharmacy benefits to a specific formulary or a restricted set of pharmacies must be explained;*
- Clearly state all monetary limits, as well as any restrictive policies that might impact a beneficiary’s access to drugs or services;*
- When annual dollar amounts or limits are provided, also mention the applicable quarterly or monthly limits, and whether any unused portion of that benefit can be carried over from one calendar quarter to the next.*
- Make the statement that the M+C organization’s contract with CMS is renewed annually, and that the availability of coverage beyond the end of the current contract year is not guaranteed; and*
- Provide instructions to enrollees that, in cases where non-contracting 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.*

*For more information on benefits, premiums and cost sharing, refer to [Chapters 4 and 8](#).*

## **50 - Guidelines for Promotional Activities**

***(Rev. 60, Issued 08-08-04, Effective: August 08, 2004/Implementation: N/A)***

This section reviews the use of promotional activities relating to the enrollment and retention of members. Section 50.1 of this section provides general guidance about

promotional activities, while [§50.2](#) provides specific guidance for provider promotional activities. Section [§50.3](#) describes CMS' policy with respect to the use of independent insurance agents for marketing purposes. Section [50.4](#) answers some frequently asked questions regarding all aspects of promotional activities.

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### **50.1.2 - Referral Programs**

*(Rev. 60, Issued 08-08-04, Effective: August 08, 2004/Implementation: N/A)*

The following general guidelines apply to referral programs under which *Medicare* health plans solicit leads from members of new enrollees. These include gifts that would be used to thank members for devoting time to encouraging enrollment. Gifts for referrals must be available to all members and cannot be conditioned on actual enrollment.

- *Medicare* health plans may not use cash promotions as part of a referral program.
  - *Medicare* health plans may offer thank you gifts of less than \$15 nominal value (e.g., thank you note, calendar, pen, key chain) when an enrollee responds to a *plan* solicitation for referrals. These thank you gifts are limited to one gift per member, per year.
  - A letter sent from the *Medicare* health plan to members soliciting leads cannot announce that a gift will be offered for a referral.
  - *An organization can ask for referrals from active members, including names and addresses, but cannot request phone numbers. Medicare health plans can then use this information for soliciting by mail.*
- 

### **50.2 - Specific Guidance About Provider Promotional Activities**

*(Rev. 60, Issued 08-08-04, Effective: August 08, 2004/Implementation: N/A)*

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

In general, providers should only market in their capacity as a member of the plan's network and only in coordination with the *Medicare* health plan (for example,

providers/provider groups could co-sponsor an open house or a health fair with a *Medicare* health plan, or could cooperatively advertise on TV).

Marketing by a plan provider shall be deemed to be marketing by the *Medicare* health plan. Therefore, *Medicare* health plans should stipulate in their contracts with providers that any coordinated marketing to be carried out by the provider must be done in accordance with all applicable CMS marketing guidelines. All marketing materials describing the *Medicare* health plan in any way must have the *Medicare* health plan's name or logo as well as the provider's/provider group's name or logo *and* adhere to the guidelines in this chapter. *Refer to §60.3.1 for information about approval of provider marketing materials (benefit-providing third party marketing materials).*

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

- Providers are usually not fully aware of all *Medicare* health plan benefits and costs; and
- A provider may confuse the beneficiary if the provider is perceived as acting as an agent of the *Medicare* health plan vs. acting as the beneficiary's provider.

Providers may face conflicting incentives when acting as a *Medicare* health plan 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 *Medicare* health plan 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 *Medicare* health plan brochures including enrollment applications. Because they may not be fully aware of all benefits and costs of the various *Medicare* health plans, providers or their representatives cannot compare benefits among *Medicare* health plans in this setting. In addition, applications may not be taken at health fairs. (See the discussion of health fairs and health promotion events in [§50.1.3](#) above.)
2. **Provider Office Activities and Materials** - In their own offices, physicians and other health care providers can give out *Medicare* health plan brochures, and posters announcing plan/organization affiliation. However, they cannot give out or accept applications. Providers cannot offer inducements to persuade beneficiaries to join *Medicare* health plans or to steer beneficiaries to a specific *Medicare* health plan.

While providers are prohibited from giving and accepting applications in the health care setting, the *Medicare* health plans and provider representatives may

conduct sales presentations and give and accept applications in health care settings as long as the activity takes place in the common areas of the setting, and as long as patients are not misled or pressured into participating in such activities. Common areas, where marketing activities are allowed, would be areas such as hospital cafeterias, community or recreational rooms, and conference rooms.

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

In addition, providers cannot offer anything of value to induce *Medicare* health plan 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 *Medicare* health plan or *Original Medicare* benefits and costs, they are advised to additionally refer their patient to other sources of information, such as 1-800-MEDICARE, the State Health Insurance Assistance Program, and/or specific health plan/M+C organization marketing representatives. Additional information can also be found on CMS' Web site, <http://www.medicare.gov/>. Physicians are permitted to printout and share information with patients from CMS' Web site.

3. **Providers/Provider Group Affiliation Information-** Providers/provider groups can announce a new affiliation with a *Medicare* health plan to their patients. An announcement to patients of a new affiliation which names only one *Medicare* health plan may occur only once. Additional contacts from providers to their patients regarding affiliation must include all the Medicare health plans with which the provider contracts. This includes, for example, annual affiliation announcements, announcements that certain affiliations have terminated, and the display of *Medicare* health plan brochures/posters. If these communications describe *Medicare* health plans in any way (as opposed to just listing them), they must be prior approved by CMS (see below).
4. **Providers/Provider Group Comparative/Descriptive Information -** Providers/provider groups may provide printed information to their patients comparing the benefits of different *Medicare* health plans with which they contract. Such materials must have the concurrence of all *Medicare* health plans involved and must be prior approved by CMS. The *Medicare* health plans may want to determine a lead *Medicare* health plan to coordinate submission of these materials. CMS continues to hold the *Medicare* health plans 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 *Medicare* health plans is marketing and health screening is a prohibited marketing activity.

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

The “**Medicare and You**” Handbook or “**Medicare Compare Information**” (from CMS’ Web site, [www.medicare.gov](http://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 *Medicare* health plans and providers without further CMS approval. Please advise your *Medicare* health plan providers and provider groups of the provisions of these rules.

### **50.3 - Specific Guidance About the Use of Independent Insurance Agents**

*(Rev. 60, Issued 08-08-04, Effective: August 08, 2004/Implementation: N/A)*

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 *Medicare* health plans 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.

*Marketing by an independent insurance agent shall be deemed to be marketing by the Medicare health plan. Therefore, Medicare health plans should stipulate in their contracts with independent insurance agents that any coordinated marketing to be carried out by the agent must be done in accordance with all applicable CMS marketing guidelines. Refer to §60.3.2 for information about approval of marketing materials prepared by independent insurance agents (non-benefit-providing third party marketing materials).*

## 50.4 - Answers to Frequently Asked Questions About Promotional Activities

*(Rev. 60, Issued 08-08-04, Effective: August 08, 2004/Implementation: N/A)*

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 *Medicare* health plan. Because we purchased a large number of these books, we were able to buy them at a cost of \$14.99 per book. However, on the inside jacket, the retail price is shown as \$19.99. May we give these books away at our marketing presentation?

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

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

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

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

**A** - Yes.

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

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

**A** - **Yes**. All these promotional items are permissible as long as they are offered to everyone who attends the event regardless of whether or not they enroll and as long as the gifts are \$15 or less. Cash gifts are prohibited including charitable



contributions made on behalf of people attending a marketing presentation, and including gift certificates that can be readily converted to cash, regardless of dollar amount.

5. **Q** - Can a *Medicare* health plan 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 organization is jointly sponsoring the prize with other *Medicare* health plans 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 *Medicare* health plans 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 *Medicare* health plans, 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 *Medicare* health plans 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 *Medicare* health plan;
- 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 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 *Medicare* health plan offer reductions in premiums or enhanced benefits based on the length of a Medicare beneficiary's membership in the *Medicare* health plan?
- A** - No. Longevity of enrollment is not a basis for reductions in premium or enhanced benefits. <sup>18</sup>
9. **Q** - Can a *Medicare* health plan provide discounts to beneficiaries who prepay premiums for periods in excess of 1 month?
- A** - No. *Medicare* health plans cannot provide any discounts to Medicare beneficiaries for prepayment of premiums in excess of 1 month.
10. **Q** - Can a *Medicare* health plan 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 *Medicare health plans* 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 *Medicare* health plans pay beneficiaries that sign up to be "ambassadors" a flat fee for transportation?
- A** - The *Medicare* health plan may reimburse the beneficiary for any actual, reasonable transportation costs but must not pay the beneficiary a flat fee for transportation. If the *Medicare* health plan 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 *Medicare* health plans that own nursing homes conduct health fairs and distribute enrollment forms to nursing home residents?
- A** - Yes, organizations that own nursing homes may conduct health fairs and distribute enrollment forms if the sales presentations are confined to a common area (i.e., community or recreational rooms) or if a member volunteered for an individual presentation. Promotional activities and sales presentations cannot be made in individual resident rooms without a prior appointment for a "home" visit. Such activities would be considered door-to-door solicitation and are prohibited.

The organization is required to meet all health fair/sales presentation and enrollment requirements as currently outlined in this chapter and regulations.

14. **Q** - Can physician groups that contract with *Medicare* health plans hire marketing firms to cold call from non- *Medicare* health plan member listings?

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

15. **Q** – *Can Medicare health plans obtain lists from providers?*

*A – Yes, a provider may provide lists of their patients to Medicare health plans for marketing purposes. However, the CMS prefers that these lists be complete patient lists (for example, not just lists of patients over 65) in order to prevent health care screening. The list may contain contact information (name, address, phone number) but must not contain health status information. The provider is responsible for ensuring that it does not violate any HIPAA rules prior to providing such lists to the organization.*

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## **60.1.2 - Relationship of Value-Added Items and Services (VAIS) to Benefits and Other Operational Considerations**

*(Rev. 60, Issued 08-08-04, Effective: August 08, 2004/Implementation: N/A)*

*Medicare* health plans can market, either through oral presentations or written materials, Value-Added Items and Services (VAIS). Organizations can also mention VAIS in their newsletters. With one exception, VAIS may not appear in the PBP, the Standardized SB, *the ANOC or the EOC*. The exception is with the discount prescription drug program, which can be mentioned in *the EOC, the ANOC and* section 3 of the SB, as long as they include the required disclaimers. *If the program is mentioned*, the *marketing material* must clearly state (in the location that the program is described) that the discount prescription drug program will be available for the entire contract year.

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

The products and services described below are neither offered nor guaranteed under our contract with the Medicare program. In addition, they 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.

Organizations may include VAIS along with their ANOC, SB, *and/or EOC* in one bound brochure as long as the value-added services are clearly distinct from the ANOC, SB, *or*

*EOC* (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 “benefit” 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 and therefore are not technically within CMS purview. 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.

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#### ***60.4.1 - Review of Marketing Materials in Non-English Language or Braille***

***(Rev. 60, Issued 08-08-04, Effective: August 08, 2004/Implementation: N/A)***

*In general, for marketing with materials that contain non-English or Braille information (in whole or in part), the health plan must submit the non-English or Braille version of the marketing piece, an English translation of the piece, and a letter of attestation. However, in an effort to reduce the burden on the organization and CMS, the organization may choose to submit an English version for approval first, and then submit the non-English or Braille version along with the letter of attestation. This way, any changes or revisions that are made to the English version will be accurately reflected in non-English materials.*

*The letter of attestation must be signed and certified by an authorized official employed by the organization, and must attest that the translation conveys the same information and level of detail as the corresponding English version. (See [§60.4.2](#) for a model attestation letter.)*

*All organizations will be subject to verification monitoring review and associated penalties for violation of CMS policy. In addition to verifying the accuracy of non-English marketing materials through monitoring review, CMS will also periodically conduct marketing review of non-English materials on an “as needed” basis. If materials are found to be inaccurate or do not convey the same information as the English version, organizations may not continue to distribute materials until revised materials have been approved. If multi-region organizations have submitted materials in*

*English to their lead RO and the materials have been approved, the same materials in other languages or Braille may be used in other regions.*

***The following applies to organizations on File and Use:***

- When an organization is on File and Use, it is on File and Use for both English and non-English materials. Therefore, continual violations in non-English materials could be grounds for placing an organization on probation.*
- When an organization is on File and Use probation, the probation is for both English and non-English materials. If File and Use status is revoked, it is revoked for both English and non-English materials.*
- If an organization is on File and Use, it must submit English and non-English versions of materials 5 calendar days prior to their use.*

***60.4.2 - Model Attestation***

***(Rev. 60, Issued 08-08-04, Effective: August 08, 2004/Implementation: N/A)***

***ATTESTATION OF TRANSLATED NON-ENGLISH MATERIALS  
FOR MEDICARE HEALTH PLANS***

*Pursuant to the contract(s) between the Centers for Medicare & Medicaid Services (CMS) and (insert organization name), hereafter referred to as the Medicare Health Plan, governing the operations of the following health plan: (insert plan and H number), the Medicare health plan hereby attests that the non-English version(s) submitted in the attached, convey the same information and level of detail as the corresponding English version.*

*The Medicare health plan acknowledges that the information concerning the translation(s) described below is for the use of and correspondence to the beneficiary and that misrepresentations to CMS about the accuracy of such information may result in Federal civil action and/or criminal prosecution.*

*The Medicare health plan is submitting to CMS the attestation with the following materials: (INSERT MATERIAL IDENTIFICATION NUMBERS).*

*Based on best knowledge, information, and belief as of the date indicated below, all information submitted to CMS in these documents are accurate, complete, and truthful.*

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*(NAME & TITLE [CEO, CFO, or delegate])*

*on behalf of*

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*(NAME OF MEDICARE HEALTH PLAN)*

---

*DATE*

## Endnotes

*(Rev. 60, Issued 08-08-04, Effective: August 08, 2004/Implementation: N/A)*

<sup>1</sup> 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 and/or cost plans.

<sup>2</sup> 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 “*Medicare* health plan” is used throughout the document to include requirements specific to both Medicare + Choice Organizations and §1876 cost contractors.

<sup>3</sup> This endnote has been deleted.

<sup>4</sup> *This endnote has been deleted.*

<sup>5</sup> *This endnote has been deleted.*

<sup>6</sup> CMS has the discretion to disapprove language based on site visit reviews identifying substantial deficiencies in *Medicare* health plan operations.

<sup>7</sup> A member of the *Medicare* health plan may use a superlative in relating their personal experience with the *Medicare* health plan so long as the testimonial is preceded with the phrase “in my opinion” (e.g., “I have been with the 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.

<sup>8</sup> Note 8 has been deleted.

<sup>9</sup> In accordance with Chapter 3, this information should be provided in at least 12-point font size.

<sup>10</sup> The 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.

<sup>11</sup> In accordance with Chapter 3, the applicable TDD/TTY number must also be provided, including the hours of operation.

<sup>12</sup> The CMS' monthly capitation rate to an M+C organization for a plan 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, because CMS created the QI-1 category of Medicaid recipients after it established the standard monthly payment upon which it bases all capitation payments, CMS policy is to not pay the Medicaid adjustment factor for this group.

<sup>13</sup> Since *Medicare* health plans are primarily responsible for conducting outreach, Chapter 3 has been written targeting that audience. However, if the *Medicare* health plan contracts with another entity for any part of this outreach, the contracting entity must abide by Chapter 3 as well.

<sup>14</sup> 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.

<sup>15</sup> Outreach proposals should go to CMS , *Division of Medicare Health Plans*, 75 Hawthorne Street *4<sup>th</sup> Floor* , San Francisco, CA 94105-3918, *Attn: Eileen Turner, Manager, Dual Eligible Proposal*; fax:415-744-3761.

<sup>16</sup> Section [1851\(e\)\(3\)](#) of the Act and [42 CFR 422.10\(b\)](#).

<sup>17</sup> An application form may be either:

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

The key feature of the application form is that it must be completed by the beneficiary in the absence of *Medicare* health plan marketing influences and returned to the *Medicare* health plan by mail. (Self-addressed, postage paid, return envelopes may be provided by the *Medicare* health plan).

<sup>18</sup> 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.