

Draft Medicare Marketing Guidelines

Comment/Response Form

Contact Person Name: California Health Advocates (David Lipschutz), National Senior Citizens Law Center (Georgia Burke), Center for Medicare Advocacy (Vicki Gottlich), Health Assistance Partnership (Kelly Brantley), Medicare Rights Center (Paul Precht)

Email: CHA: dlipschutz@cahealthadvocates.org, NSCLC: gburke@nsclc.org, CMA: Vgottlich@medicareadvocacy.org, HAP: kbrantley@hapnetwork.org, MRC: pprecht@medicarerights.org

Org	Section	Page #	Description of Issue or Comment	Suggested Revision or Comment
California Health Advocates (CHA), National Senior Citizens Law Center (NSCLC), Center for Medicare Advocacy (CMA), Health Assistance Partnership (HAP), Medicare Rights Center (MRC)	General		Distribution of Draft Guidelines	We thank CMS for its responsiveness to our concerns about the way in which the Draft Marketing Guidelines initially were made available for comment, for posting the draft guidelines on its website, and for extending the time frame for submitting comments.
CHA, NSCLC, CMA, HAP, MRC	General		Scope of Consumer Protections	In general, we are disappointed that CMS has failed to follow the spirit, and in some cases, the letter, of the law in interpreting marketing guidelines and consumer protections found in MIPPA. As discussed below, these Draft Marketing Guidelines do not rescind, alter or improve upon CMS memoranda and guidance issued in the Fall of 2008 that created gaping loopholes and otherwise weakened consumer protections found in MIPPA. We urge CMS to conduct a thorough overhaul of these guidelines and strengthen consumer protections and oversight of both plan sponsors and agents/brokers.

CHA, NSCLC, CMA, HAP, MRC	10	9	Definition of Member Communications and Issue of Plan Sponsors Enlisting Enrollees to Lobby on Their Behalf	CMS' definition of marketing materials subject to these guidelines include certain "member communications" although political communications are notably absent from the examples. We are very concerned about plan sponsors soliciting their enrollees to join "grassroots" efforts to influence Medicare policy via member newsletters and other means. For example, the Coalition for Medicare Choices, an industry-backed effort to protect the interests of plan sponsors, directs members to lobby Congress concerning the MA program (see, e.g., www.medicarechoices.org). We believe there should be a prohibition on plan sponsors soliciting members' participation in political activities, particularly those that benefit the plan sponsor, and urge CMS to analyze whether such activity already violates current law.
CHA, NSCLC, CMA, HAP, MRC	20	13	Definition of Multi Contract Entities and Submission of Representative Template Materials	CMS should not allow plan sponsors to submit only a "selection" of plan template materials; at the very least, sponsors should be required to submit materials that represent each plan type, since delivery of benefits can vary considerably based upon the type of plan (e.g. HMO, PFFS, etc.).

CHA, NSCLC, CMA, HAP, MRC	30.3	19	Use of Data from Medigap Insurers	<p>We object to permitting Medigap issuers who also offer MA and Part D products to use enrollee data to market such products to their Medigap enrollees. In addition, the allowance of MA and PDP sales to occur during outbound cold calls involving Medigaps amounts to an end-run around the prohibition on unsolicited contacts and cold calling. Given the different nature of Medigaps vs. MA and Part D products, the potential loss of rights to reacquire a Medigap policy once it is dropped, and the anticipated confusion surrounding the upcoming change in Medigap benefit structures for plans effective June 2010 and thereafter, Medigap plan sponsors that also offer MA and Part D products should be given no allowances to circumnavigate rules applicable to MA and PDP sales.</p>
CHA, NSCLC, CMA, HAP, MRC	30.4	19	Plan Sponsor Responsibility for Subcontractor Activities	<p>We appreciate the inclusion of this section, but in addition to a discussion of marketing materials, we urge CMS to clearly articulate plan responsibility for other marketing misconduct activities, and include firmer language about consequential sanctions and other means of punishment.</p>
CHA, NSCLC, CMA, HAP, MRC	30.4.1	19-20	Multiple Organization Marketing Pieces Created by Agents	<p>Agents should not be allowed to produce and disseminate generic material, particularly if neither plan sponsors nor CMS will be reviewing them. Such materials, for example, often include references -- either implicitly or explicitly -- to "\$0" premium or "no premium" options which indirectly promote MA plans.</p>

CHA, NSCLC, CMA, HAP, MRC	30.6	20	Non-English Speaking and Special Needs Individuals	<p>We urge CMS to replace the 10% threshold with the safe harbor provision of E.O. 13166 as the trigger for translation: five percent or 1,000 individuals in the PDP service area, whichever is lower. The current 10% threshold for translation requirements is inadequate. In practice, it means that the obligation of PDP sponsors is limited to providing Spanish translations to just a handful of states--no other languages, no other regions. For many MA-PDs the situation is similar. If Part D language access protections are to work, it is essential to have numerical as well as percentage thresholds. In light of the size of most Part D sponsors and the adoption of model documents, our proposed requirements are reasonable. They are critically important as well because as advocates we have seen LEP beneficiaries particularly targeted for marketing abuses and unable to access factual information in their language. In addition, the "should's" in this paragraph need to be changed to "must's." If CMS accepts these recommendations, section 90.10 would need to be changed as well.</p>
CHA, NSCLC, CMA, HAP, MRC	(same)		Serving LEP Beneficiaries -- Generally	<p>See the letter from the National Senior Citizens Law Center for more detailed recommendations on serving LEP beneficiaries.</p>

CHA, NSCLC, CMA, HAP, MRC	30.8	21	General Comment on Plan Materials and Appropriate Labeling	Many Medicare beneficiaries complain to SHIP programs about the abundance of mail they receive from plans, resulting in difficulty determining what is important information vs. what is not. In order to address this problem, we urge CMS to require plans to employ standard language on the envelope and cover of key plan information (such as ID cards, ANOC, EOC, SBs) such as "This is Important Plan Information -- Keep For Future Reference." In turn, plans should be prohibited from including this language in advertising and other non-key plan information, which should also be labeled by information such as "This is an Advertisement" to allow recipients to more easily distinguish information they receive. In addition, plan materials should be required to include information about local SHIP programs.
CHA, NSCLC, CMA, HAP, MRC	30.8.1	21-22	Pre-Enrollment Materials	4th bullet, p. 22 – should reference that plans can choose to non-renew on an annual basis; also should state that plans can change their benefits and cost-sharing on an annual basis
CHA, NSCLC, CMA, HAP, MRC	30.8.2	22-23	Post-Enrollment Materials	As argued by consumer advocates in comments to other CMS guidance, we urge CMS to require the ANOC and EOC to be separated into distinct documents.
CHA, NSCLC, CMA, HAP, MRC	30.12	23-24	Referral Programs	We object to permitting plan sponsors to solicit leads for new enrollees from their members, as well as allowing plans to provide rewards for such leads. Any effort to market to individuals based upon enrollee referrals should be treated as prohibited unsolicited contacts.

CHA, NSCLC, CMA, HAP, MRC	40.1	25	Marketing Material ID #s	This requirement does no good if plans fail to comply (see, e.g., 2008 OIG report finding that 45% of the reviewed materials failed to match the ID #s in CMS' system). If plans do not comply, they should be prevented from using any marketing materials until they are in compliance. In addition, state regulators should have access to marketing materials created by plans in order to address misleading state information (e.g., state Medicaid benefits).
CHA, NSCLC, CMA, HAP, MRC	40.9	28-29	Marketing to Members of Non-Renewing Plans	It is unclear whether this section refers to plan sponsors marketing products other than their own plan that is non-renewing or other, unrelated plan sponsors. If the former, we object to permitting the sponsor that is choosing to non-renew to market other products to members. If the latter, it is unclear how other plan sponsors would be aware of the identity of enrollees in non-renewing plans.
CHA, NSCLC, CMA, HAP, MRC	40.1	29	Product Endorsements	Any individuals paid to endorse a plan (e.g. a celebrity) should be required to state whether s/he is in fact a current member of the plan, in addition to disclosing that s/he is being paid for the endorsement.
CHA, NSCLC, CMA, HAP, MRC	40.14	31	Marketing Multiple Lines of Business	We strongly object to plan sponsors being allowed to market multiple lines of business, both health and non-health related, to both prospective and current plan enrollees.

CHA, NSCLC, CMA, HAP, MRC	40.14.1	31	Marketing Multiple Lines of Business - General Requirements	As stated above, we object to plan sponsors being allowed to market multiple lines of business to current and prospective enrollees. At the very least, prior written authorization from an enrollee should be required for the marketing of any other product – either health-related or non-health related -- by the same plan sponsor (in other words, enrollees should affirmatively "opt in" instead of opting out of receiving such solicitations). Nor should plan sponsors be allowed to market Medicare and non-Medicare related products in the same document; there is too much chance for confusion (e.g. beneficiary believing that all products are Medicare-related and/or necessary for full coverage).
CHA, NSCLC, CMA, HAP, MRC	40.14.2	31-32	Marketing Multiple Lines of Business -Exceptions	Plan sponsors should not be allowed to market non-plan lines of business, even if in a separate envelope/enclosure. In addition, plan sponsors should not be able to combine marketing for non-competing lines of business (e.g. PDP and Medigap) as these are distinct and very different types of products that generally require a good deal of explanation about how they work and work together (if at all).
CHA, NSCLC, CMA, HAP, MRC	40.14.6	33	Non-Benefit/Service Providing Entities	Plans should be prohibited from compensating non-benefit/service providing entities that are providing information to the plan's members. Instead, any such information -- e.g. comparative info re: other plans -- should only be distributed if performed by a neutral third part (e.g. Consumer Reports).

CHA, NSCLC, CMA, HAP, MRC	40.16	34-35	Plan Type in Name	While we welcome the requirement that plan sponsors include the type of plan in the name, we note that the list devised by CMS contains 13 distinct plan name types (down from 18 in the Draft 2010 Call Letter). There are benefit package variations within each of these types of plans. While we recognize that not all beneficiaries are eligible to enroll in all plan types, and that not all plan types will be available in every part of the country, the potential number of variations makes meaningful comparison and choice difficult. At a minimum, CMS needs to limit the number of plans each sponsor may offer and develop standardized benefit packages to allow beneficiaries the opportunity to make informed choices.
CHA, NSCLC, CMA, HAP, MRC	50.1.3	37	Benefit Changes	Instead of requiring current plan year info, starting Oct. 1, to include a disclaimer re: benefit changes as of following Jan. 1, we believe such a disclaimer should be in all marketing materials, regardless of what time of year the product is sold (in other words, it should be made clear to prospective enrollees that plans can, and generally do, change plan benefits and cost-sharing on an annual basis).
CHA, NSCLC, CMA, HAP, MRC	50.1.5	39	D-SNP Comprehensive Written Statement	D-SNPs should be required to provide the MIPPA-required D-SNP notice to prospective enrollees in the standardized content and format the Secretary must develop, MIPPA, Section 164(c)(3).
CHA, NSCLC, CMA, HAP, MRC	(same)		D-SNP Disclosures of Cost-sharing to People with Medicare and Medicaid who are Prospective Enrollees	MIPPA requires plans to notify prospective enrollees of the Medicaid benefits and cost-sharing. MIPPA Section 164(c)(3). Allowing D-SNPs to provide a disclaimer that the costs duals may incur "may vary based on the level of help" they receive, and that they should contact the plan for more information (page 39) does not meet the obligations placed upon D-SNPs by MIPPA.

CHA, NSCLC, CMA, HAP, MRC	50.5.3	44	Explanatory Materials	In addition to clearly stating exclusions and limitations, plan sponsors should be required to list all costs that are more than what someone would pay in Original Medicare (e.g., if the plan charges 30% for DME or any charges for home health). In addition, plan sponsors should be required to provide information about any applicable prior authorization requirements for benefits/services. Also, any out-of-pocket maximum amounts -- and any services/benefits that are carved out -- should also be disclosed.
CHA, NSCLC, CMA, HAP, MRC	(same)	45	Explanatory Materials -- Mandatory Text on Where to Get Additional Info	The wording of the first full paragraph on p. 45 is unclear ("should" vs. "must"); revise it to say the following elements <u>must</u> be included. Add SHIPs to the list re: where to get additional information. In addition, the LIS language at end of this section should be required instead of encouraged.
CHA, NSCLC, CMA, HAP, MRC	50.5.5	46	Online Enrollment Center (OEC)	Since all plan sponsors are required to use the OEC, the second paragraph is confusing by referring to plan sponsors that use the OEC. Also, the required disclaimer should refer people who want more information about the OEC to 1-800-MEDICARE instead of the plan call center.
CHA, NSCLC, CMA, HAP, MRC	50.5.6	46	Eligibility Requirement Disclaimers	Add a disclaimer warning prospective enrollees to make sure that enrollment into an MA plan or PDP does not negatively impact any retiree benefits an individual might have, noting the risk that it is possible that enrollment could lead to being terminated from such coverage, and include a referral to retiree plan administrators. Also, plan sponsors should be required to provide a disclaimer re: how, if at all, the plan coordinates with the state Medicaid program.

CHA, NSCLC, CMA, HAP, MRC	50.5.7	46-47	Medicare Subsidy Information	Reference should also be made to Medicare Savings Programs, and the description of possible assistance available through MSPs should be broader than just Part D related costs. Also, add SHIPs to the list of where to get additional information.
CHA, NSCLC, CMA, HAP, MRC	50.5.8	47	Alternate Formats	The requirement should state that the disclosure must appear prominently on the front of the document. We also ask that there be a requirement that it appear in several languages. As an alternative, plans could include a separate paper in the mailing that makes the disclosure in major languages. The alternative formats tagline should also make clear that the plan call center is available to assist individuals for whom no alternative format is available. For example, Tagalog speakers in a plan that does not translate materials into Tagalog should be able to call the plan to get the document translated orally.
CHA, NSCLC, CMA, HAP, MRC	50.5.10	48	PFFS Plans and Prior Notification	We agree that plans employing this policy should be required to state in plan documents the cost-sharing that applies in absence of prior notification. We would add that such "full" amounts should be accompanied by an asterisk and a corresponding "reduced" price on the same page in order to provide easy comparison.
CHA, NSCLC, CMA, HAP, MRC	60.1	50	Summary of Benefits - D-SNPs	The state should not be held responsible for the content of the notice to prospective enrollees about Medicaid benefits and cost-sharing. There is no statutory authority holding states responsible for the plan-mandated disclosures required by MIPPA. See MIPPA Section 164(3). This provision should reference Section 50.1.5 and make clear that MIPPA requires the same disclosures whenever D-SNPs refer to benefits and costs.

CHA, NSCLC, CMA, HAP, MRC	60.2	50	Plan ID Cards	Plan ID cards should also be required to include the plan type in the plan name, as referenced in section 40.16.
CHA, NSCLC, CMA, HAP, MRC	60.3	51	Plan ID Card Recommendations	CMS "recommendations" re: adding information about the limiting charge and directions to providers to bill the MA plan should be required.
CHA, NSCLC, CMA, HAP, MRC	60.4.6	55	Notice re: Changes to Provider Networks - Include Applicable Medigap Rights	CMS should require plans to provide notice instead of just a "good faith effort" to do so. In addition, since CA (and possibly other states) provide for a Medigap right for enrollees of MA plans when their provider terminates his/her contract with the plan, notices sent to enrollees impacted by a provider no longer contracting with the plan should be required to provide notice of this right in CA (and wherever else applicable).
CHA, NSCLC, CMA, HAP, MRC	60.5	56	Formulary and Formulary Change Notice Requirements	We endorse CMS' requirement concerning discrepancies between HPMS file and marketing material information resulting in the plan sponsor continuing to cover the drug(s) at the more favorable cost share or with less restrictive utilization management for the beneficiary through the end of the contract year.
CHA, NSCLC, CMA, HAP, MRC	60.5.2	59	Comprehensive Formulary and Discouraging Beneficiary Access	We are concerned by the note in this section that allows plans to actively discourage requests for comprehensive formulary information. CMS should neither sanction nor allow any plan efforts to restrict access to important plan information by current or prospective enrollees.
CHA, NSCLC, CMA, HAP, MRC	60.6	64	EOB - Language Unclear	First 2 paragraphs on p. 64 awkwardly worded, unclear.
CHA, NSCLC, CMA, HAP, MRC	60.7	64	ANOC and EOC	As noted above in comments re: section 30.8.2, we believe that plans should be required to send separate ANOCs and EOCs. In addition, it is unclear why D-SNPs, if they choose to separate these documents, are allowed to provide EOCs to enrollees later than other plans.

CHA, NSCLC, CMA, HAP, MRC	70.3	67	Unsolicited E-mail Policy	We appreciate the inclusion of this section and support this policy.
CHA, NSCLC, CMA, HAP, MRC	70.4	68	Unsolicited Contacts -- General Policy	We believe that CMS has failed to implement adequate safeguards against unsolicited contacts and other consumer protections pursuant to section 103(a) of MIPPA. For example, although unsolicited door-to-door contacts are prohibited, there are no effective oversight and enforcement methods outlined to prevent them. In addition, CMS has written in loopholes to some of these protections through guidance issued in the Fall of 2008 and re-stated here (e.g., scope of appointment requirements, as discussed below). In addition, neither MIPPA nor its implementing regulations spell out exceptions for plan sponsors to market other products to their current enrollees.
CHA, NSCLC, CMA, HAP, MRC	70.5	68-69	Telephonic Contact -- Plans and Agents Marketing to Own Enrollees/Clients	We strongly object to plans/agents being allowed to market to their own members/clients and note that neither statutory nor regulatory language reserves this right for plan sponsors and agents. There should be no exceptions to the prohibition on cold calling for plans or agents trying to sell other products. The wording of this section is confusing -- the 3rd bullet on p. 69 notes a prohibition on "Outbound marketing calls, unless the beneficiary requested the call. This includes contacting existing members to market other Medicare products, except as permitted below." However, the last bullet on p. 69 states that plans are allowed to "Contact their members or use third parties to contact their current members for any reason... " Assuming CMS has not improved their policy on this subject issued in guidance last Fall, we reiterate our objection.

CHA, NSCLC, CMA, HAP, MRC	(same)		Telephonic Contact -- Medigap Cold Calls	CMS should expand its marketing guidelines to prohibit cold calls involving the sale of Medigap products. In addition, any MA and PDP discussions resulting from such calls re: Medigap plans is an end run around the general prohibition on unsolicited contacts, and should also be prohibited.
CHA, NSCLC, CMA, HAP, MRC	(same)		Telephonic Contact -- Disenrollment Surveys	Disenrollment surveys should not be allowed via phone, only mail. Individuals who disenroll from a plan should not be subject to further telephonic contact from that plan for purposes that will benefit the plan only.
CHA, NSCLC, CMA, HAP, MRC	(same)		Telephonic Contact -- Plans Losing LIS Enrollees Due to Reassignment	Even with advance approval from the appropriate CMS Regional Office, plans prospectively losing LIS-eligible members due to reassignment should be prohibited from calling to encourage them to remain enrolled in their current plan. Instead, these individuals should be referred to their local SHIP, which can help provide an unbiased assessment whether remaining in these plans will indeed benefit these enrollees.
CHA, NSCLC, CMA, HAP, MRC	70.5.1	72	Third Party Contact -- Include Mailings from Organizations Generating Leads	We are pleased that CMS is reiterating its stance concerning plan sponsor liability for the conduct of downstream entities, including lead-generating organizations. This policy should also specifically include unsolicited mailings that are designed to generate leads, but that don't reference specific products, but rather reference "Medicare changes" or other statements meant to elicit interest and a response. Such mailings often generate leads in a misleading way and should be deemed to be an unsolicited contact if such mailings result in appointments with agents and subsequent plan enrollments.

CHA, NSCLC, CMA, HAP, MRC	70.6	72	PFFS Outbound Verification Calls	We urge CMS to apply this requirement to all MA enrollments, since other MA plans can also be confusing for prospective enrollees and such sales have also been subject to significant marketing abuse to the detriment of beneficiaries. We note that such a requirement would seem to fulfill the otherwise unmet mandate for all MA plans in 42 CFR sec. 422.2272(b) that requires all plan sponsors to "Establish and maintain a system for confirming that enrolled beneficiaries have, in fact, enrolled in the MA plan, and understand the rules applicable under the plan."
CHA, NSCLC, CMA, HAP, MRC	70.7	73	Educational Events	In addition to marketing events, we believe that all educational events should be reported to CMS ahead of time so that such events can be monitored to ensure that plans sponsors and agents are adhering to the rules separating educational from marketing events.
CHA, NSCLC, CMA, HAP, MRC	70.9.1 - .3	79-82	Provider Requirements	While we welcome marketing requirements that apply to providers, it is unclear who or what entity(s) are responsible for conducting oversight and enforcing these provisions -- CMS, plan sponsors, state medical associations, others? What penalties/sanctions apply if providers violate these provisions?
CHA, NSCLC, CMA, HAP, MRC	70.1	84	Individual Marketing Appointments -- Failure to Implement Adequate Protections	We believe that CMS has failed to adequately protect consumers concerning individual marketing appointments. For example, CMS has apparently abandoned the requirement that a discussion of any lines of business not agreed upon prior to an in-person appointment is subject to a 48-hour cooling off period (see 42 CFR sec. 422.2268(h)). Moreover, as discussed below, the scope of appointment process has been rendered all but meaningless.
CHA, NSCLC, CMA, HAP, MRC	(same)		Individual Marketing Appointments -- Language in Section	The first sentence of this section is awkwardly worded and is unclear.

CHA, NSCLC, CMA, HAP, MRC	70.10.1	84	Scope of Appointments -- Failure to Require "Advance" Agreement	<p>We believe that CMS has failed to follow the statutory requirements related to scope of appointments and as a result has rendered this process all but meaningless. Section 103(b) of MIPPA requires "advance agreement with a prospective enrollee on the scope of the marketing appointment and documentation of such agreement ..." With respect to "advance agreement" CMS has, through guidance, effectively ignored this requirement by: 1) allowing agents to have the beneficiary sign the form at the beginning of the appointment "if it is not feasible for [the form] to be executed prior to the appointment"; and 2) by allowing a new form to be completed at the time of the appointment if the beneficiary "request[s]" information about a type of plan not previously agreed to be discussed. Not only do these gaping loopholes render the 48-hour waiting period useless, they place enrollees at considerable risk of marketing misconduct in their own homes -- the type of high-pressure sales situation that the statute meant to address. In short, we believe that CMS' interpretation and implementation of these rules unnecessarily accor</p>
CHA, NSCLC, CMA, HAP, MRC	(same)		Scope of Appointments -- Failure to Require Agreement in "Writing" for In-Person Appointments	<p>Section 103(b) of MIPPA requires "documentation" of scope of appointment agreements, and provides even more specificity with respect to high-risk in-person sales appointments: "In the case where the marketing appointment is in person, such documentation shall be writing." CMS has abandoned this requirement by allowing beneficiaries to give consent during recorded phone calls instead of keeping a written record, reviewed and signed by the beneficiary.</p>

CHA, NSCLC, CMA, HAP, MRC	(same)		Scope of Appointments - Model Form	[Note: these comments apply to the Model Scope of Appointment Confirmation Form issued 11/08 -- we were unable to find a newer version at the link provided in these draft Marketing Guidelines.] This form only allows a choice between Part D products or MA plans collectively. Instead, a beneficiary should be allowed to select which type of MA plan to be discussed rather than an "all or nothing" MA choice. In addition, the form includes the following note: "Please note that an agent may also discuss a Medicare Supplemental policy with you." In short, the beneficiary can be subject to a Medigap sales pitch without providing prior consent, making a mockery of the notion that the beneficiary is allowed to determine the scope of the appointment. Instead, Medigap plans should be a separate option for the prospective enrollee to select.
CHA, NSCLC, CMA, HAP, MRC	80.1	95	Call Center Requirements -- Extended Days/Hours and Minimum Competence	The requirement re: extended hours/days should be lengthened to 60 days beyond the expiration of the MA-Open Enrollment Period (OEP), since both MA plans and PDPs may accept enrollment during these times from the general Medicare population. SNPs should be required to keep these extended hours/days the entire calendar year since they actively market to, and can accept enrollees, year round. In addition, CMS should mandate minimum training and competency requirements for plan call center staff, since they are the primary interface between the plan and current and prospective enrollees.
CHA, NSCLC, CMA, HAP, MRC	80.1	95-96	Call Center Requirements --List of topics	Thank you for including the BAE policy in this list.

CHA, NSCLC, CMA, HAP, MRC	80.1.3	97	Required Inbound Information	We are puzzled by the note saying that CSRs don't have to collect pharmacy and medication information in order to provide annual out-of-pocket estimates for beneficiaries who call the plan. Since such information is vital to the selection of a plan and certainly is data that is in possession of the plan, CSRs should be required to collect this information if beneficiaries request it.
CHA, NSCLC, CMA, HAP, MRC	90.6	106	Marketing Review -- File & Use	Despite the promulgation of final regulations, we continue to object to the 5-day time period for review of materials submitted through the File & Use process. The statute, 42 USC § 1395w-21(h)(1), (5) provides for a shortened 10-day review period for certain materials. Additionally, the statute says the shortened review process is available for materials that use, without modification, proposed model language. Section 90.6.1 says that general advertising materials that do not mention benefits may be submitted through file and use review, even though no model language exists for many such ads. We continue to encounter print and media ads that do mention benefits but that use misleading language. We suggest that CMS develop model guidelines for plans to use in developing general ads.
CHA, NSCLC, CMA, HAP, MRC	90.1	111	Review of Marketing Materials	We encourage CMS to implement a policy for submitting non-English materials that allows the agency to confirm easily whether plans are complying with the obligations in 30.6. For example, the system should alert CMS when a plan operating in California has not submitted materials in Spanish. Such a system would ease monitoring and improve compliance.

CHA, NSCLC, CMA, HAP, MRC	100.1	117	Websites	CMS must make clear that plan websites should provide information to LEP beneficiaries. When a population meets the threshold in 30.6, materials must be available in that language on the plan's website. The website should include an easy to spot link to information in the alternative language(s) on the front page. For languages that do not meet the 30.6 threshold, plan websites should contain taglines informing beneficiaries of the availability of language assistance services at their call centers.
CHA, NSCLC, CMA, HAP, MRC	100.3	121	Required links	Thank you for including the BAE policy in this list.
CHA, NSCLC, CMA, HAP, MRC	120	126	Marketing and Sales Oversight	While we understand that these comments are not an appropriate forum to discuss federal preemption and the role of federal regulators vs. state regulators in the monitoring of the Medicare marketplace, we believe that there are additional steps that CMS can take at the administrative level to further enhance beneficiary protections. For example, CMS should require the use of agent/broker National Insurance Producer Registry (NIPR) numbers during the sales of all Medicare products, which would greatly improve the ability of both state and federal regulators to track and monitor agent activity. In addition, CMS should implement reporting requirements that enable plan sponsors and CMS to identify and prevent unsolicited door-to-door sales; all in-home enrollments should be flagged and agents should be required to document how each invitation for an in-home appointment was secured. Finally, CMS should impose more defined and stringent requirements for agent training and testing.

CHA, NSCLC, CMA, HAP, MRC	120.1	126	Compliance with State Appointment Laws -- Need to Impose Requirements for State Requests for Information	In addition to compliance with state appointment laws, CMS should clearly articulate the timeframes within which plan sponsors must comply with state requests for information as referenced in section 103(d)(1) of MIPPA (and 42 CFR sec. 422.2274(e)). Such guidance should also articulate the penalties plans can face for failure to comply with these state requests.
CHA, NSCLC, CMA, HAP, MRC	120.3	127	Agent Training and Testing	We urge CMS to impose more identifiable and rigid standards for agent training and testing. An 85% pass rate means nothing if the standards for testing are not strengthened. Training should include how MA and Part D plans coordinate with other kinds of insurance and state-specific program eligibility.
CHA, NSCLC, CMA, HAP, MRC	130	131	Guidelines Applicable to Employer/Union Group Plans	We ask CMS to reconsider and revise its regulations, 42 CFR 422.2276, 423.2276, that exempt from CMS review marketing materials developed by plan sponsors that are designed for members of an employer group plan. We have seen the same kinds of misstatements and incomplete information in these materials – including in the materials aimed at inducing an employer or union sponsor to offer a plan as we have seen in general marketing materials. We question why the unsolicited contact, cross-selling and scope of appointment rules do not apply to beneficiaries in retiree health plans, as they may be subject to the same unwanted intrusions or manipulations as other individuals. We also believe that agent compensation rules should apply so that unscrupulous agents do not shift their focus from the individual market to the employer group market.