

# CMS Marketing Guidelines – Marketing

## **40.11.1 - Agent Broker Phone Number**

*(Rev. 93, Issued: 06-04-10, Effective/Implementation: 06-04-10)*

42 CFR 422.112(a)(7)(i) & (ii), 423.128(d)

*Advertisements that include an agent/broker's phone number should clearly indicate that calling the agent/broker number will direct an individual to a licensed insurance agent/broker. If an agent/broker phone number is listed then the plan sponsor's customer service phone number must also be included and all requirements regarding the customer service number in these Marketing Guidelines must be met (e.g., hours of operation, etc)*

## **50.1.8 - Disclaimer on Advertisements and Invitations to Sales/Marketing Events**

*(Rev. 93, Issued: 06-04-10, Effective/Implementation: 06-04-10)*

42 CFR 422.2264, 423.2264

*Advertisements and invitations to Sales/Marketing events (in any form of media) that are used to invite beneficiaries to attend a group session with the possibility of enrolling those individuals must include the following two statements on advertising and explanatory materials:*

- *“A sales person will be present with information and applications.”*
- *“For accommodation of persons with special needs at sales meetings call <insert phone and TTY number>.”*

*Such invitations must also clearly state all of the products that will be discussed during the event (i.e. HMO, PDP).*

## **50.2 - Plan Sponsor Mailing Statements**

*(Rev. 93, Issued: 06-04-10, Effective/Implementation: 06-04-10)*

42 CFR 422.2272(b), 423.2272(b)

*In order to ensure that beneficiaries can quickly and easily identify the contents of a plan sponsor's mailing, all plan sponsors that mail information to prospective or current Medicare beneficiaries should prominently display one of the following four statements on the front of the envelope or the mailing itself (if no envelope is being sent). Plan sponsors are permitted to meet this requirement through the use of ink stamps or stickers if necessary, in lieu of pre-printed statements. Any delegated or sub-contracted entities and downstream entities that conduct mailings on behalf of a plan sponsor must comply with this requirement.*

1. *Advertising pieces – “This is an advertisement”*
2. *Plan information – “Important plan information”*
3. *Health and wellness information – “Health or wellness or prevention information”*
4. *Non-health or non-plan information - “Non-health or non-plan related information”*

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*All mailings should include one of these four mailing statements. If a mailing is not advertising or a health and wellness mailing, but is related to an enrollee's plan, plan sponsors should categorize it as a plan information mailing. However, if the mailing contains non-health or non-plan related information (refer to § 170.2 for examples), a plan sponsor should use the "non- health or non-plan related information" mailing statement. Plan sponsors may not modify these mailing statements and must use them verbatim. In addition, plan sponsor are not permitted to create additional mailing categories and/or statements.*

*Mailing statements should only be placed on the mailing when no envelope accompanies the mailer (e.g., tri-fold brochure or postcard). Plan sponsors may place one of the four statements on the mailing so that they are visible from the window of the envelope (as opposed to on the outside of the envelope) only if the disclaimer is prominently displayed within the display window of the envelope and is separate and distinct from the beneficiary's name/address.*

*CMS expects that all plan envelopes or mailings will include one of the four statements and that the statements will be prominently displayed so that beneficiaries can easily identify the content of the mailer. In addition, plan sponsors must ensure that their plan name or logo is included in every mailing to plan enrollees (either on the envelope or in the mailing when no envelope accompanies the mailer).*

*Plan sponsors should not create envelopes that look like they are being sent from an official government source (e.g., red, white & blue flags on the outside of the envelope or envelopes that are made to look like checks). The review and approval of envelopes with additional information other than the four mailing statements must be submitted for a forty-five (45) day review. If no other statements are added and/or there is no modification of the four mailing statements, then envelopes may be submitted under the File & Use process.*

## **70.1 - General Guidance about Promotional Activities**

***(Rev. 93, Issued: 06-04-10, Effective/Implementation: 06-04-10)***

42 CFR 422.2268, 423.2268

Promotional activities (including provider promotional activities) must comply with all relevant Federal and State laws. Plan sponsors may be subject to compliance and/or enforcement actions if they offer or give something of value to a Medicare beneficiary that the plan sponsor knows or should know is likely to influence the beneficiary's selection of a particular provider, practitioner, or supplier of any item or service for which payment may be made, in whole or in part, by Medicare. Marketing representatives must clearly identify the types of products that will be discussed before marketing to a potential enrollee. This includes all sales presentations, events, appointments, and outbound calls that are permissible under CMS' unsolicited contacts guidance. Additionally, plan sponsors are prohibited from offering rebates or other cash inducements of any sort to beneficiaries.

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Furthermore, plan sponsors are prohibited from offering or giving remuneration to induce the referral of a Medicare beneficiary, or to induce a person to purchase, or arrange for, or recommend the purchase or ordering of an item or service paid in whole or in part by the Medicare program.

*Any promotional activities or items offered by plan sponsors, including those that will be used to encourage retention of members:*

- *Must be of nominal value (refer to § 70.2 for additional information on nominal value);*
- *Must be offered to all people eligible to enroll without discrimination;*
- **Must not** be offered in the form of cash or other monetary rebates;
- **May not** be items that are considered a health benefit (e.g., a free checkup);
- **May not** consist of lowering or waiving co-pays should the person enroll;
- **May not** be items that are otherwise available, to the general public, for free;
- **May not** be used in pre-enrollment advertising, marketing, or promotion of the plan, such as in the PBP, SB, ANOC or EOC;
- **May not** be structured to steer enrollees to particular providers, practitioners, or suppliers;
- *May be discussed in direct mailings to enrollees (as long as there is no violation of the HIPAA Privacy laws);*
- *Must be tracked and documented during the contract year;*
- *Are subject to grievances by the enrollee (consequently, the plan must explicitly advise enrollees of the right to grieve and the process for filing a grievance);and*
- **May not** be tied directly or indirectly to the provision of any other covered item or service.

## **70.1.2 - General Guidance about Rewards and Incentives**

**(Rev. 93, Issued: 06-04-10, Effective/Implementation: 06-04-10)**

42 CFR 422.2268, 423.2268

*Rewards and incentives may only be offered to promote one of the following target activities:*

- Welcome to Medicare” visit (includes a referral for an ultrasound screening for abdominal aortic aneurysm for eligible beneficiaries)
- Adult Immunization – influenza, pneumococcal and Hepatitis B vaccination
- Colorectal Cancer Screening
- Screening Mammography
- Screening Pap Test and Pelvic Examination
- Prostate Cancer Screening
- Cardiovascular Disease Screening
- Diabetes Screening
- Glaucoma Screening
- Bone Mass Measurement
- Diabetes Self-Management, Supplies and Services
- Medical Nutrition Therapy

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- Smoking Cessation

- *HIV screening for high risk groups*

*The reward items given to plan enrollees for doing any of the above target activities are subject to the following requirements:*

- *Each reward item must have a retail value monetary cap not to exceed \$10 per item or \$50 in the aggregate on an annual basis per member per year;*
- *Must be offered to all eligible members without discrimination;*
- *Must not be offered in the form of cash or other monetary rebates;* 76
- *May not be items that are considered a health benefit (e.g., a free checkup);*
- **May not** consist of lowering or waiving co-pays;
- **May not** be items that are otherwise available, to the general public, for free;
- **May not** be used in pre-enrollment advertising, marketing, or promotion of the plan, such as in the PBP, SB, ANOC or EOC (rewards and incentives may only be discussed in post-enrollment notifications);
- **May not** be structured to steer enrollees to particular providers, practitioners, or suppliers;
- May be discussed in direct mailings to enrollees (as long as there is no violation of the HIPAA Privacy laws);
- Must be tracked and documented during the contract year;
- Are subject to grievances by the enrollee (consequently, the plan must explicitly advise enrollees of the right to grieve and the process for filing a grievance);
- **May not** be tied directly or indirectly to the provision of any other covered item or service; and
- *Are subject to disclosure requirements – that is, the plan must clearly inform the enrollee what target activities are rewarded, what limitations, if any, apply, and how to claim the reward items; and*
- *Must comply with all relevant fraud and abuse laws, including, when applicable, the anti-kickback statute and civil monetary penalty prohibiting inducements to beneficiaries.*

## 70.2 - Nominal Gifts

*(Rev. 93, Issued: 06-04-10, Effective/Implementation: 06-04-10)*

42 CFR 422.2268(b), 423.2268(b)

Pursuant to 42 CFR 422.2268(b) and 42 CFR 423.2268(b), plan sponsors can offer *promotional gifts to* potential enrollees at all marketing activities as long as such gifts are of nominal value and are provided whether or not the individual enrolls in the plan. Nominal value is currently defined as an item worth \$15 or less, based on the retail *value* of the item. The following rules must be followed when providing gifts of a nominal value:

- If more than one item is offered by a plan sponsor at any marketing activities (for example a pen and a flashlight), the combined value of all items offered to a participant **must not** exceed the nominal value we stipulate.
- If a nominal gift provided is one large gift that is enjoyed by all in attendance (for example a concert or a magician) the total retail cost must be \$15 or less when it is

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divided by the estimated attendance. For planning purposes, anticipated attendance may be used, but must be based on venue size, response rate, or advertisement circulation.

- Cash gifts are prohibited, including charitable contributions made on behalf of potential enrollees and including gift certificates and gift cards that can be readily converted to cash, regardless of dollar amount.

**NOTE:** Gift cards must be used in their entirety and the balance **cannot** be issued in cash. Plan sponsors should refer to the Office of Inspector General’s website regarding advisory opinions on gift cards at <http://www.oig.hhs.gov/fraud/advisoryopinions.asp>. The dollar amount associated with the definition will be periodically reassessed by CMS. A plan sponsor may offer a prize of over \$15 to the general public (for example, a \$1,000 sweepstakes) as long as the prize is offered to the general public and not just to Medicare beneficiaries, is not routinely or frequently awarded and is awarded without regard to whether the individual enrolls in a plan.

## ***70.2.1 - Exclusion of Meals as a Nominal Gift*** ***(Rev. 93, Issued: 06-04-10, Effective/Implementation: 06-04-10)***

42 CFR 422.2268(p), 423.2268(p)

Plan sponsors **may not** provide prospective enrollees with meals, or have meals subsidized, at any event or meeting at which plan benefits are being discussed and/or plan materials are being distributed (for example a hotel conference room, restaurants, soup kitchen, shelter, or senior center).

Plan sponsors are, however, allowed to provide refreshments and light snacks to prospective enrollees. Plan sponsors must use their best judgment on the appropriateness of food products provided, and must ensure that items provided could not be reasonably considered a meal, and/or that multiple items are not being “bundled” and provided as if a meal.

Meals may be provided at educational events provided the event meets CMS’ strict definition of an educational event, and complies with the nominal gift requirement in § 70.2. ***Meals are not allowed at sales/marketing events. Refer to § 70.7 for guidance regarding education events.***

While CMS does not intend to define the term “meal” or create a comprehensive list of food products that qualify as light snacks, items similar to the following could generally be considered acceptable:

- Fruit
- Raw vegetables
- Pastries
- Cookies or other small bite size dessert items
- Crackers
- Muffins
- Cheese
- Chips

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- Yogurt
- Nuts

It is the responsibility of plan sponsors to monitor the actions of all agents selling their plan(s) and take proactive steps to enforce this prohibition. Oversight activities conducted by CMS will verify that plan sponsors and agents are complying with this provision, and enforcement actions will be taken against the plan sponsor as necessary.

## **70.2.2 - Nominal Gift Disclaimer**

***(Rev. 93, Issued: 06-04-10, Effective/Implementation: 06-04-10)***

42 CFR 422.2268, 423.2268

*Plan sponsors must include a written statement on all materials advertising/promoting drawings, prizes or any promise of a free gift that there is no obligation to enroll in the plan.* For example:

- “Eligible for a free drawing and prizes with no obligation.”
- “Free drawing without obligation.”

## **70.3 - Unsolicited E-mail Policy**

***(Rev. 93, Issued: 06-04-10, Effective/Implementation: 06-04-10)***

42 CFR 422.2268(d) 423.2268(d)

A plan sponsor **may not** send e-mails to a beneficiary, unless the Medicare beneficiary agrees to receive e-mails from the plan sponsor and the beneficiary has provided his/her e-mail address to the plan sponsor. Furthermore:

- Plan sponsors are prohibited from renting and purchasing e-mail lists to distribute information about MA, *PDP*, or *section 1876 cost plans*.
- *Plan sponsors may not e-mail prospective members at e-mail addresses obtained through friends or referrals*
- *Plan sponsors must provide an opt-out process for beneficiaries who no longer wish to receive e-mail communications.*

## **70.4 - Marketing through Unsolicited Contacts**

***(Rev. 93, Issued: 06-04-10, Effective/Implementation: 06-04-10)***

42 CFR 422.2268(d), 423.2268(d)

As reflected in 42 CFR 422.2268(d) and 42 CFR 423.2268(d), there is a general prohibition on marketing through unsolicited contacts. In general this prohibition includes the following and may extend to other instances of unsolicited contact that may occur outside of advertised sales or educational events. Some examples include:

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- *Door to door solicitation including leaving information such as a leaflet, flyer, or door hanger, or leaving information such as a leaflet or flyer on someone's car.*
- Approaching beneficiaries in common areas (e.g., parking lots, hallways, lobbies, etc.)
- *Telephonic or electronic solicitation including leaving electronic voicemail messages on answering machines, text message, or e-mail contact.*
- *NOTE: Agents/brokers who have a pre-scheduled appointment which becomes a "no-show" may leave information at the no-show beneficiary's residence.*

The prohibition on marketing through unsolicited contacts does not extend to mail and other print media provided they are constructed and approved in accordance with the information set forth in these *Medicare Marketing* Guidelines. Leads may still be generated through mailings, websites, advertising and public sales events. Refer to § 70.3 regarding email policy.

Plan sponsors will be held accountable for all actions of agents/brokers selling their products, and plans/agents/brokers should be wary of any company selling beneficiary contacts that claims to be permissible under our guidance. Plan sponsors should also note that *Medicare Marketing* Guidelines and regulations apply to Medicare age-ins as well as existing beneficiaries.

In addition, permission given by a beneficiary to be called or otherwise contacted is to be considered short-term, event-specific, and **may not** be treated as open-ended permission for future contacts. All business reply cards used for documenting beneficiary agreement for a contact must be submitted to CMS for review/approval.

## **70.5 - Specific Guidance on Telephonic Contact**

*(Rev. 93, Issued: 06-04-10, Effective/Implementation: 06-04-10)*

42 CFR 422.2268(d), 423.2268(d)

Because telephonic contact with Medicare beneficiaries is performed for a variety of reasons, the following guidance has been developed to further clarify the scope of the restrictions. While CMS understands that plan sponsors might have previously received beneficiary consent to contact them for sales activities, we view that previous consent as limited in scope, short-term, *and* event-specific. **Consent may not** be treated as open-ended permission for future contacts. The exceptions are for agents contacting their own clients and also plans and their employed or contracted agents contacting their current members. *In addition, all plans sponsors must be in compliance with § 170 regarding the use of beneficiary data as related to telephonic contact. Also refer to § 80.1.9 for information about script review and approval.*

Prohibited telephonic activities include, but are not limited to, the following:

- Conducting or allowing unsolicited contacts, including unsolicited outbound calls, to beneficiaries to offer a non-MA or non-PDP product if the unsolicited contact also discusses MA or PDP products. (Examples of non-MA or non-PDP products include, but are not limited to: a discount prescription drug card, a Medigap plan, a needs assessment,

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an educational event, a review of Medicare coverage options, or any other service or product that is not an MA plan or PDP.)

- Referrals of beneficiaries and/or their contact information resulting in an unsolicited contact. The purpose of this policy is to avoid unsolicited contacts based on a claim by an agent/broker that they have a “referral” from a friend or other third-party. Plan sponsors or agents/brokers are permitted to leave contact information such as business cards with beneficiaries for them to give to friends that they are referring to the agent or plan sponsor. However, in all cases, a referred beneficiary needs to contact the plan or agent/broker directly. A call from an agent to a beneficiary who was referred would be considered an unsolicited contact.
- Outbound marketing calls, unless the beneficiary requested the call. This includes contacting existing members to market other Medicare products, except as permitted below.
- Calls to former members who have disenrolled, or to current members who are in the process of voluntarily disenrolling, to market plans or products, except as permitted below. Members who are voluntarily disenrolling from a plan should not be contacted for sales purposes or be asked to consent in any format to further sales contacts.
- Calls or visits to beneficiaries who attended a sales event, unless the beneficiary gave express permission at the event for a follow-up call or visit (including a completed scope of appointment form).
- *Calls to beneficiaries to confirm receipt of mailed information, except as permitted below.*

Plan sponsors may do the following:

- Contact beneficiaries who submit enrollment applications to conduct quality control and agent/broker oversight activities. Scripts for this purpose, like all other call scripts, must be submitted to CMS for review and approval.
- Contact their members or use third parties to contact their current members. Examples of allowed contacts include, but are not limited to, calls to members aging-in to Medicare from commercial products offered by the same sponsoring organization and calls to an organization’s existing Medicaid plan members to talk about its Medicare products.

*However, plan sponsors may not conduct unsolicited calls to their Medigap enrollees regarding their, MA, Part D or section 1876 cost plan products.*

- Conduct outbound calls to existing members to conduct normal business related to enrollment in the plan, including calls to members who have been involuntarily disenrolled to resolve eligibility issues.

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- Call former members after the disenrollment effective date to conduct disenrollment surveys for quality improvement purposes. Disenrollment surveys may be done by phone or sent by mail, but neither calls nor mailings may include sales or marketing information.
- Under limited circumstances and subject to advance approval from the appropriate CMS Regional Office, call LIS-eligible members that a plan is prospectively losing due to reassignment to encourage them to remain enrolled in their current plan.
- *Call beneficiaries who have expressly given permission for a plan or sales agent to contact them, for example by filling out a business reply card or asking a customer service representative (CSR) to have an agent contact them. This permission applies only to the entity from which the beneficiary requested contact, for the duration of that transaction, for the scope of product (e.g., MA-PD plan or PDP) previously discussed or indicated in the reply card.*
- *Return beneficiary phone calls or messages, as these are not unsolicited.*
- *Contact current enrolled members via an automated telephone notification to inform them about general information such as the AEP dates, availability of flu shots, upcoming plan changes and other important information.*

### Agents/Brokers:

- May contact members that they enrolled in a plan to discuss plan issues and market other plan options, but **cannot** conduct unsolicited phone calls to other beneficiaries or plan members. During an agent's outbound call to a client, the agent is not required to set up an appointment to discuss other available plans/products with the beneficiary.
- May initiate a phone call to confirm an appointment that has already been agreed to by a beneficiary via a completed scope of appointment form.

Plan sponsors **may not** accept an MA plan or PDP appointment that resulted from an unsolicited contact with a beneficiary (including if the call started based on a non-MA or non-PDP product). We reiterate that any agent/broker who is a producer for an MA or PDP contractor is subject to the CMS marketing requirements at any point that an MA or PDP product becomes part of a discussion with a beneficiary, even if during a sale of an unrelated product, such as long-term care insurance. (See scope of appointment guidance in § 70.9.1)

*If during the course of an outbound call by a Medigap issuer the beneficiary requests additional information on a MA or PDP product, at this time a discussion can be held on the MA or PDP product, as long as the call is being recorded.*

Furthermore, third-parties **may not** make unsolicited MA or PDP marketing calls to beneficiaries (other than to current plan members if contracted by a plan, as described below) to set up appointments with potential enrollees.

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- Third-parties **may not** make unsolicited calls to beneficiaries for non-MA and PDP products (for example, a “benefits compare” meeting) and provide those contacts to plans for ultimate use as an MA or PDP sales appointment.
- Sales of MA and PDP products are subject to CMS’ scope of appointment guidance, even if conducted during a sales appointment for a Medigap policy.

Finally, for those outbound calls (refer to § 70.4, 70.6, and 80) that are allowable under these *Medicare Marketing* Guidelines, plan sponsors must comply to the extent applicable with the following:

- Federal Trade Commission’s Requirements for Sellers and Telemarketers
- Federal Communications Commission rules and applicable State law
- National-Do-Not-Call Registry
- Honor “Do not call again” requests, and
- Abide by Federal and State calling hours

*All* outbound scripts utilized by the plan *sponsor* or its contractors must be submitted for review and approval prior to being used in the marketplace. When conducting outbound calls:

- Scripts must include a privacy statement clarifying that the beneficiary is not required to provide any information to the plan representative and that the information provided will in no way affect the beneficiary’s membership in the plan. *Plans using outbound auto-dialing that is informational in nature will not be required to include the disclaimer in their scripts.*

*Plan sponsors are prohibited from requesting beneficiary identification numbers (e.g., Social Security numbers, bank account numbers, credit card numbers, Health Insurance Claim number (HICN), and birthdates). NOTE: This policy does not extend to calls to existing members to conduct normal business related to enrollment in the plan.*

- Plan sponsors are allowed to say they are contracted with Medicare to provide prescription drug benefits or that they are a Medicare-approved MA-PD plan/PDP.
- Plan sponsors **cannot** use language in outbound scripts that implies that they are endorsed by Medicare, calling on behalf of Medicare, or that Medicare asked them to call the member.

## ***70.5.1 - Specific Guidance on Third-party Contact*** ***(Rev. 93, Issued: 06-04-10, Effective/Implementation: 06-04-10)*** 42 CFR 422.2268(d), 423.2268(d)

*Plan sponsors and their representatives are prohibited from engaging in direct unsolicited contact* with potential enrollees, including outbound calls. This guidance applies to all downstream contractors, including third-party organizations utilized to

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generate sales leads and/or appointments. As such, plan sponsors should keep in mind that CMS views the following activities as out of compliance:

- Unsolicited MA plan or PDP marketing calls to beneficiaries (other than to current plan members if contracted by a plan, as previously described) to set up appointments with potential enrollees.
- Unsolicited calls to beneficiaries for non-MA and PDP products (for example, a “benefits compare” meeting) and providing those contacts to plans for ultimate use in an MA or PDP sales appointment.

Sales of MA and PDP products are subject to our scope of appointment guidance, even if conducted during a sales appointment for a Medigap policy. This includes the requirement for a beneficiary-completed agreement form prior to the appointment and a 48-hour waiting period.

Any plan sponsor or its representative that accepts an appointment to sell an MA or PDP product that resulted from an unsolicited contact with a beneficiary, regardless of who made the contact, will be in violation of the prohibition against unsolicited contacts.

## **70.6 - Outbound Enrollment and Verification Calls to All New Enrollees**

***(Rev. 93, Issued: 06-04-10, Effective/Implementation: 06-04-10)***

42 CFR 422.2272(b), 423.2272(b)

*All plan sponsors are required to conduct outbound enrollment and verification (OEV) calls for enrollments effectuated by agents and brokers – including both independent and employed agents and brokers - to ensure individuals requesting enrollment understand the plan rules. It is important for the plan sponsor’s sales staff to obtain from the applicant the best phone number to be used for verification and to provide a description of the enrollment verification process to the applicant during the application process. OEV calls must be made to the applicant after the sale has occurred; they cannot be made at the point of sale. The plan sponsor must ensure that the verification calls are not conducted by sales agents and that sales agents are not physically present with the applicant at the time of the verification call. Plan sponsors may not use automated calling technologies to effectuate these outbound calls; the calls must be interactive. The plan sponsor must conduct these calls for all enrollment requests generated by agents and brokers (including both independent and employed agents and brokers). Excluded from this requirement are enrollments into employer or union sponsored plans, enrollments into PACE plans, enrollments submitted to plan sponsors by qualified State Pharmaceutical Assistance programs (SPAPs), and auto-enrollments, facilitated enrollments, and reassignments effectuated by CMS. Please note that if an individual with LIS makes an enrollment request that supersedes or changes a CMS-generated enrollment, and that election is effectuated by an agent or broker, the outbound verification requirements apply.*

*The outbound verification requirements apply to sales agents and other plan representatives only when they are acting in the role of sales agents and as such, are steering beneficiaries to one or a subset of all available plans. In other words, if a licensed agent is acting strictly as a customer service representative – that is, carrying out customer service duties such as providing factual information, or taking demographic information in order to complete an enrollment request at the initiative of an enrollee who has already decided to enroll in a plan – the outbound enrollment verification*

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*requirements do not apply. However, if there is steering and/or marketing by the CSR/agent and an enrollment request results, such an enrollment request is subject to the OEV requirements.*

*Plan-to-plan switches within an MA or Part D parent organization (both contract-to-contract and within contract) require outbound enrollment verification if the enrollment request involves a change in plan type or plan product (e.g., HMO to PPO, SNP HMO to non-SNP HMO). Plan-to-plan switches within an MA or Part D parent organization involving the same plan type or product type (e.g., PFFS to PFFS, DE SNP to DE SNP, PDP to PDP) are not subject to OEV requirements.*

*A model outbound enrollment verification call script is available at ([http://www.cms.hhs.gov/ManagedCareMarketing/09\\_MarketngModelsStandardDocumentsandEducationalMaterial.asp#TopOfPage](http://www.cms.hhs.gov/ManagedCareMarketing/09_MarketngModelsStandardDocumentsandEducationalMaterial.asp#TopOfPage)).*

*Refer to Chapter 2 of the Medicare Managed Care Manual and Chapter 3 of the Medicare Prescription Drug Benefit Manual for detailed information on outbound education and verification call requirements in the context of enrollment processing.*

### **70.7 - Educational Events**

***(Rev. 93, Issued: 06-04-10, Effective/Implementation: 06-04-10)***

***42 CFR 422.2268(1), 423.2268(1)***

*Educational events are defined by the way in which an event is described to the Medicare beneficiary. An event hosted by the plan sponsor or an outside entity is considered an educational event if the event is advertised to beneficiaries as “educational.”*

*Educational events may not include any sales activities such as the distribution of marketing materials or the distribution or collection of plan applications.*

*The intent of this guidance is not to preclude plan sponsors from educating beneficiaries about their products; rather, it is to ensure that events that are advertised as “educational” comply with CMS’ requirements. **More specifically, plan sponsors may provide education at a sales or marketing event, but may not market or sell at an educational event.***

*The following are examples of acceptable materials and activities by plan sponsors or their representatives at an educational event:*

- Materials provided that meet the CMS definition of education; that is, informing a potential enrollee about MA or other Medicare programs, generally or specifically, but not steering, or attempting to steer, a potential enrollee towards a specific plan or limited number of plans. Specifically, any material distributed or made available to beneficiaries at an educational event must be free of plan-specific information (this includes plan-specific premiums, co-payments, or contact information), and any bias toward one plan type over another.*
- A banner with the plan name and/or logo displayed (See § 40.7 and 50 for disclaimer guidance).*
- Promotional items, including those with plan name, logo, and toll-free customer service number and/or website. Promotional items must be free of benefit information and consistent with CMS’ definition of nominal gift.*
- **A business card if the beneficiary requests information on how to contact the plan or agent for additional information, as long as the business card is free of plan marketing or benefit information.***

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- *Advertisements for the event may be distributed to either enrollees, non-enrollees, or both.*
- *Meals may be provided as described in § 70.2.1.*
- *Plan sponsors may participate in educational health fairs and health promotional events as either a sole sponsor or co-sponsor of an event hosted by <sup>86</sup> multiple organizations as long as the event does not include a sales presentation and is billed as educational.*
- *Respond to questions asked at an educational event. A response by plan sponsor's representative to questions will not render the event as sales/marketing provided no enrollment form is accepted.*

*Plan sponsors or their representatives **may not:***

- *Discuss plan-specific premiums and/or benefits.*
  - *Distribute plan specific materials.*
  - *Distribute or display business reply cards, scope of appointment forms, enrollment forms or sign-up sheets.*
  - *Set up personal sales appointments or get permission for an outbound call to the beneficiary.*
  - *Attach business cards or plan/agent contact information to educational materials; however, upon a request by the beneficiary a business card can be provided.*
  - *Hold an educational event where participants are asked if they want information about a specific plan or limited number of plans.*
  - *Accept enrollment forms. This included collecting completed enrollment forms or helping beneficiaries complete an enrollment form and then placing the form in a stamped envelope for the beneficiary to mail at a later date.*
- The following are examples of events that are considered marketing/sales events, and are therefore subject to all guidance noted in § 70.8:*
- *A plan sponsor advertises a presentation as educational, but after the presentation the agent asks if anyone would like to hear more about any specific options available to them. In this situation, the entire event would be considered a marketing/sales event. Similarly, a plan sponsor may not advertise an educational event and then have a marketing/sales event immediately following in the same general location (same hotel, for example).*
  - *A plan sponsor conducts events where beneficiaries can get educational materials, a blood pressure check and enroll in the plan.*
  - *An agent goes into a senior housing complex to talk about Original Medicare and/or Medigap policies, but then discusses an MA plan or PDP.*
  - *An agent attends a community-sponsored health fair, and hands out plan-specific benefits information including premium and/or copayment amounts; or <sup>87</sup> the agent hands out only educational materials but gives a brief presentation that mentions plan-specific premiums and/or copayment amounts.*
  - *A SHIP hosts an event that is not advertised to beneficiaries as “educational.” A plan sponsor may be invited to discuss plan-specific benefits.*

### **70.8 - Marketing/Sales Events**

***(Rev. 93, Issued: 06-04-10, Effective/Implementation: 06-04-10)***

***42 CFR 422.2268, 423.2268***

## CMS Marketing Guidelines – Marketing

*Marketing/sales events are defined by both the range of information provided and the way in which that content is presented to the Medicare beneficiary. In addition, marketing/sales events are defined by the plan's ability to collect applications and enroll Medicare beneficiaries during the event. There are two main types of marketing/sales events – formal and informal. All sales events are open to the general public and to all Medicare beneficiaries.*

*Note that if an event is scheduled as a marketing/sales event then requirements for marketing/sales events must be met, even if only one person is in attendance at the event. Formal marketing/sales events are typically structured in an audience/presenter style with a sales person or plan representative formally providing specific plan sponsor information via a presentation on the products being offered. In this setting, the presenter usually presents to an audience that was previously invited to attend.*

*Informal marketing/sales events are considered marketing events and are usually conducted in a less structured presentation and/or environment to an audience and/or passersby. They typically utilize a table or kiosk manned by a plan sponsor representative who can discuss the merits of the plan's products.*

*Marketing/sales events allow a plan sponsor representatives to proactively discuss the merits of a plan or plan(s) to an interested beneficiary, whereas educational events only allow representatives to reactively answer questions posed by the interested party.*

*Plan sponsor marketing of non-health care related products (such as annuities and life insurance) to prospective enrollees during any MA or Part D sales activity or presentation is considered cross selling and is a prohibited activity. Beneficiaries already face difficult decisions regarding Medicare coverage options and should be able to focus on Medicare options without confusion or implication that the health and non-health products are a package. Plans may sell non-health related products on inbound calls when a beneficiary requests information on other non-health products. Marketing to current plan members of non-MA plan covered health care products, and/or non-health care products, is subject to HIPAA rules.*

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*In addition, the following information, which applies to both formal and informal sales/marketing events, further distinguishes these marketing events from the other types of events outlined by CMS in these Medicare Marketing Guidelines.*

*At marketing/sales events plan sponsors may:*

- Distribute health plan brochures and enrollment advertising materials (including enrollment forms).*
- Accept and perform enrollments.*
- Formally present benefit information to the audience via a scripted talk, electronic slides, handouts, etc.*
- Provide a scope of appointment form for a subsequent meeting; if a beneficiary requests a one-on-one meeting then the beneficiary must fill out a scope of appointment.*
- Provide educational content to the audience or passersby.*
- Provide a nominal gift to attendees with no obligation. Note that the value of any give-away, including entertainment, must be consistent with CMS' definition of nominal gift.*
- Contribute cash towards prize money to a foundation or another entity if the event is jointly sponsored. The plan cannot claim to be the sole donor of the prize and it must be clear that the prize is attached to the event and not the individual organization.*

## CMS Marketing Guidelines – Marketing

*At marketing/sales events, plan sponsors must:*

- *Announce all products/plan types that will be covered during the presentation at the beginning of that presentation (e.g., HMO, PFFS, MSA, etc).*
- *Submit all sales scripts and presentations for approval to CMS prior to their use during the marketing/sales event (see § 80 for additional information).*
- *Clearly read or state the following disclaimer during PFFS presentations/events:*
- *For non-network PFFS plans: “A Medicare Advantage Private Fee-for-Service plan works differently than a Medicare supplement plan. Your provider is not required to agree to accept the plan’s terms and conditions of payment, and thus may choose not to treat you, with the exception of emergencies. If your provider does not agree to accept our terms and conditions of payment, they may choose not to provide health care services to you, except in emergencies. If this happens, you will need to find another provider that will accept our terms and conditions of payment. Providers can find the plan’s terms and conditions of payment on our website at: [insert link to PFFS terms and conditions of payment].”*

- *For full and partial network PFFS plans: “A Medicare Advantage Private Fee-for-Service plan works differently than a Medicare supplement plan. We have network providers (that is, providers who have signed contracts with our plan) for [[full network PFFS plan insert: all services covered under Original Medicare]][partial network PFFS plans should indicate the category or categories of services for which network providers are available]]. These providers have already agreed to see members of our plan. If your provider is not one of our network providers, then the provider is not required to agree to accept the plan’s terms and conditions of payment, and thus may choose not to treat you, with the exception of emergencies. If your provider does not agree to accept our terms and conditions of payment, they may choose not to provide health care services to you, except in emergencies. If this happens, you will need to find another provider that will accept our terms and conditions of payment. Providers can find the plan’s terms and conditions of payment on our website at: [insert link to PFFS terms and conditions of payment].”*

- *Clearly explain the following during SNP presentations/events:*

- *Eligibility limitations (e.g., required special needs status)*
- *Special enrollment period (SEP) to enroll in, change or leave SNPs*
- *Process for voluntary disenrollment if the beneficiary loses his/her Medicaid or institutional status (or becomes ineligible for the C-SNP)*
- *A description of how drug coverage works with your plan.*

*At a marketing/sales event, plan sponsors **may not:***

- *Conduct health screening or other like activities that could give the impression of “cherry picking.”*
- *Compare one plan sponsor to another by name unless both plan sponsors have concurred.*
- *Provide meals to attendees (refer to § 70.2.1 on exclusion of meals).*
- *Require beneficiaries to provide any contact information as a prerequisite for attending the event. Plans should clearly indicate on any sign-in sheets that completion of any contact information is optional.*

## CMS Marketing Guidelines – Marketing

- *Plans sponsors may not ask beneficiaries to provide personal contact information in order to participate in a raffle or drawing. Plan sponsors should use other mechanisms (e.g., raffle tickets, random numbers) for conducting the drawings.*

- *Use prohibited statements at marketing/sales event (as stated in these Medicare Marketing Guidelines). 90*

*Plan sponsors must upload all marketing/sales events prior to advertising the event (or prior to the event’s scheduled date if there is no advertisement) but no later than the last day of the month prior to the event and can complete the upload requirement via HPMS. For detailed instructions, please refer to the “Marketing Events” section in the user guide of the HPMS Marketing module. Plan sponsors should follow these instructions to upload any marketing events in HPMS. Note that EGHP events that are only for EGHP members should be excluded from entry in HPMS.*

*In the Event Name field, plan sponsors should begin each Event Name field entry with either one of the following, followed by the actual event name:*

- *Informal*
- *Formal*
- *Educational*

*For example, “Informal: Walmart Kiosk”*

*Only formal and informal marketing/sales events are required to be uploaded into HPMS, and should now be named either “Formal” or “Informal” at the start of the Event Name Field.*

*Although plan sponsors are not required to submit educational events in HPMS, many organizations are choosing to do so. Plan sponsors that submit these types of events in HPMS should ensure that the term “educational” precedes the event name in the event name field.*

*Amendments to marketing/sales events (e.g. cancellations, changes of room and other updates and edits) must be updated in HPMS at least forty-eight (48) hours prior to the scheduled event. Plan sponsors should enter cancellations of marketing/sales events as soon as possible in the HPMS Marketing Module Events module. A functionality is available for both the “New Event” and “Update Events” data entry options. For detailed instructions, please refer to the “Marketing Events” section in the user guides for HPMS marketing module.*

*CMS has established the following requirements on how all plan sponsors should notify beneficiaries when advertised scheduled sales events have been cancelled. The method used to notify beneficiaries of the cancellation may vary depending on the individual plan’s circumstances.*

*1. If a sales event is cancelled within forty-eight (48) hours before its originally scheduled date and time, the plan sponsor must:*

- *Notify its Regional Office Account Manager of the cancellation and cancel the event in HPMS.*

- *Ensure a representative of the plan sponsor is present at the site of the cancelled sales event, at the time that the event was scheduled to occur, to inform attendees of the cancellation and distribute information about the plan*

*sponsor. The representative should remain on site at least 15 minutes after the scheduled start of the event. If the event was cancelled due to inclement weather, a representative is not required to be present at the site.*

## CMS Marketing Guidelines – Marketing

*2. If a sales event is cancelled more than forty-eight (48) hours before the originally scheduled date and time, the plan sponsor must notify beneficiaries of the cancellation by the same means the plan sponsor used to advertise the event. Plan sponsors must also notify the Regional Office Account Manager. Examples of reasonable notification are:*

- If an announcement of the sales event was made in the newspaper, then the cancellation of the event must also be announced through the same newspaper. If the newspaper's production and/or distribution schedule prohibits timely notification, the plan sponsor must provide evidence to the respective Account Manager (newspaper guidelines with submission timelines, run dates, etc.).*
- If beneficiaries were identified through personal calls, then a representative of the plan sponsor must call the beneficiaries to inform them of the cancellation.*
- If beneficiaries RSVP for the sales event, then a representative of the plan sponsor must call the beneficiaries to inform them of the cancellation.*
- If an announcement of the sales event was sent through a mass mailing, then the plan sponsor should consult with the Regional Office to decide upon the most reasonable way to notify beneficiaries about the event cancellation in a short amount of time instead of a sending another mass mailing.*

*Notification of cancelled sales events should be made, whenever possible, more than forty-eight (48) hours prior to the originally scheduled date and time of the event. If beneficiaries are notified of a cancellation more than 48 hours before the event, then there is no expectation that a representative of the plan sponsor will be present at the site of the event.*

### ***70.8.1 - Additional Guidance for Marketing Events in the Provider Setting (Rev. 93, Issued: 06-04-10, Effective/Implementation: 06-04-10)***

42 CFR 422.2268(j) and (k), 423.2268 (j) and (k)

As used in specific guidance about provider activities, the term “provider” refers to all providers contracted with the plan and its sub-contractors, including but not limited to, pharmacists, pharmacies, physicians, hospitals, and long-term care facilities.

These *Medicare Marketing* Guidelines are designed to guide plan sponsors and providers in assisting beneficiaries with plan selection, while at the same time striking a balance to ensure that provider assistance results in plan selection that is always in the best interest of the beneficiary. Providers that have entered into co-branding relationships with plan sponsors must also follow these guidelines.

### ***70.8.2 - Plan Activities and Materials in the Health Care Setting (Rev. 93, Issued: 06-04-10, Effective/Implementation: 06-04-10)***

42 CFR 422.2268(k), 423.2268 (k)

Plan sponsors may not conduct sales activities in healthcare settings except in common areas. Common areas where marketing activities are allowed include areas such as hospital or nursing home cafeterias, community or recreational rooms, and conference rooms. If a pharmacy counter area is located within a retail store, common areas would include the space outside of where patients wait for services or interact with pharmacy providers and obtain medications.

## CMS Marketing Guidelines – Marketing

Plan sponsors are prohibited from conducting sales presentations, distributing and accepting enrollment applications, and soliciting Medicare beneficiaries in areas where patients primarily intend to receive health care services or are waiting to receive health care services. These restricted areas generally include, but are not limited to, waiting rooms, exam rooms, hospital patient rooms, dialysis center treatment areas (where patients interact with their clinical team and receive treatment), and pharmacy counter areas (where patients interact with pharmacy providers and obtain medications). The prohibition against conducting marketing activities also applies after business hours in these settings. An example of this includes providers sending out authorization to their members, such as nursing home members, to request that the member give permission for a plan sponsor to contact them about available plan products (through mail, hand delivery or attached to an affiliation notice).

*Only upon request by the beneficiary are plan sponsors permitted to schedule appointments with beneficiaries residing in long-term care facilities (including nursing homes, assisted living facilities, board and care homes, etc.). Providers are permitted to make available and/or distribute plan marketing materials as long as the provider and/or the facilities distributes or makes available plan sponsor marketing materials for all plans with which the provider participates. CMS does not expect providers to proactively contact all participating plans; rather, if a provider agrees to make available and/or distribute plan marketing materials they should do so knowing it must accept future requests from other plan sponsors with which it participates. Providers are also permitted to display posters or other materials within the long-term care facility and in admission packets announcing all plan contractual relationships. Long term care facility staff are permitted to provide residents that meet the I-SNP criteria an explanatory brochure for each I-SNP with which the facility contracts. The brochure can be explanatory about the qualification criteria and the benefits of being an I-SNP. The brochure may have a reply card or telephone number for the resident or responsible party to call to agree to a meeting or request additional information.*

### **70.8.3 - Provider-Based Activities**

**(Rev. 93, Issued: 06-04-10, Effective/Implementation: 06-04-10)**

42 CFR 422.2268(j), 423.2268(j)

CMS holds plan sponsors responsible for any comparative/descriptive material developed and distributed on their behalf by their contracting providers. The plan sponsor must ensure that any providers contracted (and its subcontractors, including providers or agents) with the plan sponsor comply with the requirements outlined in this chapter.

The plan sponsor must ensure that any providers contracted (including subcontractors or agents) with the plan sponsor to perform functions on their behalf related to the administration of the plan benefit, including all activities related to assisting in enrollment and education, agree to the same restrictions and conditions that apply to the plan sponsor through its contract. In addition, the plan sponsor (and subcontractors, including providers or agents) are prohibited from steering, or attempting to steer an undecided potential enrollee toward a particular provider, or limited number of providers, offered either by the plan sponsor or another plan sponsor, based on the financial interest of the provider or agent (or their subcontractors or agents). *While conducting a health screenings, providers may not distribute plan information to patients since both activities are prohibited marketing activities.*

# CMS Marketing Guidelines – Marketing

CMS is concerned with provider activities for the following reasons:

- Providers may not be fully aware of all plan benefits and costs; and
- Providers may confuse the beneficiary if the provider is perceived as acting as an agent of the plan versus acting as the beneficiary's provider.

Providers may face conflicting incentives when acting as a plan sponsor representative. For example, some providers may gain financially from a beneficiary's selection of one plan over another plan. Additionally, providers generally know their patients' health status. The potential for financial gain by the provider influencing a beneficiary's selection of a plan could result in recommendations that do not address all of the concerns or needs of a potential plan enrollee.

Beneficiaries often look to health care professionals to provide them with complete information regarding their health care choices (e.g., providing objective information regarding specific plans, such as covered benefits, cost sharing, drugs on formularies, utilization management tools, and eligibility requirements for SNPs). To the extent that a provider can assist a beneficiary in an objective assessment of the beneficiary's needs and potential plan sponsor options that may meet those needs, providers are encouraged to do so. To this end, providers may certainly engage in discussions with beneficiaries when patients seek information or advice from their provider regarding their Medicare options. All payments that plans make to providers for services must be fair market value, consistent for necessary services, and otherwise comply with all relevant laws and regulations, including the Federal and any State anti-kickback statute.

For enrollment and disenrollment guidance related to beneficiaries residing in long-term care facilities (e.g., enrollment period for beneficiaries residing in long-term care facilities and use of personal representatives in completing an enrollment application), please refer to Chapter 2 of the Medicare Managed Care Manual and Chapter 3 of the *Medicare* Prescription Drug Benefit Manual. <sup>94</sup>

Providers should remain neutral parties in assisting plan sponsors with marketing to beneficiaries or assisting with enrollment decisions. Providers not being fully aware of plan benefits and costs could result in beneficiaries not receiving information needed to make an informed decision about their health care options. Therefore, it would be inappropriate for providers to be involved in any of the following actions:

- Offering sales/appointment forms.
- Accepting enrollment applications for MA/MA-PD plans or PDPs.
- Directing, urging or attempting to persuade beneficiaries to enroll in a specific plan based on financial or any other interests.
- Mailing marketing materials on behalf of plan sponsors.
- Offering anything of value to induce plan enrollees to select them as their provider.
- Offering inducements to persuade beneficiaries to enroll in a particular plan or organization.
- *Health screening and distributing information to patients, are prohibited marketing activities.*
- Accepting compensation directly or indirectly from the plan for beneficiary enrollment activities.

Providers contracted with plan sponsors (and their contractors) are permitted to do the following:

## CMS Marketing Guidelines – Marketing

- Provide the names of plan sponsors with which they contract and/or participate (See § 70.8.4 for additional information on affiliation.)
- Provide information and assistance in *applying for the LIS*.
- *Make available and/or distribute plan marketing materials for a subset of contracted plans only as long as providers offer the option of making available and/or distributing marketing materials to all plans with which they participate. CMS does not expect providers to proactively contract all participating plans to solicit the distribution of their marketing materials: rather, if a provider agrees to make available and/or distribute plan marketing materials for some of its contracted plans, it should do so knowing it must accept future requests from other plan sponsors with which it participates. To that end, providers are permitted to:*
  - *Provide objective information on plan sponsors' specific plan formularies, based on a particular patient's medications and health care needs.* 95
  - *Provide objective information regarding plan sponsors' plans, including information such as covered benefits, cost sharing, and utilization management tools.*
  - *Make available and/or distribute plan marketing materials including PDP enrollment applications, but not MA or MA-PD enrollment applications for all plans with which the provider participates.*
- *To avoid an impression of steering, providers should not deliver materials/applications within an exam room setting.*
- *Refer their patients to other sources of information, such as SHIPs, plan marketing representatives, their State Medicaid Office, local Social Security Office, CMS' website at <http://www.medicare.gov/>.*
- *Print out and share information with patients from CMS' website. or 1-800-MEDICARE.*

*Providers are permitted to make available and/or distribute plan marketing materials for a subset of contracted plans only as long as providers offer the option of making available and/or distributing marketing materials to all*

The “Medicare and You” Handbook or “Medicare Options Compare” (from <http://www.medicare.gov/>), may be distributed by providers without additional approvals. There may be other documents that provide comparative and descriptive material about plans, of a broad nature, that are written by CMS or have been previously approved by CMS. These materials may be distributed by plan sponsors and providers without further CMS approval. This includes CMS *Medicare Prescription Drug* Plan Finder information via a computer terminal for access by beneficiaries. Plan sponsors should advise contracted providers of the provisions of these rules.