

JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

August 10, 2018

Comments submitted electronically by Justice in Aging via Survey Monkey to CMS re 2019 Medicare Communications and Marketing Guidelines https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/CY2019_Medicare_Communications_and_Marketing_Guidelines.pdf

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10. Introduction

We begin with some overarching comments. We appreciate the extensive rewrite that CMS has undertaken in this Guidance. It provides increased clarity for plans and other stakeholders.

We have concerns that the Guidance does not impose sufficient affirmative disclosure obligations on brokers and agents. For example, we recommend that in a marketing call or visit, agents and brokers be required to at least offer to review a beneficiary's current providers against the plan's provider directory and to review current medications against the plan's formulary. If a beneficiary is a dual eligible, agents and brokers should be required to point out to the beneficiary where supplemental benefits (for example dental or vision) may overlap Medicaid benefits already available to the beneficiary.

More broadly, we see a need for CMS to issue guidance on how supplemental benefits may be presented. The flexibility that CMS is now allowing plans with respect to limiting benefits to certain diagnoses or certain geographic areas will be difficult to accurately explain to beneficiaries and the potential for marketing errors or abuses is high. It is important that CMS get ahead of this issue by setting disclosure requirements and standards for transparency during marketing.

20 Communications and Marketing Definitions

The definition of marketing is confusing in that it specifically mentions MA plans twice and could be read to only apply to Medicare Advantage, although we understand that the intent is to include PDPs. We also ask that the sentence: "Additionally, marketing contains information about the plan's benefit structure, cost sharing, and measuring or ranking standards," to "Additionally, marketing may contain information about the plan's benefit structure, cost sharing, or measuring or ranking standards." The change clarifies that any of the items listed are relevant to a determination that a document is marketing and all need not be present.

We appreciate that, in this definition, CMS expressly includes retention based marketing, which is an important element in plans' marketing strategies.

20.2 Activity and Material Designation

While we appreciate the effort to distinguish between marketing and other communications, we can see instances where a plan, for example, under the communications rubric, chooses right before the annual enrollment period to remind its members to use supplemental benefits, such as vision. Reminders to "Go to the gym"--when issued in September or October and not other times in the year—look similarly

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suspicious. We urge CMS to closely monitor non-marketing communications to ensure that they genuinely do not have a marketing intent.

30.1 Anti-discrimination

We share the concern of CMS about potential discrimination in marketing. In addition to the issues mentioned in the Guidance, we urge CMS to look particularly closely at D-SNP look-alikes, which are discriminatory not just in their marketing but also in their design, which is structured so that the plans would only be a reasonable choice for dual eligible beneficiaries.

We also ask that CMS be more specific in its reference to other federal anti-discrimination rules and requirements and cite as an example, HHS regulations found at 45 C.F.R. Part 92 since this set of regulations is directly applicable to the marketing and communications activities of plans and plan sponsors.

30.2 Standardization of Plan Name Type

We urge that CMS clarify that this requirement include stating that the plan is a D-SNP or C-SNP or I-SNP if applicable.

30.6 Electronic Communication Policy

We strongly object to permitting unsolicited email communication with prospective enrollees who do not have other relationships with the plan sponsor. Emails are only slightly less intrusive than phone calls. Allowing mailing is quite enough of an intrusion on older adults and persons with disabilities who need space to make rational decisions about their health care. See also our comments to Section 40.2.

30.7 Prohibited Terminology Statements

We question why CMS would permit unsubstantiated absolute or qualified superlatives in logos or taglines. Logos and taglines can be the most powerful portions of advertising campaigns. CMS has provided no explanation of why these items should be exempt from the general prohibition. We ask the agency to reconsider this policy.

We are also confused by the statement that non-D-SNP plans cannot claim that they have a relationship with the state Medicaid agency unless the plan has contracted with the state to coordinate Medicaid services. How would such a contract exist outside of a D-SNP on an MMP context? Is this section talking about MMPs? If so, it should be more explicit.

Further, we are concerned about the requirement that MA plans may not “target their marketing efforts exclusively to dual eligible individuals.” While we applaud this restriction, we are concerned about the term “exclusively.” It is easy for D-SNP look-alike plans to make perfunctory efforts to recruit non-duals in order to avoid a charge of “exclusive” recruiting. Targeting “primarily” at dual eligibles would be a more appropriate standard. We also note that much of the inappropriate targeting of non-D-SNPs to dual eligibles begins with a plan deductible and co-insurance structure that would only make sense for dual eligible. (See discussion in June 2018 MedPac Report to Congress at p. 273). To curtail inappropriate marketing to dual eligibles, CMS should look at both plan design and marketing practices.

30.8 Product Endorsement Testimonials

In its list of requirements for endorsements or testimonials, CMS has removed several previous rules:

- An endorsement or testimonial by an individual cannot use any quotes by physicians or other health care providers.
- A contracted or employed physician or health care provider cannot provide an endorsement or testimonial.
- An endorsement or testimonial cannot use negative testimonials about other Plans/Part D Sponsors.

We do not support the removal of these prohibitions, which are in place to ensure beneficiaries have accurate, unbiased information. Allowing physicians or other providers to provide testimonials or offer endorsements could unduly impact beneficiaries, given the unique aspects of the patient-provider relationship.

40.2 Marketing Through Unsolicited Contacts

We are very concerned about allowing unsolicited emails, which are only slightly less intrusive than telephone calls. Since we assume that CMS does not provide email addresses of beneficiaries to plans, this encourages buying email lists. It will be difficult if not impossible for CMS to monitor whether emails (and the email lists that plans purchase) are targeted to particular subgroups of beneficiaries in violation of CMS's anti-discrimination requirements. Further, it is cheap and easy for plans to barrage beneficiaries with emails, a practice that does not aid informed choice.

40.3 Marketing Through Telephonic Contact

We strongly object to allowing unsolicited calls to Medicaid/MMP enrollees about other Medicare products. Plan sponsors that participate in MMP demonstrations should be required to make a commitment to those demonstrations and not be allowed to poach members away from their own MMP products. We find it disconcerting that sponsors of MMPs both claim that they need to lock in enrollees to ensure success and at the same time want the opportunity to market their own competing plans to those same enrollees.

We also have questions about the provision allowing limited marketing calls to LIS-eligible individuals who are being reassigned to another Part D plan. We worry about a situation in which the only unsolicited phone contact they receive is from a plan that would require them to pay a premium if they remained. These individuals instead would benefit from unbiased counseling to assist in making an active choice based on their prescription drug needs. It is imperative, at the very least, that scripts direct beneficiaries to SHIP counseling and provide them with specific information on how to contact the local SHIP.

40.6 Marketing Star Ratings

We encourage CMS to include language in future years to prevent sponsors from marketing plans as having received 4 or 5 stars in previous years (i.e., "2 of the last 3 years") or from marketing sub-category, rather than overall, scores.

50.2 Marketing/Sales Events

It appears that there is an important typo in this section that permits rather than prohibits health screenings.

60.4.1 Special Guidance for Institutional Special Needs Plans (I-SNPs) Serving Long-Term Care Facility Residents

We hear from advocates that nursing facilities often aggressively steer residents to particular plans they favor, even when the facilities participate with multiple plans. This steering takes place even when an I-SNP is not involved. We ask therefore that this special guidance apply to all long-term care facilities and ask especially that the limitation on social workers accepting or collecting a scope of appointment or enrollment form apply to forms for any plan, not just an I-SNP.

60.5 Provider Affiliation Announcements

We ask that CMS clarify that provider affiliation announcements may not be made by telephone or email to anyone not a member of a plan or otherwise connected with a plan sponsor. Calling an individual who is not enrolled in a plan to report a new affiliation has no other purpose than marketing, either directly or indirectly, regardless of whether the call also discussed benefits or costs. Telephone calls are intrusive and many beneficiaries, once connected, feel an obligation to engage in conversation with the caller and feel undue pressure to enroll. CMS should consistently protect beneficiaries from such calls as it does from unsolicited marketing calls more generally. Further, as noted in our comments to Section 40.2, we urge CMS to also protect beneficiaries from unsolicited emails with such announcements.

70.1.3 Required Content

CMS is removing the requirements that plan websites include information on out-of-network coverage rules, service area, premiums and cost-sharing. We strongly encourage CMS to reinstate requirements for this content. This information is critical to evaluating and selecting coverage. Beneficiaries must have the opportunity to access this data via as many access points as possible.

We also ask that CMS consider adding a requirement that plan websites include information on how to provide Best Available Evidence (BAE) to the plan and contact information within the plan for BAE. In addition, we ask that CMS consider requiring that Part C plans include information on QMB billing protections and/or links to CMS information on those protections.

80.3 Required Scripts

We suggest deleting “ideally” from the second sentence in this suggestion. We believe that, for transfers to a marketing department, use of a yes/no question is always appropriate.

We suggest adding scripts on the following topics:

- QMB status of a member or billing protections for a member who is a QMB and how to obtain assistance from the plan in instances of improper billing
- If the plan has delegated networks or other limitations on an individual’s access to all the providers in the network, information on such limitations.

- If a plan has taken advantage of the new flexibilities with respect to limitations of certain supplemental benefits to members with particular diagnoses or to those in specific geographical areas, information about those limitations.
- Continuity of care and the plan's process to transfer members to in-network providers.

90.3 Non-English Language And Alternate Format Materials

As CMS is aware, a disproportionate number of marketing abuses have involved brokers marketing to mono-lingual or limited English proficient beneficiaries. In light of that reality, we ask that:

- With respect to the requirement to submit English translations of materials created in non-English language, CMS stress to plans that the requirement encompasses broker-created materials; that plans have an obligation to affirmatively ensure that broker materials are submitted; and, further, that the English language versions submitted must accurately reflect the non-English originals.
- CMS to reconsider its decision not to require submission of non-English translations of English-language documents. While we recognize that CMS may not have the capacity to review all translations, we think there is value in having the translations on file as a resource when there are complaints about marketing actions by specific plans or brokers. Further, even if CMS cannot undertake systematic review of non-English language documents, the agency could do some spot checking with the goal of developing best practices for plans and educating plans on their obligations.

100.2.1 Notification of Availability of Electronic Materials

We appreciate that CMS states explicitly that a hardcopy request remains until the enrollee leaves the plan or requests that hard copies be discontinued. We note that the guidance does not contain a similar statement with respect to requests for non-English language materials or alternate format materials. We ask that CMS add such statements in the next revision.

More generally, we ask that CMS carefully monitor and evaluate the impact of its decision to allow electronic delivery as the default for many important documents and share its evaluation with stakeholders. Our concern, as we expressed in our response to the earlier request for comments, focuses particularly on low income individuals who may have limited access to computers and low tech literacy.

100.4 List of Required Materials

We are very appreciative that CMS has significantly expanded the number of documents that must be translated into languages that meet the 5% threshold. We are particularly pleased that CMS recognizes the critical need for translation of documents directly affecting access to benefits, including documents related to coverage determinations and appeals, disenrollment or loss of LIS status. The Guidance represents an important step in improving language access for Medicare beneficiaries.

For clarity, we ask CMS to stress in the Guidance that for templates or model documents, plans must translate not only the standard/template language but also the information that is specific to the beneficiary. For example, the specific reasons that a plan is denying a coverage determination request must be translated as well as the standard language.

As we have many times in the past, we also urge CMS to revisit its current 5% threshold and consider adding a numerical threshold as well. Despite a Medicare population that includes, as CMS has discussed, over 200,000 LEP Chinese-speaking Medicare beneficiaries and over 100,000 each of Vietnamese, Tagalog, Korean, Russian and Italian speakers, none of those individuals, except for a small number of Chinese speakers in Medicare Advantage plans in particular localities, have guaranteed access to translated documents. Even some of the over 2 million Spanish speakers do not have translation rights in several states. There is a huge disconnect between these gaps in availability of key documents in languages that beneficiaries can understand and CMS's increasing efforts to address health disparities and its focus on person-centered care.

Also relevant is the on-going consolidation of plans. As the Kaiser Family Foundation has reported, in 2018 three Medicare Part D plan sponsors account for more than half of the 43 million Part D enrollees. In any analysis weighing burden to plans against importance to beneficiaries, the cost for large plans serving millions of members to translate at most a few dozen documents pales against the needs of hundreds of thousands of beneficiaries to understand their plan benefits. If CMS is unwilling to use a numerical measure at the plan level, we ask at least that the agency set a numerical threshold at the sponsor level so that large players would be required, for example to provide translations when they serve thousands of speakers of a non-English language across states. These plans are well situated to undertake these translations.

Although we believe the need for regulatory changes in translation requirements is urgent, we also ask in the short run that CMS encourage plans to voluntarily provide more translated materials in multiple languages. CMS could also facilitate sharing among plans of translations of model/template materials into language that currently do not meet the CMS thresholds. It is in plans' own interest to have their members understand communications. If CMS can minimize the financial and administrative burden of translation and assure plans of agency support for their efforts, we expect that language access can continue to improve.

110.1 Agent Requirements

In light of the extensive new flexibilities that CMS is permitting in plan design, we urge that CMS carefully review broker training and testing materials, as well as plan designed materials, to ensure broker understanding. It is particularly important that brokers understand any limits based on diagnosis or geography for supplemental benefits and that they are trained in how to present those details in a way that beneficiaries can understand.

110.3 Plan/Part D Sponsor Oversight

We are concerned that the Guidance does not sufficiently emphasize the need for proactive oversight of brokers by plans. Our impression from advocate reports about particular cases is that plan response often is ad hoc. We urge CMS to require that plans have protocols in place to respond to complaints of questionable broker conduct and that those protocols be followed. We also ask that CMS work with plans to develop best practices in broker monitoring, with particular attention to monitoring marketing in non-English languages and marketing to other vulnerable communities.

110.7.1 Rapid Disenrollment

Two apparent typos in the second sentence: "dis" should be "is" and "who" should be deleted.

120 Use of Medicare Beneficiary Information Obtained from CMS

To the extent that Medicare has email addresses for beneficiaries, we ask that information not be shared with plans. At the very least, plans should not be allowed to use such information for any marketing or communications activities for individuals who are not plan members.