

CENTER FOR DRUG AND HEALTH PLAN CHOICE

TO: Medicare Advantage Organizations
Medicare Advantage-Prescription Drug Organizations
Cost-Based Contractors
Prescription Drug Plan Sponsors
Employer/Union-Sponsored Group Health Plans

FROM: Teresa DeCaro, Acting Director, Medicare Drug & Health Plan Contract
Administration Group

RE: Issuance of the Final 2009 Medicare Marketing Guidelines

DATE: August 10, 2009

I am pleased to announce the release of the final 2009 Medicare Marketing Guidelines for Medicare Advantage (MA) organizations (MAOs); prescription drug plan (PDP) sponsors; section 1876 cost-based contractors; demonstration plans; and employer and union-sponsored group plans, including employer/union-only group waiver plans (EGWPs). The final 2009 Medicare Marketing Guidelines are posted at: <http://www.cms.hhs.gov/ManagedCareMarketing/> and are also being issued as Chapters 3 and 2 of the Medicare Managed Care Manual and the Prescription Drug Benefit Manual, respectively.

We note that, in 2008, CMS published several regulations that focused primarily on establishing additional beneficiary protections in both the MA and Part D programs. Most of these new provisions, which impact contract year 2009, focused on marketing standards. In keeping with our continuing efforts to update and clarify marketing requirements, the changes made to the final Medicare Marketing Guidelines are focused on consolidating recent statutory and regulatory changes, as well as other policy clarifications needed to enhance marketing operations under both the MA and Part D programs. CMS has and will continue to separately issue technical and procedural clarifications regarding CMS marketing models for contract year 2010.

We released draft revised Medicare Marketing Guidelines for public comment on May 18, 2009. We received a total of 1,730 comments from 94 entities, including MAOs, PDP sponsors, consumer advocacy groups, pharmacy associations, health plan associations, and State Departments of Health on the Draft Guidelines. After careful analysis of all comments received, we have made a number of important revisions and clarifications from draft to final.

We have clarified a number of areas in the final Guidelines based on comments, including:

- Standardization of plan names in marketing materials (section 40.16).

- Added new language clarifying Summary of Benefits (SB) requirements for SNPs, including the addition of a new SB section 4 that will include a comprehensive written statement describing the benefits that the individual is entitled to under Title XIX (Medicaid); the cost-sharing protections individuals are entitled to under Title XIX; and which of those benefits and cost sharing protections are covered under the SNP for dual eligible individuals (section 60.1).
- Clarified that employed agents are exempt from our agent/broker compensation requirements (section 120.5.3).
- Clarified our requirements with respect to the training, testing and licensure of agents and brokers (section 120.3).
- Including language on the use of the Medicare mark for all organizations that offer Part D plans. This guidance was included in the previous version of the Guidelines but was inadvertently omitted from the draft Guidelines. Since these requirements are still current, we have re-integrated the language in the final Guidelines (section 150).
- Added new requirements for plan sponsors regarding marketing/sales events, including activities that can and cannot be conducted in formal or informal settings, and activities that take place in common areas of health care settings (section 70.9).
- Added new requirements for plan sponsors whose legal or marketing names include the names of network providers, or whose downstream entities' legal or marketing names include the names of network providers, to include disclaimer language on their marketing materials indicating that other pharmacies or providers are available in their network (section 30.3).
- Added new requirement for plan sponsors to provide information about their plan or plans' ratings information on <http://www.medicare.gov> in their pre-enrollment packets, as well as their Summary of Benefits and ANOC/EOC. Sponsors will be required, in their Summary of Benefits and ANOC/EOC documents, to refer current and prospective enrollees to their plan ratings information on <http://www.medicare.gov> or to their customer service line to obtain a copy of their plan's (or plans') ratings information. CMS will provide additional guidance on this issue in subsequent guidance (section 30.14, section 30.9.1).
- Clarified that plan sponsors must disclose to beneficiaries, upon request, whether their primary care provider or pharmacy is available in the plan's network (section 80.1.3).

We also received a number of constructive comments recommending changes which we intend to address in future guidance, such as the inclusion of additional required plan types as part of our requirements regarding the standardization of plan names. Presently, there are no standardized plan type names for special needs plans (SNPs), nor is there any designation for the various types of SNPs (e.g., chronic care, institutional, or dual eligible).

Thank you once more for your interest in these Guidelines; with your assistance, we believe our final Guidelines have been significantly improved in terms of their clarity and

comprehensiveness. We look forward to our continued collaboration in ensuring that beneficiaries receive accurate, clear, and meaningful information about their Medicare health plan options.