Medicare Communications and Marketing Guidelines – Frequently Asked Questions

1. What are the Medicare Communications and Marketing Guidelines (MCMG)?
The Medicare Communications and Marketing Guidelines (MCMG), formerly known as the Medicare Marketing Guidelines, are a set of rules that insurance companies selling private Medicare plans must follow, and must ensure that their representatives follow, when promoting their products. These rules are meant to prevent plans from presenting misleading information about a plan's costs or benefits and to ensure that beneficiaries can make informed, independent decisions about their coverage. The MCMG also contains rules for how plan representatives (agents and brokers) may contact and market to beneficiaries.

From October 1 through Fall Open Enrollment (October 15 through December 7 each year), plans can contact and market to beneficiaries about plan offerings for the coming year. Plans are also allowed to market to certain beneficiaries at other times during the year, but these situations are more limited (see question 11).

2. What is the difference between plan marketing and plan communication?
The MCMG defines communications and marketing in different ways. This is an important distinction because plans are required to submit marketing materials to Medicare for review, but they are not required to get Medicare's approval for their communication materials.

Communications are activities and the use of materials that provide information to current and prospective plan enrollees.

- An example of communication would be a letter sent to plan enrollees that reads, "Swell Health enrollees can get their flu shot for $0 copays at a network pharmacy." This is considered communication because it is only provided to current enrollees and does not steer recipients toward a decision, instead just informing them that flu shots are available.

Marketing is a type of communication and is defined by Medicare as a set of activities and use of materials by plans that are meant to influence a beneficiary's decision-making process when selecting a plan. Marketing materials can contain information about a plan's benefits and cost-sharing structure (such as copays and deductibles).

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- An example of marketing would be a billboard that reads, "Swell Health offers $0 Premium Plans in Example County." This is plan marketing because the intent is to steer a beneficiary toward the plan.

3. What are Medicare's rules for marketing materials?
A Medicare Advantage or Part D plan's marketing materials must follow certain rules so that they are not misleading or inaccurate.

Plans cannot:

- Compare their plan to another plan by name in advertising materials
- Suggest that their plan is preferred by Medicare or the Department of Health and Human Services
    - **Exception:** Plans **can** use Medicare in their names as long as a) it follows the plan name (for example, the Acme Medicare Plan) and b) the usage does not suggest that Medicare endorses that particular plan above other Medicare plans
- Use the Medicare name or CMS logo, which could mislead someone to think they're speaking with a Medicare representative
- Say that they will keep a beneficiary enrolled even if the beneficiary fails to pay premiums
- Advertise benefits that aren't available in a person's service area or market savings that an individual with Medicare would not experience
    - Example: A plan cannot claim that someone would save $9,000 by joining their plan, when they mean that an individual would save this much compared to not having any health insurance.
- Use the word "free" to describe a zero-dollar premium
    - **Exception:** A plan **can** say that it has a zero-dollar premium, meaning it does not charge a premium in addition to the standard Part B premium that all Medicare beneficiaries are responsible for
    - **Exception:** Plans **can** use the word "free" when describing mandatory, supplemental, and preventive benefits provided with no cost-sharing for all enrollees

4. Generally, how can plans market to and contact beneficiaries during Fall Open Enrollment?
Plans are allowed to send individuals mail. However, unless an individual is currently enrolled in the company's plan, the company is not allowed to call, email, visit the individual's home, or approach the individual in public to market their plan without permission. Even if an individual filled out a business reply card (BRC) at an

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educational or marketing event, this does not give permission for a plan representative to come to someone's home.

Even if an individual is currently enrolled in a plan, the plan must provide them with the option to opt out of calls about Medicare products. Previously plans only had to provide an opt-out opportunity once, but now this must be done annually and in writing for all enrollees.

If an individual is interested in enrolling in a plan, an agent must give them a scope of appointment (SOA) form to agree on what kinds of products will be discussed during the appointment. This is supposed to protect individuals from being sold products they are not interested in. The marketing appointment with the agent must then take place at least 48 hours after agreeing on the scope of appointment, unless an individual walks in for an appointment or are approaching the end of a valid enrollment period (specifically if the SOA was completed during the last four days of the enrollment period). This is meant to help individuals not feel pressured or rushed to enroll in a plan.

Agents and brokers can have educational exhibits at public events, but they cannot try to enroll a beneficiary in their plan at these events. They can only give out their contact information on request, and then the beneficiary must be the one to call the agent or broker for more details (see question 7).

5. What are Medicare's rules for how and when Medicare Advantage and Part D plan representatives can call beneficiaries?

An agent or broker **can**:

- Call current plan enrollees
- Call beneficiaries who submit enrollment applications to provide guidance related to enrollment
- Call former enrollees to discuss why they disenrolled
- Call individuals who have given permission for a plan agent or broker to contact them
- Return phone calls and messages from individuals or plan enrollees

An agent or broker **cannot**:

- Make unsolicited calls
- Call based on referrals
- Call to market a plan or product to an enrollee who is in the process of disenrolling or has already disenrolled

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- Call an individual who attended a marketing event, unless the individual gave the plan agent or broker permission
- Call an individual to ask if they received mailed information

6. What are Medicare's rules for Medicare Advantage and Part D plan electronic communications with current members?
Plans are increasingly sending important documents to a beneficiary's email address, rather than mailing a hard copy. For example, leading up to Fall Open Enrollment, plans can send the Evidence of Coverage (EOC), formulary, and/or provider and pharmacy directories electronically to beneficiaries currently enrolled in the plan. The email must include a phone number to call to request hard copies.

Medicare Advantage and Part D plans can provide materials through email (or other electronic means) as long as they:

- Have prior consent from the plan enrollee
- Provide a way for the enrollee to opt out of electronic communications and receive hard copies
- Provide instructions for how to access electronic materials, such as instructions for finding the EOC on the plan's website
- Ensure that the enrollee's contact information is up to date
- Deliver materials in a timely manner

Plan enrollees who have an email address on file with their Medicare Advantage or Part D plan should be on the lookout for important plan documents in their inbox. Plans must have an opt-out option for enrollees who prefer to receive hard copies of materials.

7. In what locations can Medicare Advantage and Part D plan representatives contact Medicare beneficiaries?
Plans are only allowed to contact beneficiaries in certain locations. It is a Medicare marketing violation when a plan or plan representative contacts a beneficiary in a location that is not allowed.

Plans **can:**

- In health care settings, provide sales information in common areas, such as a cafeteria, conference rooms, or community rooms
- Come to a beneficiary's residence, if the beneficiary has scheduled an appointment with the plan
- Mail information, including marketing content, to beneficiaries
- Place ads in papers, online, and on television

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Plans **cannot:**

- Approach prospective enrollees in public areas, such as parking lots or malls.
- Post plan-specific information in the waiting rooms or treatment areas of health care settings
- Go door to door promoting themselves, or visit a beneficiary without a scheduled appointment

8. What are the rules for a Medicare Advantage or Part D plan's educational and marketing events?

Medicare has rules for what Medicare Advantage and Part D plans can do at educational and marketing events, and there are differences between the two types of events.

Educational events:

- Explicitly advertised as educational
- Held in a public venue (not in home or one-on-one settings)
- May include some communication activities and distribution of communication materials
- If for current enrollees, can include plan-specific information
- If for prospective enrollees, cannot include plan-specific information

At an educational event, plans cannot:

- Distribute marketing materials or enrollment applications
- Provide information about plan costs, such as copayments and premiums
- Display or attach plan representative contact information to education materials, unless a beneficiary requests this information
- Have a marketing event immediately after in the same location (such as in the same hotel)

Marketing events:

- Designed to steer or attempt to steer potential enrollees toward a plan or limited set of plans
- Must have invitations that say, "A salesperson will be present with information and applications."

At a marketing event, plan representatives can discuss specific plan information with beneficiaries and hand out enrollment applications. Plans must submit all of their sales scripts and presentations to Medicare for approval before using them. If a plan

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event is not specifically advertised as an educational event, then Medicare considers it a marketing event.

At a marketing event, plans cannot:

- Require a beneficiary to provide contact information to attend the event
- Give beneficiaries a health screening or give the impression they only want to enroll healthy people, which is known as cherry-picking
    - An example of cherry-picking would be a plan that has a marketing event on the second floor of a building without an elevator, requiring people to walk upstairs to attend the event.

9. Can Medicare Advantage and Part D plan representatives give gifts to beneficiaries?

Medicare Advantage and Part D plan representatives cannot give gifts to beneficiaries in exchange for signing up for their plan. However, they can use gifts for promotion, as long as the gift is given to everyone who attends a promotional event, not just people who sign up for the plan. These gifts must be worth no more than $15 and cannot be in the form of cash. For example, a plan is allowed to give out a notepad with the plan's name on it, since the item value is below $15. Gifts cannot be health benefits, such as a free checkup. Plans also can offer one large gift (e.g., a raffle prize) as long as the cost does not exceed $15 per expected attendee. For example, a raffle prize cannot be worth more than $150 if 10 people are expected to attend the event. At marketing or sales events, the plan is allowed to serve light snacks and refreshments, but these snacks combined cannot add up to a meal. Meals can be served at educational events, as long as the event meets Medicare's requirements for educational events (see question 8) and the meal is not worth more than $15.

10. What can happen at an appointment with a Medicare Advantage or Part D plan representative?

A beneficiary can schedule an appointment with a plan representative to discuss plan information (including costs and covered services), and the appointment can be in a beneficiary's home or in a public place, such as a coffee shop or library. Before the appointment, a beneficiary must fill out a scope of appointment form that formally indicates the topics they would like to discuss during the appointment. The marketing appointment with the agent must then take place at least 48 hours after agreeing on the scope of appointment, unless an individual walks in for an appointment or is approaching the end of a valid enrollment period (specifically if the SOA was completed during the last four days of the enrollment period). This is meant to help individuals not feel pressured or rushed to enroll in a plan.

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The plan representative cannot tell a beneficiary about products or plans that fall outside of this scope unless the beneficiary gave permission before the representative discussed them. For example, if a beneficiary schedules an appointment with a plan agent to discuss Medicare Advantage Plans, the broker cannot speak with the beneficiary about the company's supplemental (Medigap) policies as well, **unless** the beneficiary agrees to it and the broker documents a second scope of appointment.

11. How can Medicare Advantage and Part D plans market to and contact beneficiaries during the Medicare Advantage Open Enrollment Period (MA OEP)?

Medicare beneficiaries enrolled in Medicare Advantage Plans have an opportunity to change their coverage during the MA OEP, which runs from January 1 through March 31 of each year. A beneficiary enrolled in a Medicare Advantage Plan can use the MA OEP to enroll in a new Medicare Advantage Plan or to enroll in Original Medicare with or without a stand-alone Part D plan.

During the MA OEP, plans **cannot:**

- Send unsolicited materials advertising the opportunity to make additional enrollment changes, or reference the MA OEP
- Specifically target beneficiaries who are in the MA OEP because they enrolled in a Medicare Advantage Plan during Fall Open Enrollment
- Promote activities that intend to target the MA OEP as an opportunity to make further sales

During the MA OEP, plans **can:**

- Conduct marketing activities that focus on other enrollment opportunities, such as
    - Marketing to people turning 65 (individuals in their Initial Enrollment Period)
    - Marketing 5-star plans (5-star plans can enroll beneficiaries at any time throughout the year)
- Send marketing materials when a beneficiary requests them
- Have one-on-one meetings with a beneficiary, at the beneficiary's request
- Provide information on the MA OEP through a call center, at the beneficiary's request

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12. What are some tips to help beneficiaries understand the benefits that a Medicare Advantage or Part D plan is offering?
Leading up to and during Fall Open Enrollment, beneficiaries receive a lot of mail and see a lot of advertisements about plan options for the coming year.

First, beneficiaries should know that they do not have to act immediately and should take time to consider their current coverage and the available options. A beneficiary should read their plan's Annual Notice of Change (ANOC) or Explanation of Coverage (EOC) to learn about any changes to their plan for the coming year. If they did not receive this in the mail or through email, they should contact their plan to request a copy or visit their plan's website to find an electronic version.

Second, if a beneficiary has questions about something that a plan offers, they should contact the plan and ask for confirmation of the benefits in writing. For example, some plans advertise zero-dollar copays. A beneficiary should contact the plan to learn the specifics of that benefit. It may be that only some services are covered with a zero-dollar copay, rather than all services. Another example would be if a plan advertises supplemental benefits. The beneficiary should request written documentation from the plan that describes the supplemental benefits and any requirements a beneficiary must meet in order for a certain supplemental benefit to be covered.

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