CMS Final Medicare Marketing Rules Summary

General Information

- Most importantly, CMS does not finalize its proposal to prohibit TPMOs from distributing beneficiary contact information. Notably, CMS states that it is not even addressing or discussing this proposal in the final rule. This is excellent news.

- The final rule was published in the Federal Register on April 12, 2023.

- As we expected, the final rules are effective for marketing plans for Contract Year 2024.

- As we also expected, CMS finalized most of its proposals either without modification or with just minor tweaks to the language.

- CMS did, however, modify some of its proposals, and some modifications are helpful and provide more flexibility.

CMS Proposal to Prohibit TPMOs from Distributing Beneficiary Contact Information

- As noted above, CMS does not finalize this proposal. CMS does not even discuss this proposal in the final rule. CMS merely states, "We are not addressing our proposal to prohibit TPMOs from distributing beneficiary contact information in this final rule and may address it in a future final rule." This is excellent news.

CMS Proposals Adopted with Modification

- ***Revisions to Existing TPMO Disclaimer***. CMS had proposed to revise the existing TPMO Disclaimer to: (i) add language referencing SHIP availability and (ii) to require the names of all organizations that a TPMO represents. CMS adopts the SHIP proposal but changes the proposal requiring TPMOs to list names to instead require the TPMO to disclose the number of organizations and plans the TPMO represents that are available to the beneficiary. The existing TPMO Disclaimer is only required for TPMOs that do not sell for all MA organizations and/or Part D sponsors in a service area. Accordingly, if a TPMO does not sell for all MA organizations and/or Part D sponsors in the service area, the final TPMO Disclaimer consists of the statement:
    - "We do not offer every plan available in your area. Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. Please contact Medicare.gov, 1-800-MEDICARE, or your local State Health Insurance Program (SHIP) to get information on all of your options."

- ***New TPMO Disclaimer for TPMOs that Do Represent All Available Plans***. CMS had proposed a new TPMO Disclaimer for TPMOs that do represent all plans available in an area. CMS finalized this proposal but with the same modifications as above, an additional reference to SHIP availability and a statement of the number of organizations and plans represented by the TPMO. Accordingly, if the TPMO sells for all MA organizations and/or Part D sponsors in the service area the disclaimer consists of the statement:

- "Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. You can always contact Medicare.gov, 1-800- MEDICARE, or your local State Health Insurance Program (SHIP) for help with plan choices."
- Just like the TPMO Disclaimer required for TPMOs that do not sell for all MA and/or Part D sponsors in a service area, this new TPMO Disclaimer must be:
  - Used by any TPMO that sells plans on behalf of more than one MA organization or PDP sponsor.
  - Verbally conveyed within the first minute of a sales call.
  - Electronically conveyed when communicating with a beneficiary through email, online chat, or other electronic means of communication.
  - Prominently displayed on TPMO websites.
  - Included in any marketing materials, including print materials and television ads, developed, used or distributed by the TPMO.

- ***Effective Duration of SOAs and BRCs***. CMS proposed to limit the time period that SOAs and BRCs are valid to 6 months. Prior to CMS's proposal, CMS had not specified the duration of the effective period of SOAs and BRCs in regulation. CMS adopts its proposal but extends the effective duration of SOAs and BRCs from 6 months to 1 year.
  - Final Rule: Scope of Appointments are valid for 12 months following a beneficiary's signature date. BRCs or requests to receive additional information are valid from the beneficiary's signature date or the date of the beneficiary's initial request for information.
  - CMs explains that using a 12 month limit will facilitate a beneficiary giving permission annually to be reminded about the next AEP and the opportunity to evaluate (or reevaluate) MA and Part D plan options.

- ***List MA Organizations or PDP Sponsor Names on Marketing Materials.*** CMS proposed to prohibit marketing any products or plans, benefit, or costs, unless the names (or marketing names) of the MA organizations or Part D sponsors that offered the benefits are clearly identified. CMS also proposed requirements regarding how the names are displayed. CMS finalizes its proposal as proposed with minor modifications to require the marketing names be read or displayed at the same pace or in the same font as the phone number of contact information included in the advertisement.
  - Final Rule: Marketing of any products or plans, benefits, or costs, is prohibited unless the MA organization or PDP sponsor name (or their marketing name) of the entities offering the referenced products or plans, benefits, or costs are identified in the marketing material.
    - In print: Names must be in 12-point font and not in the form of a disclaimer or fine print
    - In TV, online, or social media: Names must either be read at the same pace as the phone number OR must be displayed throughout the entire ad in a font size equivalent to the advertised phone number, contact information, or benefits
    - In radio or voice-based ads: Names must be read at the same pace as the advertised phone numbers or other contact information

- ***Collecting BRCs and SOAs at Educational Events***. In the last few years, CMS has permitted agents and brokers to set up future personal marketing appointments, collect beneficiary

contact information, collect BRC cards and collect SOAs at educational events. CMS proposed to reinstate an earlier prohibition on agents and brokers from collecting BRCs, beneficiary contact information, or SOAs at educational events and from setting up future personal marketing appointments. CMS finalizes its prohibition on collecting SOAs at educational events and prohibiting agents from setting up future marketing appointments at educational events. However, CMS does not finalize its proposal to prohibit the collection of BRCs or beneficiary contact information, so agents and brokers may still collect that information.

- Final Rule: Agents and brokers may no longer make available or collect SOAs at educational events. Agents and brokers may no longer set up personal marketing appointments at educational events. Agents and brokers MAY make available and receive beneficiary contact information, including Business Reply Cards.

- ***Use of Medicare Name, Logo and ID Card.*** CMS adopts its proposal to limit the use of the Medicare name, logo, and Medicare card but with one modification to permit the use of the Medicare card image with CMS permission.
  - Final Rule: CMS prohibits the use of the Medicare name, CMS logo, or products or information issued by the Federal Government, including the Medicare card, in a misleading manner. Use of the Medicare card image is only permitted with authorization from CMS.
  - CMS in preamble commentary explains that prior authorization must be obtained from CMS to use the image of the Medicare card. The following may be reasons that CMS will authorize the use of the Medicare card: (i) Identifying the different between a MA organization or PDP sponsor's card from the Medicare card; (ii) displaying a picture of the Medicare card to remind beneficiaries that they do need to keep the card safe even though they are in an MA plan and (iii) showing the card so a beneficiary knows where to find their Medicare Beneficiary Identification number
  - CMS states in preamble commentary that it is necessary to consider and evaluate the facts when using the Medicare name, CMS logo, and products or information issued by the Federal Government to determine whether their use violates this provision. CMS states that disclaimers or taglines that are prominently placed, in a font size and color to be readily noticed, and that clearly explain that an entity or website is not affiliated with, endorsed by or otherwise somehow related to the federal government, CMS, HHS and or Medicare are essential.

- ***SOAs Required 48 Hours Prior to Personal Appointment***. CMS finalizes its proposal to require that SOAs be obtained at least 48 hours prior to the personal marketing appointment, In the final rule, CMS modifies its proposal by adding 2 exceptions: (1) beneficiaries approaching the end of an enrollment period, including AEP, OEP, ICEP, or an SEP – the rule does not apply if the SOA is completed during the last 4 days of the enrollment period; and (2) walk-in meetings that are unscheduled and beneficiary-initiated.
  - Final Rule: The MA plan or PDP sponsor (or agent or broker) must agree upon and record the Scope of Appointment with the beneficiary 48 hours prior to the scheduled personal marketing appointment or meeting, except for: (i) SOAs that are completed during the last 4 days of a valid election period for the beneficiary; and (ii) unscheduled in person meetings (walk-ins) initiated by the beneficiary.

<u>CMS Proposals Adopted Without Modification or With Minor Modifications</u>

- ***TPMOs Required to Submit Materials Into HPMS***. CMS proposed to require that TPMOs submit marketing materials into HPMS that are developed by the TPMO for multiple plans. Prior to this proposal, CMS permitted TPMOs to submit marketing materials developed for multiple plans but did not require them to do so. CMS also proposed to require TPMOs to receive *prior approval* from each MA organization or PDP sponsor on whose behalf the materials were designed and developed by the TPMO before submitting the materials into HPMS. CMS finalizes its proposal as proposed.
    - Final Rule: TPMOs must submit marketing materials into the HPMS Marketing Module if they were developed by the TPMO for multiple MA organizations or plans or PDP sponsors or plans. TPMOs must submit the materials to each MA organization or PDP sponsor on whose behalf the materials were created or will be used for review prior to submitting them into the HPMS portal.
    - Once the materials are submitted into the HPMS Marketing Module, the current process will continue to apply whereby plans must Opt In to the material before it may be used by a TPMO.
- ***Prohibit Use of Unsubstantiated Statements Without Supporting Data***. CMS proposed to prohibit superlatives unless substantiating supporting data is also provided (for all superlatives, including those in taglines). CMS also proposed to require that the supportive documentation and/or data be based on current data. CMS finalizes its proposal with minor tweaks.
    - Final Rule: Use of superlatives are prohibited unless sources of documentation or data supportive of the superlative is also referenced in the material. Such supportive documentation or data must reflect data, reports, studies, or other documentation that applies to the current or prior contract year. Including data older than the prior contract year is permitted provided the current and prior contract year data are specifically identified.
    - CMS explains that it considers footnotes explaining the basis, noting the source (with enough information for the beneficiary to locate), or providing the actual comparison to be sufficient documentation. CMS states that a citation referring the reader to the actual documentation with a link to the documentation to be acceptable.
- ***Prohibit Advertising Benefits Not Available in a Service Area***. CMS proposed prohibiting marketing benefits not available in a service area where the marketing appears, unless doing so is unavoidable in a local market. CMS finalizes its proposal as proposed.
    - Final Rule: Marketing materials may not advertise benefits that are not available to beneficiaries in the service area where the marketing appears, unless the advertisement is in local media that serves the service area where the benefits are available and reaching beneficiaries who reside in other service areas is unavoidable.
    - The exception for unavoidable marketing does not apply to national marketing. It is only applicable to advertising in a limited area.
    - CMS provides the following as examples of permissible exceptions where marketing is unavoidable in a local market: (i) newspaper ad in a metro area which is distributed to beneficiaries that liven within the metro area but the beneficiaries do not live within the service area of the plan for which the benefits are being marketed (DC newspaper marketing DC service area benefits but unavoidable because the "normal" distribution of the local newspaper includes parts of VA and MD too); (ii) local TV commercial airing in a specific market but may be picked up in an adjacent market (Baltimore TV channels can be seen in parts of DC market and vice versa)
    - CMS states that it will provide examples and additional assistance in the MMCG – so we should expect an update to these, too!

- ***Annual Opt-Out of Plan Business Contact***. Prior to this final rule, regulations permit MA organizations and Part D sponsors to contact existing members, and to a limited extent former members, to discuss plan business. CMS defines plan business as including calling current members to discuss Medicare products. CMS currently requires that MA organizations and Part D sponsors provide beneficiaries with the opportunity to opt out of contacted about plan business but has interpreted its regulation as requiring only a one-time opt-out opportunity. CMS proposed to require each MA organization and Part D sponsor to provide the opt-out information to all enrollees (regardless of intent to contact about plan business), at least annually in writing. CMS finalizes its proposal as proposed.
    - Final Rule: If the MA organization or PDP sponsor reaches out to beneficiaries regarding plan business, the MA organization must provide notice to all beneficiaries whom the plan contacts at least once annually in writing of the individual's ability to opt out of future calls regarding plan business.
    - CMS clarifies in commentary that plan business does not include contacting current enrollees regarding their existing plan and current coverage. Plans and agents are still permitted to call members regarding their current plan.
    - CMS clarifies in commentary that plan business is discussion about OTHER Medicare products (not the enrollee's current plan) OR other types of insurance or lines of business (for example, home or auto insurance).
    - CMS defers to pans on how best to communicate the annual written opt-out. CMS does not require a specific format.
- ***Prohibit Sales Events from Directly Following Educational Events***. Prior to this final rule, regulations permit sales events to immediately follow educational events as long as beneficiaries are afforded an opportunity to leave the educational event prior to the start of the sales event. CMS proposed to change this by prohibiting sales events from following educational events in the same location within 12 hours. CMS adopts its proposal as proposed.
    - Final Rule: Marketing events may not follow educational events in the same location within 12 hours. "Same location" is defined as the entire building or adjacent buildings.
- ***TPMO Call Recordings***. Current regulation requires TPMOs to record all calls with beneficiaries in their entirety. CMS proposed to limit the calls with beneficiaries that must be recorded to only those calls that involve sales, marketing, or enrollments. CMS finalized this proposal. CMS also finalizes its proposal that TPMO call recordings include virtual connections such as video conferencing but with a modification to clarify that the recording requirement only applies to the audio portion.
    - Final Rule: Contracts, written arrangements, and agreements between the TPMO and an MA plan, or between the TPMO and an MA plan's FDR must ensure that the TPMO records all marketing, sales, and enrollment calls, including the audio portion of calls via web-based technology, in their entirety.
- ***Require MA Organizations and Part D Sponsors to Have Monitoring and Oversight Plan and Report Agent Non-Compliance to CMS***. CMS proposed to require MA organizations and PDP sponsors to establish and implement an oversight plan that monitors agent and broker activities, identifies non-compliance with CMS requirements, and reports non-compliance to CMS. CMS finalizes its proposal as proposed.
    - Final Rule: MA organizations and PDP sponsors must establish and implement oversight plan that:
        - Monitors agent and broker activities;
        - Identifies non-compliance with CMS requirements; and
        - Reports non-compliance to CMS.

- Commenters requested clarification on what non-compliance needs to be reported to CMS. CMS responds to the comment with the following:
    - CMS agrees that additional information is needed on what non-compliance needs to be reported. CMS states that it will provide additional information in its MCMG, including examples in the future. (This more than suggests that CMS will be updating its MCMG published in February 2022 again.)
    - CMS states that it does not expect organizations to report minor, insignificant issues such as failing to go over one element in a required list of 18 elements.
    - However, CMS states that if an agent continually fails to address a significant number of elements, or especially after being notified of issues, or the agent's conduct could have beneficiary impact (for example, potential harm to the beneficiary), plans must report that.
- CMS provides the following description that it says a proper oversight program would include "at a minimum:"
    - A review of internal grievances and 1-800-MEDICARE complaints
    - Reviewing random samplings of past audio sales/marketing/enrollment calls
    - Listening to sales/marketing/enrollment calls in real-time
    - Secretly shopping web-based education and sales events
    - MA organizations and PDP sponsors should be able to identify areas where agents and brokers have not been adequately trained, agents and brokers who may not fully understand the product offerings they sell, and agents and brokers who improperly marketing to beneficiaries
    - MA organizations and PDP sponsors can then quickly act, with such activities like tailored training or disciplinary measures based on the specific issue for each agent and broker
    - Report specific agent or broker non-compliance to CMS

- ***CMS List of Required Elements Prior to Enrollment***. CMS proposed to require that MA organizations and PDP sponsors ensure that their agents' and brokers' marketing calls go over each CMS required question or topic, including information regarding primary care providers and specialists, prescription drug coverage, and costs, costs of healthcare services, premiums, benefits, and specific healthcare needs. CMS did not propose agents and brokers would be required to read standardized language or questions regarding the topics, but instead proposed to require that certain topics be addressed, prior to the enrollment.
    - Final Rule: MA organizations and PDP sponsors must ensure that, prior to an enrollment, CMS's required questions and topics regarding beneficiary needs in a health plan are fully discussed. Topics include information regarding:
        - primary care providers and specialists (that is, whether or not the beneficiary's current providers are in the plan's network);
        - prescription drug coverage and costs (including whether or not the beneficiary's current prescriptions are covered);
        - costs of healthcare services;
        - premiums
        - benefits
        - specific healthcare needs
    - CMS stated in the proposed rule it would provide in -sub-regulatory guidance more detailed questions and areas to be covered based on these general topics.
- ***Effect on Current Coverage Added to the Pre-Enrollment Checklist (PECL) and Review of PECL***. CMS proposed two changes. First, CMS proposed to add the effect on current coverage to the

list fo references currently provided on the PECL. Second, CMS proposed to require that plans review the PECL with the prospective enrollee during telephonic enrollments. CMS adopted its proposal as proposed in the final rule.

  - CMS explained in the preamble commentary to the final rule that MA organizations and Part D sponsors can decide whether they will require their agents and brokers to read the PECL in its entirety or require each item on the PECL to be discussed. It is CMS's expectation that the agent ensures the beneficiary understands the items in the PECL. Agents may confirm this understanding by receiving an affirmative answer to whether the prospective enrollee understands the information provided or asking the prospective enrollee if he or she has any questions.

- ***MA Organization Searchable Provider Directories***. MA organizations are required to have a searchable provider directory on their website. Current regulations do not identify the elements by which the provider directory can be searched. CMS proposed to require that the provider directory be searchable by every element, such as name, location, and specialty, required in CMS's model directory. CMS also proposed to require that provider directories include providers' cultural and linguistic capabilities. Thus, CMS's proposal would require MA organizations' provider directories be searchable by every element, including this new element.
  - Final Rule: MA plan provider directories must be searchable by every element required in the model provider directory, such as name, location, specialty.
- ***Summary of Benefits Medical Benefits***. CMS proposed to require that the Summary of Benefits list the medical benefits on the top half of the first page and in the order specified in the regulation. CMS adopted its proposal as final.
- ***Non-Renewal Notice***. CMS proposed to change the non-renewal notice from a model communication to a standardized communication to make clear that it must be used without modification. CMS adopts its proposal as final.
- ***Comprehensive Medication Review and Safe Disposal***. CMS proposed to include the comprehensive medication review written summary which Part D sponsors must provide to all MTM enrollees who receive a comprehensive medication review, and the safe disposal information that Part D sponsors must provide to all plan enrollees targeted for MTM. CMS adopted its proposal as final.