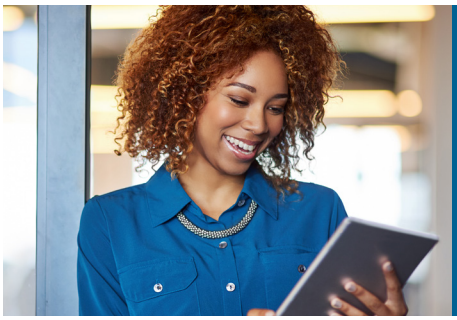

2024 CMS Final Rule Highlights & Clarification

Educational events

- No sales events may take place within 12 hours of an educational event in the same location.
- You may not set future marketing appointments or collect Scope of Appointments (SOA) at an educational event.
- You can collect Business Reply Card (BRC) or Permission to Contact (PTC) card if requested by an attendee.

Marketing materials

- Third Party Marketing Organizations (TPMOs) must get approval from carriers prior to submitting marketing materials in the Health Plan Management System (HPMS).
- Marketing materials cannot advertise benefits in areas they are not available.
- Marketing materials cannot advertise beneficiary savings based on comparisons to an uninsured individual.
- Benefits mentioned in materials must mention specific benefit amounts and identify the plan(s) offering them.
- Plans represented by marketing material must be listed on the material.

Medicare name & logo

- CMS strengthened the rule regarding the use of the word Medicare and other federally owned brand marks in a way that could confuse beneficiaries. CMS will require prior authorization to use certain marks, including the image of the Medicare Card.

Scope of appointment

- Agents must obtain a SOA no less than 48 hours prior to presenting and enrolling a beneficiary into a plan.
- There are two exceptions for the 48-hour rule:
  - SOA's that are completed during the last four (4) days of a valid election period for the beneficiary.
  - Unscheduled in person meetings (walk-ins) initiated by the beneficiary.
- SOA's are valid for 12 months following the date of beneficiary's signature date or initial request for information. The 12-month expiration also applies to BRC, PTC or requests to receive additional information.

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Door to door unsolicited contact

- CMS upholds the prohibition on unsolicited contact for Medicare Advantage/PDP (MA/PDP) products and has finalized that a BRC or PTC for not constitute permission to show up unscheduled to a beneficiary's home. Agents may only show up at a beneficiary's home with a scheduled appointment.

Call recording

- CMS is amending the requirement to record all calls. Only sales and enrollment calls are needed to be recorded starting September 30, 2023.
- CMS further clarified that virtual meetings, such as Zoom or FaceTime, do constitute a call, and the audio must be recorded as applicable.

Disclaimers

- The required disclaimer now applies to all TPMOs, including those offering only one plan in an area.
- Agents must add State Health Insurance Program (SHIPs) to the list of resources for all of their options.
- TPMOs must list the number of plans and products they represent in the area the beneficiary is in.
- If a TPMO does not sell for all MA organizations in the service area the 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 to get information on all of your options."
- If the TPMO sells for all MA organizations 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 for help with plan choices."

Pre-enrollment checklist

- The Pre-Enrollment Checklist (PECL) is a standardized form that is intended to help beneficiaries understand important plan benefits and rules. The PECL must be provided to prospective enrollees with the enrollment form. For telephonic enrollments, the contents of the PECL must be reviewed with the prospective enrollee prior to the completion of the enrollment.
- Prior to an enrollment, CMS' required questions and topics regarding beneficiary needs in a health plan choice must be fully discussed. Topics include information regarding primary care providers and specialists (that is, whether the beneficiary's current providers are in the plan's network), regarding pharmacies (that is, whether the beneficiary's current pharmacy is in the plan's network), prescription drug coverage and costs (including whether the beneficiary's current prescriptions are covered), costs of health care services, premiums, benefits, and specific health care needs.