GUIDED SOLUTIONS

IMPORTANT INFORMATION

Medicare 2024 Final Rule | New rules for agents

The rules noted are effective September 30th, 2023.

Please be sure to review the 2024 Final Rule in its entirety.

Use of Government products

The use of Government Products/info in a Misleading Way is **prohibited**. This includes the use of the CMS/ HHS and Medicare logo.

Agents may not have "Medicare" in their business name, logo, or URL.

CMS has seen instances where the word Medicare and the Department of Health and Human Services (HHS) have been used in misleading ways on websites, building signs, mailers, and other printed materials. There are also concerns about the use of Medicare in third party website URLs. CMS feels that the use of these words could mislead beneficiaries to think that the communications are coming from the federal government.

In an effort to eliminate confusion, CMS is adding language in the Code of Federal Regulations that will include additional restrictions on the use of the Medicare name, CMS logo and federal government issued information.

Medicare Advantage organizations and Part D sponsors will be held accountable for actions of those in their first tier, downstream and related entities. Because of these additional restrictions, it is likely that carriers will not approve communications and marketing materials that include the word Medicare or images of the Medicare card, except when describing the product advertised.

While there are obvious marketing items that CMS is targeting, it is also likely that other items will be examined much more closely.

Use of Superlatives in most marketing materials

The use of superlatives in most marketing materials is prohibited unless there is documented proof of the statement.

This means that words such as best, most, largest, or lowest can not be used to describe plans unless it meets CMS requirements and there is supporting language to back the statement.

Marketing benefits outside of plan coverage area

Agents may only market to beneficiaries that are in a plan's service area unless it is impossible to accomplish due to situations such as a TV ad that may also be in a market next to the intended market or newspaper ads in a metropolitan area.

This is especially important to remember when advertising 5-star plans, special needs plans (SNPs), and Part B giveback benefits.

Note: Referencing service area is one of the most frequently missed compliance points in telephonic/virtual enrollments. You must confirm that the beneficiary's primary residence (where they live for 6 months or more out of the year) is within the service area for the intended plan of enrollment.

Sponsors' Names must be included in benefits marketing.

Advertising that includes plan-specific benefits must clearly include the MAO or Part D sponsor name. If the ad is for radio or other voice related method*, the name must be clearly read at the same speed as the phone number.

The rule requires HPMS filing and carrier opt-in, where applicable, for marketing and communication material.

Marketing of Generalized Savings is prohibited.

This rule applies to statements of savings based on typical expenses of unpaid costs of dually eligible beneficiaries, uninsured individuals, and other unrealized costs.

When marketing Medicare it is not allowed to generalize savings when the savings is actually intended for a specific individual.

This is an important thing to keep in mind when working with third parties for lead generation as well as Dual Eligible Special Needs Plans (D-SNPs).

PTC & SOA updates

At least 48 hours are required between SOA completion and a scheduled personal marketing appointment. This reinstated rule includes two exceptions (A) When a beneficiary requests an appointment within four days of the end of a valid election period, including the AEP, OEP, SEP, ICEP or the month, based on eligibility; and (B) When a beneficiary initiates an in-person meeting.

SOA and BRC effective dates

A new limit of 12-months has been established for SOAs and BRCs. This time frame is based on the date of the beneficiary's signature. Once the time frame has passed a new SOA or permission to contact will be required. It is important to keep track of the start and stop dates.

Door-to-Door contact Prohibition

This rule is still in effect and makes it clear that filling out a business reply card (BRC)does not imply that a beneficiary's is giving permission for an agent to show up unannounced at their home. The agent must still have a scheduled appointment that details the date and time they will meet with the beneficiary.

Medicare Educational and Sales Events Rule Revision

Appointment Planning at Educational Events

The distribution of SOAs and scheduling of future appointments is prohibited at educational events.

The collection of BRCs and PTCs as well as distribution of business cards is allowed.

Marketing Event Following Educational Event Limitations

Marketing events are prohibited from taking place within 12 (twelve) hours of an educational event, in the same location. The same location is defined as the entire building or adjacent buildings.

Enrollment-Related Updates

New Pre-enrollment Element Requirements

Effect on Current coverage:

The pre-enrollment checklist (PECL) will now include the requirement that agents must explain how the beneficiary's current coverage will affect their enrollment choice.

The PECL contains important information prospective enrollees need to know prior to enrolling in an MA or Part D plan. It ensures beneficiaries understand important documents and what information is in such documents, such as:

- The Evidence of Coverage, which provides all costs, benefits, and plan coverage.
- Information designed to help beneficiaries, such as a reminder to make sure their doctors, pharmacies, and prescriptions are either in the plan's network or covered in their formulary.
- Reminding beneficiaries of certain plan rules, formularies, and that out-of-network services are not covered except for emergency and urgently needed care, and that benefits and costs may change on January 1 of each year.

Pre-enrollment Element Requirements

Ensure that, prior to an enrollment, CMS' required questions and topics regarding beneficiary needs in a health plan choice 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)
- Pharmacies (that is, whether or not the beneficiary's current pharmacy is in the plan's network)
- Prescription drug coverage and costs (including whether or not the beneficiary's current prescriptions are covered)

- Costs of health care services, premiums, benefits and specific health care needs.

Summary of Benefits (SB) Medical Benefits

CMS is requiring carriers to standardize their format, making it easier for beneficiaries to compare benefits.

The SB must include the following information:

Information on the following medical benefits, starting in the top half of the first page and in the order as identified, including—

(1) Monthly Plan Premium.

(2) Deductible/Out-of-pocket limits.

(3) Inpatient/Outpatient Hospital coverage.

(4) Ambulatory Surgical Center (ASC).

(5) Doctor Visits (Primary Care Providers and Specialists).

(6) Preventive Care.

(7) Emergency Care/Urgently Needed Services.

(8) Diagnostic Services/Labs/Imaging.

(9) Hearing Services/Dental Services/Vision Services.

(10) Mental Health Services.

(B) Information on prescription drug expenses, including:

(1) Deductible, the initial coverage phase, coverage gap, and catastrophic coverage.

(2) A statement that costs may differ based on pharmacy type or status (for example, preferred/non-preferred, mail order, long-term care (LTC) or home infusion, and 30-or 90-day supply), when applicable.

(C) For Medicare Medical Savings Account Plans (MSAs), the SB must include the following:

(1) The amount Medicare deposits into the beneficiaries MSA account.

(2) A statement that the beneficiary pays nothing once the deductible is met.

(D) For dual eligible special needs plan (D–SNP)s, the SB must identify or describe the Medicaid benefits to prospective enrollees. This may be done by either of the following:

(1) Including the Medicaid benefits in the SB.

(2) Providing a separate document identifying the Medicaid benefits that accompanies the SB.

(E) For D–SNPs open to dually eligible enrollees with differing levels of cost, the SB must:

(1) State how cost sharing and benefits differ depending on the level of Medicaid eligibility.

(2) Describe the Medicaid benefits, if any, provided by the plan.

(F) Fully integrated dual eligible SNPs (FIDE SNPs) and highly integrated D–SNPs, as defined in § 422.2, that provide Medicaid benefits have the option to display integrated Medicare and Medicaid benefits in the SB.

(G) MA organizations may describe or identify other health related benefits in the SB.

Medicare Call Recordings

Marketing, sales, and enrollment calls must be recorded per CMS.

Marketing includes materials that are retention based and influence a beneficiary's decision regarding enrollment in specific plans.

It is NOT necessary to record calls when setting an appointment or when checking in with a beneficiary after a sale.

Virtual calls must be recorded.

The call recording rule applies to video conferencing and other virtual telepresence types. This includes virtually conducting marketing, sales, or in enrollment calls. The video portion is not required, only the audio portion.

Beneficiary Assistance Eligibility Impact

Making Permanent: Limited Income Newly Eligible Transition (LI NET) Program

LI NET currently operates as a demonstration program that provides immediate and retroactive Part D coverage for eligible low-income beneficiaries who do not yet have prescription drug coverage. In this final rule, CMS is making the LI NET program a permanent part of Medicare Part D, as required by section 118 of the CAA.

Enhancing Financial Stability: Expanding Low-Income Subsidies Under Part D

CMS is finalizing regulations to expand eligibility for the full low-income subsidy (LIS) benefit (also known as "Extra Help") to individuals with incomes up to 150% of the federal poverty level who meet eligibility criteria. Beginning January 1, 2024, this change will provide the full low-income subsidy to those who currently qualify for the partial subsidy. This implements section 11404 of the IRA and will improve access to affordable prescription drug coverage for approximately 300,000 low-income individuals with Medicare.

Where applicable, the Guided Solutions marketing department will ensure all rule changes and updates are incorporated in the materials we develop. For more information please review the full *Medicare Communications and Marketing Guidelines, Medicare Advantage & Part D Communication Requirements or contact your manager.*