INTEGRITY®

NEW MEDICARE MARKETING RULES FOR 2023

# FREQUENTLY ASKED QUESTIONS

## Summary of Key Changes

CMS finalized new Medicare marketing rules that affect you. They are effective for marketing Calendar Year 2024 plans, which means that they are effective on October 1, 2023.

CMS also issued a memo expanding its interpretation of the definition of "marketing" to include content that mentions any type of benefit covered by a plan. This includes widely available benefits such as dental, vision, and/or hearing services. Beginning on July 10, 2023, CMS will consider any material or activity that is distributed via any means that mentions any benefit to be marketing that must be approved.

The following are some of the key changes or clarifications that you should know:

### Third-Party Marketing Organizations

- Third-party marketing organizations (TPMOs) only need to record sales, marketing, and enrollment calls
- Only the audio portion of web-based calls must be recorded
- TPMOs must use the TPMO Disclaimer even if they sell all Plans within a service area
- The TPMO Disclaimer now includes a reference to State Health Insurance Programs (SHIPs) and requires TPMOs to include the number of Carriers represented and Plans offered in a service area

### Beneficiary Contact

- Business Reply Cards (BRCs) or other beneficiary requests for information are valid for 12 months
- Agents and brokers may not go to an individual's home without a previously scheduled appointment for that date and time
- Plans must provide an annual opt-out to clients for plan business via telephone contact

### Scope of Appointments

- Scope of Appointment (SOA) forms are valid for 12 months
- Agents and brokers must obtain an SOA 48 hours prior to a personal marketing appointment unless it is the last 4 days of an individual's valid enrollment period or the individual initiated an in-person walk-in meeting

## Personal Appointments

- The Pre-Enrollment Checklist (PECL) is required to include the effect on current coverage
- Agents and brokers must fully discuss a specific list of questions and topics prior to the enrollment process
- For telephonic enrollments, agents and brokers must review the PECL in its entirety prior to the completion of the enrollment

## Events

- Agents and brokers may not hold a sales event within 12 hours of an educational event in the same location
- Agents and brokers may not distribute or collect SOA forms at educational events
- Agents and brokers may not set up future marketing appointments at educational events

## Third-Party Submissions to CMS

- Agents and brokers must submit multi-plan marketing materials in the HPMS portal
- Carriers must approve the multi-plan marketing materials prior to submission in the HPMS portal

## Marketing Materials

- Beginning on July 10, 2023, materials or activities that mention any benefit, even widely available benefits such as dental, vision, and/or hearing, will be considered marketing and must be submitted into HPMS
- Marketing materials that reference benefits, costs, products, or plans must list all Carrier names to whom the reference applies (size and speed requirements apply)
- Marketing materials may not advertise benefits that are unavailable in a service area unless it is unavoidable in the local media
- Agents and brokers may not advertise savings available based on expenses borne by uninsured individuals
- Agents and brokers may not advertise savings available based on unpaid costs of dually eligible individuals
- Agents and brokers may not advertise other unrealized “savings”

## Communications Materials

- Agents and brokers may not use superlatives without supporting data or documentation referenced
- Agents and brokers may not use “Medicare,” the CMS logo, or other products or information in a misleading manner
- Agents and brokers may not use the Medicare ID card image unless authorized to do so by CMS

## Compliance Obligations

- Carriers must have a monitoring and oversight plan that monitors agent and broker activities, identifies non-compliance with CMS requirements, and reports non-compliance to CMS

## Other Changes

- Provider directories must be searchable by every element required in the model provider directory, such as name, location, and specialty
- Plans must list the medical benefits in the top half of the first page of the Summary of Benefits in the order determined by CMS
- The non-renewal notice was changed from a model notice to a standardized notice

# Frequently Asked Questions

This Frequently Asked Questions (FAQs) document is designed to help you understand the changes, identify which changes apply to you, and inform you about resources that are available to help you comply. This document is not a summary of all Medicare marketing rules and guidelines. This document is also not intended to replace CMS's marketing rules or guidelines.

CMS's new rules apply to MA plans, PDP plans, and MAPD plans. We use the term "Plan" in this document to mean all three types and the term "Carrier(s)" to mean the MA organizations, PDP sponsors, and MAPD organizations that administer these plans.

The new changes apply to you and your downlines. Please forward this document to your downline agencies and independent agents.

**Key Takeaway:** Beware! Carriers can impose additional requirements on you. They may create their own rules and guardrails that are requirements for doing business with them. Be sure that you know the requirements of your contracted Carriers.

# Third Party Marketing Organizations

## TPMO Definition

### 1. Did CMS make any changes to the definition of a "third-party marketing organization?"

No, CMS did not change the definition of a "third-party marketing organization" or "TPMO." However, CMS made a change to the call recording requirement and made several changes to the TPMO Disclaimer.

## TPMO Disclaimer

### 2. How has the TPMO Disclaimer changed?

CMS changed the TPMO Disclaimer in three (3) ways:

- First, TPMOs that sell for all Carriers in a service area, even if a TPMO sells all commercially available Plans in the service area, must also use the TPMO Disclaimer.
- Second, the TPMO Disclaimer language now includes a reference to the local SHIP as a source of information for beneficiaries.
- Third, the TPMO Disclaimer language now requires TPMOs to state the total number of MA organizations or PDP sponsors they represent and the total number of products offered by those MA organizations or PDP sponsors in the service area.

### 3. What is the TPMO Disclaimer?

The TPMO Disclaimer is a standardized disclaimer. There is no longer one TPMO Disclaimer. There are now two different TPMO Disclaimers, and which one you should use depends on whether you represent all MA organizations or PDP sponsors within a service area.

If you do not sell for all MA organizations or PDP sponsors in the service area, you must use the following TPMO Disclaimer:

> "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 you do sell for all MA organizations or PDP sponsors in the service area, you must use the following TPMO Disclaimer:

> "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."

### 4. Can we modify the language of the TPMO Disclaimer?

No, the TPMO Disclaimer is a standardized disclaimer, so the language cannot be changed or modified in any way.

### 5. When is the TPMO Disclaimer required?

TPMOs must continue to use the applicable TPMO Disclaimer in all of the following scenarios:

- Verbally within the first minute of a sales call.
- Electronically when communicating with a beneficiary through email, online chat, or other electronic means of communication.
- Prominently on TPMO websites.
- All marketing materials, including print materials and TV ads, that the TPMO developed, used, or distributed.

TPMOs are still not required to use the TPMO Disclaimer:

- When meeting with a beneficiary in person.
- If the TPMO only sells Plans on behalf of one Carrier.

**Key Takeaway:** Except for TPMO websites and electronic communications, the TPMO Disclaimer is only required on advertisements that are marketing. If you want to avoid calculating and including the number of Carriers represented and Plans offered on advertisements, such as mailers, billboards, banners, online ads, TV ads, and radio ads, do not include any marketing content.

### 6. How do we calculate the number of carriers we represent and the number of products we offer?

The number of Carriers you represent and the number of Plans you offer will vary by the service area of the beneficiary. For example, if you represent ten (10) Carriers but only three (3) of those Carriers have a service area that includes a beneficiary's residence, the number of Carriers represented would be three (3). The number of products offered would be the total number of products offered (HMO, DSNP, PPO, etc.) available by those three (3) Carriers.

CMS does not provide any additional guidance, so it is unclear how CMS expects the number of Carriers represented and Plans offered to be populated across various media, such as TPMO websites, electronic communications, or marketing materials. This is particularly difficult for media that span multiple service areas where differing products may be available, such as a website. This is an area where additional guidance from CMS as to how to implement this requirement would be helpful, and we hope CMS will provide additional sub-regulatory guidance.

In the meantime, TPMOs should comply with the requirement when feasible to do so. Otherwise, TPMOs should comply to the extent feasible and be able to demonstrate a good faith attempt to comply with the requirement when it is not feasible.

### 7. How should we calculate the number of carriers represented and the number of plans offered in direct mailers?

You can likely control the service area to which a direct mail piece is distributed. This is because a direct mailing can be more easily targeted to a specific service area. As such, it is feasible to calculate the number of Carriers represented and Plans you offer in that specific service area. CMS would therefore likely expect that you include accurate numbers of Carriers and Plans for the service area of the mailing. You should have a reasonable process in place for updating the numbers of Carriers and Plans in your direct mailers, as they can change over time.

Remember that the TPMO Disclaimer is not required if the mailer is not marketing.

### 8. How should we calculate the number of carriers represented and plans offered in the TPMO Disclaimer on our website?

The TPMO Disclaimer is required on TPMO websites regardless of whether the website contains marketing content. In addition, a website may be viewable by any consumer in any location. It is not feasible to know the service area of all viewers, much less tailor the numbers of Carriers and Plans to their service areas.

In this case, you should be able to demonstrate a good faith attempt to comply with the requirement, and you should comply to the extent feasible. A good faith attempt to comply should take into account CMS's purpose for the requirement. CMS's stated purpose is to ensure that beneficiaries are aware about their options and that they may have multiple plans available in their service area. A good faith attempt to comply should also include having a reasonable process in place for updating the numbers, as they can change over time.

In the absence of CMS guidance, the following are some possible scenarios and ways that may convey a good faith attempt to comply with the requirement. You could use language elsewhere on your website to describe and make clear the service areas where you sell Plans. If the number of Carriers and the number of Plans is not uniform throughout the service areas, then you could use number ranges for the number of Carriers and the number of Plans. The ranges would include the lowest number in a service area, which would be zero if you do not offer Plans in a service area, and the highest number in a service area.

- Scenario 1: TPMO Sells Only in Illinois But Not in All Service Areas. Elsewhere on your website, you could make clear that: (i) you sell Plans in Illinois; and (ii) you do not sell Plans in all service areas in Illinois. It may then be reasonable for the TPMO Disclaimer to include a range for the number of Carriers (such as "0-3") and a range for the number of Plans ("0-8").

- Scenario 2: TPMO Sells in 48 States But Not in All Service Areas. Elsewhere on your website, you could make clear: (i) that you sell Plans in 48 states; (ii) the names of the states where you do not sell Plans; and (iii) that you do not sell Plans in all service areas in the 48 states. It may then be reasonable to for the TPMO Disclaimer to include a range for the number of Carriers and a range for the number of Plans. The lowest numbers of the ranges would be "0" for the service areas where you do not offer Plans and the service area with the highest number of Carriers would represent the highest number in the ranges.

### 9. How do we calculate the number of carriers represented and the plans offered for the TPMO Disclaimer in the first minute of a sales call?

First, remember that the TPMO Disclaimer is only required on sales calls, not all calls. Second, CMS interprets the term "sales" in this context as having its plain meaning. Arguably, a call that is purely informational, educational, and not marketing may not be a sales call. A call setting a future appointment would arguably not be a sales call.

However, the plain meaning of a "sales call" would certainly include calls that contain "marketing." Calls that contain marketing would be a personal marketing appointment and now first require an SOA to be obtained forty-eight (48) hours in advance. Sales calls will include calls made with an SOA after forty-eight (48) hours.

Thus, agents and brokers may now have some time to calculate the numbers of Carriers and Plans for these calls. The agent or broker will have an opportunity to obtain the service area of the individual before the sales call, such as when making the appointment and obtaining the SOA. The agent or broker has time to determine the number of Carriers represented and Plans offered before making the sales call and reading the TPMO Disclaimer.

This would not be the case for a beneficiary who is in the last four (4) days of a valid election period when the forty-eight (48) hour rule for SOAs does not apply. You may not immediately know the service area of an inbound caller. As a best practice, you should treat all calls as sales calls during the last four (4) days of the Annual Enrollment Period (AEP) and the Open Enrollment Period (OEP) and record those calls. You should also immediately attempt to determine the individual's service area and make a good faith attempt to state the TPMO Disclaimer within the first minute with the numbers of Carriers and Plans offered as accurately as possible.

## Required Call Recordings

### 10. What has changed about call recordings?

For the past year, TPMOs have been required to record all calls with beneficiaries in their entirety. CMS revised the rules so that only all marketing, sales, and enrollment calls must be recorded in their entirety. The requirement still applies to inbound and outbound calls.

You also must continue to obtain an individual's consent to record the call, and you must end the call if the individual refuses to grant permission to record the call.

### 11. Are Zoom or other web-based calls required to be recorded?

Yes, the audio portion of calls via web-based technology must be recorded if the calls are marketing, sales, or enrollment calls. This includes Zoom calls or other web-based technology platforms.

### 12. How does CMS define "marketing, sales, and enrollment calls?"

"Marketing" is defined in the same way that CMS defines whether communications materials and activities are "marketing" using the content and intent standard. A call is "marketing" if the call is:

- Intended to draw a beneficiary's attention to a Plan or Plans, influence a beneficiary's decision-making process when making a Plan selection, or influence a beneficiary's decision to stay enrolled in a Plan, and
- Includes or addresses content regarding Plan benefits, premiums, or cost sharing, measuring or ranking standards, or rewards and incentives.

"Sales" and "enrollment" are defined by the plain meaning of those words.

### 13. We make outbound calls to set future appointments with agents in response to Business Reply Cards (BRCs) and online forms completed by individuals requesting to be contacted. Do these outbound calls to set appointments need to be recorded?

No, calls merely to set appointments do not need to be recorded anymore because they are not sales, marketing, or enrollment calls. However, if any marketing content is discussed or it can be construed as a sales call, the entire call must be recorded. Please see the prior FAQ for the definitions of these words.

Aside from the TPMO call recording requirement, if a telephonic SOA is obtained on the call, the telephonic SOA must be recorded, and the recording must be retained for 10 years.

### 14. Are there other examples of calls that we do not need to record?

Yes, assuming that there is no marketing content discussed and the call cannot be construed as a sales call, the following are examples of calls that you do not need to record:

- Calls to confirm a beneficiary received a Plan welcome packet
- Calls to provide a beneficiary the opportunity to ask non-marketing questions (such as when the Plan will be effective)

**15. We are a TPMO, but we do not have the capability to record all marketing, sales, and enrollment calls. What resources does Integrity have to help?**

You are responsible for compliance with this requirement. Nonetheless, Integrity has built a call recording capability into Medicare Center. This call recording technology is FREE for all Integrity partners and their downline independent agents and brokers.

Integrity makes the technology available in an effort to assist you with Medicare compliance. However, you are not required to use Medicare Center. You may choose to use a different vendor if you prefer. If you use a different vendor, however, you are responsible for entering into an agreement with and paying that vendor directly.

# Beneficiary Contact, Appointments, and Events

## Beneficiary Contact

### 1. How long are BRCs or other beneficiary requests to receive additional information valid?

BRCs and other beneficiary requests to receive additional information, such as requests through online forms, are valid for twelve (12) months from the beneficiary's signature date or the date of the beneficiary's initial request for information. CMS believes 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.

### 2. Can we still collect BRCs at educational events?

Yes, you can still make available and receive BRCs or beneficiary contact information at educational events.

### 3. If a beneficiary returns a BRC or provides other documentation of a request for additional information, can we door knock or go the beneficiary's home?

No, contacting a beneficiary at the individual's home is unsolicited door-to-door contact that is not permitted unless an appointment at the beneficiary's home at the applicable date and time was previously scheduled.

A returned BRC or other documentation whereby a beneficiary requests additional information and provides their address does not permit an agent to go to the beneficiary's home.

### 4. Do beneficiaries have the opportunity to opt out of calls for plan business?

Yes, the final rules require Plans to 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.

Thus, beneficiaries must now receive an annual opt-out notice in writing.

### 5. Does CMS require a specific format or specific language for the annual opt-out notice?

No, Plans may determine how best to communicate the notice, as long as it is in writing. CMS does not specify how the notice should be communicated, specific language that must be used, or when the notice must be provided each year. The notice may be in a single letter, in a welcome packet, or in another method of written communication.

### 6. What can I do if an enrollee opts out of future calls for plan business?

You may not call them for plan business until they opt in. An enrollee's decision to opt out of calls for purposes of plan business remains in effect until an enrollee chooses to opt in.

However, plan business does not include contacting current enrollees regarding their existing plan and current coverage. You are still permitted to call members regarding their current plan. Plan business includes other Medicare products (not the enrollee's current plans) or other types of insurance or lines of business, so you may not call members about these plans.

You may also continue to reach out through email (with an opt-out function), direct mail, events, or other general marketing means.

### Scope of Appointment

**7. Is it true that agents and brokers must obtain an SOA forty-eight (48) hours prior to the personal marketing appointment?**

Yes, agents and brokers must obtain an SOA forty-eight (48) hours prior to the personal marketing appointment. There are only two (2) exceptions to this rule.

The first exception is for beneficiaries approaching the end of an enrollment period, including AEP, OEP, the Initial Coverage Election Period (ICEP), and a Special Election Period (SEP). The forty-eight (48) hour rule does not apply to enrollment within the last four (4) days of a beneficiary's valid enrollment period. This means the following:

- For AEP: If an SOA is completed on or after December 3, the appointment can occur between December 3 and December 7
- For OEP: If an SOA is completed on or after March 27, the appointment can occur between March 27 and March 31
- For other enrollment periods that end on the 31st of the month, the SOA can be completed on or after the 27th of the month
- For other enrollment periods that end on the 30th of the month, the SOA can be completed on or after the 26th of the month

The second exception is for walk-in in-person meetings that are unscheduled and are initiated by the beneficiary. This applies to beneficiaries who walk into an agent's office, a kiosk, a plan's office, or any other walk-in location.

**8. Does this mean that the forty-eight (48) hour rule does not apply during the last four (4) days of AEP or OEP?**

Yes, that is correct for AEP. For OEP, that is correct for individuals who are enrolled in an MA or MAPD Plan, because they are eligible to make a change during OEP.

**9. Does the forty-eight (48) hour rule apply to telephonic sales?**

Yes, it applies to personal marketing appointments that are telephonic sales. The walk-in exception does not apply to telephonic sales, so the only exception available for telephonic sales are for beneficiaries within the last four (4) days of a valid enrollment period.

### 10. Does the forty-eight (48) hour rule apply to call centers? Or are call centers exempt?

Yes, it applies to call centers. Call centers are not exempt. The walk-in exception does not apply to call centers, so the only exception available for call centers are for beneficiaries within the last four (4) days of a valid enrollment period.

### 11. Does the walk-in exception apply to "virtual walk-ins" or inbound calls received from individuals?

No, the walk-in exception does not apply to "virtual walk-ins" or inbound calls received from individuals. The walk-in exception only applies to walk-ins that are in-person meetings that are unscheduled and are initiated by the beneficiary.

### 12. What if the individual is returning an outbound call made by an agent?

The same forty-eight (48) rule applies to this scenario as well. The walk-in exception does not apply to calls, so the only exception available would be if the inbound call is made within the last four (4) days of a valid enrollment period for that individual.

### 13. How literally do we interpret the forty-eight (48) hour rule?

The forty-eight (48) hour rule should be interpreted literally. For example, if an individual signs an SOA at 4:00 PM on a Tuesday, their appointment cannot take place until after 4:00 PM on Thursday.

### 14. How long is an SOA valid?

SOAs are valid for twelve (12) months following a beneficiary's signature date.

### 15. Can we collect SOAs at educational events?

No, you may no longer make SOAs available or collect SOAs at educational events. Additionally, you may no longer set up future marketing appointments at educational events.

## Events

### 16. What changes has CMS made to educational events?

Agents and brokers may no longer do the following at educational events:

- Make available SOAs
- Collect SOAs
- Set up personal marketing appointments

Agents and brokers may continue to make available and collect beneficiary contact information, including BRCs. CMS states that it will interpret using BRCs at educational events like it permits Plan materials to be located in common areas of a provider's office.

**17. Is it true that sales events may not immediately follow educational events anymore?**

Yes, sales events may no longer immediately follow educational events if they are in the same location. A sales event may not follow an educational event in the same location within twelve (12) hours. "Same location" is defined as the entire building or adjacent buildings.

However, an agent may immediately conduct a sales event following an educational event as long as it is not in the same location. Alternatively, an agent may conduct a sales event in the same location following an educational event as long as twelve (12) hours have passed.

**18. Can two agents coordinate to have different types of events in the same location within a twelve (12) hour window?**

No. Two agents cannot coordinate to have different types of events in the same building or adjacent building within a twelve (12) hour window in order to circumvent the rule.

**19. Can two competing agents who inadvertently have different types of events in the same location within a twelve (12) hour window violate this new rule?**

No, if it is truly inadvertent. However, if the agents discover each other's events, they cannot coordinate in any way to circumvent the rule.

## Personal Appointments

**20. Do we need to explain any additional information to a beneficiary before enrolling a beneficiary in a plan?**

Yes, agents and brokers must now fully discuss a list of questions and topics regarding a beneficiary's needs prior to starting the enrollment process. CMS requires a specific list of topics to be addressed. The list of topics does not replace the PECL.

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 has indicated that it will provide more detailed questions and areas to be covered based on these general topics in sub-regulatory guidance.

### 21. Did CMS change the PECL?

Yes, CMS changed the PECL by adding the effect on current coverage to the PECL. The effect on current coverage was added to address CMS's concern that beneficiaries were not aware that their current coverage, such as an existing MA plan, a Medigap plan, or their TRICARE plan, would end once they enrolled in the MA plan.

### 22. Do we have to review the entire PECL? Or just the effect on current coverage?

Agents and brokers must now review the entire PECL with a prospective enrollee during telephonic enrollments. This requirement applies to the entire PECL, not just the effect on current coverage.

It is up to the Carriers to decide whether they will require their agents and brokers to read the PECL in its entirety or whether they will instead require each item on the PECL to be discussed. Regardless, CMS expects that agents and brokers will ensure that 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.

## Third-Party Submissions to CMS

### 1. When can third parties submit marketing materials directly to CMS?

As you know, all materials that meet CMS's definition of "marketing," including those created or used by third parties and downstream entities, must be submitted to CMS via the HPMS Marketing Module.

Previously, third parties were permitted to submit marketing materials directly to CMS. The final rules require third parties to submit marketing materials directly to CMS on behalf of their contracted Plans when the marketing materials created by the third parties:

- Include marketing content; and
- Are used by two or more Plans.

The third-party submission process is intended for multi-plan submissions. Third parties should not use the third-party submission process for marketing materials that only mention one Plan. In that case, the Plan should submit the material directly to CMS using the standard submission process.

Marketing materials should be submitted in CMS's HPMS Marketing Module.

### 2. What should third parties do before submitting multi-plan materials through the HPMS Marketing Module?

Third parties are required to obtain prior review of their multi-plan materials by each Carrier on whose behalf the materials were created or will be used before submitting through the HPMS Marketing Module.

Before this final rule, many Carriers already required third parties to submit the marketing materials they created to the Carriers for prior approval before filing the material in the HPMS Marketing Module.

Accordingly, you should allow plenty of time prior to the date you intend to use the marketing materials for the Carrier's review process and the CMS multi-plan submission process. Note that a Carrier may have a 20-business day turnaround time (or longer) for reviewing the material.

**Key Takeaway:** You are now required to submit multi-plan marketing materials to the HPMS Marketing Module, and you must obtain approval of multi-plan marketing materials from each Carrier **before** you submit the marketing materials to CMS.

### 3. Are there any other changes to the third-party multi-plan submission process?

No, unless CMS sub-regulatory guidance makes changes to the HPMS Marketing Module process, all other aspects of CMS's marketing material submission process remain the same. 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.

**Key Takeaway:** You may not use multi-plan marketing materials to sell any Plan for which the Carrier has not Opted-In to that material in the HPMS Marketing Module.

# Marketing Materials

### 1. What new changes apply to marketing materials?

CMS recently expanded its interpretation of the definition of "marketing" to include content that mentions any type of benefit that beneficiaries can receive, such as dental, vision, cost-savings, and/or hearing services. Beginning on July 10, 2023, all materials and activities that are distributed via any means (e.g., mailings, TV ads, social media, etc.) that mention any benefit are considered marketing and must be submitted into HPMS.

In addition, three (3) new requirements apply to the content of marketing materials.

- All marketing materials that market any products or plans, benefits, or costs, must clearly state the names of the MA organizations or PDP sponsors (or their marketing names) offering the referenced products or plans, benefits, or costs.
- Agents and brokers may not advertise savings available to potential enrollees that are based on a comparison of typical expenses borne by uninsured individuals, unpaid costs of dually eligible individuals, or other unrealized costs of a Medicare beneficiary.
- Agents and brokers 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 and advertising to beneficiaries outside the service area is unavoidable.

### 2. Do we need CMS approval to mention generic "dental, vision, and hearing" benefits or "cost-savings?"

Yes, CMS recently released guidance expanding its interpretation of the definition of "marketing." Content stating that beneficiaries can receive benefits such as dental, vision, cost-savings, and/or hearing services is sufficient to meet the content standard of "marketing." The agency also stated that inclusion of these statements in advertisements and activities directed to Medicare beneficiaries clearly meets the intent standard. Accordingly, you must obtain Carrier approval and CMS approval through the HPMS Marketing Module before you include general statements about any benefits, even widely available benefits.

Beginning on July 10, 2023, you may not distribute any material or activity through any means that mentions any benefit unless it has been submitted into HPMS. If you have not received Carrier and CMS approval for a material that mentions any benefit, you must remove the material before July 10, 2023.

**Key Takeaway:** Any material or activity that mentions any benefit, including, dental, vision, hearing, is now marketing and must be approved by the Carriers, submitted into the CMS HPMS Marketing Module, and Opted In to by the Carriers prior to use.

### 3. When are Carrier names required on marketing materials?

You must clearly state the names of all MA organizations or PDP sponsors (or their marketing names) offering the referenced products or plans, benefits, or costs on all marketing materials that market any products or plans, benefits, or costs.

### 4. Does this mean that there is no longer generic marketing?

Yes, this effectively means that there is no longer "generic" marketing (or marketing that does not mention a specific Plan or Carrier). This is because if an advertisement markets any products, plans, benefits, or costs, the names of all Carriers (or their marketing names) offering the referenced products, plans, benefits, or costs being marketed must be listed on the material.

### 5. How must Carrier names appear in marketing materials?

Carrier names must appear as follows in marketing materials:

- In print marketing, the names must be in 12-point font and may not be in the form of a disclaimer or fine print.
- In TV, online, or social media marketing, the 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 marketing, the names must be read at the same pace as the advertised phone numbers or other contact information.

"Fine print" means how it is generally defined to mean printed matter in small type or print displayed in an inconspicuous manner.

### 6. How can we list all Carriers on marketing material if it is fluid?

Remember that all marketing materials must be approved in advance by the Carriers whose products you will sell using those materials, and all such marketing materials must be submitted into the HPMS Marketing Module and Opted In to by all of those Carriers before you can use the materials. This means that you will need to allow a lot of time to obtain approval for materials after you contract with a Carrier. If your Carrier contracts are fluid such that you cannot allow sufficient time for approval from contracting, then you should either avoid using marketing materials or use only marketing materials that are created and provided to you by your contracted Carriers.

### 7. What do we do if all but one Carrier approves the marketing material and that one Carrier requires a change to the material?

If you want to use that material, you must make the change requested by the Carrier and then resubmit the material with the change to all of the other Carriers again for approval. This is why it is extremely important to submit your materials to the Carriers well in advance of when you intend to use them. You must also allow time for the Carriers to Opt In to the materials in the HPMS Marketing Model after you receive their prior approval.

### 8. Can we still advertise benefits?

Yes, but you may not advertise benefits that are not available to beneficiaries in the service area where the marketing appears. The only exception to this requirement is for advertisements:

- In local media that serve the service area where the benefits are available; and
- Reaching beneficiaries who reside in other service areas is unavoidable.

This exception for unavoidable marketing in local media does not apply to national marketing. It is only applicable to local advertising in a limited area.

### 9. Does this mean that we cannot advertise MA benefits in national media?

Yes, in effect, this means that you cannot advertise MA benefits in national media. MA plans are not available in some areas of the country, and the exception only applies to local media.

### 10. What are examples of unavoidable marketing in local media?

The following are examples of when marketing benefits to beneficiaries in other service areas is unavoidable using local media that serve the service area where the benefits are available:

- A newspaper ad in a metro area which is distributed to beneficiaries that live within the metro area but the beneficiaries do not live within the service area of the Plan for which the benefits are being marketed. For example, a Washington, D.C. newspaper may market D.C. service area benefits, but marketing is unavoidable in parts of Virginia and Maryland because the "normal" distribution of the local newspaper includes parts of Virginia and Maryland, too.
- A local TV commercial airing in a specific market but may be picked up in an adjacent market. For example, Baltimore TV channels can be seen in parts of the D.C. market and vice versa.

CMS has stated that it will provide examples and additional assistance in its Medicare Marketing Guidelines.

### 11. Are billboards on a national highway considered to be national media?

No, probably not. A billboard's location would likely be considered to be local media. Although a billboard on a national highway may be viewed by individuals who reside elsewhere and are passing through, it still can only be viewed by individuals driving within that local area. It would be an example of an advertisement in local media that could advertise benefits available in that service area but may reach beneficiaries who reside in other service areas would be unavoidable.

### 12. Can we still market generic MA plan benefits such as "gym memberships," "dental coverage," or "hearing coverage?"

Yes, you can. However, gym memberships, dental coverage, and hearing coverage are all benefits. If you are going to advertise these benefits, or any other benefits, you may only advertise them in service areas where they are available (unless the local media exception applies). Inclusion of any of these benefits also constitutes "marketing." You must also list all Carrier names of the Carriers you are referencing by stating the benefits, obtain approval for the marketing from all of the Carriers in advance of submission to CMS, and then have all of the Carriers Opt In to the material in the HPMS Marketing Module.

### 13. What is the new requirement related to advertising cost savings?

Agents and brokers may not advertise savings available to potential enrollees that are based on unrealized costs of a Medicare beneficiary, including a comparison of typical expenses borne by uninsured individuals or unpaid costs of dually eligible individuals.

There is no exception to this prohibition, even if the advertisement includes a prominent disclaimer.

Examples of prohibited advertisements based on a comparison of typical expenses borne by uninsured individuals include:

- An advertisement touts that a beneficiary can save $9,000 or more on their prescription drugs with a particular Part D plan, but the advertisement includes a small disclaimer stating that the "savings" are based on usual and customary price that someone without prescription drug insurance would pay.
- An advertisement touts "savings" of over $7,000 for a plan, but the costs saved refer to a prescription drug savings program in which eligibility for the program is based on income and the beneficiary currently not having drug coverage. A beneficiary who already has Part D coverage or other creditable prescription drug coverage would not save the money in out-of-pocket costs by switching to the advertised plan because they already had coverage for their drugs through a different plan.

The following is an example of a comparison based on unpaid costs of dually eligible individuals:

- An advertisement touts DSNP plans that provide savings of over $7,000. The savings described refer to the Medicare Part B premium and cost-sharing amounts that are covered by Medicaid for full-benefit dually eligible beneficiaries. The advertised savings require dual eligibility. Fine print states that the individual may need to become income eligible or Medicare and Medicaid eligible in order to receive the savings. Since dually-eligible beneficiaries already have Medicaid or may already be enrolled in a DNSP, the individuals would not be saving the full amount because they never paid the full amount. Moreover, if the beneficiary is eligible for Medicaid to pay certain costs on their behalf (i.e., Part B premiums) or is protected from paying cost sharing, the advertised savings are not specific to the advertised plan because the same "savings" would accrue if the individual enrolled in any DSNP plan.

### 14. Can marketing still include statements about cost savings?

Yes, advertisements based on comparisons to specific costs that a Medicare beneficiary would or could face are still permissible. This would include, for example, accurate comparisons of plan copayments for specific services to Original Medicare cost sharing for the same services (assuming, of course, compliance with all other CMS marketing rules).

Agents and brokers may still market cost savings associated with a specific plan's coverage of Part A, Part B, or supplemental benefits. Agents and brokers may still advertise savings on Part D costs that would come from an enrollment change.

### 15. These new marketing requirements are very onerous. We are a small agency. Do we really have to comply? Is there any flexibility for us?

Yes, these new marketing requirements apply to all agents and brokers. No, there is no exception or additional flexibility for smaller agencies or brokerages or independent agents or brokers.

If these new requirements seem too onerous to you, you can reduce some of the burden on you by choosing to use only marketing materials created and provided by the Carriers. You must still be sure that you only use those marketing materials in the service areas where any benefits referenced on the materials are actually offered (unless the exception for local media applies). You will still also need to tailor the number of Carriers represented and Plans offered in the TPMO Disclaimer on the Carrier-provided material to the products that you sell in that service area.

Another way to reduce most of the burden is to avoid marketing and to keep your advertising materials to communications.

# Communications Materials

### 1. What new changes apply to communications?

Two (2) new changes apply to all communications.

Agents and brokers may not use the Medicare name, CMS logo, and products or information issued by the federal government in a misleading manner. The Medicare card ID image may not be used at all unless the use has been previously authorized by CMS.

Additionally, agents and brokers may not use superlatives in communications without referencing sources of documentation or supporting data that applies to the current or prior year.

### 2. What are examples of using the term "Medicare" in a misleading manner?

The following are a few examples:

- "Medicare" in the names of a store front where a beneficiary could assume that the store front is affiliated with CMS or the Medicare program
- "Medicare" on notices or postcards or TV ads where "Medicare" is in large font while disclaimers are tiny and beneficiary could assume that advertisement is coming from CMS or the Medicare program
- A postcard with "Medicare Notice" in large, bold letters at the top, "Personal & Confidential" and "Important Medicare Information," and a box listing a "Customer ID" formatted to look like an official Medicare beneficiary number

### 3. We have the word "Medicare" in our name. Do we need to change our name?

Yes, if you have the word "Medicare" in your legal name or your "doing business as" name, you should change your name. Names with the word "Medicare" can be misleading. Moreover, some states also prohibit the word "Medicare" to be used in an organization's name. Integrity is reviewing its names and websites, and you should do the same. For example, Integrity is changing "MedicareEnroll" to "PlanEnroll."

### 4. We have the word "Medicare" in our URL? Do we need to change our URL?

Yes, if you have the word "Medicare" in your domain name, you should change your domain name. Web addresses with the word "Medicare" in the domain name can be misleading. As stated above, Integrity is reviewing its web addresses, and you should do the same.

**5. What are examples of using the CMS logo or information appearing to be issued from the federal government in a misleading manner?**

The following are two examples:

- Logos that are very similar to the HHS logo on websites and print materials that feature circles with writing around the circle and a bird, wings or other images that appear to be the same image used by the federal government
- Websites with a logo similar to the HHS logo potentially causing beneficiary to click on a private site when they intend to go to Medicare.gov or are seeking official Medicare information or access

**6. Can we still use the Medicare name, CMS logo, and products or information issued by the federal government in communications?**

Yes, if they are not used in a misleading manner. Whether the use is misleading will depend upon how the terms or images are used and presented. Prominently displayed disclaimers will also be important.

Additionally, CMS still permits the use of the Medicare Part D mark because CMS gives Part D sponsors contractual permission to use the mark.

**7. Can we still use the Medicare ID card image in communications?**

No, agents and brokers may not use the Medicare ID card image.

If you want to use the Medicare ID card image in any way, you must obtain authorization from CMS. Examples of situations where CMS may approve its use include:

- You are identifying the difference between an MA organization's or PDP sponsor's card from the Medicare ID card
- You are displaying a picture of the Medicare card to remind beneficiaries that they do need to keep the card safe, even though they are in a Medicare Advantage plan
- You are showing the Medicare ID card so a beneficiary knows where to find their Medicare Beneficiary Identification Number

If you do not obtain prior authorization from CMS to use the Medicare ID card image, you must remove all images of the Medicare ID card in your communications before October 1, 2023. As a reminder, communications are broadly defined and include websites, banners, billboards, mailers, and all advertisements.

**8. How do we obtain CMS prior authorization to use the Medicare ID card?**

CMS has not yet explained the process for obtaining prior authorization to use the Medicare ID card. Additional guidance is needed on this point. In the meantime, you should ask your contracted Carriers.

### 9. Can we still use superlatives in communications?

Yes, you can still use superlatives in communications. However, agents and brokers must now reference sources of documentation or supporting data that support the superlative in the communication material itself.

Examples of ways to reference to sources of documentation or supporting data include the following:

- A footnote explaining the basis, noting the source (you must provide enough information for an individual to locate the source, such as a link to the source); or
- Providing the actual comparison done to support the superlative.

For example, if you state that a Carrier has the lowest premiums, you must either: (i) identify the specific MA or Part D Plan with its premium and the premiums of other Plans in the service area; or (ii) reference a study, review, or other documentation that supports the superlative so an individual can make accurate comparisons between Plans.

### 10. What documentation or supporting data do we have to use?

Supporting data or documentation must reflect data, reports, studies, or other documentation that applies to the current or prior year. The standard is not based on when a study or report is published. For example, you may not use a study published in the current year (2023) but based on data from 2018 because the support must reflect data applicable to the current or prior year.

You can include data older than the prior contract year as long as the current and prior contract year data are specifically identified. For example, you could advertise that an MA organization has received five Stars since X date if it has received five Stars consecutively since X date. However, if the MA organization received four Stars in the previous year, you could not advertise that they received a five Star rating since X date or in 4 out of the past five years.

### 11. Are superlatives in logos and taglines still permitted?

There is no longer an exception for unsubstantiated statements in logos and taglines. The same new rule applies to logos and taglines. If you use a superlative in a logo or tagline, you must provide supporting data or documentation in the communication itself.

## Compliance Obligations

### 1. What should a Carrier's monitoring and oversight program include?

Carriers must 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 describes a proper Carrier oversight program "at a minimum" as including:

- Review of internal grievances and 1-800-MEDICARE complaints;
- Review of random samplings of past audio sales/marketing/enrollment calls;
- Listen to sales/marketing/enrollment calls in real-time; and
- Secretly shop web-based education and sales events.

Through monitoring, Carriers 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 are improperly marketing to beneficiaries.

CMS expects that the Carriers can then quickly act, with such activities like tailored training or disciplinary measures based on the specific issue for each agent and broker. They can also report specific agent or broker non-compliance to CMS.

### 2. What non-compliance should be reported to CMS?

CMS knows that additional information is needed on what non-compliance should be reported and stated that it will provide additional information and examples in the future in its Medicare Marketing Guidelines.

In the meantime, the agency offers the following guidance. CMS does not expect organizations to report minor insignificant issues, such as failing to go over one element in a required list of eighteen (18) elements. However, Plans must report if an agent continually fails to address a significant number of elements, continually fails to correct issues after being notified of issues, or the agent's conduct could have beneficiary impact (for example, potential harm to the beneficiary).

### 3. Are we required to have a monitoring and oversight plan?

CMS imposes the obligation to have a monitoring and oversight plan on the MA and PDP Carriers. You are not required to have your own monitoring and oversight plan (as described by CMS in the new final rules) unless you are otherwise contractually obligated to do so by your MA or PDP Carriers.

You should be prepared to cooperate with the Carriers and assist them upon request with implementing their monitoring and oversight plans. Carrier plans and expectations of your organization may differ. You should also be prepared to answer questions from the Carriers about your agent oversight and monitoring activities and to demonstrate such activities.

### 4. Are we required to report agent non-compliance to CMS?

The requirement to establish and implement an oversight plan that includes reporting non-compliance with CMS requirements is placed on the MA and PDP Carriers. As stated in the prior FAQ response, you should be prepared to cooperate with and assist the Carriers with implementing their monitoring and oversight plans, which may include reporting non-compliance to the Carriers or CMS.

You are already obligated by your contracted Carriers to report suspected or detected non-compliance related to the Medicare program to the Carrier. The methods for reporting may vary by Carrier. Moreover, as a TPMO, you are already contractually obligated to report to the Plans monthly any staff disciplinary actions or violations of any requirements that are associated with beneficiary interaction.

# OTHER CHANGES

### 1. What other new rules did CMS finalize in 2023?

CMS finalized the following additional changes:

- MA Plan provider directories must be searchable by every element required in the model provider directory, such as name, location, specialty
- The Summary of Benefits must list the medical benefits on the top half of the first page and in the order specified by CMS
- The non-renewal notice was changed from a model communication to a standardized communication to make clear that it must be used without modification
- 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, must be provided to all plan enrollees targeted for MTM