



March 7, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue SW
Washington DC 20201

RE: CMS-4192-P

Dear Administrator Brooks-LaSure:

I am writing on behalf of the National Association of Health Underwriters (NAHU), a professional association representing over 100,000 licensed health insurance agents, brokers, general agents, consultants, and employee benefits specialists. We are pleased to have the opportunity to comment on "Medicare Program: Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs," published in the Federal Register on January 12, 2022.

The members of NAHU work daily to help millions of people purchase, administer, and utilize health insurance coverage, including Medicare-eligible individuals purchasing private-market coverage options. As such, we are grateful to be able to share our thoughts on the provisions in this proposed rule. To develop our comments, NAHU assembled a representative group of members who routinely help the Medicare population fulfill their health insurance coverage needs. Their thoughts on the issues addressed in the proposed regulation are presented below.

Changes to Medicare Advantage and Part D Marketing Requirements

The proposed rule would make significant changes to existing marketing requirements for both Medicare Advantage and Part D plan marketing requirements. NAHU members understand and support the concept of protecting Medicare beneficiaries from unscrupulous third-party marketing organizations (TPMOs) that use deceptive tactics and offer inaccurate information about Medicare products and coverage. Our members who work directly with Medicare beneficiaries battle these misinformation campaigns daily and work tirelessly to make sure that beneficiaries do not make choices based on misleading and inaccurate information. Instead, it is always the goal of licensed and professional health insurance producers who work in the Medicare field to ensure that their clients purchase coverage that best meets both their personal needs and financial situation.



NAHU members see several problems in the marketplace today that we are not sure will be adequately tackled by the proposed rule, and we believe that the definition of TPMO is overly broad and will needlessly impact many entities who are acting responsibly. Furthermore, we are concerned that implementing such profound changes with less than a year to prepare will not be feasible for Medicare Advantage and Part D plan sponsors that would need to update all contracts and oversight processes.

Instead of moving forward with less-than-adequate proposed changes right away, NAHU members request that CMS delay its proposed marketing changes for the 2023 plan year. Instead, we request that CMS take the balance of 2022, including the 2023 annual election period, to meet with all stakeholders and observe market conduct. By gathering feedback from all parties and working with carriers, agents, consumer organizations, state regulators and enrollees, we believe it will be possible to craft a comprehensive and quality proposal that protect all Medicare beneficiaries in a truly meaningful fashion.

Some examples of questionable marketing behavior our members deal with regularly that are not currently addressed by the proposed rule include the problems created by certain lead aggregators who sell people's personal information to many different entities. Those entities have no idea that they are purchasing "leads" that have been sold to dozens of others. Further, some of these entities have offshore IP addresses and may be beyond the reach of CMS. Therefore, Medicare beneficiaries are contacted many times by people who may or may not provide quality data. Similarly, Medicare beneficiaries or their relatives may provide contact information to multiple sources, including both legitimate lead aggregators and questionable resellers, leading to many attempts to contact the beneficiary with no control over the type of entities that reach out and the information they provide to this vulnerable population. Certainly, it is the responsibility of any independent agent who chooses to purchase leads from an aggregator to ensure that they are working with a quality organization that does not mislead consumers on the front end. However, a responsible licensed agent cannot control, and has no way of knowing, how many other entities will interact with a beneficiary and what type of information those entities will provide.

Another issue that would not be addressed by the regulation as currently proposed is the prevalence of overly broad and misleading advertisements being sponsored by entities that largely do not directly contract with CMS but instead collect personal information from potential enrollees and provide that data to plans or other sources. Entities that sponsor Medicare Advantage and Part D plans, as well as their licensed and appointed agents and brokers, are subject to strict marketing guidelines and are prohibited from making the types of broad and misleading statements that regularly appear in these advertisements.

It is also critically important to ensure that the proposed rule's definition of TPMOs targets those it is intended to regulate and is not overly broad. Our association is concerned that the scope and structure of the proposed definition of TPMOs would inadvertently affect independent agents who perform legitimate marketing of their



services. They are not the source of these deceptive tactics and instead play a critical role in combatting the problems that can be caused by unscrupulous TPMOs. The proposed rule would define TPMOs as “organizations that are compensated to perform lead generation, marketing, sales, and enrollment related functions as a part of the chain of enrollment (the steps taken by a beneficiary from becoming aware of an MA plan or plans to making an enrollment decision). TPMOs may be a first tier, downstream or related entity (FDRs), as defined under § 422.504(i), but may also be entities that are not FDRs but provide services to customers, including an MA plan or an MA plan’s FDR.” Such a broad definition would apply the new requirements and restrictions to virtually all professionals who assist Medicare beneficiaries with their coverage and enrollment needs. NAHU believes that instead of moving forward with the proposed definition, CMS should continue to meet with stakeholders and observe market conduct to pinpoint the scope of its proposed regulation more accurately in this area. At minimum, we request that the definition be altered to merely apply to lead-generation entities and exclude licensed professional health insurance producers appointed to sell MA plans with licensed insurance issuers.

Changes to Medicare Advantage and Part D Plan Communications and Materials

The proposed rule includes several changes designed to improve beneficiary-communication materials. One would reinstate a prior requirement mandating the inclusion of a multi-language insert in specified materials to inform beneficiaries of the availability of free language and translation services. NAHU supports this change to ensure that beneficiaries know how they can access plan information in an understandable way. Other proposed changes NAHU supports include mandatory enrollee ID card standards and requiring plans to provide a disclaimer when access to preferred cost-sharing pharmacies is limited. Finally, NAHU members endorse the proposed change to require plans to include instructions on their websites for beneficiaries explaining enrollment processes, how to access certain forms and how to appoint a representative.

Point-of-Sale Price Concessions for Consumers

Our association appreciates the intention of the proposed policy change to require all Medicare Part D plans to provide all price concessions they receive from in-network pharmacies to affected beneficiaries at the point of sale and using the lowest negotiated rate as the baseline for pharmacy payments. Lowering the costs of prescription drugs for Medicare consumers and all Americans is a priority for NAHU as well. However, we are concerned that this proposal, as structured, would only truly benefit select Medicare beneficiaries based on their medical conditions and related prescriptions and pharmacy choice. Meanwhile, there is strong evidence that the impact of this proposal could be reduced Part D benefits and premium increases for all beneficiaries. Prior attempts to shift prescription drug rebate distribution to Medicare beneficiaries at the point of sale led both private researchers and the Congressional Budget Office to conclude that all beneficiaries would pay the price. As the proposed rule itself acknowledges, this component of the proposed rule would increase premiums across the Part D program. NAHU is concerned about any proposal that would raise beneficiary costs across the board.



Beneficiary Access to Care During Disasters and Emergencies

NAHU members support the proposed changes to require Medicare Advantage plans to cover certain out-of-network providers and services at an in-network cost-sharing level and without the application of utilization-management procedures during national public health emergencies, just as they are already required to do during natural disasters and other national emergencies.

Holding Plans Accountable for Prior Actions

NAHU members agree with the proposed changes to standards CMS applies to entities applying to be new Medicare Advantage and Part D plans and existing organizations seeking to expand their service areas. Allowing CMS to deny applicants based on their bankruptcy filings or status provides will provide additional financial protections for consumers against potential insurer insolvency. Furthermore, allowing denials based on a star rating of 2.5 or lower will help hold all plans better accountable for a wide range of consumer-protection standards and ensure that all consumers have access to only quality plans and products.

Medical Loss Ratio (MLR) Reporting

The current regulations require that Medicare Advantage and Part D plans annually report the percentage of their revenue spent on patient care and quality improvement to CMS. If they do not spend at least 85 percent of revenue on these endeavors, then they must pay a remittance to CMS. The proposed rule would reinstate additional reporting requirements in place between 2014 and 2017 and require Medicare Advantage and Part D Plans to report the underlying cost and revenue information needed to calculate and verify the MLR percentage and remittance amount, if any. In addition, the proposal would require that MA organizations report the amounts they spend on various types of supplemental benefits not available under original Medicare. NAHU believes reinstating these requirements will increase price transparency.

Enrollee Advisory Committees

The proposed rule would require all Dual Need Special Needs Plans (D-SNPs) to establish and maintain one or more enrollee advisory committees and that D-SNPs consult with advisory committees on issues related to health equity. NAHU members believe that consumer feedback is crucial and endorse the creation of enrollee advisory committees.

Social Determinants of Health and Special Needs Plan Health Risk Assessments

Medicare Advantage Special Needs Plans SNPs must currently conduct enrollee health risk assessments at enrollment and annually. NAHU members support the changes to the standardized assessment questions outlined in the proposed rule adding questions on housing stability, food security and access to transportation. These new questions will add important data to the risk assessments since these factors are all social determinants of health.



Simplified Appeals and Grievance Processes for D-SNPs

The proposed rule would expand the number of D-SNPs permitted to combine their appeals processes for beneficiaries into one plan-level Medicare-Medicaid appeals process. This prevents beneficiaries from having to engage in separate and potentially duplicative appeals with both Medicare and a Medicaid managed care organization (MCO). NAHU members agree with the proposed changes, as they will seemingly make the claims-appeal process easier for a very vulnerable beneficiary population.

Simplifying D-SNP Materials for Enrollees

Similarly, our association supports streamlining enrollment materials for D-SNP beneficiaries. Currently, most D-SNP enrollees receive separate plan materials related to their Medicare benefits and their Medicaid benefits, which can cause confusion among enrollees. The proposed rule would allow states to require certain D-SNPs to use integrated materials to make it easier to understand the full scope of Medicare and Medicaid benefits available through the D-SNPs.

Star Ratings Specific to the Performance of the Local D-SNP

Medicare star ratings are calculated at the contract level for both Medicare Advantage and Part D plans. This means, in many cases, performance metrics are combined for both SNPs and traditional plan options, making it difficult to accurately assess both different types of plans. The proposed rule would allow for star ratings that are specific to a SNP's local performance, to both differentiate between the two kinds of plans and drive plan quality improvements for dually eligible beneficiaries. The NAHU membership endorses these changes, which will allow our members to provide their clients with more accurate plan metrics and enable better consumer decision-making.

Maximum out-of-Pocket Policy for Dually Eligible Beneficiaries

Medicare Advantage plans currently have an out-of-pocket limit, ending beneficiary cost-sharing for Medicare Part A and B services after a certain spending point, defined annually. After that point, the plan must pay 100 percent of the service costs. When calculating the out-of-pocket limit, Medicare Advantage plans may count just the amounts the individual enrollee is responsible for paying and exclude any cost-sharing borne by a state Medicaid program for dual-eligible individuals. In practice, the current rules place no mandatory cap on the amount a state Medicaid program may absorb for enrollee cost-sharing expenses. The proposed rule would change the mandatory out-of-pocket cost maximum calculation so that it includes Medicare cost-sharing in the plan benefit, whether that Medicare cost-sharing is paid by the beneficiary, Medicaid, or other secondary insurance. The changes to the proposed cap would also count cost-sharing that remains unpaid because of state limits on the amounts paid for Medicare cost-sharing and dually eligible individuals' exemption from Medicare cost-sharing. Implementing these changes will yield significant cost savings for state



Medicaid programs and allow the lowest-income beneficiaries the potential of meeting maximum out-of-pocket cost-sharing caps currently available to higher-income consumers.

Thank you for the opportunity to provide input on the proposed changes to the Medicare Advantage and Medicare Part D programs for 2023. If you have any questions about our comments or need more information, please do not hesitate to contact me at (202) 595-0639 or jtrautwein@nahu.org.

Sincerely,

A handwritten signature in black ink that reads "Janet Stokes Trautwein". The signature is written in a cursive style.

Janet Stokes Trautwein
Executive Vice President and CEO
National Association of Health Underwriters