August 31, 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-4203-NC

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 benefit specialists. We are pleased to respond to your "Request for Information (RFI) about the Medicare Program," published in the *Federal Register* on August 1, 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 questions you posed about the Medicare Advantage program. Given that this RFI is specifically directed at Medicare Advantage policies, our answers to the questions are focused on Medicare Advantage too. However, in most cases, the applicability of our comments is broader, and could apply to all aspects of the Medicare marketplace.

To develop our response to this RFI, NAHU assembled a representative group of members who routinely help the Medicare population fulfill their health insurance coverage needs. Their thoughts on the specific RFI questions that were relevant to the expertise of Medicare-certified health insurance professionals are presented below, broken down by sections listed in the RFI.

Part A - Advancing Health Equity

What steps should CMS take to better ensure that all MA enrollees receive the care they need, including but not limited to the following:

- **Enrollees from racial and ethnic minority groups.**
- **Enrollees who identify as lesbian, gay, bisexual or another sexual orientation.**
- **Enrollees who identify as transgender, nonbinary or another gender identity.**
- **Enrollees with disabilities, frailty or other serious health conditions, or who are nearing end of life.**

- **Enrollees with diverse cultural or religious beliefs and practices.**
- **Enrollees of disadvantaged socioeconomic status.**
- **Enrollees with limited English proficiency or other communication needs.**
- **Enrollees who live in rural or other underserved communities.**

NAHU members support CMS' dedication to ensuring that all populations have adequate support as Medicare and Medicare Advantage (MA) beneficiaries. However, it is also valuable to keep in mind that one thing that all people have in common as they transition to Medicare eligibility is that Medicare is an entirely new experience. It is different way of accessing and paying for healthcare services than any have ever encountered before, and all people, of all backgrounds and circumstances, need and want trusted advice, accurate information, and peace of mind when it comes to their care and coverage decisions. This is true for both new enrollees and longtime Medicare beneficiaries.

Accordingly, NAHU members believe that CMS should focus first on ensuring that all populations have access to accurate and personalized information about their coverage options through individuals and entities that are subject to licensure, certification and regulatory scrutiny, such as licensed and Medicare-certified health insurance agents and brokers. Then, our association recommends that CMS conduct focus groups and community-specific outreach to better understand any access and care issues that may be population-specific.

Regarding rural areas, our membership reports a significant lack of access to MA programs. Since MA coverage options cap the number of Medicare beneficiaries that can be seen by a single provider for quality-of-care reasons, in areas where the provider shortage is most significant, there is also a MA access issue. CMS has made significant progress in addressing provider shortages and serving rural care needs in other federal programs and efforts, and we are hopeful that you can replicate that success in the private Medicare market as well.

How are MA SNPs, including Dual-Eligible SNPs (D-SNPs), Chronic Condition SNPs (C-SNPSs) and Institutional SNPs (I-SNPs), tailoring care for enrollees? How can CMS support strengthened efforts by SNPs to provide targeted, coordinated care for enrollees?

CMS can provide support to the SNP population in two specific ways. First, D-SNPs may change plan options more than other traditional Medicare beneficiaries. There are pros and cons to this, but one consideration is that, because they can change plan options mid-year, D-SNPs are often plagued by unscrupulous marketing entities. These entities may be able to change an enrollee's plan option mid-year, based on the flimsiest of reasons and contact, and our members have observed beneficiaries being switched seemingly without consent. The switching can really impede quality of care, and oftentimes benefits no one but the dishonest actor who initiated the plan switch. To combat this problem, NAHU members suggest that CMS allow D-SNPs

to "lock" or "freeze" their accounts after their initial enrollment, and to only allow for plan switches following a dual-factor identification process and confirmation from the enrollee that the switch is approved and wanted by them.

The other suggestion NAHU members have, which we believe would reduce the amount of unwanted marketing to the SNP population, as well as to other vulnerable beneficiaries, is for CMS to impose tighter controls on the Medicare Advantage Rx (MARx) system. NAHU members report that health plans and other entities with MARx access are providing log-in capabilities to contractors and call-center operators, enabling them to generate leads lists based on beneficiary enrollment data. If CMS were to take steps to reduce access to the sensitive MARx data and enforce violations of the use of protected health information for purposes unrelated to health-plan operations and instead for marketing purposes, the amount of unsolicited beneficiary contact would drastically be reduced.

Part B - Expand Access: Coverage and Care

What tools do beneficiaries generally, and beneficiaries within one or more underserved communities specifically, need to effectively choose between the different options for obtaining Medicare coverage, and among different choices for MA plans? How can CMS ensure access to such tools?

Our association believes that all Medicare beneficiaries deserve the opportunity to work with licensed and certified professionals when they choose between their different Medicare coverage options and amongst their different choices for MA plans. One way CMS could help further Medicare beneficiary access is to emulate the partnership CMS has with certified and licensed agents and brokers who help individuals purchasing coverage through the federally facilitated health insurance exchange marketplace. To that end, we would suggest the inclusion of a certified agent-referral system on the Medicare.Gov website, as there is on Healthcare.gov. Training 1-800-MEDICARE call-center operators on making referrals to licensed and certified agents as warranted and including references to the agent-referral system and information about selecting a reputable, licensed and certified agent in the *Medicare and You* handbook would also provide beneficiaries with better access to choose between the different Medicare options.

What additional information is or could be most helpful to beneficiaries who are choosing whether to enroll in an MA plan or Traditional Medicare and Medigap?

Ensuring that all beneficiaries have access to accurate information would be an extraordinarily helpful way CMS could support beneficiaries who are deciding between traditional Medicare options, Medigap and MA plans. Our members report that individuals often get inaccurate or incomplete advice from non-licensed individuals who have exposure to Medicare beneficiaries. For example, as our members were meeting to

discuss the content for this very letter, a member of NAHU's Medicare Working Group was alerted to an issue involving a gentleman in his 90s with MA coverage. The individual was being advised by a nursing home social worker to change his coverage to original Medicare and then purchase a supplemental policy, even though the gentleman would never qualify for supplemental coverage due to underwriting rules. Furthermore, the related cost-sharing and premiums did not meet his budget. While the social worker may have been well-meaning, the lack of accurate information about how Medicare coverage options work could have led to a bad decision. Fortunately, our member agent, who has decades of experience serving the Medicare population, was able to step in, provide accurate advice and prevent a coverage catastrophe. Situations like this happen with Medicare beneficiaries many times every single day. CMS could help prevent these situations by providing more education, support and oversight of entities and individuals who give tangential advice to Medicare-eligible individuals.

Another way CMS could help would be to dedicate resources to ensure that the Medicare provider look-up feature and the Medicare plan-finder resource are always up-to-date and accurate, as well as effectively linked together. These tools are important resources for beneficiaries and advisors alike when choosing appropriate coverage options.

How well do MA plans' marketing efforts inform beneficiaries about the details of a given plan? Please provide examples of specific marketing elements or techniques that have either been effective or ineffective at helping beneficiaries navigate their options. How can CMS and MA plans ensure that potential enrollees understand the benefits a plan offers?

Our members see a wide dichotomy when it comes to marketing MA plan options to beneficiaries. On the low end of the spectrum are the marketing organizations and lead generators who contact people unsolicited, often provide misleading information, and are largely unregulated when it comes to the content and quality of the information they provide. On the high end of the spectrum are the licensed and certified agents and brokers, who provide beneficiaries with direct and personalized service while abiding by both federal Medicare requirements and marketing rules and are also bound by state-level market conduct and licensing standards. In between are all the other entities who may encounter beneficiaries are provide them with advice and information about their coverage options. This group spans everyone from Medicare call-center operators to carrier representatives to SHIP counselors and people like pharmacists and social workers who may provide incidental advice. All these entities have separate roles in the coverage system, but they are not regulated equally. State-licensed agents and brokers, carriers and entities like SHIP counselors follow strict marketing and informational-accuracy rules. The lead-generation and marketing companies are generally unlicensed, are not certified in any way by CMS, and in many instances operate from overseas locations or IP addresses.

Every group that touches Medicare beneficiaries needs to be held to strict standards and regulated as to the quality and accuracy of information it provides. However, each of these entities are different in terms of the populations served and their business structures and institutional resources, so they should not all be held to identical rules. CMS needs to craft appropriate regulatory guidelines on an entity basis to ensure only quality marketing of MA products, as well as the protection of all beneficiaries. Recent regulatory changes group licensed and certified agents and brokers in with the lead-generation and marketing entities under the moniker of third-party marketing organizations, or new TPMOs. This definition is overly broad and adds an additional burden to licensed and certified agents attempting to assist Medicare beneficiaries when choosing a suitable MA plan, while it does not regulate the lead-generation and unscrupulous marketing entities effectively.

How are MA plans providing access to behavioral health services, including mental health and substance use disorder services, as compared to physical health services, and what steps should CMS take to ensure enrollees have access to the covered behavioral health services they need?

Our membership reports that, at the individual beneficiary level, there seems to be a greater emphasis on mental health and substance use disorder prevention on a general basis. To fully assess if coverage is in parity between medical/surgical coverage and mental health/substance use disorder coverage, it would be necessary to require MA plans to submit greater documentation at the product-approval level. If CMS were to do this, the current parity requirements for private plans covered by the Mental Health Parity and Addiction Equity Act could be a model. Also, some states, such as California and Pennsylvania, require carriers to submit detailed parity information at the product-approval stage.

What role does telehealth play in providing access to care in MA? How could CMS advance equitable access to telehealth in MA? What policies within CMS' statutory or administrative authority could address access issues related to limited broadband access? How do MA plans evaluate the quality of a given clinician or entity's telehealth services?

Access to telehealth services is a very important way to provide MA recipients with access to medical care. Not only is it important to rural beneficiaries but it is also a blessing to seniors in all locales whose ability to travel is limited. Further, it can be a way for caregivers to participate in medical visits. It is critical to ensure continued reimbursement for telehealth visits at typical visit levels. CMS and MA plans should also prioritize making telehealth participation as easy as possible for providers in terms of back-end operations. Finally, to advance access, CMS should focus resources on technology support. Eventually, every Medicare beneficiary will need it due to declining health status.

How do MA plans use utilization-management techniques such as prior authorization? What approaches do MA plans use to exempt certain clinicians or items and services from prior-authorization requirements?

What steps could CMS take to ensure utilization management does not adversely affect enrollees' access to medically necessary care?

Our membership reports that MA plans utilize medical-management techniques largely in the same way as private health insurance plans serving other market segments. Accordingly, CMS should look to the ways in which CCIIO, EBSA and state regulators ensure the use of reasonable medical-management procedures in the commercial marketplace as a model.

Part C - Drive Innovation to Promote Person-Centered Care

How do beneficiaries use the MA Star Ratings? Do the MA Star Ratings quality measures accurately reflect quality of care that enrollees receive? If not, how could CMS improve the MA Star Ratings measure set to accurately reflect care and outcomes?

NAHU members report that Medicare beneficiaries view the star ratings similarly to any other online rating and review scale. Clients always want a five-star plan, and they are upset if one is not available to them. Some individuals put much more weight into the star ratings than others, some carefully review what constitutes a star-rating level, and others do not pay much heed to the applicable criteria. Accordingly, while the star ratings are an important feature to make available to Medicare-eligible beneficiaries, it is also a hard feature to improve in a way that will best suit all individuals. Agents and brokers are required to explain the star ratings to all beneficiaries they serve. Making sure that the rankings are always accurate and that all entities who may advise beneficiaries are required to explain the star ratings to them in a fair and reasoned way would be helpful.

What issues specific to Employer Group Waiver Plans (EGWPs) should CMS consider?
Our members who work in this market suggest that CMS take steps to inform more aggressively and proactively the public and employers that EGWPs are an available coverage option for group plan sponsors, regardless of employer contribution level. Using these plans not only can eliminate the annual Part D deductible, but they can be used to fill the "donut hole" with both generic and brand-name drugs. Since EGWPs more closely mirror what retirees had through their traditional employer-sponsored coverage, the formulary is generally more extensive than other options for beneficiaries. Many retirees prefer this coverage and really appreciate the availability of a familiar and less disruptive coverage option. Additional promotion and exposure by CMS would be very helpful.

Part D – Support, Affordability and Sustainability

As MA enrollment approaches half of the Medicare beneficiary population, how does that impact MA and Medicare writ large and where should CMS direct its focus?

Given the volume of MA beneficiaries enrolled in MA Plans, CMS should designate a large amount of focus and attention on the needs of those plan participants. However, almost all of the recommendations we provide herein are applicable not only to MA plans, but also to all Medicare coverage options, so making global improvements will benefit all populations.

Part E - Engage Partners

What information gaps are present within the MA program for beneficiaries, including enrollees, and other stakeholders? What additional data do MA stakeholders need to better understand the MA program and the experience of enrollees and other stakeholders within MA? More generally, what steps could CMS take to increase MA transparency and promote engagement with the MA program?

Misleading marketing efforts directed at Medicare beneficiaries is the biggest source of information gaps, and it negatively affects both enrollees and honest actors helping individuals with their coverage options, including licensed and Medicare-certified health insurance agents and brokers. Senior citizens are regularly besieged by inaccurate and disingenuous advertisements using “bait and switch” marketing techniques regarding Medicare coverage options. The inaccurate information comes at them through television commercials, emails, phone calls and targeted online advertisements. Entities such as lead-generation agencies, overseas call centers and other marketing firms not subject to state licensure operate under different standards then certified and licensed agents and brokers when it comes to advertisement content and overall regulation. The unregulated entities need to be held accountable for their actions and to follow Medicare marketing rules, including review and approval of beneficiary communications and marketing solicitations.

Furthermore, as we suggested previously, to help CMS direct individuals to quality sources of information and advice, we suggest the inclusion of a certified agent-referral system on the Medicare.Gov website, as there is on Healthcare.gov. We also urge training for 1-800-MEDICARE call-center operators so that they can make referrals to licensed and certified agents as warranted. Finally, we suggest including references to the agent-referral system and information about selecting a reputable, licensed and certified agent in the *Medicare and You* handbook.

How could CMS promote collaboration amongst MA stakeholders, including MA enrollees, MA plans, providers, advocacy groups, trade and professional associations, community leaders, academics, employers and unions, and researchers?

Our organization believes that if CMS were to promote greater collaboration and cooperation between SHIP counselors and licensed, Medicare-certified agents and brokers, it would benefit all parties. Additionally, when our organization and others reach out to CMS for answers to questions on Medicare and MA plan issues, we are directed to a variety of different staff members and internal departments based on the specific nature of the request. If CMS were to designate staff members to coordinate outreach and communications with specific stakeholder groups, it could be very helpful.

What steps could CMS take to enhance the voice of MA enrollees to inform policy development?
To enhance the voice of enrollees, NAHU members suggest increased use of beneficiary focus groups. In doing so, CMS should be aware of all segments of the beneficiary population and confirm that the focus groups touch each of them. Additionally, licensed health insurance agents and brokers enroll and meet with millions of Medicare beneficiaries. NAHU members would be happy to contribute our voices to inform CMS about the views expressed by their clients.

To inform policy development and promote transparency, it would be helpful for CMS to report on complaints it receives on matters like MA marketing issues in a deidentified way. The reports CMS and EBSA provide on other health-plan violations and plan-audit data should be a helpful resource for CMS to model.

What additional steps could CMS take to ensure that the MA program and MA plans are responsive to each of the communities the program serves?

The two most critical steps CMS could take to be responsive to enrollee needs and reduce unwanted beneficiary solicitations by unscrupulous actors would be to ensure proper regulation of call centers and lead-generation entities to rigorously protect use of and access to MARx system data. These entities are largely unregulated today, and the misinformation they provide to beneficiaries, as well as unwanted contact, is a huge stain on the Medicare system. These entities should be held to the highest of standards, as other licensed and regulated entities that serve Medicare beneficiaries are. MARx system data appears to be a source of beneficiary information for lead generators, call centers and others, and CMS should take all necessary steps to restrict access to that information.

Additionally, NAHU members report that, in certain geographic areas, MA carriers do not permit agents to make day-to-day account changes, like address changes, on behalf of their clients. In other areas, this is not an

issue. If CMS were to ensure consistency across plans and market regions, it would be beneficial for all enrollees.

Thank you for the opportunity to provide input about the Medicare Advantage program. 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,

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