National Association of Benefits and Insurance Professionals
NABIP
Shaping the *future* of healthcare

February 13, 2023

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-4201-P

Dear Administrator Brooks-LaSure:

I am writing on behalf of the National Association of Benefits and Insurance Professionals (NABIP), an association previously known as NAHU that represents over 100,000 licensed health insurance agents, brokers, general agents, consultants, and employee benefit specialists. We are pleased to respond to the proposed regulation titled "Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C and D Overpayment Provisions of the Affordable Care Act and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications" and published in the *Federal Register* on December 27, 2022.

The members of NABIP 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 potential changes to the marketing rules concerning the Medicare Advantage and Part D programs. To develop our response to this measure, NABIP assembled a representative group of members who are licensed and certified agents who help the Medicare population fulfill their health insurance coverage needs. Their thoughts are presented below, broken down by sections listed in the proposed rule.

<u>General Concerns</u>

NABIP members believe every group that touches Medicare beneficiaries needs to be held to strict standards and regulated as to the quality and accuracy of information they provide. 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. Regulatory guidelines are needed on an entity basis to ensure marketing of Medicare Part C and D products is done appropriately and protects 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.

The lead-generation and marketing companies covered by this definition are generally unlicensed, are not certified in any way by CMS and, in many instances, operate from overseas locations or IP addresses. In contrast, independent Medicare agents and brokers are state-licensed, certified by each issuer they work with, and required to abide by strict market conduct, privacy, and continuing-education standards, among others.

The current definition of TPMO that persists in this proposed rule is overly broad and adds an additional burden to licensed and certified agents attempting to assist Medicare beneficiaries when choosing a suitable Medicare Advantage plan, while it does not regulate the lead-generation and unscrupulous marketing entities effectively. NABIP members again request revision of this definition to remove its applicability to licensed and certified independent Medicare agents and brokers.

One way to decrease churn and unscrupulous actors that is not addressed in the rule would be to prohibit Medicare advantage commissions from being "heaped." This has become a common practice with smaller call centers with 15 to 100 producers. They are under-capitalized, receive a lump-sum payment and the beneficiary is transferred to an investor as agent of record shortly after issue. This incentivizes the call center to be aggressive in sales practices with no responsibility to provide service to the beneficiaries after the sale is made. Beneficiaries are then left without the assistance of a year-round licensed and certified agent to service their plan. Requiring any agent-of-record change to happen after the first year would likely decrease the likelihood of heaped commissions, other than when an agent or agency decides to sell their block of business. Making such a change also ensures fair market value is followed and promotes the idea of level commissions for Medicare Advantage products.

<u>New General Marketing Changes</u>

The proposed rule includes several general marketing rule changes, including a prohibition on advertising benefits that are not available to beneficiaries in the geographic area where the advertisement appears. It also prohibits Part D sponsors from using information about savings available to potential enrollees that are based on a comparison of typical expenses borne by uninsured individuals, unpaid costs of dually eligible beneficiaries, or other unrealized costs of a Medicare beneficiary in its advertising. The only advertisements allowed, moving forward, would be for those plans and products that are approved and entered in the HPMS system.

Additionally, when it comes to printed material, the proposed rule calls for a requirement like one already in place in California. It specifies that Part D sponsors or marketing names must be in 12-point font in print and may not be in the form of a disclaimer or in fine print. For television, online or social media, the Part D sponsor or marketing name(s) must be either read at the same pace as the phone number or must be displayed throughout the entire

advertisement in a font size equivalent to the advertised phone number or benefits. In radio or other audio-based advertisements, any content identifying the Part D sponsor name must be read at the same speed as the rest of the advertisement. NABIP members support all these proposed changes to the Medicare Advantage and Part D marketing rules.

Broker/TPMO Oversight Proposed Changes

According to the proposed rule, CMS intends to establish and implement an oversight plan that monitors agent and broker activities, identifies non-compliance with CMS requirements, and reports non-compliance to CMS. NABIP supports this proposal and would like to formally offer our association's assistance in its endeavors.

We appreciate the focus on agent and broker activities and the recognition that independent agents and brokers who are the servicing brokers of record are different from large-scale call centers and TPMOs that are simply attempting to conduct fast enrollments. However, NABIP would appreciate further action be taken to differentiate these entities in the marketing rules by taking independent agents and brokers out of the definition of TPMO.

Our membership and state regulators already work directly with state regulators on market conduct and other compliance issues, and request to be involved, where appropriate, for the monitoring and compliance activities. Furthermore, we would be happy to provide feedback on potential data points to monitor and assist with education efforts and outreach to independent servicing agents and brokers. An immediate suggestion to detect enrollment problems up front would be to urge health insurance issuers to return to the business practice of conducting enrollment-verification calls with beneficiaries as a means of detecting issues on an up-front basis when they still may be corrected easily.

Another proposed broker- and TPMO-specific change addressed in the proposed rule is the specification that personal beneficiary data collected by one TPMO may not be distributed to other TPMOs. NABIP members understand the intention of this proposal; however, we note that this provision would have different implications for the varied types of entities this regulation broadly classifies as TPMOs. Independent health insurance brokers are already bound by HIPAA and GLBA health and financial privacy requirements that govern their disclosures of protected health and financial information, including all data collected about Medicare beneficiaries as part of the enrollment process. However, call centers and lead generators are not subject to these requirements. Rather than subjecting agents and brokers to additional and potentially conflicting privacy and data-sharing requirements, NABIP suggests amending the definition of TPMO to remove the inclusion of independent agents and brokers.

Additionally, we urge CMS to work with the FCC and FTC regarding improper disclosures of data, which may be already addressed under existing regulations, rather than putting an

additional and possibly contradictory layer of regulatory requirements on independent licensed health insurance agents and brokers.

Door-to-Door Solicitation

The proposed rules clarify the existing prohibition on door-to-door solicitation related to Medicare Advantage and Part D products. It specifies that contact is unsolicited door-to-door contact unless an appointment, at the beneficiary's home at the applicable time and date, was previously scheduled. NABIP members support this change.

Beneficiary Contact

According to the new proposal, if a Part D sponsor reaches out to beneficiaries regarding plan business, the Part D sponsor must provide notice to all beneficiaries whom the plan contacts as least once annually, in writing, of the individual's ability to opt out of future calls regarding plan business. NABIP members request clarification in any final rule about the scope of "plan business" calls. For example, NABIP members do not believe that beneficiaries should be able to opt out of contact from their broker of record, who is bound to service their policy, because of the consumer-related harm that would ensue. NABIP recommends that CMS provide guidance on what is a "plan business" call that would require the additional notice to prevent beneficiaries from receiving multiple notices, which may lead to confusion.

Educational Events

The proposed rule would prohibit marketing events from taking place within 12 hours of an educational event in the same location. The same location is defined as the entire building or adjacent buildings. NABIP members request clarification about this proposal. Specifically, our members would like to ensure that they may collect scope-of-appointment cards at educational events, and that they may hand out business cards at such events, should a beneficiary wish to contact them voluntarily later.

Scope of Appointment

Regarding the scope-of-appointment forms, the proposed rule would change existing requirements and mandate that at least 48 hours prior to the personal marketing appointment beginning the Part D plan (or agent or broker, as applicable) must agree upon and record the scope of appointment with the beneficiary(ies). NABIP members have concerns with the proposed 48-hour requirement, given that there are many occasions when a beneficiary contacts an agent or broker and needs client services sooner than 48 hours ahead of time. On other occasions, beneficiaries may believe that they can wait the 48 hours necessary for an appointment. However, when the appointment occurs, an immediate need is revealed and the beneficiary would have benefited from more timely assistance. This is particularly an issue at the end of each month, as waiting 48 hours can result in a coverage delay of a month or more. In these cases, the 48-hour cooling-off period often does the beneficiary more harm than good.

NABIP members propose any final rule include a safe harbor for agents and brokers whose clients sign a waiver opting out of the 48-hour rule. This waiver could be incorporated into existing scope-of-appointment forms, and should be a beneficiary option, at minimum, in time-critical situations.

TPMO Disclaimer

The proposed rule requires all TPMO members to read or provide a disclaimer to Medicare beneficiaries. Currently, the proposed rule offers two potential versions of the statement, one for if a TPMO does not sell for all Part D sponsors in the service area, and another for TPMOs that do offer all plan options from all plan sponsors. Both options involve the TPMO reading out, or listing, all the plans offered in the area or all the plans the TPMO offers, which is likely an unwieldly list. For listener clarity's sake, NABIP members propose that the mandatory oral content be revised to simply say the TPMO does or does not offer all plan options in the service area.

Regarding the disclaimer's delivery requirements for phone calls, our association feels the requirement this disclaimer be verbally conveyed withing the first minute of a sales call be stricken. As written, this requirement is unreasonable, since frequently when a call is placed by an independent agent or broker, the first minute of a call is when the broker is explaining why they are calling. Instead, NABIP believes this requirement should only apply to cold-calls and should not apply to phone calls with existing clients for which the broker is the writing and/or servicing agent and they or their agency holds the broker of record designation. Additionally, if the Medicare beneficiary contacts the TPMO directly, then the specification should not apply. We also note that the language requirement may be impossible to meet for verbal communications, particularly within the first minute of a call when the preferred language of the beneficiary may yet to be determined.

Concerning printed materials, NABIP members suggest that the disclaimer be treated like a privacy notice, and only need to be distributed once a year.

Pre-Enrollment Checklist (PECL)

The proposed rule creates a PECL and defines it as "a standardized communications material that plans must provide to prospective enrollees with the enrollment form so that the enrollees understand important plan benefits and rules." According to the proposed measure, the contents of the PECL must be reviewed with the prospective enrollee prior to the completion of the enrollment during telephonic enrollments.

NABIP members support the concept of the PECL, but request clarification as to how it will be developed and who will be the entity(ies) developing it. It is unclear to us if each issuer will be charged with developing their own PECL, or if all PECLs will be uniform or follow a CMS-developed template. Our association believes that it would be most effective if all PECLs were

based on a CMS-developed template to ensure that critical enrollment information is presented consistently across carriers. In addition, our membership would like to offer its services to CMS in helping to develop and review any potential checklist template. Our membership expects there to be official guidance on all the topics that must be discussed with enrollees so that all advisors who may be involved with enrolling and servicing Medicare beneficiaries will have a clear understanding of what is required. Additionally, we believe that a clear and consistent checklist will make both compliance and enforcement much easier for all stakeholders.

One specific suggestion our membership has for the content of the checklist is to allow those assisting with enrollment to inquire about the beneficiary's doctors and prescription drug needs. Currently, rules prohibit agents and brokers from specifically asking about a beneficiary's doctors and prescription drugs, which prevents them from providing a thorough analysis of the beneficiary's true plan needs. As a result, agents are trying to encourage beneficiaries to share all important information without specifically being able to ask the questions that are desperately needed for a thorough assessment.

Additional Issues

As CMS works to finalize this proposed regulation, NABIP members respectfully ask for clarification and reconsideration of some issues related to the new phone call-recording requirements established by prior regulation. Currently, TPMOs, which include independent certified agents and brokers, must record many client phone calls. We appreciate the clarification this regulation provides about the types of calls that must be recorded, and we ask for additional clarification in the following areas: Can marketing call recording be voluntary? For example, NABIP believes it should be a voluntary requirement if the call comes to the broker from a client or is generally an incoming call, such as a call from an individual who was referred to the broker rather than the broker placing the call to the client/prospective client. For current broker of record, NABIP believes it should be voluntary to record calls to existing clients from people who already have Medicare Part D or Medicare Advantage coverage.

NABIP also asks for reconsideration of the 10-year timeframe for recorded phone call retention, and suggest using a timeframe of one year, or the entirety of the person's plan year, as an alternative. We recognize that the 10-year time limit is based on both HIPAA and marketing material data-retention requirements. However, NABIP believes these requirements are outdated based on paper storage and do not reflect the current practice of using electronic data recordings, which need to be stored digitally in the cloud and can be very large in size. Accordingly, storing these files is both onerous and expensive. To reduce the burden on independent agents and brokers, most of whom are operating very small businesses, we ask that the storage time be reduced.

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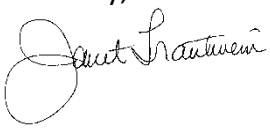
Thank you for the opportunity to provide input on the proposed changes to the Medicare Advantage and Part D programs. If you have any questions about our comments or need more information, please do not hesitate to contact me at (202) 595-0639 or jtrautwein@nabip.org.

Sincerely,



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