April 6, 2020

The Honorable Seema Verma
Administrator, Centers for Medicare and Medicaid Services
200 Independence Ave, SW
Washington, DC 20201

RE: Medicare and Medicaid Programs: Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program and Programs of All-Inclusive Care for the Elderly - CMS-4190-P

Submitted Electronically via www.regulations.gov

Dear Ms. Verma:

I am writing on behalf of the National Association of Health Underwriters (NAHU), a professional association representing more than 100,000 licensed health insurance agents, brokers, general agents, consultants and employee benefits specialists. We are pleased to have the opportunity to provide comments in response to the proposed rule titled "Medicare and Medicaid Programs: Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program and Programs of All-Inclusive Care for the Elderly," which is also referenced as CMS-4190-P.

The members of NAHU work daily to help millions of individuals and employers purchase, administer and utilize health insurance coverage. Thousands of our members specialize in the senior marketplace, and ensuring that our nation's Medicare beneficiaries have access to affordable and high-quality coverage options that meet their specific needs and budgets is one of our association's top goals. Our comments are organized by section, and they reflect the views of our Medicare Advisory Committee, which is comprised of agents and general agents who focus their practices solely on senior citizens and their healthcare needs.

"Look-Alike" Dual-Eligible Special Needs Plans

NAHU supports the proposal to limit access to Medicare Advantage plans that are designed to be very similar to the Dual-Eligible Special Needs Plan (D-SNP). These "look-alike" plans have similar levels of dual-eligible enrollment as D-SNPs but are not subject to the federal regulatory and state contracting requirements applicable to D-SNPs. Based on the market observations of our members, D-SNP look-alike plans are designed with very attractive benefits and aggressive marketing efforts by

large organizations targeting dual-eligible beneficiaries. However, these plans do not adhere to strict CMS regulations like a DSNP plan, and therefore have no responsibility to coordinate Medicare and Medicaid benefits, which can cause disruption and gaps in care. To NAHU members, helping all Medicare beneficiaries find the policy option that best meets their specific care needs and budget is paramount, and we do not tolerate misrepresentation. Therefore, we support this proposal to restrict look-alike plans from the market.

Requirements for Medicare Communications and Marketing - §§ 422.2260-422.2274; 423.2260-423.2274

In the preamble of the proposed rule related to these sections, CMS requests comments about how it should implement prohibitions related to plan marketing during the open enrollment period (OEP). As an association of health insurance agents and brokers, we certainly understand and appreciate the importance of marketing. However, based on our experience working daily with Medicare beneficiaries during both the annual election period (AEP) and the Medicare Advantage open enrollment period (MA OEP), we believe that marketing and advertisements should be restricted during the MA OEP. Beneficiaries get heavy exposure to marketing materials during the AEP, which is sufficient for their needs and the needs of the marketplace. During the MA OEP, excessive marketing is confusing to seniors and brings people in thinking they need to make plan changes unnecessarily. The MA OEP should be a time to help seniors process necessary changes that are based on real issues, not those that have been influenced by excessive marketing. For example, our association would support a ban on television advertising during this time unless the commercial contains obvious disclaimer language such as "If you will soon be 65," that makes it clear the advertisement is only intended for people who are newly eligible for Medicare or have special enrollment rights, not most existing beneficiaries.

Beneficiary Contact - § 422.2264 and § 423.2264

In the beneficiary-contact restrictions in outlined in both §§422.2264 and § 423.2264(a)(2)(iv), a prohibition on robocalling is implied. However, our membership observes significant ongoing robocalling occurring in the marketplace. With the growing reliance on artificial intelligence in the insurance and marketing industries, we suggest the addition of a specific prohibition on unsolicited robocalls.

With regard to §§422.2264 and 423.2264(b)(1)(i), NAHU members request a clarification with regard to contact by MA organizations based on plan business. §§422.2264 and 423.2264(b)(1)(i)(C) allow MA organizations "to contact members in a Part D plan to discuss other Medicare products." However, this provision currently allows individuals who already have an established agent relationship to receive many unsolicited and confusing calls from their carrier. As such, NAHU requests an amendment to §§422.2264 and 423.2264(b)(1)(i)(C) so that they read: "Members in a

Part D plan to discuss other Medicare products unless the member has an external agent of record."

NAHU members also request modifications to the scope-of-appointment language outlined in §§422.2264 and 423.2264(c)(3)(i). NAHU understands why the original scope of appointment was put in place, but the issues it was intended to address have largely been solved over time and by the implementation of carrier-appointment requirements a number of years ago. Currently, the scope-of-appointment requirement impedes the ability of agents to provide personalized service and creates unnecessary paperwork for beneficiaries. NAHU suggests allowing the scope-of-appointment provision to be satisfied by a simple question on the coverage application, and a specification that additional paperwork only is required if the appointment topic shifts beyond the scope of Medicare.

Agent, Broker and Other Third-Party Requirements § 422.2274 and § 423.2274
The proposed rule eliminates §§422.2274 (h) and 423.2274 (h) and makes changes to §§ 422.2274 and 423.2274(b) regarding referral fees in order to clarifying CMS's intent that compensation be on a per-enrollment basis. The rationale provided for this change in the preamble to the proposed rule is "Since referral fees are part of compensation, organizations may not pay independent agents more than regulatory limits. Because referral fees are already incorporated into compensation, limiting the amount of a referral fee has no impact on the statutory requirement of an agent enrolling a beneficiary in the plan that best meets their healthcare needs. With respect to captive and employed agents, who only sell for one organization, the referral fees also have no impact given the organization sets rates of pay, nor is there a statutory steerage impact."

NAHU understands and appreciates the intent of this proposal. However, we are not sure it will fully address the problems we are seeing in the marketplace regarding marketing and referral fees. Currently, there is limited enforcement of the marketing-fee ban and the referral-fee limits. Rather than make changes to the requirements, NAHU suggests greater coordination with the state departments of insurance to enforce existing regulations, such as the requirement that individuals shall not discuss the benefits in any Medicare plan unless they are licensed and certified when required.

The requirements in §§422.2274 and 423.2274 section (c) apply to agents and brokers appointed by a particular carrier. Section (c)(4) requires carriers to "on an annual basis, provide agent/broker training and testing on Medicare rules and regulations, the plan products that agents and brokers will sell including any details specific to each plan product, and relevant state and federal requirements." NAHU notes that many agents specialize in the Medicare marketplace and participate in these annual trainings and tests year in and year out. To encourage longevity and stability among private Medicare agents and brokers, NAHU suggests that CMS consider providing relaxed training

and testing requirements for individuals who have been certified with at least one Medicare Advantage issuer for five years or longer.

Section (c)(8) requires each carrier to "ensure agents and brokers do not charge beneficiaries a marketing fee." However, NAHU members report that, in their experience in the marketplace, the agents and individuals who are charging individual beneficiaries a marketing fee are not appointed agents. Instead, these are often non-appointed individuals who are charging people referral fees and consulting fees. As such, NAHU is concerned about limited enforcement of these abuses and suggests language be incorporated in any final rule to address this market problem.

In Section (d) (2)(i) and (ii), NAHU requests elimination of the references to prorated commissions. The amount of work to enroll an individual does not change if the enrollment takes place in November or in January, so the requirements related to prorating payments do not make sense and are unfair to Medicare-certified health insurance agents.

Medicare Advantage Plan Options for End-Stage Renal Disease Beneficiaries
The proposed rule codifies the requirement in the 21st Century Cures Act to allow all end-stage renal disease patients who qualify for Medicare (ESRD beneficiaries) to join a Medicare Advantage plan even if they were not already enrolled in Medicare Advantage prior to their diagnosis. The proposed rule also establishes that Medicare Advantage issuers are not responsible for organ-procurement costs for kidneys and changes the cost benchmarks relative to kidney transplants.

NAHU appreciates that CMS needs to carry out the requirements of the 21st Century Cures Act and we recognize that Medicare Advantage plans may be attractive to certain ESRD beneficiaries. We also acknowledge the attempt to mitigate the extraordinary cost of organ transplants. However, our association is concerned that the addition of new ESRD beneficiaries to Medicare Advantage plans will ultimately increase costs for all beneficiaries. It is our hope that, in the final rule, CMS will provide insurers with even more ways to account for increased costs related to ESRD beneficiaries, including with their day-to-day medical needs and dialysis costs. According to MEDPAC, the average cost to cover Medicare beneficiaries with ESRD in 2016 was over $67,000, and the average amount of out-of-pocket costs for Original Medicare ESRD beneficiaries was $13,000. This is significantly more than the healthcare costs of an average Medicare Advantage beneficiary so CMS will need to make additional cost and payment adjustments to avoid an ultimate cost-shift to other beneficiaries. We understand that CMS is considering raising the maximum out-of-pocket cost limit for ESRD beneficiaries to $7550, but that is just $850 more than the maximum out-of-pocket limit for traditional Medicare Advantage beneficiaries.

NAHU members know that millions of American seniors are well-served by either no-premium or low-premium Medicare Advantage plans. In your work to accommodate new ESRD beneficiaries, we urge to give equal consideration to cost containment for all Medicare beneficiaries.

Medicare Advantage and Part D Prescription Drug Program Quality Rating System
NAHU members support the plan outlined in the proposed rule to increase the weight of patient experiences, complaints and access measures in the quality rating star methodology. We appreciate the effort to put patients first and to empower patients to work with their doctors to make healthcare decisions that are best for them.

Permitting a Second, "Preferred" Specialty Tier in Part D
The proposed rule would allow Part D sponsors to establish a second, "preferred" specialty tier with lower cost sharing than the current specialty tier and creates other related requirements. NAHU members believe that Medicare beneficiaries with specialty drug needs will appreciate the ability to potentially obtain needed medications at a lower price point. However, when implementing the new specialty drug tier, NAHU members urge CMS to ensure that the existence of the new pricing design is clearly communicated in the Medicare Plan Finder tool and other prescription drug price information transparency tools.

Beneficiary Real-Time Benefit Tool
The proposed rule would require each Part D plan to implement a beneficiary real-time benefit tool (RTBT) by January 1, 2022, to allow enrollees to view plan-provided, patient-specific, real-time formulary and benefit information both online and through the plan's customer service call center. NAHU members who specialize in private Medicare market services are extremely concerned about this proposal. It is our view that this proposal would both undermine the existing Medicare Plan Finder (MPF) and limit the possibility of fixing some of the current issued with the functionality of the MPF.

Instead of improving the functionality of the existing MPF, which was created to be the centralized tool that all advisors, SHIPs and beneficiaries have to obtain and compare specific plan information, this proposal seems to be asking individual issuers to create their own plan-specific tools that will include additional functionality. The logic cited as the impetus for the proposal is that beneficiaries would derive value from their own tool, separate from the one that will already be available to providers in 2021, to use at the time of care regarding potential prescriptions.

However, it is our view that the provider tool will be sufficient for drug comparisons in the care setting, and that when beneficiaries will really need this information is during the annual election period when they are comparing plan options. The benefit of the MPF is that is combines all

necessary information into one tool, which allows licensed and certified agents, SHIPs and beneficiaries to compare plans and drug coverage nuances efficiently. By requiring additional Part D information to be included only in carrier-specific tools that are not available in the MPF, the result will be that beneficiaries, agents and SHIP counselors will need to review many different carrier tools to find the right Part D plan for a beneficiary. This is not a system that provides value or expediency during the short October 15-December 7 window of annual enrollment season. If CMS believes that beneficiaries need additional information, then NAHU members believe the far more advantageous solution would be to update the MPF with the additional data so that all information remains centralized and easily accessible to all who need it, when they need it.

Establishing Pharmacy-Performance-Measure Reporting Requirements

CMS proposes to require Part D plans to disclose their current pharmacy performance measurement standards to enable CMS to track how plans are applying them. CMS also plans to report this information publicly to increase transparency. In the proposed rule, you also solicit comments about pharmacy-performance measures more broadly, including potential alterations to the Part D star ratings metrics to incentivize the uptake of a standard set of pharmacy-performance measures.

NAHU members appreciate the attempt to standardize pharmacy performance measurement tools and increase transparency. However, we suspect that most Medicare beneficiaries judge pharmacy performance on a highly personalized basis and will not place much value on star-rating metrics relative to generalized pharmacy performance. Our members and their clients are far more interested in lowering prescription drug costs, and we believe that CMS's efforts relative to pharmacies should be centered as such.

Medical Loss Ratio

The proposed rule would amend the Medicare Advantage medical loss ratio (MLR) requirements to allow MA organizations to include in the MLR numerator as "incurred claims" all amounts paid for covered services, including amounts paid to individuals or entities that do not meet the definition of "provider" as defined at §422.2, in alignment with changes to MA supplemental benefits in recent years. It would also add deductible-based adjustment to the MLR calculation for Medicare Advantage medical savings account (MSA) contracts receiving a credibility adjustment. The proposed adjustment would remove a potential deterrent to the offering of MSAs by MA organizations that may be concerned about their inability to meet the MLR requirement as a result of random variations in claims experience, the risk of which is greater under health insurance policies with higher deductibles. NAHU strongly supports the proposed MLR changes, particularly with regard to MSAs. It is our hope that they will lead to the greater availability of Medicare Advantage MSA products in the marketplace, as they would be very attractive option for many consumers.

Medicare Advantage and Cost Plan Network Adequacy
CMS proposes to strengthen network-adequacy rules for Medicare Advantage plans by codifying our existing network-adequacy methodology. CMS is also proposing new policies to improve access in rural areas and encourage the use of telehealth in all areas. NAHU supports this effort and notes that the COVID-19 pandemic, which increased in its intensity in the United States after the publication of this proposed rule, highlights the extreme need for more access to telehealth providers and greater network adequacy, particularly in rural areas.

Supplemental Benefit Requirements
NAHU supports the codification of existing policy with respect to supplemental benefits, including the Managed Care Manual (Chapter 4) definition of a supplemental benefit, the expanded definition of "primarily health related" and the reinterpreted uniformity requirements, such as reductions in cost sharing are an allowable supplemental benefit. Our members note that the new supplemental benefits added to many Medicare Advantage plans are extraordinarily popular with seniors and provide great value. As such, NAHU members support this and any other measures to increase beneficiary access to supplemental benefits.

Special Election Periods for Exceptional Conditions
The proposed rule would codify a number of existing exception circumstance special election periods (SEPs) already adopted through sub-regulatory guidance. It would also create two new SEPs, one for individuals enrolled in a plan that has been identified by CMS as a consistent poor performer and another for individuals enrolled in a plan placed in receivership. NAHU supports these SEP additions but we request that if a beneficiary who is eligible for any of these new SEPs or any other SEP has an agent of record, that a pathway be created for the agent of record to make the plan change.

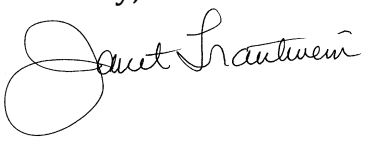
Telehealth Provisions
The proposed rule was crafted long before it was clear that the COVID-19 pandemic would impact the United States as significantly as it has. Since the publication of the rule, the spread of the virus and the related social-distancing requirements have led to numerous changes and expansions to the availability of telehealth services to Medicare beneficiaries beyond what was proposed in this rule. NAHU members believe one of the only positives of the pandemic to date is how it highlights the value of telemedicine services. As such, we believe that when the rule is finalized, § 422.135(d) should be revised to allow all Medicare Advantage plan types, including preferred provider organizations, to offer telehealth through non-contracted providers and treat them as basic benefits under Medicare Advantage.

Supplemental Benefits, Including Reductions in Cost Sharing
NAHU supports the language in the proposed rule that grants Medicare Advantage plans additional flexibility with regard to the structure of mandatory supplemental benefits through cost-sharing reductions. Our members report that these benefits are very popular with their clients and we appreciate the ability for issuers to increase their availability through innovative plan designs.

Special Supplemental Benefits for the Chronically Ill
NAHU members believe that the recognition CMS gives through the proposed rule that there may be other medical issues that may meet the statutory definition of a chronic condition but are not included in the Medicare Managed Care Manual is important. We support the new specification that, beginning in contract year 2021, plans be allowed to target other chronic conditions with regard to supplemental-benefit offerings.

We sincerely appreciate the opportunity to voice our viewpoint on the proposed rule. We are also grateful for your commitment to gathering the views of all stakeholders about these critical topics. If you have any questions about our comments or if NAHU can be of assistance as you move forward, please do not hesitate to contact me at either (202) 595-0639 or jtrautwein@nahu.org.

Sincerely,



Janet Stokes Trautwein
CEO
National Association of Health Underwriters