January 5, 2024

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-4205-P

Submitted electronically via www.regulations.gov

Dear Ms. Brooks-LaSure:

I am writing on behalf of the National Association of Benefits and Insurance Professionals (NABIP), formerly known as NAHU, which is an association representing over 100,000 licensed health insurance agents, brokers, general agents, consultants and employee benefits specialists. We appreciate the opportunity to provide comments on the Center's recently published regulation titled, "Medicare Program: Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications."

NABIP members work daily to help millions of people and businesses purchase, administer and utilize health insurance coverage. Thousands of our members specialize in assisting Medicare beneficiaries with their coverage needs. As such, we are grateful for the opportunity to share feedback on this draft guidance. We've broken down our comments by topic presented in order of appearance in the proposed rule. The substantive content of our letter was developed based on feedback from the members of our national Medicare Working Group and our national Medicare Field Marketing Organization (FMO) Council.

Improving Access to Behavioral Health Care Providers-Outpatient Behavioral Health Facilities

To go along with increased behavioral health support funding in Medicare in the Consolidated Appropriations Act, 2023 (CAA 2023) and the related CAA 2023 implementation final rule, the proposed rule would add "outpatient behavioral health facilities" to the list of Medicare facilities subject to network adequacy requirements including time-and-distance requirements. The outpatient behavioral health specialty type also would be eligible to receive a 10 percent credit for the percentage of enrollees who reside within the time-and-distance standards when the MA plan includes one or more telehealth providers of that specialty. NABIP members support this change.

Special Supplemental Benefits for the Chronically Ill (SSBCI)

Medicare Advantage plans may provide supplemental coverage of items or services for chronically ill individuals, but these services must have a reasonable expectation of improving or maintaining the health or overall function of the enrollee. CMS currently has the burden of generating evidence to determine whether the "reasonable expectation" standard has been met, but the proposed rule would give Medicare Advantage Plans the responsibility for making the determination and outlines criteria that must be used. It also amends the related disclaimer language. NABIP members approve of these changes, as we believe they may increase access to services for chronically ill beneficiaries.

To address unused supplemental benefits available to chronically ill people, the new rule would require Medicare plans to provide a mid-year notice to enrollees, between June 30 and July 31, informing them of any unused supplemental benefits available to them that they did not use during the first six months of the year. CMS seeks comment on this proposal, particularly on the timing, if any, of the notice for enrollees who enroll in the plan mid-year.

NABIP members strongly support providing increased notice to beneficiaries about their unused benefits. In fact, our membership would prefer that CMS to provide quarterly updates about the status of these benefits, as they function on a use-or-lose it basis and many people do not use all or even any of their benefits. So, regular notification would be very helpful. Further, NABIP suggests that these reminders should be written in plain language and include pictures, since our members who regularly work with this beneficiary population report that many supplemental benefit recipients have cognitive issues, or suffer from other conditions that impact literacy. If notification is provided quarterly, then the notices should be sent mid-quarter, so that they accurately reflect the person's utilization status and provide enough time for the person to obtain their available benefits.

Proposed Changes to Agent and Brokers' Compensation and Relationships with FMOs, MAOs, General Agencies, and other Entities Providing Administrative Service Support

The proposed rule includes two significant changes to the way health insurance agents and brokers who serve the Medicare population would interact with Medicare plans and be compensated for their services. The first would prohibit contract terms between Medicare Advantage plans and agents, brokers, or other third-party marketing organizations (TPMOs) that "may interfere with the agent's or broker's ability to objectively assess and recommend the plan which best fits a beneficiary's health care needs."

Almost all of the NABIP members who work in the Medicare space are servicing agents, whose businesses depend on long-standing customer relationships and satisfaction, as well as personal client referrals. To a NABIP member, the health and well-being of their clients is paramount, and no contract term would influence a servicing agent's recommendation about which policy

would best fit a client's needs. However, our members do have concerns with the proposed language regarding the terms of their contracts appointing them to sell specific Medicare Advantage plans.

First, contracts between plans and agents and brokers are those of adhesion, and individual servicing agents have no ability to change the terms with the carriers in their service area. Second, NABIP members are also concerned that the proposed language about prohibited contracts is arbitrary and lacks clear definitions and standards. We are concerned that it would be impossible for servicing agents to determine if their contracts were appropriate or not. Further, we are concerned about CMS's ability to enforce such subjective standards. Finally, while contracts with different carriers vary and include differences in compensation, these differences in no way affect the assistance or advice NABIP members provide to their clients. Our membership notes that minor differences in plan contract terms do no more to influence a servicing agent's decision to represent a plan than a minor variation in CMS reimbursement rates affect a plan's decision to offer coverage in a given county.

NABIP members know that there are bad actors, and clearly CMS wants to ensure that unscrupulous marketing efforts cease. NABIP members feel similarly, which is why we have some suggestions about how existing rules could be more uniformly and effectively enforced, thereby significantly curbing such practices. For example, better communication between CMS and all carriers for which an agent is appointed about problem activities is needed. Typically, agents are appointed with multiple issuers simultaneously, even if they focus most of their efforts selling one entity's products. When an agent breaks the rules, the affected carrier can terminate them for cause. However, since there is no communication between CMS and the other entities with which the agent is appointed about cause-based terminations, a problem agent can turn around and sell for the other carriers with which they hold appointments. The effective result is an unprincipled agent can remain in the marketplace for years without significant consequence. Another concern in the marketplace are incentives that may be offered to a physician, which could be addressed by better and more uniform enforcement of the Stark law.

A key reason that problems exist in this marketplace is not the lack of existing rules, but CMS's lack of enforcement resources. To that end, NABIP members suggest that CMS work more directly with Medicare field marketing organizations (FMOs), as these entities are currently serving the marketplace by providing their down-stream servicing agents with training and compliance resources. Our members who represent these organizations are eager to work with CMS to ensure that the Medicare marketplace is serviced by committed and quality agents who adhere to all existing proscribed standards. Further, we suggest that CMS increase carrier coordination and communication to enforce existing rules. Based on their appointment relationships as approved producers with health insurance issuers contracted with CMS to

provide Medicare Advantage and Part D services, Medicare-certified agents and brokers are required to comply with all applicable carrier requirements too.

The second major change proposed by CMS would be to revise what is considered “compensation” by eliminating any variance in compensation paid by plans, so that all agents and brokers would be paid the same amount whether from the Medicare Advantage plan or an FMO (except for referral payments). Further, the concept of “compensation” would extend to cover all agent-beneficiary activities, such as responding to follow-up questions during the year or gathering health risk assessment information to assist Medicare Advantage plans and beneficiaries. Finally, the proposed rule would eliminate the separate regulatory provision for “administrative payments” to FMOs, since the proposed rule states these administrative fees “effectively circumvent the Fair Market Value (“FMV”) caps on agent and broker compensation.” Any administrative payment would be a component of the standardized, capped compensation paid to agents and brokers, which in 2025 would be just $31. NABIP members strongly oppose all of these changes and believe they would cause havoc to the way Medicare Advantage plans are currently marketed and serviced, at great detriment to Medicare beneficiaries.

The new compensation standards contained in the proposed rule would effectively eliminate the existing model of servicing agents working with and through FMOs, thereby denying the marketplace all of the benefits these entities provide to both agents and brokers and Medicare beneficiaries. The proposed rule appears to be based on some misunderstandings about how both sales, marketing, training and other sources of essential support are currently provided to servicing agents today, as well as a misunderstanding about how compensation currently flows in the Medicare Advantage marketplace and how different sources of funds are directed and utilized. To help clear up some of these issues, NABIP offers the following overview of the way the Medicare Advantage marketing support structure for servicing agents and brokers works currently.

In today’s marketplace, the vast majority of Medicare Advantage plans outsource virtually all of their sales and marketing support for servicing agents to FMOs. FMO is a loose term for a brokerage upline agency that provides administrative support to a downstream group of servicing brokers. The FMO label is not consistent either – there are use different terms and acronyms to describe a “FMO” in the industry, which can include NMO, NMA, PMO, FMO, SMO, IMO, SGA, MGA, GA and so forth. Distinct names and anacronyms are used in different parts of the country, and in some cases different names are used based on the size of the organization and if the entity works with agents and carriers on a national basis, or if the FMO serves more local markets.

For the purposes of this comment letter, NABIP will refer to all entities that directly contract with and certified by one or more Medicare Advantage carrier to provide marketing support as

an FMO. However, it is important to note that while current CMS rules classify all FMOs as third-party marketing organizations, or TPMOs. While every group that NABIP is referring to as an FMO is this letter is also a TPMO, there are entities that also fall under the TPMO grouping that are NOT FMOs. TPMOs can also be an entity that is not contracted and certified with any Medicare Advantage carrier.

The TPMOs who do not qualify as FMOs are often the multi-vertical lead generators that buy and sell "lead" data across multiple industries, FMOs and brokers. The purchasing parties are often kept in the dark on how "their" lead is **also** being sold to other parties and brokers. These are the TPMOs that frequently run the problematic national MA/PDP beneficiary focused TV commercials. We fully support HHS' efforts on reigning in these types of TPMOs that operate outside of the CMS' regulations.

Many NABIP members in the Medicare space are servicing agents and brokers, or those individuals who work directly with Medicare beneficiaries. These agents and brokers choose to work with an FMO because they provide a wide range of support services that the servicing agent cannot obtain anywhere else including from the Medicare Advantage carrier whose products they are selling. Such services include things like compliance support, training, web services, enrollment technology, client relationship management (CRM) technology, sales leads, and full back-office service teams. Servicing agents voluntarily select their FMO and are free to move to a different FMO at any point.

Other NABIP members work for, own, or manage FMOs. FMOs provide essential assistance and support to servicing agents that most would assume are provided by the Medicare Advantage plans themselves. To help delineate typically outsourced functions, and the interrelated role of both the servicing agents and the FMOs that support them, we have prepared the following chart:

Function	**Servicing Agent Need**	**Role of the FMOs/GAs**
Contracting and Licensing	Agents must be licensed in every state in which they do business and, in most states, appointed with every carrier with which they do business. This is a time-consuming and expensive process.	Send recruiting links to interested agents and communicate the value proposition of the carrier. Assist in ensuring all contracts submitted are complete and in good order for carrier processing.
Continuing Education	Agents have to meet significant and ongoing continuing education requirements, and typically	Provides/sponsors continuing education courses and course content for servicing agents. Many FMOs sponsor annual

Function	Servicing Agent Need	Role of the FMOs/GAs
	accessing approved continuing education content is an expensive endeavor.	in-person forums for training and education.
Certifications	Agents must obtain national certifications and certification from each applicable carrier annually, which is both expensive and time-consuming.	Provides access to/sponsorship of carrier and FWA certifications. Communicate to agents on their Ready to Sell status.
Errors and Omissions Insurance	For the protection of both beneficiaries and their business endeavors, agents need to obtain and maintain errors and omissions insurance coverage.	Provides access to high-quality coverage to protect both clients and servicing agents. Group E&O discounts are sponsored programs.
Enrollment Support	Agents need resources to process their enrollments and serve the vulnerable senior population effectively.	Provides state-of-the-art technology and tools to support agents with enrollment, including iPads, online enrollment platforms, compliant phone and zoom-based enrollment technology, provider and drug look up features, plan comparison technology, access to Medicare blue button data with client consent to ease enrollment and improve accuracy, and more.
Call Recording	Agents were required to record all MA/PDP calls starting in 2023 and store them which requires access to expensive technology.	Provides technology to allow independent agents to record calls, to store them for 10 years and to be able to retrieve their recordings.

Function	Servicing Agent Need	Role of the FMOs/GAs
Client Relationship Management	Agents need technological resources to track client and potential client data, in order to best meet servicing needs.	Provides CRM database technology and tools so that servicing agents can better manage crucial client relationships.
Lead Generation and Sales Support	Agents need access to potential clients and sales training resources.	FMOs provide lead generation resources and sales, including resources for agents to purchase leads from vetted and reputable vendors, direct mail sources and lists, referrals and more.
Carrier Materials	Agents need training on carrier products and access to printed carrier materials.	Sponsorship of specific product training, and distribute carrier-specific printed materials and marketing tools.
Marketing Materials and Support	Independent agents need resources to develop and maintain compliant marketing materials.	Provide access to compliant and CMS-approved designs, agent website development and maintenance services, social media and electronic mail marketing tools and support.
Client Escalations	Servicing agents work with their clients year-round to address and resolve plan-based issues.	Serve as a direct link to affiliated carriers, providing escalation resources and client issue resolution support.
Compliance Resources	Medicare sales and service is subject to both federal and state-level regulation. Independent agencies need help to always stay on the right side of constantly evolving rules and requirements.	Provide 24/7 access to compliance officers, resources, training, industry overviews and guidance, and more.

To provide all this critical support to servicing agents and brokers, Medicare Advantage plans currently pay the FMO between $200 and $300 per beneficiary. This payment amount varies based on geographic conditions and by carrier, with smaller, regional entities typically paying towards the higher end of the range. The administrative fee paid by carriers to FMOs is entirely separate from the fair market value (FMV) compensation payment made to the servicing agent.

The proposed rule would reduce administrative payments to $31 per year and include it as part of the servicing agent's FMV compensation. If this change goes into effect as currently written, it would unravel the entire existing system of support provided by GAs and FMOs. Limiting FMOs to approximately 15 percent of their current funding would mean that all of these independent companies will no longer be financially viable. Not only would that have a detrimental economic impact – as FMOs are thriving businesses located in every state and employing tens of thousands of people – it would also have a catastrophic impact on the entire Medicare Advantage population.

Medicare Advantage carriers routinely outsource agent support services today, as subcontracting saves the carriers money and provides better results for issuers, servicing agents, and consumers alike. However, if the proposed rule is adopted as written and FMOs are forced out of the marketplace, then the functions independent FMOs provide for multiple carriers simultaneously will need to be assumed by each carrier on an individual basis. Not only will this increase carrier expenses, which in turn will ultimately negatively affect premiums and the Medicare Trust Fund, but consumers will also see a detrimental service impact.

Today, FMOs provide both servicing agents and their Medicare beneficiary clients the ability to easily compare and contrast between most, if not all, Medicare Advantage product offerings available in their area, all at the same time. If sales, marketing, and enrollment services are brought back in-house to each carrier, then each carrier's product offerings will be isolated, and it will be much more difficult for independent servicing agents to represent multiple issuers. Furthermore, some issuers will likely choose to focus more on direct sales, meaning that the beneficiaries who engage with those issuers will only learn about one carrier's offerings.

Another concern is how different carriers will weather a forced transition to handling all sales, marketing, and agent services internally. Some will likely be able to ramp up broker support services more quickly and efficiently than others, incenting servicing agents and their clients to work with those carriers, rather than their competitors. Also, not all Medicare Advantage carriers will have the ability, or appetite, especially initially, to contract with the thousands of independent servicing agents and brokers who will want to represent them. The result will be less representation of carrier choices in the marketplace.

NABIP members understand that, as things stand today, it may not be clear to many why the administrative fees paid to FMOs efficiently pays for much needed enrollment, compliance,

education, and customer communication services. To address the concerns that CMS has about the lack of transparency regarding administrative fees, and to ensure that administrative payments are fair and do not favor any one plan over another, NABIP proposes complete disclosure and transparency of these administrative fees. Further, we would support a flat rate for administrative service payments, so that there is no ability or incentive for a FMO to favor one issuer over another. However, the administrative fee needs to be based on a fair market value rate, which is no less than $250 per beneficiary currently, and will need to be adjusted annually for inflation.

Besides the administrative fee, which goes to the FMO entirely, there are three other sources of funding that are being addressed by the proposed rule. The first is the fair market value or FMV compensation that applies to independent servicing agents and brokers. The second is the fees that are paid to agents and brokers for performing health risk assessments for Medicare Advantage carriers. The final source of funds is marketing monies that are paid by carriers to FMOs. It is important to understand how and why each of these types of funding are being used in the marketplace today.

The FMV is the maximum rate that the CMS sets every plan year that Medicare Advantage carriers are allowed to pay servicing agents and brokers. While a FMO may distribute this money to their downstream servicing agents, in virtually all cases they pass 100 percent of that rate along to the servicing agent or broker. By publishing the annual FMV rates, CMS ensures that servicing agents understand their FMV compensation level and sets the standard that they will receive all of that compensation for their work. That is why the FMV rate is currently completely separate and distinct from any administrative fees a FMO receives from the Medicare Advantage carriers as part of their certified marketing support contracts with those carriers. Legitimate FMOs use their administrative fees to carry out their contractual obligations with the Medicare Advantage plans they represent by providing marketing and back-office support to their downstream servicing brokers.

The second source of Medicare Advantage carrier funding that may go to servicing agents and brokers are health risk assessment fees, which in almost all cases ranges between $25-100 per assessment, with $200 being the maximum amount an agent could receive for assessment administration. These fees are paid by individual carriers and go directly to the servicing agent performing the assessment for a specific carrier. These fees are never retained, in whole or in part, by the FMO. Further, servicing agents decide if they would like to perform health risk assessment services for carriers.

The amounts different carriers pay their agents to conduct health risk assessments are based on the type of plan, the complexity of the product, and the complexity of related questionnaire, since more complicated products and questionnaires require significantly more time and work on the administrating agent's part. The payments for D-SNP population assessments are

generally higher than what a carrier will pay for an assessment with a typical Medicare beneficiary for several reasons. First of all, carriers are paid more by CMS for D-SNP beneficiaries, so they can compensate agents slightly more for assisting with D-SNP assessments. Furthermore, health risk assessments for the D-SNP population require the collection of more data and involve a more rapid production timeframe. The D-SNP population is also far more likely to have low literacy levels and/or chronic or progressive conditions that impact memory and cognition, making the process of completing D-SNP risk assessments with the beneficiaries much more difficult and time-consuming.

Many carriers believe that getting agents to complete these assessments with beneficiaries is the most efficient way of collecting the data. However, since completing health risk assessments is not a mandatory function for independent servicing agents, the related compensation needs to be competitive. Further, the opportunity cost for agents to perform health risk assessments are high, particularly when the Medicare annual election period is looming. Therefore, the proposed rate of $13 per every assessment, with no consideration of the type of assessment, beneficiary population, and time involved is much too low. If it stays at this level, most agents will not feel like it is worth their time to complete them, and it is unclear then how carriers will begin to make up this void in the data collection process.

Carriers use the information to determine if a qualified health professional needs to conduct a further evaluation of medical needs so that they can be properly placed into medical protocols or treatments to avoid more costly health events. They also assess the beneficiary in their home environment and determine if they have appropriate transportation for example. Without the assessments, valuable time is lost.

The final source of funding that potentially could flow through servicing agents and brokers are the “marketing funds” that are provided by Medicare Advantage carriers to FMOs. The amount of these funds varies by carrier and recipient FMO, and these funds are used for a wide range of purposes. Some of these purposes include expenditures that in no way involve a direct flow of money to a servicing agent, such as using the money for lead generation lists, advertising buys, social media expenditures, and other broad-scale marketing expenses incurred by the FMO. However, in other cases, a FMO may use marketing funds to pay for things like hosting community events or reaching out to diverse populations of potential enrollees. In those cases, marketing funds may be used to reimburse servicing agents for things like the cost of travelling to meet with potential clients in an underserved area.

Of concern is the lack of transparency and accountability when it comes to the use and distribution of “marketing funds.” These funds not only flow through to legitimate FMOs but are also provided by some carriers to TPMOs who do not perform FMO services. Furthermore, some, but not all, Medicare Advantage carriers require FMOs to provide documentation and receipts regarding the use of such funds. NABIP member FMO representatives indicate that

agencies require similar documentation from servicing agents who seek and obtain reimbursement that flows from such funds, but this is a best industry practice, not a required one. Some of our members also report that they have heard rumors of marketing funds being used by some unscrupulous industry actors as a means of providing back-end incentives to agents and others, but we have no direct evidence of this practice. Nevertheless, NABIP in no way condones the use of funds in such manner, and we propose that CMS take steps in any final rule to regulate the use of marketing funds.

To that end, we suggest that the distribution of all such funds from Medicare Advantage carriers to both FMOs and other TPMOs, be both reported and transparent. We suggest that CMS require that FMOs and TPMOs who are not directly contracted with Medicare Advantage carriers, such as lead generation agencies and call centers, maintain transparent documentation of both the receipt of such funds and their source, as well as how account for how all such funds are spent and distributed. Finally, we suggest that it be required that any servicing agent or other entity that is provided with such funds to reimburse incurred marketing expenses be required to document and account for such expenditures in a transparent manner. Imposing such reasonable controls should ensure that marketing funds provided by the carriers to FMOs and other TPMO recipients are only used for reasonable and legal purposes.
to them that they did not use during the first six months of the year.

Annual Health Equity Analysis of Utilization Management Policies and Procedures

As per prior rulemaking, as of January 1, 2024, Medicare Advantage plans must have a utilization management review committee. The proposed rule would require the committee to include at least one member with expertise in health equity, such as "experience conducting studies identifying disparities amongst different population groups." The committee also would be required to conduct an annual health equity analysis of the plan's use of prior authorization on enrollees with one or more of the following social risk factors: (1) receipt of the low-income subsidy or being dually eligible for Medicare and Medicaid; or (2) having a disability. Each Medicare Advantage plan would also be required to publish its health equity analysis on its public website. Given that ensuring health equity is a core part of NABIP's mission to ensure all individuals have equitable, culturally competent, high quality health care and treatment, we strongly support the proposed new health equity requirements for Medicare Advantage plans.

In addition to the populations the proposed rule seeks comment on whether additional communities, such as LGBTQ+, limited English proficiency, or other persons should be included in the health equity analysis. While NABIP members see the value of assessing health equity and these additional populations, we do caution CMS to consider the available sources of relevant data. For example, a plan would not have a definitive way of knowing a beneficiary's LGBTQ+ status or their literacy level, and plan certainly would not have the authority to collect such data, especially during the prior authorization process.

Regarding the request for information about how CMS and the affected issuers should determine expertise in health equity, NABIP notes that the National Committee for Quality Assurance offers an equity designation for issuers. Certain state-based exchanges require all approved issuers to complete this designation, since it is the most comprehensive being offered in the marketplace today, and CMS could take similar action. Further, NABIP feels that health equity training and certification must be continuous and go beyond understanding how to collect data. It should also speak to how to analyze, interpret, and implement that data. Also, when assessing health equity. experience and qualitative measures are just as important as quantitative. Further, assessing health equity requires measuring community engagement.

Dr. Serio Aguilar-Gaxiola, founder and director of the UC Davis Center for Reducing Health Disparities, has led a body of work around how to measure meaningful community engagement as a core component to advancing health equity. Building off this work more broadly, Dr. Sergio partnered with the National Academy of Medicine to establish a measurement framework and taxonomy.[1] The conceptual model posits four broad categories or domains of measurable outcomes:

- Strengthened partnerships and alliances
- Expanded knowledge
- Improved health and health care programs and policies
- Thriving communities

Under each domain are potential and relevant indicators. The conceptual model presents nineteen mutually exclusive indicators divided across the four domains. We urge CMS to work in partnership with private sector to establish the measurable indicators that can reviewed within each of these four domains.

Mid-Year Formulary Changes

The proposed rule would let Part D plans make mid-year formulary changes to substitute an FDA-approved biosimilar biological product which has not been deemed interchangeable, for a reference product as a maintenance change (meaning it could apply to all plan beneficiaries mid-year with 30 days' notice). NABIP members support this proposal, as we believe it would help with prescription drug access due to supply-chain issues and also better align Part D practices with state/private market rules. However, we suggest that it be accompanied with a special enrollment period (SEP) for individuals who are directly affected by the formulary change, so that they have the opportunity to change plans to one that covers their original

[1] Source: Assessing Meaningful Community Engagement: A Conceptual Model to Advance Health Equity through Transformed Systems for Health - National Academy of Medicine (nam.edu)

medication. In addition, when creating this SEP, it will be important to specify that Medicare beneficiaries can rely on their brokers to assist them, since the broker provides year-round service to their clients.

Increasing the Percentage of Dually Eligible Managed Care Enrollees Who Receive Medicare and Medicaid Services from the Same Organization

The proposed rule would create new monthly special enrollment periods for standalone prescription drug plans and fully integrated care plans ("D-SNPs") available to dual-eligible and low-income subsidy ("LIS") individuals. CMS would also limit cost-sharing in certain D-SNPs and gradually lower the enrollment threshold for MA plans that enroll dual-eligible individuals before the MA plan is considered a D-SNP "look-alike" plan. Our membership recognizes that this proposal would affect a very limited number of D-SNP plans, so we do not object to the creation of this new SEP. However, our membership would like to caution CMS about the trend of increasing the number of available SEPs generally with the D-SNP community. Unfortunately, bad actors often use SEP periods as a mechanism for marketing bad practices and preying on a vulnerable community.

Thank you for the opportunity to comment on this draft regulation, as well as your willingness to consider the viewpoints of all stakeholders. If you have any questions or need additional information, please do not hesitate to contact John Greene, senior vice president of government affairs, at jgreene@nabip.org or (202) 595-3677.

Sincerely,

John Greene
Senior Vice President of Government Affairs
National Association of Benefits and Insurance Professionals (NABIP)