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March 7, 2022

Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services

Department of Health and Human Services

Attention: CMS-4192-P

P.O. Box 8013
Baltimore, MD 21244-8013

Re: Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs

Dear Administrator Brooks-LaSure,

Thank you for this opportunity to comment on the Proposed Rule entitled "Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs."[1] eHealth is a publicly-traded company operating its consumer online marketplace www.eHealthInsurance.com and is a web-broker that has enrolled millions of individuals in health insurance through its consumer-centric website over the last 22 years. For more than a decade, eHealth has collaborated with the Centers for Medicare & Medicaid Services (CMS), enrolling hundreds of thousands of Medicare-eligible individuals into Medicare Advantage and Medicare Part D prescription drug plans through our best-in-class consumer-centric website and customer care centers.

In these comments we provide feedback and insights in response to the CMS' proposal to institute additional regulatory oversight over third-party marketing organizations (or, TPMOs), which the agency proposes to define as "organizations who are compensated to perform lead generation, marketing, sales, and enrollment related functions as a part of the chain of enrollment."[2] As discussed below, in light of the fragmented evidence presented, we urge the agency to conduct further research before adopting such a far-reaching policy.

[1] 87 Fed. Reg. 1842 (January 12, 2022)

[2] Proposed 42 C.F.R. § 423.2260.

I. eHealth Supports the CMS Proposal to Regulate TPMOs but Notes that it Appears to be Premised on Anecdotal Evidence

eHealth is broadly supportive of policies designed to improve the plan selection and enrollment experience for Medicare beneficiaries. We particularly share CMS' concerns with respect to third-party advertising that is misleading, confusing, or otherwise not in the best interests of the Medicare Advantage program. Effective oversight, especially over currently unregulated entities, may well be necessary. For its own part, eHealth continues to adopt improvements in its beneficiary interactions to increase the quality of our customer enrollment experience, including by implementing new, sophisticated call monitoring software and increasing the number and quality of our compliance trainings.

We are concerned, however, that CMS' proposed regulatory actions appear to be premised upon anecdotal evidence of a handful of bad actors and not based on sufficient data points to adequately support the proposed policy. In the preamble, CMS acknowledges the limitations on its own analysis. The agency provides data from its Complaints Tracking Module (CTM) for just two years (2020 and 2021), and admits that the agency lacks the ability to tie these complaints to actions of TMPOs.[3] The evidence that the agency does provide ("Based on the CTM data, CMS also has reviewed several sales and enrollment call recordings between TPMO staff and beneficiaries") appears anecdotal and incapable of being specifically tied to one actor in the chain of enrollment. Again, while we share the agency's concerns about problematic and misleading behavior, we suggest additional data collection may be necessary to reasonably structure the proposed new level of regulatory oversight.

The CTM data cited is also notably confined to a time period coinciding with a global pandemic and public health emergency when many beneficiaries previously accustomed to working with an in-person agent or broker were suddenly reliant on telephone and internet communication to shop for a plan. The last two years has witnessed a seismic shift toward telesales, largely driven by the pandemic. While these virtual access options played a tremendous role in ensuring beneficiaries had the ability to continue to shop for and select Medicare health plans, it has not been without its learning curve, particularly for beneficiaries new to this style of tele-shopping. While CTM rates increased, the number of beneficiaries shopping using these new modalities also increased. We encourage CMS to consider the extent the data upon which it relies is a symptom of a changing environment.

To the extent the agency does move forward with this proposal, we encourage CMS to modify its proposed regulatory language at 42 C.F.R. § 422.2274(g)(2)(iii) to clarify that TPMOs need only report staff disciplinary actions to the plan when such action is the result of a violation of CMS marketing requirements in order to avoid the needless reporting of non-germane information.

[3] *See* 87 Fed. Reg. at 1845 ("We are unable to say that every one of the complaints are a result of TPMO marketing activities, but based on a targeted search, we do know that many are related to TPMO marketing.")

II. Reliance on CTM Data Could Result in Inaccurate and Flawed Conclusions

eHealth has previously communicated to the agency our concerns with overreliance on CTM data, which can provide an inaccurate picture of the enrollment experience. As the primary basis for the proposed TPMO policy, CMS cites the number of marketing complaints it has received through the CTM in 2020 (15,497) and 2021 (39,617).[4] Not only does this data lack historical context (in other words, CMS has not contextualized these numbers outside of a two-year period which overlapped with a global pandemic), but it also provides little insight into what is driving the complaints or even the source of these complaints (for example, whether they originated at the carrier, broker, or TPMO level).

Reliance on CTM complaints as a basis for a major new policy change must also be balanced with the limitations of what CTM data actually suggests. CMS' current CTM Standard Operational Procedures acknowledge that certain complaints, including marketing complaints, may be resolved by a determination that the complaint was unfounded, but CMS explicitly bars plans from re-categorizing these complaints.[5] Despite the wide gradation in marketing complaints captured in the CTM, current CMS policy is to treat all complaints captured in the CTM, including marketing complaints, the same whether they are founded or unfounded, or insignificant. Complaints are also afforded the same level of impact regardless of whether or not the complainant beneficiary is enrolled in the plan.

To remedy these concerns, CMS could amend its CTM Standard Operational Procedures to allow for the further sub-categorization of marketing complaints, at a minimum, to distinguish founded from unfounded complaints. Unfounded complaints should not impact a plan's star rating.

While eHealth fully understands the gravity of the concerns raised through the precipitous rise in CTM complaints in recent years, we believe that without further context this data is only a partial picture of the Medicare enrollment experience. For its own part, eHealth has recently undertaken a number of new initiatives to improve quality in our enrollment processes. For example, in 2021 eHealth implemented new training and initiatives to focus on quality, taken additional steps to verify enrollment selections, and launched a new technology for more sophisticated call monitoring. The early results of our efforts appear very promising in reducing CTM complaints. We urge CMS to examine additional data prior to making any major policy changes. While we understand that further categorization of CTMs as described above is more likely to be reflected in future sub-regulatory guidance, we look forward to an opportunity to discuss these suggestions with CMS.

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[4] *Id*.

[5] *See* Complaints Tracking Module (CTM) Plan Standard Operational Procedures (SOP) (Effective March 30, 2019) (available at https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/ctm%20plan%20sop%20eff053019_0.pdf) ("Plans should not submit Plan Requests seeking re-categorization of marketing complaints when a plan determines a complaint was unfounded.")

III. CMS Should Align New Disclaimer Requirements with Existing Guidance

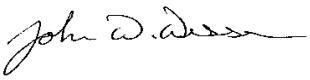
In the event CMS moves forward with its new disclaimer proposal, TPMOs would be required to display on *all* marketing materials a new standardized disclaimer which provides: "We do not offer every plan available in your area. Any information we provide is limited to those plans we do offer in your area. Please contact Medicare.gov or 1–800– MEDICARE to get information on all of your options." This information would similarly be required to be verbally conveyed within the first minute of a sales call and electronically conveyed when communicating through electronic means.

Given CMS' existing regulatory oversight over plans and FDRs, we encourage CMS to make consistent its requirements in order to reduce the administrative burden on plans and FDRs. For example, previous CMS guidance required materials developed by a third party which list or market a subset of plans to include the following disclaimer: "For a complete list of available plans please contact 1-800- MEDICARE (TTY users should call 1- 877-486-2048), 24 hours a day/7 days a week or consult www.medicare.gov."[6] This language is both clearer and provides several additional benefits: (1) it only requires a disclaimer in the event the material in question is marketing a specific list of plans; and (2) like other disclaimers, it is not required on banners and banner-like ads, envelopes, outdoor advertising, text massages, and social media.[7] The combination of CMS's recent guidance regarding what constitutes marketing material and the proposed disclaimer requirement seemingly require the use of the disclaimer on materials where doing so is not practical.

Lastly, we urge CMS to be more flexible with respect to oral disclaimers. Requiring the disclaimer in the first minute of a sales call is too rigid and inflexible of a requirement that often may not fit the circumstances. We suggest that the requirement be one of prominence to allow for flexibility and to allow for the disclaimer to come at a more natural point in the interaction with the Medicare beneficiary.

Thank you for your attention to our comments. We would be pleased to answer any questions that you may have.

Sincerely,



John D. Desser
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[6] Medicare Communications and Marketing Guidelines (XX/XX/2019).

[7] Medicare Communications and Marketing Guidelines (February 9, 2022).