AWHIB

The Association of Web-Based Health Insurance Brokers

February 10, 2023

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-4201-P
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted electronically via www.regulations.gov

Re: Medicare Program; Contract Year 2024 Policy and Technical Changes to Medicare Advantage and Medicare Prescription Drug Benefit Programs —AWHIB Comments

Dear Administrator Brooks-LaSure:

On behalf of the Association of Web-Based Health Insurance Brokers (AWHIB) and its member companies, we appreciate the opportunity to comment on CMS-4201-P, Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs (CMS-4201-P). AWHIB is a trade association of web-broker entities (WBEs) that have signed agreements with the Centers for Medicare and Medicaid Services (CMS) and are currently using the Federally-facilitated Exchange's (FFE) Direct Enrollment and Enhanced Direct Enrollment application programming interfaces (APIs). Several of AWHIB's members also actively assist Medicare beneficiaries with selection of, and enrollment into, Medicare Advantage plan and Part D prescription drug benefit plan coverage that best meet their needs. AWHIB collaborates with consumers, issuers, regulators, lawmakers, and other industry groups to continually develop technologies and enrollment strategies that provide Americans with access to health insurance products and services.

Agents and brokers serve a critical role in educating beneficiaries about the Medicare Advantage and Prescription Drug programs. Among other things, they are trained and tested annually to be prepared to conduct detailed assessments of beneficiary health insurance needs and recommend available plan offerings that best meet each beneficiary's identified needs. Many also provide, at no additional cost to the beneficiaries, post-enrollment services to help ensure that the beneficiaries are aware of, and making use of, the benefits provided with their plans. Further, independent agents and brokers are able to offer beneficiaries plan options from multiple MA Organizations and/or Part D Plan Sponsors.

AWHIB requests the Department consider the following recommendations and perspectives as it finalizes the proposed rule.

TPMO Distribution of Beneficiary Contact Information to Other TPMOs (42 CFR §§ 422.2274(g) and 423.2274(g))

AWHIB recommends modifying the prohibition on distribution of personal beneficiary data collected by a TPMO to other TPMOs and allow for transfers to an independent agent.

In §§ 422.2274(g) and 423.2274(g), CMS proposes to prohibit personal beneficiary data collected by a TPMO from being distributed to other TPMOs. While AWHIB shares CMS' concerns about the continual reselling of personal beneficiary data by multiple TPMOs, the proposed rule as drafted appears to also preclude the transfer of information to an independent agent (although it does not preclude transfer to the MA Organization/Part D Plan or a captive agent of either). However, allowing transfer to an independent agent, who can offer a choice of plans from multiple MA Organizations, would be in the interest of the beneficiary. Many beneficiaries seek referrals to trusted agents to help them understand the Medicare Advantage Program and the plans that are available to them. The proposed rule would preclude those referral sources from sharing a beneficiary's information with an agent/broker, even where the beneficiary has requested it to be shared. For example, many beneficiaries seek referrals of this nature from their financial advisors or from a senior club of which they are a member. Similarly, in working with a beneficiary, an independent agent (which is included in the definition of TPMO) may discover that the beneficiary would like to enroll in a Medicare Advantage plan from an MA Organization to which the agent is not appointed. The proposed rule would preclude the ability of the beneficiary's agent to share the beneficiary's information with another agent who could help enroll the beneficiary in his or her plan of choice. AWHIB recommends that the proposed prohibition be modified to allow for beneficiaries to explicitly consent to having their information shared with an agent or broker that is clearly identified to the beneficiary. The exception would be specific to sharing beneficiary information with independent agents and brokers since they are licensed to offer the product, and not all TPMOs. This would allow for transfer of information to agents or brokers when doing so is in the best interest of the beneficiary and with beneficiary consent.

Revisions to TPMO Disclaimer (42 CFR §§ 422.2267(e)(41) and 423. 2267(e)(41)); and Identification of Names of MA Organizations or Part D Sponsors That Are Being Advertised (42 CFR §§ 422.2263(b) and 423. 2263(b))

AWHIB recommends waiting to finalize, or at least considering alternatives to, the proposal to require TPMOs to list every available MA organization or Part D sponsor in a service area in the TPMO disclaimer. For print advertisements, AWHIB recommends allowing for the MA organization or Part D sponsor name to be the same font size as the displayed benefits or phone number contained in the advertisement.

In §§ 422.2267(e)(41) and 423. 2267(e)(41), CMS proposes to revise the recently adopted TPMO disclaimer to require TPMOs to list the MA organizations or Part D sponsors with which they contract in the beneficiary's service area. The TPMO Disclaimer is required to be used, among other times, in all marketing materials and in the first minute of a sales call. Notably, TPMOs only just started using the TPMO Disclaimer in October 2022. Before changes are made to it, AWHIB proposes that CMS wait to see if the TPMO Disclaimer, as currently required, is

sufficient to address the concerns CMS has raised. However, if CMS is not willing to wait, AWHIB recommends that it consider alternative solutions because, as drafted, the proposed changes are not practical. For AWHIB members, the list of contracted MA organizations or Part D sponsors is lengthy, particularly if the broker contracts with many MA organizations or Part D sponsors. This is compounded by the fact that many MA Organizations have multiple subsidiaries. For phone calls, reading the entire disclaimer would take longer than the first minute of the call. For print and TV advertisements, including the full list of MA Organizations being offered would simply not fit or would take up so much space as to distract from other important information and/or disclaimers and is likely to confuse the beneficiary.

Because compliance would be impractical or impossible when offering beneficiaries many choices, the only way that agents and brokers could comply with the law would be to provide fewer choices to beneficiaries. This clearly would not be in the best interest of the beneficiary. As a result, we recommend that CMS consider the following alternative solutions:

- Require the marketing material/TPMO Disclaimer to state the minimum number of MA Organizations that may be offered by the TPMO; or

- Require the names of all MA Organizations that may be offered to be included on the marketing material/TPMO Disclaimer, but only if less than 3 or 4 are being offered.

CMS also proposes to amend §§ 422.2263(b) and 423. 2263(b) to prohibit MA organizations from marketing any product or plan unless the MA organization or marketing name is identified in the marketing material. AWHIB recommends that CMS consider the same alternatives to this requirement that it is proposing with respect to the proposed revisions to the TPMO Disclaimer.

In 42 CFR §§ 422.2263(b) and 423. 2263(b), CMS also proposes to require that the MA organization name should be displayed on print advertisements in 12-point font. Depending on the advertisement, a 12-point font may be considerably larger than or smaller than the rest of the text displayed. AWHIB recommends against specifying a specific font-size for print advertisements, and instead requiring that the font size be consistent with other important content such as the displayed benefits or phone number.

Prohibition on Personal Marketing Appointments Until 48 Hours After Scope of Appointment (42 CFR §§ 422.2264(c)(3)(i) and 423.2264(c)(3)(i))

AWHIB recommends including exceptions for consumer-initiated contact.

CMS proposes to amend §§ 422.2264(c)(3)(i) and 423.2264(c)(3)(i) by codifying previous marketing guidance prohibiting personal marketing appointments from taking place until at least 48 hours has passed since the time of the Scope of Appointment (SOA) was completed. While AWHIB understands the intent of the proposed provision, it does not distinguish between TPMO-initiated and beneficiary-initiated contact. As a result, it may not permit the beneficiary to be fully in charge of when he or she would want to meet with an agent. For example, if the beneficiary walks into an agent's office or places a call to an agent, the agent would be restricted for 48 hours from the time the beneficiary reached out to the agent from helping the beneficiary to find a plan.[1] This is particularly problematic when the beneficiary has a limited window in which to enroll, as all beneficiaries do, especially during last 48 hours. As proposed, this

[1] This is also problematic if a beneficiary requests a call back from an agent and expects to receive that call within less than 48 hours.

provision might prevent a beneficiary from enrolling at end of an enrollment period. AWHIB recommends that CMS instead permit agent or broker response to beneficiary-initiated contact be exempt from the 48-hour waiting period or if the beneficiary affirmatively waives the 48-hour waiting period at any time. This would place the beneficiary in control of contact with the agent.

TPMO Submission of Marketing Materials to CMS for Review (42 CFR §§ 422.2261(a)(2) and 423. 2261(a)(2))

AWHIB recommends not finalizing the proposal to require TPMOs to submit marketing materials to CMS for review.

CMS proposes to remove §§ 422.2261(a)(3) and 423.2261(a)(3) and modify §§ 422.2261(a)(2) and 423.2261(a)(2) to require that TPMOs submit to CMS marketing materials designed on behalf of and with prior approval from the applicable MA organizations or Part D sponsors. The proposal would codify the review process that is currently in place. However, AWHIB members' experience indicates that the current process requires multiple and duplicative reviews, and that use of HPMS reporting is inefficient, costly and cumbersome on all parties involved. The current process is largely unworkable from a logistical and timeframe perspective, and the proposed rule would codify a dysfunctional process. AWHIB instead recommends that review of marketing materials be streamlined to a single review, and that CMS allow an independent arbiter (which could be selected by CMS) to review TPMO marketing materials. This would eliminate multiple rounds of review, differing and inconsistent interpretations of CMS guidance, and permit CMS to have greater control over marketing material review.

Misleading Use of "Medicare" in Marketing Materials (42 CFR §§ 422.2262(a)(1) and 423. 2262(a)(1))

AWHIB recommends clarifying what constitutes misleading use of the Medicare name.

CMS proposes in §§ 422.2261(a)(2) and 423. 2261(a)(2) to address the improper or misleading use of the Medicare name, CMS logo and other Federal government-issued materials like the Medicare card. AWHIB shares CMS' concern about practices that may mislead beneficiaries to believe that they are contacting Medicare or the Federal government rather than a private third-party entity. However, use of the term "Medicare" is not in and of itself misleading and is actually needed in certain circumstances in order to avoid being misleading. We encourage CMS to clarify what specifically would be considered misleading (or not misleading).

As an example, CMS indicates that there are numerous third-party internet sites with "Medicare" in the URL, potentially causing a beneficiary to click on a private site when they intend to go to Medicare.gov or are seeking official Medicare information or access. The concern we have with this statement is that because "Medicare" is used in the name of the product being offered (e.g., Medicare Advantage and Medicare Supplement insurance both use the word Medicare in the name of the product), it is not misleading to use either of those terms in the URL as long as the site clearly discloses that it is not an official Medicare website. AWHIB proposes that CMS clarify that the use of the term Medicare in a URL would not be misleading where the landing page clearly discloses that it is not an official Medicare website. AWHIB further proposes the following disclaimer be used on any website with Medicare in the URL to avoid being considered misleading: "This website is not affiliated with Medicare or with the Federal government."

Prohibition on Advertising of Benefits Not Available in the Service Area (42 CFR §§ 422.2263(b) and 423. 2263(b))

AWHIB recommends clarifying that the prohibition does not apply to dental, hearing, vision and/or prescription drug coverage, even if not offered in the service area.

CMS proposes to amend §§ 422.2263(b) and 423. 2263(b) to prohibit TPMOs from advertising benefits that are not available in a service area unless it is unavoidable in a local market. AWHIB recommends that CMS confirm that the prohibition would not apply to dental, hearing, vision and/or prescription drug coverage if marketing materials indicate that these benefits "may" be offered in a service area. Refining these benefits to a specific geographic area would be highly burdensome and inefficient. AWHIB's recommendation would prohibit marketing that such benefits ***are*** covered in geographies where they are not, while providing a key qualifier that the benefits may be offered depending on the geography. This is a more practical approach and aligns with how CMS generally describes Medicare Advantage in its nationally distributed materials, including the "Medicare and You Manual" and on its website. For example, the following is how CMS describes the benefits that may be offered by Medicare Advantage plans as follows:

> "**Plans may offer some extra benefits**
> With a Medicare Advantage Plan, you may have coverage for things Original Medicare doesn't cover, like fitness programs (gym memberships or discounts) and some vision, hearing, and dental services (like routine check ups or cleanings). Plans can also choose to cover even more benefits. For example, some plans may offer coverage for services like transportation to doctor visits, over-the-counter drugs that Part D doesn't cover, and services that promote your health and wellness. Check with the plan before you join to see what benefits it offers, and if there are any limitations."

See https://www.medicare.gov/publications/10050-Medicare-and-You.pdf, at page 62.

Marketing of "Savings" for Beneficiaries (42 CFR §§ 422.2263(b) and 423. 2263(b))

AWHIB recommends that marketing materials be permitted to make savings comparisons to original Medicare.

CMS proposes in §§ 422.2263(b) and 423. 2263(b) to prohibit MA and Part D sponsors from including information about savings to enrollees based upon comparison of typical expenses of uninsured individuals, unpaid costs of dually eligible beneficiaries, or other unrealized costs of a Medicare beneficiary. AWHIB understands why comparisons of costs for uninsured individuals may not be appropriate for Medicare beneficiaries, or why savings based on costs for dually eligible individuals may not be appropriate given how the interplay between Medicare and Medicaid is structured. However, a legitimate comparison of savings to original Medicare is important so that beneficiaries can understand the differences between a Medicare Advantage plan and original Medicare. AWHIB recommends that the proposal be modified to continue to permit savings comparisons to original Medicare only to help beneficiaries better understand their choices.

Limitation on Scope of Appointments to Six Months (42 CFR §§ 422.2264(c)(3)(iii) and 423. 2264(c)(3)(iii))

AWHIB recommends modifying the six-month limitation to allow for contact during Open Enrollment.

CMS proposes in 42 CFR §§ 422.2264(c)(3)(iii) and 423.2264(c)(3)(iii) to limit the validity of Scope of Appointment (SOAs) and Beneficiary Reply Cards (BRCs) to six months from the date of the beneficiary's signature or request for more information. AWHIB members agree that SOAs and BRCs should not be open-ended, and that there should be a time limit on the validity of SOAs and BRCs. However, if the beneficiary completes a BRC or SOA early in the calendar year, a six-month limitation would preclude the agent from contacting the beneficiary during the Annual Enrollment Period ("AEP"), even if the beneficiary consented to such contact. Instead, AWHIB recommends that BRC and SOA validity be limited to six months or end of the next AEP, whichever is later. This would provide a six-month limit while at the same time also affording the beneficiary of contact by the agent or broker during the next AEP.

Closing

AWHIB appreciates the opportunity to offer comments on the proposed rule. We look forward to continuing to partner with CMS and states to enroll consumers in health insurance coverage across the nation.

Sincerely,

The Association of Web-Based Health Insurance Brokers