Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS-4201-P Comments

Administrator Brooks-LaSure:

Extend Health, LLC and its affiliate Extend Insurance Services, LLC dba Via Benefits Insurance Services (collectively "Extend" or "we") submit this letter commenting on the above-referenced Proposed Regulations. We support CMS attempts to stop misleading marketing practices and to bring clarity to the Medicare Advantage and Part D programs, while continuing to enable beneficiary access to valuable insurance coverage. We are commenting because the Proposed Regulations do not seem to contemplate our unique, employer-focused, consultative model of providing individual Medicare Advantage, Part D, Medicare Supplement, and other individual health insurance options to the retirees of our employer clients. We note that many of the proposed rules seem aimed at correcting aggressive and, in some cases, misleading marketing and lead generation practices. However, our employer-focused model does not rely on consumer marketing or lead generation. Rather, our employer clients hire us to communicate on their behalf and provide their former employees with information about their individual health plan options once they are no longer eligible for employer-sponsored group health coverage. We offer the retirees of our employer clients support in understanding their options and selecting the best option for them, leveraging robust decision support tools and taking into account each retiree's individual circumstances.

In our employer-focused, consultative model, we believe that at least two aspects of the Proposed Regulations will likely have unintended and harmful consequences to the millions of retirees / beneficiaries that we serve: (1) those requiring disclosure of all Medicare Advantage organizations and Part D plan sponsors (collectively "MA and Part D organizations") that are being offered (both in marketing materials and in the TPMO disclaimer) and (2) those requiring that beneficiaries must wait and delay 48 hours after signing the Scope of Appointment before starting a personal marketing meeting. Therefore, in Sections II and III below we propose that CMS consider certain limited adjustments to these aspects of the Proposed Regulations. In Section IV, we request that CMS consider not codifying, and instead changing, the inefficient and circular process by which TPMOs are required to seek review and approval of marketing materials from all applicable MA and/or Part D organizations and obtain full agreement from all before submitting them in HPMS.

I. Extend Offers Hundreds of Individual Health Plan Options to Millions of Retirees Through a Unique, Consultative Model.

Extend works on behalf of employers to deliver benefits programs for their retired employees through the individual health insurance market, including Medicare Advantage (MA), Part D Prescription Drug (PDPs) and Medicare Supplement (MS) plans. Instead of offering a traditional group health insurance plan with premiums subsidized by the employer, in our model employers contract with Extend to make our individual insurance marketplace

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services available to their retirees. Those employers typically help subsidize the premiums charged for whatever coverages their retirees select through a retiree-only health reimbursement account (HRA) that we administer for the employer. Extend has been offering this service for the past 17 years, and we represent over 600 employer clients across both private and public sectors, including states, counties and municipalities. We have helped over 3 million retirees, across all 50 states, find individual insurance coverage that fits their needs.

We offer wide carrier and plan choice on our individual marketplace, attempting to include any plan that we believe might be desirable to, and beneficial for, our employer-clients' retirees. For the 2023 enrollment season, we represented almost 200 different insurance carriers when considering Medicare Advantage organizations (approximately 93), Part D plan sponsors (approximately 30), and Medicare Supplement carriers (approximately 76).
In the Extend model, our employer clients' retirees can shop for the healthcare coverage that fits their needs and budget through our dynamic marketplace offering meaningful choice among a wide array of individual health plans and insurance carriers. Rather than simply offering plans from one or a select few insurance providers, we offer wide product and carrier choice and work on behalf of our employer clients' individual retirees to help them select the product(s) and carrier(s) that are most suitable for them. Simply put, our employer clients count on us to offer meaningful choice to place the best interests of their retirees first. Our licensed, independent benefit advisors and helpful online decision tools provide unbiased support to retirees shopping for and comparing plans to help them select the products and carriers that are best for them under their unique circumstances. Our benefit advisors are product and carrier agnostic, with no personal incentive to recommend a MA vs MS plan or to prefer any carrier's plan over others. Factors considered when assisting retirees include the individual's preferred physicians, drug cabinet, geographic location and travel plans, and budget. Our benefit advisors are trained to help the retiree make the best use of the employer HRA subsidy. Of course, we also administer, on behalf of our employer clients' HRA plans, the HRA subsidy that the vast majority of their retirees enjoy.

Customer complaints are rare. Despite our substantial amount of retiree interaction and policy volume, we have experienced very few complaints, most of which are unfounded. Data from our highest-volume carriers indicates that our CTMs per 1,000 enrollments are less than 1/10th those of the carriers' broader books of business. Our own data across all carriers, and including both CTMs and carrier grievances, shows just 0.7 total complaints per 1,000 enrollments, with less than 10% of those being founded.

II. The Proposals Requiring the Inclusion of All Plan Names in Marketing Materials and the TPMO Disclaimer Would Be Impractical or Impossible to Comply with While Offering Broad Plan Choice, Particularly in a National Service Area.

Extend endeavors to provide as many individual insurance options as possible to the retirees of our employer clients, who are spread across the country in all 50 states. With approximately 123 MA and/or Part D organizations nationwide, and as many as 11 Medicare Advantage, 8 Part D and 8 Medicare Supplement plans in a given service area. Currently, there is no service area in the United States where we offer less than six Part D plans.

When offering such wide choice, it would be at best impractical, and in many cases impossible, to list all plan names in marketing materials and in the TPMO Disclaimer. First, when servicing retirees on a nationwide basis, it would be logistically difficult to accurately separate marketing materials and TPMO Disclaimers on an individual or service area basis. There would not be room to list all MA and Part D plans that we offer nationwide on most marketing materials, and even doing so would risk being misleading to a beneficiary who might have access to a particular plan in their service area that we offer elsewhere. Second, even if the plans being offered could be accurately separated by service area in marketing materials and the TPMO Disclaimer, physically there is not enough space in the marketing material, or enough time in the first minute of a sales call, to list all of the plans being offered. National marketing materials might have to list as many as 123 MA and/or Part D organizations, although such a listing might still be considered misleading because many of those options would not be available in a particular service area. It could take several minutes to just read a list of those plan names to a beneficiary. Finally, it is hard to understand how reading a long list of various plan names would be helpful to a beneficiary. The beneficiary is unlikely to know all the plans that are available in the service area. One can only imagine the conversation with a beneficiary as a representative starts to read the fourteenth and fifteenth plan name. Will the beneficiary be able to pay attention? Will the beneficiary be able to keep track of all the plan names? Will the beneficiary be confused? We believe that this proposal would severely disrupt the enrollment process in areas that include a large number of plans and would not provide the beneficiary with meaningful information to make a better informed enrollment decision.

If these Proposed Regulations are not modified, compliance likely will require that we and others that provide wide beneficiary choice would have to consider restricting the number of plans offered to beneficiaries, and quite possibly to just a few national carriers. Beneficiaries would have fewer choices. This seems likely to lead to less plan competition overall, and especially less competition from newer, smaller, more local, and potentially better-suited plans. On the other hand, those who market on behalf of a single plan, where efforts are made to sell a beneficiary the only plan that is being marketed, can comply with little impact. The market seems likely to shift further towards single plan marketing efforts, again resulting in less beneficiary choice.

We do not believe that this is the result that CMS intended with the Proposed Regulations, and we urge CMS to consider alternatives that help preserve and promote meaningful beneficiary choice, such as by keeping the regulations for disclosures in marketing materials and the TPMO Disclaimer as-is. Additionally, CMS could require the agent or broker at any time during the plan selection or enrollment process to advise the beneficiary of all of the MA and/or Part D organizations that the agent or broker is able to offer the beneficiary. We note that these were just strengthened for Contract Year 2023 and already advise beneficiaries that not all plans are available and of their right to call 1-800-Medicare.

In the event CMS understands our concern but nevertheless believes even more change is required, we have an alternative proposal for consideration. In fact, we acknowledge that these Proposed Regulations might be effective to help beneficiaries in situations where marketing is being done on behalf of one or only a small number of MA or Part D organizations

and beneficiaries are being asked to respond without knowing who those MA or Part D organizations are. In those situations, we agree that it would be preferable for the beneficiary to know what organization or plan is being offered before they respond. However, when a beneficiary is going to be offered the ability to comparison shop across a number of MA or Part D organizations and/or evaluate other options such as MS insurance, providing a list of all such organizations and options becomes both much less helpful and impractical, if not impossible. Therefore, we also propose that CMS could require the identification of the plan(s) being offered in both marketing materials and the TPMO Disclaimer when there are only a limited number of plan(s) being offered, such as when the offer is on behalf of less than five MA or Part D organizations. If, however, the marketing materials or sales call will involve the opportunity for the beneficiary to consider multiple organizations and/or plans (e.g., five or more), marketing materials and the TPMO Disclaimer could simply replace the identification of the specific plans being offered with a disclosure that informs the beneficiary that if they respond or continue, they will have the opportunity to consider or enroll in multiple plans. In such cases, the disclosure in any marketing materials and the statement in the TPMO Disclosure that identifies all of the specific plans could be replaced with a statement such as "We offer multiple Medicare Advantage and/or Prescription Drug plans in your area." If the beneficiary may also be offered MS plans, we believe that an alternative disclaimer could be used, such as "We offer multiple Medicare Advantage, Medicare Supplement and Prescription Drug plans in your area." Of course, the TPMO Disclaimer would still state that not all plans will be offered and advise the beneficiary of their option to call 1-800-Medicare.

III. The Proposal Requiring a 48 Hour Waiting Period Between the Completion of the Scope of Appointment and the Personal Marketing Meeting is Unnecessary in our Consultative Model and Would Frustrate and Inconvenience Beneficiaries, and in Some Cases Could Discourage or Even Prevent Enrollment into a Medicare Advantage and/or Part D Plan.

In our consultative model, beneficiaries receive a consultative service, selected by their employer and provided on behalf of their employer, to help them select the individual insurance options that work best for them in the context of their employer's retiree program and their individual situation. As beneficiaries are receiving a consultative service as opposed to marketing on behalf of insurance carriers, it would unnecessarily inconvenience beneficiaries if they cannot select and enroll in their chosen insurance plan(s) on their own timetable. Further, requiring a 48 hour wait in all cases might lead some plans or agents and brokers to sell beneficiaries a Medicare Supplement policy that could be sold without wait. Finally, we note that the busiest days of enrollment into MA and Part D plans typically occur during the last days of the Annual Enrollment Period ("AEP") or other Special Election Period ("SEP"). The Proposed Regulation, as currently written, would preclude beneficiaries who wait to act until the last 48 hours of AEP or any applicable SEP from accessing the MA and Part D programs.

In order to avoid these undesirable consequences, we propose that CMS could instead enact one or more of the following alternatives:

- Instead of removing all beneficiary choice and convenience to enroll on the beneficiary's timetable, require TPMOs and Plans to expressly advise beneficiaries of their right to

wait 48 hours between the SOA and the personal marketing appointment, but allow beneficiaries to waive that requirement if they expressly, affirmatively indicate that they understand they have the option to wait but prefer not to do so. We submit that this proposal, which advises the beneficiary of the option to wait but keeps the beneficiary in control of their own timetable, makes the most sense, especially in the context of employer-focused, consultative model.

- Reinstate the beneficiary "walk-in" exception similar to what had been previously in place under 42 CFR 422.2268(g) and (h), 423.2268(g) and (h). In instances where a beneficiary initiated contact with an agent at their office, whether face-to-face or telephonically, on their own accord, the 48 hour requirement for the SOA can be waived. The MA organization/Part D sponsor or agent/broker still must document the SOA prior to discussing MA and/or PDP plans.

- At the very least, permit the beneficiary to waive the right to the 48 hour waiting period when there is very limited time remaining in the AEP or any applicable SEP. The amount of time would have to be at least the last 48 hours of such AEP or SEP, but we propose it be longer – up to the week prior to the expiration of the AEP or SEP, to spread call volume and avoid unnecessary wait times.

IV. CMS Should Consider Changing the Process by which TPMO Materials Are Required To Be Approved by Multiple MA and Part D Organizations Before Submission in HPMS

Currently, TPMOs (including independent agents and brokers) submit their materials in HPMS only after obtaining prior review and approval from each applicable MA and/or Part D plan. This results in the same materials being reviewed, approved, and submitted multiple times. In our case, it means that applicable materials must be submitted and approved by tens of MA and/or Part D organizations. For example, the same material could be submitted for review and approval to over 40 different MA and/or Part D organizations, who all must agree on the materials with no changes. If any one of the organizations requests a change, the material must be re-reviewed and re-approved by all organizations. This process can repeat itself multiple times before material is able to be submitted in HPMS. We believe that this creates a time consuming and inefficient process, both for the TPMOs and the MA and Part D organizations. It is difficult for us to offer CMS an alternative solution to this problem, but we do believe the current process is extremely inefficient for all involved and could be improved, perhaps by a single approval process that all TPMOs and carriers can rely upon. Such a process would lead to efficiencies for TPMOs and plans with no negative consequences to beneficiaries. It should also decrease the number of submitted and resubmitted materials for CMS to review and approve.

In closing, Extend appreciates the opportunity to provide comments on the Proposed Regulations. We hope that the description of our employer-focused, consultative approach to assisting retirees with their Medicare-related insurance options and the alternative proposals

that we have suggested are helpful. If CMS is interested in discussing our concerns and/or proposals, we would happily participate in a meeting or call to do so at your convenience. Please contact Ryan Jessell at ryan.jessell@extendhealth.com or me at the phone number below if you are willing to discuss the recommendations that we have presented.

Sincerely,

Paul Hilliar, Head of Government Relations
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