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February 13, 2023

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

Re: File Code CMS-4201-P, Contract Year 2024 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs

Dear Administrator Brooks-LaSure,

Please accept the comments herein on the captioned Centers for Medicare & Medicaid Services' ("CMS") proposed rule[1] (the "Proposed Rule") submitted on behalf of a group of eleven client entities (the "Companies") that operate as first tier and downstream marketing and/or enrollment vendors to Medicare Advantage ("MA") Organizations and Part D Prescription Drug ("Part D") plan sponsors[2]. The Companies serve Medicare beneficiaries and supports MA Organizations and Part D plan sponsors (together "MA-PD plan sponsors"). Some of the Companies are marketing/marketing/lead generating agencies that use technology to connect interested beneficiaries with insurance agencies or licensed insurance agents[3] who can explain and if desired, enroll the beneficiary into available MA and Part D plans. Other Companies are field marketing organizations ("FMO") which, through their licensed agents, provide beneficiaries with assistance in understanding MA and Part D plan options, including education on the MA and Part D programs, conduct detailed assessments of the beneficiary's individual needs, and make recommendations on the available plan offerings that best meet the beneficiary's health care

[1] Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act and Programs of All-Inclusive Care for the Elderly Health Information Technology Standards and Implementation Specifications. 87 Fed. Reg. 79452, 79535 (Dec. 27, 2022).

[2] Each of these entities also falls within the definition of a "Third Party Marketing Organization," under 42 C.F.R. 422.2260.

[3] We use the term "agent" throughout this comment letter to refer to both "agents" and "brokers."

needs.[4] FMOs can also provide post-enrollment services to help ensure that the beneficiary is aware of, and making use of, the benefits that come with their plan and remain available to the beneficiary enrollee. Beneficiaries pay nothing for these services provided by both marketing/lead generating agencies and independent agents/ FMOs.

The Companies appreciate the opportunity to comment on the Proposed Rule aimed at addressing what CMS notes as its concerns in the area of MA and Part D marketing. They understand that CMS observed an increase in marketing related complaints from 2020 to 2021. CMS has stated its belief that this increase in complaints is largely attributable to Third-Party Marketing Organizations ("TPMOs") and has sought to increase controls on and oversight of such entities. The Companies recognize that there are certain problematic entities operating as TPMOs and welcome CMS's assistance in ensuring that Medicare beneficiaries are protected from confusing and potentially misleading activities.[5] In pursuing this goal, however, we encourage CMS to not lose sight of the valuable information on available plan choices that TPMOs provide to beneficiaries, access to which would be significantly disrupted by several of the stated regulatory proposals. The Social Security Act allows MA-PD plan sponsors to rely on agents for marketing and enrollment support where those agents are licensed and appointed as required under state law, and the plan's agent compensation arrangements comply with CMS rules which were structured to "create[ ] incentives for agents and brokers to enroll individuals in the Medicare Advantage plan that is intended to best meet their health care needs."[6] Through examination of historical data and business practices, the Companies' have determined that, in CMS's eagerness to ensure a robust response to its expressed concerns, certain of CMS's proposals would interfere with agents' ability to find the best plan to meet the beneficiaries' health care needs. These proposals would incentivize TPMOs to drastically reduce their relationships with MA Organizations and Part D plan sponsors and limit marketing efforts to the plan offerings of a few of the largest of these entities, which would prevent beneficiaries from obtaining professional licensed assistance in comparing their plan options as intended by Congress.

Significant numbers of beneficiaries seek information about plans each year, including those new to Medicare, those currently in Original Medicare (with or without Part D), and those enrolled in MA. In 2022, of the 58.6 million Medicare beneficiaries, 28 million were enrolled in MA or Medicare Advantage-Prescription Drug plans and 23.1 million were enrolled in stand-alone

[4] Some of these entities also provide MA and Part D plans with captive agent services, whereby the external agents/brokers operate as an extension of the plans' internal marketing and enrollment resources.

[5] CMS's current regulatory proposals appear to be a continuation of CMS's efforts to address the increase in complaints that CMS observed during the 2020 and 2021 calendar years. CMS discussed the rise in complaints in its 2023 proposed and final rules and finalized several regulatory changes to specifically address its concerns. Those changes took effect for Calendar Year 2023 and they appear to be having their intended effect. Based on the numbers of complaints conveyed to them by their contracted plan partners and through anecdotal conversations with those plan partners, the Companies understand that, for calendar year 2022, the number of marketing complaints submitted to CMS through the Complaints Tracking Management ("CTM") Module within the Health Plan Management System ("HPMS") and from other sources represented a decrease from the numbers CMS received during 2020 and 2021. As these numbers are not publicly available, we request that CMS address in the 2024 final rule the level of marketing complaints experienced in 2022 as compared to 2020 and 2021, its oversight and enforcement of the previously finalized regulatory provisions.

[6] Sec. 1851(h)(7), (j) Social Security Act.

Part D plans.[7] This represented a growth in Medicare Advantage enrollment of about 2.2 million beneficiaries between 2021 and 2022.[8] In addition to new enrollees, current beneficiaries should review their plan coverage each year and many who do choose to switch plans. During the annual open enrollment period ("OEP") in 2020, approximately 2.7 million beneficiaries switched plans.[9] Additionally, 29% of Medicare beneficiaries reported that they compared their current Medicare plan with other Medicare plans offered in their area during the open enrolment period for 2020. Creating barriers to beneficiaries' access to plan information could not just prevent beneficiaries from exercising their plan choices, but could also result in their abandonment of MA options altogether and their return to Original Medicare; a result that could also directly impact beneficiaries' health and mortality."[10]

TPMOs are aware of their role as the source of sought-after managed Medicare plan information, and that they act as a bridge to agents who can connect beneficiaries with MA and Part D plans. They use a variety of media—direct mail, television advertisements, radio, email, digital advertisements on social media platforms including Facebook, Google, and others—to inform consumers about available enrollment opportunities and different Medicare products. Once a beneficiary follows up on an advertisement, a marketing/lead generating agency will pass the beneficiary's information through an electronic routing system to pair the beneficiary with a licensed agent at an FMO or an independent insurance agent that is actively writing policies in the beneficiary's geographic area. This cuts down on the due diligence required by beneficiaries and benefits them by providing information individually tailored to their geographic needs.

While many beneficiaries claim to make their plan selections without outside assistance, of those that do seek assistance, independent insurance agents were the most frequent source of assistance for beneficiaries when selecting an MA or Part D plan. Although few studies appear to have been done to analyze how beneficiaries shop for and select plans and their resulting experiences in this area,[11] one survey showed that, of MA beneficiaries who sought assistance with their plan choices, 31 percent reported having received assistance from agents, compared to 20 percent having received assistance from friends and family, 9 percent having received help from 1-800-MEDICARE or Medicare.gov, and only 4 percent receiving assistance from a State Health Insurance Program ("SHIP").[12]

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[7] Kaiser Family Foundation (KFF), *An Overview of the Medicare Part D Prescription Drug Benefit* (Oct. 19, 2022).
[8] *Id.*
[9] *Id.*

[10] S. Parente, *Silenced Voices: The Consequences of the Government's Ban on Advertising Medicare Advantage Plans*, https://www.americanactionforum.org/insight/.

[11] The Companies note with concern that CMS presents *no data* in the proposed rule regarding the mechanisms through which beneficiaries are educated on and enrolled into MA and Part D plans. Our thorough review of CMS's available research data files, beneficiary enrollment forms and other data collection resources failed to identify any source through which CMS collects information on beneficiary use of the different available enrollment mechanisms. We question how CMS can make policy in an area about which they appear not to have collected data nor studied using focus groups or other methods to understand beneficiaries' experiences with the marketing and enrollment process. Such baseline information is critical to assess the likely impact on beneficiaries of the TPMO provisions in the proposed rule.

[12] Commonwealth Fund, *Traditional Medicare or Medicare Advantage: How Older Americans Choose and Why* (Oct. 17, 2022). Commonwealth's survey further shows that, for beneficiaries in Original Medicare who sought assistance

Between 2020 and 2021, CMS noted that marketing-related complaints more than doubled, rising from 15,497 marketing complaints in 2020 to 39,617 marketing complaints in 2021.[13] While we do not discount the importance of addressing *any* level of complaints regarding Medicare marketing, we do note that the only .03 percent of beneficiaries in 2020 and .08 percent of beneficiaries in 2021 filed marketing complaints, demonstrating that only a very small percentage of enrolled beneficiaries submitted complaints.

The MA and Part D Marketing and Enrollment Sector Operates as a Complex Technology-Based Network to Connect Beneficiaries with Available Agents who Represent Plans in the Beneficiary's Geographic Area

The MA and Part D marketing sector operates as a complex integrated network to help a beneficiary identify available independent information and enrollment resources and to connect the beneficiary with licensed agents that can assist the beneficiary in understanding the options available in their county and which of those options best meet the beneficiary's needs.

To ensure effective resource use, entities in the MA and Part D marketing sector specialize in handling particular responsibilities, in a similar manner to how marketing and sales for other types of insurance are handled. Marketing/lead generating agencies are experts in the use of varied types of media as a means to reach and identify consumers interested in MA and Part D products and then connect them with a licensed agent at an FMO or an independent agents who can assist them with finding the right plan. FMOs, agencies, and independent insurance agents leverage their agent expertise to assist beneficiaries in navigating the complexities of selecting a MA or Part D plan in today's market, taking into consideration the beneficiary's priorities and then helping them understand benefit and financial tradeoffs across plans. Lead generating agencies, FMOs, agents and MA and Part D plan sponsors work together to make consumers aware of enrollment periods and of the broad benefits of these Medicare products and the enrollment periods within which they can be obtained. MA and Part D plans cannot serve beneficiaries if they cannot identify which beneficiaries want and need their help.

Marketing costs are significant, and demand varies significantly during the calendar year due to the MA and Part D programs' structure around the limited annual enrollment period ("AEP"). Marketing/lead generating agencies have the experience and technical skills to reach beneficiary consumers and connect those interested beneficiaries with agency partners at a scale and level of efficiency that neither agents, FMOs, nor plans can accomplish alone. Most marketing/lead generating agencies are incentivized to operate in an ethical manner as their approach reflects directly on their licensed agent, FMO and plan clients for whom the entity is identifying potential customer enrollees. A customer that feels frustrated or confused by the process through which they enter a marketing interaction will be less likely to trust the entity to

in making their plan choices, insurance agents were also the primary source relied on twice as much as the next most utilized resource, friends and family.

[13] Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs, 87 Fed. Reg. 27704, 27707 (May 9, 2022).

whom they have been referred, making the referral less effective and less likely to result in a successful beneficiary enrollment.

FMOs largely depend on marketing/lead generating agencies to alleviate the prohibitively high costs associated with regional-specific marketing. The benefit of a partnership between marketing/lead generating agencies, multiple independent agents, and FMOs is that the marketing/lead generating agencies can deploy broader media and outreach, effectively reducing the overall cost of beneficiary application, while then directing interested beneficiaries to both regional and county-focused agents as well as more nationally-focused FMOs. This gives beneficiaries access to more options. The proposals' effective elimination of all web-based lead generation all but guarantees that only large plans with large, sophisticated internal marketing teams will benefit, impeding beneficiaries from getting information about plan options that might better suit them. In addition, the increase in the marketing and enrollment costs will likely not be absorbed by MA-PD plan sponsors but instead will be passed to beneficiaries through higher costs or less robust benefits.

I. The Prohibition on the Transfer of Beneficiary Data Among TPMOs Will Directly Interfere with Beneficiaries' Access to Independent Agents and Smaller Plans and Will Disproportionately Benefit the Larger Medicare Plans

CMS proposes to add a new provision to the regulations governing agents, brokers, and other third parties, at §422.2274(g)(4), stating, "Personal beneficiary data collected by a TPMO may not be distributed to other TPMOs."

Comments on CMS Proposal

The Companies appreciate CMS's concern with preventing beneficiaries from receiving numerous unanticipated and unwanted phone calls due to having responded to a single advertisement for information on MA or Part D. The Companies believe, however, that CMS could protect beneficiaries from such difficulties through a less severe approach that would not have the accompanying negative consequences that the current proposal will have both on beneficiaries as well as on the industry.[14]

It is largely through marketing/lead generating agencies that beneficiaries learn about available independent agents who can help the beneficiary assess their needs and compare available plan options. Preventing marketing/lead generating agencies from connecting interested beneficiaries with independent agents will make it more difficult for the beneficiary to access information about their plan options. Without this method of access to an independent agent who

[14] The Companies note that CMS's proposal to prohibit TMPOs from sharing beneficiary contact information is inconsistent with how CMS treats beneficiary data and beneficiaries' ability to control the use of their data in other MA contexts. This proposal would prohibit beneficiaries from more broadly sharing their contact information if desired. In particular, CMS allows for a beneficiary to direct their MA plan to release the beneficiary's protected health information to third party application developers through the Patient Application Programming Interface. Under the current proposal, CMS would impose more stringent protections on beneficiary contact information than it applies to protected health information.

could present a range of available plan options and help the beneficiary compare, beneficiaries will bear the brunt of the burden of identifying available plans, contacting each individual plan to obtain information on the plan specifics, and interpreting and comparing that information across multiple plans to assess which would best meet their needs.[15]

Prohibiting the sharing of the contact information of interested beneficiaries between TPMOs would likely drive marketing/lead generating agencies from the market.[16] Independent agents and FMOs, which focus on supporting beneficiaries in assessing plan options, would need to diversify and, prior to the upcoming annual enrollment period, significantly increase their marketing staff and develop the internal expertise to conduct the sophisticated technology-based process of identifying and connecting with interested beneficiaries within appropriate geographies. However, these entities will not be able to operate at the scale and technical level of a marketing/lead generating agency which can spread its costs across multiple independent agents and FMOs as well as MA Organizations and Part D plan sponsors. As previously explained, even if these entities could develop the internal expertise, it will be costly for plans, agents, or FMOs to maintain the staff and resources to conduct year-round marketing and beneficiary outreach to meet the level of beneficiary demand for information, which varies during the year.[17] Agents, FMOs

[15] The Companies appreciate that 1-800-MEDICARE, Medicare.gov and SHIPs are available and can help beneficiaries understand plan options. We note, however, that Medicare.gov relies on the beneficiaries themselves to interpret the information provided, and neither 1-800-MEDICARE nor SHIPs are sufficiently funded, staffed, or trained to support the large number of beneficiaries that currently rely on agents, agencies and FMOs.

[16] CMS did not consider the effect the Proposed Rule will have on TPMOs. Although the proposed rule contains a Regulatory Impact Analysis ("RIA"), the RIA fails to properly account for the full impact of the proposed regulations. For instance, the RIA does not address the fact that requiring TPMOs to list all the plans they deal with in their calls and advertisements may lead TPMOs to deal with only a few large MA and Part D plans, thus disadvantaging the smaller MA and Part D plans. Further, while the RIA mentions a variety of stakeholders, including pharmacies, clinical laboratories, ambulatory health care services, hospitals, SNFs, MA organizations, and enrollees, it does not discuss the impact on TPMOs generally or on agents in particular. Preventing TPMOs from selling or otherwise transferring beneficiary data to other TPMOs may drive many TPMOs out of business, which, in turn, may harm small MA plans, as well as many agents, which do not have the capacity to handle lead generation activities in-house. This may also harm beneficiaries, both by limiting the choice of plans available, and by reducing the number of agents and brokers available to advise beneficiaries regarding their choice of MA plans. CMS's failure to account for these impacts in the final rule would be arbitrary and capricious, and would violate the Administrative Procedure Act, 5 U.S.C. §551, *et seq.* ("APA"). *See, e.g., Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983) ("an agency rule would be arbitrary and capricious if the agency … entirely failed to consider an important aspect of the problem"); *Mayor of Baltimore v. Azar*, 973 F.3d 258, 276 (4th Cir. 2020) ("The arbitrary and capricious standard of review is not a carte blanche for agencies to issue a rule, and then defend it only by saying, 'because we said so.'"); *Home Box Off., Inc. v. FCC*, 567 F.2d 9, 35–36 (D.C. Cir. 1977) (an agency violates the APA if it fails to respond to "significant points" and consider "all relevant factors" raised by the public comments).

[17] A cost-benefit analysis of regulations is required by Executive Order 12866, Executive Order 13563, and OMB Circular A-4. Like CMS's RIA, CMS's "Summary of Costs and Benefits" beginning on 87 Fed. Reg. 79,456 fails to consider the potential impact of the proposed changes on TPMOs. The summary of costs and benefits is contained in Table 1 in the Proposed Rule and the provision pertaining to the changes in marketing requirements appears at 87 Fed. Reg. 79,462. There, in the column labelled "Impacts," CMS states: "We recognize the impact of these provisions to be primarily one of changes to Plans' policy and procedure documents." CMS states that the one-time costs of the changes will be $172,593. CMS also states that there would be "an impact of time and cost to Plans for the requirement to report non-compliant agents and brokers to CMS" but states that it is unable to estimate that cost. As noted in Footnote 16 above in the context of RIAs, this completely overlooks the potential impacts of the changes on TPMOs and the resultant impacts on other market participants and beneficiaries.

and plans currently rely on marketing/lead generating agencies for the beneficiary marketing and outreach needed to respond to the significant increase in demand that comes during the compressed AEP timeframe each Fall.

Medium and smaller plans will be differentially impacted, as they primarily rely on independent agents, agencies and FMOs and the marketing/lead generating agencies that support them to reach potential beneficiary enrollees (due the relative lack of brand awareness among beneficiaries). As a result, medium and smaller TPMOs that focus solely on marketing will likewise be disproportionately disadvantaged by the Proposed Rule, as compared to larger companies that offer a range of services that includes marketing.[18] Without the broad marketing expertise of the marketing/lead generating agencies generally, these plans will find it difficult to educate beneficiaries about their offerings, as they lack the resources to conduct the needed level of outreach. In the longer term, without the ability to efficiently attract enrollees, beneficiaries may find that these smaller MA Organizations will simply leave the market, unable to compete, further reducing choice and creating even further consolidation in the MA market. While larger plans would also be impacted, they are more likely to have some in-house capacity and internal resources to spend on connecting with potential beneficiary enrollees.[19]

[18] When promulgating rules, Agencies must assess the impact of regulations on small businesses. The Regulatory Flexibility Act ("RFA"), 5 U.S.C. § 604, "obliges federal agencies to assess the impact of their regulations on small businesses." *U.S. Cellular Corp. v. FCC*, 254 F.3d 78, 88 (D.C. Cir. 2001). But the discussion of the RFA fails to consider the impact on TPMOs. The proposed rule states that a RFA is not necessary because the rule will not have a significant economic impact on a substantial number of small entities. But this fails to consider the direct impact the changes will have on TPMOs. The courts have held that the RFA requires an agency to perform a Regulatory Flexibility Analysis of small entity impact only when a rule "directly" regulates small entities. However, the Small Business Administration Office of Advocacy has stated that "it is good public policy for the agency to perform a regulatory flexibility analysis even when the impacts of its regulation are indirect." TPMOs, moreover, are *directly* impacted by the proposed changes. In *Mid-Tex Elec. Co-op., Inc. v. FERC*, 773 F.2d 327, 343 (D.C. Cir. 1985), the court stated that "Congress did not intend to require that every agency consider every indirect effect that any regulation might have on small businesses in any stratum of the national economy." However, here, the proposed regulations impose requirements directly on TPMOs. For instance, they require, in § 422.2267 and § 423.2267, that TPMOs provide a specified disclaimer listing the names of all plans offered and that they inform beneficiaries that they can obtain information from SHIPs. Similarly, they provide, in § 422.2274 and § 423.2274, that a TPMO cannot share beneficiary data with other TPMOs. Additionally, in §422.2263(b) and § 423.2263(b), they prohibit marketing by TPMOs unless the names of the plans offered are clearly identified. Although the proposed regulations state in § 422.2267 and § 423.2267 that "The MA organization must ensure that the disclaimer is as follows," and in § 422.2274 and § 423.2274, that "MA plans must implement the following as part of their oversight of TPMOs," this does not mean that the regulation does not "directly" impact TPMOs. This is similar to the issue addressed in *Aeronautical Repair Station Ass'n, Inc. v. F.A.A.*, 494 F.3d 161 (D.C. Cir. 2007). There, the court distinguished *Mid-Tex Elec.*, holding that while the regulations at issue were "immediately addressed to the employer air carriers" they "expressly require that the employees of contractors and subcontractors be tested." *Id.* at 177. Thus, court concluded that "the contractors and subcontractors are regulated employers and that the RFA therefore requires that the FAA consider the economic impact of the 2006 Final Rule on them." *Id.* at 176. Similarly, the present proposed rule imposes requirements directly on TPMOs. The fact that the MA or Part D plan may be responsible for ensuring that the TPMOs comply with these requirements does not make the impact of the requirements on the TPMOs "indirect." Because the proposed regulations will have a direct impact on numerous small TPMOs, CMS should have undertaken a Regulatory Flexibility Analysis that considered TPMOs.

[19] Moreover, the proposed rule does not prohibit MA and Part D plans from obtaining leads from marketing/lead generating agencies. As such, although CMS expresses concern that agents may not represent all plans in a market,

As an alternative to prohibiting the transfer of beneficiary contact information between all TPMOs, CMS should implement the proposed prohibition with an exception for licensed agents and agencies. This exception could be reflected as part of CMS's amendment to §422.2274(g) in the following manner (in *italics*): "Personal beneficiary data collected by a TPMO may not be distributed to other TPMOs, *unless both TPMOs (the distributor and recipient of the personal beneficiary data) are licensed under state law to sell Medicare Advantage plans.*" Licensed agents must meet state standards and are subject to state compliance and oversight, as well as to certain federal laws such as the Gramm-Leach-Bliley Act[20] that would provide protection against misuse of beneficiary information. By exempting licensed agents from the transfer prohibition, CMS would incentivize marketing/lead generating agencies to seek licensure (and the enhanced regulatory scheme that it entails) or exit the Medicare marketing business. This is the approach taken by the U.S. Department of Housing and Urban Development in the mortgage brokerage space, whereby marketing/lead generating agencies are considered part of the loan origination process and, therefore, are required to hold licensure as mortgage brokers.[21] Incentivizing such entities to obtain licensure in order to be part of the Medicare marketing process would bring marketing/lead generating agencies more firmly into the "chain of enrollment." As such, marketing/lead generating agencies would be required to meet the same licensing standards as agents which would ensure that those who operate these vendor agencies are well educated on not just the ethical and compliance requirements for the marketing and sale of Medicare plans, but would have actual product knowledge as well. Requiring licensure would further put these vendors more squarely within the view of state regulators who have also expressed recent concern with Medicare marketing practices.

Allowing an exception for licensed agents would further protect beneficiaries' ability to connect with agents, agencies and FMOs as it would enable these entities to transfer the beneficiary's person contact information to ensure that the beneficiary is able to connect with someone who can best assist the beneficiary. As explained previously, a significant portion of insurance agencies and FMOs have limited numbers of employees and largely service customers through independent agents with whom the entity holds a contract. The agency/FMO supports the independent agents in providing services such as training, administrative support, customer service and marketing.[22] Despite the advanced technology used by marketing/lead generating agencies, a lead may not always be transferred to an entity or agent that is able to market and sell products to the beneficiary that is reaching out.[23] Perhaps the beneficiary lives in a nearby state and the agent

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the proposed rule would make it easier for beneficiaries to be connected directly to individual plans rather than to resources that would allow the beneficiary to assess a range of plan choices.

[20] Pub. L.106-102, 113 Stat. 1338, codified in relevant part primarily at 15 U.S.C. §§ 6801-6809, §§ 6821-6827.

[21] SAFE Mortgage Licensing Act, enacted by Congress in 2008 as part of the Housing and Economic Recovery Act.

[22] CMS recognizes these administrative costs as allowable under its marketing regulations as long as they do not exceed the value of these services in the marketplace. *See* 42 C.F.R. 422.2274(e)

[23] Lead generation data is still imperfect, sometimes even due to errors in what the beneficiary provides. For example, more and more beneficiaries rely on their cellphone rather than a landline phone number, and are able to take their mobile number with them if they move to a new area. Therefore, the area code on the cellphone number from which a call is received may not accurately reflect where the beneficiary lives. Similarly, beneficiaries that use their phone, tablet, or laptop will have a varying IP address depending upon where the mechanism through which they interact with a marketing/lead generating agency is located at the moment in which it is used. Relying on these datapoints no

they are connected with does not hold licensure or represent plans in that state. Under the proposed prohibition, that agent could not transfer that beneficiary to another independent agent affiliated with the same agency/FMO who would be able to assist the beneficiary.[24]. In these cases, the licensed agent or FMO would need to transfer the beneficiary's information in order to make a real connection, but any transfer would need to be a transfer to another licensed agent to be allowed under the regulations.

In addition to the proposed exception for licensed agents, CMS could further safeguard beneficiaries and their data through additional protections or parameters on how data can be shared. CMS could protect beneficiaries from unanticipated and unwanted use of their contact information for unrelated sales solicitations while still allowing beneficiaries to benefit from the services of marketing/lead generating agencies in connecting them with independent agents or FMOs by putting limits on how a TPMO can use a beneficiary's personal information. For example, CMS could prohibit plans from directly or indirectly contracting with marketing/lead generating agencies that, when collecting beneficiary consent and contact information to share with agents or FMOs for Medicare marketing and enrollment purposes, seek to rely on that same consent to allow the entity to use or sell that information for other non-health care related purposes.

Another protection would be for CMS limit the timing and number of outreach calls a marketing/lead generating agency or agent/FMO entity could make based on the beneficiary's request for contact through a marketing/lead generating mechanism. For example, CMS could model its parameter on the approach taken by the Federal Trade Commission under its Telemarketing Sales Rules[25], to limit contact efforts from an electronic lead to a 90-day from the initial receipt of the beneficiary contact to a marketing/lead generating agency or, if no marketing/lead generating agency was involved, directly to an agent or FMO. The lead would no longer be effective once the 90 days had run. These parameters would allow beneficiaries to connect with marketing/lead generating agencies and agents/FMOs to discuss plan options while protecting the beneficiaries from excessive and unwanted calls.

The suggestions above illustrate approaches to accomplish CMS's stated goals of protecting beneficiaries' personal data while also ensuring that a beneficiary is able to connect with an independent agent that can provide them with substantive information about the Medicare Advantage and Part D programs and assist with plan comparisons.

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longer serves as a definitive way for a marketing/lead generating agency to transfer a customer to the most appropriate agent/FMO.

[24] Some lead systems allow for the automatic transfer between agencies for customer calls or communications that go unanswered for a certain number of rings or timeframe. This prevents the beneficiary from having to call back at another time or reach out again to an entity. That would also appear to be prohibited by CMS's proposal.

[25] This timeframe aligns with that established by the Federal Trade Commission in their promulgation of the Telemarking Sales Rules. *See* 16 C.F.R. § 310.2(q), which defines as "Established Business Relationship" as the period three moths immediately following the consumer's inquiry or application regarding a product or service.

II. The Requirement That an MA Plan, Agent, or Broker Obtain a Scope Of Appointment at Least 48 hours Prior to a Personal Marketing Appointment Will Inconvenience Beneficiaries and Could Prevent Beneficiaries From Enrolling in a Plan When Their Enrollment Period Is About to Expire

CMS proposed to amend its regulations to require that all beneficiaries must wait at least 48 hours between completing a Scope of Appointment ("SOA") form and a scheduled personal marketing meeting. This addition would codify the timeframes found in in the Medicare Communication and Marketing Guidance but remove the "when practicable" flexibilities currently in the guidance "given the many reasons that might be cited for why waiting the full 48 hours is 'not practicable'…"[26]

Comments on CMS Proposal

If implemented as proposed, MA-PD plan sponsors and TPMOs would be required to strictly apply the 48 hour pause between obtaining the SOA and holding a personal marketing appointment with a beneficiary, regardless of the wishes of the beneficiary or the "practicalities" of the individual beneficiary's situation. This may inadvertently require additional coordination and other efforts from a beneficiary or their representative to prepare for and participate in a personal marketing appointment with an agent or an MA or Part D plan, when in actuality, the beneficiary or representative was prepared, and would have preferred, in that moment, to discuss or even enroll in a plan.

In order to restore the focus on beneficiary access to information, protect the beneficiary's right to autonomy and personal choice[27], and to avoid potential ambiguity associated with waiving the 48 hour pause "when practicable," we respectfully suggest limited exceptions for those beneficiaries that choose to waive the 48 hour pause contemporaneously with executing their SOA (or through an agreement recorded telephonically) and for those whose enrollment period is expiring in less than 48 hours. In each of these scenarios, the MA or Part D plan or TPMO would not be required to make a judgement call as to whether waiting to begin the personal marketing appointment is "practicable." Rather, the limited exceptions serve to safeguard against potentially complicating a beneficiary's enrollment process, especially when there is a narrow window left in the beneficiary's enrollment period.

III. CMS's Proposals to Require Advertisements to Include the Names of the Medicare Advantage Organizations or Part D Plan Sponsors Offering Referenced Benefits as Well as Those Whose Plans are Being Sold through the Advertisement, are Duplicative, Will Result in Beneficiary Confusion, and Will Likely Lead to Beneficiaries Being able to Access a More Limited Number of Plans through Agents.

[26] 87 Fed. Reg. 79452, 79531 (Dec. 27, 2022).
[27] This proposed rule references the very same right to autonomy in stating, "beneficiaries should be in charge of with whom they speak, when they meet with an agent, and what products they want to discuss with that agent." 87 Fed. Reg. 79452, 79530 (Dec. 27, 2022).

CMS has proposed to add several new provisions that would affect the content and use of MA and PD plan and TPMO advertising. These rules would prohibit marketing unless the names of the MA-PD plan sponsors (or the applicable marketing name(s)) that offer the products, plans, benefits, or costs that are being advertised are clearly identified in the marketing material. The rules would also prohibit the advertising of benefits "which are not available to the beneficiary in the service area where the advertisement airs." Further, CMS would specify how the names of the sponsoring organization would need to be displayed or identified in the marketing materials. Specifically, CMS has proposed to require that:

- Print advertisements must have MA and Part D plan or marketing names in 12-point font and may not be solely in the disclaimer or fine print (i.e., "printed matter in small type or in an inconspicuous manner").
- Television, online, or social media-based advertisements must have MA or Part D plan or marketing names displayed during the entire advertisement in the same font size as displayed benefits and phone numbers, or such names must be read within the advertisement at the same pace as advertised benefits or phone numbers.
- Radio or other advertisements that are voice-based only must have MA, Part D plan or marketing names read at the same speed as the phone number.

In addition, CMS has proposed to modify §§ 422.2267(e)(41) and 423.2267(e)(41) to require that one of two disclaimers be provided within the first minute of a call, or electronically conveyed when communicating with a beneficiary through email, online chat, or other electronic means, prominently displayed on the TPMO's website, and included in any TPMO marketing materials, including print materials and television advertising. The two disclaimers require the following information to be provided:

- For TPMOs that do not sell for all MA or Part D plans in a service area, the disclaimer would read, "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 which are [insert list of MA organizations or Part D sponsors]. Please contact Medicare.gov, 1–800–MEDICARE, or your local State Health Insurance Program to get information on all of your options."

- For TPMOs that sell for all MA or Part D plans in a service area, the disclaimer would read, "We offer the following plans in your area [insert list of MA organizations or Part D sponsors]. You can always contact Medicare.gov, 1–800– MEDICARE, or your local State Health Insurance Program for help with plan choices."

Comments on CMS Proposals

MA and Part D contracts are identifiable by various corporate and marketing names, which generally serve different purposes, and provide differing levels of specificity about the entity offering the product and the product being offered. Medicare beneficiaries are unlikely to be familiar with an organization or legal entity name of an MA Organization or Part D plan sponsor and inclusion of plan marketing names may similarly not provide the transparency CMS is assuming that beneficiaries are seeking. Moreover, this proposal turns the entire purpose of

marketing and reliance on agents and FMOs on its head by assuming that the beneficiary is already familiar with the MA Organization and Plan Sponsor plan names and is making decisions on that basis. The benefit beneficiaries gain from conferring with independent agents/FMOs is the chance to speak with a licensed and trained individual who can help the beneficiary learn about the range of plan offerings available to him or her and for which they are eligible – including those plans the names of which the beneficiary may have not heard previously. Inclusion of a list of all of the represented MA and Part D plan names, either in the advertisement's main portion or disclaimer, will likely result in the beneficiary opting for those entity names with which they are familiar, most likely the large entities that are also active in the under-65 market, rather than the names with which the beneficiary is not familiar, most likely the smaller regional or Medicare-focused plans.

Further, given the large number of plan-level offerings that many TPMOs represent, this proposal would be unwieldy and impractical. In 2022, the average Medicare beneficiary had access to 39 MA plans; 25 percent of beneficiaries could choose from among more than 50 MA plans; and in the county with the most plans available, Medicare beneficiaries had 82 MA plans to choose from. Also, TPMOs generally represent numerous plan offerings in a geographic area, many of which may not be available to a particular beneficiary based on the beneficiary's demographics or condition, e.g., a dual eligible or chronic special needs plan. Accordingly, providing beneficiaries with a list of plans that the TPMO represents, which in some geographic areas could require listing 50 or more names, would be ineffective, time-consuming, and unnecessarily confusing, especially when not all of those plan offerings are available to the beneficiary seeing the marketing material. A radio or television ad in which the names of even ten plans must be read would be wholly ineffective and cost prohibitive. The practical result of this requirement will likely be TPMOs focusing their advertising on the largest plans to keep the number of names from overwhelming a beneficiary, and even limiting their contracting arrangements to those larger plans, which would make it difficult for smaller and mid-sized plans to compete. This would result in a de facto reduction of plan options for beneficiaries. Agents will be artificially limited to the plans they can discuss with a beneficiary by virtue of what is in the advertising material to which the beneficiary responded, rather than being based on which plan best meets the needs of the beneficiary.

In addition, it is difficult to include dynamic content within marketing materials based on the home address of beneficiaries while still maintaining data integrity, especially for digital, radio, and television-based marketing, as the exact location of the beneficiary cannot be confirmed until the beneficiary contacts a TPMO and provides their location information. To address these issues, an alternative approach could be for the advertisement to inform beneficiaries that a full list of plan offerings is available on the TPMO's website or by calling a listed phone number for nondigital marketing pieces to accommodate those beneficiaries looking for a non-electronic option to gain this information. This would avoid overloading the beneficiary with an extended list of plan names that will serve to confuse rather than inform them.

Further, the proposal to add a full list of available plans would contradict CMS's position as expressed in the most recent final rule, in which CMS stated that the disclaimer as it was finalized in the 2023 Final Rule "provides the most pertinent information *without including more content than a beneficiary can reasonably absorb and understand, especially during the limited*

duration of a television or radio advertisement."[28] The addition of the full list of plan offerings being represented through an advertisement – to both the advertisement content itself as well as to the disclaimer that is required to be included on the advertisement – will add a level of duplicative content that will distract rather than inform beneficiaries.[29] When the disclaimer language must be provided verbally, it will be very difficult to list out the names of all plans the TPMO represents within the first minute of a sales call with the beneficiary. Instead, the goal should be for the TPMO to first gather relevant demographic information from the beneficiary, in order to inform the beneficiary of the plan offerings that the TPMO represents that are applicable to that individual. However, it is unreasonable to assume that all of this can be achieved within the first minute of a call.

Before implementing this requirement, the Companies strongly suggest that CMS hold focus groups to gather input from beneficiaries on their experiences in interacting with TPMO marketing. CMS states that it is taking action based on the complaints it has reviewed but these complaints represent only a small fraction of the beneficiaries that are interacting with TPMOs. CMS cannot make policy without first gathering data. Focus groups with beneficiaries could help identify the information beneficiaries find most useful and informative to them, in order to balance the important role that agents play in helping beneficiaries navigate a very complex system while still providing transparency into the relationships that the TPMO has and the extent to which the TPMO represents all of, or only a subset of, the options available to the beneficiary.

Further, the Companies understand that CMS wants to be able to identify the organizations that have "opted into" a TPMO's marketing materials, in order to be able to quickly notify such plans if any issues arise with those materials. CMS's current use of the Standardized Material Identification number (SMID) would allow for such tracking without the need to include all of the plan names in the advertisement. CMS could require a TPMO to capture the SMID of the advertisement through which a beneficiary lead is obtained and include that information on the beneficiary's enrollment application. This would serve the dual purpose of allowing CMS to identify beneficiaries who enrolled through independent agents and would also enable CMS to connect marketing material used by a marketing/lead generating agency agent/FMO and the plans that have "opted in" to use of that material. Plan names would not be needed to ensure the transparency of that connection.[30]

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[28] 87 Fed. Reg. 22704, 27823 (May 9, 2022) (emphasis added).

[29] Researchers have shown the expansion of choice, such as suggested by CMS in requiring that all available plans be named in advertisements or disclaimers, can actually lead to people making plan choices that are not in their own best interests. *See* J. Abaluck and J. Gruber, *Less Is More: Structuring Choice for Health Insurance Plans*, One Percent Steps for Health Care Reform, Feb. 8, 2021. *See also* S. Bhargava, G. Loewenstein and J. Sydnor, *Choose to Lose: Health Plan Choices From a Menu with Dominated Options*, The Quarterly Journal of Economics, Apr. 27, 2017 ("[T]he complexity of the plan menu might cause individuals to choose suboptimally in a way they would not if the menu were simpler ('menu complexity'). A large or otherwise complicated menu could cause people to limit the set of plans they consider or to suffer more generally from the adverse consequences that researchers have associated with information and choice overload….").

[30] We recognize the possibility that a Lead Generation Vendor may be unable to identify the SMID of the marketing materials through which each Lead was obtained. For example, a beneficiary may no longer have the post card from which the beneficiary obtained the Vendor's telephone number, or the beneficiary may have written down the Vendor number from a social media platform or other ephemeral source. To address this, CMS may consider potential audits

Finally, should CMS move forward with the limitation on marketing benefits only in service areas in which a beneficiary resides, the Companies request that CMS provide a definition of "service area" for purposes of confirming the availability of plans offering the referenced benefit(s) in that area. Could a plan or TPMO run national advertisements if, for example, the benefits being referenced are available in at least 50% of the plans being sold through the advertisement across the area in which the advertisement is running? The more targeted an advertisement with respect to audience and geographic area, the more expensive the ad and the more ads an entity would need to run to market its products.

IV. Limit the validity of the SOAs and Business Reply Cards to six months from the beneficiary signature date or the beneficiary's request for more information.

CMS has proposed to modify the current regulations in §§ 422.2264(c)(3)(iii)(A) and 423.2264(c)(3)(iii)(A), and place a six month expiration date on the ability of an MA or Part D plan or TMPO to reach out to a beneficiary after they have consented to being contacted or requested more information by submitting a Business Reply Card ("BRC"). The proposed rule indicates that beneficiaries submit a BRC to learn about their plan options for the following contract year and outreach beyond that six month period would be moot and therefore, may be unwanted. Instead, the beneficiary would need to submit a new BRC should they wish to engage in marketing discussions with that plan or TPMO for another six month period.

Comments on CMS Proposal

The Companies understand the purpose of the BRC and agree with its utility in preventing perpetual, unwanted outreach by plans and TPMOs. However, the proposal to restrict a BRC's validity for a six-month timeframe, regardless of when the beneficiary completes it, in relation to the beginning of the next OEP or AEP, may well create an unintended barrier for beneficiaries to learn about their plan options without duplicative action on their parts at the start of the OEP or AEP.

For example, a current Medicare Advantage beneficiary dissatisfied with their plan may begin to research their options and complete a BRC for an attractive plan on May 1st of this year. However, if that beneficiary does not have any qualifying event to make them eligible for a special enrollment period, the beneficiary would not be able to gather the appropriate information to make an informed choice until the start of the next OEP on January 1st, which is seven months away from the execution of the BRC. In this scenario, even though the beneficiary has affirmatively opted-into hearing from an MA or Part D plan(or their TPMO), they would never actually receive the requested outreach due to the expiration of their BRC without additional outreach to the plan.

Therefore, we respectfully suggest changing the six month expiration of a BRC to the end of the next OEP or AEP. In this same example, the MA Part D plan that received the beneficiary's BRC on May 1st would be able to reach out to the beneficiary until the following March 31st, after

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of plans whose TPMO entities that submit enrollment applications through Agents or Brokers large numbers of which do not have the SMID included.

which the beneficiary would need to complete a new BRC to authorize continued contact. This extended "shelf-life" of the BRC maintains CMS's intended protection against "contact[] by the MA organization/ Part D sponsors or TPMO…well beyond the timeframe that the beneficiary would reasonably expect to be contacted about their plan choices and decision-making…" while reducing the duplicative information gathering efforts that would otherwise be needed immediately after any educational events more than six months away from the subsequent OEP or AEP.[31]

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As a final suggestion, CMS's proposals reflect a strong concern with respect to beneficiaries' ability to use and understand the MA and Part D information available to them largely through the internet. CMS should consider offering beneficiaries an Internet 101 training to help them use and understand the resources available to them. CMS has proposed to require that MA plans identify and provide training for members with "low digital health literacy" to facilitate these beneficiaries' ability to access telehealth benefits. All MA beneficiaries would benefit from education and training in accessing and understanding information about their Medicare benefits, including the basic sources of the information they may find on the Internet (e.g., that a website ending in .gov is run by the government). Education on this topic would benefit beneficiaries beyond facilitating their understanding of and access to Medicare information.

Thank you for your consideration of these comments. We would welcome the opportunity to meet with you and/or your staff to further expound on the information contained herein. We will reach out separately to request such a meeting.

Very truly yours,

Helaine I. Fingold

[31] 87 Fed. Reg. 79452, 79531 (Dec. 27, 2022).