

March 4, 2022

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4192-P
P.O. Box 8013
Baltimore, MD 21244-8013

Via Regulations.gov

To Whom It May Concern:

The following comments on **CY 2023 Medicare Advantage and Part D Proposed Rule (CMS-4192-P)**, as published in the Federal Register on January 12, 2022, are submitted on behalf of the members of the National Association of Insurance Commissioners (NAIC), which represents the chief insurance regulators in the 50 states, the District of Columbia, and the United States territories. The comments specifically address the portion of the proposed rule focused on the practices of third-party marketing organizations (TPMO) of Medicare Advantage (MA) Plans.

CMS notes in its own explanation of its proposed rule that the Federal government is seeing an increase in beneficiary complaints associated with TPMO advertisements and has received feedback from beneficiary advocates and stakeholders concerned about marketing practices. State insurance regulators have also heard many complaints regarding these TPMOs and the advertisements of MA plans.

The NAIC's Senior Issues (B) Task Force and the Improper Marketing of Health Insurance (D) Working Group have heard from many state regulators regarding consumers being switched from their original plans after either inquiring in response to ads or receiving cold calls from these marketers. One insurance commissioner described some of these ads as somewhat misleading at the very best and close to fraudulent at the very worst.

State insurance regulators and consumer advocates have noted an increase in the improper marketing of MA plans geared toward seniors that have included not only the running of television commercials that provided incorrect information, but a significant increase in social media ads, unsolicited phone calls to seniors and mass mailings from unidentified entities attempting to solicit business. During the past several years, advertising for these plans has increased and has emphasized extra or chronic care benefits often only available in particular sets of circumstances and not to the average MA plan enrollee.

The NAIC and state regulators have heard many stories in which beneficiaries have enrolled in or been enrolled in plans with narrow networks that didn't include their current providers, had pharmacy benefits with higher costs, imposed higher copayments than expected, didn't have the benefits they had seen advertised, or that were completely inappropriate for their particular needs and not what they thought they were buying. These sales often involve agents/brokerages or TPMOs that represent only some of the options available to Medicare beneficiaries.

Many of these TPMOs have names with "Medicare" or "Seniors" (i.e. American Medicare Advisors, Medicare Insurance Advisors, Medicare Plan Store, Senior Health Plans, etc.) and/or contain endorsements by known celebrities adding further confusion and misrepresentation. Many complaints involve agents or third-party marketers cold-calling or going door-to-door, often in senior-living housing/communities.

The NAIC notes there are gaps in MA regulation. The states are only allowed, by federal law, to initially license the plan, ensure the financial solvency of the carrier, and hold the license of both the carrier and insurance producer who sells the plan. The federal government oversees the MA plans themselves and sets out rules for the marketing of them.

Many state insurance regulators work with State Health Insurance Assistance Programs (SHIP) coordinators and state Senior Medicare Patrol (SMP) coordinators on multiple complaints from beneficiaries but are confronted with limited or no positive results. State regulatory authority for these plans is limited to the agents and any misrepresentation; however, most complaints fall into an area that limits any actions states can take against these agents/brokers or TPMOs.

Some states, using state laws, have successfully prosecuted producers when they have violated CMS rules in the sale of the product. We ask CMS to provide the states all of the evidentiary information CMS collects for prosecution.

While the proposed rule may not go far enough for some, we feel this is a good start. We have received suggestions and recommendations that CMS should consider additional language; stronger marketing disclosure language; labeling the marketing disclosures in a separate color or in a text box with defined borders in at least a larger font that garner attention from the consumer; and requiring all producers to identify existing coverage and inquire about an applicant's intent to replace existing coverage before taking an application from someone already covered.

Other suggestions and recommendations CMS should consider include requiring TPMOs to inform beneficiaries of the option to use 1-800-MEDICARE or www.medicare.gov to compare the total cost of drugs that the beneficiary will incur if they select any MA or Part D plan and requiring TPMOs to report the number of complaints they receive each month from consumers.

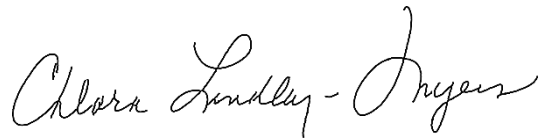
Finally, consumers must have a source of unbiased information in the very complex Medicare world. CMS should consider adding contact information for states' SHIP programs, SMP programs, and other Medicare consumer advocate divisions and programs to marketing disclosure requirements and to written, oral and online information about Medicare enrollment.

The NAIC will continue to review proposed rules and provide comments on the potential impact on market competition and consumer protections. We are available to discuss these or other issues as this proposed rule is finalized.

Sincerely,



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