National Association of Benefits and Insurance Professionals
NABIP
Shaping the *future* of healthcare

January 27, 2024

Mehmet Oz, M.D.
Administrator, Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Submitted electronically via www.regulations.gov
CMS-4208-P

Dear Administrator Oz:

I am writing on behalf of the National Association of Benefits and Insurance Professionals (NABIP), formerly known as NAHU, which is an association representing over 100,000 licensed health insurance agents, brokers, general agents, consultants, and employee benefits specialists. Our mission is to advocate for consumer-friendly policies that enhance affordability, ensure access to quality healthcare, and promote a transparent, thriving insurance marketplace. We appreciate the opportunity to provide comments on the Center's recently published Contract Year (CY) 2026 MA and Part D proposed rule (CMS-4208-P).

NABIP members work tirelessly to assist millions of individuals, families, and businesses in navigating health insurance options. Thousands of our members specialize in serving Medicare beneficiaries, providing invaluable support not only during enrollment but also throughout the year. They address complex questions, resolve issues, and advocate for their clients to ensure that coverage meets their evolving needs.

As such, we are grateful for the opportunity to share feedback on this draft guidance. We've broken down our comments by topic, with the content developed by the members of our Medicare Working Group. Over 7,000 testimonials shared with NABIP from Medicare beneficiaries form the foundation of this feedback.

We appreciate the opportunity to provide input on this critical draft guidance and have organized our comments by topic to ensure clarity and focus. Thank you for considering our feedback and for your ongoing efforts to enhance the Medicare program for all stakeholders.

Agent Compensation Concerns Threaten Medicare Beneficiaries' Ability to Access Critical Guidance

The message throughout this comment letter is that agents and brokers are in alignment with the agency's goals of ensuring that Medicare beneficiaries are

empowered to make healthcare decisions that best support their health and well-being. Agents and brokers work every day to ensure that seniors have the healthcare coverage they need. **Over 7,000 Medicare beneficiaries have strongly echoed this statement, confirming that they heavily rely on us to help them navigate this increasingly confusing and ever-changing environment impacting the options for Medicare plan enrollment.** We want to continue to foster this built-up trust and continue to advocate on their behalf regarding healthcare issues directly to them.

It is critical to notify CMS of market developments that pose a significant risk to this shared mission. **Over 30% of the 61.2 million Medicare beneficiaries who currently rely on agents for guidance could lose access to this trusted community of professionals.** Recent actions by many Medicare Advantage and Part D carriers, namely discontinuing commissions with little or no notice—even during the Annual Enrollment Period (AEP)—threaten the sustainability of the agent profession. These commissions are essential to supporting the work agents do to assist beneficiaries, while also enabling them to provide for their families. Without fair compensation, many agents will be unable to continue their service, leaving seniors to navigate the complex Medicare system without the personal, informed assistance they have come to depend on. This could shift millions of beneficiaries to government resources that are already strained and may not provide the individualized support that agents offer.

To address these challenges, we urge CMS to establish regulations to safeguard the stability and fairness of the agent profession. **Specifically, CMS should require carriers to honor commission agreements for plans sold and prohibit changes to commission structures, such as making plans non commissionable, after October 1 each year.** This would provide agents with adequate time to plan for the upcoming year and protect them from abrupt and significant income disruptions that disproportionately impact on their ability to serve beneficiaries. This timeline is like the proposed deadline proposed by the agency for plan sponsor's finalization of in-network pharmacies for similar reasons (as highlighted in a later section of this letter).

Additionally, we recommend that CMS address the broader issue of lifetime commission agreements, which were often included in contracts but have been terminated unilaterally by carriers. Lack of regulation and enforcement has allowed carriers to retroactively negate compensation agreements, undermining the premise on which plans were initially sold. Additionally, some carriers have chosen to remove products from agent platforms, restricting enrollments to telephonic or Medicare.gov channels. These actions hinder beneficiary choice and limit the accessibility of the professional guidance they depend on via jeopardizing the livelihoods of agents. Carriers are effectively steering beneficiaries into selecting plans carriers prefer.

It is imperative to protect the critical role that agents and brokers play in empowering beneficiaries to make informed healthcare decisions. We ask CMS to consider regulatory measures that ensure fair and transparent compensation

practices, which will ultimately preserve the trust beneficiaries place in their agents and maintain access to the personalized care and guidance they rely on.

We close this section of our response with a few selected Medicare beneficiary testimonials and invite further engagement with the agency on this significant issue:

"When I first started to read information about Medicare, I found it extremely confusing. Trying to navigate "original" Medicare, supplements, Medicare Advantage, Part D, and so on, is hard. Why is this that hard? For most of us that did not have schooling about this, we are very confused by it. Having someone who can navigate this for us for our best interest is very necessary and appreciated. What my agent researched and discussed with me works best for me. Not a cookie cutter plan, one for me personally. Medicare is extremely important and confusing so please continue to let these agents help others like myself. And all the work and research they do should be compensated for. We need them!!"

"My husband and I recently had an incident where our primary doctor left their practice, closing the practice without any warning. It worried me because my husband has lots of issues like diabetes and heart problems and I have issues as well. I reached out to my agent who got back to me right away. I let her know what was going on and that we needed a primary doctor right away. She got back to me the same day with the names of primary doctors and their information. As the time comes for changing Medicare Advantage plans, we will be needing the help of our insurance agent to find a new plan to match up with our current doctors, specialists and dentists. We appreciate having someone there for us to find a solution for our health needs. Thank you for always coming through for us!"

"Working with my agent is the best thing that could have ever happened to me. When my employer no longer provided health care insurance, I was referred to my agent, who helped me obtain the very best coverage, which ultimately saved my life. Six months later I was diagnosed with cancer, and my coverage provided a safety net for me through the most challenging period of my life. I don't know what I would have done without my agent."

Promoting Informed Choice—Enhancing Review of Marketing and Communications

The proposed rule aims to expand the definition of "marketing" for Medicare Advantage (MA) and Part D plans in §§ 422.2260 and 423.2260 to focus solely on intent, rather than content criteria to determine which materials and activities could be classified as marketing. This means more materials and activities would effectively be required to be submitted to CMS for review.

National Association of Benefits and Insurance Professionals

NABIP

Shaping the *future* of healthcare

We wholeheartedly support CMS's goal of strengthening beneficiary protections against misleading and confusing advertising tactics in the Medicare Advantage and Part D markets. **We strongly oppose the rise of harmful marketing practices and bad actors that undermine trust in the Medicare system.**

We hear from beneficiaries regularly about this issue, with one senior sharing, *"I have major concerns about the direct-to-consumer marketing of advantaged programs by telemarketers on TV, in print, and in the mail. Many descriptions are deceptive in that they misrepresent the availability of providers in their network that don't present the whole picture of required preauthorization & restrictions on treatments."*

We want to emphasize an important distinction: Licensed agents and brokers are not the same as third-party marketing organizations, such as 1-800 number call centers. Agents and brokers operate under a professional and legal obligation to evaluate all plan options with beneficiaries and help them make well-informed, personalized enrollment decisions. Unlike some third-party entities, agents and brokers are required to secure consent from beneficiaries for plan enrollment, maintain rigorous licensure, and adhere to compliance and training standards designed to prioritize the beneficiary's needs.

As one NABIP agent shared, *"Every month, and especially during the Annual Enrollment Period, I am fixing poor plan selections facilitated by telemarketers. As an example, one telemarketer did not look up the beneficiary's doctors and prescription drugs, assuring the beneficiary that they'd be in the proposed plan. Only to find this is not the case. Without my help, they would have lost access to 10 of their 13 doctors and their prescription drug costs would have grown by over $10,000."*

Beneficiaries trust us to provide this critical guidance, particularly due to the continuous barrage of misleading marketing from non-agent entities. One senior confided to us, *"My agent has been invaluable in helping me navigate Traditional Medicare and Medicare Advantage. The endless mailings, confusing rules, and scam advertisements make it almost impossible to figure things out alone. Having someone to help sort through the options and explain the changes every year is essential. Without this help, so many people, especially older citizens, would fall victim to bad decisions or deceptive advertising. Losing this kind of support would be devastating."*

As CMS moves forward with these regulatory changes, we urge careful consideration of how these rules are implemented to ensure they effectively address third-party marketing organizations without creating undue burdens on licensed agents and brokers who serve as a trusted resource for millions of Medicare beneficiaries. We ask the agency to reconsider their proposed change that makes the scope broader via an intention-based criteria, as it provides little guidance to committed stakeholders about how to best align with agency expectations.

National Association of Benefits and Insurance Professionals

NABIP

Shaping the *future* of healthcare

Agent and Broker Requirements Regarding Medicare Savings Programs, Extra Help, and Medigap

We align with CMS's overall goal of ensuring beneficiaries are well-informed about their Medicare Advantage and Part D enrollment options. NABIP members work every day to uphold transparency and provide beneficiaries with the necessary tools to make fully informed choices about their healthcare coverage. Within Sections 422.2274(c)(12) and 423.2274(c)(12), CMS proposes adding LIS, MSP, and Medigap to the list of topics agents and brokers discuss with beneficiaries prior to completing an enrollment. Despite contrary claims highlighted within the proposed rule, many NABIP members already include these topics within their discussions with beneficiaries.

As one senior shared, *"[My agent] helped my husband and I evaluate Medigap, Part D drug plans and Medicare Advantage plans. Because my husband has numerous medical problems, he guided us in selecting plans to help with out-of-pocket costs for us. He has helped us navigate the very confusing maze of plans. With him, we wouldn't have known that if my husband changed from a Medigap plan to Medicare Advantage plan, he would have difficulty returning to a Medigap plan because of his many pre-existing conditions."*

Additionally, one NABIP member recounted, *"I started working with a couple paying $600 a month for a Medigap plan. They had to sell their car because they couldn't afford the premiums along with their expensive medications. I discovered they qualified for MSP and LIS, enrolled them in a special needs plan with extra benefits, and saved them $12,000 a year. Their quality of life improved dramatically."*

CMS proposes to adjust § 422.2274(c)(12) to require agents and brokers to pause to proactively ask beneficiaries about whether they have questions about the topics the agent and broker has discussed, or other questions related to enrollment in an MA, MA-PD or Part D plan to further promote informed decision-making among beneficiaries. The proposed rule itself clearly states that CMS *"understand[s] that many agents and brokers may do this already as a routine part of sales calls with beneficiaries."*

A large number of seniors echoed that to NABIP as well, with one beneficiary reporting, *"I never expected enrolling in Medicare and choosing the best plan to be so complex. My agent guided me through the process, answering all my questions and providing valuable information with no pressure to make an immediate decision. They even send regular updates about coverage changes and hold workshops to keep me informed. Thanks to my agent, I feel confident in my choices and have recommended them to friends who are just starting this process."*

In order to achieve the agencies' outlined goals of making sure beneficiaries are empowered to make the best Medicare Advantage, Part D plan, or Medigap plan

choices, we ask CMS to revisit the existing Scope of Appointment (SOA) and 48-hour requirement.

Agents are required to document the beneficiary's agreement to discuss specific plan types before the meeting takes place. This documentation must be completed at least 48 hours in advance of a marketing appointment unless the beneficiary initiates a walk-in or same-day appointment. The SOA requirement inherently limits what agents and brokers can discuss with beneficiaries, as we are restricted from discussing any options outside of the previously agreed-upon scope. If the beneficiary raises questions or wishes to discuss any information outside of the existing SOA, a new SOA would be required, resetting the 48-hour waiting period, delaying meaningful conversations with the beneficiary and plan enrollment decisions. Beneficiaries do not understand this requirement and it further confuses them, creating unnecessary inconvenience and sometimes vexation within the process. These requirements conflict with the agency's overarching intention of making sure beneficiaries have as much information as possible to make the best decision, as oftentimes their questions cannot be answered within the original meeting time. Additionally, the SOA and 48-hour rule does not provide effective hindrance to bad actors, as they will continue to falsify the SOA. These existing rules only provide additional burdens on seniors and the good agents that support them.

Promoting Transparency for Pharmacies and Protecting Beneficiaries from Disruptions

We support the spirit of proposals aimed at preventing drug coverage disruptions and enhancing transparency and continuity of care for Medicare beneficiaries. The proposed rule requiring Part D plan sponsors to inform pharmacies by October 1st about their network status for the following year is a crucial step toward ensuring that beneficiaries receive accurate and timely information about their pharmacy's participation in their plan network.

As one agent shared, *"The Annual Enrollment Period (AEP) is only seven weeks long lasting until December 7th, whereas doctors and pharmacies have until the end of the year to finalize their contracts with insurers. This creates a significant risk, as we can't be 100% certain whether a doctor or pharmacy will be in-network until the year ends. In my opinion, this tight timeframe is far from ideal and poses challenges for both agents and beneficiaries."*

We refrain from commenting on the proposed policy allowing pharmacies to terminate their network contracts without cause. However, we do encourage CMS to take a more active role in ensuring that contract negotiations between plan sponsors and pharmacies do not disrupt beneficiaries' ability to access their prescriptions.

As one beneficiary shared, *"When we learned that our pharmacy was no longer in-network with our existing plan or many other plans available to us, [our agent] helped us enroll in a plan that avoided us being hit with super high payments and guided us in transitioning to a different pharmacy. We might have been stuck paying high amounts for our prescriptions had we not seen her."*

By prioritizing transparency and consistency in pharmacy networks, CMS can ensure that beneficiaries are better equipped to navigate their prescription drug options with confidence and stability.

Improving Access—Enhancing Rules on Internal Coverage Criteria

We strongly support transparency, fairness, and patient-centered decision-making within the Medicare Advantage (MA) program. While we will not comment on how to design the rules governing utilization management within Traditional Medicare and Medicare Advantage programs, we wish to share recurring concerns from beneficiaries and agents that they are experiencing stricter utilization management requirements within their coverage, particularly in the areas of skilled nursing and prescription drugs. We support the spirit of one of the sections of this proposed rule, which aims at aligning Medicare Advantage and Traditional Medicare's method of prior authorization determinations.

Agents continuously provide feedback that has been shared for years - that bypassing prior authorization hurdles are too cumbersome for patients.

As one agent shared, *"I have a beneficiary who takes an expensive prescription drug, which was on formulary for his plan but required prior authorization. Not taking this prescription would have had a severe impact on his rheumatoid arthritis and caused him great concern. I was able to call Wellcare with him, walk him through the process, and acquire the documents needed for prior authorization from his doctor. Without my help, it would have likely taken him three times as many phone calls and caused him undue stress over an already difficult situation."*

NABIP does not oppose the practice of utilization management, but we hope there is continued agency evaluation of market practices and stakeholder conversations about areas for improvement.

Additionally, with regards to algorithms and artificial intelligence (as another section of this proposed rule addresses), they can serve as valuable tools, but they must not override individualized patient considerations. Every decision should still account for the unique medical history and needs of the beneficiary, and we welcome tools that allow for prior authorization determinations to minimize, rather than amplify, the impact of decisions on beneficiaries.

National Association of Benefits and Insurance Professionals
NABIP
Shaping the *future* of healthcare

Additional Sections of the Proposed Rule

Vaccine & Insulin Cost Sharing

We continue to support the provisions that ensure greater access to vaccines and insulin for Medicare beneficiaries by the removal of cost-sharing policies. We advocate that these policies remain in place with the new Administration.

Medicare Prescription Payment Plan

We express our appreciation for the spirit of ensuring that people can afford their medications. However, we have observed that many pharmacies are unaware of the Medicare Prescription Payment Plan program's existence, leading to confusion when beneficiaries inquire about this option at the pharmacy check-out. As a result, the program is not currently having a meaningful impact on improving prescription drug affordability for seniors. That said, we support the proposed auto-renew, opt-out election process as a step toward greater accessibility and consistency for beneficiaries.

Ensuring Equitable Access to Behavioral Health Benefits Through Section 1876 Cost Plan and MA Cost Sharing Limits

We support efforts to ensure equitable access to behavioral health benefits by aligning cost-sharing requirements for in-network behavioral health services between traditional Medicare and Medicare Advantage (MA) plans. This alignment promotes consistency and fairness in access to critical mental health services. However, we urge CMS to provide Medicare Advantage plan sponsors with adequate transition time to implement these changes, ensuring that existing services are not disrupted, and beneficiaries continue to receive uninterrupted, high-quality care during this adjustment period.

We truly appreciate the opportunity to comment on this draft regulation, as well as your willingness to consider the viewpoints of all stakeholders. If you have any questions or need additional information, please do not hesitate to contact Michael Andel, Vice President of Government Affairs, at mandel@nabip.org.

National Association of Benefits and Insurance Professionals
NABIP
Shaping the *future* of healthcare

Sincerely,

Michael Andel
Vice President of Government Affairs
National Association of Benefits and Insurance Professionals