NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

May 29, 2024

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–4207–NC
P.O. Box 8013
Baltimore, MD 21244–8013

Via *Regulations.gov*

To whom it may concern:

Thank you for the opportunity to provide comments on data collection and reporting related to Medicare Advantage. The National Association of Insurance Commissioners (NAIC) represents the insurance regulators in the 50 states, the District of Columbia, and 5 U.S. Territories. Our members regulate fully insured health plans, seeking to protect consumers and maintain stable markets for private health insurance. Since Medicare and Medicare Advantage affect the entire health care sector, we offer these comments in support of improved data availability to help health insurance and health care markets in our states function better for all stakeholders.

State insurance regulators urge CMS to enhance data collection and reporting in several of the areas referenced in the Request for Information, including marketing; provider contracting, payment, and network issues; supplemental benefits; claims denials; and prior authorization practices. States have important, but limited, authority over Medicare Advantage plans—state regulators license and monitor the solvency of insurers who offer MA plans in our states. Regulators need better data about MA plan activities to better understand insurers' solvency positions. When an insurer's solvency is at risk, its plans may exhibit red flags such as offering benefits it cannot deliver, struggling to contract with or pay providers, or denying an inordinate number of claims. State and federal regulators can make better decisions when they have more data about red flags like these. In addition, protecting insurance consumers in our states requires more and better information about MA plan activities, from marketing to access to care to claims processing.

State insurance regulators recommend that CMS collect and share (at least with state departments of insurance) detailed data on marketing conducted by and on behalf of MA plans. State regulators have fielded numerous complaints from consumers about deceptive and misleading marketing of health plans, often including MA plans. Regulators, though, sometimes struggle to identify the entities behind the improper marketing practices, especially when they are third party marketing organizations. We urge CMS to collect information from MA insurers as well as from any entities who market their plans. Insurers should report who they contract with and provide enough data to allow regulators to "follow the money." Insurers should be required to detail the payments they make to marketers and how those payments are structured so that regulators can trace the compensation for enrollments and identify how plan payments reach those who engage in improper marketing. Sharing this information with state regulators would allow us to take action against improper marketers who fall under state authority, such as agents and brokers.

MA insurers' interactions with health care providers have also generated considerable complaints to state regulators. We encourage CMS to require MA insurers to report much more information on their provider contracts and payments and again to share this data with state regulators. Beneficiaries in Puerto Rico and several states have experienced delays or disruptions to care due to providers leaving MA networks. We urge CMS to collect and share the data needed to closely monitor provider participation in MA networks, including network composition and network changes. When large facilities or specialty providers leave a MA network, it can have a disruptive effect for thousands of beneficiaries and also for other providers and plans in the state and region. In addition, MA plans should expand coverage only to areas where they have adequate provider contracts in place. State regulators are concerned that MA plans have expanded to areas where networks are lacking. CMS should have access to data that is detailed and timely enough to assure MA plans' networks remain adequate when material changes happen during a plan year or geographic expansion occurs. State regulators further request that CMS collect information on MA insurers' practices in building networks, including payment rates offered and contract terms. This information can help regulators understand the competitive balance in insurance markets and evaluate plans' overall contracting strategies. Conversely, we also encourage CMS to collect information regarding difficulties that MA plans may encounter when attempting to contract with large hospital systems that may be affiliated with MA plans. It would be helpful to know when health systems require a lump sum up-front fee for the privilege of contracting. We are concerned that the choice between not contracting at all or paying a lump sum fee to contract at potentially high provider rates could adversely impact competition in local insurance markets.

In particular, we encourage CMS to collect and share more data on the claims processing and payment practices of MA plans in Puerto Rico. With the high concentration of MA participation in the Territory, and the very low federal reimbursement rate, a crisis is developing. Puerto Rico's insurance regulator has raised his concerns with CMS and requested additional data and clarification on the regulator's consumer protection authority, and there have been some positive conversations. However, we ask that those discussions be expedited and that CMS review the federal reimbursement amount to ensure it is sufficient.

The flexibility of the MA program allows plans to offer supplemental benefits and these benefits can be an important aspect of consumer plan choice. We ask CMS to collect and make publicly available detailed information on which supplemental benefits are offered by which plans, their cost to plans and beneficiaries, and their rates of utilization. State regulators are concerned that some supplemental benefits may not be accessible to beneficiaries and that supplemental benefits may result in greater claims payment difficulties than traditional benefits. Making available greater information on supplemental benefits and comparative denial rates will allow researchers and policymakers to better understand the MA market and help assure that plans are fulfilling their responsibility to make promised services available.

Health insurance claims processing practices are an ongoing matter of concern for state insurance regulators. Insurers are using new methods, such as artificial intelligence, to process claims. Regardless of the method, the basis for denials can be unclear for providers and patients. We believe CMS has an opportunity in Medicare Advantage to establish greater transparency with regard to claims processing and denials. Because MA plans are offered by private insurers but funded by public dollars, CMS may have unique authority to promote transparency in claims processing. We recommend that CMS routinely collect data on MA plans' claims processing, rather than only when a plan is audited. The agency should collect information on what methods and contractors MA insurers use and how claims

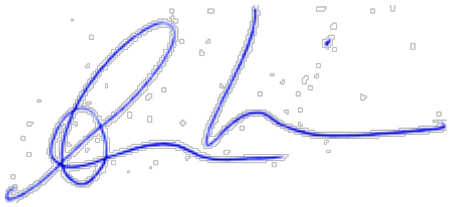
decisions are communicated to providers and beneficiaries. CMS should further obtain and publish information on MA plans' claims processing outcomes, including timeliness, denials, and detailed denial reasons. Claims difficulties can be an important early warning sign of an insurer's performance, up to and including its solvency. CMS could model its reporting requirements on the transparency in coverage process currently required for health insurers seeking certification as Qualified Health Plans (QHPs) to operate on state and federal individual market exchanges.

Prior authorization and other utilization management techniques represent additional areas where CMS should consider collecting and reporting more detailed outcome data. CMS's recent Interoperability and Prior Authorization final rule will require MA plans to post prior authorization metrics annually to their websites. CMS taking steps to collect this data and make it available in a single place may add value for stakeholders and facilitate comparisons across plans and across states.

As CMS revises its data collection practices for Medicare Advantage, we urge it to also consider policy changes to enable more collaboration with state regulators. States generally lack authority to regulate non-solvency matters in Medicare Advantage. Nonetheless, state regulators remain interested in preventing and addressing consumer confusion, delays in care, and provider access challenges. Involving state regulators in enforcement of CMS standards can help extend capacity and bring greater knowledge of local markets. We encourage CMS to find opportunities for more state collaboration under current law and to support a greater role for states should Congress update Medicare Advantage statutes.

Thank you for considering our comments in response to the Request for Information.

Sincerely,



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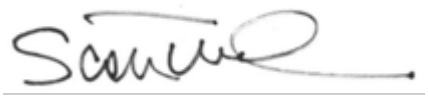

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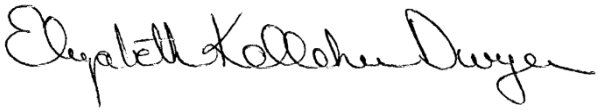

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