NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

September 25, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Administrator Brooks-LaSure:

On behalf of the National Association of Insurance Commissioners (NAIC), the standard-setting organization representing the chief insurance regulators in the 50 states, the District of Columbia, and the United States territories, we write to you regarding provider withdrawals from Medicare Advantage (MA) plans and the subsequent process for beneficiaries to request a return to traditional Medicare and Medicare Supplement Insurance (Medigap) coverage. We are seeking guidance on several aspects of the process and have a recommendation that could mitigate some of the problematic situations we are encountering.

State regulators in several states are seeing hospitals and crucial provider groups making decisions to no longer contract with any MA plans, which can leave enrollees without ready access to care. In some cases, the provider groups and carriers attempt to renegotiate their contracts until the last day of the current contract and when negotiations fail the provider group can become an out-of-network provider overnight. This can have an immediate and direct impact to plan beneficiaries who may already have services scheduled with the now out-of-network provider. Beneficiaries are faced with either paying the increased out-of-network costs or rescheduling their necessary medical services with another provider who may not have prompt availability. A delay in access to medically necessary services is likely to result in harm. There is considerable, and soon will be more, confusion as to what their options are and we request guidance from CMS so we can help our constituents. Lack of CMS guidance could result in unnecessary financial or medical injury to America's seniors.

At the recent NAIC Summer National Meeting in Chicago, the Senior Issues (B) Task Force requested that a representative from the Medicare Drug and Health Plan Contract Administration Group (MDHPCAG) come and explain the options available to MA enrollees who have lost access to their providers. The individual(s) from MDHPCAG cancelled their appearance right before the national meeting leaving state regulators with a multitude of questions. While we appreciated a CMS representative at the meeting, he was not part of MDHPCAG and could not answer our questions fully.

 

As we understand it, MDHPCAG is the one that determines whether a significant provider network change has occurred and, once that determination is made by MDHPCAG, a special election period (SEP) is automatically granted for the beneficiaries that are impacted. We also understand that the SEP allows for guaranteed issue (GI) into original Medicare and Medigap. How is that determined? Is it on an individual enrollee basis? Are time and distance standards utilized? Once a determination is made, how is that communicated to affected constituents and state insurance regulators? Can state insurance regulators assist MDHPCAG in making a rapid determination?

Once the determination is made, it is unclear what steps follow that decision. For example, is it an automatic reversion in original Medicare for all the individuals involved? Does the individual have to contact CMS on an individual basis? If so, this would seemingly cause an undue burden on a beneficiary and could lead to individuals who don't respond, for whatever reason, having coverage that may be nominal at best. We do not believe such a burden should be placed upon beneficiary policyholders.

The Secretary of the Department of Health and Human Services (HHS) has the authority to establish SEPs under exceptional circumstances on a case-by-case basis and we suggest that CMS consider a blanket SEP into original Medicare and a Medigap GI when a hospital or provider group exits an MA network contract.

In the meantime, we seek guidance on how the current process works:

- How is CMS made aware of providers leaving a network? Is it only through enrollee inquiries or must MA plans notify CMS of the changes? What is the timeframe within which the plans are required to notify CMS?

- Once CMS is made aware that a provider and/or a carrier are no longer going to contract with each other, what are the steps in evaluating and determining the eligibility for original Medicare and then guarantee issue into Medigap? Does guarantee issue apply to all Medigap plans or only select ones?

- What role can state regulators play and what information can be provided to state regulators in identifying provider network changes and requesting an SEP?

- How long does the review and consumer notification process typically take?

- After the CMS evaluation, how are notifications provided to the policyholders? Are the notifications just done via the MA plan?

- Are state departments of insurance (DOIs) and state health insurance assistance program (SHIPs) offices to be notified about the communication so

our staff(s) can be prepared for calls and, if we do get calls, where do we refer them about the issue?

- Will MA plans be expected to offer continuity of care protections for individuals who experience the loss of a key provider?

State Departments of Insurance across the country are fielding consumer inquiries about the withdrawal of their providers from MA plans and since states do not regulate these plans, DOI staff are unable to offer recommendations to consumers beyond referring them to CMS or the administrator of their MA plan. Without clear guidance or a resolution from CMS, these consumers are left with few options. We are open to a dialogue with your office and appropriate CMS personnel and would appreciate answers to these questions and guidance on how we may best assist our beneficiary constituents.

Sincerely,

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Commissioner
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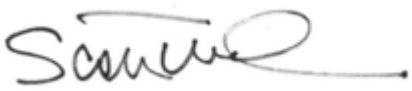

Scott White
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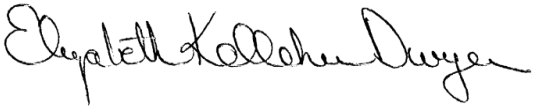

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