NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

September 5, 2025

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Administrator Oz:

We are writing on behalf of the National Association of Insurance Commissioners' (NAIC) Senior Issues (B) Task Force (SITF) regarding provider withdrawals from Medicare Advantage (MA) plans, carriers leaving networks, and the subsequent process for beneficiaries to request a return to traditional Medicare and Medicare Supplement Insurance (Medigap) coverage.

The NAIC is the standard setting organization representing the chief insurance regulators in the 50 states, the District of Columbia, and the United States territories. The NAIC's SITF is charged with considering policy issues; developing appropriate regulatory standards; and revising, as necessary, the NAIC models, consumer guides, and training materials on Medigap, long-term care insurance (LTCI), senior counseling programs, and other insurance issues that affect older Americans.

At the recent NAIC Summer National Meeting in Minneapolis, the SITF requested representatives from the Medicare Drug and Health Plan Contract Administration Group (MCAG) to come in-person and explain the process of determining provider network changes and the options available to MA enrollees who have lost access to their providers. We seek guidance on several aspects of the process and have a recommendation that could mitigate some of the problematic situations we are encountering.

As open enrollment (OE) is rapidly approaching, we are requesting a Regulator-Only meeting with you and your staff as soon as possible, ideally within the next couple weeks, to discuss these issues.

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 on consumers who may already have services scheduled with the now out-of-network provider. Consumers 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 patient harm. There is considerable confusion and soon will be more as to what patients' 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.

As we understand it, MCAG determines whether a significant provider network change has occurred and, once that determination is made by MCAG, a special election period (SEP) is automatically granted for the beneficiaries who 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 MCAG in making rapid determinations? Additional information about what states can and should do would be very helpful as states are on the front line of consumer complaints and calls, despite the fact that states do not have jurisdiction over MA plans.

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 consumers.

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.

We seek guidance on how the current process works and answers to questions raised at the SITF meeting:

- 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 consumers about the issue?

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

Several states had specific questions and concerns regarding the CMS Plan Finder. A number of generic prescriptions failed to appear on plan formularies even though they were covered. Additionally, many of these prescriptions did not consistently show up in clients' drug lists (i.e. they were entered but the system would not save them). Similarly, the prescriptions would not pull up on the list of prescriptions when the comparisons were run. Other issues included:

- Issues with zip codes. Use of some zip codes would bounce SHIP staff & counselors out of Plan Finder or would result in an error message saying zip code could not be found.

- Changes to the Plan Finder, which only allowed one person to be logged in to a client's Plan Finder account, is extremely problematic. Previously more than one person was allowed, which meant SHIP counselors providing phone counseling sessions could be logged in to the account while the client was also logged in. States would like CMS to change the system back to allow more than one person in a consumer's account so we can continue our advocacy efforts in a transparent manner and with the consumer following along.

- Plan Finder pricing does not include pricing for LTC pharmacies and many consumers are in nursing homes and use LTC pharmacies. Is there a way to change this?

- Serious concerns exist about a mandatory email requirement. We understand CMS is running an evaluation to assess the impact of making email addresses mandatory in Plan Finder. Previously a client was able to opt out if they did not have an email

address. Requiring an email address to set up an account would impact a person's ability to set up a medicare.gov account and their ability to enroll in a plan through Plan Finder. We know based on counselor feedback that a significant number of older consumers, and consumers in rural areas, do not use email and/or have access to the internet. In addition to creating new barriers for seniors, we believe that making email addresses mandatory will create additional unnecessary issues, including 1) creating security issues as persons who wish to use Plan Finder and do not have email may create random email accounts that could create a security risk, and 2) reducing the number of persons who can be served as SHIP counselors are forced to assist with the creation of email addresses. This is especially important during a short timeframe such as OE when demand for services already surpasses supply. We respectfully request that CMS not implement any policies that require use of an email to create either a Medicare or Plan Finder account.

State DOIs 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,

Ned Gaines, Chair
Senior Issues (B) Task Force
Acting Commissioner
Nevada Division of Insurance

Chrystal Bartuska, Vice Chair
Senior Issues (B) Task Force
Division Director
North Dakota Insurance Department

Cc: Kathryn Coleman, Director, Medicare Drug and Health Plan Contract Administration Group (MCAG)