NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

January 22, 2026

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4212-P
P.O. Box 8013
Baltimore, Maryland 21244-8013

To whom it may concern:

The National Association of Insurance Commissioners (NAIC), representing the chief insurance regulators in the states, the District of Columbia, and U.S. territories, submits the following comments on the proposed rule entitled *Medicare Program: Contract Year 2027 Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program*.

Special Enrollment Period for Provider Terminations (§ 422.62(b)(23))

Provider network changes can create burdensome challenges for Medicare beneficiaries enrolled in Medicare Advantage plans. A provider going out-of-network can delay needed care, make a plan significantly less valuable for a beneficiary, and/or impose new costs on enrollees. We appreciate CMS's actions in recent years to better inform state insurance regulators about CMS determinations that a network change is significant.

The proposed rule would streamline notifications to beneficiaries about provider terminations and their rights to a special enrollment period (SEP) and guaranteed issue (GI) of Medicare supplement plans. Instead of a plan notice that a provider is leaving the network and a potential second notice that CMS has determined the network change to be significant, CMS proposes that plans would use the same notice to inform enrollees about provider terminations and their SEP and GI rights. CMS also proposes to remove the requirement for a CMS determination of a significant change from the eligibility criteria for the SEP and GI. Thus, any beneficiary who meets the definition of "affected enrollee" would qualify for the SEP and GI. CMS says a separate SEP (for exceptional circumstances) has long been available even without a CMS determination of significance for beneficiaries who call Medicare and explain they have been adversely affected by a network change.

State insurance regulators urge CMS to consider the potential effects of these changes on state insurance markets and to provide more clarity on the proposed reforms. Streamlining eligibility criteria and notifications may lead to increased use of the SEP and GI rights. Greater availability of the SEP and GI would be advantageous for many beneficiaries and we support this increased availability for those who stand to lose access to providers crucial for their care.

At the same time, increasing availability of the SEP and GI has the potential to add challenges for state Medicare supplement markets. CMS cites a low rate of beneficiaries taking advantage of its current SEP for a Significant Change in Provider Network. Under the proposed policies, however, more beneficiaries may use the SEP and GI. A beneficiary would receive a notice, SEP, and GI rights due to the termination of

any provider they have seen recently, including ancillary providers like physical therapists or others who may not be in short supply. The beneficiaries most motivated to use their GI rights may be those who have significant medical needs. If the set of beneficiaries who take advantage of the GI rights to leave Medicare Advantage and enroll in Medicare supplement plans is disproportionately more in need of health care services, Medicare supplement plans and the supplement market as a whole would be disadvantaged. We urge CMS to conduct analysis to determine the impact of the proposed policy change on state markets for Medicare supplement insurance and share the results with states and other stakeholders.

We further urge CMS to consider whether maintaining the definition of "affected enrollee" meets the goals of the policy change. "Affected enrollees" are defined as those who "are assigned to, are currently receiving care from, or have received care within the past three months from a provider or facility being terminated from the MA (or MA-PD) plan's provider network." Some beneficiaries may be seeking care from a provider, but not yet receiving care. Beneficiaries on a waiting list to see a particular provider may wish to use SEP or GI rights if that provider leaves a plan network. CMS could clarify that "assigned to" covers this situation. Other beneficiaries may wish to maintain in-network access to a provider who delivered an important episode of care in the past, for instance a cancer patient who desires to maintain access to a particular oncologist during periods of remission. CMS should consider lengthening the look-back period to 12 months and potentially more in some circumstances. Many people do not need to visit their providers every three months for necessary medical care – a longer window is needed.

The proposal notes that beneficiaries could avoid calling Medicare and attest directly to a MA plan that the beneficiary meets the eligibility criteria for an SEP. We believe further clarification is necessary for Medicare supplement plans—are they permitted or required to accept beneficiary attestation of eligibility for GI?

Medicare Advantage/Part C and Part D Prescription Drug Plan Quality Rating System (Star Ratings) (§§ 422.164, 422.166, 423.186, and 423.184)

We strongly oppose the proposal to remove the "Plan Makes Timely Decisions about Appeals (Part C) and Reviewing Appeals Decisions (Part C)" Star Rating measures (section V.B).

Monitoring and transparency of the appeals process is a critical aspect of ensuring access to timely care. The risk of erroneously denied care and subsequent appeal process experiences are a pivotal decision point for Medicare Advantage members that should be *increased* in weight in the Star Ratings, not removed. Part C denials and appeals are an increasing problem; Medicare Advantage members struggle to access care:

- Eighty-two percent of Part C prior authorizations appeals are successful (KFF, 2023).
- Congressional subcommittees conducted two investigations into Medicare Advantage organizations' harmful, inappropriate denials of post-acute care in 2023: Examining Health Care Denials and Delays in Medicare Advantage and Avoiding a Cautionary Tale: Policy Considerations for Artificial Intelligence in Health Care.
- Another Congressional report published in 2024 titled Refusal of Recovery: How Medicare Advantage Insurers Have Denied Patients Access to Post-Acute Care documents how insurers severely denied post-acute care and recommended that CMS should collect and audit prior authorization denials by category.

We suggest that CMS incorporate data that measures the number of overturned denials into the Star Rating system. Plans with high percentages of denials that had successful appeals, indicating the denial should never have been issued, should have lower Star Ratings.

We also oppose removing the "Complaints about the Health/Drug Plan (Part C and Pard D)" star rating measure. CMS states that the volume of complaints has significantly decreased since this measure was first introduced. Complaints are a key indicator of consumer satisfaction and often of access to plan benefits and medically necessary services. We suggest CMS should consider that complaints have decreased because they impacted star ratings and companies moved to address those issues that were impacting consumers. Removing this measure removes the incentive for MA plans to resolve complaints fully and timely.

Rescind Mid-Year Supplemental Benefits Notice (§§ 422.111(l) and 422.2267(e)(42))

NAIC opposes the provision of the proposed rule that would end the requirement for Medicare Advantage plans to notify enrollees about supplemental benefits they are eligible for and haven't yet used.

Data about supplemental benefit usage remains inaccessible to the public and advocates. Supplemental benefits are a driving factor in enrollment decisions, but many beneficiaries do not realize there can be additional eligibility requirements to access benefits. The mid-year notice would ensure that supplemental benefits actively benefit members rather than serving as an unfulfilled promise. The notice will be even more important starting in 2026 since the Medicare Advantage Value-Based Insurance Design (VBID) Model's end will result in much stricter eligibility requirements to access the much-advertised supplemental benefits.

Many SHIP teams regularly receive requests for assistance from beneficiaries who either do not understand supplemental benefits they are eligible for or are having issues accessing these benefits. While the proposed rule noted that 70% of MA enrollees are accessing at least one supplemental benefit, it should be noted that the average MA plan has an extensive list of benefits. Accessing a single benefit does not guarantee that beneficiaries are aware of all the benefits available to them. Many consumers do not utilize supplemental benefits because they are not aware of the full list. This means consumers are not receiving benefits that CMS has already paid MA plans to provide. Notifying beneficiaries is a sound policy that should be maintained.

Rescinding the Annual Health Equity Analysis of Utilization Management Policies and Procedures (§ 422.137(c)(5), (d)(6) and (d)(7))

We oppose the proposal to drop the requirement for Medicare Advantage plans to publicly report prior authorization activity data (section VII.E).

Prior authorizations are an increasing burden for patients and healthcare providers. According to a 2023 KFF analysis:

- Medicare Advantage plans issued almost 50 million prior authorization determinations in 2023, a dramatic increase from 37 million in 2021.
- Though just twelve percent of prior authorizations are appealed, 82% of those appeals are successful. By comparison, 29% of Original Medicare denials are overturned at appeal.
- In 2022, a third of prior authorization denials were overturned at the first level of appeal.

The fact that most appealed prior authorizations are overturned suggests that prior authorization denials are overwhelmingly misapplied to medically necessary care. Inappropriate delays and denials can harm a person's health. They also burden healthcare providers and systems with avoidable paperwork.

Transparent data is essential because rampant use of prior authorization is harming patients and overwhelming providers and advocates. Beneficiaries should be able to make informed decisions about expected red tape prior to enrollment; providers should be able to evaluate expected paperwork burdens before entering or terminating contracts; and advocates and legislators should be able to meaningfully analyze data to address systemic issues. We request CMS keep the requirement to release prior authorization reports, including analyses of impacts of prior authorization on different communities.

Updating Third-Party Marketing Organizations (TPMO) Disclaimer Requirements (§§ 422.2267 and 423.2267)

We fundamentally disagree with the rationale CMS has put forward to justify removing references to State Health Insurance Assistance Programs (SHIP) from the required disclosures third-party marketing organizations must provide and urge this guidance to be preserved. Currently, 42 CFR § 422.2267(e)(41)(ii) requires third-party marketing organizations (TPMOs), whenever they make sales calls, to disclose the availability of consumer assistance organizations, including SHIP programs, 1-800-MEDICARE, and Medicare.gov. The Proposed Rule would remove SHIPs from this requirement, while maintaining the Medicare contact information. The Proposed Rule's rationale that some SHIP counselors do not always provide accurate information to beneficiaries in complex cases, and that the Medicare phone line and website are the only sources of impartial information that consumers need, is simply not accurate or supported by the actions of consumers who routinely turn to SHIP for help.

SHIP remains a critical resource for customers. 1-800-MEDICARE customer service representatives often refer to SHIPs because SHIPs have expertise in state programs, can meet with people in-person, and provide a higher level of advocacy and assistance than 1-800-MEDICARE. This in-person assistance makes SHIPs the 'field offices' of the Medicare program and they are vibrant places of encounter with beneficiaries. SHIP counselors play an invaluable role in helping consumers understand the complexities of Medicare. SHIP counselors are highly trained individuals who present unbiased information, developed using CMS resources, to help consumers better understand their options and make informed decisions. We believe that the availability of SHIP counselors in addition to the Medicare contact information is important information consumers should continue to receive.

The proposal to eliminate the citation of SHIPs as an informational source to beneficiaries is short sighted. Eliminating this requirement for sales calls is not in the best interests of Medicare beneficiaries, particularly at a time when they could most benefit from impartial, informed assistance. Therefore, we strongly urge that CMS reverse its position on the proposed rule and continue to include in disclosures references to the 54 SHIP programs that have served new and existing beneficiaries for decades.

Removing Rules on Time and Manner of Beneficiary Outreach (§§ 422.2264, 423.2264, 422.2274, and 423.2274)

We oppose the proposed elimination of a separation between educational events intended to inform consumers and sales and marketing events intended to promote product sales as well as the waiting period after the completion of a scope-of-appointment form. Currently, if a Medicare organization or its sales representative conducts educational and marketing events at the same location, there is a mandatory 12-hour waiting period between the two events. The proposed rule would eliminate this requirement, allowing the educational event to be followed immediately by a sales presentation to the same prospective customers in the same location, as long as attendees are permitted to leave the room between the two events. The proposed rule suggests that this could be accomplished by providing a brief restroom or snack break.

The statutory prohibition[1] against sales and marketing activities at educational events would become meaningless without a meaningful separation between the two events. Although the proposed rule maintains that this change is designed to improve the enrollment decision-making process, a waiting period gives Medicare beneficiaries a chance to digest the information presented and carefully assess what type of plan best meets their needs. In light of the vulnerabilities of the Medicare-eligible population, requiring a meaningful separation between the educational and marketing events is a prudent consumer protection.

For these same consumer protection reasons, we also strongly oppose the proposed elimination of the 48-hour waiting period between the completion of a scope-of-appointment form (a signed agreement on what types of plans will be discussed during a subsequent meeting) and the actual personal marketing appointment. Although the current rule provides two exceptions to this requirement, the proposed rule would eliminate the waiting period entirely. We believe these protections are necessary to enable consumers to make informed decisions about complex insurance matters with which many have no prior experience.

Relaxing the Restrictions on Language in Advertising (§§ 422.2262(a)(1)(i), 422.2262(a)(1)(ii), 423.2262(a)(1)(i), and 423.2262(a)(1)(ii))

The proposed elimination of the prohibition on marketing organizations using superlatives in their marketing and communication materials unless the sources of documentation or data supporting the superlative are also referenced in the material should be removed.[2] Without this prohibition, marketing organizations would be free to engage in exaggerations about the performance of a plan and its benefits, which may lead to misrepresentation and consumer confusion.

Request for Information on Future Directions in Medicare Advantage

State insurance regulators request that CMS implement policy changes to alleviate market pressures, support more effective competition, and make Medicare plan choice easier for beneficiaries to navigate.

Current commission structures incentivize enrollment in Medicare Advantage plans over Original Medicare with supplemental coverage, contributing to the 100% increase in the last 10 years in the share of Medicare beneficiaries enrolling in Medicare Advantage. However, plans are experiencing growing pains, impacting providers, patients, and agents alike.

- Hospital Reimbursement Issues: Hospitals often receive inpatient authorization from plans, only to have claims reimbursed at lower outpatient rates. These losses are unsustainable, particularly for rural health systems, leading many to exit networks.
- Prior Authorization Challenges: Despite proposed rule changes, prior authorization remains a significant barrier for providers and patients. Many beneficiaries and providers are unaware of appeal rights, and those who do appeal often face lengthy delays. During these periods, patients frequently go without necessary care, compromising recovery outcomes.
- Need for State Oversight: Enhanced state regulatory oversight of Medicare Advantage plans could better align sales practices and protect consumers.

State regulators are committed to working with CMS and federal partners to protect seniors and people with disabilities from market manipulation by MA companies. We value the relationship between state and federal regulators and believe it would benefit consumers for states to have a more active role in the MA plan markets in each respective state. While CMS continues to administer and regulate the plan

[1] Social Security Act § 1851(j)(1)(D)(ii).
[2] 42 CFR §§422.2262(a)(1)(i), 422.2262(a)(1)(ii), 423.2262(a)(1)(i), and 423.2262(a)(1)(ii)

design and benefits, the states are best suited to address the unfair trade practices that may be outside of the CMS scope of authority. These activities can have a direct impact on the local consumer, as well as impact on insurer solvency. States hold the authority over insurance company licensure in their markets, as well as ensuring insurer solvency to protect consumers. The MA market is larger, more dynamic and more impactful than a decade ago. Volatility in the market now has a broader impact within state markets. State-based regulation is best suited to address the real-time market shifts and can help avoid the chaos created by unfair trade practices by insurers. We remain committed to upholding the shared responsibility of regulating these products to ensure beneficiaries have access to the coverage they need.

We request CMS recognize the state role in shared enforcement by updating current information sharing agreements to Collaborative Enforcement Agreements, allowing states to lead in areas where they are best suited to protect consumers. In the meantime, states will continue to enforce state laws to protect seniors and support healthy insurance markets.

Further, Medicare plan options have grown exponentially over the last two decades. Many counties have more than 100 Medicare plan options and an overwhelming number of Special Needs Plans. Even the most educated beneficiaries struggle to digest the complexity of the Medicare program and their plan choices. We recommend that CMS reinstate the "measurable difference" review when approving contracts to prevent carriers from offering multiple plans with minimal distinctions.

The proliferation of Special Needs Plans has oversaturated the market, and we urge CMS to address this issue. We share CMS' concern, expressed in the request for information, that "The growth in C–SNP [chronic condition special needs plan] enrollment could be an intentional approach by MA organizations to circumvent Federal and State requirements for dual eligible special needs plans (D–SNPs), such as States determining which D–SNPs will be offered in a State through their State Medicaid agency contract authority and general coordination and integration requirements."

It is our understanding that institutional special needs plans (I-SNPs) and C-SNPs are being offered outside of states' Medicaid agency contract requirements, reducing transparency and oversight. In addition, we are aware of concerns that I-SNPs and C-SNPs may not be offering enrollees appropriate services to promote care coordination needed by dually eligible populations. We are most concerned that dually-eligible individuals receive all of the benefits available to them, given their often fragile health status. We encourage CMS to consider policies to improve oversight of C-SNPs and I-SNPs.

Each year, the annual enrollment period becomes increasingly burdensome for Medicare beneficiaries, SHIPs, and agents. Plan terminations, confusing or inaccurate beneficiary communications, and state-specific issues make the eight-week enrollment window (October 15–December 7) insufficient for providing adequate assistance.

We suggest that CMS share plan termination details with state departments of insurance, including:

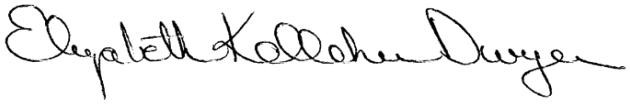
- Which plan contracts have terminated
- The number of impacted beneficiaries
- Whether crosswalks were permitted
- Geographic details (county or ZIP code) of affected beneficiaries

We also request consideration of replacing the fixed annual enrollment period with a rolling enrollment aligned to beneficiaries' birth months, which would allow for better resource allocation and improved support.

State regulators appreciate the opportunity to provide comments on the proposed rule. We look forward to continued collaboration in supporting Medicare beneficiaries and the markets that serve them.

Sincerely,

Scott White
NAIC President
Commissioner
Virginia Bureau of Insurance



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