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January 16, 2018

Submitted via regulations.gov

Seema Verma
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program (CMS-4182-P)

Dear Administrator Verma:

eHealth appreciates the opportunity to comment on Centers for Medicare & Medicaid Services (CMS) notice of proposed rulemaking entitled “Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program,” published in the Federal Register, vol. 82, no. 227, pages 56336 to 56527.

eHealth is a public company, operating its consumer online marketplace www.eHealthInsurance.com, and is a web-based broker that has helped enroll millions of individuals and families into coverage through its consumer-centric website over the last 16 years. We are proud of the work we have done to enroll hundreds of thousands of Medicare-eligible individuals into Medicare Advantage, Medicare Part D prescription drug and Medicare supplement coverage through our best-in-class consumer-centric website and customer care centers.

At the outset, we would like to emphasize the value proposition that web-brokers, like eHealth, bring to the Medicare enrollment experience. Through our proprietary enrollment technology, eHealth annually enrolls hundreds of thousands of Medicare beneficiaries in Medicare Advantage and Medicare Part D prescription drug plans – and we accomplish this with lower costs and higher user satisfaction than would otherwise be possible without private sector innovation. Through our websites

(eHealthInsurance.com; eHealthMedicare.com) and call centers, Medicare beneficiaries can get quotes from leading health insurance carriers, compare plans side-by-side, and apply for Medicare Advantage, Medicare Part D prescription drug and Medicare supplement coverage.

In general, eHealth supports many of the commonsense reforms in the proposed rule, which will improve the beneficiary experience, reduce unnecessary regulatory burden, and promote enhanced competition in the Medicare marketplace. In several cases, however, CMS has offered proposals which we believe will instead *increase* the burden on regulated entities and *harm* the beneficiary experience. We offer our comments on a number of these proposals below.

I. Reducing the Burden of Compliance Training Program Requirements (§§ 422.503 and 423.504)

eHealth strongly supports CMS' proposal to eliminate the requirement that plan sponsors provide compliance training to their first tier, downstream and related entities ("FDRs"). We appreciate the agency's recognition that existing compliance program operations and systems are well established – and that existing training and learning models exist to ensure FDR compliance with applicable fraud, waste, and abuse rules.

As CMS notes in the rule, despite previous, well-intentioned efforts by the agency to reduce the burden of compliance with existing training requirements by creating a single, standardized compliance program training module, many sponsors continue to not accept completion of the CMS training as fulfillment of the training requirements. As a result, each year, thousands of brokers must complete multiple, duplicative trainings, resulting in increased costs and reduce efficiencies. eHealth believes that the proposal – to eliminate any explicit training requirements but to still hold sponsoring organization responsible for compliance for all applicable requirements, including for their FDRs – strikes the right balance in protecting the program, while promoting competition in the program.

In addition to finalizing this proposed regulatory change, we also urge the agency to amend its existing rules under 42 C.F.R. § 422.2274(c) to eliminate the burdensome and duplicative training requirements for agents and brokers. Just as CMS recognizes in the proposed rule that the agency "does not generally interfere in private contractual matters between sponsoring organizations and their FDRs," we believe it is both consistent with agency policy and more pragmatic to defer to sponsoring organizations on the type and content of training provided to agents and brokers. Under current rules, our broker agents must annually certify with every Medicare Advantage and Part D prescription drug plan eHealth works with, resulting in each of our broker agents taking upwards of 35-40 different trainings from August through October each year. This process is time consuming, costly, and diverts resources that could otherwise be

focused on improving the consumer experience. In line with CMS' proposal to eliminate training requirements for FDRs, CMS should similarly eliminate any such requirement for agents and brokers.

Should CMS insist on maintaining a training requirement for brokers, we would urge the adoption of a universal training similar to the universal enrollment script currently filed by brokers with their lead carriers. Establishing a single, universal training would eliminate the need for multiple, duplicative trainings and significantly reduce the existing burden on carriers. For example, under current practice, brokers that no longer sell certain plan products are still required to go through the annual training requirements for that plan in order to receive recurring commissions. Such burdensome requirements would be eliminated with a universally accepted training.

II. Limitation on the Special Enrollment Period for LIS Beneficiaries With an At-Risk Status (§ 423.38)

In the proposed rule, CMS proposes to exercise its discretion under section 704(a)(3) of CARA to limit the availability of special enrollment periods ("SEPs") for dually- and other low income subsidy ("LIS")-eligible individuals who have been designated by their plan as potential at-risk beneficiaries. By law, LIS-eligible individuals are generally eligible for an unlimited number of SEPs throughout the year, unlike other Part D enrollees who generally are only eligible for enrollment during an annual enrollment period.

eHealth is concerned that eliminating the SEP-option for LIS-eligible individuals will cause significant market disruptions and a significant increase in consumer complaints from LIS-eligible individuals trying to switch plans. While we understand CMS's stated goal in protecting at-risk beneficiaries, we are concerned that the LIS-eligible population, as a particularly vulnerable one, often requires the SEPs available to them in order to navigate complex medical conditions and changing market conditions.

If CMS insists on moving forward with this proposal, we urge the agency to identify a solution for what otherwise promises to be a disruptive and dissatisfactory experience for at-risk beneficiaries seeking coverage during a SEP. Absent any identified solution, we anticipate assisting beneficiaries (whom eHealth is not able to pre-identify as at-risk) select new coverage, only to have that coverage later denied.

III. Prohibition on Marketing During the Open Enrollment Period

eHealth applauds Congress' creation of a new continuous open enrollment and disenrollment period (OEP) in the 21st Century Cures Act for MA and certain PDP members. We believe the creation of this new OEP reflects this Administration's focus on consumer choice and competition. Under the new

OEP, certain beneficiaries are granted a 3-month continuous open enrollment and disenrollment period, permitting these beneficiaries to select the right plan for their personal circumstances.

In general, eHealth believes that CMS should exercise its discretionary authority and extend OEP for all beneficiaries. We believe that choice – and options – drive the Medicare program and make it the success that it is. We are concerned, however, by CMS’ proposal to limit or eliminate marketing to this population during OEP.

As CMS is well aware, marketing often takes the form of educating beneficiaries about their options and their rights to change plans, or remain in their plan if they are satisfied. Restricting such marketing will effectively undo much of the “good” that was established under OEP, discouraging beneficiaries from exploring various plan options and selecting the plan that is best for them, and their families. eHealth strongly supports a policy which would allow marketing to all beneficiaries during OEP, including those beneficiaries eligible for OEP.

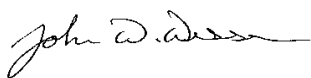
If CMS insists on putting in place restrictions, it must address the major concerns it has already identified in the proposed rule. In particular, it would be largely unworkable to limit marketing only to a subset of individuals who have not yet enrolled in a plan during OEP. One potential option is to only prohibit direct marketing communications to OEP beneficiaries, but permit broader communications including: television ads, general mailing campaigns, internet marketing, and radio ads.

IV. Changes to the Agent/Broker Compensation Requirements (§§ 422.2274 and 423.2274)

eHealth broadly supports CMS’ decision in 2014 to link payment rates for renewal enrollments to current Fair Market Value (FMV) rates, rather than the rate paid for the original (initial) enrollment. As noted in the proposed rule, the previous methodology was complicated to implement and monitor, and created perverse incentives in the system. We support CMS’ decision to codify technical changes to the language established by the 2015 IFR relating to agent/broker compensation.

As noted above, eHealth appreciates the opportunity to comment on this proposed rule. We would be happy to answer any questions you might have.

Sincerely,

A handwritten signature in black ink, appearing to read "John D. Desser".

Sr. Vice President Government Affairs and Public Policy