January 26, 2026

Administrator Mehmet Oz
Centers for Medicare and Medicaid Services
Secretary Robert F. Kennedy Jr.
Department of Health and Human Services

Re: Comment on the Medicare Program; Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program

Dear Administrator Oz and Secretary Kennedy:

The SCAN Foundation (TSF) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) notice of proposed rulemaking entitled "Medicare Program; Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program" (90 FR 54894). We appreciate your work on the notice, particularly given the competing demands on the agency.

The SCAN Foundation (TSF) envisions a society where all of us can age well with purpose. We pursue this vision by igniting bold and equitable changes in how older adults age in both home and community. Our grants and impact investments prioritize communities that have been historically marginalized with an emphasis on: older people of color, older adults with lower incomes, and older residents in rural communities. The SCAN Foundation is a public charity that operates with independent governance and leadership and advances its mission through nonpartisan policy analysis, research, and engagement focused on improving outcomes for older adults and caregivers

We appreciate the opportunity to offer comments in support of common goals to empower beneficiaries, support beneficiary choice, and create an improved Medicare Advantage (MA) program that serves American taxpayers while also balancing and reducing areas of administrative burden for plans and enrollees. This proposed rule includes many provisions that would revise regulations for the MA program (Part C) and the Medicare Prescription Drug Benefit program (Part D).

Our comments focus on the following proposals in the rule:

- Proposed Removal of requirement for mid-year notification for supplemental benefits
- Proposed Special Enrollment Period for Provider Terminations
- Proposed Removal of Certain Marketing and Advertising Requirements
- Proposed Rescinding of the Notice of Availability of language assistance services and Auxiliary Aids and services material
- Proposed Limited Income Newly Eligible Transition (LI NET) Program decreased hours

At TSF, we also strongly believe that policymakers must consider the experiences of older adults and people with disabilities who use the Medicare program to inform any policy changes. This is especially relevant for policies that may affect beneficiaries' ability to choose or remain in Medicare coverage that meets their needs. Incorporating lived experience into Medicare Advantage policymaking helps ensure that program changes reflect beneficiary circumstances and how they navigate coverage, access care, and maintain trusted provider relationships— supporting informed decisions.

TSF has long prioritized efforts to elevate beneficiary perspectives to inform policy discussions. Over the past several years, we have supported multiple initiatives designed to better understand how people experience aging, navigate Medicare, and interact with their Medicare Advantage coverage. We would welcome the opportunity to brief you on any one of these projects.

1. Just over three years ago, TSF, in collaboration with the Public Policy Lab, created The People Say, an online, publicly available, research hub that features first-hand insights from older adults and caregivers on the issues most important to them. This platform documents the lived experiences of over 140 older adults in 15 different states with the health care system. There are many interview segments from The People Say participants that illustrate the challenges some MA beneficiaries (including dual eligibles) encounter when trying to navigate their care and the barriers they face in getting trustworthy information to inform plan choice. For example, a People Say participant from North Carolina, Rose, has found it difficult to receive accurate information from MA plans about which providers are taking new patients, *"I think they [MA plans] should differentiate the providers that are taking new patients and the providers that are full. That would help reduce the number of phone calls to a few rather than stay on the phone and call 20 different providers that would help." Without accurate information, it makes it difficult for people like Rose to make the best decision for their health care needs. Videos and clips like the one from Rose are available publicly and we encourage you to listen to the experiences of these Medicare enrollees.*

2. A *Health Affairs Forefront* featured a series titled "Supplemental Benefits in Medicare Advantage," an effort to diversify the evidence base regarding supplemental benefits, and elevate how stakeholders, including enrollees, interact with these benefits. Key themes included:
    a. Challenges faced by MA enrollees, community organizations, and vendors who deliver MA services;
    b. Improving the supplemental benefits encounter data collection; and
    c. The intersection of MA supplemental benefits with Medicaid long-term services and supports
3. Lastly, in collaboration with the Medicare Policy Initiative at Georgetown University, we developed the *Medicare Advantage Advisory Group* – a first-of-its-kind advisory group that convenes MA enrollees, some of whom were interviewed for The People Say, from various regions across the country to share their experiences and recommendations for how to improve the program to better serve older adults. The advisory group treats these individuals as experts in the Medicare Advantage program, as they are the ones who actually have to use the program for their health care needs. They inform what it means to navigate the MA program's challenges and advise on its successes and failures firsthand in a way that policymakers in Washington, D.C. may not otherwise consider. The first meeting of this group was in early November 2025 and AG members provided many insights on their experiences with information gathering during open enrollment for the 2026 plan year. A webinar on January 14th features one of the advisory group members and a SHIP counselor responding to some of the proposed changes to the program.

In our comments about the rule provisions below, we will draw, primarily, from these three endeavors, as we aim to elevate the MA enrollee perspective by allowing their experiences and recommendations to inform some of the proposals in this rule. **Our comments generally focus on provisions we believe will directly impact enrollees' access to information, their ability to make informed and empowered decisions about their MA care, and/or their ability to utilize MA benefits effectively.**

Proposed Removal of requirement for Mid-Year Notification for Unused Supplemental Benefits (§§ 422.111(l) and 422.2267(e)(42))

CMS has proposed to remove the requirement for MA plans to provide a mid-year notification to their enrollees of any unused supplemental benefits that the enrollee is eligible for.

TSF CMS's concern that the notice may be considered an "unnecessary regulatory burden," but TSF believes that the intended benefit for beneficiaries would outweigh that burden. **TSF urges CMS to reconsider finalizing the proposal.**

In the proposed rule, CMS stated that these Mid-Year Notifications unnecessarily duplicate information from the standardized annual Evidence of Coverage (EOC) document. We do not believe that the Mid-Year Notice would be redundant to MA enrollees, as the notifications would be tailored to specific unused supplemental benefits that the enrollee is eligible for, rather than all benefits discussed in the EOC document received annually. Many of our MA Advisory Group participants knew exactly which benefits they wanted to use and how to use them when they joined the MA plan, but at least two members stated there were benefits they did not know were offered (such as the transportation benefit for appointments, the pharmacy, or a gym) until after at least a year later. Their learning about the other benefits were serendipitous in nature and, if not for the luck of speaking with a plan representative who happened to ask about that benefit, those individuals may never have been able to use the benefits they are entitled to, like the transportation benefit to travel to and from appointments, the pharmacy, or the gym.

CMS stated in the proposed rule that 70 percent of respondents in a survey reported using at least one supplemental benefit in the past year. However, using a single supplemental benefit is not a clear indicator that enrollees are utilizing all of the benefits they may require to achieve the highest level of health in a given plan year. Taking advantage of the full suite of benefits offered may improve overall health outcomes and enrollee satisfaction. TSF believes that MA enrollees would benefit from the Mid-Year Notification of Supplemental Benefits because the notification would inform enrollees when they have access to potentially crucial benefits they may need, but are unaware of, as evidenced by the MA Advisory Group. Having this information be clear and transparent is critical for older adults to understand what plan might work for them.

In addition to the MA Advisory Group testimonials, current evidence, including the evidence cited by CMS in the proposed rule, suggests that enrollees are not using supplemental benefits to the degree to which enrollees may gain the most utility from them. TSF's Health Affairs Forefront series focused on understanding the challenges, value, and utilization of MA supplemental benefits. This series consistently highlighted confusion among MA enrollees as to what benefits they can access, and the need for more, not less, transparency on how to access supplemental benefits, including any eligibility and time-limiting requirements of specific supplemental benefits.

Such an extension in the timeline would grant MA organizations more time to send out individualized messages of unused benefits, while still leaving ample time for enrollees to use those unused benefits.

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

We applaud CMS's proposal to revise the SEP for Significant Change in Provider Network and appreciates CMS's recognition of the patient–provider relationship to continuity of care. Currently, after a "significant" change in the MA plan's provider network, "impacted enrollees" are eligible for an SEP. Yet, this SEP only applies if CMS determines that the change in the MA plan's provider network is "significant" – a requirement that is currently subjective and undefined. The ambiguity in the determination of what constitutes a "significant" provider network change makes it difficult for enrollees and their loved ones to know when they can expect and use an SEP in this circumstance. The rule proposes to eliminate this requirement for CMS to determine whether the network change is "significant" in order for the SEP to apply to "impacted enrollees."

Enabling enrollees affected by any provider network change to qualify for the SEP without an overarching (and subjective) determination of "significant" provider network change by CMS or an MA organization will empower patients to seek the best care for themselves. Establishing, maintaining, and rebuilding trust with a new provider can be difficult, particularly for older adults and individuals with complex care needs. For instance, Daisy, an older adult from Iowa interviewed for The People Say, shared that trust is built through consistent listening and regular check-ins over time—an approach she finds deeply meaningful. When trusted provider relationships are disrupted, permitting enrollees to change plans can support meaningful choice and continuity of care.

As part of the *Medicare Advantage Advisory Group*, many of the participants stated that the top reason they decided to enroll in a new MA plan is because their previous provider was no longer in network. In some cases, enrollees learned of a provider's network termination mid-year when they tried to set an appointment for urgently needed care. They were unable to change their MA plan at the time to see their preferred provider who had previously ordered their lab tests due to CMS's existing policy. A clearly defined SEP to account for provider terminations would reduce these disruptions and help prevent avoidable delays or lapses in care.

As CMS considers pathways to operationalize this SEP, TSF raises that **if enrollees do not know that the SEP exists, they will not be able to use it effectively. TSF hopes that if CMS finalizes**

this provision, the agency would ensure that all enrollees are aware of when this important SEP is available to them and how they can use it. CMS must prioritize clear communication and notification of the SEP through various methods. For example, MA organizations could be required to notify enrollees if a provider they have an established relationship with is no longer in network. To do this, MA plans could notify anyone who has seen the provider within the last year. Ensuring insurer communication of a provider change would protect enrollees from disruptions in health care, such as those experienced by some MA advisory group participants, and require that MA plans better maintain accurate and timely provider directories.

CMS may also consider distributing to enrollees clear instructions, in multiple languages as needed, about the new SEP policy, including the steps an enrollee must take to use it. The instructions could include a clear phone number for enrollees to call and a website link with more information in accessible manner. CMS could also consider notifying all MA enrollees through a mid-year reminder that if their provider is no longer in-network, they could qualify for this SEP. In particular, almost all participants in the MA Advisory Group used the Medicare and You handbook as a key source of information. CMS may consider including, in a prominent location in the handbook, information regarding the policy change and step-by-step instructions for how to use this new SEP, if CMS finalizes the proposal.

Proposed Removal of Certain Marketing and Advertising Requirements

In the rule, CMS proposed several different changes to marketing and advertising requirements. These include updating third-party marketing organizations (TPMOs) disclaimer requirements, removing various rules on time and manner of beneficiary outreach, and relaxing the restrictions on language advertising.

Regarding the proposal to remove references to State Health Insurance Assistance Programs (SHIPs) from TPMOs' disclaimer messages (§§ 422.2267 and 423.2267)
In CMS's proposal to remove references to SHIPs from TPMOs' disclaimers, CMS cited a lack of expertise as a key reason they should not be included. CMS also acknowledged SHIPs as a key source of unbiased information about plan choices. In our MA Advisory Group, participants highly prioritized unbiased, trustworthy information for evaluating MA plan options. Advisory Group **participants who used a SHIP counselor expressed greater satisfaction with the SHIP counselor than with any agents or brokers they used, citing agents' biased and incomplete offerings.** Several MA Advisory Group members stated that they only found out an agent was

limited in their sales offerings because they, as an enrollee, took initiative to speak with multiple different agents and/or consult Medicare.gov, where they learned about new plan offerings and found out their agent/broker was not providing them with all the options in their area.

MA Advisory Group members who used a SHIP counselor were at least as satisfied with their SHIP counselor's knowledge and expertise, compared to enrollees who only used agents and brokers to learn more about MA plans. A few MA Advisory Group members who only used an agent or a broker even expressed that they wished they knew about SHIP counselors when evaluating plan options. Our Advisory Group members' experiences suggests that not all advisory group members were aware of SHIP counselors – even those who used agents and brokers. Almost all advisory group members used an agent or broker at some point in their MA shopping process, and yet, several had no idea that the agents and brokers only sold a limited number of MA plans until they were in conversation with other MA enrollees, such as during the group meeting.

One of the key issues raised by the advisory group members is how complicated it is to shop for an MA plan. Many MA Advisory Group members acknowledged the utility and importance of having agents and brokers in their decision-making process – TSF also acknowledges the important and oftentimes positive role agents and brokers play in helping MA enrollees make informed and empowered decisions about their MA plan. We have seen participants from the People Say voice strong satisfaction with their individual broker. At the same time, however, MA Advisory Group members wished that it was made clearer to them that there were other options beyond what their agent and broker mentioned to them, and **they wished there was more access to unbiased sources of assistance that present the full range of options in a way that helps enrollees select the plan that is truly best for them.**

Regarding Proposed changes to beneficiary outreach, time and location of marketing events following educational unaffiliated events

Convenience is an important priority for many MA enrollees. TSF appreciates CMS's intention to alleviate burden on MA enrollees by proposing to enable educational MA events and sales/marketing efforts to occur in the same location without a "cooling off" period in between. TSF also understands CMS's recommendation to remove similar time constraints on Scope of Appointment documents. However, TSF would like to raise concerns that removing such beneficiary protections may result in marketing tactics and behaviors which previously raised concerns for CMS and MA enrollees alike.

CMS noted particular attention to the benefit this proposal would have on lower income, dually-eligible beneficiaries, and underserved populations, especially if they have trouble accessing transportation to attend educational and marketing events. But, these same populations may also feel the most pressure to sign up for a plan at these events without a cool down period, even if taking more time to think about other plans might be in their best interest. This can be due to a combination of their financial vulnerabilities, the complexity of coverage options, and specific high-pressure tactics that can be used by marketers in-person. As recently as 2023, there were many reported instances in which dually-eligible beneficiaries had their Medicaid-related coverage complicated due to inappropriate plan changes because of aggressive tactics by agents and brokers. CMS has also reported a sharp rise in marketing-related complaints, noting in the 2023 Part C rule that complaints more than doubled between 2020 and 2021.

TSF urges CMS to delay this decision to finalize this proposal, until the release of an U.S. Health and Human Services Office of Inspector General (OIG) report regarding deceptive and misleading sales practices by agents and brokers. TSF urges CMS to consider the findings and recommendations in this pending report to inform a decision on this matter in future rulemaking.

The proposed changes have the potential to create confusion for current beneficiaries and potential MA enrollees. For this reason, TSF asks that, if CMS chooses to finalize these proposals, that **CMS consider modifying the provision to require MA plans and agents/brokers to clarify verbally (or with a signature acknowledgement) that potential enrollees understand they do not need to commit to or enroll in an MA plan during a marketing events, particularly those following educational events.**

TSF appreciates CMS's decision to include a requirement that plans and agents/brokers must notify the beneficiary that the educational event is ending and a marketing event will begin shortly. However, **TSF urges CMS to consider providing a clear definition of what would constitute a "sufficient opportunity to leave" in regulation or sub-regulation, as the ambiguity that exists currently may not be sufficient for agents and brokers to follow in a standard way and could lead to confusion for beneficiaries and potential enrollees.**

Regarding the Proposed Changes to MA Plans' use of Superlatives

TSF has concerns about the proposal to remove the policies described at §§ 422.2262(a)(1)(ii) and 423.2262(a)(1)(ii). These regulations specify that MA plans and their downstream entities must

comply with the overarching rule to not mislead, confuse, or provide materially inaccurate information to current or potential enrollees. Regulations at §§ 422.2262(a)(1)(ii) and 423.2262(a)(1)(ii) provide clear specifications for MA organizations and Part D plans to follow when they choose to use a superlative in their advertising and marketing materials. In particular, they prohibit the use of superlatives without sources of documentation or data being referenced in the advertisement or marketing material and clarify that such data or documentation must be from the current or prior contract year.

Currently, enrollees can trust that any superlatives they see on MA and Part D advertisements or marketing materials have come from either the current or prior contract year's data, because MA plans must include a clear reference to the data or documentation that supports the claim. While TSF acknowledges CMS's assertion that MA organizations must still generally adhere to the prohibition of using misleading, confusing, and inaccurate marketing and communications materials, **we are concerned that part of what makes this regulation effective is its clear and distinct specifications of what is considered misleading, confusing, and inaccurate.**

Removing these regulations could create ambiguity in the use and development of superlatives, potentially creating confusion for beneficiaries about how recent the data supporting the superlative is. This lack of clarity could require beneficiaries to take additional steps to determine which contract year a superlative is based on. As a result, the change may increase the burden on enrollees or create the potential for misunderstanding about whether a claim reflects current or prior-year performance. For these reasons, TSF urges CMS to consider the potential beneficiary impacts before finalizing this proposed change.

Should CMS choose to finalize this proposal, CMS should consider including in sub regulatory requirements that plans must disclose the contract year for which the data or documentation supporting the superlative claim derives from. Such a requirement would support beneficiaries to be fully informed consumers and understand from which year the superlative claim is derived from, saving beneficiaries, or their loved ones, time and effort in doing supplemental research to figure out such information for themselves.

Proposed Rescinding of the Notice of Availability (NOA) of language assistance services and Auxiliary Aids and services material

CMS has proposed to remove certain regulations related to which types of communication must include a notice of availability of language assistance services and auxiliary aids and services material (Notice of Availability). At 42 CFR 422.2267(e)(31), CMS allows MA plans to disseminate a

standalone, general Notice of Availability that clarifies all the items for which language assistance and auxiliary aids can be requested. CMS makes clear that, "When mailing multiple required materials together, only one [NOA] is required." In adding these specifications, CMS actually reduces the burden on MA plans because, unlike the Office of Civil Rights (OCR) regulations CMS refers to in this proposed rule, which requires the Notice of Availability to be included in all listed electronic and written communications.

Therefore, the removal of 42 CFR 422.2267(e)(31) may unintentionally remove CMS's unique to sent alongside multiple required documents. This may result in much larger amounts of mail and redundancy for both MA enrollees and MA plans. Although many enrollees stated that the information in required mailings were crucial to their understanding and decisions about MA plans, a few enrollees in the MA Advisory Group also expressed frustration with overwhelming amounts of repeat mail and communication. Maintaining existing requirements would ensure the NOA is only sent once within groupings of required notifications and would alleviate some of the burden of overwhelm without withholding crucial information for enrollees. As previously discussed, reminders and notifications are crucial for enrollees to utilize benefits they are entitled to. The current CMS requirement to have one NOA standalone reminder with each instance of communication, unless an enrollee indicates they do not want that reminder anymore, is crucial to ensure access to all enrollees.

Additionally, TSF is concerned that the OCR regulation does not include the 5 percent service area threshold for translation, as the current CMS regulation does. The ability to read about and evaluate MA plans is crucial to maintaining an informed consumer base. Enrollees, even those with limited English reading proficiency, are a part of that MA consumer base. Seven percent of Medicare beneficiaries living in the community had limited English proficiency in 2023. This is a significant amount of MA enrollees that may not be able to make informed decisions without receiving an NOA in their language, especially if their preferred language exceeds the 5% threshold in a county, but is not one of the 15 languages most commonly spoken by the state.

TSF urges CMS to reevaluate whether OCR's less-specific regulations may result in fewer NOAs accompanying required MA plan communications. OCR regulations at 45 CFR 92.11(c)(5) include two key categories of written or electronic communications that must include an NOA of language assistance services and auxiliary aids and services: "Notices of denial or termination of eligibility, benefits or services, including Explanations of Benefits, and notices of appeal and grievance rights" and "Communications related to an individual's rights, eligibility, benefits, or services that require or request a response from a participant, beneficiary, enrollee, or applicant."

This regulation covers broad categories that cover some items CMS currently requires MA plans to include NOAs for at 42 CFR 422.2267(e). However, some important items may still not be included because of the regulation's more ambiguous language. It seems certain important documents and communications may not be included under OCR's regulatory language. It seems that the Mid-Year Change Notifications, Star Ratings Document, and Federal Contracting Statement are some examples of important items that may not be included under OCR's regulatory language.

Proposed Limited Income Newly Eligible Transition (LI NET) Program decreased hours (§ 423.2536)

The SCAN Foundation recognizes that decreasing the hours required for the LI NET program is an opportunity to deregulate and reduce Part D program spending. Total Medicare spending in 2024 surpassed $1.1 trillion. While certain actions should be taken to lower Medicare spending and support sustainability of the Medicare program, the savings generated by waiving the requirements at 42 CFR 423.128(d)(1)(i)(A) specifying the LI NET necessary business hours would amount to approximately 0.000001 percent of annual Medicare spending. Shortening the required available hours for the customer call center by one hour daily removes the convenience for potential beneficiaries who may have less flexible schedules. Moreover, including the Eastern Time (ET) specification as proposed by CMS is concerning because it could have a disproportionately negative impact on all prospective LI NET beneficiaries not in the Eastern Time Zone. Ultimately, any reduction in hours and availability has the potential to diminish prospective enrollees' ability to learn more and get support at a time that is convenient for them. **For these reasons, TSF urges CMS to reconsider finalizing the proposal to reduce the LI NET customer call center hours.**

Proposed Dual-Special Needs Plans (D-SNP) related changes

The SCAN Foundation expresses support for CMS's initiative in the "Request for Information on Dually Eligible Individual Enrollment Growth in C-SNPs and I-SNPs." Given the challenges many people in our The People Say research project faced in coordinating their Medicare and Medicaid care, we believe this is a timely and important RFI for CMS. Esme from North Carolina said it well, *"I'd like to see [Medicare and Medicaid make] it easier to maneuver the paperwork for people like me, where you don't have to go every time to the computer."* Older adults want to make it easier to access the care they need. With that shared goal in mind, TSF looks forward to seeing the responses to this RFI.

Conclusion

The SCAN Foundation appreciates your consideration of these issues. We value the ongoing collaboration between CMS and TSF on Medicare Advantage policy, particularly in what proposed changes mean for beneficiaries based on their shared lived experiences and recommendations for policy improvement. We look forward to continuing this relationship and would be pleased to serve as a resource to CMS, including sharing insights from our work with older adults and community partners or responding to any questions that may be helpful as policies are refined.

Sincerely,

Sarita A. Mohanty, MD, MPH, MBA
President and CEO
The SCAN Foundation