

National Association of Benefits and Insurance Professionals (NABIP) Summary for the White House Office of Management & Budget Regarding CMS-4205-P (the “Proposed Rule”)

March 20, 2024

For over forty-years, Field Marketing Organizations (FMOs) have played a critical role in the Medicare insurance marketing ecosystem. Services provided by FMOs are the foundation upon which independent insurance agents are empowered to assist seniors with the challenging task of selecting the best Medicare Plan to meet their needs. Among other key services, FMO’s provide independent agents with:

- Quoting and enrollment tools;
- Back-office support;
- Training;
- Compliance resources;
- Carrier contracting support, including increased access to carriers;
- Call-recording technology;

NABIP and its FMO members share in CMS’ desire to ensure that independent agents act in the best interest of the American seniors they serve. However, if the Proposed Rule is adopted without change, there will be serious and unintended consequences, which are likely to include increased costs, lower service levels, and less choice for seniors.

The Proposed Rule eliminates “administrative payments,” the way in which FMOs are compensated by carriers for the provision of these needed services. The Proposed Rule is unclear as to whether the elimination of such payments is applicable to FMOs. If this ambiguity is not resolved, beneficiaries would be seriously impacted. Specifically, the elimination or reduction of the role of FMOs would result in:

- Adverse impact to consumer choice, as carriers would need to hire “captive agents” to sell their products;
- Decreased ability of seniors to obtain objective information concerning multiple plans;
- Increased plan-switching and complaints due to lack of objective plan comparison information at time of sale;
- Increased cost to carriers to develop infrastructure currently provided by FMOs, which would be passed to consumers in increased premiums and out-of-pocket costs;
- Decreased competition in development of innovative technology (i.e. quoting and enrollment tools)
- Degradation of compliance services, including call recording and marketing review;

CMS should engage experts, and collect and analyze additional data, to understand the implications that Proposed Rule would have upon seniors, particularly those in underserved populations. At a minimum, CMS should conduct substantive analysis of the following important data points:

- Complications faced by today’s seniors in attempting to select the best Medicare Advantage Plan;
- High levels of satisfaction expressed by seniors to work with independent insurance agents (supported by FMOs) to navigate these choices;
- Consumer-reported information regarding their independent agents’ compliance with CMS Rules;
- Lower rates of plan switching that exist when independent insurance agents provide options from multiple carriers;
- Costs that would be incurred by carriers to recreate independent agent network and/or the full complement of FMO services and technology, including call recording & storage services;

- Impacts that reversion to a carrier-based captive-agent distribution model would have upon seniors' access to local agents, particularly in low-income, underserved and rural areas;
- Impacts to consumer choice and out-of-pocket costs that would result from reversion to a carrier-based captive-agent distribution model;
- HRA time requirements and related quality for a 20-minute assessment, given many states' minimum wage is above the \$12.50 threshold.

Easily-accessible data exists to aid in assessing many of the above-noted factors, including:

- **AEP Gut Check Survey, 2023** (Deft Research)
- **A Relatively Small Share of Medicare Beneficiaries Compared Plans During a Recent Open Enrollment Period, November 2022** (Kaiser Family Foundation)
- **Exploring Age Groups in the 2020 Census** (United States Census Bureau)
- **Medicare Advantage Industry Voluntary Lapse Rates & Total Termination Rates for Call Center Distribution Models – 2023** (Telos Actuarial)
- **Medicare Member Experience Survey, December 2023** (Deft Research)
- **Medicare OEP and Disenrollment Prevention Study, 2023** (Deft Research)
- **Medicare Shopping and Switching Survey, December 2022** (Deft Research)
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Additionally, CMS should consider important differences between FMOs and other Third-Party Marketing Organizations (TPMOs), such as lead aggregators, who engage in aggressive marketing tactics that confuse seniors. In stark contrast to other Third Party Marketing Organizations, FMOs are:

- Contracted and certified with, and audited by, carriers;
- Required to be licensed with the Departments of Insurance in every state in which they do business;
- Regulated by each state Department of Insurance under which they are licensed;
- Required to appoint a Designated Responsible Licensed Producer, who themselves are licensed, and register that person with each state where the FMO does business
- Defined as “FDRs” with CMS, which means they are a First Tier, Downstream or Related Entity that provides health or administrative services for an enrollee. FDRs are held to very specific compliance-related requirements, and are subject to audit by CMS and First Tier entities (such as carriers);

Left unresolved, the ambiguities in the Proposed Rule will have a chilling effect on the Medicare marketplace that will result in reduced services for seniors in need of support. There is palpable concern that the current language would have the effect of eliminating administrative payments to FMOs, or severely limiting those payments.

Throughout the Proposed Rule, CMS stresses the need to address anti-competitive practices; however the elimination of the role of the FMO would have the opposite effect. Without a wide network of FMOs, there would be a centralization of services with carriers; and thus an elimination of the competitive incentive to innovate, improve, and provide low-cost services to the agents who service American seniors.