National Association of Benefits and Insurance Professionals
NABIP
Shaping the *future* of healthcare

November 15, 2023

The Honorable Frank Pallone, Jr.
2107 Rayburn House Office Building
Washington, DC 20510

The Honorable Richard Neal
2309 Rayburn House Office Building
Washington, DC 20510

The Honorable Chiquita Brooks-LaSure
Administrator, Centers for Medicare and Medicaid Services
200 Independence Avenue SW
Washington, DC 20024

Dear Ranking Members Pallone and Neal and Administrator Brooks-LaSure,

I am writing on behalf of the National Association of Benefits and Insurance Professionals (NABIP) – a professional association representing over 100,000 licensed health insurance agents, brokers, general agents, consultants and employee benefits specialists – to clarify the significant and essential role that our members and Field Marketing Organizations (FMOs) have in the Medicare market.

The members of NABIP help millions of individuals and employers of all sizes purchase, administer and utilize health plans of all types, including Medicare plan options, as servicing agents. The marketplace is highly regulated at both the state and federal level and agents spend many hours maintaining their continuing education (C.E.) certifications every year and learning about the insurance coverages they present to their clients. Medicare is a referral business, and agents build their book of business by providing excellent service. That book of business is their retirement nest egg so it is in their best interest to always provide the best service to the beneficiary, who can change their Agent of Record at any time. Servicing agents handle claims issues or anything beneficiaries need related to their health benefits for the entire plan year.

Many agents working with seniors are the most experienced agents in the business and are sometimes close in age to the Medicare beneficiaries they serve. Providing outstanding customer service that is tailored to each individual beneficiary is in the best interest of every agent. Individuals qualifying for Medicare at age 65 typically have three months before their 65th birthday, their birthday month, and three months following their birthday month to explore their options and make choices. Thereafter, they can change their choice annually during the Annual Enrollment Period (AEP), which is underway now.

Because of the complexity of the plan-selection process, many beneficiaries rely on licensed and certified insurance agents to help them identify the coverage and benefits options that best meet their needs. Independent agents assist Medicare beneficiaries with the best options available to them, which may include Medicare supplements, Medicare Part D and Medicare Part C, known as Medicare

Advantage. During the 2021 AEP, 31 percent of surveyed MA beneficiaries relied on brokers, as did 30 percent of those picking a traditional plan.[1]

When consumers are considering their Medicare plan options or are looking for specific drugs and services to be covered, there is no greater resource than a licensed agent or broker. Brokers educate clients on how Medicare works (both broadly and in conjunction with other coverage options), research physician networks and prescription formularies for the plans to ensure a suitable health and drug plan is recommended, and review plan-comparison and enrollment changes annually. Since agents tend to work with seniors in their community, they often know which pharmacy works best and know the local provider networks.

By taking the time to understand the unique requirements and preferences of each beneficiary, agents offer tailored solutions and answer any questions a beneficiary may have. This personalized interaction not only simplifies the decision-making process but also addresses individual concerns, making beneficiaries feel valued and understood. Independent agents are also almost always members of the same communities that their clients live in. Above all else, Medicare agents offer a human connection and empathetic understanding of a beneficiary's position, thus providing comfort during a time many seniors find stressful.

Since 2009, CMS has set annual limits on per-enrollee Medicare broker commissions. For plan year (PY) 2024, the fees are capped at $611 nationally for initial enrollment and $306 (50 percent of fair market value) for renewals. It has been asserted that MA plans are regularly circumventing CMS commission caps by paying brokers for marketing, recruitment, customer service and other related services. This alleged total broker compensation can amount to $1,300 or more. However, the belief that the difference between $611 and $1,300 is going directly into the independent agent's pockets is based on a fundamental misunderstanding of how agencies and FMOs operate.

The overwhelming majority of Medicare agents contract with at least one FMO; over half of agents contract with two or more FMOs. FMOs are the same as General Agents (GAs) in the commercial market, and this market efficiency has been carried over to the Medicare market. This is because FMOs serve as a necessary intermediary between agents and carriers that offer MA and MAPD plans. FMOs operate as variable cost sales offices working on a contracted basis with multiple carriers. The organizations provide a wide variety of services that empower agents and their clients, from handling contracting and credentialing processes to helping agents navigate the regulatory environment. For example, many small independent agencies would not be able to fully comply with recent call-recording requirements without FMO assistance, since they do not possess the proper technology to comply with the rule.

This fact is explicitly acknowledged by CMS in the recently released Contract Year (CY) 2025 Policy and Technical Changes proposed rule. In their draft provisions to restructure Medicare agent and broker compensation, CMS recognizes the importance of these administrative fees, stating that "this leaves agents and brokers unable to directly recoup administrative costs such as overhead or lead purchasing

[1] Leonard, Faith. "Traditional Medicare or Medicare Advantage: How Older Americans Choose and Why." *The Commonwealth Fund*. 17 October 2022.

from its compensation from Medicare health and drug plans, unless the agent has a certain volume of business."

In addition to these services, FMOs provide agents: contracting and licensing support, carrier certifications, Fraud, Waste and Abuse (FWA) certification, errors and omissions (E&O) insurance, C.E. credits, product training, business planning, plan service support, technology troubleshooting and more. Without an FMO to provide these services, carriers would have to either take on these responsibilities directly or find alternative distribution channels. This shift could lead to changes in administrative expenses, including MLR calculations. All of this would likely lead to increased premiums at a time when one in five adults aged 65 and older are already struggling to afford their premiums.[2]

FMOs and insurance carriers choose which entities to work with based on a variety of reasons. For example, a regional FMO may not choose to contract with a small plan because the FMO seeks to represent all plans in its region. FMOs may also consider factors like a carrier's star rating or technology capabilities. Some carriers, on the other hand, choose not to contract with large national FMOs because they only want to work with local agencies.

It has also been alleged that a significant number of independent agents are intentionally steering seniors onto more costly national plans. However, a recent NABIP survey of over 1,600 Medicare agents conveyed that 60 percent of agents sell both national and regional plans, with nearly one-third of respondents selling only regional plans. FMOs also connect agents with regional plans that agents may not have been aware of previously, with 60 percent reporting that they only learned about the availability of a regional plan through an FMO.

It is relatively common for Medicare Advantage enrollees to switch between different Medicare Advantage plans or between Medicare Advantage and traditional Medicare; this trend is known as churning. Between 2012 and 2017, 15 percent of new MA enrollees changed insurance within one year after enrollment, and 49 percent had changed insurance within 5 years.[3] Churning is not caused by steering practices, but can happen for various reasons – such as changes in health needs or changes in plan benefits and formularies.

In addition to the points raised in this letter, NABIP intends to submit further comments to CMS that elaborate on the proposed rule in greater depth. Our goal is to ensure that legislators and regulators possess a thorough understanding of how agents and FMOs serve the best interests of the beneficiary. Like CMS and the members of Congress addressed in this letter, NABIP wants to protect the vulnerable senior population from the unscrupulous actors in our healthcare system. Independent agents serve beneficiaries across the country as trustworthy advocates who provide accurate and ethical guidance. Ultimately, without licensed and certified agents assisting in enrollments, Medicare beneficiaries will have few choices in finding accurate enrollment assistance and will be led directly to the bad actors that the federal government seeks to protect them from.

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[2] Leonard, Faith. "Medicare's Affordability Problem: A Look at the Cost Burdens Faced by Older Enrollees." *The Commonwealth Fund*. 19 September 2023.
[3] Dong, Jeffrey. "Turnover Among New Medicare Advantage Enrollees May Be Greater Than Perceived." *The American Journal of Managed Care.* October 2022.

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If you have any questions about our comments or if NABIP can be of assistance as you move forward, please do not hesitate to contact me at jgreene@nabip.org or (202) 595-3677.

Sincerely,

John Greene
Senior Vice President of Government Affairs
National Association of Benefits and Insurance Professionals (NABIP)