January 5, 2024

Via Federal eRulemaking Portal at www.regulations.gov

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4205-P
P.O. Box 8013
Baltimore, MD 21244

RE: Proposed Rule – Medicare Program; Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications (CMS-4205-P)
(the "Proposed Rule")

Dear Administrator Brooks-LaSure:

On behalf of the National Association of Insurance and Financial Advisors ("NAIFA"), I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule captioned above regarding the Medicare Advantage and Medicare Part D programs.

Background and Executive Summary

Founded in 1890 as The National Association of Life Underwriters, NAIFA is the oldest, largest, and most prestigious association representing the interests of financial professionals from every Congressional district in the United States. Our mission – empowering financial professionals and consumers with world-class advocacy and education – is the reason NAIFA has consistently and resoundingly stood up for agents and called upon members to grow their knowledge while following the highest ethical standards in the industry.

NAIFA members are Main Street financial professionals. NAIFA members—comprised primarily of insurance agents, many of whom are also registered Broker-Dealer representatives—serve primarily middle-market clients, including individuals and small businesses. Nine out of ten NAIFA members report serving middle-income individuals and families and 67 percent work with small businesses. A typical client's annual household income falls below $150,000 for 69 percent of NAIFA members. In some cases, our members are the only financial advisor across multiple

counties.

NAIFA members are also small business owners. Many of our members work in small firms—sometimes firms of one—with little administrative or back-office support. Often, their business practices are dictated by the broker-dealer with whom they work, including the format and provision of client forms and disclosures. They are also subject to transaction-level oversight and review by the broker-dealer.

NAIFA members 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. NAIFA members participate in classes that agents are required to complete to maintain their professional license on topics such as compliance, ethics, plan designs, and regulation changes mandated by CMS, STARs Ratings, actuarial/underwriting rules for Medicare supplements and much more. Servicing agents handle claims issues or anything beneficiaries need related to their health benefits for the entire plan year.

Providing outstanding customer service that best serves each individual beneficiary is in the best interest of every agent. Due to the difficulty and complexity in deciphering many aspects 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. 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 (MA). According to a study conducted by the Commonwealth Fund during the 2021 annual enrollment period, 31 percent of surveyed Medicare Advantage beneficiaries relied on agents and brokers, as did 30 percent of those picking a traditional plan.[1]

There is no greater resource than a licensed agent or broker for consumers that are considering their Medicare plan options or are looking for specific drugs and services to be covered. Agents and 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.

Agents and brokers tailor solutions specifically to their beneficiaries while also answering any questions that might arise. For the beneficiary, this serves to simplify the decision-making process while addressing individual concerns, making beneficiaries feel valued and understood. Medicare agents provide that personal touch, that allows their clients to feel respected and valued.

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

Agent Compensation Adjustment

The proposed national agent/broker fixed compensation amount for MA is $642. This is an increase of $31 over the existing national compensation cap of $611, which CMS has stated would eliminate the current variability in payments and improve the predictability of compensation for agents and brokers. This cap on agent and broker compensation applies regardless of the plan a beneficiary enrolls in. This new cap would encompass all payments that plans can pay agents and brokers. This proposal would generally prohibit insurers from paying volume based "bonuses" to third-party marketing organizations (TPMOs) now defined to include any field marketing organizations (FMOs) or individual, including independent agents and brokers.

The current compensation regulation allows for payments other than compensation so long as the amounts "are at or below the value of those services in the marketplace" or at fair market value. CMS registers concern in the proposed rule that "when the value of administrative payments offered to agents and brokers reaches the levels that CMS has observed in recent years, these payments may distort the process that agents and brokers are expected to engage in when they assist beneficiaries in weighing the merits of different available plans."

Determining fair market value generally considers factors such as publicly available economic and healthcare industry data; U.S. Bureau of Labor Statistics wage data; publicly available research and market data for companies involved in the same or similar lines of business; discussions with and documents provided by management pertaining to the services being valued; and the professional experience and judgment of a credentialled individual or entity.

The proposed rule does not cite any quantitative data or analysis to indicate that CMS has undertaken a market review to assess whether the payments that exist in the MA market are in fact concerning, or whether they reflect the fair market value for the services undertaken to administer value-added programs necessary for the consumer-focused sale of MA plans. A cap on fair agent and broker compensation has the potential to drive certain agents out of the MA market, which in turn would lead to a lack of education and choice for beneficiaries.

Revised Definition of Compensation

The proposed rule makes amendments to §422.2274(d)(2) requiring all payments to agents or brokers that fall within the following categories to be included under the regulatory definition of "compensation" and be regulated by the compensation requirements: (1) payments tied to enrollment; (2) payments related to an enrollment in an MA/PDP plan or product, or; (3) payments that are for services conducted as part of the relationship associated with the enrollment into an MA/PDP plan or product. These caps on compensation payments would be changed to reflect rates

that would be paid by all plans.

CMS has cited a host of potential issues regarding agent and broker compensation within the proposed rule, including voicing concern that the lack of a uniform compensation standard across plans can encourage the types of arrangements that provide strong financial incentives for agents and brokers to favor some plans over others and that these incentives could result in beneficiaries enrolling in plans that do not best fit their needs. While CMS cites a few examples obtained from unspecified locations, such information should not be a substitute for the body of evidence that could be available by gathering information from agents and brokers. NAIFA members could provide evidence that would demonstrate most agents and brokers are focused on helping consumers select the plan that best fits their needs and circumstances. Although CMS cites examples of bad actors in the industry, there is no evidence presented that would indicate this practice is widespread. Ultimately, this one-size-fits-all approach punishes agents and brokers that have dedicated years of service to ensuring their clients receive the best guidance available.

Administrative Payments

The proposed rule includes substantial changes to §422.2274(e) regarding payments other than compensation. CMS proposes to: (1) modify (e)(1), which currently provides that "payments made for services other than enrollment of beneficiaries (for example, training, customer service, agent recruitment, operational overhead, or assistance with completion of health risk assessments) must not exceed the value of those services in the marketplace", to sunset after 2024; (2) replace the current language in (e)(2), which states that "administrative payments can be based on enrollment provided payments are at or below the value of those services in the marketplace", with language indicating that starting in 2025 "administrative payments are included in the calculation of enrollment-based compensation."

Based on CMS' dismissal of the importance of administrative payments, there appears to be a lack of understanding or appreciation of the way most agents, brokers, general agencies, field marketing organizations, and other TPMOs function in the market. CMS risks discounting the value to consumers provided by having multi-carrier options in existence. Due to the competitive forces imposed by the market, such value-added multi-carrier alternatives are constantly developing new, data-driven technology to better support consumers as they shop for the best health care plan available to them.

As consumers shop, enroll, and access their benefits throughout the year, agents and brokers are on standby to answer key questions, enable plan usage, and monitor evolving consumer needs. NAIFA is deeply concerned that CMS's proposed rule will have the effect of eliminating administrative payments to FMOs. This would lead to serious disruption in our healthcare industry and increased costs to beneficiaries in America.

FMOs work impartially with hundreds of insurance companies and a large network of independent agents across the United States to allow for consumers to have access to a wide variety of choices when it comes to their health care needs. NAIFA believes that a well-informed consumer and a well-informed, service and compliance-focused agent – with access to numerous competitive plans to choose from and the ability to leverage technology to learn about and help advise on the right plan that best fits the consumer's individualized needs – is the formula for success. There are so many complexities involved in making, often for the first time as a beneficiary, vitally important health care decisions. FMOs simplify that process for agents, and ultimately consumers, by serving as critical intermediaries between insurance companies and millions of independent insurance agents across the country who work with their clients throughout the year to ensure they purchase the right Medicare coverage for their personal and financial needs.

FMOs are proven to be cost-effective and expert providers of numerous outsourced functions across the insurance industry. As a result, insurance companies have been able to fix their costs for administrative outsourced services, which has helped them manage their cost structures and keep costs down for the American consumer. FMOs allow agents to compare coverage options for their clients, taking into account a plan's available doctors, premiums, and prescription drug options to help ensure their client selects the health plan that is truly in their best interest. Without FMO-provided technology and services, independent agents and consumers would be left to their own devices to understand the complex differences between available plans in a consumer's geographic area. In addition, without FMO services paid for by insurance companies, agents and brokers would experience higher costs to run their businesses, and consumers would experience higher premiums from insurance companies passing on their increased costs to consumers. CMS's elimination of separate administrative payments under its proposed rule could have the effect of eliminating fair fees paid by insurance companies to FMOs.

Should the rule be finalized as proposed, many agents and brokers are unlikely to continue to provide consumer-focused, value-added administrative services without any payments to fund such efforts, potentially affecting over 6 million current individual MA beneficiaries[2]. This same phenomenon would have negative effects on agents and brokers' ability to provide the expert level of advice that consumers deserve. The proposed rule as written could also lead to a reduction in agent and broker access to MA plan options to offer and will increase their costs and burden in developing the knowledge and functionality to assist consumers shopping for plans available in their area – in other words, it will make it harder for agents to sell MA plans, and increase the likelihood that consumers do not receive all the information they need to make informed decisions about their health care, reducing rather than increasing market competition and choice.

[2] *See Medicare Advantage in 2023: Enrollment Update and Key Trends* at https://www.kff.org/medicare/issue-brief/medicare- advantage-in-2023-enrollment-update-and-key-trends/; *FierceHealthcare article* at https://www.fiercehealthcare.com/payers/commonwealth-fund-survey-most-use-brokers-and-agents-pick-medicare-plans

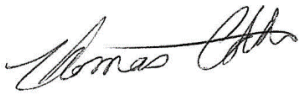
Conclusion

NAIFA recommends that CMS reconsider this proposed rule in its entirety. In the alternative, I encourage CMS to consider a more collaborative engagement with us, health plans, and others in the industry to develop relevant data to better assess the current state of the market and more carefully consider potential regulatory changes for future release.

***

Thank you for your consideration of our submitted comments. If you should have any questions or require additional information, please do not hesitate to contact Michael Hedge, NAIFA's Senior Director of Government Relations at mhedge@naifa.org.

Sincerely,



Thomas M. Cothron, LUTCF, FSCP
President
National Association of Insurance and Financial Advisors