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DEFT RESEARCH SPECIAL EXECUTIVE RESEARCH BRIEF

The Value of the Health Insurance Agent/FMO Model

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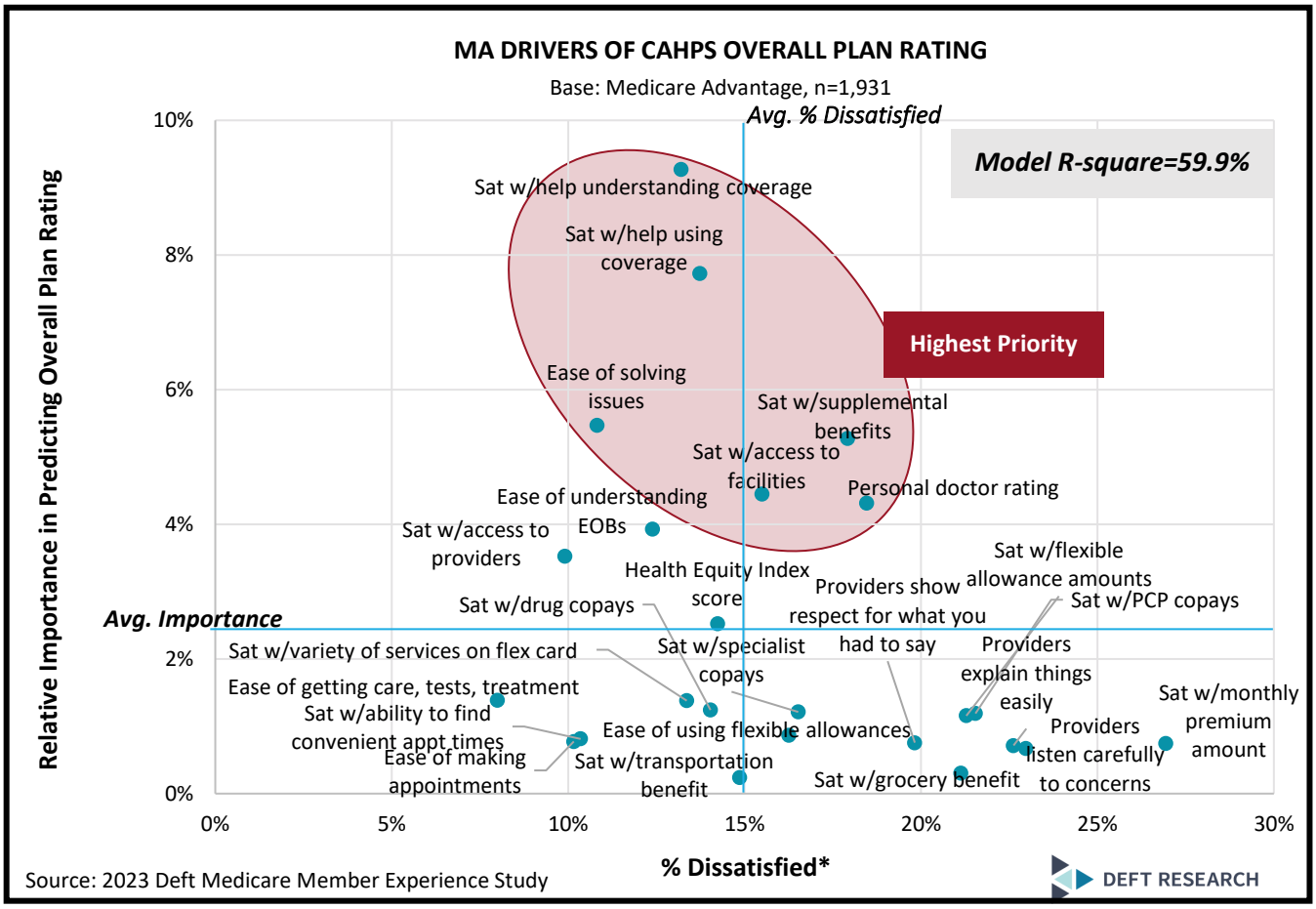
Recently, the economics associated with the current health insurance agent/FMO model have come under pressure. CMS has proposed rule changes that would cap MA payments to both entities. Should this proposed rule become final, the combined agent/FMO payment per new enrollee may not exceed $631. Currently, $601 is the top end first year payment in most states for the agent, and FMOs can receive additional payments above that from carriers for their service based on fair market value. Under the proposed rule change, FMO overrides may be severely limited or eliminated altogether, restraining the ability of FMOs to continue providing the services their agents need to help seniors.

Such a cap would effectively reduce payments to either the agent serving the senior, the FMO serving the agent, or both. This brief examines the value that the current agent/FMO distribution model provides, and the impact reduced payments may have on the Medicare beneficiary.

CMS rule changes affecting the agent/FMO model are transmitted to the experience of beneficiaries. Rules that are enacted to protect the senior (from CMS) flow to the institutions who turn government dollars into effective and efficient healthcare (carriers), to the organizations who ensure those benefits are properly marketed and sold (FMOs), to the ones who ensure the best plan is connected to the senior based on health needs (agents), and then ultimately to the senior member (beneficiary). Most times the positive intentions at the top make it to the beneficiary despite disruption along the way. For example, the 2022 CMS rule change where Medicare agents were asked to record calls created negative disruption to FMOs and agents. But ultimately, seniors appreciated the call recording and indicated it gave them more trust in the sales and enrollment process. So, whereas agents/FMOs may have been negatively disrupted in 2022, the senior benefited. Unlike the 2022 rule change, the proposed 2025 rule change would create a direct, negative impact on services FMOs and agents provide leading to negative disruption, this time, to the beneficiary.

Two 2023 Deft Research reports examined the relationship between agents, FMOs, and seniors and are discussed further in this brief: the OEP and Disenrollment Prevention Study and the Medicare Member Experience Study.

Across dozens of Deft Research studies, and across both Medicare and ACA beneficiaries, one factor has emerged as the defining driver of why members feel they have the "Best Health Plan Possible". That experience is satisfaction with help understanding and using coverage.



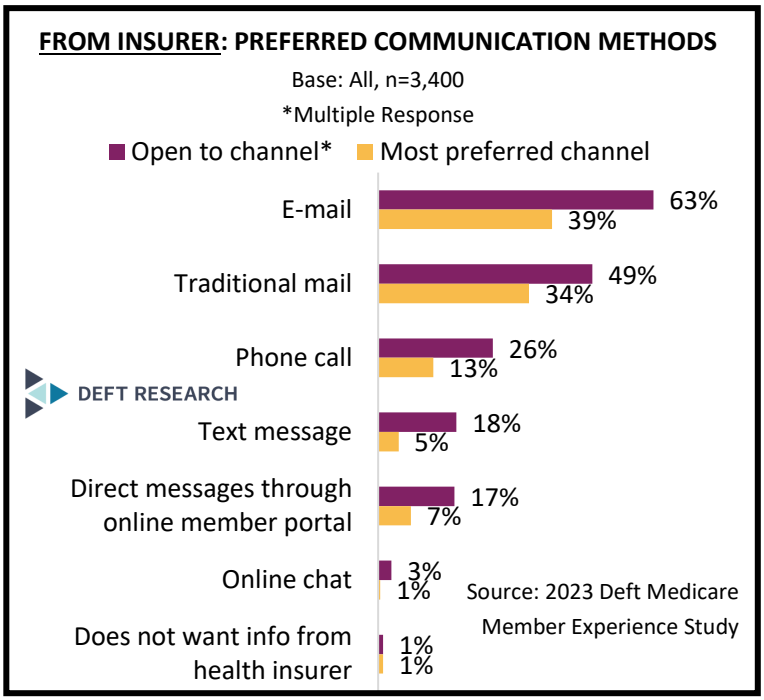
Per the chart above[1], six experiences matter the most in predicting why an MA member will score a "9" or "10 out of 10" in the CAHPS "Best Health Plan Possible" question as seen in the Highest Priority oval. Those are "Satisfaction with Help Understanding Coverage", "Satisfaction with Help Using Coverage", "Ease of Solving Issues", "Satisfaction with Access to Facilities", "Personal Doctor Rating", and, of course, "Satisfaction with Supplemental Benefits". All of the experiences shown matter to a degree, but the most powerful drivers for why some seniors feel they have the "Best Health Plan Possible" (and others, the worst) are found at the top of the Y-axis. And nothing is higher on the Y-Axis than "Satisfaction with Help Understanding Coverage" and "Satisfaction with Help Using Coverage". These factors have remained what matters most to the health insurance consumer since Deft introduced the "Best Health Plan/Worst Health Plan" CAHPS question into member experience reports starting in 2015.

However, conveying an ability and willingness to help understand and use coverage to members has been consistently difficult for carriers since that time (and likely even before). For starters, the MA enrollment total has nearly doubled in that time from 16.7 million to around 32 million, making carriers' ability to convey a personalized understanding of benefits more difficult. Another factor? Senior preferences for

[1] 2023 Deft Medicare Member Experience Study

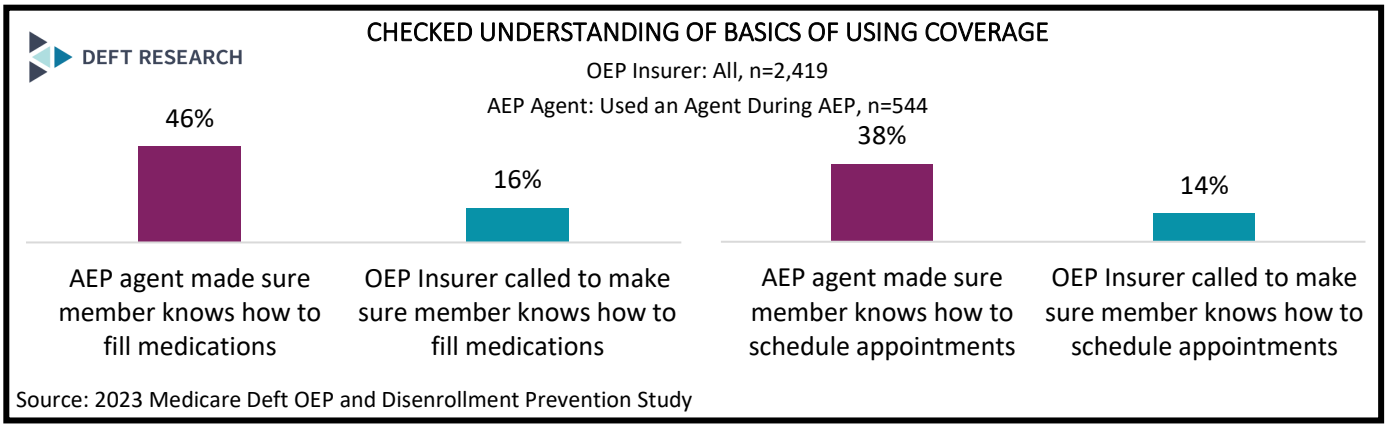
communication today show minimal support for conversation with carriers over the phone. Instead, seniors would rather receive plan communication by mail or email, communication that can all too easily end up in the recycling bin.

As seen on the chart to the right, only about an eighth of seniors (13%) prefer the telephone as the method to hear from their carrier, and only about a quarter (26%) are even willing to entertain telephone calls from their carrier at all[2]. With so few seniors today willing to answer their phone when their carrier calls, dialing efforts by call centers are mostly heard by the answering machine even when carriers are committed to helping seniors understand and use their benefits. The opportunity to show seniors how to use their plan benefits is wasted, adding to admin costs without consumer benefit.



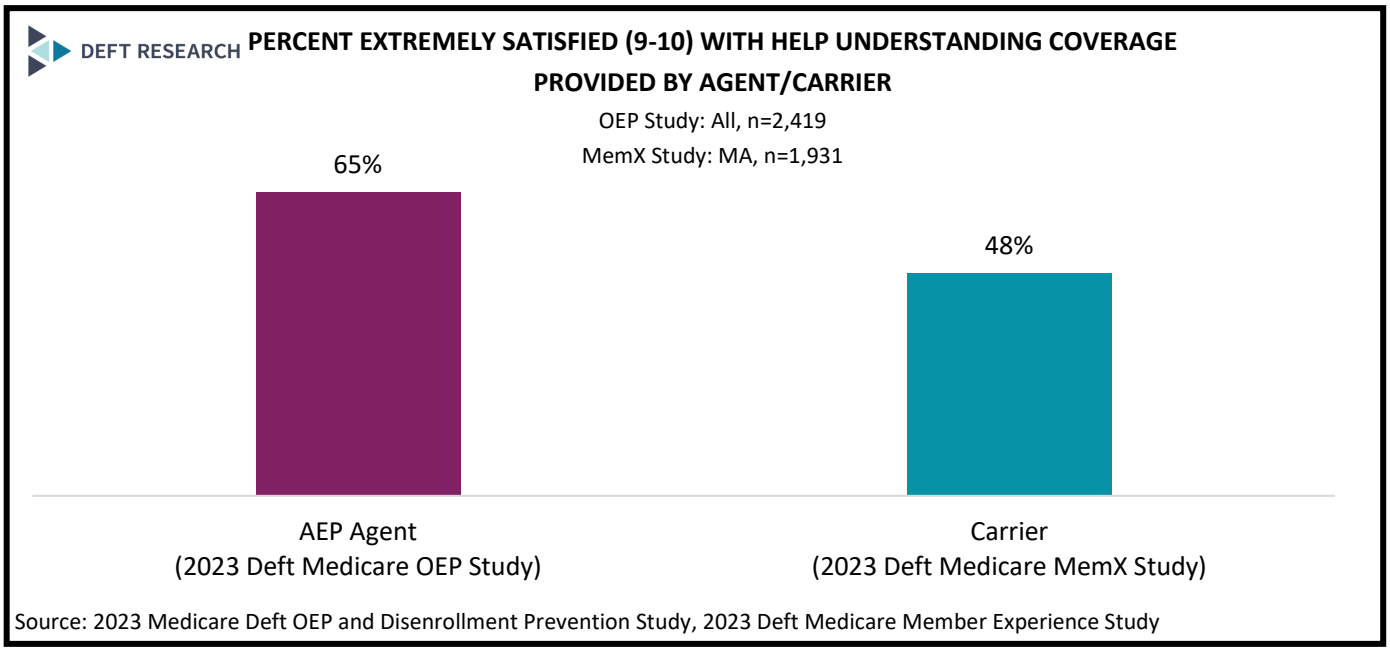
And even though email and mail are more "preferred" by seniors—and more often used by carriers (welcome kits, e-newsletters, etc.)—those channels are not getting the message across. Less than a third of seniors in MA reported that their carrier *attempted* to reach out to them about their coverage. Of course, all of these seniors' carriers did reach out—likely many times. But their calls went unanswered; their mail was tossed; their email is still marked as unread. These challenges impact carriers' ability to help their members understand and use their coverage—the two most important experiences that drive senior's perception of the quality of their Medicare Advantage plan.

As seen on the chart below, seniors are more than twice as likely to report that their AEP agent made sure they knew the basics of using coverage compared to reporting that they received a call from their carrier at the start of the plan year to ensure the same[3].



[2] 2023 Deft Medicare Member Experience Study
[3] 2023 Deft Medicare OEP and Disenrollment Prevention Study

And likely because of this, seniors are more satisfied with their agent's "Help in Understanding Coverage" than they are with their carrier's "Help in Understanding Coverage".

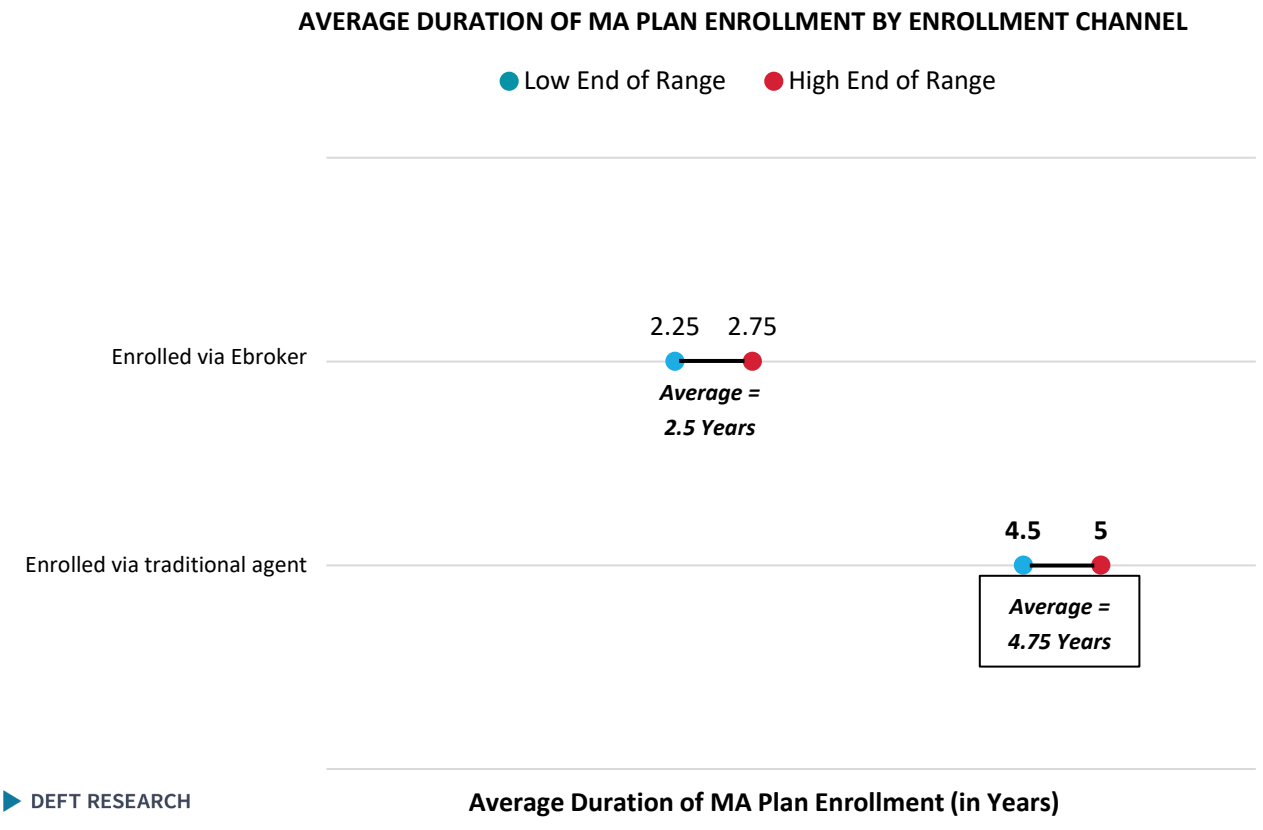


Per the chart above, seniors are more likely to give their agent a "9" or "10 out of 10" on "Satisfaction with Help Understanding Coverage" than they are their carrier (65%[4] vs 48%[5]). For carriers, the 48% number is down slightly from 51% in 2022. It's not that carriers aren't putting forth the effort to help their members understand and use their coverage—they are. But the need for one-on-one communication, coupled with too many members for carriers to reach in a personalized way, coupled with seniors' reluctance to pick up the phone when their carrier calls, coupled with the ease of ignoring carrier mail, means the good efforts by carriers too often go unrecognized. Agents are skilled at helping ensure seniors understand their coverage, and they rely on FMOs to provide them the technical resources to do their best. These are services worth paying for—especially considering the lack of an effective alternative.

The reality is that agents who sell to seniors are more capable of helping the senior understand and use their coverage than carriers today. (One can argue this is not even something that agents are being compensated for.) Again, this is not due to lack of effort on the carriers' part—rather, the current agent/FMO structure simply allows for more one-on-one assistance between the well-intentioned helper and the in-need senior. The capacity-saving effort of the FMOs to help agents with training, compliance, and CRM management allows the agent to spend as much one-on-one time with the beneficiary as needed. Additionally, FMOs open up more choice to seniors than they would otherwise have. This all drives better understanding and use of coverage, and that drives Overall Health Plan Ratings more than anything else.

And according to our friends at Telos Actuarial, the personalized one-on-one support that agents provide their clients likely leads to greater loyalty between senior and carrier compared to another major form of Medicare distribution: Ebroker.

[4] 2023 Deft Medicare Member Experience Study
[5] 2023 Deft Medicare OEP and Disenrollment Prevention Study



Source: Telos Actuarial's "Medicare Advantage Industry Voluntary Lapse Rates & Total Termination Rates for Call Center Distribution Models – 2023" and Telos Actuarial internal data.

Ebroker's average length with plan for MA enrollees is between 2.25 and 2.75 years; the average length with plan for traditional agent-facilitated enrollments is longer, between 4.5 years and 5 years[6].

The independent agent/FMO model affords the agent the ability to spend the time needed with their clients to drive plan understanding and effective usage through a personalized communication method that works for today's senior. That is the most powerful driver of why seniors feel they are in the best health plan possible. And when seniors feel that they've found the best plan possible, they stay with their plan longer—not because they have to, but because their coverage works for them. That's something that is in the best interest of all Medicare stakeholders: CMS, carriers, FMOs, agents, and most importantly, the senior beneficiary.

It's also something worth rewarding. Agents, empowered by FMOs, are helping seniors find their best plan every day. Restricting this ability—as the proposed rule change would do—would result in Medicare coverage that works less for seniors.

[6] Telos Actuarial's "Medicare Advantage Industry Voluntary Lapse Rates & Total Termination Rates for Call Center Distribution Models – 2023" and Telos Actuarial internal data.