TOPIC: ENROLLMENT, AGENTS, AND BROKERS

Background

If sufficient protections are in place, agents, brokers, and other authorized entities can serve as trusted information sources to inform Medicare beneficiaries about enrollment options, including joining a Medicare Advantage (MA) plan.[1,2] For example, CMS requires agents and brokers to act in beneficiaries' best interest and to ensure that MA plan enrollment is voluntary, informed, and documented. [3] In addition, CMS emphasizes that beneficiaries should receive clear, accessible information about plan options.[4] If a beneficiary is enrolled in an MA plan without proper notice or receives misleading marketing materials by an agent, broker, or other authorized entity, then that beneficiary becomes eligible for a special enrollment period to switch plans.[5]

Key Points

- Agents and brokers are an important source of information for TM and MA beneficiaries. They can receive commissions and administrative payments from MA organizations and third-party marketing organizations for MA plan enrollments.
- The incentive structure for agents and brokers, along with other information gaps, contributes to the FWA risks of uninformed or unvoluntary enrollment.
- Mitigation strategies include limiting payments to agents and brokers, implementing oversight mechanisms to ensure actors uphold best practices, prohibiting suppression technology, improving oversight of MA marketing, improving beneficiary information, and implementing an opt-in policy for employer and union retirement MA benefits.

Agent and broker compensation is much higher for MA enrollment than for Traditional Medicare (TM) enrollment. In 2025, for MA plan enrollments, agents and brokers could receive compensation from MA organizations of $626 to $780 per beneficiary for initial enrollments and $313 to $390 for renewals, depending on the state they operate in.[6,7] Agents and brokers receive no compensation for beneficiaries who enroll in TM; however, they can receive a maximum of $109 in compensation for initial enrollment and $55 for renewal enrollment in Medigap and stand-alone Part D plans that beneficiaries often purchase to supplement their Part A and Part B TM benefits.[8,9] This payment differential creates an incentive for agents and brokers to encourage beneficiaries to enroll in MA over the Medigap and stand-alone Part D plans they can offer to complement TM coverage.

Most agents and brokers work with or for third-party marketing organizations (TPMOs).[10] MA organizations contract with TPMOs and pay commissions to agents and brokers for enrolling beneficiaries in their plans. Currently, there are no limits on payments to TPMOs and "administrative payments" to agents and brokers for non-enrollment activities, such as agent and broker training, certification, and technology support.[11,12]

Potential for FWA

Fraud, waste, or abuse situations relating to enrollment may arise when beneficiaries are (1) enrolled in MA plans without their knowledge or consent, or (2) misled by marketing or other information that influenced enrollment decisions. The incentive structure for agents and brokers contributes to FWA risks. Independent agents and brokers receive higher commissions from MA organizations for initial MA enrollments compared to reenrollments, which incentivizes agents and brokers to identify beneficiaries who are not currently enrolled in MA plans. In addition, agents and brokers who are employed by TPMOs may not be subject to the same commission structure as those that contract directly with MA organizations, and thus, for example, could receive incentives only for new enrollments and not for renewals.[13]

CMS strictly regulates maximum commission amounts, as stated previously. However, actual payments vary by MA organization and even across plans offered by a given MA organization. Agents and brokers do not represent all plans and may be paid more for enrollments in some plans over others, which may incentivize agents and brokers to promote some plans over others and potentially contribute to abuse. MA organizations can sidestep financial caps on agent and broker compensation by adding "administrative payments."[14] A 2025 U.S. Senate Committee on Finance report found typical administrative payments for agents and brokers ranged from $150 to $250 but can exceed $1,000 per enrollee.[15] In addition, agents and brokers may receive bonuses via MA insurers for meeting enrollment benchmarks.[16]

Enrollment compensation and administrative payments may influence what information on MA plans is shared by agents and brokers or which plans they choose to present as options to potential enrollees, which can contribute to abuse.[17,18] Prior research found that agents and brokers may steer beneficiaries into MA plans, especially larger MA plans, to earn higher payments.[19,20] In addition, in 2025, the U.S. Department of Justice joined a lawsuit alleging that MA insurers knowingly paid brokers to enroll individuals into specific plans.[21] The lawsuit alleges that insurers and brokers concealed payments by claiming they were related to marketing and administrative services.[22]

The 2025 Senate Committee on Finance report found a lack of transparency in lead generation, which refers to the process of identifying and attracting potential beneficiaries who may be interested in enrolling in MA plans for the purpose of selling information to TPMOs or other

advertising entities.[23] Lead generators are independent from MA organizations but they can partner with MA organizations to provide leads.[24] Beneficiaries targeted by lead generators can be overwhelmed with unauthorized contacts that may misrepresent plan benefits, omit pertinent plan information, and cause beneficiary confusion about the plan in which they are enrolling.[25] If agents and brokers selectively target beneficiaries who have low utilization relative to expected MA payment rates, it could contribute to FWA related to favorable selection (see the Favorable Selection chapter). Agents and brokers can receive relatively generous bonus payments from MA organizations for conducting health risk assessments of potential enrollees,[26] exacerbating the risk of favorable selection. In addition, the committee report highlighted the experiences of beneficiaries with dementia who were targeted with multiple marketing calls that may have caused them to unenroll and reenroll in MA plans,[27] which could be considered enrollment fraud. Finally, TPMOs sometimes use offshore call centers, which exacerbate risks because it may be more difficult for CMS to monitor these call centers for deceptive marketing practices.[28]

Information gaps can also present a risk. Currently, individuals who are 65 years of age and who receive Social Security payments are automatically enrolled in Medicare Part A and may be unaware of all their coverage options, such as TM for Parts A and B plus a Part D plan and an optional Medigap plan versus MA.[29] Meanwhile, beneficiaries are exposed to much more marketing material about MA than about TM. Lack of understanding of health plan information presents opportunities for bad actors to mislead beneficiaries about plan trade-offs, increasing the potential for fraud or abuse.

Special rules for employer and union MA plans can create risks for uninformed enrollment. Employers and unions that offer retirement health benefits can contract with MA organizations to provide group MA plans.[30,31] Employers may offer MA plans to retirees to reduce employer administrative burdens and costs as some plans would cover retiree dental and vision plans.[32] Employers and unions must provide advance notice of the possible MA plan enrollment and a way for their members to opt out of participating.[33] CMS can waive or modify MA requirements for employer-sponsored MA plans such as not having to submit data for Medicare Plan Finder and having different open enrollment periods from TM.[34] Individuals who do not opt out can be enrolled automatically in their employer or union MA plan, rendering them ineligible for TM,[35] and potentially unaware of the implications of their plan membership.

Mitigation Approaches

Limit payments to agents and brokers. CMS could regulate payments to agents and brokers to reduce adverse incentives. For 2025, CMS set new guardrails for MA plan compensation to agents and brokers to prevent steering and reinforced the prohibition against financially incentivizing agents, brokers, and TPMOs to recommend and possibly enroll beneficiaries in MA

plans that are not in their best interest.[36,37] The rule combined administrative payments with enrollment-based compensation payments and eliminated separate administrative payments (thereby increasing compensation for new enrollments by $100), and required that all MA organizations that choose to engage agents and brokers pay the same enrollment-based compensation,[38] a policy similar to that proposed by the Senate Finance Committee.[39] These provisions in the rule were not implemented due to a lawsuit filed by trade associations representing agents and brokers who claimed that CMS failed to assess how the rule would harm their business model.[40] In addition to appealing the ruling or reintroducing a similar policy, CMS could consider other options to regulate payments to agents and brokers, such as setting administrative payment limits to reduce their use as financial incentives for higher enrollment in certain MA plans.[41,42,43]

Another policy option that limits payments to agents and brokers is strengthening regulations concerning enrollment benchmark bonuses for agents and brokers. A complete ban on enrollment benchmark bonuses for agents and brokers is unlikely to be palatable and would be difficult to enforce. However, limiting the size of the bonuses that agents or brokers can receive may curb the risk of inappropriate steering created by enrollment benchmark bonuses.[44]

Implement oversight mechanisms to ensure actors uphold best practices. Several policy options could reinforce best practices, as defined in existing legislation, regulations, and guidance, and increase accountability among agents and brokers.[45,46] To support compliance with best practices, CMS could monitor disenrollment trends and the numbers of beneficiaries receiving special enrollment periods due to marketing issues by MA plans or by agents and brokers.[47,48] This could include collecting data on which agents and brokers facilitated each enrollment. CMS could then identify agents and brokers with disproportionately high disenrollment and use this information to seek insights from affected beneficiaries and conduct targeted audits of MA plans.[49,50] For contract year 2026, CMS discussed plans to monitor disenrollment patterns but it is not clear whether CMS plans to publish this information.[51] CMS has the authority to penalize MA organizations if they (or their employees or contractors) enroll a beneficiary solely for the purpose of a commission or without a beneficiary's consent, or misrepresent information or fail to comply with marketing requirements.[52] Penalties can include fines, suspension of enrollment, and termination of MA contracts when agents, brokers, or MA organizations violate current best practices.[53] Congress could update penalties for MA organizations and consider granting CMS additional authority to issue penalties directly to any agent, broker, or company that is noncompliant.[54] Enforcing compliance and publishing accountability measures may disincentivize steering beneficiaries to plans that do not suit their needs.

As of 2026, MA plan Star Ratings include the measure "Members Choosing to Leave the Plan." CMS proposed removing this measure for 2029 Star Ratings and retaining the information as a display measure, which means it will be publicly reported but will not be used to calculate Star Ratings (see the chapter on Star Ratings and the Quality Bonus Program). [55] CMS has since confirmed that the Disenrollment Reasons Survey, which is the source of data for "Members Choosing to Leave the Plan" and other display measures of reasons for leaving, is no longer being conducted, and that it therefore will not publish these measures on the display page for 2027 and subsequent years.[56] Retaining the survey and potentially revising the disenrollment measure—for example, to track rapid disenrollments—could help incentivize MA organizations to ensure agents and brokers are following best practices. If the survey were retained, CMS could also continue to publish the reasons for disenrollment as display measures,[57] which, combined with the rates of members choosing to leave the plan, would provide additional accountability.

Prohibit suppression technology. CMS could prohibit the use of suppression technology, contracts that require use of suppression lists, and TPMO software provisions to MA plans that limit information brokers and agents can see.[58] TPMOs often offer contracted agents and brokers software to search plan options and enroll beneficiaries in MA plans.[59] The 2025 Senate Finance Committee report found that current technology, paid for by MA organizations through contracts with TPMOs, can be manipulated to limit results and essentially "suppress" some MA plans.[60] The technology discourages agents and brokers from informing beneficiaries about all available options.[61]

Improve oversight of MA marketing. Regulating aggressive as well as false and misleading marketing tactics could reduce uninformed or involuntary MA enrollment. The Senate Finance Committee reported on evidence indicating that beneficiaries are targeted by TPMOs with aggressive marketing tactics and misleading information.[62] As a result, beneficiaries may be confused about plan information and feel pressured to enroll in MA plans that do not meet their health care needs.[63] The committee also found incidents of beneficiaries being enrolled in plans without their consent after responding to an MA plan advertisement.[64] The committee's report called on CMS and Congress to pursue multiple corrective actions, including ***strengthening regulations for, and conducting regular reviews of, MA marketing materials***.[65] Starting in 2025, CMS restricted use of the Medicare name, the CMS logo, and of quoting or reproducing information issued by the federal government in marketing for MA that may mislead or confuse beneficiaries.[66] The intent of these marketing limitations was to increase transparency and reduce beneficiary confusion.[67,68,69] States can also regulate marketing. One state has additional requirements for MA plans that include a notice to be displayed prominently for beneficiaries that reads, "This policy or certificate may not cover all your medical expenses."[70]

Starting in 2023, CMS allowed for special enrollment periods for beneficiaries who received inaccurate material or relied on incorrect information provided by employers, group health plans, or others that affected their enrollment in Medicare Part A or B.[71] CMS could consider a similar ***special enrollment period*** for beneficiaries who relied on inaccurate or incorrect information from agents or brokers when enrolling in an MA plan. This could add another incentive for agents and brokers to provide accurate information and also protect beneficiaries, assuming they know the special enrollment period is an option.

The Senate Finance Committee's report called on Congress to grant CMS the authority to ***regulate lead generators***.[72] With authority to oversee lead generators, CMS could ensure that partnerships between MA organizations and lead generation companies are approved and in good standing.[73] Further, CMS could potentially ban offshore call centers that are harder to monitor.[74] In contract year 2025, CMS finalized a rule prohibiting TPMOs from sharing personal beneficiary data, or leads, with other TPMOs unless express written consent from the beneficiary was obtained,[75] which could help reduce aggressive marketing to those beneficiaries who do not consent.

In a 2025 request for information, CMS indicated that it is considering several ways to improve oversight of MA marketing.[76] It sought information on ways to hold MA organizations accountable when TPMOs provide inaccurate, misleading, and confusing information and on options that could reduce risks associated with agents and brokers such as updating training and testing requirements and improving how they interact with beneficiaries. CMS also requested information on how to use data effectively to monitor MA organizations, TPMOs, and other downstream entities for compliance with marketing and enrollment requirements. Improved oversight could help reduce fraud, waste, and abuse risks associated with enrollment marketing.

Improve beneficiary information. Another possible policy option is for CMS to ***regulate and standardize the language used to describe MA plan processes and benefits***. The Senate Finance Committee has repeatedly recommended that CMS provide model language to clearly explain beneficiary out-of-pocket costs, network limitations, and extra benefits.[77,78] CMS also could move to standardize definitions and require MA plans to use consistent language during enrollment.[79,80] Another possible solution to misleading marketing is for CMS to create and provide coverage information to beneficiaries, including about TM.[81,82,83,84] This could help reduce information gaps and allow beneficiaries to make informed choices between TM and MA as well as among MA plans.

To improve beneficiary experiences with using Medicare Plan Finder, CMS could consider using an ***artificial intelligence (AI)-based tool*** that could help beneficiaries compare plans accurately

and give more personalized suggestions.[85] Look-alike tools closely mirroring Medicare Plan Finder, which may be operated by agents and brokers, exist and are easily located through search engine queries. Our team found that these tools only provided information on select plans, so they are not as comprehensive as Medicare Plan Finder but may be preferred by beneficiaries due to additional features. For consumers to be effective shoppers, they need to be able to access, review, and understand unbiased information about TM, MA plans, and other options in their area, including from independent sources such as CMS and State Health Insurance Assistance Programs (SHIPs).[86,87] Plan information that is more accessible would also help beneficiaries make more informed decisions about shopping for a new MA plan rather than defaulting to their existing plans.[88,89] CMS has requested information on how it might use AI and other technology to enhance decision support tools,[90] suggesting that changes may be forthcoming. To implement an AI-based tool, the language used to describe health plans would need to be standardized and CMS may need to collect and release more MA plan characteristics.[91]

Implement an opt-in policy for employer and union retirement MA benefits. One option for addressing unwanted enrollment in an employer or union MA plan is to ***switch from an opt-out policy to an opt-in policy***.[92] With an opt-in policy, beneficiaries would be assured an active role in their choice of health insurance and reduce the risk of involuntary MA enrollment.[93] However, an opt-in policy likely would require MA organizations to invest more in education and marketing for those who are eligible for an employer or union MA plan, including directing them to information on the implications of opting out at different times. In addition, employers may not want an opt-in policy as they would have fewer covered people in their retiree pool, exposing them to more high-risk outliers and increasing their risk of adverse selection.

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