Challenges of Choice in Medicare

The Role of Agents and Brokers in a Public Program

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Medicare beneficiaries face many choices when entering the program and during the annual open enrollment period. They can elect to enroll in the traditional Medicare (TM) program, dozens of Medicare Advantage (MA) and Prescription Drug Plans, or 10 standardized Medigap supplemental coverage plans. Research suggests that beneficiaries struggle to make decisions when faced with so many choices, and that many Medicare enrollees cannot determine which coverage options would minimize their costs (MedPAC 2023). Many beneficiaries, therefore, seek assistance from health insurance agents, brokers, and other resources when evaluating their options (Leonard et al. 2022). However, previous research has indicated that the marketing and enrollment efforts of the growing MA sales industry may steer beneficiaries into MA even when other options may better meet their needs (Leonard et al. 2023; Neuman et al. 2024).[1]

MA enrollment has grown rapidly over the past decade, from 31 percent of Medicare enrollment in 2014 to 54 percent in 2024 (Freed et al. 2024a). This growth was fueled by MA overpayment that often led to richer benefits for MA enrollees at no additional cost and heavy investment in marketing (Jacobson and Uccello 2025; Leonard et al. 2022; Neuman et al. 2024).[2] A recent report from Senate Finance Committee Ranking Member Ron Wyden found that MA insurers spent a combined $6.9 billion on agent and broker commissions in 2023, up from $2.4 billion in 2018 (Wyden 2025), suggesting rapid growth in the MA sales industry. In 2024 and 2025, however, news reports and data tracking suggest that MA margins have tightened (NAIC 2025), leading some insurers to stop offering commissions

altogether for some plans or to exit markets in some states. Nevertheless, the size of incentives for agents and brokers remains a matter of concern,[3] and MA plans continue to have strong incentives to compete for MA enrollment through investments in sales and marketing strategies that may not serve beneficiaries or taxpayers well.

To explore how agents and brokers may influence Medicare enrollment and identify any gaps in oversight of agents, brokers, and marketers, we conducted a literature review and interviewed 19 representatives from agent and broker trade associations, field marketing organizations, agencies and brokerages, state departments of insurance, health plan associations, beneficiary advocacy organizations, and the Centers for Medicare & Medicaid Services (CMS).

Our key findings include the following:

- Beneficiaries struggle to make Medicare enrollment decisions, and our interviewees said that the educational and decision-support resources provided by CMS are inadequate to meet beneficiaries' needs.
- Agents and brokers are an important resource for beneficiaries, but their financial incentives are sometimes misaligned with the needs of the beneficiaries they serve.
  - » CMS sets maximum commissions in the MA market, and these have grown rapidly in recent years and appear higher than commissions in other insurance markets.
  - » CMS does not have the authority to regulate other administrative fees that may be paid to agents, brokers, and other sales organizations, limiting its ability to create a level playing field among MA plans or between MA and TM products.
  - » MA commissions and fees paid to agents, brokers, and other sales organizations add to the program's administrative costs and may not only steer beneficiaries into MA, but also encourage more spending on buying Medicare sales leads.
- Despite growing concerns about MA sales and marketing practices, the regulatory environment for agents, brokers, marketing organizations, and lead generators is patchy.
  - » Interviewees said that direct regulation and oversight of agents, brokers, marketing organizations, and lead generators is limited and complicated by state and federal overlaps.
  - » Interviewees expressed significant concerns that organizations that generate sales leads for agents and brokers may engage in misleading marketing and overwhelm beneficiaries with many phone calls.
- The MA sales industry, fueled by Medicare overpayment and years of high insurer profit margins in MA, spends billions of taxpayer dollars annually and continues to grow as MA enrollment increases, though this growth has shown signs of slowing in 2025 (NAIC 2025). MA's overall marketing and enrollment costs may represent a significant, understudied target for reducing MA overspending.

Our interviews and literature review suggest several areas of payment and benefit policy that can be addressed to improve Medicare sustainability, reduce taxpayer burdens, and help beneficiaries navigate Medicare enrollment, including simplifying and strengthening Medicare, tying agent and broker commission increases to inflation and benchmarking them to other insurance markets, reining in MA overpayment, increasing funding for neutral enrollment assistance, and improving transparency, oversight, and enforcement.

Data and Methods

We conducted a literature scan on the role agents and brokers play in the Medicare market, as well as the role commissions may play in agent and broker recommendations. The literature scan included academic journal articles, gray literature, and news articles through searches in PubMed and Google. We also examined recent rules, regulations, and model laws addressing agents and brokers from CMS and the National Association of Insurance Commissioners. We used the literature scan to inform a set of interviews, specifically to guide interviewee selection, develop a discussion guide, and provide context for our qualitative and quantitative findings.

We conducted interviews with 19 individuals from state departments of insurance, beneficiary advocacy organizations, health plan associations, agent and broker associations, agencies and brokerages, field marketing organizations (which often provide back-office support and sales and marketing tools to agents and brokers), and former CMS officials between December 2024 and July 2025. We were unable to secure interviews with any lead generator organizations, which are independent organizations that advertise and gather beneficiary contact information to sell to agents, brokers, and MA plans for follow-up sales efforts. This is a limitation of our study, though we could validate some of the claims our interviewees made about these organizations in our literature review.

Interviewees were offered confidentiality to encourage participation and candor, so we do not name our interviewees or their organizations here. Our interviews covered the following broad questions:

- What is the role of agents and brokers in Medicare enrollees' plan choices?
- What are the problems, if any, with agents and brokers in Medicare?
- What is the regulatory environment for agents and brokers selling Medicare products, and are there any gaps in oversight?
- What are your suggestions for alternative approaches?

To provide further context for our interviews, we also analyzed data on agent and broker commissions. We first gathered the fair market value of agent and broker commissions in MA, which represents the CMS-established upper limit on commissions in the MA market, from CMS rules and other sources from 2014 to 2026. We also used CMS's published data on the minimum and maximum agent and broker commissions offered by plans for both initial enrollments and renewals in 2023.[4] We

focused on 2023 because it is the most recent year of total MA plan payment data available. We linked the 2023 commission data to MA enrollment and MA total plan payments for 2023, which are also available from CMS.[5] We used the linked data to estimate the weighted average of MA plans' maximum agent and broker commissions for initial enrollments and for renewals as a percent of total MA plan payments in 2023, using MA plan enrollment as the weights.

We focused on maximum agent and broker commissions offered by plans because many MA plans do not report a minimum or actual commission. In addition, in its 2025 Medicare Advantage final rule, CMS noted that most MA plans using agents and brokers paid the maximum commission amount, rather than lower amounts,[6] which was supported by our interviewees. However, we note that MA plans may choose to pay different commissions to different agents and brokers, which we do not observe in the data. Our estimates, therefore, represent an upper bound of the share of MA plan payment going to agent and broker commissions.

Findings

Medicare Enrollment Choices Are Complex, and Public Resources Are Inadequate to Meet Beneficiaries' Needs

Medicare beneficiaries face many choices when they first enroll in the program and during the annual open enrollment period (box 1). Beneficiaries must decide whether to enroll in TM, which offers a broad choice of providers but can have significant cost-sharing, or MA, which offers lower cost-sharing and additional benefits in return for a limited provider network and prior authorization requirements. Beneficiaries also must decide if they want prescription drug coverage, which is optional in both TM and MA. Those who select TM can also choose among 10 standardized Medigap plans offered by various insurers to help cover cost sharing (Freed et al. 2024b). For those who select MA, an average of 42 different MA plans were available to select from within their counties in 2025 (Freed et al 2024c).

Research has indicated that the number of choices available to Medicare beneficiaries can be overwhelming, making it difficult to identify the lowest-cost plans that meet their health care needs and leading them to forgo a full review of their options (McWilliams et al. 2011; MedPAC 2023). Evidence from across health insurance markets suggests that consumers do not necessarily make rational decisions when faced with health insurance choices, with many selecting plans that are objectively worse for all possible health needs (called "dominated" plans; Bhargava, Lowenstein, and Sydnor 2015; Chu et al. 2021; Rasmussen and Anderson 2021; Sinaiko and Hirth 2011). Although these studies focus on employer insurance and the Marketplaces, Medicare offers even more choices, likely worsening the problem. As one broker interviewee put it, "There's no class to explain how the four parts of Medicare work, the supplements, the thousands of options. The choice is overwhelming." Most of our interviewees suggested that CMS-funded resources like Medicare.gov, 1-800-MEDICARE, and State Health Insurance Assistance Programs (SHIPs) are insufficient to meet beneficiaries' needs for assistance with enrollment choices.

BOX 1

Why Is It So Hard for Beneficiaries to Navigate Medicare Choices?

Medicare is structured differently from the private insurance many Americans have before they enroll in the program, in part because Medicare benefits and coverage options have been added piecemeal over time.

Medicare consists of four parts:

- Part A covers hospital services, skilled nursing facilities, and most home health care and is financed primarily by payroll taxes. Most beneficiaries do not have to pay a premium for Part A.
- Part B covers medical services like office visits and is financed partly by general revenues and premiums. The standard Part B premium for 2025 is $185, though premiums are higher for higher-income beneficiaries.
- Part C is Medicare Advantage, and it is financed by payroll taxes, general revenues, and premiums. MA enrollees must be eligible for both Part A and Part B and generally must also pay Part B premiums.
- Part D covers prescription drugs, is only available through private plans, and is financed by general revenues and premiums. Part D can be purchased stand-alone or may be integrated into an MA plan.

It can be difficult or impossible to compare Medicare coverage choices between MA and traditional Medicare because coverage is structured very differently between the two options.

Traditional Medicare (TM)

TM Parts A and B cover hospital and medical services, but they have relatively high cost-sharing. Without supplemental coverage, in 2025, beneficiaries would be required to pay a $1,676 deductible for each hospital stay, copays for long hospital and skilled nursing facility stays, and a $257 deductible plus 20 percent coinsurance for many Part B services—with no cap on out-of-pocket spending.

Many beneficiaries who choose TM therefore purchase supplemental coverage, like Medigap plans, to cover cost-sharing. There are 10 standard Medigap plan designs, but beneficiaries may have a choice of many insurers, and state rules around coverage and premiums vary substantially. In addition, most TM beneficiaries also select a Part D plan for prescription drug coverage. The average beneficiary could choose from among more than a dozen Part D plans in 2025.[a]

Medicare Advantage (MA)

Beneficiaries who select an MA plan generally receive integrated Part D coverage and are not eligible to purchase supplemental coverage like Medigap. However, even beneficiaries who are only interested in MA may face an overwhelming number of plans to choose from. The average beneficiary had a choice of 42 different MA plans in 2025, up from 18 in 2017. Beneficiaries in Cumberland County, PA, had a choice of 87 different MA plans in 2025.[b] Plans may differ across numerous parameters that can be difficult for consumers to understand, including deductibles, other cost-sharing, benefits, provider networks, drug formularies, and utilization management practices.

Notes: [a] Juliette Cubanski, "A Current Snapshot of the Medicare Part D Prescription Drug Benefit," KFF, October 9, 2024, https://www.kff.org/medicare/a-current-snapshot-of-the-medicare-part-d-prescription-drug-benefit/.
[b] Meredith Freed, Jeannie Fuglesten Biniek, Anthony Damico, and Tricia Neuman, "Medicare Advantage 2025 Spotlight: A First Look at Plan Offerings," San Francisco: KFF, November 15, 2024, https://www.kff.org/medicare/medicare-advantage-2025-spotlight-a-first-look-at-plan-offerings/.

"There's no class to explain how the four parts of Medicare work, the supplements, the thousands of options. The choice is overwhelming."
—Interviewed broker

Beneficiaries Turn to Agents and Brokers to Help Navigate Complex Enrollment Choices, and CMS Sets Commissions for That Support

In the absence of adequate public assistance, Medicare beneficiaries often rely on agents and brokers to help navigate complex enrollment decisions. According to a 2022 survey by the Commonwealth Fund, Medicare beneficiaries were more likely to rely on agents and brokers for help selecting a plan than any other source of information, though only about 30 percent used an agent or broker (Leonard et al. 2022). Our interviewees said that agents and brokers play an important educational role in the Medicare market, and several interviewees said that SHIPs and CMS are underfunded to provide the kind of "hand-holding" that many beneficiaries want.

MA, Part D, and Medigap plans use agents and brokers as part of their sales strategy. A 2021 report found that 96 percent of MA and Part D plans contract with agents and brokers (Ali et al. 2021). Agents and brokers can work directly for a specific insurer (captive agents and brokers), but most sell plans offered by multiple insurers in return for commissions and other fees. These independent agents and brokers may be supported by field marketing organizations, which receive administrative and other fees from MA plans to provide back-office support, enrollment tools, and marketing for independent agents and brokers. In 2023, MA plans spent $6.9 billion in commissions and fees to independent agents and brokers and another $2.2 billion on direct sales via captive agents and brokers, not including other marketing costs (Wyden 2025).

Nearly all of our interviewees said that agents and brokers who operate in their local community have strong incentives to help their clients find plans that meet their needs, as they rely on repeat business and good word-of-mouth to build their businesses. However, this motivation is less applicable to national and web-based brokerages and agencies. For example, one interviewee noted that call centers and large agencies may use alternative compensation structures for agents and brokers, having them assign their commissions to their employer and instead paying bonuses and other fees more focused on generating new enrollments than on keeping clients satisfied.

Some prior research has found that agents and brokers may steer beneficiaries into MA to earn higher commissions (Leonard et al. 2023). In addition, uneven commissions or fees across MA plans could lead agents and brokers to preferentially sell particular plans. For example, in 2024 and 2025, several MA insurers stopped offering commissions on some of their less profitable products so that agents and brokers would not continue to sell them.[7]

One interviewee noted that larger plans pay higher total compensation to agents and brokers, including administrative fees and other add-on compensation, making it harder for small, local plans to compete. These additional payments can include bonuses, reimbursements for marketing and other expenses, or payments for other activities like administering Health Risk Assessments (MedPAC 2025). These fees and add-ons can add hundreds of dollars to agent and broker commissions, with one health plan association estimating that total compensation for agents and brokers in 2023 was up to $1,300 for a new enrollee.[8] To address this, CMS finalized rules in 2024 to regulate spending on administrative and add-on payments, not just commissions.[9] However, in August 2025, a judge vacated portions of the rule, saying CMS did not have the authority to regulate administrative and add-on payments.[10]

CMS'S FAIR MARKET VALUES FOR MA AND PART D COMMISSIONS HAVE GROWN SUBSTANTIALLY

To reduce financial incentives for agents and brokers to steer beneficiaries into specific plans, CMS regulates agent and broker commissions in MA and Part D. However, CMS does not regulate Medigap commissions and therefore cannot ensure overall commissions for selling TM-related products are equivalent to those for selling MA.

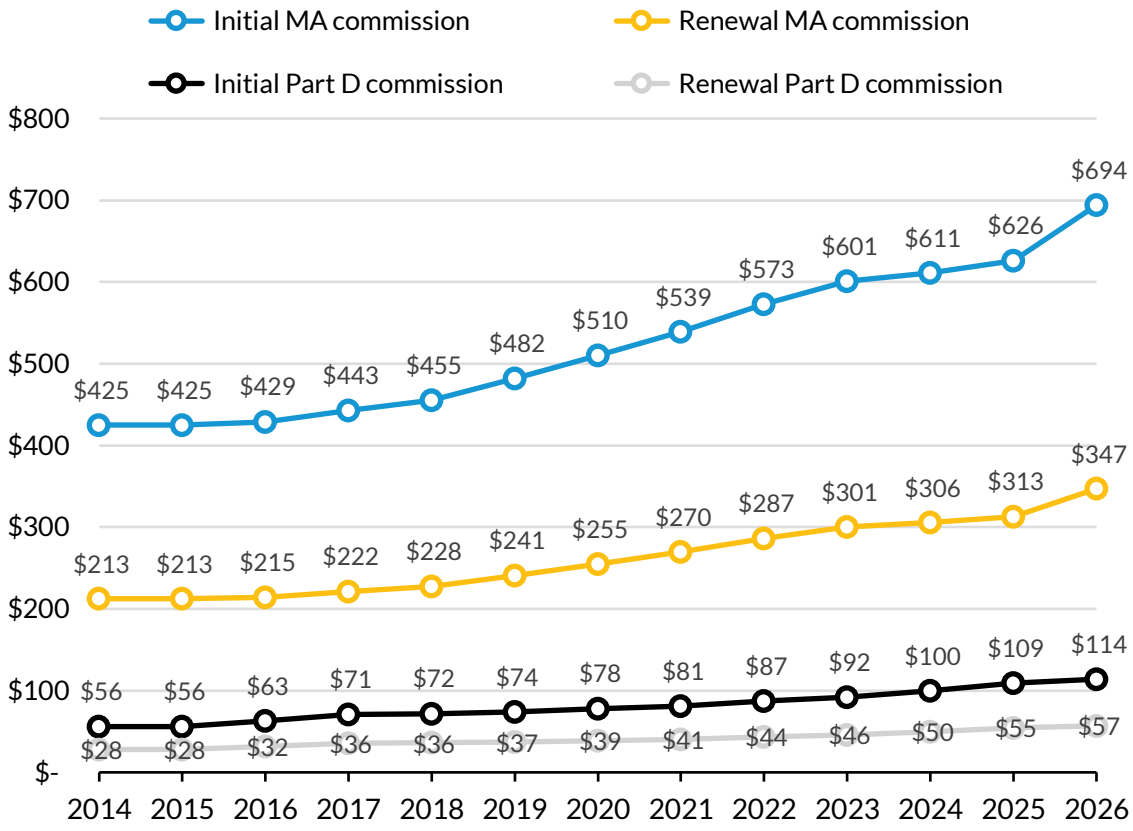
CMS sets maximum commissions for MA plans according to "fair market value" (FMV). According to CMS, most MA plans using agents and brokers pay the maximum commission amount, rather than lower amounts,[11] which was supported by our interviewees. CMS's rules do not provide detailed information on how the agency determines FMV for commissions, however. In its final rule for the 2025 MA plan year, CMS indicated that FMV is updated annually by multiplying the prior year's FMV by the annual growth in MA benchmarks,[12] which are based on average TM spending in each county. Because TM spending has historically grown faster than inflation, MA commissions have as well. However, our interviewees were not sure whether FMV is benchmarked to other insurance markets. CMS did not respond to our requests for additional information.

In addition to regulating the maximum commissions offered in MA, CMS also sets rules for when plans must pay initial versus renewal commissions. CMS requires that agents and brokers receive the higher, initial commission for beneficiaries who are new to MA, including those just entering Medicare and those switching from TM or certain non-MA plans. However, agents and brokers receive a renewal commission for beneficiaries who stay in the same plan or switch among MA plans, which accounts for the majority of MA activity during open enrollment periods (Dong et al. 2022).

CMS's FMV for MA commissions has risen substantially since 2014 (figure 1). In 2026, CMS set FMV at $694 for each new enrollee and $374 for each renewal (CMS 2025).[13] These maximum commissions are higher in some states with a high cost of living, including $781 in Connecticut, the District of Columbia, and Pennsylvania; and $864 in California and New Jersey.

FIGURE 1

CMS' Fair Market Value for Medicare Advantage and Part D Commissions, 2014–26



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Sources: National Contracting Center, "Medicare Agent Training Guide: Commissions," accessed August 26, 2025, https://nccagent.com/commissions-medicare-agent-training-guide/; United Insurance Group, "2018 CMS Medicare Advantage and Part D Broker Commissions," June 1, 2017, https://uigbrokerage.com/2018-cms-medicare-advantage-and-part-d-broker-commissions/; Eldercare Insurance Services, Inc. « Increased 2017 Commissions for Medicare Advantage & Part D Announced. » accessed August 28, 2025, https://eldercarebroker.com/news-increased-2017-commissions-for-medicare-advantage-part-d-announced; "Contract Year 2016 Agent/Broker Compensation Rate Adjustments and Submissions & Agent/Broker Training and Testing Requirements," CMS, May 29, 2025; and "Medicare Advantage and Prescription Drug Plans," CMS, August 28, 2014.
Notes: CMS = Centers for Medicare & Medicaid Services; MA = Medicare Advantage. From 2019 to 2024, fair market value was the upper limit on commission that an MA or Part D plan could pay to agents and brokers. Beginning in 2025, CMS's fair market value is the required commission for agents and brokers if the plan offers commissions.

Between 2014 and 2026, the CMS FMV for initial MA commissions grew from $425 to $694, and the FMV for renewal commissions grew from $213 to $347, both a 63.3 percent increase (figure 1). Part D FMVs doubled over this period, from $56 to $114 for a new enrollee and from $28 to $57 for a renewal. Commissions in MA grew faster than the rate of inflation[14] because CMS uses the MA benchmark growth[15] rather than measures of wage, price, or spending inflation that may more accurately reflect the agents and brokers' costs, to increase commissions each year. In fact, CMS's MA FMV for agent and broker commissions grew by 10.9 percent between 2025 and 2026 alone (from

$626 to $694 for an initial commission and from $313 to $347 for a renewal commission; figure 1). During this period, MA plans received a 5.06 percent increase in payment.[16]

In 2023, the most recent year of MA plan payment data available, the enrollment-weighted average maximum commission for continuing MA enrollees or those switching among MA plans represented 2.3 percent of weighted average MA payments (table 1). This represents a significant, ongoing administrative cost for MA plans for the average beneficiary enrolled by an agent or broker. Initial commissions paid for new MA enrollees are even higher, but those one-time costs represent a smaller share of annual MA enrollment (Dong et al. 2022).

For comparison, commission amounts in Medigap are generally lower than those in MA, though Medigap commissions may represent a higher percentage of total premiums paid by enrollees (MedPAC 2025).[17] One of our interviewees noted that, over the life of a policy, eHealth (a web-broker) estimates that Medigap pays higher total expected commissions, though we note this estimate does not appear to include administrative and add-on fees.[18] Interviews suggested that securing local agent and broker participation in MA and leveling the playing field across MA plans, rather than making commissions consistent with other markets, drove the design of MA commission policy.

TABLE 1

Maximum Agent and Broker Commissions Offered by MA Plans Relative to Total MA Payments, 2023, Weighted by MA Enrollment

	Initial commission for a new enrollee	Renewal commission for a continuing enrollee
Weighted average maximum commission	$615.67	$ 307.71
Weighted average maximum commission as a percent of total MA payments after risk adjustment	4.5%	2.3%

Source: Author's analysis of MA plan payment data and agent and broker commission data from CMS. CMS, "Agent Broker Compensation," accessed August 20, 2025, https://www.cms.gov/medicare/health-drug-plans/managed-care-marketing/medicare-marketing-guidelines/agent-broker-compensation; CMS, "Medicare Advantage/Part D Contract and Enrollment Data," accessed August 20, 2025, https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-advantagepart-d-contract-and-enrollment-data; and CMS, "Plan Payment Data," accessed August 20, 2025, https://www.cms.gov/medicare/health-drug-plans/plan-payment-data.

Notes: CMS = Centers for Medicare & Medicaid Services. MA = Medicare Advantage; PMPY = per member per year. Maximum commissions and total MA payments are weighted by MA enrollment. We applied enrollment weights to reflect the share of total payments going to commissions for an average enrollee who uses an agent or broker receiving the plan's maximum commission.

MA commissions are also high relative to other comprehensive health insurance markets. In 2021, KFF found that average broker compensation in the individual market was $181 per member per year, $316 per member per year in the small group market, and $112 per member per year in the large group market.[19] That year, CMS set the FMV of MA commissions at $539 per member per year for new MA enrollees and $270 for renewals and beneficiaries switching among MA plans. Although the estimated compensation for individual market brokers is not directly comparable to CMS's FMV commissions, it aligns with other evidence that MA initial commissions are higher than commissions in other health

insurance markets, and that renewal commissions are higher than average commissions in the individual and large group markets.

Although initial and renewal commissions are not paid for every enrollee because not every enrollee uses an agent or broker, they represent a substantial share of total MA payments and do not include administrative, add-on payments, and spending on marketing. Some commentators on CMS rules, as well as some of our interviewees, noted that CMS's commission requirements for agents and brokers could further reduce enrollment in smaller local plans that cannot afford large commissions and high marketing spend.[20]

OTHER FACTORS AFFECT THE CHOICES AGENTS AND BROKERS OFFER TO BENEFICIARIES

Agents, brokers, their associations, and state insurance regulators all said that the need for personal referrals creates incentives for local agents and brokers to keep their clients happy by enrolling them in plans that meet their needs, regardless of commission rates. However, agents and brokers acknowledged that they do not sell every MA or Medigap plan in their service area. A 2021 report found that large online broker plan selection tools included fewer than half of MA plans and about two-thirds of Part D plans (Ali et al. 2021). One interviewee said this decision to streamline the number of plans offered can lead to smaller local plans being cut out of agent and broker sales, even if they are willing to pay commissions, because there are simply too many plans in some areas for agents and brokers to have the time to learn about and offer every plan in the market. National call centers and web platforms, including the enrollment tools developed for independent agents and brokers by field marketing organizations, may not include smaller local and regional plans. Our interviewees said there are no rules requiring agents and brokers to disclose which plans they do and do not sell. CMS recently proposed a rule requiring agents and brokers to discuss Medigap and Medicare Savings Programs with clients for plan year 2026, but that proposal was not finalized.[21]

Some of our interviewees noted that the complexity and cost of Medigap lead some agents and brokers to focus on MA. In particular, agents and brokers in national call centers or large agencies and brokerages may not have adequate information on state variations in Medigap rules to feel comfortable selling Medigap across many different states and may instead focus on selling only MA. Our interviewees also emphasized that the growth in Medigap premiums has led more people to select MA over time, which is supported by the literature (Ryan et al. 2025).

As MA Has Grown, So Has the Sales Industry

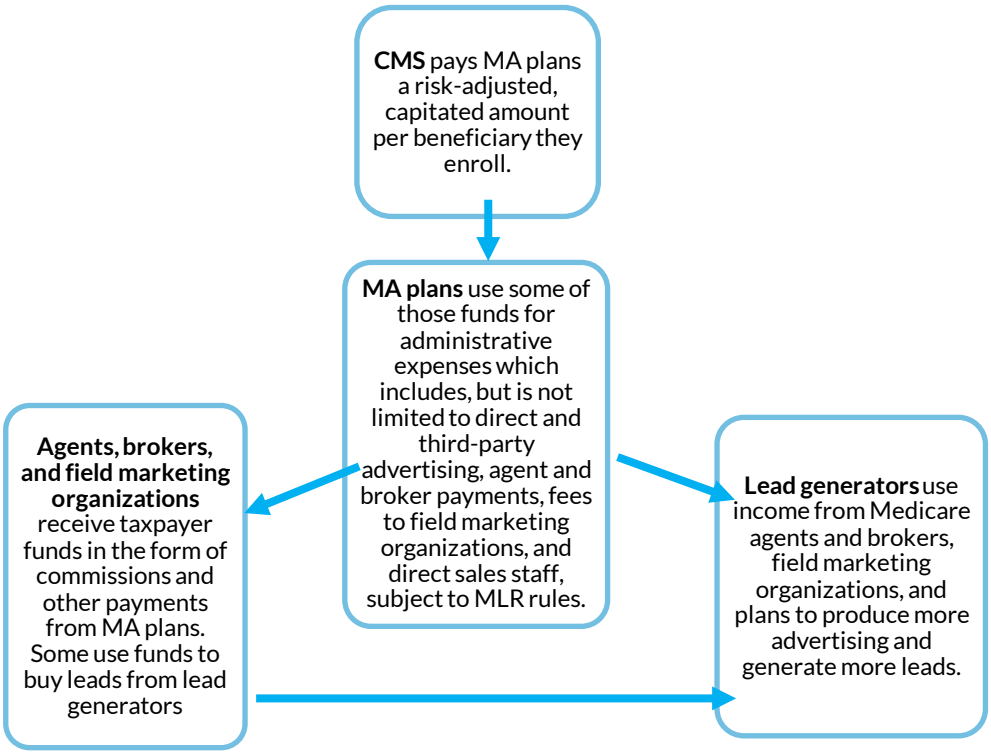
MA is a profitable market for health insurers. In 2023, MA had a gross margin per enrollee[22] of $1,982, nearly double other health insurance markets, including the individual market ($1,048), the group market ($910), and the Medicaid managed care market ($753; Ortaliza et al. 2024). That year, MA plans spent $9.1 billion on agent and broker commissions and direct sales salaries and benefits to help enroll beneficiaries in MA, not including other marketing expenses (Wyden 2025). For comparison, CMS spent just $70 million on grants to SHIPs in 2023[23] and about $660 million on 1-800-MEDICARE and other call center and customer support for CMS programs that year.[24] Although MA margins appear to have

tightened in 2024 and 2025 (NAIC 2025), it is not yet clear if MA has reduced overall spending on commissions, fees, and marketing. Even with tighter margins, MA plans still have incentives to compete for enrollment through investments in sales and marketing strategies that may not serve beneficiaries or taxpayers well.

Our interviewees described a sprawling sales industry that has grown alongside MA, funded with taxpayer dollars via the capitated, risk-adjusted payments to MA plans (figure 2). Along with agents and brokers, MA's high gross margins fund field marketing organizations, lead generators, and direct advertising by MA plans. Figure 2 describes how taxpayer dollars flow to various components of the Medicare sales industry.

FIGURE 2

How Taxpayer Dollars Flow to the MA Sales Industry



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Source: Authors' analysis of interviewee comments.
Notes: MA = Medicare Advantage; CMS = Center for Medicare & Medicaid Services; MLR = Medical Loss Ratio.

Our interviewees were united in expressing concern about lead generators. Lead generators are independent organizations that advertise MA products and gather beneficiary contact information to sell as sales leads. Many lead generators are fully independent, generating revenue by selling MA leads to field marketing organizations and independent agents and brokers. In either case, lead generators are supported by a share of MA commissions and MA gross margins, which are paid for with public funds. Our interviewees noted that at least some of these organizations are headquartered offshore, making

them very difficult to regulate. These claims of offshore marketing companies are supported by the recent report on MA marketing from Senator Wyden's office (Wyden 2025).

While many of our interviewees said that agents and brokers play a valuable role in educating Medicare beneficiaries in a complex market and should be compensated fairly for that service, some of the spending on enrollment or marketing activities in the MA market may directly harm or confuse beneficiaries. For example, beneficiaries targeted by lead generators may get 20 or more calls per day to sell them Medicare plans (Wyden 2025). CMS has also noted growing complaints about confusing or misleading MA marketing.[25] Our interviewees also widely condemned what they saw as "misleading" celebrity advertisements and said that these lead-generation businesses are behind reports of incessant MA marketing calls to beneficiaries. Despite the beneficiary confusion and widespread concern these lead generators cause, they persist because, as one interviewee put it, "everyone wants a lead." Interviewees said this is particularly true of agents and brokers who work in call centers, as they do not have the community ties to generate referrals.

THE MA SALES INDUSTRY IS NOT WELL-REGULATED

MA and Part D plans, Medigap plans, and third parties that sell these products are overseen by an overlapping and uncoordinated set of state and federal regulations and policies, but many gaps exist. In general, CMS has sole authority to regulate MA and Part D plans, but state departments of insurance still oversee financial statement filings for those plans. In contrast, states have sole authority to regulate Medigap plans, though CMS sets the standard plan designs and some enrollment requirements. Regulation of agents and brokers lies somewhere in between those two extremes. Agents and brokers are licensed by states, but CMS regulates agent and broker commissions for MA and Part D plans and provides some oversight via its authority over MA plans.

The National Association of Insurance Commissioners has requested that Congress give states more authority to regulate MA plans, particularly noting issues around sales and marketing oversight.[26] The state regulators we spoke to said that information sharing between CMS and states can be poor, making it difficult for states to fulfill their regulatory obligations around agent and broker licensing and overseeing MA and Part D financial statements. For example, CMS does not always pass through complaints about agents, brokers, and marketing to the relevant states, making it difficult for state regulators to know what issues consumers are facing in their jurisdictions. Marketing issues also often cut across state lines, but CMS does not share information on problems and sanctions broadly across states, so state regulators do not know if issues they are seeing are specific to their local area or fit into a national pattern. The former CMS officials we spoke to confirmed that communication and coordination between states and CMS could be improved.

Beneficiary advocates said that beneficiaries often cannot tell what advertisements and mailings are coming from CMS, MA plans, agents and brokers, or third parties, leading to confusion. Many complaints to 1-800-MEDICARE are marketing-related (Skopec, Pugazhendhi, and Feder 2024).[27] In addition, beneficiaries are increasingly bombarded with mail and calls purporting to help with Medicare choices, but do not clearly disclose they are not from CMS (Skopec, Pugazhendhi, and Feder 2024;

Wyden 2025). CMS has attempted to reduce marketing abuses and increase oversight of lead generators and other marketing organizations in recent years,[28] but significant concerns about MA marketing persist (OIG 2024; Wyden 2025).[29]

Our agent, broker, and field marketing organization interviewees said that state licensing is not a significant hurdle for them, and that state and federal oversight of their business is minimal. Because most agents and brokers do not work directly for an MA plan, CMS cannot easily use its authority over MA plans to regulate the actions of independent agents and brokers. As one agent noted, "I think overall, there is a lack of oversight of good versus bad agents. Who's out there to make sure there are good agents and not bad agents?"

State regulators said regulating agents and brokers working for national call centers is also difficult, as they do not have ties to the local community or directly to MA plans. Former CMS officials noted that 1-800-MEDICARE has added a tag with agent and broker identifiers to its complaint tracking system, but they noted this data would not provide a comprehensive picture of agent and broker activity and remains unavailable to states and the public. Because CMS does not collect comprehensive data on the use of agents and brokers, the share of beneficiaries assisted by a national call center versus a local agent or broker remains unclear. Nearly all our interviewees said that oversight and regulation of lead generators is even more problematic. State regulators and former CMS officials noted that these organizations do not fall under the jurisdiction of state departments of insurance or CMS. Although CMS has attempted to rein in some marketing abuses through additional regulation of MA plans,[30] CMS does not have the authority to directly regulate lead generators. Our interviewees suggested these organizations could be subject to regulation or sanction by the Federal Communications Commission or the Federal Trade Commission, but some interviewees also noted that many of them reside offshore.

"I think overall, there is a lack of oversight of good versus bad agents. Who's out there to make sure there are good agents and not bad agents?"
—Interviewed agent

The Solutions: Simplify Beneficiary Choices, Align Incentives, and Improve Decision Support

In the absence of legislative action to simplify Medicare or provide adequate public sources of beneficiary education and support, the Medicare sales industry has thrived (Neuman et al. 2024; Wyden 2025). Our interviewees noted that agents and brokers fill a valuable educational role for Medicare beneficiaries, but we were unable to identify any research that assesses whether agents and brokers improve plan selection relative to other sources of information. In addition, agents, brokers, and

marketers have financial incentives to encourage MA enrollment that do not necessarily align with helping beneficiaries choose a Medicare coverage option that best meets their needs, and MA overpayment has led to high levels of spending on marketing to generate more enrollment. Further, the Medicare sales industry that has grown rapidly alongside MA is funded by public dollars, yet there is little, if any, evidence that this spending improves beneficiaries' access to care or health outcomes.

Our interviews and the broader literature suggest several areas of payment and benefit policy that can be addressed to improve Medicare sustainability, reduce taxpayer burdens, and help beneficiaries navigate Medicare enrollment.

Simplify and Strengthen Medicare Choices

Our interviewees all noted that Medicare beneficiaries face a complex array of choices and that many beneficiaries do not feel comfortable making enrollment decisions on their own. This complexity does not serve beneficiaries, and it requires tax dollars to support more extensive education, communications, navigation, and marketing programs. Moreover, there is little evidence that the publicly financed support for making difficult enrollment choices (e.g., through 1-800-MEDICARE, SHIPs, Medicare.gov, and MA plan spending on agents, brokers, and marketing) is allocated appropriately and effectively across beneficiary education and support programs. Many proposed policies to simplify and strengthen Medicare would lessen beneficiaries' need for intensive decision support. These include, for example:

- Simplify TM cost-sharing to include a combined deductible and/or an out-of-pocket maximum to make coverage more closely resemble private insurance or MA and reduce the need for supplemental coverage (CBO 2013; Gangopadhyaya et al. 2022).
- Standardize MA plans to make it easier for beneficiaries to make choices, similar to the approach in the Marketplaces or Medigap (Ginsburg and Lieberman 2024; MedPAC 2024). Alternatively, CMS could reinstitute "meaningful difference" rules, which limited the number of different plan designs MA insurers could offer by requiring each plan to be substantially different in terms of cost sharing or supplemental benefits. This rule was repealed for plan year 2019 by CMS.[31]
- Set limits on the number of MA contracts awarded to reduce the number of plan choices beneficiaries face and allow for stronger oversight and enforcement (Lieberman et al. 2018).
- Align benefits in TM with MA so beneficiaries can get access to hearing, vision, and dental coverage no matter which option they choose (Davis et al. 2005; Garrett, Holahan, and Zuckerman 2025).[32]

One interviewee suggested simplifying Medicare choices not by reducing the number of choices available but by providing better public tools to help beneficiaries make enrollment decisions. For example, AI-based online tools could allow beneficiaries to compare plans along more dimensions than the Medicare Plan Finder currently allows and could provide personalized plan suggestions. Such tools

could be developed through public-private partnerships or by CMS contractors, but would require CMS to collect and release more data on plan characteristics to be successful.

Reduce Agent and Broker Commission Growth

In the absence of authority to regulate all agent and broker payments, CMS should consider reducing the growth rate it sets for agents and broker commissions to gradually better align commissions with compensation in other markets, including Medigap. Right now, CMS increases the FMV for agent and broker commissions by the MA benchmark growth rate each year, rather than by the Consumer Price Index or an alternative measure of inflation. Choosing a more appropriate growth rate for commissions and benchmarking them to other markets could reduce incentives for agents and brokers to steer beneficiaries into particular options while also lowering public spending on commissions. However, some of our interviewees noted that lowering commissions could drive local agents and brokers out of business, concentrating the sales industry in the hands of national brokerages and web-brokers that lack strong ties with their communities.

Rein in MA Overpayment

MA is a lucrative market for insurers and for agents and brokers (Jacobson and Uccello 2025; Ortaliza et al. 2024).[33] MedPAC and researchers have long recommended reducing overpayment to MA plans by reforming the MA payment system, addressing risk adjustment abuses, and reforming or eliminating the quality bonus program.[34] Reducing overpayment would leave MA plans with less excess to spend on marketing and sales, reducing the market for predatory lead generation and marketing tactics. As MA margins fell in 2025, administrative fee ratios also fell (NAIC 2025), suggesting that financial pressure on MA plans may reduce administrative spending, which includes marketing, commissions, and other plan administrative needs. However, even with tighter margins, MA plans will continue to have incentives to pursue effective sales and marketing strategies, even if those strategies are not optimal for beneficiaries or taxpayers. Reducing overpayment alone will therefore not fully address the problems with the MA sales and marketing industry. Further research is needed to assess the relationship between MA plan payments, margins, and administrative spending.

Increase Funding for Neutral Enrollment Assistance

CMS funds SHIPS to help beneficiaries understand their enrollment options and provide guidance about how to navigate enrolling in their Medicare coverage, but funding for these programs is inadequate to meet demand (Garrido et al. 2024; Skopec, Pugazhendhi, and Feder 2024). Total spending on SHIPs amounted to about $1 per beneficiary in 2023. In comparison, the federally facilitated Marketplaces spent about $8 per enrollee on navigator support that year (Skopec, Pugazhendhi, and Feder 2024), though Marketplace navigator support is expected to fall by 90 percent in 2026.[35] Increased funding for SHIPs, 1-800-Medicare, and Medicare.gov could help beneficiaries access neutral sources of information and enrollment support. Alternatively, Congress could create a certified Medicare Navigator program, similar to that in the Marketplaces, that would allow agents and brokers to continue

to help beneficiaries make plan decisions but would provide additional oversight, training, and transparency requirements.

Former CMS officials also noted that CMS itself is not adequately funded to perform its oversight functions, making it difficult to review marketing materials and monitor the MA market. Increasing funding for CMS oversight activities alongside increased support for neutral enrollment assistance could help reduce marketing and enrollment abuses.

Improve Transparency and Oversight

The National Association of Insurance Commissioners has asked Congress to give state departments of insurance additional authority to oversee MA plans.[36] The state regulators we spoke to agreed with this recommendation, suggesting that CMS could implement an approach similar to that used in the Marketplaces. Under such an approach, CMS would set the rules for MA at the federal level, but states would have primary responsibility for enforcement. If a state were to fail to enforce CMS rules or request assistance, CMS would step in as the fallback enforcement entity. This approach would allow states to better align their Medigap and MA markets, enforce rules consistently across health insurance markets, and address marketing and enrollment issues in their local communities. However, former CMS officials noted that MA is a federal program that should have consistent rules and enforcement mechanisms nationwide.

Though our interviewees did not agree on delegating MA oversight authority to states, there was more agreement that additional transparency could also help CMS, states, and stakeholders identify problems in MA and help consumers deal with them. For example, CMS does not publish or share complaint data, making it difficult for states to identify bad actors among their licensed agents and brokers. One of our interviewees also suggested additional data collection on agents and brokers in Medicare, including collecting the agent of record for every Medicare enrollee and collecting data on complaints against the agent/broker and MA disenrollment rates among their clients. Such data would help CMS and states identify potential problems, take enforcement action, and assess the effects of regulation on agent and broker behavior. Another interviewee suggested that CMS develop methods to evaluate the impact of regulatory changes related to agents, brokers, and marketing to ensure rules are targeted and produce the intended outcomes.

Finally, some of our interviewees, as well as Senator Wyden's office, suggested that Congress give CMS the authority to regulate lead generators and other types of marketing organizations, including banning offshore call centers and overseeing MA plan contracts with these organizations (Wyden 2025).

Notes

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[10] *Americans for Beneficiary Choice v. United States Department of Health and Human Services* (2025).

[11] "Medicare Program; Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program for Contract Year 2024," HHS.

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[13] CMS, "Contract Year 2026 Agent and Broker Compensation Rates, Referral/Finder's Fees, Submissions, and Training and Testing Requirements," June 18, 2025, Baltimore, MD: CMS.

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