

Medicare Advantage Marketing, Brokers, and Agents

Flaws in Medicare Advantage (MA) payment methodologyⁱ yield significant overpayments that threaten Medicare sustainability.ⁱⁱ Plans use these extra dollars to perpetuate the cycle: They fund benefits and marketing strategies that attract enrollees, creating an ever-increasing cycle of overspending.

The MA plan choice landscape is cluttered and confusing. It is packed with information and disinformation, as plans market themselves directly and through proxies like third-party companies, an approach that can result in varying degrees of message oversight, accuracy, and quality.ⁱⁱⁱ With an ever-growing number of plans that have increasingly imperceptible differences,^{iv} MA plan marketing can quickly overwhelm beneficiaries. Seeking help with decision-making and discernment, beneficiaries frequently turn to agents and brokers, who are readily available and eager to assist.^v



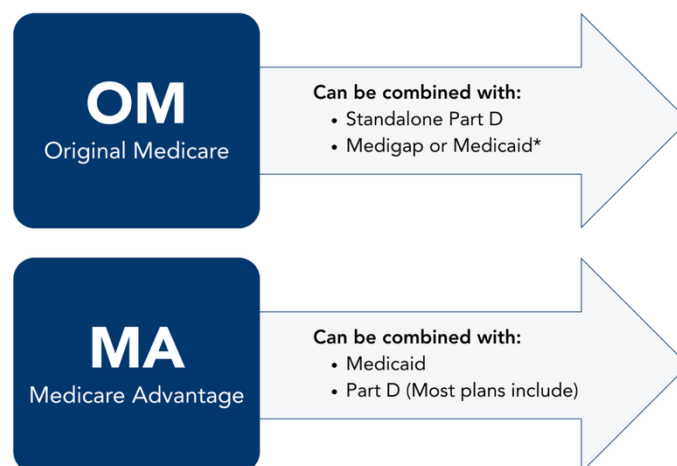
Unfortunately, these entities may not always be acting in the beneficiary's best interest. Statutorily, MA broker and agent compensation is supposed to be structured in a way that encourages them "to enroll individuals in the Medicare Advantage plan that is intended to best meet their health care needs."^{vi} But in practice, there are many financial incentives baked into the system—including higher commissions and added perks^{vii}—that can influence agent and broker behavior, causing them to enroll people in unsuitable MA plans.

These suboptimal enrollments carry serious consequences, including higher costs, problems accessing preferred providers, and delayed care. Despite the risk, there are few avenues for relief. Beneficiaries may be stuck in a plan that does not work for them until the next available enrollment period, or locked into MA indefinitely, due to disenrollment barriers like unaffordable Medigap coverage.

Agent and Broker Commissions

Original Medicare (OM) does not pay commissions, but insurers offering add-on plans that OM enrollees often have, like Part D standalone plans (PDPs) and Medigap, do.

Brokers do receive plan-paid commissions for MA. Where MA plans include Part D (MA-PDs), commissions are at the higher MA rate.^{viii} Maximum commissions for initial MA enrollments are set at the federal level.



* Federal law prohibits the sale of a Medigap policy to people with both Medicare and full Medicaid.

Similarly, PDPs have a nationally set maximum for enrollments. For both types of plans, renewals—such as when a beneficiary keeps their plan the following year—can pay up to 50% of the maximum initial enrollment commission.^{ix}

For MA or PDPs, an “initial” enrollment is adding new coverage or a switch to an “unlike plan type.”^x For example, adding a standalone Part D plan to OM is an initial enrollment, as is switching from OM to MA.

A “renewal” is when an enrollee keeps the same plan or enrolls in a “like plan type.”^{xi} A switch from one MA plan to another or from one standalone Part D plan to another is a renewal. Renewal commissions are capped at 50% of initial commissions.^{xii}

Commissions by Plan Type				
	MA*	PDP*	Medigap†	OM
Initial year	\$626	\$109	\$521 (20% of premium)	\$0
Renewal year	\$313	\$55	\$260 (10% of premium)	\$0

* Maximum set nationally † National average

Medigaps operate differently. While Medigap plan benefits are standardized at the federal level,^{xiii} commissions are not. These rates are generally a percentage of the annual premium, around 20% for new enrollments and 10% for renewals.^{xiv} The Commonwealth Fund estimated average commissions for new enrollments was \$322 and \$166 for renewals in 2020.^{xv} For 2023, the Medicare Payment Advisory Commission (MedPAC) estimated these numbers leapt to \$521 and \$260, based on KFF analysis of average premiums.^{xvi} Importantly, Medigap premiums are extremely variable nationally, making their commissions attractive in some regions and unattractive in others.^{xvii}

For some plans and brokers, commissions are their only driver and Medigap commissions can be competitive, especially when combined with Part D. But for others, especially very large insurers and giant Third-Party Marketing Organizations (TPMOs), financial incentives go farther, increasing the risk of steering.

“Administrative” Payments

In a recent proposed rule, the Centers for Medicare & Medicaid Services (CMS) flagged that, under the guise of “administrative” payments, brokers are increasingly being paid bonuses, and treated to perks like trips and parties, for enrollments. These payments are especially common for brokers and umbrella TPMOs, which are “organizations and individuals, including independent agents and brokers, who are compensated to perform lead generation, marketing, sales, and enrollment related functions as a part of the chain of enrollment (the steps taken by a beneficiary from becoming aware of an MA plan or plans to making an enrollment decision).”^{xviii}

Such administrative payments can include reimbursement for overhead for each enrollee even for one-time expenses like travel,^{xix} as well as training, technology, and the completion of health risk assessments^{xx} that can be used to further drive plan overpayment.^{xxi}

TPMOs may also be double dipping by benefitting from both commissions and referral fees, as MA plans pay them for sales as well as for compiling lists of potential enrollees, known as “leads.”^{xxii} These various add-ons, along with rising MA enrollments, have increased insurer payouts to agents, brokers, and TPMOs from \$2.4 billion in 2018 to \$6.9 billion in 2023.^{xxiii}

TPMOs can have enough reach to distort MA markets by steering enrollees toward higher-paying insurers or, in the case of ongoing litigation, through alleged widespread steering of enrollees with higher projected costs away from the client insurers.^{xxiv}

In the Contract Year 2025 MA final rule,^{xxxv} CMS attempted to reduce incentives to steer beneficiaries by limiting administrative payments to a fixed fee and requiring insurers to ensure contracts do not create “an incentive that would reasonably be expected to inhibit an agent or broker’s ability to objectively assess and recommend which plan best fits the health care needs of a beneficiary.” Litigation from insurers and TPMOs quickly halted implementation of these changes through a nationwide stay,^{xxxvi} and CMS reverted to its previous commission structure to comply.^{xxxvii} As a result, administrative payments continue to distort broker and TPMO incentives, allowing entities to profit from plan sales that harm enrollees.

Incentives in Action: Marketing the Part B Premium Buydown or “Giveback Benefit”^{xxxviii}

One of the more aggressively marketed MA supplemental benefits is the Part B premium buydown, commonly called the “giveback benefit.”^{xxxix} This supplemental benefit allows plans to pay for part of an enrollee’s Part B premium.

Many Medicare beneficiaries with low incomes are already eligible for a Medicare Savings Program (MSP) which would cover their entire Part B premium as well as triggering other cost-saving coverage.^{xxx} But MSP application processes are notoriously complex, and many eligible people are not enrolled.^{xxxi}

These vignettes illustrate how callers to the Medicare Rights National Helpline were drawn to MA specifically for the buydown when the MSP would be a better fit:

Heard on the Helpline:

The Part B Premium Buydown or “Giveback Benefit”

Ms. LP chose her MA plan because it offered a buydown for 50% of the Part B premium. She said the plan was not a good fit for her otherwise. She wanted to enroll in an MSP instead so that her full premium was covered and expressed that this would allow her to enroll in another plan that suited her better.

Ms. LM is a “partial dual” because she is eligible for the Qualified Medicare Beneficiary (QMB) MSP which would pay her Part B premium as well as other Medicare cost sharing. But she was having trouble reenrolling in the MSP after being sent the incorrect paperwork by the Medicaid office. She enrolled in an MA plan with a premium giveback to partially compensate for her inability to access the MSP that she was entitled to.

As these vignettes show, the giveback benefit is a way to draw in enrollees to compensate for an underused federal benefit. And marketers see that clearly.

Starting in 2020, the first year MA plans could offer the Part B benefit buydown, TVs across America were flooded with commercials touting its availability. In 2021, an ad from the “Medicare Coverage Helpline” featuring Joe Namath garnered outsized attention. In it, Mr. Namath explains the giveback “Adds Money to Your Social Security Check... Every Single Month” and could be worth up to “\$1,700 a year” which was nearly the full amount of the Part B premium that year.^{xxxii}

But CMS subsequently flagged that a giveback benefit of that magnitude was rare:

[I]n 2021 there were national advertisements that claimed a beneficiary “could get up to \$144 back” on their Social Security check.... However, the number of counties or states where one or more available plans offered the advertised Part B premium reduction of \$144 was small. In fact, for CY 2021, Florida and Puerto Rico were the only states or territories that had plans with a reduction of \$140 or more, and in CY 2022 the only states or territories that had plans with a reduction of \$140 or more were California, Florida and Puerto Rico.^{xxxiii}

CMS also noted that not all beneficiaries would have access to an MA plan offering a giveback, as “there may not even be a Part B premium reduction in [their] particular service area” and that even if such plans were available “the actual reduction may be minimal, anywhere from \$1 to \$25.”^{xxxiv}

These misleading advertisements, along with heightened beneficiary complaints about MA marketing, triggered CMS to release guidance later that year,^{xxxv} noting:

CMS is particularly concerned with national advertisements promoting MA plan benefits and cost savings, which are only available in limited service areas or for limited groups of enrollees, as well as using words and imagery that may confuse beneficiaries or cause them to believe the advertisement is coming directly from the government. In addition, CMS receives complaints from beneficiaries and caregivers that highlight sales tactics designed to rush or push beneficiaries into enrolling into a plan.... We are also working with other federal agencies regarding the appropriateness of the content of certain advertisements.

A year later, in 2022, CMS used rulemaking to formally tighten plan marketing restrictions by disallowing the advertisement of benefits that are not available to beneficiaries in the service area where the advertisement airs, calling such practices “misleading.”^{xxxvi}

Commoditizing Beneficiary Information

Big national or regional ads drive potential MA enrollees to 800 numbers or websites hosted by TPMOs. In the case of the Joe Namath ads, if callers gave its “Medicare Coverage Helpline” their contact information, it was sent to agents and brokers who did the actual enrollments through follow-up phone calls,^{xxxvii} likely garnering both referral and commission fees for the TPMOs and contracted brokers.

But all too often, the MA coverage that beneficiaries think they are signing up for and the benefits they actually receive are not the same. The agents and brokers do not necessarily represent every plan in their areas, and the plans can incorporate incentives to spur, or discourage, enrollment.

As CMS noted when formalizing the plan guardrails, the ad in question was “designed to attract a beneficiary's attention so that the beneficiary will call the number and then be subject to additional marketing and potentially switched to a plan unsuited to meeting the beneficiary's health care needs.”^{xxxviii}

More Beneficiary Experiences^{xxxix}

Callers to Medicare Rights’ National Helpline have personal experience with these marketing tactics.

Heard on the Helpline

Misleading Ads

Ms. CL called the Helpline with complaints about misleading MA ads promising extra Social Security benefits, as well as prepaid debit cards for purchasing over-the-counter health products and food. She said when she asked the plan about them, she learned there were limitations on the policy and that she wasn’t eligible for any of the advertised benefits.

Beyond the shady bait and switch, these enrollments may trap beneficiaries within MA. Most MA enrollees have limited windows to switch back to OM due to lack of Medigap access or Open Enrollment Periods.^{xi}

Heard on the Helpline

Trapped in MA

Ms. MF switched to an MA plan and wanted to switch back to Original Medicare but missed the Medicare Advantage Open Enrollment Period, so she must wait until the Fall Open Enrollment.

Mr. RS was enrolled in a Medigap plan for several years. An MA agent said that Mr. RS could try out MA and had a two-year period within which he could change back to Medigap. Mr. RS decided to return to his Medigap plan, but the agent would not return his calls. When he called his MA plan directly, representatives told Mr. RS that he could have re-enrolled in his Medigap plan within one year of enrolling in MA, but the one-year period had expired. Mr. RS had no right to re-enroll but must apply to see if the plans would accept him. The Medigap plans he applied for denied him.

Discussion

The rulemaking limiting fictive administrative payments would have been an important step towards curbing some of the worst financial mis-incentives and excesses of insurers, TPMOs, and brokers. But if the system is to truly center beneficiary needs and preferences, a comprehensive overhaul is required.

The current compensation structure is simply unsustainable. Even for brokers and plans who follow the rules, the financial incentives to promote MA plans—regardless of the beneficiary's best interest—are enormous. MA commissions are outsized compared to those of PDPs and Medigap, and OM by itself pays no commission at all. Illegal or quasi-legal bonuses, perks, kickbacks, discrimination, and administrative fees make steering all but guaranteed. This puts many beneficiaries at grave risk of being enrolled in plans that do not suit their needs or fit their circumstances, undermining their health and financial security.

Improved access to MSPs would reduce some of the pressure on beneficiaries with lower incomes, and equalizing commissions between MA plans and PDPs would offset some of the market distortions. But MA overpayment is at the heart of this problem, rewarding MA insurers

for funneling money into marketing and other drivers of enrollment. Making MA payments more accurate, including through changes to quality bonus payments, risk adjustment, and benchmarking, could correct both the market and the threat to Medicare’s financial stability, while aggressive oversight and expanded audits could catch bad actors and prevent discriminatory practices.

To truly remove unnecessary risk from beneficiary decision-making and reliance on third parties, all MA plans must be high quality and easy to compare. Standardizing MA offerings and addressing the proliferation of plans could help enrollees better understand their options, reducing confusion and exposure to steering.

ⁱ Medicare Rights Center, “Payments to Medicare Advantage: The Methodology” (July 17, 2023), <https://www.medicarerights.org/policy-documents/payments-to-medicare-advantage-the-methodology>.

ⁱⁱ For more on this overpayment cycle, see Medicare Rights Center, “The Overpayment Cycle: Payments to Medicare Advantage” (July 17, 2023), <https://www.medicarerights.org/policy-documents/the-overpayment-cycle-payments-to-medicare-advantage>.

ⁱⁱⁱ Jessica Hall, “Medicare Advantage’s ‘secretive maze’ of costly marketing and incentives needs an overhaul, Senate report says” (April 16, 2025), <https://www.marketwatch.com/story/medicare-advantages-secretive-maze-of-costly-marketing-and-incentives-needs-an-overhaul-senate-report-says-8d90cbdb>.

^{iv} Medicare Rights Center, “Medicare Advantage Proliferation: Too Much of a Complicated Thing” (July 23, 2025), <https://www.medicarerights.org/policy-documents/medicare-sustainability-ma-proliferation>.

^v Faith Leonard, *et al.*, “Traditional Medicare or Medicare Advantage: How Older Americans Choose and Why” (October 17, 2022), <https://www.commonwealthfund.org/publications/issue-briefs/2022/oct/traditional-medicare-or-advantage-how-older-americans-choose>

^{vi} Pub. L. 110–275 § 103.

^{vii} Riaz Ali & Leslie Hellow, “Agent Commissions in Medicare and the Impact on Beneficiary Choice” (October 12, 2021), <https://www.commonwealthfund.org/blog/2021/agent-commissions-medicare-and-impact-beneficiary-choice>.

^{viii} 42 CFR 422.2274.

^{ix} Centers for Medicare & Medicaid Services, “UPDATED: Contract Year 2025 Agent and Broker Compensation Rates, Submissions, and Training and Testing Requirements” (July 18, 2024), https://www.grassley.senate.gov/imo/media/doc/ab_compensation_and_testing_requirements_cy2025.pdf.

^x 42 CFR 422.2274.

^{xi} 42 CFR 422.2274.

^{xii} Centers for Medicare & Medicaid Services, “UPDATED: Contract Year 2025 Agent and Broker Compensation Rates, Submissions, and Training and Testing Requirements” (July 18, 2024), https://www.grassley.senate.gov/imo/media/doc/ab_compensation_and_testing_requirements_cy2025.pdf.

^{xiii} Medicare Interactive, “Comparing Medigap options” (last accessed June 23, 2025), <https://www.medicareinteractive.org/understanding-medicare/health-coverage-options/supplemental-insurance-for-original-medicare-medigaps/comparing-medigap-options>.

^{xiv} Riaz Ali & Leslie Hellow, “Agent Commissions in Medicare and the Impact on Beneficiary Choice” (October 12, 2021), <https://www.commonwealthfund.org/blog/2021/agent-commissions-medicare-and-impact-beneficiary-choice>.

^{xv} Riaz Ali & Leslie Hellow, “Agent Commissions in Medicare and the Impact on Beneficiary Choice” (October 12, 2021), <https://www.commonwealthfund.org/blog/2021/agent-commissions-medicare-and-impact-beneficiary-choice>.

^{xvi} Ledia Tabor, *et al.*, “Background: Medicare insurance agents” (March 6, 2025), https://www.medpac.gov/wp-content/uploads/2025/03/Medicare-agents-MedPAC-03.25_SEC.pdf.

^{xvii} For example, Plan G was the reported top-selling Medigap plan at 53.2% of Medigap enrollees in 2024 and, that year, a woman turning 65 could find Plan G monthly premiums in a range from a low of \$99.64 in Phoenix to a high of \$526.85 in Manhattan. With a 20% new enrollment rate, commissions on these plans could range from \$239 to \$1264. American Association for Medicare Supplement Insurance, “Medicare Insurance Statistics 2024” (last accessed June 20, 2025), <https://medicaresupp.org/medicare-insurance-statistics-2024/>.

^{xviii} 42 CFR 422.2260.

^{xix} 88 Fed. R. 78476, 78554.

^{xx} Senate Finance Committee Ranking Member Ron Wyden, “Pushing Medicare Advantage on Seniors : Unraveling the Complex Network of Marketing Middlemen” (March 2025), <https://www.finance.senate.gov/imo/media/doc/pushing-medicare-advantage-on-seniors-unraveling-the-complex-network-of-marketing-middlemen-32425docx.pdf>.

^{xxi} Dept. of Health and Human Services Office of Inspector General, “Medicare Advantage: Questionable Use of Health Risk Assessments Continues To Drive Up Payments to Plans by Billions” (October 21, 2024), <https://oig.hhs.gov/reports/all/2024/medicare-advantage-questionable-use-of-health-risk-assessments-continues-to-drive-up-payments-to-plans-by-billions/>; Meredith Freed, *et al.*, “Medicare Advantage Insurers Often Use Rewards and Incentives to Encourage Enrollees to Complete Health Risk Assessments (HRAs)” (April 28, 2025), <https://www.kff.org/medicare/issue-brief/medicare-advantage-insurers-often-use-rewards-and-incentives-to-encourage-enrollees-to-complete-health-risk-assessments-hras/>.

^{xxii} 88 Fed. R. 78476, 78554.

^{xxiii} Senate Finance Committee Ranking Member Ron Wyden, “Pushing Medicare Advantage on Seniors : Unraveling the Complex Network of Marketing Middlemen” (March 2025), <https://www.finance.senate.gov/imo/media/doc/pushing-medicare-advantage-on-seniors-unraveling-the-complex-network-of-marketing-middlemen-32425docx.pdf>.

^{xxiv} U.S. Department of Justice, “The United States Files False Claims Act Complaint Against Three National Health Insurance Companies and Three Brokers Alleging Unlawful Kickbacks and Discrimination Against Disabled Americans” (May 1, 2025), <https://www.justice.gov/opa/pr/united-states-files-false-claims-act-complaint-against-three-national-health-insurance>.

^{xxv} 89 Fed. R. 30448.

^{xxvi} *Americans for Beneficiary Choice v. US Dept. of Health and Human Services*, No. 4:24-cv-00439 (N.D. Tex.), <https://law.justia.com/cases/federal/district-courts/texas/txndce/4:2024cv00439/389767/40/>.

^{xxvii} David Kopans, “CMS reverses changes to agent and broker compensation rules” (July 23, 2024), <https://www.dlapiper.com/en-us/insights/publications/2024/07/cms-reverses-changes-to-agent-broker-compensation-rules>.

^{xxviii} For more on the giveback benefit, see our companion pieces on beneficiary experiences of MA marketing and supplemental benefits.

^{xxix} *See, e.g.* Humana, “Medicare Part B Giveback Benefit explained” (August 7, 2025), <https://www.humana.com/medicare/medicare-resources/part-b-giveback-benefit>.

^{xxx} Medicare Interactive, “Medicare Savings Program basics” (last accessed November 13, 2025), <https://www.medicareinteractive.org/understanding-medicare/cost-saving-programs/medicare-savings-programs-gmb-slmb-qi/medicare-savings-program-basics>.

^{xxxi} Giovanni Florez, *et al.*, “Medicare Savings Programs: A Lifeline for Millions” (August 7, 2025), <https://www.medicarerights.org/policy-documents/medicare-savings-programs-a-lifeline-for-millions>; Centers for Medicare & Medicaid Services, “Navigating the Medicare Savings Program (MSP) Eligibility Experience” (last accessed November 13, 2025), <https://www.cms.gov/files/document/navigating-medicare-savings-program-msp-eligibility-experience-journey-map.pdf>.

^{xxxii} *See, e.g.*, Medicare Coverage Helpline, “Medicare Open Enrollment Deadline Featuring Joe Namath” (last accessed November 19, 2025), <https://www.youtube.com/watch?v=9BCo8oUXx8&list=PLwYIfaHYLSdR4kepBpPX6xv75cpVJEsf>.

^{xxxiii} 87 Fed. Reg. 79452, 79526.

^{xxxiv} 87 Fed. Reg. 79452, 79526.

^{xxxv} Centers for Medicare & Medicaid Services, “Third Party Marketing” (October 8, 2021), <https://www.cms.gov/files/document/thirdpartymarketingmemo1082021.pdf>.

^{xxxvi} 88 Fed. Reg. 22120, 22240.

^{xxxvii} U.S. Senate Committee on Finance Minority Staff, “Deceptive Marketing Practices Flourish in Medicare Advantage” (last accessed November 19, 2025), <https://www.finance.senate.gov/imo/media/doc/Deceptive%20Marketing%20Practices%20Flourish%20in%20Medicare%20Advantage.pdf>; the website for the Medicare Coverage Helpline is no longer functioning, but an archived version can be accessed via the Internet Archive: <https://web.archive.org/web/20210303043546/https://www.medicarecoveragehelpline.com/>.

^{xxxviii} 87 Fed. Reg. 79452, 79527.

^{xxxix} For more from our National Helpline, see our companion pieces on beneficiary experiences of MA marketing tactics and MA supplemental benefits.

^{xl} Sarah Jane Tribble, “Older Americans say they feel trapped in Medicare Advantage plans” (January 3, 2024), <https://www.npr.org/sections/health-shots/2024/01/03/1222561870/older-americans-say-they-feel-trapped-in-medicare-advantage-plans>; see, e.g., Angela Liu, *et al.*, “Medigap-guaranteed issue associated with Medicare Advantage disenrollment for beneficiaries administered a part B drug” (October 23, 2024), <https://academic.oup.com/healthaffairsscholar/article/2/11/qxae136/7831814>.