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ANALYSIS: CY 2025 REVISIONS TO MEDICARE ADVANTAGE AND PART D RULES GOVERNING AGENT, BROKER AND THIRD PARTY COMPENSATION

On April 4, the Centers for Medicare & Medicaid Services (CMS) released the Contract Year (CY) 2025 Medicare Advantage (MA) and Medicare Part D Policy and Technical Changes final rule ("Final Rule"), which included revisions to the regulations governing how MA organizations and Part D plan sponsors (referred to collectively throughout as "issuers") compensate agents, brokers and third parties. In this rulemaking, CMS raised a number of concerns about third party marketing organizations (TPMOs) and, specifically, field marketing organizations (FMOs) having undue influence over beneficiary plan selection and competition among issuers. Despite some speculation that CMS would force an overhaul of issuers' contractual relationships with TPMOs, the Final Rule should only affect contract provisions that could interfere with agent and broker objectivity. This conclusion is supported by the final regulatory text, the underlying statutory authority, regulatory history, and sub-regulatory guidance, as well as CMS's own assertion that it "does not believe [the Final Rule] will have an adverse effect, either on TPMOs, FMOs or independent brokers."[1]

Overview of Changes

CMS made three primary changes to regulations governing relationships between issuers and independent agents, brokers and other third parties:

1. Prohibiting contract terms between issuers and agents, brokers or TPMOs that may interfere with the agent's or broker's ability to objectively assess and recommend the plan which best fits a beneficiary's health care needs. 42 C.F.R. § 422.2274(c)(13) and § 423.2274(c)(13) ("subparagraph (c)(13)").

2. Amending the definition of compensation to include "administrative payments" and setting a single compensation rate for agents and brokers that reflects the inclusion of such administrative payments. 42 C.F.R. § 422.2274(a) and § 423.2274(a).

3. Eliminating the separate treatment of "administrative payments" at 42 C.F.R. § 422.2274(e) and § 423.2274(e) ("subparagraph (e)").

Limitations on Scope

While at times CMS speaks in sweeping language, the scope of these changes is necessarily limited by the authority CMS asserts it is exercising: Social Security Act 1851(j)(2)(D) and 1860D-4(*l*). These provisions direct the Secretary (and, by delegation, CMS) to promulgate regulations governing agent and broker compensation that "ensure that the use of compensation

[1] Medicare Program; Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program for Contract Year 2024-Remaining Provisions and Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (PACE), 89 Fed. Reg. 30,448, 30,802 (April 23, 2024) (hereinafter referred to as "Final Rule").

creates incentives for agents and brokers to enroll individuals in the Medicare Advantage plan that is intended to best meet their health care needs." Compensation that does not create incentives for agents and brokers to enroll individuals into particular plans falls outside the scope of the statutory authorities cited and, therefore, falls outside the scope of the regulations issued under those authorities.

Analysis

1. *The new limitation on contract terms at subparagraph (c)(13) should not materially affect TPMO contracts with issuers.*

With the possible limited exception of reimbursement for expenses related to leads, TPMOs, generally, do not pass through payments or other financial incentives received from issuers to affiliated agents and brokers for MA or Part D enrollments. Payments that do not flow down to agents and brokers cannot "reasonably be expected to inhibit" agent and broker objectivity and, therefore, should not be affected by the new contract limitation. In fact, agents and brokers have limited or no visibility into the payment arrangements between the issuers whose plans they sell and the TPMOs they affiliate with. This way, TPMOs can help promote agent and broker objectivity and enable plan selection based on a beneficiary's health care needs.

2. *The expansion of the definition of "compensation" and one time-increase to fair market value are designed to encompass payments issuers were already making to agents and brokers, such as reimbursement for expenses.*

The expanded definition of compensation now encompasses what CMS considers to be "necessary" administrative expenses such as those related to "State appointment laws, training, certification, and testing costs"; "mileage to and from appointments with beneficiaries"; and "costs associated with beneficiary sales appointments."[2] The one-time $100 increase to the FMV compensation rate for agents and brokers is designed to allow agents and brokers to continue to receive payments to cover these enumerated expenses and other expenses that CMS views as legitimate. In CMS's own words, the intent of the revisions was to "transfer[] funds currently being allocated to administrative to compensation in a transparent and uniform manner" and increase FMV in an amount consistent with current administrative payments agents and brokers are already receiving for legitimate activities.[3] Under the revisions, agents and brokers are not expected to receive an increase in net payments.[4]

3. *The expansion of the definition of "compensation" should not affect payments to TPMOs for services they furnish to issuers, such as training, customer service and agent recruitment.*

[2] Final Rule at 30,829; 42 C.F.R. §§ 422.2274(a), 423.2274(a) (effective Oct. 1, 2024).

[3] Final Rule at 30,802.

[4] Final Rule at 30,783.

The amended definition of compensation, on its face, applies to payments made to agents and brokers. Existing regulations fix the commissions that issuers may pay agents and brokers per beneficiary enrollment at an amount CMS has determined to be "fair market value."[5] Notably, the regulations clearly state that these compensation limits "only apply to independent agents and brokers."[6] The very definitions of "compensation" and "fair market value"—both the current and the newly expanded definitions—on their face apply to "payments" made or "compensation" paid to agents and brokers.[7] This could arguably extend to indirect payments to agents and brokers, such as payments made to a third party like a TPMO, which then passes the incentives along to the agents and brokers as rewards or inducements for enrollments. However, there is no evidence in the regulatory text or structure that suggests the compensation limits apply more broadly to payments TPMOs receive for services that the TPMO does not pass through to agents and brokers.[8]

The preamble to the Final Rule largely supports this conclusion. In it, CMS explicitly states "all agent and broker compensation rules…are limited to independent agents and brokers, and do not extend to TPMOs more generally" and that the final compensation limits represent "a limitation on payments in excess of those paid under 'compensation' only for commissions paid for enrollments to independent agents and brokers."[9] Payments from plans to TPMOs "for activities that are not undertaken as part of an enrollment by an independent agent or broker" are not affected by the new compensation limits.[10]

While CMS does raise concerns about issuer payments to FMOs "for services that do not necessarily relate" to enrollment activities, it neither proposed nor finalized regulations restricting these payments.[11] CMS expressly acknowledges that payments for services such as "training, material development, customer service, direct mail, and agent recruitment" do not

[5] 42 C.F.R. §§ 422.2274(d)(1)(ii), 422.2274(d)(1)(ii).

[6] 42 C.F.R. §§ 422.2274(d), 422.2274(d).

[7] 42 C.F.R. §§ 422.2274(a), 422.2274(a).

[8] Indeed, the primary problem CMS sets out to solve is the use by insurers of "financial incentives outside and potentially in violation of the compensation cap set by CMS to encourage agents and brokers to enroll individuals in their plan over a competitor's plan." CMS specifically calls out financial incentives such as "bonuses and perks (such as golf parties, trips, and extra cash) in exchange for enrollments" as problematic where the insurer accounts for these payments as "administrative" rather than "compensation" and therefore not subject to the regulatory limits on compensation. The solution, according to CMS, is to treat all financial incentives to agents and brokers—including those that insurers may have historically classified as administrative payments—as compensation. Thus, the clear import of the rule is that only those administrative payments that serve as financial incentives for agents or brokers must not be considered compensation.

[9] Final Rule at 30,626.

[10] *Id*.

[11] As discussed further below, CMS did sunset the regulatory provision at subparagraph (e) that required all payments other than for enrollment of a beneficiary (administrative payments) to be consistent with market value. This provision was introduced in 2008 in direct response to the concern about "bidding wars" among plans. *See* 73 Fed. Reg. at 67,409-410. In other words, while seeking comment on how to better regulate plan payments to FMOs for non-enrollment activities, CMS, perhaps inadvertently, appears to have eliminated the singular regulatory provision designed to keep such payments in check.

typically "flow down to the agent or broker who deals with the beneficiary."[12] According to CMS, the issue presented by this category of payments is not the potential to interfere with agent and broker objectivity, but the potential for anti-competitive effects in the MA plan market. Larger plans may be able to pay increasingly high fees to FMOs for their services, and win a "bidding war" that results in the exclusion of smaller, local or regional plans that cannot afford to access an FMO's services.[13] CMS requested comment on the subject, but left regulation of non-enrollment activities, such as training material development, customer service, direct mail, and agent recruitment, to future rulemaking.[14]

The second concern CMS identifies as related to TPMO activities involves payments made to FMOs, which CMS defines as "a type of TPMO that employs agents and brokers to complete enrollment activities and may also conduct marketing activities on behalf of MA plans, such as lead generation and advertising."[15] In contrast to the payments described in the preceding paragraph, these payments, according to CMS, may "trickle down" to agents and brokers[16] and "influence or obscure" their activities.[17] CMS appears to have addressed this concern in two ways. First, CMS prohibits contract terms between plans and TPMOs that create incentives that are likely to inhibit agent and broker objectivity. Second, CMS limits the ability of plans to use FMOs as a conduit to offer additional financial incentives to agents and brokers by counting pass-through payments as compensation (and therefore subject to the caps).

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[12] *See* 88 Fed. Reg. at 78,554 (citing a 2008 Interim Final Rule revising compensation regulations); 73 Fed. Reg. 67,406, 67,409-410 (Nov. 14, 2008). In another part of the Final Rule, CMS responds to a comment regarding "override" payments to FMOs that seems to suggest that these override payments flow down to agents and brokers in the form of "free" enrollment tools, trainings, and contracting and compliance support services. *See* Final Rule at 30,624. This characterization is difficult to square with CMS's earlier statements that training and agent recruitment activities do not relate to enrollment and do not "flow down" to the agent and broker. CMS neither adopts nor refutes this characterization, though it suggests that overrides have been "removed" and that this changes the "current flow of payments from an MA organization to agents and brokers for an enrollment." *Id.* The amended regulations do not eliminate, or even address, what CMS describes as overrides, so this comment response is, at best, incoherent. To the extent that CMS was attempting to articulate an interpretation of the new regulations that prohibits plans from paying FMOs for trainings, customer service and agent recruitment activities, such interpretation would be plainly inconsistent with both the regulatory text and other contemporaneous statements that the compensation limits "do not extend to placing limitations on payments from an MAO to a TPMO…for activities not undertaken as part of an enrollment." *See* Final Rule at 30,626. As such, it would be difficult to enforce.

[13] 73 Fed. Reg. at 67,409-410; Final Rule at 30,619.

[14] As in any rulemaking, in any future attempt to regulate issuer payments to FMOs, CMS will need to identify the source of its regulatory authority. Social Security Act Sections 1851(j)(2)(D) and 1860D-4(*l*), which it relied upon in this Final Rule, do not give CMS blanket authority to regulate issuer arrangements with TPMOs. Rather, to rely on those authorities, CMS must establish that the payments it wants to regulate create inappropriate incentives for agents and brokers that are likely to interfere with agent and broker objectivity.

[15] 88 Fed. Reg. at 78,553. TPMOs that do not employ agents and brokers to complete Medicare enrollments would likely not be considered an FMO as CMS defines the term.

[16] Final Rule at 30,620.

[17] 88 Fed. Reg. at 78,553.

4. *Issuers May Continue to Pay TPMOs for non-enrollment services on a per-enrollment basis.*

    a. Nothing in the Final Rule prevents insurers from continuing to pay TPMOs for non-enrollment services on a per-enrollment basis.

First, the new limitation on contract terms at subparagraph (c)(13) does not prohibit issuers from paying agents, brokers and TPMOs on a per-enrollment basis, and it would not prohibit enrollment-based payments that have no ability to influence agent and broker enrollment activities. As for per-enrollment payments, the compensation rules outlined in subparagraph (d) plainly contemplate this payment method, and CMS never suggested that a purely pay-per-enrollment methodology would trigger the prohibition.[18] Rather, CMS explicitly calls out other types of payment methodologies that reward individuals and entities with bonuses or increased rates in exchange for reaching certain volume-based targets or enrollment quotas.[19]

Second, the sunsetting of the subparagraph (e) should also not prevent issuers from paying TPMOs on a per-enrollment basis. The amendments to subparagraph (e) are, according to CMS, meant to "eliminate the regulatory framework which currently allows for separate payment to agents and brokers for administrative services."[20] As part of these amendments, CMS sunset current subparagraph (e)(1), which stated that payments for non-enrollment services "(for example, training, customer service, agent recruitment, operational overhead, or assistance with completion of health risk assessments) must not exceed the value of those services in the marketplace." CMS also deleted subparagraph (e)(2), which currently states "[a]dministrative payments can be based on enrollment provided payments are at or below the value of those services in the marketplace." These changes should not prevent insurers from continuing to pay TPMOs for non-enrollment services on a per-enrollment basis.

The regulatory history demonstrates that subparagraph (e) was never intended to authorize payments to TPMOs—no such authority was needed. Rather, it was intended to keep those payments from increasing to levels that smaller local and regional plans could not afford. The current subparagraph (e) derives from a provision originally codified in 2008 which was

[18] According to CMS, this prohibition could be triggered where a contract creates incentives linked to "meeting enrollment quotas" or volume targets, as well as payments made to FMOs "with the explicit or implicit understanding the money will be passed on to agents or brokers based on enrollment volume." Final Rule at 30,620.

[19] Final Rule at 30,621. As explained above, for TPMOs that do not pass through any portion of the payments received from issuers to independent agents and brokers, payments from issuers would arguably have no effect on agent and broker enrollment activities, and therefore, and would not trigger the prohibition.

[20] Final Rule at 30,627. At other points in the Final Rule, CMS paraphrases the effects of its changes using broad language such as "eliminating separate payments for administrative services," *id.* at 30,622, and "eliminate the use of administrative payments," *id*. at 30,805. While it is possible to argue that this language indicates that CMS eliminated *all* forms of administrative payments, including those paid to TPMOs non-enrollment services that never get passed through to agents and brokers, such a reading is unsupported by the regulatory text and is in tension with CMS's clearly stated intent of addressing administrative payments as payments *to agents and brokers*. Such a reading would also stretch the regulations to the point where they exceed CMS's statutory authority to regulate agent and broker compensation.

designed to prevent the "bidding wars" described above.[21] As originally drafted, the provision required amounts paid to third parties (like FMOs) to be consistent with fair market value and commensurate with historic payments for similar services.[22] Later, in 2011, CMS revised this provision to distinguish between payments to "a third party and its agents *for enrollment* of a beneficiary into a plan," which had to be paid in accordance with agent and broker compensation limits, and payments for services *other than selling insurance products*, which had to be consistent with fair-market value and historical practices.[23] These regulations remained in place until 2021, when CMS made what it called "technical and organizational edits were used to improve clarity and reduce duplication in the proposed regulation text."[24] The 2021 changes also incorporated then-current subregulatory guidance, which stated that administrative payments to third parties could be based on enrollment, provided they were consistent with FMV.[25] This history makes clear that subparagraph (e) regulates, but does not authorize, administrative payments to third parties. It follows, then, that the sunsetting of subparagraph (e) does not affect issuers' ability to pay TPMOs, on a per-enrollment basis or otherwise, for services other than enrollment activities.

b. The Anti-Kickback Statute is not implicated by plan payments to TPMOs, even when those payments are made on a per-enrollment basis.

In the Final Rule, CMS makes several cautionary statements regarding issuer payments to agents, brokers and TPMOs that could "potentially" violate the Federal Anti-Kickback Statute (AKS).[26] As a threshold matter, it is important to note that CMS does not enforce the AKS and cannot create new policy regarding its application.[27] Further, the AKS has never been read to preclude enrollment-based payments to agents, brokers and third

[21] *Id*. CMS does not clearly specify which authority it was exercising when it enacted this provision in 2008. Again, sections 1851(j)(2)(D) and 1860D-4(*l*) do not authorize CMS to regulate payment arrangements that do not create agent and broker enrollment incentives.

[22] 42 C.F.R. §§ 422.2274(a)(1)(iv) (2008). The provision read: "If the MA organization [or Part D plan sponsor] contracts with a third party entity such as a Field Marketing Organization or similar type entity to sell its insurance products, or perform services (for example, training, customer service or agent recruitment), the amount paid to the third party must be fair-market value and must not exceed an amount that is commensurate with the amounts paid by the MA organization to a third party for similar services during each of the previous 2 years."

[23] 42 C.F.R. §§ 422.2274(a)(1)(iv) (2012).

[24] 86 Fed. Reg. 5864, 5984 (Jan. 19, 2021).

[25] In the Medicare Marketing Guidelines for Contract Year 2018, CMS added a "note" stating that "Plans/Part D Sponsors can tie the third-party (e.g., FMOs) administrative fees per enrollment as a way to attribute the FMV costs of services to a particular Plan/Part D Sponsor." *See* https://www.cms.gov/medicare/health-plans/managedcaremarketing/downloads/cy-2018-medicare-marketing-guidelines_final072017.pdf (last accessed April 18, 2024). This guidance re-appeared in subsequent versions of the Medicare Marketing Guidelines and was ultimately codified in 2021.

[26] *See, e.g.*, Final Rule at 30,617.

[27] The AKS is a criminal statute, and Congress gave the Secretary of the U.S. Department of Health and Human Services (HHS) the authority to develop regulations defining the scope of "permissible" activities and issue Advisory Opinions on what does and does not constitute prohibited remuneration under the AKS. The Secretary delegated this authority to the HHS Office of Inspector General.

parties. Commissions and other enrollment-based payments do not implicate the AKS under a plain reading of the statute. The AKS prohibits knowingly and willfully offering or paying remuneration to induce a person "to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program" or "to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program."[28] While an agent or broker may be in a position to enroll an individual in an MA or Part D plan, that agent or broker is not in a position to refer that individual for federally reimbursable health care items or services. Simply put, MA and Part D coverage is not a "good," "facility," "service," or "item."[29]

This conclusion is further supported by the fact that commissions and enrollment-based payments to agents, brokers and third parties have been explicitly permitted under Medicare regulations. For instance, current regulations provide that, for MA organizations and Part D plan sponsors using agents and brokers to sell Medicare plans, "[p]ayments may be made to individuals for the referral (including a recommendation, provision, or other means of referring beneficiaries) to an agent, broker or other entity for potential enrollment into a plan."[30] Given the long history of regulatory treatment of enrollment-based payments to agents, brokers and third parties, as well as the widespread adoption of the compensation model in the industry, the government would have a difficult time establishing an AKS violation, let alone a knowing violation.[31]

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[28] 42 U.S.C. § 1320a–7b(b)(2).

[29] At least one court has dismissed a False Claims Act action premised on an allegation that commissions paid to agents of an insurance brokerage by insurance carriers constituted kickbacks under the AKS. U.S. ex rel. Holt v. Medicare Medicaid Advisors, Inc., No. 18-CV-00860-DGK, 2022 WL 3587358, at *3 (W.D. Mo. Aug. 22, 2022), reconsideration denied, No. 18-CV-00860-DGK, 2023 WL 3807046 (W.D. Mo. June 2, 2023) (dismissing case arguing that commissions to agents of an insurance brokerage by MA plans were kickbacks giving rise to false claims, asking "But where is the claim to be paid by the Government here?" and holding "the Government did not pay commissions to [the insurance brokerage], the Insurance Carriers did, which is insufficient to establish presentment of a false claim for payment by the Government"); see also U.S. ex. rel. Rasmussen v. Essence Grp. Holdings Corp., No. 17-3273-CV-S-BP, 2020 WL 4381771, at *8 (W.D. Mo. Apr. 29, 2020) (dismissing case in which the whistleblower alleged that an MAO violated the AKS by paying $100 to doctors for an "Enhanced Encounter" visit, finding that the "Enhanced Encounters are not paid for by CMS" but rather by the MA plan and that, therefore, "the service 'induced' or 'arranged' by the $100 is not paid for in whole or in part by CMS as required for a violation of [the AKS]"; U.S. ex rel. Gray v. UnitedHealthcare Ins. Co., No. 15-CV-7137, 2018 WL 2933674, at *10 (N.D. Ill. June 12, 2018) (dismissing case in which the whistleblower alleged United violated the AKS by providing free in-home examinations and $25 Walmart gift cards to beneficiaries, holding that, under a capitated payment system, "United has neither received a kickback for its remunerations nor has Medicare been injured through increased reimbursements" and that "[t]his does not violate the purpose of the [AKS]—to prevent kickbacks from influencing the provision of services that are charged to *Medicare*") (internal quotation marks and citation omitted) (emphasis in original)).

[30] *See, e.g.*, 42 CFR § 422.2274(f) (emphasis added).

[31] Courts are very disinclined to find that a conduct violates the AKS when it is contemplated by other rules and regulations. *See, e.g.*, U.S. ex rel. Villafane v. Solinger, 543 F. Supp. 2d 678, 697-98 (W.D. Ky. 2008) (declining to interpret the AKS in a manner that would "render almost every [one of a type of arrangement

Conclusion

The above analysis reflects our best reading of the Final Rule and related authorities. It is possible that CMS adopts a different interpretation. In the event that CMS takes an enforcement action based on an interpretation that is contrary to that outlined above, or announces a new, unfavorable interpretation through subregulatory guidance, TPMOs and other affected groups would have grounds to challenge the validity of any such enforcement action or interpretation in federal court.

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seemingly permitted by the Stark law] illegal," as doing so "'would set dangerous precedent' . . . since any of the arrangements clearly contemplated by the Stark law exception would run afoul of such a broad interpretation of the [AKS]") (quoting Feldstein v. Nash Cmty. Health Servs., Inc., 51 F. Supp. 2d 673, 686-88 (E.D.N.C. 1999)).