

CHAPTER

2

**The complexity of
Medicare enrollment decisions
for beneficiaries**

The complexity of Medicare enrollment decisions for beneficiaries

Chapter summary

Once an individual becomes eligible for Medicare and during certain times of the year or after specified situations occur, they must make several complex enrollment decisions about their coverage. In our annual focus groups, beneficiaries often report confusion about enrolling in Medicare and their different coverage options. Some stakeholders have raised concerns that the growth in marketing by insurers and third-party marketing organizations has increased confusion for some beneficiaries. The complexity of the choices and numerous sources of information make it increasingly difficult for individuals to understand the requirements and relevant time frames so they can make the enrollment choice that is right for them. Some choices can have implications for as long as the individual has Medicare coverage. Given both the complexity of these choices and the potentially high stakes involved, access to clear and accurate information is especially important.

Generally, Medicare is for people 65 and older and certain people under 65 who are eligible due to disability or end-stage renal disease. The Medicare eligibility notification process is tied to eligibility for Social Security. Individuals already receiving Social Security benefits are notified of their eligibility and automatically enrolled in Medicare Part A and Part B. Historically, eligibility for both Medicare and Social

In this chapter

- Medicare eligibility and enrollment options
- Complex enrollment environment with financial implications
- Factors affecting the choice to enroll in or switch between FFS Medicare and MA
- MA marketing may contribute to confusion
- Medicare information sources: CMS, SHIP, and insurance agents
- Appendix 2-A: Special enrollment periods and situations specific to Medigap
- Appendix 2-B: Beneficiaries' experiences assessing their coverage options, according to Medicare's annual survey

Security full retirement benefits generally began at age 65. However, as the age for full retirement benefits from Social Security has gradually increased, a growing number of individuals become eligible for Medicare before they begin collecting Social Security benefits. For these individuals, there is no automatic enrollment in Medicare and, prior to December 2021 when some individuals began receiving notice by email, they were not notified of their eligibility for coverage when they turned 65. Individuals who do not enroll in Medicare Part A (if applicable because they must pay a premium for Part A), Part B, or Part D during their initial enrollment period (i.e., the seven-month window around turning 65) will owe late-enrollment penalties, typically for the rest of their lives, after they eventually do enroll, unless certain circumstances (such as having delayed enrollment because they were covered by an employer's group health plan) make them eligible for a special enrollment period.

Once enrolled in Medicare, beneficiaries must choose between receiving benefits from the fee-for-service (FFS) Medicare program or from private plans through Medicare Advantage (MA). Beneficiaries who do not enroll in MA remain in FFS Medicare. Most MA plans include Part D prescription drug coverage, an out-of-pocket cap, and supplemental benefits including reduced cost sharing as part of their benefit package. Beneficiaries enrolling in FFS Medicare may select a stand-alone Part D plan for prescription drug coverage (known as a prescription drug plan, or PDP). Beneficiaries who enroll in FFS Medicare may also obtain secondary insurance through a retirement plan or, if eligible, through Medicaid; otherwise they may purchase a Medigap policy to protect themselves against cost-sharing liabilities (e.g., the 20 percent FFS coinsurance rate that applies to most Part B outpatient services). Beneficiaries generally have few opportunities to enroll in a Medigap plan with guaranteed-issue protections, so their initial decision of whether to enroll in FFS Medicare with Medigap or in MA can have long-lasting implications. Whether they opt for FFS Medicare with a Part D and a Medigap plan or MA, beneficiaries choose from a number of different plans. In 2026, beneficiaries with FFS Medicare can choose from 10 standardized Medigap plan types with numerous insurers offering each type and have an average of 11 PDPs from which to choose, each with differing premiums, formularies, and benefit structures. Beneficiaries who opt for MA in 2026 choose from an average of 39 plans (offered by an average of eight organizations) available in their area, with differing out-of-pocket costs, provider networks, and supplemental benefits.

Beneficiaries make enrollment and coverage decisions during different periods over their lifetime: the initial enrollment period, an MA initial coverage period, a Medigap enrollment period with federal guaranteed-issue rights, general enrollment period, annual enrollment period, the open enrollment period that applies to MA enrollees, and any special enrollment periods that may apply depending on the individual's circumstances. These enrollment periods can add to the complexity of a beneficiary's choices both because they occur at different times throughout the year and because the requirements for each period often differ by the part of Medicare. After their initial enrollment, beneficiaries selecting MA or Part D may join, switch, or drop their plans during certain times of the year unless a special enrollment period applies.

Beneficiaries in various focus groups and surveys conducted by MedPAC and other researchers report that they consider numerous factors when making a choice of FFS Medicare or MA and the plans within those options, including financial protection, access to care, and extra benefits. Beneficiaries who enroll in MA are typically subject to provider networks and utilization-management tools such as prior authorization in exchange for lower premiums and a maximum out-of-pocket cap. By contrast, FFS Medicare offers a broader choice of providers with limited use of utilization-management tools but can expose beneficiaries to high out-of-pocket costs or higher premiums if they choose to acquire supplemental insurance such as Medigap. MA plans typically offer a variety of supplemental benefits not available in FFS Medicare, such as dental, vision, and hearing benefits. While it can be challenging for beneficiaries to understand each plan's package of supplemental benefits, especially when the package can change substantially from year to year, these extra benefits help fill gaps in Medicare coverage and thus appeal to many beneficiaries. When making enrollment choices, beneficiaries must weigh these factors, considering their current health needs as well as potential future health needs that may not be evident at initial enrollment.

Beneficiaries may want to change their Medicare coverage, including switching from MA to FFS Medicare and vice versa, or change their MA plan for a wide variety of reasons. Some of those reasons could reflect changes in their personal circumstances or dissatisfaction with a current plan due to changes in their plan or plan performance. At the same time, Medicare has some features that make it harder for beneficiaries to switch MA plans or return to FFS Medicare, including limited enrollment periods, the out-of-pocket maximum resetting when switching MA plans during the year, a limited time period for

guaranteed issue of Medigap policies (depending on the beneficiary's state of residence), and lack of an out-of-pocket maximum in FFS Medicare. Many of those features, including limited enrollment periods, were designed to combat adverse selection both within MA and between MA and FFS (that is, to prevent beneficiaries from switching to certain types of coverage or plans when they have expensive health care needs).

To make Medicare enrollment decisions, beneficiaries rely on a variety of sources for information and advice, including:

- **CMS tools.** CMS has several tools that can be accessed by visiting Medicare.gov or calling the 1-800-MEDICARE help line. These tools are designed to provide free, accurate, and objective information to help navigate enrollment and coverage choices. Medicare.gov provides numerous resources about Medicare enrollment and benefits, including the *Medicare & You* handbook, *Choosing a Medigap Policy* guide, and the Medicare Plan Finder tool. Plan Finder allows beneficiaries to compare the features of MA plans, PDPs, and Medigap plans offered in their area. Beneficiaries can customize the results shown on Plan Finder in several ways (for example, they can use the tool to determine whether plans cover their prescription drugs, pharmacies, and clinicians), but the tool has some notable limitations (such as limited detail about MA supplemental benefits and Medigap premiums). In our analysis of Medicare Current Beneficiary Survey results, many respondents said they were satisfied with the availability of information about the Medicare program, and awareness of these CMS information sources was generally high.
- **The federally funded State Health Insurance Assistance Program (SHIP).** The SHIP is a federal program that provides grants to the 50 states, the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands to deliver objective Medicare counseling, information, and assistance at no cost to beneficiaries, and some grantees help enroll beneficiaries in Medicare plans. SHIP counselors can be especially helpful for beneficiaries because they have knowledge of local health care resources and are able to provide one-on-one assistance specific to individual beneficiary needs. However, SHIP funding has not kept pace with growth in Medicare enrollment, and grantees depend on the availability of volunteer staff. In semistructured interviews with individuals involved with the SHIP, participants reported that SHIP counselors face capacity constraints as call volumes have risen and as the growing complexity of

Medicare enrollment decisions has led to longer counseling sessions that require special expertise. A Commonwealth Fund survey conducted in 2022 found that 4 percent of MA enrollees and 5 percent of FFS enrollees reported using the SHIP to guide their plan choice. Few beneficiaries in our annual focus groups were aware of their local SHIP grantee, but those who used it reported positive experiences.

- **Insurance agents.** Many beneficiaries rely on insurance agents to help navigate their Medicare options. (“Agents” and “brokers” are trained insurance professionals, and the terms are often used interchangeably; we use the term “agents” in this chapter.) Agents are licensed individuals who are paid by insurance companies to enroll people in insurance products. Virtually all MA and Part D plans report using agents to sell their plans. Agents typically secure contracts with multiple insurance companies, but they are not required to contract with all available companies in their market. As a result, a single agent will not necessarily present every available plan to a beneficiary, something that may not be understood by the beneficiary even if agents disclose it in their communications. The ways in which agents are compensated for their services vary and can be complex. Commonly, agents contract with multiple insurance carriers that pay commissions tied to initial enrollment and retention of beneficiary enrollment in the MA, Medigap, or Part D plans they sell. CMS has established maximums on compensation per enrollment that MA and Part D plans can pay agents, but agents may also receive supplemental compensation (such as a bonus for meeting enrollment benchmarks), which is not subject to federal limits. In our annual focus groups, many beneficiaries report positive experiences working with agents to determine the premiums and out-of-pocket costs of different plans. Beneficiaries described how their insurance agents tailored suggestions based on individual health needs, especially medication lists and clinician preferences. But some stakeholders have voiced concern that agents have financial incentives to steer beneficiary decision-making. These incentives could favor enrollment in MA plans over Medigap plans and PDPs, in higher-premium Medigap plans over lower-premium Medigap plans, and in plans that offer bonuses for reaching enrollment benchmarks.

The Commission is concerned about the complexity of Medicare enrollment choices and the sufficient availability of free, objective, and accurate resources to help beneficiaries navigate their choices without facing unintended

consequences such as an inability to obtain a Medigap policy on a guaranteed-issue basis when desired. There may be a need for additional updates to Plan Finder and greater support for the SHIP, as well as an increased role for technology to help reduce the complexity of the choices that beneficiaries face. The Commission will continue to monitor this issue and explore potential policy options. ■

Once an individual becomes eligible for Medicare and during certain times of the year or after specified situations occur, they must make several complex enrollment decisions about their coverage. The complexity of the process makes it increasingly difficult for Medicare beneficiaries to understand the relevant requirements and time frames necessary to select the enrollment option that is right for them. Some enrollment decisions have lifelong implications; for example, failing to enroll in Medicare at the appropriate time can result in permanent late-enrollment penalties. Given both the complexity of these choices and the high stakes involved, access to clear and accurate information is especially important. Many beneficiaries report being satisfied with their information sources, though a substantial share say that it is difficult to understand their Medicare choices and to find good sources of information. Although beneficiaries have many potential sources of information, those sources, including advertising, can be overwhelming, influenced by financial incentives, or misleading.

In our annual focus groups, some beneficiaries have expressed confusion regarding enrolling in Medicare, including having insufficient information (NORC at the University of Chicago 2025, NORC at the University of Chicago 2024).¹ These beneficiaries reported that they did not have a clear understanding of the different options for Medicare coverage as they approached enrollment, and some continued to express confusion about the different options. As one beneficiary said in 2024:

When I turned 65, I hadn't prepared myself to educate myself about these plans. As a matter of fact, I just went in thinking, Medicare, all this is going to be short. So . . . a Medicare agent came to my house and he kind of ran through it and I'm not comprehending all this stuff. He's just throwing all this information at you.

One beneficiary who was dually eligible for Medicare and Medicaid noted in 2025:

It was truly, truly confusing and I don't understand how people who are real seniors, and are beginning to lose touch . . . I don't understand how they do it because it's confusing for me, and I'm supposed to be relatively smart, I suppose.

Adding to the confusion regarding Medicare choices, many participants in our beneficiary focus groups described the amount of information they received about Medicare plans as overwhelming. These participants reported receiving “constant” phone calls and frequent mailings from insurance companies, especially during open enrollment. A beneficiary who eventually enrolled in a Medicare Advantage (MA) plan said, “Well, before turning 65, I was getting the mail. A little overwhelming at first. . . . So, I just signed up with that without, you know, thinking too much about it.” Other participants reported receiving many phone calls related to enrolling in Medicare plans, with one noting, “Why is it—it's like every day, somebody calling you about your insurance? I already did this for this year” and another estimating the number of calls: “I get five, six a day.”

Many beneficiaries described turning to formal resources for help making these decisions, including agents, plan representatives, health fairs, and Medicare.gov. Others described relying on guidance and recommendations from less formal sources, including family members and friends.

The experiences reported in our focus groups are consistent with other research. For example, in 2023, KFF also conducted focus groups with beneficiaries and reported that most participants found the process of selecting their coverage to be confusing, difficult, and overwhelming (Freed et al. 2023). A 2022 Commonwealth Fund survey found that more than half of beneficiaries used a variety of sources for information and advice on Medicare plan choice (e.g., insurance agents, Medicare.gov) (Leonard et al. 2022). Also, we examined results from the Medicare Current Beneficiary Survey (MCBS) and found that many respondents are generally satisfied with the information available to compare their insurance options; however, some beneficiaries also report that they do not have the information needed to make informed comparisons across coverage options (see Appendix 2-B, p. 86, on results from CMS's MCBS).

The Commission is concerned about the complexity of Medicare enrollment choices and the sufficient availability of free, objective, and accurate resources to help beneficiaries navigate their choices without facing unintended consequences such as an inability to obtain

a Medigap policy on a guaranteed-issue basis when desired. There may be a need for additional updates to Plan Finder and greater support for the State Health Insurance Assistance Program (SHIP), as well as an increased role for technology to help reduce the complexity of the choices that beneficiaries face. The Commission will continue to monitor this issue and explore potential policy options.

In this chapter, we explain Medicare eligibility and enrollment options. We then discuss the complex beneficiary enrollment environment with financial implications, including the growing problem of beneficiary notification as the full retirement age for Social Security benefits has risen from age 65. Next, we review the factors that beneficiaries consider when choosing between fee-for-service (FFS) Medicare and MA, including feedback from beneficiary focus groups regarding how beneficiaries weigh these factors. We also discuss issues related to switching between MA, Part D, and Medigap plans. We then outline how marketing by MA plans and third-party marketing organizations may add to beneficiary confusion. Finally, we take a closer look at the information sources that beneficiaries use to make Medicare enrollment decisions, with a focus on CMS information sources, the SHIP, and insurance agents.

Medicare eligibility and enrollment options

Individuals are eligible for Medicare either because they have turned 65, they are disabled and have received Social Security disability insurance payments for two years, they have been diagnosed with end-stage renal disease (ESRD), or they have just begun to receive disability insurance payments and have a diagnosis of amyotrophic lateral sclerosis (ALS). In 2022, 88 percent of beneficiaries were eligible for Medicare because of their age, 11 percent because they were disabled, and 1 percent because of an ESRD diagnosis (Medicare Payment Advisory Commission 2025a).

Eligible individuals are entitled to Medicare Part A, which helps pay for inpatient hospital stays, post-acute care following those hospital stays, and hospice care. Part A is available to 99 percent of Medicare beneficiaries without a monthly premium because they

or their spouse or parent paid Medicare payroll taxes for at least 10 years (40 quarters) (Centers for Medicare & Medicaid Services 2025b).² Individuals entitled to Medicare Part A due to age, ESRD, or disability who do not meet the required years of payroll taxes must pay a monthly premium.³ In 2026, the full Medicare Part A premium is \$565 per month (Centers for Medicare & Medicaid Services 2025j).

Eligible individuals can also enroll in Medicare Part B, which helps pay for clinician and other outpatient services. For most beneficiaries (including those in an MA plan), the Part B premium is deducted from their monthly Social Security benefits.⁴ In 2026, the standard Part B premium is \$202.90 per month for beneficiaries with a modified adjusted gross annual income of up to \$109,000 (or \$218,000 for a married couple) (Centers for Medicare & Medicaid Services 2025b). Beneficiaries with higher incomes pay higher Part B premiums, known as the income-related monthly adjustment amount (IRMAA) (Table 2-1) (Centers for Medicare & Medicaid Services 2025b). The standard Part B premium amount is the same for individuals entitled to Medicare due to age, disability, or ESRD.⁵

Prescription drug coverage is available through Part D, either through stand-alone prescription drug plans (PDPs) or MA plans that include drug coverage. Part D enrollees with higher incomes are also required to pay higher premiums due to the Part D IRMAA, based on the same income thresholds used for Part B premiums. The average stand-alone PDP premium in 2026 was estimated at \$44 per month, while the average cost of the Part D portion of an MA premium was \$9 per month (Medicare Payment Advisory Commission 2026).

Once enrolled in Medicare, beneficiaries can choose to continue in FFS Medicare (Part A, Part B, and Part D) or enroll in MA plans (known as Part C, which bundles Part A, Part B, and usually Part D together). In addition to covering basic Part A and Part B services, MA plans may provide “supplemental” benefits to their enrollees, such as reduced cost sharing for Part A and Part B services, reduced Part B and Part D premiums, enhanced Part D benefits, and other benefits not covered under FFS Medicare such as dental, vision, or hearing services (Medicare Payment Advisory Commission 2025b). Beneficiaries who enroll in FFS Medicare may be eligible for Medicaid, purchase secondary insurance such as Medigap, or obtain

**TABLE
2-1**

Part B income-related monthly adjustment amounts, 2026

Beneficiaries who file individual tax returns with modified adjusted gross income of:	Beneficiaries who file joint tax returns with modified adjusted gross income of:	Income-related monthly adjustment amounts	Total monthly premium amounts
Less than or equal to \$109,000	Less than or equal to \$218,000	\$0.00	\$202.90
Greater than \$109,000 and less than or equal to \$137,000	Greater than \$218,000 and less than or equal to \$274,000	\$81.20	\$284.10
Greater than \$137,000 and less than or equal to \$171,000	Greater than \$274,000 and less than or equal to \$342,000	\$202.90	\$405.80
Greater than \$171,000 and less than or equal to \$205,000	Greater than \$342,000 and less than or equal to \$410,000	\$324.60	\$527.50
Greater than \$205,000 and less than \$500,000	Greater than \$410,000 and less than \$750,000	\$446.30	\$649.20
Greater than or equal to \$500,000	Greater than or equal to \$750,000	\$487.00	\$689.90

Note: The modified adjusted gross income is an individual's total (gross) income from all sources with certain adjustments from the most recent federal tax return, generally two years prior (Social Security Administration 2024a).

Source: Centers for Medicare & Medicaid Services 2025k.

employer- or union-sponsored insurance coverage that supplements the Medicare benefit package.

Beneficiaries who qualify for both Medicare and Medicaid are known as “dually eligible beneficiaries.” Medicaid is a joint federal and state program designed to help people with low incomes obtain the health care they need. For dually eligible beneficiaries, Medicare is the primary payer for acute and post-acute services and Medicaid provides varying levels of assistance with Medicare premiums and cost sharing. For many beneficiaries, Medicaid also covers services not included in the Medicare benefit, such as long-term services and supports (Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission 2025). A total of 13.6 million individuals were dually eligible for Medicare and Medicaid benefits in at least one month of 2022 (Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission

2025). Dually eligible beneficiaries are more likely than non-dually eligible beneficiaries to be enrolled in a Medicare managed care plan and less likely to have other secondary coverage, such as employer-sponsored coverage or Medigap (Medicare Payment Advisory Commission 2025a).

Under mandatory Medicaid eligibility pathways referred to as Medicare Savings Programs (MSPs), dually eligible beneficiaries qualify for assistance that is limited to payment of Medicare premiums and, in some cases, Medicare cost sharing. There are four MSPs with differing requirements: the Qualified Medicare Beneficiary Program, Specified Low-Income Medicare Beneficiary Program, Qualifying Individual Program, and Qualified Disabled and Working Individual Program. States have the authority to expand eligibility for MSP benefits by using less restrictive methodologies for counting income and assets. As of August 2025, 18 states and the District of Columbia

have expanded eligibility for MSPs (Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission 2025).

Individuals may also qualify for Part D's low-income subsidy (LIS), also referred to as the Medicare Part D Extra Help program, which assists individuals with limited income and resources with payment for Part D premiums and cost sharing. Individuals receive the LIS automatically if they have full Medicaid coverage, have help from their state in paying their Part B premiums through an MSP, or are receiving Supplemental Security Income (SSI) payments from Social Security, while other individuals need to apply (Centers for Medicare & Medicaid Services 2025f). Individuals qualifying for the LIS will be automatically enrolled in a PDP if they do not have one already.

Seventeen states also have State Pharmaceutical Assistance Programs (SPAPs), which help pay prescription drug-related costs for certain populations with limited financial resources, including older adults (Centers for Medicare & Medicaid Services 2026b, McSpadden 2024). SPAPs typically pay for services that wrap around Part D coverage but vary by state. Individuals apply to their state to enroll in the MSPs and SPAPs.

Complex enrollment environment with financial implications

The Medicare eligibility notification process has been historically tied to eligibility for Social Security. Individuals already receiving Social Security benefits are notified of their eligibility and automatically enrolled in Medicare Part A and Part B. Historically, eligibility for both Medicare and Social Security full retirement benefits generally began at age 65. However, as the age for full retirement benefits from Social Security has gradually increased, a growing number of individuals become eligible for Medicare before they begin to collect Social Security benefits. For these individuals, there is no automatic enrollment in Medicare and historically they were not notified of their eligibility for coverage when they turned 65. Individuals who do not enroll in Medicare Part A (if applicable because they must pay a premium for Part A), Part B, or Part D during their initial enrollment

period (IEP) (i.e., seven-month window around turning 65) will owe late-enrollment penalties, typically for the rest of their lives, after they eventually do enroll, unless certain circumstances (such as having delayed enrollment because they were covered by an employer's group health plan) make them eligible for a special enrollment period (SEP). After the IEP, beneficiaries may continue to face enrollment and coverage decisions during different periods over their lifetime, such as the MA initial coverage period; the Medigap enrollment period; general enrollment period (GEP); annual enrollment period (AEP); the open enrollment period (OEP) that applies to MA enrollees; and any SEPs that may apply depending on the individual's circumstances. These enrollment periods can add to the complexity of a beneficiary's choices both because they occur at different times throughout the year and because the requirements for each period often differ by the Medicare part. After their initial enrollment, beneficiaries selecting MA or Part D may join, switch, or drop their plans only during certain times of the year unless an SEP applies. Beneficiaries generally have few opportunities after their IEP to enroll in a Medigap plan without medical underwriting, meaning their initial decision of whether to enroll can have long-lasting implications.

A growing number of individuals need to take steps to enroll in Medicare

The Medicare automatic enrollment process has been historically tied to eligibility for Social Security.⁶ Individuals who are about to reach age 65 and receive Social Security benefits are notified of Medicare eligibility and automatically enrolled in Medicare Part A and Part B when they turn 65.⁷ Individuals who do not receive Social Security benefits at age 65 are not automatically enrolled in Medicare Part A and Part B and need to take steps to enroll, and historically, these individuals may not have been notified of the need to take action.

The Social Security Administration (SSA) is responsible for determining the Medicare eligibility of individuals and for notifying CMS of their enrollment. If individuals are receiving or have applied for Social Security benefits four months before they turn 65, the SSA will send their records to CMS four months before they turn 65. CMS notifies these individuals about their automatic enrollment in Part A and Part B and

sends the IEP package to the individual three months before the month the individual turns 65. This package includes the “Welcome to Medicare” letter, the *Welcome to Medicare* booklet that provides an overview of the Medicare program, the Medicare card, and a Part B refusal card and return envelope for those enrollees who do not wish to be enrolled in Part B (Social Security Administration 2024b). In a separate mailing, CMS also sends the *Medicare & You* handbook to these individuals. Only individuals who receive or have applied for Social Security benefits four months before turning 65 are automatically enrolled in Medicare when they first become eligible.

The Social Security Amendments of 1983 gradually raised the full retirement age for Social Security benefits, also known as the Old-Age, Survivors, and Disability Insurance (OASDI) Program, from 65 to 67. The age for full retirement benefits for individuals born in 1960 or later is 67, although individuals can retire early and collect reduced Social Security benefits beginning at age 62. Individuals receiving Social Security benefits four months before turning 65 will be notified of their Medicare eligibility and automatically enrolled in Medicare at age 65.

Historically, most individuals were receiving full retirement benefits from Social Security at age 65, which is the same age for Medicare eligibility, so the majority of eligible individuals were notified of Medicare eligibility and automatically enrolled. However, the share of 65-year-olds receiving Social Security has decreased over the last few decades, falling from 92 percent in 2002 to 60 percent in 2016 (Medicare Payment Advisory Commission 2019). The increase in the age for full Social Security benefits means that Medicare-eligible individuals not receiving Social Security benefits four months before turning 65 are not automatically enrolled in Medicare at age 65. This situation was not a problem historically because the eligibility age for the two programs was aligned. As the age of eligibility for full Social Security benefits has risen, many people are still working at age 65 and are delaying Social Security.

Individuals who are not automatically enrolled in Medicare at age 65 must take active steps to enroll. These individuals may use one of the following methods to enroll: apply on the SSA website, complete a form and mail or fax the form to the local Social

Security office, call the SSA to set up an appointment, or visit the local Social Security office (Centers for Medicare & Medicaid Services 2025o). Of the approximately 3.6 million individuals who turned 65 in 2012 (as projected by the Census Bureau), based on previous analysis, we estimate that 30 percent, or 1.1 million, were not receiving Social Security benefits and may not have been notified of the need to enroll in Medicare (Medicare Payment Advisory Commission 2019, Census Bureau 2012).

In December 2021, the SSA and CMS began collaborating on an outreach campaign to send emails to individuals approaching age 65 who are not yet receiving Social Security benefits to remind them of the need to enroll in Medicare. Originally the campaign was limited to individuals who had established an online “my Social Security account” with the SSA, but the campaign has since been broadened to include any individuals who have provided an email address to the SSA. Individuals who have an email address on file with the SSA and are approaching 65 years old receive monthly email reminders about the need to enroll in Medicare on time and avoid penalties.⁸

The disconnect between the applicable age for Medicare eligibility and the full retirement age for Social Security means that an increasing number of Medicare-eligible individuals will not be automatically enrolled in Medicare and may be unaware of their eligibility status because they did not take action to enroll. Some individuals who registered an email address with the SSA may not receive or see an email regarding the need to enroll. These individuals could be at risk for gaps in coverage and late-enrollment penalties that may be imposed for the rest of their lives.

In addition, some individuals find it confusing that they must enroll in Medicare through the SSA but that once they have enrolled, the relevant federal agency to contact is CMS. Individuals will also interact with private-insurance companies if they select Medicare Advantage, Part D, or Medigap, potentially leading to further confusion.

Multiple enrollment periods and potential late-enrollment penalties

Once an individual becomes eligible for Medicare, they must make many complex enrollment decisions

that may affect coverage and cost for the rest of their lives. Generally, individuals who do not enroll in Part B or Part D during their IEP will owe late-enrollment penalties if they eventually do enroll and are ineligible for a SEP. Beneficiaries selecting MA may join, switch, or drop their MA plan only during certain times of the year unless an SEP applies.

Beneficiaries generally have few opportunities, after their IEP, to enroll in a Medigap plan without medical underwriting, meaning their initial decision of whether to enroll can have long-lasting implications. There are guaranteed-issue protections during a one-time six-month Medigap enrollment period that begins when a person is 65 or older and newly enrolled in Medicare Part B, as well as during periods precipitated by certain events, including periods that may vary by state. Outside of these periods, a Medigap policy may not be available to purchase due to medical underwriting in states without additional guaranteed-issue protections.

In our June 2019 report to the Congress, we examined a cohort of 2.9 million beneficiaries we followed who turned 65 in 2012 and were enrolled in Medicare Part A and/or Part B sometime between 2012 and 2017 (Medicare Payment Advisory Commission 2019). By 2017, about 40,000 beneficiaries—roughly 1.5 percent of the 2012 cohort—were paying Part B late-enrollment penalties. We found that about 20 percent of those paying penalties in 2017 also delayed enrolling in Part A and may not have been notified of the potential penalties for delaying Part B when they turned 65 (Medicare Payment Advisory Commission 2019).

Enrollment periods

Beneficiaries make many complex enrollment decisions during different periods over their lifetime, both when they are first eligible for Medicare and later when they can change aspects of their coverage. The following enrollment periods are available to beneficiaries:

- the IEP for Part A, Part B, and Part D, the seven-month window around turning 65;
- an initial coverage period for MA (known as the initial coverage election period) once an individual enrolls in Part A and Part B;
- a GEP for Part A and Part B;

- the AEP for MA and Part D;
- the MA open enrollment period, an annual period for people already enrolled in MA to switch;
- a Medigap enrollment period when federal guaranteed-issue rights are available; and
- any SEPs or guaranteed-issue rights that may apply depending on the individual's circumstances.

These enrollment periods can add to the complexity of a beneficiary's choices because they occur at different times throughout the year and may depend on the beneficiary's circumstances.

Enrollment periods when an individual first becomes eligible for Medicare When an individual first becomes eligible for Medicare, they have different periods in which they can enroll in Part A, Part B, and Part D, select MA coverage, and purchase a Medigap policy with guaranteed issue (Table 2-2).

Initial enrollment period When aged individuals are first eligible for Medicare, they have a seven-month IEP to sign up for Part A, Part B, and Part D. The seven-month IEP begins three months before the month an individual turns 65, includes the month they turn 65, and ends three months after the month they turn 65. For aged individuals who enroll before the month they turn 65, Part A and Part B coverage begins the month when the individual turns 65. For aged individuals who enroll the month they turn 65 or during the six months after, Part A coverage will begin at age 65 and Part B coverage will begin the month after enrollment. Aged individuals who do not have to pay a premium for Part A and who miss the IEP may sign up for Part A anytime after they turn 65, and the Part A coverage starts six months before Part A enrollment or when they apply for benefits from Social Security (Centers for Medicare & Medicaid Services 2024f). For individuals who must pay a premium for Part A, coverage begins the next month after enrollment. Generally, Part D coverage is effective the first of the month following the plan's receipt of the enrollment request, assuming the individual is enrolled in Part A and/or Part B.

After the IEP, beneficiaries face penalties for late enrollment unless an SEP applies. Beneficiaries will pay a Part B late-enrollment penalty for each full 12-month period during which the individual could have been

**TABLE
2-2**

Medicare initial enrollment periods when turning 65

Enrollment period	Description	Length of time
Initial	First period for beneficiary to enroll in Part A, Part B, and Part D	7-month window around turning 65 (3 months before birth month, birth month, and 3 months following the birth month) or, for Part D, the 7-month window around initial Part A and/or Part B enrollment
MA initial coverage	First period to enroll in MA after initial Part A and Part B enrollment	Concurrent with the IEP unless the individual does not enroll in Part B during the IEP, then the 3-month period before enrolling in Part A and Part B for the first time through the 2-month period after eligibility for MA or the end of the IEP, whichever is later
Medigap	First period to purchase a Medigap policy with guaranteed issue	6-month window beginning after the individual is 65 and is also enrolled in Part B

Note: MA (Medicare Advantage), IEP (initial enrollment period). This table does not include relevant time frames that may apply for individuals with end-stage renal disease or disabilities.

Source: Centers for Medicare & Medicaid Services 2024e, Centers for Medicare & Medicaid Services 2024f.

enrolled in Part B (not including the IEP).⁹ Beneficiaries will pay a Part D late-enrollment penalty if they go without Part D or other creditable prescription drug coverage for any period of 63 or more days in a row during which the individual could have been enrolled in Part D (not including the IEP). Creditable prescription drug coverage is coverage that is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage (Centers for Medicare & Medicaid Services 2025q).

For example, an individual born on June 10, 1955, turned 65 on June 10, 2020, when the full retirement age is 66 years and two months. Assuming this individual does not receive Social Security benefits before the full retirement age, they will not be automatically enrolled and will need to initiate enrollment on their own. In this example, the individual does not have to pay a premium for Part A. Their IEP begins in March 2020 (three months before their birthday) and concludes at the end of September (three months after their birth month). If this individual enrolls in Part A and Part B and requests to enroll in a PDP in April 2020, then

Part A, Part B, and Part D coverage will begin in June 2020. If the individual enrolls in Part A and Part B and requests to enroll in a PDP on August 14, 2020, then the individual’s Part A coverage will begin in June 2020, and the Part B and Part D coverage will begin in September 2020. This individual would not be subject to late-enrollment penalties.

Individuals entitled to Social Security benefits based on disability are automatically enrolled in Part A and Part B after receiving disability benefits for 24 months, except those with ALS, who are entitled to Part A and Part B the first month they are entitled to disability benefits and are automatically enrolled then.

Individuals entitled to Part A and Part B based on ESRD begin their Medicare coverage at different times, depending on whether the individual is on dialysis or getting a kidney transplant. If the individual is on dialysis, Medicare coverage usually starts on the first day of the fourth month of a regular course of dialysis (after a three-month waiting period) or the first month a regular course of dialysis begins if the individual engages in home dialysis training, the doctor

expects the individual to finish training and do dialysis treatments at home, and the individual maintains a regular course of dialysis (Centers for Medicare & Medicaid Services 2025e). In addition, if an individual has employer or union group health coverage and becomes eligible for Medicare because of permanent kidney failure, there is a coordination period of 30 months in which the employer or union coverage pays first and Medicare pays second (Centers for Medicare & Medicaid Services 2025e). If the individual is getting a kidney transplant, Medicare coverage can begin the month of kidney transplant or two months before the month of transplant if the individual was hospitalized during those months in preparation for the transplant (Centers for Medicare & Medicaid Services 2025e).

Beneficiaries who qualify for Medicaid or the MSPs or who are eligible for Medicare due to ESRD do not pay the Part A (applicable only to those paying a premium for Part A) or Part B late-enrollment penalties.¹⁰

Previously, individuals may have enrolled in a high-deductible health plan along with a health savings account (HSA), which is a tax-advantaged account that is used to pay for certain medical expenses not covered by insurance, such as deductibles and coinsurance (Congressional Research Service 2020). Once enrolled in Medicare, individuals can no longer contribute to an HSA, and any contributions made after Medicare enrollment are known as excess contributions and subject to a tax penalty (Internal Revenue Service 2025). Individuals can withdraw the excess contribution before their tax filing date for the year the contributions were made. Some individuals contributing to an HSA may not realize that when they enroll in Medicare Part A, the enrollment will be retroactive to the previous six months (or to the age of 65, whichever is shorter). If these individuals do not stop their HSA contributions before Medicare enrollment or withdraw their excess contributions by the applicable tax filing date, they will be subject to tax penalties.

MA initial coverage period for people who have just enrolled in both Part A and Part B Beneficiaries are eligible to enroll in an MA plan after having initially enrolled in both Part A and Part B. For beneficiaries who enrolled in Part A during their IEP but not Part B, there is an initial coverage period for MA enrollment for beneficiaries newly enrolled in Part B that begins three months before the beneficiary first has both

Part A and Part B and ends two months after the beneficiary first has both Part A and Part B or the last day of the Part B IEP, whichever is later. During this period, beneficiaries can enroll in an MA plan with or without drug coverage. Beneficiaries who desire MA coverage but missed their IEP to enroll in Part A and Part B or missed the MA initial coverage period after first enrolling in Part A and Part B, and are ineligible for an SEP, must generally wait for the AEP described below (October 15 through December 7) to enroll in MA, effective January 1. Individuals enrolling in a Medicare Advantage Prescription Drug plan (MA-PD) plan after going 63 days without Part D or creditable coverage may pay a late-enrollment penalty for Part D.

Individuals paying a late-enrollment penalty for Part B or Part D (or Part A if they are paying a premium for Part A) must continue to pay those late-enrollment penalties after they enroll in MA, as applicable. There are no MA late-enrollment penalties, so individuals enrolling in MA at any time after they were first eligible to enroll do not pay any additional penalties, beyond any late Part B or Part D (or Part A if they are paying a premium for Part A) enrollment penalties.

Part D initial coverage period for people who have just enrolled in either Part A or Part B A beneficiary must enroll in either Part A or Part B to be eligible to join a PDP. If the beneficiary does not enroll in a PDP during the seven months around turning 65, the individual may enroll in a PDP during the seven-month period around when the individual became eligible to enroll in a PDP because the individual enrolled in Part A and/or Part B. If the beneficiary remains in FFS Medicare and misses the IEP and is ineligible to enroll during an SEP, the beneficiary may next enroll during the AEP described below (October 15 through December 7). Beneficiaries who enroll in Part D 63 days or more after their IEP and do not have creditable coverage face late-enrollment penalties and a gap in coverage. Beneficiaries who qualify for the LIS do not pay the Part D late-enrollment penalty.

For example, an individual turning 65 on June 10, 2020, who was not notified of Medicare eligibility or automatically enrolled, learns that they are entitled to Part A after the IEP (March 2020 through the end of September 2020) has concluded. This individual enrolls in Part A in May 2022. They do not pay a premium for Part A and choose not to enroll in Part B or Part D at the same time because of the premiums. In October 2022,

they decide that they would like to enroll in a combined MA and prescription drug plan. However, they have not yet enrolled in Part B, which is required before MA enrollment. Unless an SEP applies, this individual will have to wait until the next GEP (January 1, 2023, through March 31, 2023) to enroll in Part B and will be subject to Part B late-enrollment penalties. If this individual enrolls in Part B in February 2023, Part B coverage starts on March 1, 2023. The MA initial coverage period after the individual first has Part A and Part B coverage begins in December 2022 and ends in April 2023. If this individual requests MA enrollment on March 15, 2023, MA coverage begins on April 1, 2023. If the individual, after starting Part B coverage on March 1, 2023, decides not to enroll in MA before April 30, 2023 (including a combined MA and prescription drug plan), and stays in FFS Medicare instead, the individual will have to wait until the AEP described below (October 15 through December 7, 2023) to enroll in a PDP for coverage effective on January 1, 2024, unless an SEP applies. This outcome results from missing the Part D initial coverage period after becoming eligible for Part D when they first obtained Part A in May 2022. In addition to Part B late-enrollment penalties, this individual will be subject to Part D late-enrollment penalties.

Medigap enrollment Individuals in FFS Medicare seeking insurance to cover any cost sharing may choose to enroll in Medigap. Federal law allows Medigap enrollment with guaranteed-issue protections during a one-time six-month Medigap enrollment period that begins with the first day of the first month on which an individual is 65 or older and is also enrolled in Medicare Part B. Generally, during the Medigap enrollment period, a beneficiary may buy any Medigap policy sold in the beneficiary's state from any insurer that is licensed in that state to sell one without medical underwriting (known as "guaranteed issue").

After Medigap enrollment, an insurer cannot make beneficiaries wait for coverage to start, except for coverage related to a preexisting condition. In some cases, the insurer can delay coverage of out-of-pocket costs for preexisting conditions for up to six months, called a "preexisting-condition waiting period." After six months, the Medigap policy will cover the out-of-pocket costs for services related to the beneficiary's preexisting condition. However, if a beneficiary is buying a Medigap policy to replace certain kinds

of health coverage that Medigap deems "creditable coverage," such as employer-sponsored insurance or a commercial plan, the beneficiary can avoid or shorten the preexisting-condition waiting period.

State law determines whether insurers must offer Medigap policies to individuals under age 65. Thirty-six states require insurers to offer at least one kind of Medigap policy without medical underwriting to Medicare beneficiaries under age 65 with disabilities during a Medigap enrollment period (CSG Actuarial 2025). Seven states (Hawaii, Kansas, New Jersey, Oklahoma, Oregon, Pennsylvania, Virginia) offer eligibility for at least one plan for beneficiaries under age 65 when they are first eligible for Part B, at the same Medigap premium as for beneficiaries ages 65 and older (CSG Actuarial 2025). Individuals under age 65 with disabilities will have guaranteed-issue rights when they turn 65 and may obtain a new Medigap policy at that time with a premium set at the state's rate for 65-year-olds.

Enrollment periods when Medicare beneficiaries can change their coverage There are periods of time throughout the year when beneficiaries can change some of their coverage: the GEP for Part A and Part B; the AEP for MA and Part D; the OEP for enrollees in MA; and the SEPs for Part A, Part B, Part D, and MA, and Medigap guaranteed-issue rights (Figure 2-1, p. 52).

Annual enrollment period for Medicare Advantage and prescription drug plans Each year during the AEP, which occurs from October 15 through December 7, all individuals enrolled in Part A and/or Part B may join or switch MA plans or PDPs or return to FFS Medicare. (Beneficiaries face some issues related to switching between MA and FFS, which are discussed later in the chapter.) Individuals may change their minds and switch plans multiple times during the AEP. The last selection made during the AEP is effective. This new coverage begins January 1 of the following year.

The Social Security Act requires the Part B premium for the following year to be announced in September; occasionally, however, the premium amount is announced in November, which leaves less time for beneficiaries to review their budget and plan options. MA plans or PDPs can make changes to their plans each year, such as changes to their cost-sharing amounts or to which providers and pharmacies are in their

FIGURE 2-1

Enrollment periods when Medicare beneficiaries can change their coverage

Enrollment period	Jan.	Feb.	Mar.	Apr.	May	Jun.	Jul.	Aug.	Sep.	Oct.	Nov.	Dec.
Annual Annual period for all enrollees to join, switch, or drop MA or Part D plans										Oct. 15–Dec. 7		
General After missing the IEP, the next period to enroll in Part A and Part B	Jan. 1–Mar. 31											
MA Open Annual period for MA enrollees to switch or drop MA plans	Jan. 1–Mar. 31											
Special All programs have federal SEPs, and Medigap may have additional state enrollment periods	Varies depending on the individuals' circumstances											

Note: MA (Medicare Advantage), IEP (initial enrollment period), SEP (special enrollment period). The annual enrollment period is also commonly referred to as the "open enrollment period." This figure does not include relevant time frames that may apply for individuals with end-stage renal disease or disabilities.

Source: Centers for Medicare & Medicaid Services 2024f.

networks. Individuals currently enrolled in plans should review the materials their plans send them, like the "Evidence of Coverage" and "Annual Notice of Change" documents as well as the "Summary of Benefits" document. If their plans are changing, individuals should make sure their plans will still meet their needs for the following year. Those beneficiaries who are satisfied with their current plan do not need to do anything during the AEP to remain in their current plan.

General enrollment period for people who did not enroll in Part B (or Part A if they must pay a premium) during their IEP Individuals who are not automatically enrolled or did not enroll in Part A during their IEP can enroll in Part A at any time after they are first eligible for coverage if they do not have to pay a premium for Part A. Aged individuals who did not enroll in Part B (or

Part A if they must pay a premium for Part A) during their IEP and are not eligible for an SEP can enroll in Part A and/or Part B between January 1 and March 31, known as the GEP. Coverage for individuals enrolling during the GEP begins the first day of the month following the month of enrollment. These individuals may face lifelong Part B late-enrollment penalties for not enrolling when they were first eligible and may experience a gap in their coverage. Beneficiaries who qualify for Medicaid or the MSPs or are eligible for Medicare due to ESRD do not pay the Part A premium (if applicable) or Part B premium or penalties.

Open enrollment period for people enrolled in Medicare Advantage Individuals enrolled in an MA plan may switch their plan or return to FFS Medicare and join a PDP during the OEP, which occurs from January 1

**TABLE
2-3**

Medicare’s late-enrollment penalties vary in amount and duration, 2026

Part of the Medicare program	Penalty description	Penalty amount per month after delayed enrollment for 12 months	Duration
Part A	10% of Part A premium (up to \$565 per month depending on the number of work credits)	\$56.50	Twice the number of uncovered years
Part B	10% of Part B premium (\$202.90 per month) for each full 12-month period of delayed enrollment	\$20.30	As long as the individual retains Part B coverage
Part C	See Part B and Part D (and Part A if paying a premium for Part A)*	See Part B and Part D (and Part A if paying a premium for Part A)*	See Part B and Part D (and Part A if paying a premium for Part A)*
Part D	1% of Part D national base beneficiary premium (\$38.99 per month) for each uncovered month	\$4.70	As long as the individual retains Part D coverage

Note: * Beneficiaries enrolled in a Medicare Advantage plan (Part C) continue to pay Part B and Part D (and Part A if paying a premium for Part A) premiums and any late-enrollment penalties associated with them. Penalties associated with late enrollment in Part A are not common because 99 percent of Medicare enrollees are eligible for premium-free Part A and face no late-enrollment penalties. The monthly penalty is always rounded to the nearest \$0.10. This table shows the amount of the penalty in 2026, but the amount of the penalty will increase each year as the premium increases.

Source: Centers for Medicare & Medicaid Services 2025a, Centers for Medicare & Medicaid Services 2025b.

through March 31 of each year. This coverage is effective the first of the month after the plan receives the request to enroll. This period is an opportunity for individuals enrolled in an MA plan who wish to change plans or return to FFS Medicare. Any individual enrolled in an MA plan, whether they recently enrolled during the previous AEP or have been enrolled in the plan for a long time, may use this period. Individuals may switch plans or return to FFS Medicare only one time during this period.

Special enrollment periods and situations specific to Medigap There are a variety of Medicare SEPs, which apply in certain situations when an individual may need to enroll or change their enrollment due to circumstances often beyond their control. Each SEP has detailed requirements that must be met to qualify. However, not every circumstance that may affect insurance coverage has an SEP. Circumstances that often qualify for an SEP include a coverage gain or

loss, an error made by a party advising the individual, changes in the individual’s location, certain changes made to the MA or PDP plan, or other exceptional circumstances. We discuss three common situations in Appendix 2-A (p. 81): no longer being covered by an employer’s group health plan, trial rights, and a significant change in a plan’s provider network, as well as issues specific to Medigap.

Late-enrollment penalties

Late-enrollment penalties are different for Medicare Part A, Part B, and Part D (Table 2-3). Late-enrollment penalties only apply to Part A if an individual must pay a premium. Most individuals do not pay a premium for Part A and would not be subject to a late-enrollment penalty.

If an individual has to pay a premium for Part A but did not enroll in Part A when first eligible during their IEP, they may have to pay a higher monthly premium

if they decide to enroll later. The monthly premium for Part A may increase up to 10 percent. The individual will have to pay the higher premium for twice the number of years that the individual could have had Part A but did not enroll. SEPs may apply depending on the circumstances.

If an individual did not sign up for Part B when first eligible, the individual may have to pay a late-enrollment penalty for as long as the individual has Medicare. The individual's monthly premium for Part B will go up 10 percent for each full 12-month period that the individual could have had Part B but did not enroll. Penalties accrue only after a full 12-month window in which the individual was eligible but did not enroll. SEPs may apply depending on the circumstances. Beneficiaries who qualify for Medicaid or the MSPs or are eligible for Medicare due to ESRD do not pay the Part B penalty.

Beneficiaries can enroll in an MA plan after having enrolled in both Part A and Part B without incurring an additional late-enrollment penalty for delayed MA enrollment. However, individuals facing a Part B or Part D (or Part A if applicable) late-enrollment penalty must continue to pay those penalties after enrolling in an MA plan, as applicable.

A person may owe a late-enrollment penalty if, after their IEP (when they first enroll in Medicare Part A and/or Part B), they go without Part D or other creditable prescription drug coverage for any period of 63 or more days in a row. The penalty is calculated by multiplying 1 percent of the national base beneficiary premium (\$38.99 in 2026) by the number of full, uncovered months that the person did not have Part D or creditable coverage.¹¹ The monthly penalty is added to the monthly Part D premium. SEPs may apply depending on the circumstances. Beneficiaries who qualify for Part D's LIS do not pay the Part D penalty.

For those individuals who must pay a Part A premium, the penalty applies for only twice the number of uncovered years. In contrast, the Part B and Part D penalties are incurred for as long as the beneficiary maintains Medicare coverage (with certain exceptions described previously). In general, relatively few beneficiaries face late-enrollment penalties. In 2021, roughly 0.05 percent of Part A enrollees (30,000 people), 1.3 percent of Part B enrollees (779,000 people),

and 5 percent of Part D enrollees (2.5 million people) paid a penalty (Komisar and Lind 2024).

In 2021, for Part B enrollees, the average late-enrollment penalty equaled 27 percent of the standard premium (Congressional Research Service 2022). Assuming the average Part B penalty is also 27 percent in 2026, we estimate that the average Part B penalty this year is about \$55 per month. As for Part D, using Medicare enrollment data, we found that the average late-enrollment penalty in that program has grown over time, from 27 percent of the base beneficiary premium in 2014 to 36 percent in 2024. Assuming some continued growth, we estimate that the average Part D penalty in 2026 equals 37 percent of the base premium, or roughly \$14 per month.

Factors affecting the choice to enroll in or switch between FFS Medicare and MA

After a beneficiary has enrolled in Medicare, they must choose between receiving benefits from the FFS Medicare program or from private plans through the MA program. Within the FFS and MA coverage options, beneficiaries face additional decisions. Beneficiaries who enroll in FFS Medicare often buy Medigap insurance to protect themselves against cost-sharing liabilities. Beneficiaries selecting Medigap choose from 10 standardized Medigap plan types, and there are numerous insurers offering each plan type (see text box, pp. 56–57, on Medigap policies) (Centers for Medicare & Medicaid Services 2025d). Beneficiaries enrolling in FFS Medicare may also select a stand-alone PDP for prescription drug coverage. Beneficiaries choose from an average of 11 PDPs in their region with differing formularies and benefit structures (Medicare Payment Advisory Commission 2026). Within MA, beneficiaries choose from an average of 39 plans (offered by an average of eight insurers) available in their area. Beneficiaries mainly choose from health maintenance organizations (HMOs) or preferred provider organizations (PPOs), which can have differing cost-sharing and provider-network requirements (Medicare Payment Advisory Commission 2025c).¹² Most MA plans offer Part D and some supplemental benefits.

About 90 percent of people under the age of 65 have health care coverage either through employer-sponsored insurance, individual insurance, or Medicaid (Tolbert et al. 2026). Thus, beneficiaries may have some familiarity and experience with health insurance and utilization management, such as prior authorizations, when they enter the Medicare program. Even with this experience, selecting Medicare coverage and plans may be difficult because of differences in the financial protections, access, and extra benefits offered. As discussed below, researchers have found that individuals have more difficulty selecting coverage options when they have many choices.

Beneficiaries consider various factors when making a choice to enroll in or switch between FFS Medicare and MA, and when choosing among the plans within those options, including financial protection, access to care and specific providers, and extra benefits. Beneficiaries weigh these factors, considering their current health needs as well as future health needs that may not be evident at initial enrollment. There may also be financial implications, beyond the enrollment penalties described above, that can make it difficult for a beneficiary to switch from one MA plan to another or from MA to FFS Medicare.

Research on consumer decision-making has found that individuals have difficulty making optimal decisions about health coverage when they have many choices

Researchers have found that individuals have more difficulty selecting a health plan when they have many choices. Studies included in a review of the literature on consumer decision-making for health plans have found that, as the number of choices increases, individuals are less likely to correctly identify the lowest-cost plan, less likely to review all of their coverage options, and more likely to select a plan that is clearly inferior to another available plan (Taylor et al. 2016).¹³ Many of those studies found that individuals had difficulties when the number of choices increased. The same literature review found that many people have difficulty understanding concepts such as coinsurance and deductibles, tend to put more emphasis on premiums over cost sharing when picking plans, and are influenced by how plan choices are presented.

Studies have also found that people are prone to status quo bias, in that they remain enrolled in initial plan

choices even if prices change or if new, potentially better choices become available. One study found that, because of the difficulty associated with selecting a plan, beneficiaries feel little incentive to reevaluate their plan choice after achieving general satisfaction with their plan (Stults et al. 2018). Another study that analyzed MCBS and CMS Medicare Compare data found that MA beneficiaries have a strong preference for remaining with the same MA plan over time (Atherly et al. 2020). The same study also found that, when individuals did switch MA plans, they were more likely to switch between plans offered by the same insurer rather than switch between insurers.

One study that compared growth in MA enrollment with growth in the number of MA plans found that enrollment grew faster in areas where the increase in the number of plans was relatively small (fewer than 15 plans), suggesting that beneficiaries were more likely to enroll when they had a more manageable number of choices (McWilliams et al. 2011). The same study also found that beneficiaries with some degree of cognitive impairment did a poorer job of selecting plans that would minimize their out-of-pocket costs.

Since the literature described above was published, there has been an increase in the development and use of artificial intelligence (AI) and machine-learning technologies to support people's insurance-choice decisions. Researchers are beginning to study how AI-based decision support tools could affect plan choice. For example, one study found that when an AI-based machine-learning decision support tool was used by skilled agents in a private retiree Medicare insurance exchange selling MA plans, consumer costs went down on average (i.e., annual premium and predicted out-of-pocket costs) and heterogeneity across agents' performance was reduced (Gruber et al. 2020). While the decision tool is a complement to agents' skill on average, this study found that it is a substitute across the skill distribution; "lower-quality agents" provide better recommendations with an AI-based tool than the top agents did without it. The same study also found that individuals enrolled in plans not recommended by the AI-based decision support tool were more than twice as likely to switch plans the following year compared with individuals who enrolled in a recommended plan. As another example, a randomized controlled trial of digital expert advice

Medigap policies are standardized

Beneficiaries with fee-for-service (FFS) Medicare can obtain a Medigap policy to protect themselves against cost sharing (e.g., 20 percent of Part B outpatient services). Medigap policies are subject to federal and state law and regulation. Unlike many other insurance policies, all Medigap policies are standardized, but the premiums can vary. Federal law specifies 10 standardized policies (Table 2-4), and Medigap plans are named in most states by letters A-D, F, G, and K-N, with the same letter offering the same basic benefits. (In Massachusetts, Minnesota, and Wisconsin, Medigap policies are standardized differently.) This standardization facilitates “apples-to-apples” comparisons among policies. Some Medigap policies also cover services that

FFS Medicare does not cover except in limited circumstances, like a portion of emergency medical care when traveling outside the U.S. In 2024, Medigap Plans F and G were the most popular plans, with about 41 percent of beneficiaries with Medigap in each of those plans.

Plan F, which is no longer available to new policyholders eligible for Medicare after January 1, 2020, covers all cost sharing. Plan G is the most comprehensive policy available to new policyholders, covering the Part A deductible and all cost sharing for Part A- and Part B-covered services but not the Part B deductible, which is \$283 in 2026. ■

(continued next page)

in the context of prescription drug insurance found that digital expert advice provided consumers with information but also altered how consumers value product features (Bundorf et al. 2024). With the digital expert advice, consumers were more likely to switch their plans and select a plan with lower expected costs. However, researchers found that individuals for whom they predicted the largest effects from exposure to expertise were the least likely to demand such expertise, which may signal that passively offering these tools is unlikely to reach those who need the most help navigating the selection of insurance.

Weighing financial protection, access to care, and extra benefits

Beneficiaries in various focus groups and surveys conducted by MedPAC and other researchers report considering various factors when making a choice of FFS or MA and the plans within those options, including financial protection, access to care and specific providers, and extra benefits (Freed et al. 2023, Leonard et al. 2022, NORC at the University of Chicago

2025). Beneficiaries who enroll in MA accept provider networks and utilization-management tools such as prior authorization in exchange for lower premiums and an out-of-pocket maximum, though they pay more if they seek care from out-of-network providers. By contrast, FFS offers broader choice of providers with limited utilization management but can expose beneficiaries to high out-of-pocket costs unless they purchase additional coverage. MA plans also typically offer a variety of extra benefits not available in FFS, such as dental, vision, and hearing benefits. While it can be challenging for beneficiaries to understand each plan’s package of supplemental benefits, these extra benefits help fill gaps in Medicare coverage and appeal to beneficiaries. Beneficiaries weigh these factors, considering their current health needs as well as future health needs that may not be evident at initial enrollment.

Beneficiaries may want to switch their Medicare coverage or plan for a wide variety of reasons. Some of those reasons could reflect changes in their personal circumstances, such as a new diagnosis or a change in

Medigap policies are standardized (cont.)

**TABLE
2-4**

Covered benefits and out-of-pocket costs in standardized Medigap plans, 2024

	Medigap standardized plan type									
	A	B	C	D	F	G	K	L	M	N
Part A hospital coinsurance and costs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Part B coinsurance or cost sharing	✓	✓	✓	✓	✓	✓	50%	75%	✓	\$20/\$50
Blood (first 3 pints)	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Hospice coinsurance or cost sharing	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
SNF coinsurance			✓	✓	✓	✓	50%	75%	✓	✓
Part A deductible		✓	✓	✓	✓	✓	50%	75%	50%	✓
Part B deductible			✓		✓					
Part B excess charges					✓	✓				
Foreign-travel emergency			80%	80%	80%	80%			80%	80%
Out-of-pocket limit	N/A	N/A	N/A	N/A	N/A	N/A	\$7,220	\$3,610	N/A	N/A
Lives covered (in thousands)	109	134	405	146	5,084	5,109	69	28	1	1,321
Percentage enrolled	1	1	3	1	41	41	<1	<1	<1	11

Note: SNF (skilled nursing facility), N/A (not applicable). Three states (Massachusetts, Minnesota, and Wisconsin) have different plan types and are not included in this chart. The ✓ indicates that the plan covers all cost sharing for that benefit. Percentages indicate that the plan covers that share of the total cost sharing. The "\$20/\$50" indicates that the plan covers all but \$20 for physician office visits and all but \$50 for emergency room visits. Plans C and F are no longer available to people new to Medicare on or after January 1, 2020. However, those eligible for Medicare before January 1, 2020, but who have not yet signed up may be able to buy Plan C or Plan F. Plans F and G offer a high-deductible plan in some states. Plans K and L show how much they will pay for approved services before a beneficiary meets their out-of-pocket yearly limit and Part B deductible. After a beneficiary meets their out-of-pocket yearly limit and Part B deductible, the plan pays 100 percent of the beneficiary's cost. The enrollment percentages do not sum to 100 percent due to rounding. The number of beneficiaries represented in this chart is 12.4 million.

Source: MedPAC analysis of National Association of Insurance Commissioners data 2024, Medicare Payment Advisory Commission 2025a.

financial circumstances. Beneficiaries may also want to switch their MA or Part D plans due to undesirable changes in their current plan or switch their Medigap policy if premiums increase. But financial implications,

beyond the enrollment penalties described above, can make it difficult for a beneficiary to switch from one MA plan to another or from MA to FFS Medicare.

Financial protection

Most MA plans have lower premiums compared with FFS with Medigap and PDP coverage. In 2026, more than three-quarters of MA enrollment is projected to be in “zero-premium” plans with drug coverage, while FFS enrollees may pay, on average, a premium of \$217 per month for a Medigap policy and \$44 per month for a Part D plan (Freed et al. 2024b, Medicare Payment Advisory Commission 2026, Medicare Payment Advisory Commission 2025c).^{14,15} In 2024, the average monthly MA-PD premium for all plan types was \$12 for HMO plans and \$16 for local PPO plans (Freed et al. 2024a).

MA plans may also attract some beneficiaries because they typically have a different cost-sharing structure than FFS. MA plans must have an annual cap on out-of-pocket spending for in-network Part A and Part B services, known as a maximum out-of-pocket (MOOP) limit, while FFS does not have an annual cap.¹⁶ In 2025, the MOOP limit for in-network services was \$9,350, but many plans used some of the rebates they receive under the MA payment system to offer a lower limit, and the average MOOP limit for MA enrollees was \$5,320 (Ochieng et al. 2025). Compared to FFS, many MA plans also use rebates to reduce cost sharing for certain services, such as primary care visits (where enrollees often pay no cost sharing) and inpatient care. These features provide some protection against high out-of-pocket costs and may be appealing to beneficiaries who either cannot or do not want to purchase a Medigap policy. However, for beneficiaries who use more medical services, the cost sharing in an MA plan may be higher, in aggregate, than the amount they would have spent on premiums for a Medigap policy.

Beneficiaries who purchase Medigap insurance exhibit a strong preference for Medigap plans that reduce or eliminate cost sharing: Over 80 percent of those beneficiaries are in Plans F and G, which have the most comprehensive coverage (see text box, pp. 56–57, on Medigap policies). Although comprehensive supplemental coverage available to new enrollees limits most out-of-pocket liability for beneficiaries, research has shown that secondary insurance coverage may induce service use (Direct Research 2014). Research also finds that even relatively small levels of cost sharing are associated with reduced use of care, including necessary services (Artiga et al. 2017).

In our annual focus groups, beneficiaries who chose MA plans mentioned cost as a driver of their decision to enroll (NORC at the University of Chicago 2025).¹⁷ Several beneficiaries mentioned low or no out-of-pocket expenses (including premiums) or cost sharing as their primary reason for choosing MA over FFS Medicare. One beneficiary enrolled in MA noted, “It was a good choice. It was basically zero deductible on most doctor visits, hospital stays, etc.” Another noted, “I retired on disability. . . . I didn’t want . . . out-of-pocket [costs].”

A 2022 Commonwealth Fund survey also found that 20 percent of MA enrollees surveyed reported that the limit on out-of-pocket costs was the main reason they chose their Medicare coverage and the second-highest reason for choosing MA, with more benefits being the most reported reason for choosing MA (Leonard et al. 2022). In contrast, only 4 percent of FFS beneficiaries surveyed reported lower cost as the main reason they chose their Medicare coverage (least commonly reported reason), with more provider choice being the most reported driver of the FFS choice.

Access to care

FFS enrollees have broader choice of providers and are largely not subject to utilization management. MA plans are required to provide the same set of benefits that are available under FFS Medicare. MA enrollees who are in an HMO plan often must select an in-network primary care provider (PCP) who manages referrals to specialists and, except for urgent or emergency care, they are generally liable for out-of-network provider charges (not to exceed 100 percent of the FFS amount). MA enrollees who are in PPO plans have more flexibility because they are not required to name a PCP and are allowed to see both in- and out-of-network specialists without a referral; however, they may pay higher cost sharing for out-of-network providers compared with in-network providers (which may include preferred and nonpreferred providers). MA plans can require enrollees to obtain prior authorization to access certain services, a practice that has limited use in FFS Medicare.¹⁸ Potential impacts of prior-authorization requirements on receiving care may not be fully apparent when beneficiaries first enroll in Medicare, especially if they are healthy and have not experienced the prior-authorization process with previous insurers.

MA plans negotiate payments with individual providers. MA plans can also use utilization-management tools to contain spending and prevent beneficiaries from receiving unnecessary or low-value services. On the one hand, provider networks and prior authorization have the potential to promote more efficient care, including better quality outcomes (Medicare Payment Advisory Commission 2024). On the other hand, misapplication of these tools could lead to delay or denial of beneficiary care. CMS currently regulates certain aspects of both tools, through network-adequacy standards and Medicare coverage requirements, but limitations persist in current data-collection and enforcement mechanisms. In 2024, nearly all MA enrollees were in plans that required prior authorization for some categories of services; those requirements varied across MA plans (Freed et al. 2024a). Because prior-authorization requirements vary by service type and by plan, they can affect beneficiaries with certain conditions and their ability to obtain services from some provider types and specialties more than others.

In our focus groups, many FFS beneficiaries described choosing FFS Medicare over MA because they wanted unrestricted access to clinicians or because their clinician recommended FFS Medicare. Participants with serious or chronic health conditions, as well as those who described themselves as relatively healthy, described choosing FFS Medicare because it allowed them to access a broader range of specialists without needing referrals or facing network restrictions. Several participants noted that their physicians steered them in the direction of FFS Medicare. One said, “My doctors, because I need a monthly treatment, wanted all the people who get this treatment to have traditional Medicare.” While we cannot verify the details and circumstances of beneficiary reports, several beneficiaries who chose FFS Medicare cited negative perceptions or experiences with MA. A few participants expressed distrust of or dissatisfaction with MA plans, especially regarding examples they had heard of denials of care. One mentioned:

An Advantage plan is fine as long as you don’t get sick. I just had a lady call me. Her husband had a stroke a few months ago. He needs a wheelchair. The plan she has with Advantage won’t give it to her. He needs therapy. They won’t give it to her.

A 2022 Commonwealth Fund survey also found that FFS beneficiaries made their coverage choice for more access to providers, with 40 percent of FFS beneficiaries surveyed citing more doctor, hospital, and health care provider choice as the main reason they chose to remain in FFS Medicare (Leonard et al. 2022).

Extra benefits

In addition to covering basic Part A and Part B services, MA plans may provide “supplemental” benefits to their enrollees, such as enhanced Part D benefits and other benefits not covered in FFS Medicare such as dental, vision, or hearing services (non-Medicare services) (Medicare Payment Advisory Commission 2025b). Nearly all plans now have dental, vision, and hearing benefits. Dental benefits account for about 40 percent of spending on supplemental benefits (Government Accountability Office 2023). MA plans have increasingly offered coverage of nonmedical benefits and use of “flex” cards. (Flex cards are prefunded debit cards through which plans can administer benefits that are offered.) It can be challenging for beneficiaries to understand each plan’s package of benefits.

A few beneficiaries in our focus groups were drawn to MA plans because of the additional benefits not typically included in traditional Medicare. They specifically cited their use of flex cards for over-the-counter items and plans that offered dental and vision coverage. One noted, “I used to get \$160 a month for frivolity stuff—toothpaste, aspirin, that kind of stuff.” Another reported, “[One MA plan] wasn’t offering dental care, eye care, or anything. . . . So I joined [another MA plan] and was able to get what I needed.”

Many dually eligible beneficiaries in our focus groups described the importance of extra benefits not typically included in FFS Medicare when choosing an MA plan. These participants frequently mentioned dental, vision, transportation, wellness incentives, and flex cards as key motivators. One participant noted, “My aunt had told me [her plan] gives a \$250 card that you can pay your bills or your gas with. So, I called them. They set me up.” Another explained, “Mine was offering dental, vision, and physical. . . . I have a lot of health issues, so [my priority] was to know what I was covered with.” A third said, “I can pay for cash bills, healthy food, and that \$250 comes [in] handy.”

A 2022 Commonwealth Fund survey also found that MA enrollees valued extra benefits in their coverage choice, with 24 percent of MA enrollees surveyed citing more benefits as the main reason they chose their Medicare coverage (Leonard et al. 2022).

Issues related to switching in MA, Part D, and Medigap

Beneficiaries may want to switch their Medicare coverage for a wide variety of reasons. Some of those reasons could reflect changes in their personal circumstances. For example, beneficiaries might have received a new cancer diagnosis or experienced a recent health-related event like an injury or a heart attack. Their financial situation may have changed, such as when they can no longer afford a Medigap plan's premium, or their preferences for how they receive health care may have changed (for example, the desire to switch to a new doctor or the need to see a specialist with experience treating their condition who may not be in their current plan's network).

Beneficiaries may also want to switch their MA or Part D plans due to undesirable changes in their current plan, such as increased premiums or cost sharing, the exclusion of a particular provider from the plan's network, expanded use of prior authorization or other forms of utilization management, changes in the coverage or cost of a beneficiary's medications, or changes to the plan's package of supplemental benefits. Beneficiaries may wish to switch their Medigap policy if premiums increase.

But Medicare has some features that beneficiaries must consider if they want to switch coverage and plans. First, as described above, beneficiaries are largely prohibited from enrolling or changing plans outside of certain limited enrollment periods, although there are a variety of SEPs that allow beneficiaries in certain situations to switch plans at other times. Second, in the MA market, if a beneficiary switches MA plans during eligible enrollment periods during a year, the annual maximum out-of-pocket resets, which may be a financial burden. For example, if in February a beneficiary in an MA plan has already reached half of their out-of-pocket limit amount due to the use of certain services with large cost sharing, if they use the OEP to switch MA plans in March, the new plan will not credit them with the spending incurred in the previous

plan toward their out-of-pocket limit. Instead, the plan will begin the new plan's annual out-of-pocket limit calculation at \$0 without giving the enrollee credit for their out-of-pocket spending under the previous plan. In contrast, in Part D, when a person switches PDPs during the year, the balance of the amount that counts toward a person's annual out-of-pocket threshold (known as the person's true out-of-pocket costs) transfers to the new drug plan. Third, in the Medigap market, beneficiaries who try to buy a policy outside of the Medigap enrollment period, a state-designated period, or an SEP may also be subject to medical underwriting, where the insurer may not sell the plan to the beneficiary due to the beneficiary's health conditions. These features are primarily intended to prevent or reduce adverse selection.

If beneficiaries want to switch plans, they must consider that FFS Medicare does not have an annual limit on out-of-pocket costs, while MA and Part D do (as described above). Beneficiaries who are accustomed to limited cost sharing (because they have been enrolled in private plans before age 65 and in Medicare have been enrolled only in MA) may not anticipate the impact that the lack of out-of-pocket maximum in FFS Medicare could have on their finances and therefore may underestimate the need for Medigap coverage. Some beneficiaries wishing to leave MA, such as after a new diagnosis, and return to FFS may find it difficult to do so because they cannot afford to incur FFS's higher out-of-pocket costs but also find Medigap premiums to be too expensive or may be unable to purchase a Medigap policy at all due to underwriting. A recent study found that the rate of switching from MA to FFS in the year after a cancer diagnosis was more than twice as high in states with Medigap guaranteed-issue protections (4.7 percent) than in those without (2.7 percent), underscoring the protective association of state Medigap regulations in facilitating a switch to FFS (Kwon et al. 2025). In our June 2012 report to the Congress, the Commission, noting that no upper limit exists on the amount of Medicare cost-sharing expenses a beneficiary in FFS can incur, recommended a redesign of Medicare's FFS benefit package including an out-of-pocket maximum (see text box on the Commission's recommendation to reform Medicare's benefit design) (Medicare Payment Advisory Commission 2012).

The Commission's 2012 recommendation to reform Medicare's benefit design

Under the current fee-for-service (FFS) benefit design, no upper limit exists on the amount of Medicare cost-sharing expenses that a beneficiary can incur. Without additional coverage, the FFS benefit design exposes Medicare beneficiaries to substantial financial risk. In June 2012, the Commission recommended that the Congress direct the Secretary to develop and implement a FFS benefit design that would replace the current design and would include:

- an out-of-pocket maximum;
- deductible(s) for Part A and Part B services;
- replacing coinsurance with copayments that may vary by type of service and provider;
- secretarial authority to alter or eliminate cost sharing based on the evidence of the value of services, including cost sharing after the beneficiary has reached the out-of-pocket maximum;

- no change in beneficiaries' aggregate cost-sharing liability; and
- an additional charge on supplemental insurance.

The Commission's recommended redesign of Medicare's FFS benefit package provides better protection against high out-of-pocket spending and thus enhances the overall value of the FFS benefit, mitigating the need for beneficiaries to purchase supplemental insurance (Medicare Payment Advisory Commission 2012). It also creates clearer incentives for beneficiaries to make more informed decisions about their use of discretionary care while holding the aggregate beneficiary cost-sharing liability about the same as under current law. The redesign allows for ongoing adjustments and refinements in cost sharing as evidence of the value of services accumulates and evolves. An additional charge on supplemental insurance would recoup at least some of the additional costs imposed on the Medicare program due to the insurance effect of supplemental coverage. However, it would still allow beneficiaries to buy supplemental coverage if they wish to do so. ■

MA marketing may contribute to confusion

MA insurers and third-party marketing organizations (TPMOs) rely on marketing to attract and retain enrollees, such as TV ads, direct mailings, phone calls, and digital ads.¹⁹ In the 2022 Commonwealth Fund survey, 3 percent of respondents in FFS and 7 percent of MA respondents reported using advertisements on TV or somewhere else to guide their plan choice (Leonard et al. 2022). Though MA organizations must submit all marketing materials, all election forms, and certain designated communications materials for

CMS review, some stakeholders have raised concerns about an increase in marketing by plans and TPMOs, arguing that the volume of ads, mailings, and calls may be overwhelming to some beneficiaries and that some marketing materials may be misleading. CMS has noted an increase in the number of beneficiary complaints about MA insurers' marketing activities. Stakeholders have also raised concerns about the increasing role of lead generators and offshore entities in MA marketing. The increase in concerns about MA marketing may be associated with a finding that the number of MA beneficiaries who "rapidly disenroll" from their plan tripled from 2017 to 2022 (rising from 3.5 percent to 12.2 percent) (defined as switching to FFS Medicare or

a new MA plan within the OEP during the first three months of the year) (Balkan et al. 2026).

Beneficiaries receive lots of marketing about MA, and some marketing may be misleading

A KFF study found that beneficiaries are “flooded” with TV ads for MA plans, with nearly 650,000 airings (more than 9,500 per day) during the 2022 AEP on mainly local media markets (Fuglesten Biniek et al. 2023). Many participants in our annual beneficiary focus groups reported being overwhelmed by the amount of marketing information they received (NORC at the University of Chicago 2025, NORC at the University of Chicago 2024). These participants reported receiving “constant” phone calls and frequent mailings from insurers, especially during the AEP. Other participants reported receiving many phone calls related to enrolling in MA plans, with one noting, “Why is it—it’s like every day, somebody calling you about your insurance? I already did this for this year already” and another estimating the number of calls: “I get five, six a day.”

Digital advertising, communication, and outreach by health plans and TPMOs are common sources of Medicare information for beneficiaries, and today these efforts compete with nonprofit and government sources for beneficiary attention (Commonwealth Fund 2021b). In 2021, the Commonwealth Fund conducted a series of online searches with Medicare keywords and found that agents’ and insurers’ Medicare resources are widely available online and are likely to be among the first information sources seen in online searches. Agents and health plans accounted for a third of the search results and 87 percent of all ads (paid placements); only 7 percent of ads were from the federal government.

Increasing beneficiary complaints about Medicare marketing

In 2022, CMS reported that it has “seen an increase in beneficiary complaints associated with TPMOs and has received feedback from beneficiary advocates and stakeholders concerned about the marketing practices of TPMOs who sell multiple MA and Part D products” (Centers for Medicare & Medicaid Services 2022b). In 2020, CMS received a total of 15,497 complaints related to marketing. In the first 11 months of 2021, there were

39,617 complaints. CMS stated that many of these complaints were related to TPMO marketing (Centers for Medicare & Medicaid Services 2022b).

CMS said its “experience in reviewing beneficiary complaints and listening to recorded calls between agents/brokers and beneficiaries revealed many instances during which agents/brokers failed to provide enough information” or “provided inaccurate information about plan benefits” (Centers for Medicare & Medicaid Services 2023a). CMS also identified instances where agents “led beneficiaries to believe the beneficiaries were calling Medicare rather than an insurance agent” (Centers for Medicare & Medicaid Services 2023a). According to CMS, in listening to hundreds of marketing and enrollment calls, the agency found “in the majority of the calls (over 80 percent), agents and brokers failed to ask pertinent questions to help a beneficiary enroll in a plan that best meets the individual’s needs” (Centers for Medicare & Medicaid Services 2023a). Examples included “beneficiaries being told that if their medication was not on the formulary, the doctor could tell the plan, and the plan would simply add it; or incorrectly stating that ‘nothing would change’ when beneficiaries asked if their current health coverage would stay the same” (Centers for Medicare & Medicaid Services 2022a).

CMS stated that these “complaints are typically filed by enrollees or their caregivers through 1-800-MEDICARE or CMS regional offices, and generally allege that a beneficiary was encouraged or pressured to join an MA plan, and that once enrolled, the plan was not what the enrollee expected or what was explained to them when they spoke to an agent or broker” (Centers for Medicare & Medicaid Services 2023b). CMS stated that “the rise in MA marketing complaints noted above suggests that agents and brokers are being influenced to engage in high pressure tactics, which may in turn cause beneficiary confusion about their enrollment choices, to meet enrollment targets or earn ‘administrative payments’ in excess of their compensation payment” (Centers for Medicare & Medicaid Services 2023b).

In 2022, the Senate Committee on Finance released a report on Medicare beneficiary complaints regarding the marketing of MA plans and PDPs by plans and TPMOs (U.S. Senate Committee on Finance 2022). The Committee found evidence of “aggressive or deceptive MA and Part D marketing practices” that

were “widespread, not isolated events.” The Committee said that “[a]gents were found to sign up beneficiaries for plans under false pretenses, such as telling a beneficiary that coverage networks include preferred providers even when they do not.”

Changes in third-party marketing organizations over time

CMS defines TPMOs as “organizations and individuals, including independent agents, 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)” (Centers for Medicare & Medicaid Services 2008a). In conversations with some agents and others in the industry, we commonly heard that the structures and roles of organizations and individuals involved in marketing MA plans and enrolling beneficiaries have changed over time. We heard that individual agents, field marketing organizations (FMOs), call centers, marketing firms, and lead generators are all lumped together under the current TPMO definition but serve different roles. In 2022 and 2025, the Senate Finance Committee majority and minority staff, respectively, reported on the growing, complex network of marketing organizations in MA (U.S. Senate Committee on Finance 2025, U.S. Senate Committee on Finance 2022). The committee reported that MA plan marketing efforts were initially handled by smaller, independent brokerages and agents. While some brokers still operate independently or in small brokerages, marketing activities are now largely overseen by FMOs that provide back-end administrative support for agents and brokers and serve as the primary contact for insurers (U.S. Senate Committee on Finance 2025). FMOs can be large national organizations or smaller regional organizations. The report highlighted questionable lead-generation techniques, the role of onshore and offshore call centers, and a “marketing and administrative payments arms race” (U.S. Senate Committee on Finance 2025). In recent proposed rules, CMS issued a request for information on ways to modify the current definition of TPMOs and to delineate the roles of and requirements applicable to the different kinds of TPMOs (Centers for Medicare & Medicaid Services 2025i).

Medicare information sources: CMS, SHIP, and insurance agents

In our annual beneficiary focus groups, many beneficiaries described turning to formal resources for help making Medicare enrollment decisions, including insurance agents, plan representatives, health fairs, and Medicare.gov (NORC at the University of Chicago 2025, NORC at the University of Chicago 2024). Others described relying on guidance and recommendations from less formal sources, including family members and friends. In this section, we focus on three of these sources: CMS tools, the federally funded SHIP, and insurance agents.

CMS information sources include Medicare.gov, 1-800-MEDICARE, and Medicare Plan Finder

CMS has several tools available to individuals and their families or caregivers that can be accessed by visiting Medicare.gov or calling the 1-800-MEDICARE help line. These tools are designed to provide beneficiaries with unbiased information to help them navigate their enrollment and coverage choices.

Medicare.gov

Medicare.gov has numerous resources about Medicare enrollment and benefits, including the *Medicare & You* handbook, the *Choosing a Medigap Policy* guide, and the Medicare Plan Finder tool (discussed below). The annual *Medicare & You* handbook includes information about Medicare coverage, Medicare plan enrollment options, and what is new in Medicare for the current year. The annual *Choosing a Medigap Policy* guide explains what Medigap policies cover, when individuals have guaranteed-issue rights to Medigap policies, and the steps to buy a Medigap policy.

1-800-MEDICARE

The toll-free 1-800-MEDICARE line and a live chat on Medicare.gov are available 24 hours a day except for certain federal holidays. Customer inquiries are received through the telephone, mail, email, telecommunications device for the deaf/teletypewriter (TDD/TTY), fax, and webchat. Individuals call 1-800-MEDICARE to obtain information about MA, prescription drug plans, or Medigap policies available in their area; what services are covered by Medicare;

and the status of claims, among other topics. Calls placed to 1-800-MEDICARE are answered initially by an interactive voice-response system that routes a call to a customer service representative or provides other information, such as a recording. Customer service representatives rely on written scripts to answer callers' questions and may also consult other tools, such as information on Medicare.gov.

In 2025, 1-800-MEDICARE received 24.2 million calls, with the interactive voice-response system completely managing 30 percent of call volume (7.3 million calls) (Centers for Medicare & Medicaid Services 2026c). CMS targets a five-minute average speed of answer for calls to 1-800-MEDICARE, but we do not have current data on actual wait times (Centers for Medicare & Medicaid Services 2026c). In 2023, 49 percent of MCBS respondents reported that they were aware of 1-800-MEDICARE, and 33 percent reported calling the phone line (see Appendix 2-B, p. 86, on results from the MCBS).

Medicare Plan Finder

One key resource for Medicare beneficiaries seeking information about their coverage options is the Medicare Plan Finder, an online search tool available at Medicare.gov. CMS initially developed Plan Finder in 1998 and has made numerous modifications to it since then to incorporate newer technology and reflect changes in Medicare, such as the addition of the Part D drug benefit and the ability of MA plans to offer a broader range of supplemental benefits (Centers for Medicare & Medicaid Services 2019, Government Accountability Office 2019). Plan Finder can be found at www.medicare.gov/plan-compare.

To use Plan Finder, beneficiaries enter their ZIP code and indicate whether they want information about MA plans, stand-alone Part D prescription drug plans (PDPs), or Medigap plans. Beneficiaries who indicate interest in MA plans or PDPs are asked whether they receive assistance from Medicaid, the Medicare Savings Programs, or Part D's low-income subsidy. (When beneficiaries indicate that they receive one of these types of assistance, Plan Finder automatically adjusts the cost information for plans and the order in which plans are listed.) Plan Finder provides information for all conventional MA plans, MA special-needs plans, and PDPs offered in a beneficiary's county of residence,

including plan premiums, deductibles, cost-sharing amounts, and annual out-of-pocket limits. Beneficiaries can enter information about the prescription drugs and pharmacies they use and, for each PDP and MA plan with drug coverage, get a personalized estimate of their total annual spending for premiums and cost sharing. For MA plans, Plan Finder indicates whether the plan offers at least some coverage for approximately 25 distinct types of supplemental benefits. If a beneficiary selects an MA plan or PDP, they can enroll in the plan directly through the website.

For beneficiaries interested in traditional FFS Medicare, Plan Finder has some information on Medigap plans, such as the specific policies that are available (all Medigap plans use 1 of 10 standardized benefit packages, but insurers may not sell every type of policy), an estimated premium, and contact information for each insurer. Beneficiaries who want to select a Medigap plan must contact the insurer to determine their exact premium and enroll in the plan.

It is not clear how often beneficiaries use Plan Finder. According to a 2022 Commonwealth Fund survey that asked beneficiaries which sources of information they used to select a plan, 5 percent of beneficiaries in traditional FFS Medicare and 9 percent of beneficiaries in MA used the Medicare hotline or Medicare.gov (Leonard et al. 2022). In 2023, less than half of respondents (46 percent) in the MCBS reported visiting the Medicare.gov website for any purpose (see Appendix 2-B, p. 86, on results from the MCBS). However, those figures may significantly understate the use of Plan Finder because several other sources of information that beneficiaries rely on—such as insurance agents, friends and family, and SHIP counselors—may use Plan Finder themselves in assisting beneficiaries. In our beneficiary focus groups, several beneficiaries have reported using Plan Finder to review their coverage options, although relatively few said they relied on it as their only source of information in making a decision (NORC at the University of Chicago 2025, NORC at the University of Chicago 2024).

In 2025, CMS made two significant changes to Plan Finder. First, information about the specific providers that participate in an MA plan's network was added, making it easier for beneficiaries to understand which plans have their providers in network. Previously,

beneficiaries needed to visit the websites for each individual plan to find this information. Second, more detail about each MA plan’s coverage of various supplemental benefits was added, such as the in-network and out-of-network cost-sharing amounts and whether the plan limits its coverage in some way. Previously, for most types of benefits, Plan Finder simply indicated whether plans had “some coverage” or “no coverage.”

Although Plan Finder has improved over time, it still has some limitations. For example, with respect to MA supplemental benefits, Plan Finder provides relatively little information about issues such as potential limits on a plan’s coverage, requirements to obtain services from specific providers, or the need to obtain prior authorization. Similarly, regarding Medigap, the premium information in Plan Finder may not be accurate for beneficiaries who are interested in buying a plan in situations where they might have to go through medical underwriting.²⁰ Both limitations are clearly noted in Plan Finder, and they are difficult to incorporate into a search tool given the substantial plan-level variation in MA supplemental benefits and the state- and insurer-level variation in policies that affect Medigap premiums.

The addition of information from plans’ provider directories, in particular, addresses a key gap in Plan Finder’s capabilities, but further improvements will be needed. The approach that CMS employed last year was an interim step that used provider data collected by a private company (SunFire Matrix) and did not have information for all plans. However, CMS has started requiring all plans to submit their provider directories to the agency and aims to incorporate these data into Plan Finder in time for the next AEP, which starts in October. The provider data now used in Plan Finder are also largely limited to individual clinicians, and beneficiaries can include only up to five providers in their search; future improvements could allow beneficiaries to enter information about more than five clinicians and see if plans cover other important providers such as specific hospitals or skilled nursing facilities. There are long-standing concerns that the information in MA provider directories can be inaccurate—for example, a provider’s address may have changed or they may not be accepting new patients.²¹ (The provider directories for other types of health

insurance can have similar problems.) Inaccuracies in the underlying data from MA provider directories could make Plan Finder less useful and could result in some beneficiaries selecting plans that do not actually cover all of the providers they use.²²

CMS has expressed interest in incorporating artificial intelligence–based tools into its information sources

In February, CMS issued a request for information (RFI) about existing commercial products or services that use AI technology and “are capable of enhancing the Medicare experience for beneficiaries” (Centers for Medicare & Medicaid Services 2026f). The agency expressed interest in using AI tools in a variety of ways that would affect each of the information sources discussed in this section, such as:

- developing virtual assistants and chatbots to provide “real-time conversational support” to beneficiaries;
- automating routine inquiries to the 1-800-MEDICARE helpline;
- translating plan documents and other Medicare information into plain English; and
- developing personalized plan recommendations that incorporate data from a beneficiary’s FFS claims, Part D claims, and MA-plan encounters to help them select plans that meet their needs.

In the RFI, CMS said that it anticipated issuing formal solicitations for AI-related tools in the future but did not discuss its plans in detail.

The State Health Insurance Assistance Program is a key federal source of Medicare counseling for beneficiaries

The SHIP is a federal program that provides grants to the 50 states, the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands to deliver objective information, outreach, and counseling at no cost to Medicare beneficiaries. Established in 1990, the SHIP is currently administered by the Administration for Community Living (ACL) within the Department of Health and Human Services. Local grantees deliver individual assistance through in-person, phone, online, and written communications

and are not compensated by insurers. Grantees rely heavily on the availability of volunteer staff to provide SHIP services. From April 2022 to March 2023, paid staff and volunteer SHIP counselors assisted nearly 4.3 million beneficiaries and their families or caregivers through counseling sessions or outreach events—about 6 percent of the Medicare population (Administration for Community Living 2025). From July 2025 to December 2025, 10,043 paid staff and volunteer SHIP counselors provided individual counseling to nearly 1.2 million beneficiaries.²³ The SHIP is funded through a combination of discretionary and mandatory federal funding from the Medicare trust funds and state and local funding. Federal funding over the past 17 years has not kept pace with growth in Medicare enrollment.

In our annual beneficiary focus groups, few beneficiaries were aware of their local SHIP grantees, but those who used them reported positive experiences (NORC at the University of Chicago 2025, NORC at the University of Chicago 2024). A Commonwealth Fund survey conducted in 2022 found that 4 percent of MA enrollees and 5 percent of FFS enrollees reported using the SHIP to guide their plan choice (Leonard et al. 2022).

As part of our work examining the complexity of enrollment choices in Medicare, we conducted semistructured interviews with ACL staff that direct the SHIP, staff at the SHIP Technical Assistance (TA) Center, and counselors or staff from seven grantees. We focused on the interviewees' experiences working with beneficiaries to help them make Medicare enrollment decisions, as well as the functions and challenges of the SHIP. We selected SHIP grantees to interview in areas with varying MA penetration rates, shares of beneficiaries who are dually eligible for Medicare and Medicaid, and differing Medigap guaranteed-issue policies. As described below, all interviewees reported funding and capacity challenges as call volumes have risen, counseling sessions have lengthened, and more expertise is required of volunteers.

SHIP funding and operations

Local SHIPs are the primary federally funded source of community-based individualized counseling for beneficiaries navigating their enrollment and coverage decisions. SHIP grantees provide no-cost assistance to

beneficiaries about FFS Medicare (Part A and Part B), MA (Part C), the Medicare Prescription Drug Program (Part D), Medigap, and Medicaid (Congressional Research Service 2023). SHIP counselors provide one-on-one counseling to help beneficiaries make informed enrollment and benefit decisions. In addition to individual counseling, grantees conduct public education and outreach on a variety of topics related to Medicare, including plan comparison, enrollment periods, and understanding coverage and benefits. The SHIP also receives federal funding dedicated to outreach to hard-to-reach Medicare beneficiaries, such as those in rural areas.

The ACL provides grants to the states and territories to fund the infrastructure, training, and administration needed to support SHIP staff, nearly half of whom are volunteers, in over 2,200 community-based organizations. Nearly two-thirds of SHIP grantees are administered by state- or territory-level agencies that advocate for and provide assistance to older residents, their families, and adults with physical disabilities, known generally as state units on aging (Administration for Community Living 2024, Congressional Research Service 2023). The remaining one-third of grantees are administered by their respective state departments of insurance. At the local level, many grantees partner with a public or private nonprofit agency designated by the state to address the needs of older persons in the community, known generally as area agencies on aging. Some grantees are colocated with their local Senior Medicare Patrol offices, which are federal programs dedicated to the determent and prevention of Medicare fraud and abuse (Administration for Community Living 2025).

Beneficiaries can also visit Medicare.gov or call 1-800-MEDICARE with their Medicare enrollment questions. Beneficiaries who raise complicated issues during calls to 1-800-MEDICARE may be referred to their local SHIP grantee. Sometimes grantees require assistance from 1-800-MEDICARE to resolve beneficiary issues. SHIP counselors can contact 1-800-MEDICARE on behalf of a beneficiary using the counselor's unique identification number on a dedicated 1-800-MEDICARE line that allows them access to information to resolve beneficiary issues, a service some SHIP grantees we interviewed reported using several times a week.

Funding sources The SHIP is funded through a combination of discretionary and mandatory federal funding from the Medicare trust funds (with half of total funding drawn from the Hospital Insurance fund and half from the Supplementary Medical Insurance fund) and state and local funding. Discretionary federal funding supports SHIP operations that serve all Medicare beneficiaries, while mandatory federal funding supports additional individual counseling and outreach services targeted to hard-to-reach populations.

Each year, the Congress appropriates discretionary funding for the SHIP, which represents the primary source of SHIP funding. This funding supports grants to state and territory grantees (the amounts of which are determined based on regulatory formulas), the ACL's oversight of the program, and the operations of the SHIP TA Center that provides training and technical assistance to the 54 grantees and operates a telephone line and a website with a SHIP directory to aid beneficiaries in finding their local grantee (Administration for Community Living 2026, Congressional Research Service 2023).²⁴ For fiscal year 2026, \$55.2 million in discretionary funding was appropriated to the SHIP (U.S. House of Representatives 2026). This amount is consistent with recent years (Congressional Research Service 2023), but funding has not kept pace with inflation or growth in Medicare enrollment. From 2008 to 2025, the annual amount of discretionary funding appropriated to SHIP grantees, adjusted for inflation, has declined 26 percent, while Medicare enrollment has increased by about 53 percent (Figure 2-2, p. 68).

In addition to the discretionary funding, the SHIP also receives mandatory federal funding intended to support additional outreach and assistance for hard-to-reach Medicare beneficiaries, including beneficiaries living in rural communities, those with low incomes, and those with limited English proficiency.²⁵ Mandatory funding was first provided in the amount of \$7.5 million (or \$11.6 million as adjusted for inflation) in 2009 and has gradually increased over the years (Congressional Research Service 2023).²⁶ A total of \$16 million in mandatory federal funding was issued for SHIPs in 2026 (U.S. House of Representatives 2026, U.S. House of Representatives 2025). This change in mandatory federal funding from 2009 to 2026 represents about a 38 percent increase since

2009 when adjusted for inflation. With this funding, SHIPs educate beneficiaries about the LIS program for Medicare Part D, the MSPs, and the availability of Medicare preventive services like flu shots while also providing in-depth application assistance to help Medicare beneficiaries apply for benefit programs that would lower their health care costs.

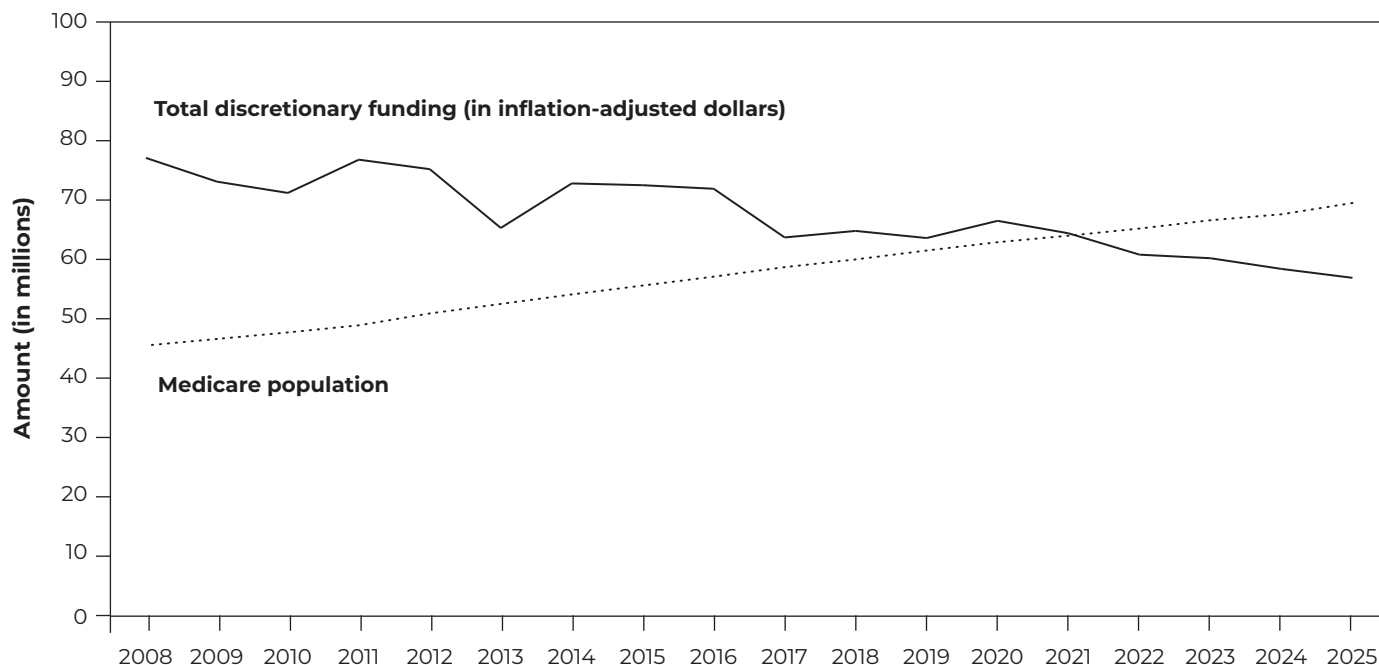
SHIP grantees may also receive funding or in-kind services (such as paid staff from other organizations or a telephone line or case-management system) from states, territories, or local governments. For example, some states have Medicaid funds specifically for outreach to individuals eligible for Medicaid. Grantees often use state and local funding to compensate full-time employees, who, apart from counseling beneficiaries, are responsible for handling administrative tasks (including reporting to the SHIP Tracking and Reporting System (STARS)), coordinating beneficiary outreach and enrollment events, and overseeing SHIP volunteers. Of the 10,043 SHIP staff and volunteers in place from July 2025 to December 2025, 20 percent were federally funded, 32 percent were funded by in-kind services such as paid staff from partner organizations or other state and local funding, and 48 percent were unpaid volunteer staff.²⁷

SHIP counselor training and certification All SHIP staff, both volunteer and paid, must complete training before assisting beneficiaries. On-the-job or “shadow” training with experienced counselors is an important complement to formal instruction. The SHIP TA Center has developed a 23-module training and certification program for SHIP grantees, which is currently used by 51 out of 54 grantees in some capacity. The SHIP TA Center regularly updates the curriculum to address emerging or complex topics, based on input from SHIP grantees and the ACL. Recent additions include Medicare interactions with employer coverage (e.g., the Federal Employee Health Benefits Program and TRICARE), ESRD benefits, and the needs of individuals with intellectual and developmental disabilities. The SHIP TA Center also responds to questions from SHIP grantees and generates beneficiary educational materials for use by SHIP counselors.

Grantees select which courses are required for their staff to complete; most require counselors to complete eight or nine courses as part of their training, along with additional program-specific training. In our

**FIGURE
2-2**

Change over time in SHIP discretionary funding and the size of the Medicare population, 2008-2025



Note: SHIP (State Health Insurance Assistance Program). “SHIP discretionary funding” refers to the primary amount of funding appropriated to the SHIP by the Congress. Discretionary funding amounts have been adjusted for inflation to reflect 2026 dollars using historical values from the Congressional Budget Office Consumer Price Index for All Urban Consumers.

Source: MedPAC analysis of 2008 CMS newsroom press release; 2009 through 2025 Department of Health and Human Services, Administration for Community Living, and CMS budget justifications; the 2015, 2020, and 2025 Medicare Trustees’ reports; and 2026 Congressional Budget Office Historical Data and Economic Projections.

interviews with SHIP representatives, one explained that they conducted three types of annual training: summer sessions on MA and Part D issues, monthly counselor training webinars, and statewide continuing-education training in preparation for the AEP. Another grantee reported using a combination of SHIP TA Center training, experiential training, and CMS national training. SHIP counselors must be regularly recertified, either through the SHIP TA Center testing or grantee-specific testing.

A recent secret-shopper study evaluating the Medicare information provided by SHIP sites found that the percentage of accurate answers provided by SHIP grantees ranged from 26 percent to 94 percent,

depending on the Medicare-related topic (Dugan et al. 2025). The study found that SHIP counselors provided more accurate information on topics related to initial Medicare enrollment and evaluating coverage options and less accurate information related to discussions of special-needs plans for dually eligible beneficiaries (or D-SNPs) and questions on specific MA plans, highlighting the need for additional training resources on these subjects. This study did not investigate the accuracy of information provided to Medicare beneficiaries by insurance agents or by 1-800-MEDICARE, so it is unclear whether SHIP grantees perform better or worse than these other information sources. In line with Dugan et al.’s findings,

when surveyed, SHIP counselors have expressed the desire for more training related to Medicaid (Garrido et al. 2024).

To promote consistency in counselor certification and due to increasing complexities in Medicare, the ACL is developing a national SHIP counselor certification program. All SHIP team members will need to pass this certification before engaging with Medicare beneficiaries and the public. The program will likely be based on the existing SHIP TA Center training program and CMS's insurance agent training and testing guidelines (Centers for Medicare & Medicaid Services 2026a). All SHIP grantees would require their counselors to complete the national certification, though grantees could continue to offer additional testing.

SHIP activity reporting and performance measurement

SHIP grantees report their activities and beneficiary demographic information to the ACL through the STARS web-based data system (State Health Insurance Assistance Program 2017). Launched in 2018, STARS was designed to streamline the process of data entry for data reporting and performance measurement (e.g., beneficiary contacts, outreach contacts, under-65 contacts, "hard-to-reach" contacts, and enrollment contacts). Information from STARS is used for the five performance measures that evaluate the work of the SHIP grantees. The ACL includes the results of the measures at the grantee level in the annual report to the Congress posted on the ACL's website (Administration for Community Living 2021). STARS is also intended to streamline the data-reporting process across multiple federal grant programs (e.g., for the Senior Medicare Patrols). SHIP grantees report information to STARS at least monthly. In September 2025, the ACL contracted with a private entity to develop and implement a new, revised STARS over a five-year period, considering feedback on system improvements from the SHIP grantees. The new STARS will incorporate the national counselor certification program described above.

SHIP counselors use the Plan Finder tool to help beneficiaries compare and enroll in MA and PDP plans. SHIP counselors described using a SHIP TA Center tool called the Medigap Plan Finder to compare available Medigap plans. The Medigap Plan Finder uses proprietary data from the CSG Actuarial database to

display current and past premium amounts as well as data from the National Association of Insurance Commissioners (NAIC) to display Medigap plan enrollment amounts. This tool has more information about Medigap than may be found on CMS's Plan Finder. While beneficiaries cannot use the Medigap Plan Finder themselves to enroll in a Medigap plan, SHIP counselors use the tool as another information source to help clients select a plan.

Interviewees mentioned some technological constraints that affect their ability to effectively counsel beneficiaries. For example, some grantees do not have a unified telephone system that allows calls to be transferred between counselors or that allows caller identification so that a beneficiary knows that a SHIP counselor is calling.

Some SHIP grantees are using proprietary case-management systems that allow them to save information (with the beneficiary's knowledge and consent) about a beneficiary's concern or issue so that when the beneficiary calls again or if another counselor is needed to assist, the history of the concern or issue is available. Some of these systems are used by other state agencies, allowing more effective case management for beneficiaries with multiple enrollment issues. Some enrollment issues, such as assisting with an MSP, may require multiple counseling sessions, and interviewees without case-management systems noted that it can be frustrating for a beneficiary to have to explain their issues again each time they call.

Key themes from SHIP interviews

In our 2026 interviews with SHIP staff, we focused on their experiences working with beneficiaries to help them make Medicare enrollment decisions, as well as the functions and challenges of the SHIP. Interviewees reported on the following: (1) assisting beneficiaries with a wide range of Medicare needs and income levels, (2) providing in-person assistance and staying up-to-date on local market conditions, and (3) concerns about ongoing limited capacity.

Assisting beneficiaries with a wide range of Medicare needs and income levels The grantees we spoke with reported assisting beneficiaries with a wide range of Medicare decisions, reflecting substantial variation in beneficiaries' understanding of the program.

Interviewees explained that new beneficiaries typically contact SHIP grantees to gain a basic understanding of Medicare’s structure and coverage options. Several interviewees highlighted the free “Medicare 101” information sessions as a key outreach tool they used in their communities. One interviewee said that every Medicare 101 session includes at least one individual who is surprised to learn that premiums are required for certain parts of Medicare. Interviewees also explained that some beneficiaries are unable to identify the MA, Part D, or Medicaid plan that they are enrolled in and often confuse Medicare and Medicaid plans, which can make counseling difficult.

Interviewees also described working with beneficiaries with varying income levels. One counselor noted that individuals contacting their SHIP seemed to be at the “extremes of income distribution.” Beneficiaries with higher incomes often sought assistance understanding the effects of Medicare’s income-related monthly adjustment amount (IRMAA) on their Part B and Part D premiums or requested validation that they had selected an appropriate Part D plan or Medigap policy.²⁸ All interviewees discussed helping beneficiaries navigate Medigap options, with common questions related to premiums, carriers, enrollment periods, and guaranteed-issue protections.

By contrast, beneficiaries with lower incomes typically required assistance applying for Medicaid or the MSPs. One counselor reported that most of the low-income individuals who contacted the grantee were eligible for those programs. All interviewees described assisting beneficiaries with completing MSP applications, a process that is particularly streamlined for SHIP counselors that have access to Medicaid eligibility and enrollment data. Interviewees also noted a high volume of interactions with dually eligible beneficiaries. One interviewee characterized these cases as the “most complicated” counseling sessions, due to the challenges associated with coordinating Medicare and Medicaid benefits. Consistent with these reports, a recent survey of SHIP counselors found that questions related to dual eligibility were among the most common topics raised by beneficiaries (Garrido et al. 2024). Interviewees further reported hearing from beneficiaries that they could only afford to enroll in MA plans with low or zero-dollar monthly premiums because they did not qualify for Medicaid or the MSPs.

Interviewees had varied access to state Medicaid eligibility and enrollment information. One SHIP with many dually eligible beneficiaries in their area reported having access to Medicaid eligibility and enrollment data, which they used to inform beneficiaries on Medicaid-related topics such as D-SNPs in MA and MSP applications. At other SHIP grantees, counselors must instruct the client to call or make an appointment with the Medicaid agency to confirm enrollment information. Another interviewee reported that, despite receiving approximately 1,000 referrals per month from their state’s Medicaid program, their SHIP lacked access to Medicaid enrollment data.

Interviewees described SHIP counseling sessions as covering a broad range of topics beyond plan selection. While questions during the AEP typically focus on choosing coverage, SHIPs reported receiving non-Medicare enrollment-related questions outside of the AEP, pertaining to issues such as filing MA coverage appeals, navigating use of MA supplemental benefits, and midyear changes in Part D plan formularies. SHIPs also receive questions on late-enrollment penalties and Social Security retirement or disability benefits. Several interviewees also reported receiving finance-related calls, such as when beneficiaries with Part D plans have trouble paying for prescription drugs. Interviewees explained that such calls often become enrollment related as SHIP counselors provide information on options available to low-income beneficiaries, who may have more flexibility than other beneficiaries to change plans outside of the AEP.

Interviewees emphasized the increasing complexity of the Medicare program and its implications for SHIP operations. One interviewee stated that it is “unreasonable to expect a volunteer program to start picking up the slack on the growing complexity of the Medicare program.” Although SHIP training materials are updated each year to prepare counselors for complex beneficiary cases, interviewees explained that some calls require referral to counselors with specialized expertise (for example, questions about how Medicare interacts with retiree health coverage offered by a local employer).

Providing in-person assistance and staying up-to-date on local market conditions All interviewees pointed to the value of the local nature of SHIP grantees because they can meet in person with beneficiaries, particularly

those with low health literacy or other circumstances that require enrollment assistance. Interviewees said that SHIP counselors possess knowledge of provider and pharmacy networks and available plans in the local area. The 1-800-MEDICARE customer service representatives have expertise in Medicare enrollment, coverage, and billing issues, but the call center is national and does not meet with beneficiaries in person or have specific expertise on local health care resources, such as knowing about recent local MA plan network changes (e.g., a local health system no longer in network for an insurance carrier) when counseling beneficiaries on their plan choices.

Interviewees also reported that SHIP counselors receive referrals directly from 1-800-MEDICARE. According to interviewees, 1-800-MEDICARE customer service representatives may refer beneficiaries to SHIP counselors when a greater level of in-person advocacy or more time-intensive assistance is needed, such as reviewing paperwork or providing extended counseling that may not be feasible for the national call center. Some interviewees noted that these referrals frequently involve questions related to Medicaid eligibility since SHIP counselors are familiar with state-specific eligibility requirements and can help guide beneficiaries through the application process for Medicaid-administered programs such as MSPs. One interviewee noted that beneficiaries may prefer contacting their local SHIP counselor instead of 1-800-MEDICARE because wait times are “significantly less.”

Interviewees reported that many beneficiaries commonly learn about the SHIP grantees through local marketing efforts, community outreach events, and word of mouth. Interviewees also noted that beneficiaries are referred to SHIP counselors by local Medicare insurance agents. Some described long-standing productive relationships with local agents to meet beneficiary needs when appropriate, as well as an increase in agent referrals to SHIP counselors when agents cannot earn a commission for enrolling the beneficiary in a plan. In contrast, one interviewee reported concerns about negative commentary from at least one local agent at public SHIP events and on SHIP website postings that may have been intended to steer beneficiaries to the local agent instead of the SHIP grantee.

Concerns about ongoing limited capacity Recent reports indicate that demand for SHIP counseling has increased alongside the continued growth of the Medicare population and the growing complexity of beneficiary coverage decisions (AARP 2025). The ACL reports that the average length of a one-on-one SHIP counseling session increased from 28 minutes in 2014 to 33 minutes in 2021, reflecting more complex counseling needs (Administration for Community Living 2021). The average SHIP session length is more than three times the average call time to the 1-800-MEDICARE call center (Administration for Community Living 2025). A recent survey of SHIP counselors found reports of capacity constraints, particularly during the AEP (Garrido et al. 2024). Furthermore, a recent secret-shopper study evaluating the Medicare information provided by SHIPs revealed challenges in reaching SHIP sites (Dugan et al. 2025). Nearly 47 percent of attempted phone calls to 131 unique SHIP sites could not be completed, with the most common reason for an incomplete phone call being that the secret shopper left a message and was not called back.

Our interviewees echoed these capacity challenges. Interviewees consistently expressed that they felt “inundated with calls” referred from 1-800-MEDICARE, insurance agents, and their local communities. One interviewee noted that the length of calls with beneficiaries can vary anywhere from five minutes to an hour, depending on beneficiary needs. We heard from all interviewees that existing SHIP capacity is insufficient to meet demand, particularly during the AEP. When surveyed, SHIP counselors have previously described capacity constraints, particularly during prior AEPs (Garrido et al. 2024). Even outside of the AEP, SHIP grantees are stretched thin, with one interviewee describing their counselors as “overburdened.”

Interviewees reported that the 2025 AEP presented a unique set of challenges, with one interviewee describing it as a “perfect storm” due to an increased volume of beneficiary contacts created by several contributing factors. Each SHIP grantee we spoke with noted that the volume of beneficiary contacts received during the 2025 AEP was substantially higher compared with previous years. One interviewee noted that they received four times as many calls per day during the

2025 AEP compared with the months before the 2025 AEP. Interviewees pointed to several contributing factors, including increased MA plan terminations in certain regions, providers exiting MA networks, increased referrals from Medicare agents following insurers' decisions to stop paying commissions for certain plans, expanded SHIP outreach and marketing efforts, and confusion about the continued operation of 1-800-MEDICARE during the 2025 federal government shutdown. Many beneficiaries called SHIP grantees for assistance switching to another MA plan or moving from MA to FFS Medicare, and an interviewee estimated that there was a "50/50 breakdown" between these two options. Other interviewees noted calls during the 2025 AEP for assistance with MA enrollment because of either high Medigap premiums or beneficiaries switching out of D-SNPs and into conventional MA plans.

Several interviewees noted that their local SHIP reached capacity (meaning that they could no longer accept any appointments to counsel beneficiaries for the remainder of the AEP (October 15 to December 7)) before Thanksgiving. One interviewee said their local SHIP was at capacity only three weeks into the 2025 AEP. Once at capacity, grantees are no longer able to help beneficiaries who do not already have an appointment through the rest of the AEP. When capacity is reached, local SHIPs notify 1-800-MEDICARE that they are at capacity and can no longer accept beneficiary referrals and inform the public through website postings, voicemail messages, and other outreach that the public needs to obtain assistance from 1-800-MEDICARE instead.

To extend their reach despite capacity constraints, interviewees described a range of process-improvement efforts. For example, the SHIP TA Center and SHIP grantees have developed more self-directed beneficiary education resources, such as videos, fact sheets, and other online materials that may help beneficiaries when counselors are unavailable. SHIP grantees also described implementing triage systems to assess the urgency of a particular inquiry and whether it can be handled with publicly available resources instead of individual counseling, determining which counselor has the requisite expertise to handle the issue in the event of complex matters, or redirecting inquiries to 1-800-MEDICARE due to capacity limits. One interviewee reported exploring the use of rule-based chatbots to handle routine questions.

Many beneficiaries work with insurance agents to navigate their Medicare options

Agents and brokers are trained insurance professionals who can help beneficiaries enroll in Medicare insurance plans. ("Agents" and "brokers" are often used interchangeably. In this chapter, we generally use "agents," who are appointed by insurance companies to sell their products.) There are two main types of insurance agents: independent agents, who are not employees of the insurance company and sell products from multiple insurance companies, and agents who are employed by or contracted with one insurance company (also referred to as a "captive agent"). A 2022 Commonwealth Fund survey found that, among Medicare beneficiaries ages 65 and older who received help with their plan choice, about 30 percent of FFS beneficiaries and 31 percent of MA enrollees turned to agents for help (Leonard et al. 2022).

In our annual focus groups, many beneficiaries report positive experiences working with agents to determine the premiums and out-of-pocket costs of different plans (NORC at the University of Chicago 2025, NORC at the University of Chicago 2024). Beneficiaries described how their insurance agents tailored suggestions based on individual health needs, especially medication lists and clinician preferences. However, because agents are not required to contract with all available companies in their market, a single agent will not necessarily present every available plan to a beneficiary, something that may not be understood by the beneficiary even if agents disclose it in their communications.

Some agents contract with multiple insurance carriers that pay commissions tied to initial enrollment and retention of beneficiary enrollment in the MA, Medigap, or Part D plans they sell. CMS has established maximums on compensation per enrollment that MA and Part D plans can pay agents—for instance, \$694 for initial enrollment in an MA plan (Centers for Medicare & Medicaid Services 2025m). In addition to commissions per enrollment, agents may receive supplemental administrative compensation such as a bonus for meeting enrollment benchmarks or payments for carrying out other activities for plans (e.g., beneficiary health risk assessments). There is no set cap for these payments, and CMS estimates that

administrative payments far exceed the compensation paid for enrollment (Centers for Medicare & Medicaid Services 2024c). These compensation arrangements have led some stakeholders to voice concern that agents have financial incentives to steer beneficiary decision-making. These incentives could favor enrollment in MA plans over Medigap plans and stand-alone prescription drug plans, in higher-premium Medigap plans over lower-premium Medigap plans, and in plans that offer bonuses for reaching enrollment benchmarks.

Beneficiaries report positive experiences working with insurance agents

In our annual focus groups, many beneficiaries said they had positive experiences working with agents to determine the out-of-pocket costs, premiums, and prescription costs of individual plans (NORC at the University of Chicago 2025, NORC at the University of Chicago 2024). Most of these beneficiaries described wanting help understanding the different Medicare options, including traditional FFS Medicare versus MA, and more specific plan choices under each option. In general, beneficiaries in our focus groups found the agents they worked with to be helpful for navigating their choices and ultimately selected their plans after discussing options with their agent.

Beneficiaries described how their agents tailored suggestions based on individual health needs, especially medication lists and clinician preferences. These beneficiaries said that when they were establishing a relationship with an agent, they had comprehensive discussions about the medications they were taking, the specific clinicians they wanted to be certain were in a plan's provider network, and their preferences for specific hospitals or health systems.

Most of the beneficiaries in our focus groups who used insurance agents said they received information about multiple plans from different insurers. One beneficiary noted, "He presented five or six different companies. And we told him what we wanted." Another reported, "[My agent] looked through all the plans, then presented two or three different ones, and I really liked that." A subset of beneficiaries who described using an agent said the agent recommended a single plan. One participant noted, "[The agent] gave us options. But

then he said, 'Out of all these, this is the one I suggest because it fits you guys better.'"

In our focus groups, some beneficiaries questioned how agents are compensated by insurers, although most felt that their agents acted in their best interest. These beneficiaries questioned whether agents had financial incentives that might bias their recommendations and whether some plans pay agents more than others. One beneficiary noted: "How can you be assured that they have your best interest at heart? Because do they get the same amount of money from every company?" Although participants expressed awareness that agents are compensated by insurance companies, most felt that their agents still acted in their best interest. One beneficiary made this comment about their agent:

You know, you can't ask somebody to do something for free. But every year, as soon as the new Medicare stuff comes out, which I think is in October, I'm not 100 percent certain, but we always go and visit with her and she goes through everything and weighs it all.

Most beneficiaries in our focus groups reported checking in with their agent annually during the AEP to reassess their plan. A subset of beneficiaries used agents for additional services, such as finding travel insurance for cruises or answering questions about changes in their coverage, but most did not have interactions with their agent outside of the AEP.

Federal and state requirements to practice as an agent, including training

CMS requires that agents who represent MA and Part D insurers must be (1) licensed in the state in which they do business, (2) trained and annually tested on their knowledge of Medicare and health and prescription drug plans and achieve 85 percent or higher on all forms of testing, and (3) secure and document a scope of appointment before meeting with potential enrollees (Centers for Medicare & Medicaid Services 2026a, Centers for Medicare & Medicaid Services 2024a).²⁹ MA and Part D insurers must report to CMS all enrollments made by unlicensed agents and for-cause terminations of agents.

Each state's licensing requirements for agents vary. Generally, requirements involve specialized coursework and training, as well as passing a licensing exam. In

Michigan, for example, 40 hours of education are required before sitting for an exam covering principles pertaining to one's insurance field (Kaplan Financial Education 2025). However, not every state requires specialized coursework and training. For example, any Tennessee resident over the age of 18 may sit for the state's agent-licensing exam, regardless of whether they have completed any education courses. Some states also have annual continuing-education requirements for agents to keep their license in good standing. While state licensing exams generally cover the same health insurance topics across states, such as basic insurance product knowledge, they differ in their sections pertaining to state regulations that licensed agents must follow.

An agent also does not typically have to be a resident of the state in which they are applying for a state insurance license, which allows agents to serve clients in multiple states. States typically have a reciprocity provision in which an individual holding an active license in good standing from one state can apply for what is known as a nonresident state health insurance producer license in another state. Since these individuals are already licensed, they often do not have to complete the preclicensing requirements or pass a licensing exam in their nonresident state. Instead, they are often required to submit an insurance license application for that state and pay the applicable fee.

CMS requires that MA and Part D insurers provide training and testing to agents on Medicare rules and regulations, the plans that agents will sell (including any details specific to each plan), and relevant state and federal requirements. CMS annually provides MA insurers with training and testing guidelines (Centers for Medicare & Medicaid Services 2025p). In addition, the insurers themselves often require agents to complete product and sales training. Many insurers require agents to complete a training program developed by AHIP, a national association of health insurers, in order to sell MA products (AHIP 2025).

CMS requires that MA plans and PDPs put systems in place to ensure that agents appropriately communicate with beneficiaries, including that agents appropriately complete scope-of-appointment records for all personal marketing appointments (including telephonic and walk-in). The scope-of-appointment form specifies which Medicare plans and topics will be discussed

during the meeting and is intended to prevent unexpected sales pitches.

Agents typically sell plans from multiple insurers but are not required to sell all available plans in their market

Independent agents typically have contracts with multiple insurers but are not required to contract with every insurer that offers plans in their market. As a result, an agent will not necessarily represent every plan that is available to a beneficiary. In this way, agents filter plan options, which may not be apparent to the beneficiary even if the agents disclose it in their communications.

It is not clear what proportion of total available plans in a given geographic area a typical agent will represent, though some analysis suggests that it varies. The Commonwealth Fund compared the MA plans and PDPs listed on Plan Finder with the plans listed on three large online-agent tools for five metropolitan areas (Commonwealth Fund 2021b). They found that, on average, each online-agent tool included less than half (43 percent) of MA plans and less than two-thirds (65 percent) of PDPs listed on Plan Finder (Commonwealth Fund 2021b).

Agents are compensated by insurers, with compensation tied to initial enrollment and enrollment retention

Insurers must report to CMS if they use agents to sell MA and Part D plans. In our analysis of the information publicly reported by CMS for coverage year 2025, virtually all insurers (99 percent) reported that they were using independent agents to sell their plans (Centers for Medicare & Medicaid Services 2024a). (Ninety-six percent of MA and Part D insurers also use employed agents to sell their products, and those agents are exempt from compensation requirements (Centers for Medicare & Medicaid Services 2026a, Centers for Medicare & Medicaid Services 2024a).) A survey of Medigap insurers found that 85 percent used independent agents to sell their plans (Gen Re 2025, Gen Re 2024).

The ways in which agents are compensated for their services vary and can be complex. Commonly, agents contract with multiple insurers that pay commissions tied to initial enrollment and beneficiary retention in the MA, Part D, or Medigap plans they sell.³⁰ CMS

has established maximums on the compensation per enrollment that MA and Part D plans can pay agents. In addition to commissions per enrollment, agents may receive supplemental compensation, which does not have set federal maximums, such as a bonus for meeting enrollment benchmarks or payments for carrying out other activities for plans such as beneficiary health risk assessments.

Payments to agents for enrolling beneficiaries in MA or Part D Compensation caps reduce the variation in commissions across plans, which can limit the ability of insurers to incentivize agents to steer beneficiaries toward their plan by offering a larger commission. The Medicare statute requires that CMS develop guidelines to ensure that the use of agent compensation creates incentives to enroll individuals in the MA plan that is intended to best meet their health care needs (Centers for Medicare & Medicaid Services 2024b). CMS has also established that agent compensation is an administrative cost for insurers in the calculation of an MA plan’s medical loss ratio (MLR) (Centers for Medicare & Medicaid Services 2025g).³¹ Based on insurer-reported information, spending on agent and broker fees and commissions increased from \$2.4 billion in 2018 to \$6.9 billion in 2023—a 19 percent compound average growth rate (U.S. Senate Committee on Finance 2025). Because of data limitations, this figure is likely an underestimate of spending.³²

For each initial year of enrollment, MA plans and PDPs may pay agent compensation up to a maximum amount known as the fair market value (FMV), which is updated annually (Centers for Medicare & Medicaid Services 2005). The FMV amounts are originally based on 2006 to 2007 commission data that plans submitted to CMS and have been adjusted since then by the national per capita MA growth percentage (Centers for Medicare & Medicaid Services 2012, Centers for Medicare & Medicaid Services 2008b). Agents receive initial enrollment payments from insurers during the first year of a beneficiary’s enrollment or when there is an enrollment change to an “unlike plan type.”³³ Once a beneficiary has enrolled in an MA plan or PDP, agents can earn a renewal enrollment payment of up to 50 percent of the FMV when the beneficiary stays with their original plan or switches to a “like plan type.”³⁴

Insurers determine the exact compensation level they will pay agents for enrollment in a plan. There is no requirement for MA and Part D organizations to report the exact amounts they compensate agents. However, on an annual basis, organizations must report to CMS the minimum and maximum rates they will pay independent agents (Centers for Medicare & Medicaid Services 2024a). In our analysis of 2025 data that plans reported, we found that close to 85 percent of reporting MA plans and over 90 percent of reporting Part D plans use the FMV maximum initial and renewal commissions as their maximum reported rates and zero dollars as the minimum reported rates. We have heard from some agents that MA and Part D organizations typically pay the FMV maximum compensation amount.

For 2026, the FMV amount for most states is \$694 for an initial enrollment in an MA plan and \$347 for a renewal year (Table 2–5, p. 76) (Centers for Medicare & Medicaid Services 2025m). The FMV limits are higher in California, Connecticut, the District of Columbia, New Jersey, and Pennsylvania and lower in Puerto Rico and the U.S. Virgin Islands. The FMV amount for all states for initial PDP enrollment is \$114 and \$57 for renewal years. (When a beneficiary enrolls in an MA plan that has prescription drug coverage (an MA–PD), insurers pay only the MA compensation amount.) All FMVs are updated annually by adding the current year’s FMV and the product of the current-year FMV and the national per capita MA growth percentage for combined aged and disabled beneficiaries, which is published each year in the annual MA rate notice (10.7 percent in 2026) (Centers for Medicare & Medicaid Services 2025c).

In addition to the compensation for enrollment, MA and Part D organizations can also pay agents for referrals of beneficiaries for enrollment in MA and Part D plans (also known as “finder’s fees”) (Centers for Medicare & Medicaid Services 2005). CMS has stated that referral fees are not contingent on a beneficiary being enrolled in a plan and are essentially payments for sales leads (Centers for Medicare & Medicaid Services 2021). Plans may determine the circumstances as to when they pay referral fees. CMS sets a referral fee limit that “reflects an amount CMS determined is reasonably expected to provide financial incentive for an agent or broker to refer a beneficiary for an enrollment into a plan that is not the most appropriate

**TABLE
2-5**

Maximum insurance-agent compensation per enrollment in Medicare Advantage and Part D plans, 2026

Compensation type	National	Connecticut, Pennsylvania, District of Columbia	California, New Jersey	Puerto Rico, U.S. Virgin Islands
MA				
Initial year	\$694	\$781	\$864	\$474
Renewal years	347	391	432	237
PDP				
Initial year	114	—	—	—
Renewal years	57	—	—	—

Note: MA (Medicare Advantage), PDP (prescription drug plan). CMS establishes maximum annual compensation amounts that an insurer can pay an independent agent for initial enrollment in MA and Section 1876 cost plans and PDP plans, as well as in renewal years. The compensation rate for an initial enrollment must be at or below the fair market value (FMV), and renewal compensation is limited to a maximum of 50 percent of the FMV. The FMV for MA plans is higher than the national rate in five states and lower in two U.S. territories. There is no variation by state/territory in the maximum compensation for PDP enrollment.

Source: Centers for Medicare & Medicaid Services 2025m.

to meet his or her needs” (Centers for Medicare & Medicaid Services 2021). These fees are one-time only and may not exceed \$100 for a referral into an MA plan and \$25 for a referral into a PDP.

Some insurers are willing to compensate agents beyond the enrollment and referral fees. MA and Part D organizations can also make administrative payments for services other than enrollment of beneficiaries (for example, training, customer service, agent recruitment, operational overhead, or assistance with completion of health risk assessments (HRAs)). As defined in regulation, the payments for these services must not exceed the value of those services in the marketplace (Centers for Medicare & Medicaid Services 2005). CMS does not set a maximum value for administrative payments as it does with enrollment-based compensation. CMS has said that “it is our understanding that the administrative fees paid per enrollee far exceed the compensation paid for that enrollment” (Centers for Medicare & Medicaid Services 2024c).³⁵

In focus groups convened by the Commonwealth Fund, agents said that they can earn extra income from

conducting beneficiary HRAs during the MA enrollment process (Commonwealth Fund 2023). All focus-group participants who sold MA plans said they were paid to complete HRAs when their clients enrolled in a new MA plan. Many characterized the assessments as an easy way to earn extra money because they take only around five minutes to complete. In 2023, CMS reported that some agents receive up to \$125 for completing an HRA of a new enrollee, an amount that was about 10 times higher than CMS’s estimate of the FMV for such an assessment when provided by nonmedical staff (Centers for Medicare & Medicaid Services 2023b). However, we heard from some agents that most MA plans have since changed their compensation policies to only provide HRA-related payments for SNP enrollees. One large MA insurer is offering agents a payment of \$35 to complete HRAs for SNP enrollees in 2026 (Humana 2026). It is not clear how plans use the HRA information collected by agents. Such information could help plans identify beneficiaries for follow-up, including documentation of diagnoses through clinician-conducted HRAs. (The diagnoses listed on HRAs can increase plan payments under the MA risk-adjustment system, but only if the HRAs are conducted by a clinician.)

Payments to agents for enrolling beneficiaries in

Medigap In general, the sale of Medigap plans is governed by state law and regulation, which are deemed to meet federal requirements if the state's law and regulation provide for standards at least as stringent as those contained in the NAIC model regulation (Centers for Medicare & Medicaid Services 2017). The NAIC model regulation permits compensation only if the first-year enrollment commission or other compensation is no more than 200 percent of the commission or other compensation paid for selling or servicing the policy in the second year. Renewal compensations must be the same amounts and are provided for no fewer than five renewal years (National Association of Insurance Commissioners 2025). The NAIC model regulation defines compensation as any kind of payment or nonmonetary item relating to the sale or renewal of the policy, including but not limited to bonuses, gifts, prizes, awards, and finder's fees (National Association of Insurance Commissioners 2025).

The agent's commission is typically a percentage of the annual plan premium; the insurer sets the percentage, and the commission is paid by the insurer (Commonwealth Fund 2021a). This structure can tend to provide an agent with a higher commission for enrolling beneficiaries in a higher-premium Medigap policy. A recent industry report indicates that first-year commissions for enrollments in Medigap are approximately 20 percent of annual premiums, but they can vary based on the state or plan type (Gurley 2025). The commission for subsequent years (i.e., the renewal or residual commission) is generally set at 10 percent of the premium (Commonwealth Fund 2021a). The renewal commissions can drop to 1 percent or 2 percent of the premium after 6 years and to zero percent after 10 years (Clark 2022). Agents have anecdotally reported that some insurers do not pay commissions (sometimes known as "zero-dollar commissions") for Medigap plans covered by guaranteed-issue requirements (Centers for Medicare & Medicaid Services 2024d).

The average monthly premium for Medigap plans was \$217 in 2023, or \$2,604 for a full year of coverage, according to a KFF analysis of data from the NAIC (Freed et al. 2024b). However, premiums vary by state and by policy type. For example, the average monthly premium for people enrolled in Plan G was \$164 (\$1,968

for 12 months), but this amount varied from a low of around \$140 in Hawaii, New Mexico, and the District of Columbia to a high of \$236 in New York. Based on the national average of \$2,604 and the industry reports cited above on the percentage of premiums used to determine agent compensation, an agent could be paid about \$521 for the first year and \$260 as a renewal commission. These are estimates of average premiums because premiums and rate adjustments for policies vary and commissions may shift based on beneficiary, type of policy sold, and location.

Agent compensation may create financial incentives to steer beneficiary decision-making

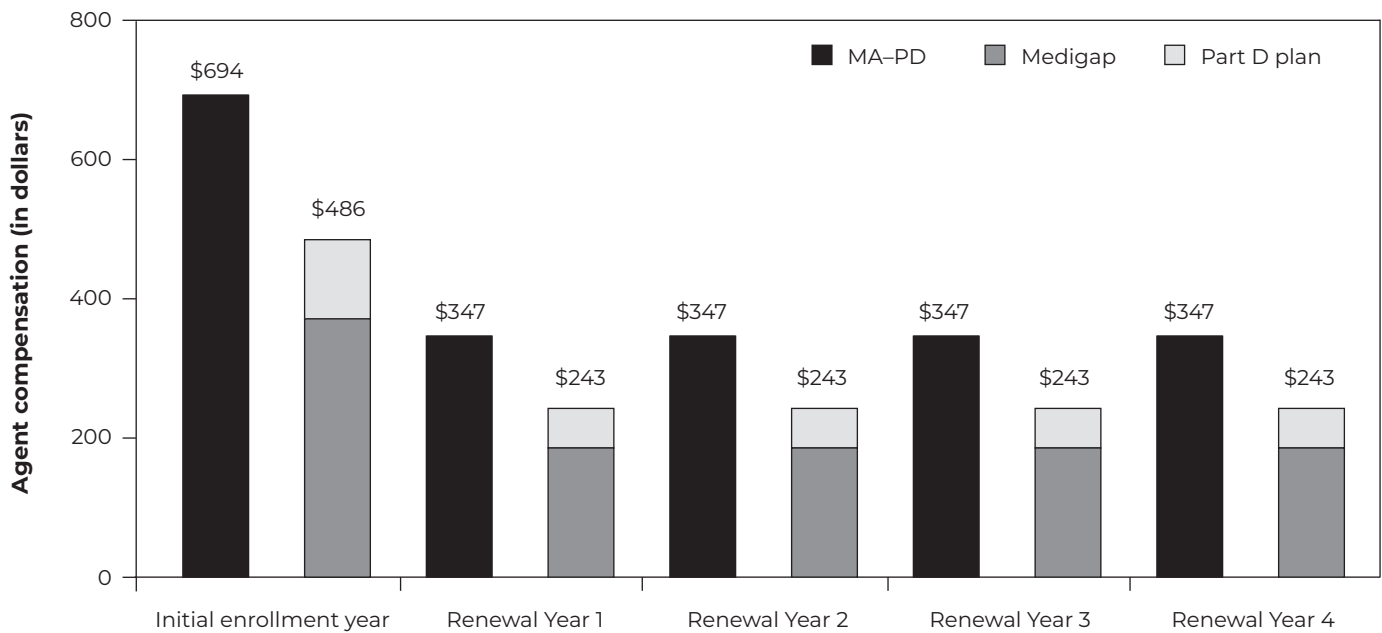
Beneficiaries choose their coverage by weighing the costs and financial protections, access to care, and extra benefits offered by different insurance options with their own needs and preferences. Insurance agents can help beneficiaries consider their enrollment options, saving beneficiaries significant time researching plan details. Their personalized guidance, which may include year-round support (e.g., helping beneficiaries with claims or answering coverage questions) comes at no cost to the beneficiary since agents are paid by insurance companies. The agents we spoke with reported that they assume a fiduciary role with their clients and want to get beneficiaries into the plan that is right for them, regardless of the financial incentives.

But some stakeholders have voiced concern that agents have financial incentives to steer beneficiary decision-making. These incentives could favor enrollment in MA plans over FFS Medicare with Medigap plans and PDPs, in higher-premium Medigap plans over lower-premium Medigap plans, and in plans that offer bonuses for reaching enrollment benchmarks.

Enrollment in MA-PDs over Medigap and PDPs In the Commonwealth Fund's agent focus groups, most agents recalled receiving higher commissions—sometimes much higher—for enrolling people in MA plans compared with Medigap plans, with some variation by geographic region and new enrollments versus renewals (Commonwealth Fund 2023). One agent in the Commonwealth Fund focus groups recalled getting paid three times more to sell an MA plan; even when the PDP and Medigap commissions were added together, most agents said that MA commissions were

**FIGURE
2-3**

Illustrative example of agent compensation providing financial incentives to enroll beneficiaries in an MA-PD plan over Medigap and a stand-alone Part D plan



Note: MA-PD (Medicare Advantage Prescription Drug [plan]). For the coverage year 2026, CMS established maximum agent compensation for initial enrollment in an MA plan at \$694 and a PDP at \$114. The maximum renewal-enrollment compensation for MA is \$347 and \$57 for PDPs. This example uses the median annual premium for a Plan G Medigap plan (\$1,860) based on Plan Finder results for a 65-year-old female with no tobacco use and no household discount in ZIP code 22206 (Arlington, VA). We assume that agent compensation for Medigap is 20 percent of the annual premium for initial enrollment and 10 percent of the annual premium for renewal enrollment. This illustrative example does not include administrative and bonus payments that insurers may pay agents.

Source: MedPAC analysis of CMS compensation amounts and Medicare Plan Finder tool.

much higher. The difference in commissions could create incentives for agents to steer beneficiaries to certain plans.

However, we spoke with some agents who reported that they think about their compensation over time rather than just the initial commission amount. These agents told us that their goal is to have a successful long-term relationship with the beneficiary and that the difference in commission payments between MA plans and Medigap policies would not induce them to steer the beneficiary to a plan that was not right for that beneficiary. We also heard from some agents that Medigap plans have more “plan persistency” than MA, meaning that Medigap plans are more likely to be consistent year after year and that beneficiaries tend to stay in the same Medigap plan over time. Thus,

writing a Medigap policy may have a more reliable renewal commission with less time spent consulting a beneficiary every year, compared with MA plans, which can change every year.

Using the information presented in the sections above, we now present an example that illustrates the financial incentives that an agent might have to encourage beneficiaries to enroll in an MA-PD over a Medigap plan and a PDP. This illustrative example is incomplete and may be a lower estimate because we do not have data on administrative and bonus payments that insurers pay agents. In our illustrative example, an agent selling an MA-PD to a new enrollee in Virginia could earn \$694 in compensation in 2026 (the FMV limit) (Figure 2-3). If the agent instead enrolled that beneficiary in a median-priced Medigap policy (Plan G)

and a PDP, they could earn an estimated \$372 (20 percent of the \$1,860 annual premium) for the Medigap plan plus \$114 for the PDP, for a total of \$486. Thus, for the initial year of enrollment, the agent would make \$208 more for enrolling the beneficiary in MA over Medigap and a PDP.

In the subsequent year, if that enrollee stayed in their initial MA plan or switched to a “like” MA plan, the agent could receive \$347 (Figure 2-3). If the enrollee stayed in their Medigap plan and PDP, the agent would receive \$186 (10 percent of the \$1,860 annual premium) and \$57 for the PDP, or \$243 in total, which is \$104 lower than the MA renewal fee. Over a five-year period, an agent could make \$624 more by enrolling a beneficiary in an MA plan versus a Medigap plan and PDP. (This example assumes that the beneficiary stays in the plan for five full years.)

Note that in our illustrative example, the compensation amounts for renewal remained the same over the period. However, in actuality, the financial incentives to enroll beneficiaries in MA instead of Medigap could be increasing over time. A Commonwealth Fund analysis that used 2016, 2018, and 2020 data found that MA plans had higher commissions in all three years and that the difference between MA and Medigap commissions increased over that period (Commonwealth Fund 2021a).

Enrollment in higher-premium Medigap plans over lower-premium Medigap plans Since the agent-compensation structure for Medigap is typically a percentage of the premium, agents have an incentive to enroll beneficiaries interested in Medigap in plans with higher premiums. Most beneficiaries with Medigap plans choose plan types that provide comprehensive coverage, such as Plan G, which covers all Part A and Part B cost sharing other than the Part B deductible (see Appendix 2-A, p. 81). The premium amount is the key difference between Medigap policies within the same plan letter sold by different companies, and there is variation in the premiums that different insurance companies charge for the same types of coverage (Freed et al. 2024b).³⁶

As an illustrative example, if an agent enrolled a beneficiary in Virginia in a median-priced Plan G Medigap plan, they could make \$372 (20 percent of the \$1,860 annual premium) (Figure 2-4, p. 80). If the

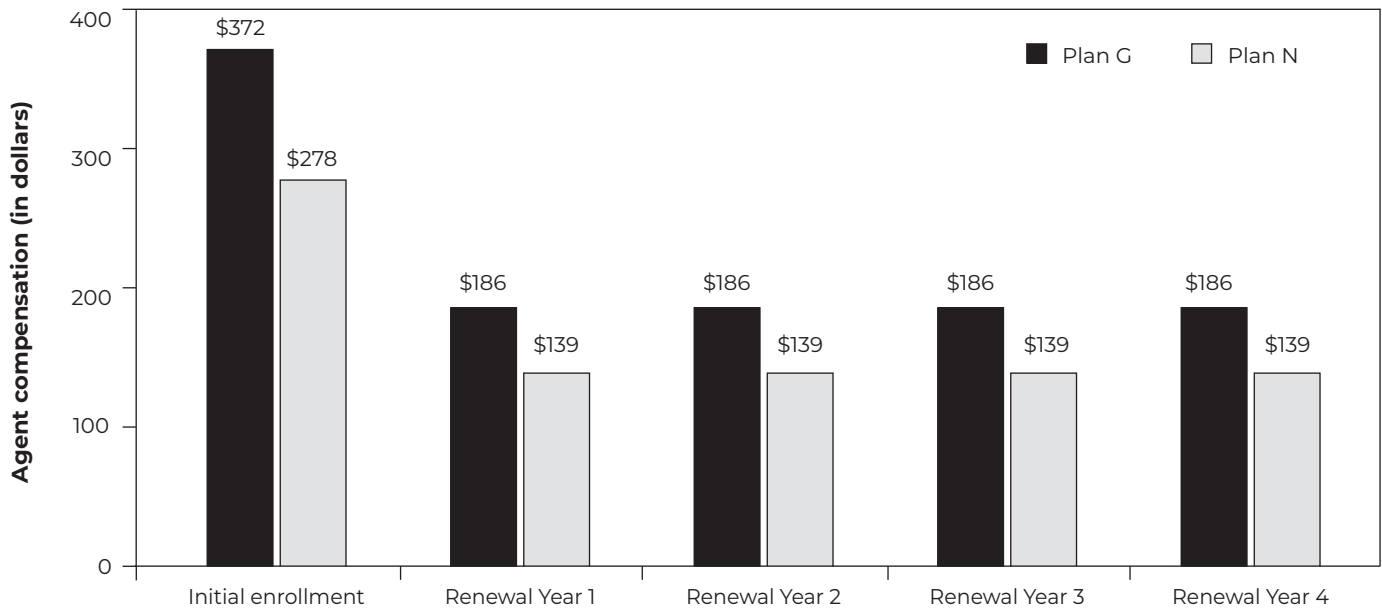
beneficiary instead enrolled in the median-priced Plan N policy, the agent would make \$278 (20 percent of the \$1,392 annual premium). Thus, on that initial enrollment, the agent would make \$94 more for enrolling the beneficiary in Plan G instead of Plan N. In the subsequent year, if that beneficiary remained enrolled in their Medigap plan, the agent could receive \$186 (10 percent of the \$1,860 annual premium) for the Plan G policy versus \$139 (10 percent of the \$1,392 annual premium) for the Plan N policy, a difference of \$47. Over a five-year period, an agent could make \$282 more for enrolling a beneficiary in the higher-premium Plan G Medigap policy.

Bonuses for reaching enrollment benchmarks In the Commonwealth Fund’s agent focus groups, agents said that insurers commonly provide bonus payments for reaching enrollment benchmarks, with some payments described as “substantial” (Commonwealth Fund 2023). Describing one insurer’s bonus program, a focus-group participant said, “I think it was 20 policies within a three-month period. That bonus was actually a hundred bucks a policy.” The Department of Justice (DOJ) recently filed a complaint against three insurers and three large insurance brokers that allegedly directed Medicare beneficiaries to plans offered by insurers that paid the most in “kickbacks,” regardless of the plan’s suitability for the beneficiary (Department of Justice 2025).

Insurers may stop paying commissions for certain plans Insurers do not have to pay commissions to agents for enrolling beneficiaries in MA plans. There are reports of some insurers halting commission payments for new enrollment in certain MA plans. For example, partway through the 2024 AEP, three insurers (Aetna, Cigna, and Elevance) stopped offering commissions to agents and third-party marketers for certain plans and in certain markets (Tepper 2024). Beginning in July 2025, UnitedHealth Group stopped paying commissions in all or part of 38 states and the District of Columbia for more than 180 plans (Young and Tepper 2025). The plans affected by this change were PPO products but included some HMO products and special-needs plans. Insurers may stop paying commissions for some plans because sales are higher than desired. Some insurers have also stopped paying agent commissions on PDPs, which may be an attempt to encourage agents to direct consumers into the insurer’s MA plans (Herman 2025, Herman 2024). As noted above, CMS has also heard that

**FIGURE
2-4**

Illustrative example of agent compensation providing financial incentives to enroll beneficiaries in a higher-premium Medigap plan over a lower one



Note: This example uses the median annual premiums for a Plan G Medigap plan (\$1,860) and Plan N Medigap plan (\$1,392) based on Plan Finder results for a 65-year-old female with no tobacco use and no household discount in ZIP code 22206 (Arlington, VA). We assume that agent compensation for Medigap is 20 percent of the annual premium for initial enrollment and 10 percent of the annual premium for renewal enrollment. This illustrative example does not include data on administrative and bonus payments that insurers may pay agents.

Source: MedPAC analysis of CMS compensation amounts and Medicare Plan Finder tool.

some Medigap insurers do not pay commissions for guaranteed-issue Medigap plans (Centers for Medicare & Medicaid Services 2024d).

In late 2025, roughly a dozen state departments of insurance warned insurers about the use of zero-dollar commissions under state laws because they hinder consumer access to plans (Tong 2025).³⁷ CMS then issued a memo to state insurance commissioners noting that federal law likely preempts state laws in regulating MA broker compensation (Centers for Medicare & Medicaid Services 2025n).

Agents told us that if they enroll beneficiaries in zero-dollar-commission plans, they will not be paid for their work. Some agents reported that they do enroll beneficiaries in zero-dollar-commission plans, particularly when there is a long-standing relationship

between the agent and the beneficiary and the agent believes the zero-dollar-commission plan is the right plan for the beneficiary. Some agents reported that they will refer beneficiaries to SHIP counselors or 1-800-MEDICARE when they think a zero-dollar-commission plan is best, because they prioritize enrollments with a commission. ■

2 - APPENDIX A

.....

**Special enrollment periods and
situations specific to Medigap**

.....

We discuss three common special enrollment periods (SEPs) and situations specific to Medigap in this appendix: no longer covered by an employer's group health plan, trial rights, and a significant change in a plan's provider network, as well as issues specific to Medigap.

No longer covered under an employer's group health plan

Most individuals are eligible for Part A without a premium, so individuals who are still working and covered under their (or their spouse's or parent's, as applicable) employer-sponsored group health plan will typically enroll in Part A when eligible and do not need an SEP. However, individuals who are working and are covered by an employer-sponsored group health plan can postpone Part B (and Part A if they must pay a premium) enrollment without a penalty by using the SEP for employer group health plan coverage.³⁸ These individuals who postpone Part B enrollment also preserve their guaranteed-issue right to a Medigap plan when they are no longer covered by a group health plan sponsored by an employer. This SEP begins after the individual is no longer covered by a group health plan because they (or their spouse or parent, as applicable) are no longer actively employed or the employer-provided medical coverage ends, and the SEP concludes after eight months from the month the employment or employer-provided coverage ends. Individuals who use this SEP to enroll will avoid Part B (and Part A if they must pay a premium) late-enrollment penalties unless there is a gap after the end of the SEP before the individual enrolls.

However, individuals (or their spouse or parent, as applicable) who are no longer actively employed or whose employer-sponsored coverage ends may have insurance that is not an employer-sponsored group health plan. Having this insurance does not confer eligibility for the Part B SEP. Examples of insurance not considered an employer-sponsored group health plan for the purpose of the Part B SEP are Consolidated Omnibus Budget Reconciliation Act (COBRA) plans, retiree health plans with coverage for individuals (or their spouse or parent, as applicable) no longer actively

working, Veterans Affairs coverage, TRICARE, or individual health coverage (such as through the Health Insurance Marketplace).

In contrast to the Part B SEP requirements, the Part D SEP requirements allow consideration of whether the other insurance is creditable prescription drug coverage. Health plans that offer prescription drug coverage, like plans from employers or unions, are required to notify their Part D-eligible members if the coverage they offer is creditable coverage. However, a failure to notify members that they are eligible for Part D does not lead to an SEP. Individuals with creditable coverage will not be subject to the Part D late-enrollment penalty unless there is a gap of creditable prescription drug coverage for 63 or more days in a row. This situation means that an individual with COBRA coverage would not be eligible for a Part B SEP but may be eligible for a Part D SEP if the COBRA coverage includes creditable prescription drug coverage.

If an individual loses their employer group health plan because they are no longer actively employed or their employer-sponsored coverage ends, or when they elect into or out of employer-sponsored coverage, such as during an employer's "open season," there are also SEPs for Medicare Advantage (MA) and Part D. Individuals desiring to enroll in MA and/or Part D have two months after their group health plan coverage ends to enroll in a plan.

Once individuals enroll in Part B, they have six months to enroll in a Medigap plan to obtain a guaranteed-issue policy (some states may have additional guaranteed-issue rights). Individuals may have employer-sponsored coverage that would allow a Part B SEP if they enrolled in Part B after their employer coverage ends. Sometimes individuals will enroll in Part B when they turn 65, even if they have employer coverage. However, the six-month Medigap guaranteed-issue period starts when they are 65 or older and enroll in Part B. Individuals may not realize that they should wait to enroll in Part B or that they need to enroll in Medigap during that six-month period to preserve their guaranteed-issue rights if they do not qualify for the employer group health plan situation below.

Part B-enrolled individuals who are members of an employer group health plan offered by an employer

of a certain size (20 or more employees for aged beneficiaries or 100 or more employees for disabled beneficiaries) are eligible for Medigap guaranteed-issue rights when their employer coverage ends. This situation allows individuals 63 days from notice of the loss of employer coverage to buy certain Medigap plans sold in their state without medical underwriting.

The Medigap guaranteed-issue right is broader than the Part B SEP due to the consideration of the type of insurance that is ending. The Part B SEP applies only when employer group health plans are ending (or the beneficiary is choosing to leave the employer group health plan) and not when retiree or COBRA coverage is ending. In contrast, the Medigap guaranteed-issue right applies when employer group health plans as well as retiree or COBRA coverage is ending.

Trial rights

There are two SEPs that let individuals who have been in MA for less than 12 months exercise “trial rights” to buy a guaranteed-issue Medigap policy without medical underwriting after the Medigap enrollment period. The first SEP applies to beneficiaries joining an MA plan when they are first eligible for Part A and Part B at age 65 and within the first year of MA plan enrollment, decide to return to FFS Medicare and purchase a Medigap policy. The beneficiary may apply for certain Medigap policies sold in their state on a guaranteed-issue basis no more than 63 days after disenrolling from the MA plan.

The second trial-right period applies to beneficiaries who dropped a Medigap policy to join an MA plan for the first time and have been in the MA plan for less than a year. These beneficiaries may apply for a Medigap policy no more than 63 days after disenrolling from the MA plan unless other circumstances apply. The beneficiary can buy the same Medigap policy that they had before enrolling in the MA plan if it is still sold by the same insurer; otherwise the beneficiary may buy certain Medigap policies sold in their state on a guaranteed-issue basis no more than 63 days after disenrolling from the MA plan.

Significant change in provider or pharmacy network

There is an MA and Part D SEP for exceptional circumstances, including a significant change in the beneficiary’s provider network.³⁹ If a significant change in network has occurred, within two months of notice of the significant change, the affected enrollee has the option to stay enrolled in the plan, change MA plans, or return to fee-for-service (FFS) Medicare and purchase certain guaranteed-issue Medigap policies without medical underwriting. Enrollees affected by the significant change are those who are assigned to, are currently receiving care from, or have received care within the past three months from a provider or facility being terminated from the plan’s provider network.

Plans have considerable discretion to select the providers with whom to contract to build their provider networks, and providers have discretion about which plans to participate in. Plans can make changes to provider and pharmacy networks at any time during the contract year, after beneficiaries have already enrolled. CMS states that plans “may be in the best position to determine whether or not a provider termination without cause is significant,” regardless of the cause of the provider’s termination from the network (Centers for Medicare & Medicaid Services 2016a). CMS expects plans “to take a conservative approach in determining whether the no-cause provider termination represents a significant change to the network by notifying CMS if there is any doubt” as to whether the termination represents a significant change to the network (Centers for Medicare & Medicaid Services 2016a).

CMS considers significant changes to provider networks “to be those that go beyond individual or limited provider terminations that occur during the routine course of plan operations and affect, or have the potential to affect, a large number” of the plan’s enrollees (Centers for Medicare & Medicaid Services 2016a). CMS stated that it has “a rigorous internal review process that evaluates the totality of the unique circumstances around each termination to carefully determine whether that network change is ‘significant’ and requires an SEP” (Centers for Medicare & Medicaid Services 2024d). If a termination represents

a significant change in the plan's provider network, the plan is notified and must notify its enrollees of their eligibility for this SEP, including the right to Medigap guaranteed issue, and how to use the SEP (Centers for Medicare & Medicaid Services 2025h). CMS provides a model notice for MA plans to use to send to beneficiaries who disenroll from the plan and enroll in FFS Medicare about their temporary right to Medigap guaranteed issue.

CMS proposed a new rule for contract year 2027 to streamline the SEP and the change in provider-network plan notification by (1) replacing the current SEP for significant change in provider network with a new, broader SEP for provider terminations, thereby removing the need to make a determination on the significance of the change before enrollees are eligible for the SEP; and (2) requiring MA organizations to provide information about SEP eligibility as part of their notification to enrollees of an upcoming change in their provider's network status (Centers for Medicare & Medicaid Services 2025i). However, while acknowledging the broad interest in this topic, CMS ultimately decided not to finalize the proposal, stating that it will continue to consider the extent to which it may be appropriate to engage in future rulemaking in this area (Centers for Medicare & Medicaid Services 2026e).

Even if the determination is made that the change to a provider is not a significant change on a plan basis, SEP eligibility determinations may be made on an enrollee-by-enrollee basis, considering an enrollee's individual circumstances. Enrollees may contact 1-800-MEDICARE to request an SEP due to exceptional circumstances, such as situations in which access to services is compromised and adverse health consequences would result, including maintaining continuity of care for a chronic condition and to prevent interruptions in treatment (Centers for Medicare & Medicaid Services 2024d). The supporting details and documentation are reviewed to determine whether the enrollee is eligible for an SEP. If the enrollee is eligible, the SEP application is forwarded to the plan for processing, and the plan will send a notification to the enrollee. The enrollee may use that notification to enroll in another plan or, for MA enrollees, to return to FFS Medicare and enroll in a Medigap policy on a guaranteed-issue basis as part of the SEP.

Medigap guaranteed-issue rights and state variation

Regarding Medigap, individuals can obtain a guaranteed-issue Medigap policy at other times after the Medigap enrollment period in certain limited situations. As of 2024, 35 states require Medigap insurers to issue policies to Medicare beneficiaries ages 65 and older due to certain specified circumstances (Freed et al. 2024b). Outside of the federal and state enrollment periods, the right to purchase a Medigap policy is not guaranteed. Insurers may require medical underwriting before issuing a policy.

States have established requirements regarding the sale and pricing of Medigap plans. Individuals may be eligible for a guaranteed-issue Medigap policy during certain limited time periods precipitated by individual circumstances, depending on applicable state law. Some insurers may not sell a Medigap policy to an individual with certain medical conditions if the individual is subject to medical underwriting.

Four states (Connecticut, Maine, Massachusetts, and New York) require either continuous or annual guaranteed-issue protections for Medigap for all beneficiaries ages 65 and older, regardless of medical history (CSG Actuarial 2025). In Connecticut and New York, insurers are required to issue Medigap policies at any time during the year without medical underwriting to all individuals over age 65, while Massachusetts limits annual enrollment without medical underwriting from February 1 through March 31 (CSG Actuarial 2025). In Maine, each insurer must designate a one-month guaranteed-issue period each year when any applicant ages 65 to 70 will be accepted in Medigap Plan A without medical underwriting (CSG Actuarial 2025). Minnesota recently enacted legislation to institute annual guaranteed-issue protections, with an anticipated effective date of August 1, 2026. In these states, individuals who missed their initial Medigap enrollment period may obtain a Medigap policy without medical underwriting during the continuous or annual period, as applicable in the state. Individuals with a Medigap policy may also switch Medigap policies during the continuous or annual period, as applicable in the state.

After the initial Medigap enrollment period, there is no federally required annual enrollment period (AEP) that would allow beneficiaries to join or switch Medigap policies or insurers without medical underwriting unless a specific situation applies. In general, beneficiaries may drop their current Medigap policy and try to switch to another Medigap policy—or drop their MA plan, switch to FFS Medicare, and try to buy a Medigap policy—at any time. However, unless state law requires the sale of guaranteed-issue Medigap policies after the Medigap enrollment period or other federal situations apply, due to medical underwriting, individuals may not qualify for another Medigap policy. In contrast, federal rules allow beneficiaries to join, switch, or drop their MA plan or PDP annually during the AEP from October 15 through December 7. Enrollees may also switch or drop their MA plan annually during the open enrollment period (OEP) from January 1 through March 31.

For those with Medigap policies, state law may permit switching Medigap policies to other Medigap policies at certain times during the year. For example, in Maine, individuals with an existing Medigap policy may purchase another policy that provides equal or lesser benefits up to 60 days before the requested coverage effective date without medical underwriting (CSG Actuarial 2025). Washington allows individuals already enrolled in Medigap to switch to another plan or carrier at any time during the year, with some restrictions about which lettered plan the enrollee may switch to; for example, persons with Plan H, I, or J may move only to a less comprehensive Medigap plan (CSG Actuarial 2025). Minnesota’s recently enacted Medigap legislation includes a guaranteed-issue AEP that will align with the dates of the MA OEP (January 1 through March 31), which may help reduce some of the enrollment complexity for enrollees in that state.

As of January 1, 2026, 12 states have a version of what is known as a “birthday rule” in place (CSG Actuarial 2025). The birthday rule is an annual application period around the Medigap beneficiary’s date of birth that typically allows a beneficiary with a Medigap policy to change Medigap policies or carriers, usually only to

a policy with equal or lesser benefits, often without medical underwriting, as dependent on state law. For example, an individual with a Medigap policy issued in Maryland has 30 days from the individual’s birthday each year to switch to another available Medigap policy with equal or lesser benefits than the individual’s current Medigap policy (CSG Actuarial 2025). Because the individual in Maryland already has a Medigap policy, the individual may switch policies without medical underwriting (or without additional medical underwriting if the individual was subject to medical underwriting when they first purchased their Medigap policy).

Missouri has an “anniversary rule” in place in which Medigap enrollees who terminate their Medigap plan within 30 days of the Medigap policy’s annual anniversary date in a year may obtain the same lettered plan from another insurer with no medical underwriting for a period of 63 days from the termination (CSG Actuarial 2025). For example, if an individual in Missouri purchased a Medigap policy on February 8, 2024, in order to take advantage of this rule in 2025, the individual would have had to terminate their existing policy within 30 days of their policy’s anniversary date (February 8, 2025), which would have been by March 10, 2025. The individual could obtain the same lettered plan from another insurer within 63 days of the termination date of their policy. For example, if the individual terminated their existing policy on March 10, 2025, they would have had until May 12, 2025, to complete their purchase of a policy from another insurer. Because the individual in Missouri already has a Medigap policy, the individual may switch policies without medical underwriting (or additional medical underwriting if the individual was subject to medical underwriting when they first purchased their Medigap policy).

The birthday and anniversary rules apply only to individuals who currently have a Medigap policy. Individuals without a Medigap policy may try to obtain a policy at any time during the year, but due to medical underwriting, they may not qualify. ■

2 - B

A P P E N D I X

**Beneficiaries' experiences
assessing their coverage
options, according to
Medicare's annual survey**

Medicare beneficiaries face complex decisions about their coverage, and they often report confusion about their coverage options and say that they use various sources of information to make their coverage decisions. We examined results from CMS’s Medicare Current Beneficiary Survey (MCBS), a nationally representative survey that asks beneficiaries about a range of topics including their understanding of Medicare, satisfaction with the information available about the program, and how often they review their Medicare plan options. We analyzed changes in national-level responses over time (2019 to 2023) and variation in 2023 responses stratified across different beneficiary characteristics, such as enrollment in traditional fee-for-service (FFS) Medicare versus Medicare Advantage (MA), age, geography (rural/urban), dual eligibility for Medicare and Medicaid, race/ethnicity, and education level.⁴⁰

Our examination of the results from the MCBS adds to findings from our beneficiary focus groups and other surveys that beneficiaries use different information sources to navigate their decision-making and are generally satisfied with the availability of the information. Nevertheless, a sizable minority of beneficiaries between 2019 and 2023 found Medicare difficult to understand, although there has been a decline in the share of beneficiaries reporting that it is difficult to review and compare Medicare coverage options. This finding may signal opportunities to reduce program complexity and assist groups of beneficiaries who may need more guidance.

Understanding the Medicare program

When asked how easy it is to understand Medicare, 29 percent of respondents in both 2019 and 2023 said that the program was “very” or “somewhat” difficult to understand (Table 2-B1, p. 88). There were some differences across subgroups of beneficiaries, which may indicate the need for more targeted decision-making support. In 2023, full-benefit Medicare–Medicaid dually eligible beneficiaries were more likely to respond that the Medicare program was “very” or “somewhat” difficult to understand compared with non-dually eligible beneficiaries (33 percent compared with 28 percent; data not shown).⁴¹ When looking across race/ethnicity groups in 2023, Hispanic

beneficiaries were more likely than White and Black beneficiaries to say that the program was difficult to understand (38 percent compared with 28 percent and 24 percent, respectively). In 2023, beneficiaries with no high school diploma were also more likely to report that Medicare was difficult to understand (34 percent compared with 27 percent of beneficiaries with a college degree or more).

When asked how easy it is to review and compare Medicare coverage options, about a third of beneficiaries said it was “very” or “somewhat” difficult (Table 2-B1, p. 88). The share of beneficiaries reporting that it was difficult to compare Medicare plan options decreased from 2019 to 2023 (37 percent to 33 percent). In 2023, full-benefit dually eligible beneficiaries, Hispanic beneficiaries, and beneficiaries with no high school diploma were more likely to report that it was difficult to compare Medicare options (data not shown).

Experiences with information sources about the Medicare program

The vast majority of all respondents (92 percent) said they were satisfied with the availability of information about the Medicare program. There were no meaningful differences in the level of satisfaction with the availability of information across groups of beneficiaries we analyzed. About a quarter of beneficiaries reported trying to get information about the Medicare program in the past year. This share has increased from 23 percent of beneficiaries in 2019 to 27 percent in 2023 (Table 2-B1, p. 88). In 2023, 83 percent of respondents said that they “completely” or “somewhat” agree that they had the information needed to make informed comparisons across insurance options, an increase from 80 percent in 2019 (Table 2-B1).

The MCBS asks beneficiaries about their awareness of and experiences using three sources of information about Medicare: the *Medicare & You* handbook, the Medicare.gov website, and the 1-800-MEDICARE phone line. In 2023, 82 percent of all respondents reported that they either received the *Medicare & You* handbook in the mail or reviewed it online, and 64 percent said that they thoroughly read the handbook or read parts of it (the other 36 percent said they read none of

**TABLE
2-B1**

Changes in national-level MCBS responses over time, 2019–2023

MCBS question	2019	2023	Percentage point change
Understanding the Medicare program			
Medicare program is easy (very or somewhat) to understand	71%	71%	0%
Medicare program is difficult (very or somewhat) to understand	29	29	0
Easy (very or somewhat) to review and compare Medicare coverage options	63	67	4
Difficult (very or somewhat) to review and compare Medicare coverage options	37	33	–4
Experiences with information sources about the Medicare program			
Satisfied (very or satisfied) with availability of information about the Medicare program	90	92	2
Tried to get information in the past year about Medicare	23	27	4
Agree (completely or somewhat) that they have the information needed to make informed comparisons across insurance options	80	83	3
Received in mail or reviewed <i>Medicare & You</i> book online	86	82	–4
Thoroughly read through or read parts of <i>Medicare & You</i>	63	64	1
Read none of <i>Medicare & You</i>	38	36	–2
Visited Medicare.gov	47	46	–1
Aware of 1-800-MEDICARE before today	61	49	–12
Called 1-800-MEDICARE before today	37	33	–4
Reviewing Medicare plan options			
Review Medicare options at least once a year	46	52	6
Never review Medicare options	23	19	–4
During last open enrollment, compared insurance plans	29	32	3
During last open enrollment, reviewed changes in costs	47	53	6
During last open enrollment, reviewed changes in services	45	50	5

Note: MCBS (Medicare Current Beneficiary Survey). This analysis includes only community-dwelling beneficiaries not living in institutions such as nursing homes. It excludes beneficiaries who were not in Part A or Part B throughout their Medicare enrollment in the year or who had Medicare as a secondary payer. The number of beneficiaries represented in this analysis is 56.7 million in 2023. The MCBS is collected from a sample of Medicare beneficiaries; year-to-year variation in some reported data is expected. Response rates for initial interviews are approximately 60 percent; once the first interview is completed, participation in subsequent rounds is 80 percent or more. Components may not sum to 100 percent due to rounding.

Source: MedPAC analysis of CMS's Medicare Current Beneficiary Survey, 2019–2023.

the book) (Table 2-B1). Less than half of beneficiaries (46 percent) reported visiting the Medicare.gov website. In 2023, 49 percent of beneficiaries reported that they were aware of 1-800-MEDICARE, and 33 percent reported calling the phone line. Awareness of 1-800-MEDICARE decreased by 12 percentage points from 2019 to 2023 (from 61 percent to 49 percent);

however, the share of beneficiaries who said they called the phone line only decreased by 4 percentage points (37 percent to 33 percent). Although respondents' awareness of these information sources was generally high, there could be opportunities to better promote the availability of the phone line and use of the Medicare.gov website.

Reviewing Medicare plan options

In 2023, 52 percent of beneficiaries reported that they review their Medicare plan options at least once a year, an increase from 46 percent in 2019 (Table 2-B1). In 2023, 19 percent of beneficiaries said they never review their Medicare plan options, a decrease from 23 percent in 2019.

In 2023, 32 percent of beneficiaries reported comparing insurance plans during the most recent annual enrollment period (AEP), which is the primary opportunity for beneficiaries to make changes to their coverage (Table 2-B1). Fifty-three percent of

respondents said they reviewed changes in the costs of their coverage during the last AEP, and 50 percent said they reviewed changes in covered services. Beneficiaries enrolled in MA were more likely to review their Medicare options annually compared with beneficiaries in traditional FFS Medicare (57 percent compared with 45 percent; data not shown). The cost-sharing rules and supplemental benefits for MA plans can change every year, which may lead to more MA enrollees reviewing changes in their plans annually. Non-dually eligible beneficiaries, Black beneficiaries, and beneficiaries with more education were more likely to report that they reviewed their Medicare options at least once a year (data not shown). ■

Endnotes

- 1 Understanding the experiences and perspectives of Medicare beneficiaries and providers is central to MedPAC's work. A benefit of the focus-group approach is that it allows us to ask questions with answers that cannot easily be put into numbers, for example, the "how" and "why" of experiences. The findings provide narratives and real-life examples that are useful as the Commission discusses issues affecting the Medicare program. Even with these benefits, we want to note that due to the nature of focus-group research, our sample size was limited, so findings cannot be generalized to the communities we studied or to the nation as a whole.
- 2 Individuals may be eligible for Medicare based on the work credits of the individual, the individual's spouse, or the individual's parents in the case of an adult with a disability that began before age 22 (Social Security Administration 2025). Individuals are also eligible for Medicare based on covered railroad service and creditable earnings (Railroad Retirement Board 2024). For simplicity, we refer only to "Social Security" in the remainder of this chapter.
- 3 Individuals pay the full Part A premium of \$565 per month in 2026 if they are eligible for Medicare but they did not pay Medicare payroll taxes for at least 7.5 years. Individuals pay a discounted Part A premium of \$311 per month if they paid Medicare payroll taxes for at least 7.5 years but less than 10 years (Centers for Medicare & Medicaid Services 2025j). The required credits for individuals entitled to Medicare due to disability or ESRD will vary according to the individual's age. Because so few beneficiaries pay the Part A premium, this chapter is limiting references to the premium for the Part A program.
- 4 MA plans can reduce the amount deducted from enrollees' benefits by "buying down" some or all of the standard Part B premium amount. Ninety-nine percent of beneficiaries have access to plans that offer some reduction in the Part B premium; in 2025, about 32 percent of enrollees in conventional plans (excluding enrollees in employer group and special-needs plans) were projected (in plan bids) to be in these premium-reduction plans, and the average monthly premium reduction was \$44 (the monthly Part B premium for 2025 was \$185) (Medicare Payment Advisory Commission 2025b).
- 5 Individuals who are under 65 and had a kidney transplant more than three years prior and therefore no longer qualify for Medicare due to ESRD can qualify for Medicare coverage of their immunosuppressive drugs under the Part B Immunosuppressive Drug Benefit (Part B-ID). Enrollees in Part B-ID with higher incomes are required to pay higher premiums, based on the same IRMAA thresholds used for Part B premiums. In 2026, the standard monthly Part B-ID premium is \$121.60 (Centers for Medicare & Medicaid Services 2025k). In 2023, approximately 155 enrollees with immunosuppressive drug coverage had roughly \$90,000 in Part B benefits (Boards of Trustees 2025).
- 6 Receiving benefits from the Railroad Retirement Board at age 65 will also lead to notification. To simplify for the purpose of this chapter, we refer to "Social Security."
- 7 Puerto Rico residents are automatically enrolled in Part A when they turn 65 but must actively enroll in Part B.
- 8 SSA staff email, April 2026.
- 9 Beneficiaries paying a premium for Part A will be subject to Part A late-enrollment penalties if they delayed enrollment 12 months or more.
- 10 Upon losing Medicaid eligibility, beneficiaries have a SEP of six months to sign up for Part B without a late-enrollment penalty.
- 11 The national base beneficiary premium is the starting point for calculating a plan-specific basic Part D premium. This value is calculated according to a statutory formula.
- 12 Among plan types, HMOs continued to enroll the most beneficiaries (57 percent) in 2025. Enrollment in HMOs grew by 5 percent between 2024 and 2025, outpacing growth of local PPOs (3 percent) (Medicare Payment Advisory Commission 2025c).
- 13 The literature review completed by Taylor et al. analyzed a total of nine studies published from 2009 to 2015. These included studies that relied on survey data asking consumers to evaluate different (mostly Medicare) health plans.
- 14 A zero-premium plan is a conventional (open to all MA-eligible beneficiaries) MA plan that includes Part D drug coverage and charges no Part C or Part D premium (enrollees may pay the Medicare Part B premium).
- 15 Using National Association of Insurance Commissioners data from Mark Farrah Associates, KFF found that the average monthly Medigap premium across all current Medigap policyholders in 2023 was \$217, ranging from \$191 in Alaska to \$267 in New York.

- 16 Plans that use a PPO model, which provide some coverage for services delivered by out-of-network providers, must also have a cap on total out-of-pocket costs for both in-network and non-network providers.
- 17 We annually conduct separate focus groups with beneficiaries enrolled in FFS Medicare and MA. We also conduct groups with dually eligible beneficiaries enrolled in either MA or FFS, and in 2025 all dually eligible beneficiaries in our groups were enrolled in MA. We organize findings by beneficiary source of coverage.
- 18 FFS Medicare has adopted prior authorization to reduce the unnecessary use of certain types of hospital outpatient department services and durable medical equipment (Medicare Payment Advisory Commission 2018). CMS has tested the use of prior authorization to reduce unnecessary use of hyperbaric oxygen therapy in FFS Medicare; however, it was not adopted by FFS Medicare as a permanent policy (Centers for Medicare & Medicaid Services 2016b). Prior authorization for repetitive, scheduled nonemergent ambulance transport (RSNAT) is voluntary; however, if an ambulance supplier elects to bypass prior authorization, applicable RSNAT claims are subject to prepayment medical review (Centers for Medicare & Medicaid Services 2023c). The Wasteful and Inappropriate Service Reduction (WiSeR) Model, launched in 2026, is using AI and data analytics to test new prior authorization for selected services in FFS Medicare in six states: New Jersey, Ohio, Oklahoma, Texas, Arizona, and Washington. Participating data companies will conduct medical reviews and be rewarded for reducing unnecessary spending (Centers for Medicare & Medicaid Services 2026g).
- 19 Insurers can contract with outside organizations and individuals, such as individual agents, to reach and enroll members; in return, these organizations and individuals earn compensation directly from insurers.
- 20 In the Medigap market, insurers must charge the same premium to beneficiaries who enroll in a given plan during a one-time enrollment period (which usually starts when a beneficiary turns 65) and in certain other situations (such as moving to another state or being enrolled in an MA plan that leaves the market). Outside of those situations, insurers in most states can engage in medical underwriting to guard against adverse selection.
- 21 Starting with the 2028 plan year, MA plans will be subject to several new requirements aimed at ensuring that their provider directories are accurate. Plans will be required to verify and update the information in their directory at least every 90 days and conduct an analysis that estimates the directory's accuracy for a sample of providers. In addition, if enrollees make an appointment with a provider that is incorrectly listed in the directory as an in-network provider, the plan must cover the service as an in-network service and charge enrollees the in-network amount for cost sharing.
- 22 For the 2026 plan year, CMS has created a temporary SEP for beneficiaries who use the provider information in Plan Finder, enroll in an MA plan, and then find that their preferred provider is not actually in the plan's network. The SEP can only be used during the first three months that a beneficiary is enrolled in the MA plan and is also limited to those who enrolled in a plan through Plan Finder (as opposed to enrolling through an insurer's website). Beneficiaries who qualify for the SEP can enroll in another MA plan or switch to traditional Medicare. We do not have any information about the number of beneficiaries who have used the SEP. CMS has not indicated whether a similar SEP will be available in future plan years.
- 23 Administration for Community Living, SHIP administrative data.
- 24 Grant allocations to states and territories are determined based on formulas that account for factors such as the share of the national Medicare population residing in the state, the proportion of the state's Medicare beneficiaries living in rural areas, and the percentage of Medicare beneficiaries in the state relative to the state's total population (Congressional Research Service 2023). Grant recipients and subrecipients and the funding amounts are available on the ACL's website.
- 25 In our March 2008 report, the Commission recommended that the Secretary increase SHIP funding for outreach to low-income Medicare beneficiaries to increase participation in the MSPs (Medicare Payment Advisory Commission 2008). The Commission explained that Medicare beneficiaries, particularly those who are hard to reach, get most of their information from personal contact and that increasing funding for SHIP grantees, which provide one-on-one counseling, would permit more beneficiaries to have access to programs for which they are eligible (Medicare Payment Advisory Commission 2008).
- 26 The mandatory-funding grant amounts are allocated to states based on the number of individuals who are not enrolled in, but who are eligible for, the LIS relative to the total number of individuals who meet the requirements for the LIS, as well as the number of Part D-eligible individuals residing in a rural area relative to the total number of such individuals in the state (Congressional Research Service 2023).
- 27 Administration for Community Living, SHIP administrative data.

- 28 The IRMAA is an amount added to the Medicare Part B and Part D prescription drug coverage premiums based on a beneficiary's modified adjusted gross income (see Table 2-1, p. 45, for Part B income-related monthly adjustment amounts).
- 29 These federal requirements for agents do not apply to the sale of Medigap plans. While agents who sell Medigap plans have to be licensed according to the requirements of the applicable state, state law may vary regarding any marketing or training requirements.
- 30 Medicare insurance agents' annual compensation can vary and is often higher for agents that have been selling insurance policies for several years and built a client base. The Bureau of Labor Statistics reports that the median annual wage for insurance sales agents was \$60,370 in May 2024, which gives a general sense of potential Medicare agent compensation (Bureau of Labor Statistics 2026). The lowest 10 percent earned less than \$36,390, and the highest 10 percent earned more than \$135,660. Some in the industry report that average annual compensation for a Medicare insurance agent was about \$87,000 (Seven Figure Medicare Agent Summit 2025).
- 31 MA plans are required to maintain an MLR of 85 percent (42 CFR Sec. 422.2410(b)). The MLR is the minimum percentage of revenue that an insurer is required to spend on benefits for their members. An MLR requirement of 85 percent means that the insurer is required to spend at least 85 percent of their revenue on care for their enrollees and can use no more than 15 percent of their revenue for administrative costs and profit. MLR requirements for MA organizations are monitored at the contract level. The numerator of the MLR includes incurred expenses for members' medical claims, including both Medicare and non-Medicare services (i.e., basic and supplemental benefits).
- 32 Not all MA plans report to the NAIC, data from California are limited, and those MA plans that do report may not include spending on marketing and administrative costs under "agent and broker," causing the data to potentially underestimate the total market spending.
- 33 A change to an "unlike plan type" is defined as changing from (1) an MA or MA Prescription Drug plan (MA-PD) to a PDP or Section 1876 cost plan, (2) a PDP to a Section 1876 cost plan or an MA or MA-PD, or (3) a Section 1876 cost plan to an MA or MA-PD or PDP.
- 34 A change to a "like plan type" is defined as changing from (1) a PDP to another PDP, (2) an MA or MA-PD to another MA or MA-PD, or (3) a cost plan to another cost plan.
- 35 For contract year 2025, CMS proposed eliminating the regulatory framework that allows for separate payment to agents for administrative services. Following the finalization of these regulations, the U.S. District Court for the Northern District of Texas issued preliminary injunctions in *Americans for Beneficiary Choice v. HHS*, No. 4:24-cv-00439, and *Council for Medicare Choice v. HHS*, No. 4:24-cv-00446, meaning that certain provisions cannot be implemented. In August 2025, the court held that CMS exceeded its statutory authority and vacated the administrative-payments portion of the rule.
- 36 Medigap policies may include benefits in addition to the required benefits.
- 37 The Idaho Department of Insurance filed emergency cease-and-desist orders against two insurers alleging that the insurers changed the commission structure as an attempt to discourage enrollment in their MA plans. The insurers sued the state, saying that federal MA law preempts state law in this area, and the district judge agreed that the insurers were likely to succeed in their lawsuit (*UnitedHealthcare of the Rockies and Care Improvement Plus South Central Insurance Company v. Dean Cameron, Director of the Idaho Department of Insurance*, U.S. District Court, December 2025).
- 38 However, in the case of aged individuals or their spouses in group health plans offered by employers with fewer than 20 employees (or in the case of disabled individuals or their parents, by employers with fewer than 100 employees), Medicare coverage is considered primary to the group health plan. These individuals are not eligible for this SEP. Based on data from the Survey of Income and Program Participation, which is administered by the Census Bureau, in 2023 about 40 percent of people 65 years and older who were employed worked for an employer with fewer than 25 employees (or about 7 percent of all people 65 years and older) (Census Bureau 2025). Although not an exact comparison because of differences in employer size, these points illustrate that a portion of Medicare beneficiaries are affected by this policy.
- 39 MA plans and providers are allowed to terminate their network agreements at any point in the year. Plans are required to notify affected enrollees of a termination of a contracted provider. When a primary care or behavioral health provider leaves a network, only enrollees currently assigned to that primary care provider and to enrollees who have been patients of the primary care or behavioral health provider within the past three years are required to be notified, and the notice period is at least 45 calendar days before the termination effective date. When other providers leave the network, the notice must be sent to enrollees who are assigned to or currently received care from or received

care in the past three months from the provider. These enrollees must be notified at least 30 calendar days before the termination date.

40 This analysis includes only community-dwelling beneficiaries not living in institutions such as nursing homes. It excludes beneficiaries who were not in Part A and Part B throughout their Medicare enrollment in the year or who had Medicare as a secondary payer. The number of beneficiaries represented in this analysis was 56.7 million in 2023.

Response rates for initial interviews are approximately 60 percent; once the first interview is completed, participation in subsequent rounds is 80 percent or more (Centers for Medicare & Medicaid Services 2026d). The MCBS is collected from a sample of Medicare beneficiaries; year-to-year variation in some reported data is expected.

41 All comparisons of responses across groups of beneficiaries are statistically significant at $p < 0.05$.

References

- AARP. 2025. The State Health Insurance Assistance Program (SHIP): Trusted Medicare assistance and education. <https://www.aarp.org/content/dam/aarp/ppi/topics/health/coverage-access/state-health-insurance-assistance-program-ship-trusted-medicare-assistance-education.doi.10.26419-2fppi.00390.001.pdf>.
- Administration for Community Living, Department of Health and Human Services. 2026. *Code of Federal Regulations*. 42 CFR part 1331: State Health Insurance Assistance Program. <https://www.ecfr.gov/current/title-45/subtitle-B/chapter-XIII/subchapter-C/part-1331>.
- Administration for Community Living, Department of Health and Human Services. 2025. *Justification of estimates for appropriations committees*. Washington, DC: ACFC.
- Administration for Community Living, Department of Health and Human Services. 2024. State units on aging. <https://acl.gov/programs/aging-and-disability-networks/state-units-aging>.
- Administration for Community Living, Department of Health and Human Services. 2021. *State Health Insurance Assistance Program (SHIP) report to Congress*. Washington, DC: ACL. <https://acl.gov/sites/default/files/SHIP/ship-report-to-congress-2021-acl.pdf>.
- AHIP. 2025. Why you should choose AHIP for your MFWA training. <https://www.ahipmedicaretraining.com/page/login>.
- Artiga, S., P. Ubri, and J. Zur. 2017. *The effects of premiums and cost sharing on low-income populations: Updated review of research findings*. Washington, DC: KFF. <https://www.kff.org/medicaid/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings>.
- Atherly, A., R. D. Feldman, B. Dowd, et al. 2020. Switching costs in Medicare Advantage. *Forum for Health Economics & Policy* 23, no. 1 (March 5).
- Balkan, E., J. Shroff, A. N. Trivedi, et al. 2026. Rapid disenrollment rates tripled for Medicare Advantage beneficiaries, 2017–22. *Health Affairs* 45, no. 3 (March): 285–291.
- Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. 2025. *The 2025 annual report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*. Washington, DC: Boards of Trustees. <https://www.cms.gov/oact/tr/2025>.
- Bundorf, M. K., M. Polyakova, and M. Tai-Seale. 2024. How do consumers interact with digital expert advice? Experimental evidence from health insurance. *Management Science* 70, no. 11 (January 9).
- Bureau of Labor Statistics. 2026. *Occupational outlook handbook: Insurance sales agents*. <https://www.bls.gov/ooh/sales/insurance-sales-agents.htm#tab-5>.
- Census Bureau. 2025. *2024 survey of income and program participation: Users' guide*. Washington, DC: Department of Commerce. https://www2.census.gov/programs-surveys/sipp/tech-documentation/methodology/2024_SIPP_Users_Guide.pdf.
- Census Bureau. 2012. National population projections: Downloadable files: Table 1. Projected population by single year of age, sex, race, and Hispanic origin for the United States, 2012 to 2060: Middle series. http://www.census.gov/population/projections/files/downloadables/NP2012_D1.csv.
- Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2026a. 2026 agent and broker training & testing guidelines. <https://www.cms.gov/files/document/cy2026agentbrokertrainingtestingguidelinespdf.pdf>.
- Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2026b. Coordination of benefits (COB). <https://www.cms.gov/medicare/coverage/prescription-drug-coverage-contracting/coordination-benefits-cob>.
- Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2026c. *Fiscal year 2027: Justification of estimates for appropriations committees*. Baltimore, MD: CMS. <https://www.cms.gov/files/document/fy-2027-justification-estimates-appropriations-committees.pdf>.
- Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2026d. Medicare Current Beneficiary Survey (MCBS). <https://odphp.health.gov/healthypeople/objectives-and-data/data-sources-and-methods/data-sources/medicare-current-beneficiary-survey-mcbs>.
- Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2026e. Medicare program; contract year 2027 and certain contract year 2026 policy and technical changes to the Medicare Advantage program, Medicare prescription drug benefit program, and Medicare cost plan program. Final rule. *Federal Register* 91, no. 65 (April 6): 17384–17602.
- Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2026f. *Request for information: AI tools for Medicare experience modernization*. Baltimore, MD: CMS.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2026g. WISeR (Wasteful and Inappropriate Service Reduction) Model. <https://www.cms.gov/files/document/wiser-fact-sheet.pdf>.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2025a. 2026 Medicare Part D bid information and Part D Premium Stabilization Demonstration parameters. <https://www.cms.gov/newsroom/fact-sheets/2026-medicare-part-d-bid-information-and-part-d-premium-stabilization-demonstration-parameters>.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2025b. 2026 Medicare Parts A & B premiums and deductibles. <https://www.cms.gov/newsroom/fact-sheets/2026-medicare-parts-b-premiums-deductibles>.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2025c. Advance notice of methodological changes for calendar year (CY) 2026 for Medicare Advantage (MA) capitation rates and Part C and Part D payment policies. <https://www.cms.gov/files/document/2026-advance-notice.pdf>.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2025d. *Choosing a Medigap policy*. Baltimore, MD: CMS. <https://www.medicare.gov/publications/02110-medigap-guide-health-insurance.pdf>.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2025e. End-stage renal disease (ESRD). <https://www.medicare.gov/basics/end-stage-renal-disease>.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2025f. *Help with drug costs*. Baltimore, MD: CMS. <https://www.medicare.gov/basics/costs/help/drug-costs>.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2025g. Medical loss ratio. <https://www.cms.gov/medicare/health-drug-plans/medical-loss-ratio>.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2025h. Medicare Advantage enrollment and disenrollment guidance appendices and exhibits. <https://www.cms.gov/files/document/cy-2026-ma-appendices-and-exhibits.pdf>.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2025i. Medicare program; contract year 2027 policy and technical changes to the Medicare Advantage and Medicare prescription drug benefit program, and Medicare cost plan program. Proposed rule. *Federal Register* 90, no. 227 (November 28): 54894–55030.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2025j. Medicare program; CY 2026 Part A premiums for the uninsured aged and for certain disabled individuals who have exhausted other entitlement. Notice. *Federal Register* 90, no. 221 (November 19).

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2025k. Medicare program; Medicare Part B monthly actuarial rates, premium rates, and annual deductible beginning January 1, 2026. Notice. *Federal Register* 90, no. 221 (November 19).

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2025l. Memo to all Medicare Advantage organizations, prescription drug plans, cost plans, Medicare-Medicaid plans (MMPs), and PACE organizations regarding the special election period for incorrect Medicare Plan Finder Medicare Advantage (MA) provider directory information. September 12.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2025m. Memo to Medicare Advantage organizations, prescription drug plan sponsors, and Section 1876 cost plans regarding contract year 2026 agent and broker compensation rates, referral/finder's fees, submissions, and training and testing requirements. June 18. https://blog.actionbenefits.com/hubfs/2026.06.19_Memo_Agent%20Broker%20Compensation%20and%20Training%20and%20Testing%20Requirements%20CY2026.pdf.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2025n. Memo to state departments of finance regarding important communication from the Centers for Medicare & Medicaid Services. December 4. https://www.seniormarketsales.com/hubfs/documents/advocacy/Important_Communication_from_the_Centers_for_Medicare_Medicaid_Services.pdf.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2025o. Original Medicare (Part A and B) eligibility and enrollment. <https://www.cms.gov/medicare/enrollment-renewal/original-part-a-b>.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2025p. Updated: 2025 agent and broker training and testing guidelines. <https://www.cms.gov/files/document/cy2025-agent-broker-training-testing-guidelines-revised.pdf>.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2025q. Chapter 4: Creditable coverage period determinations and the late enrollment penalty guidance. <https://www.cms.gov/files/document/cy-2026-final-chapter-4-guidance.pdf>.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2024a. Agent broker compensation. <https://www.cms.gov/medicare/health-drug-plans/managed-care-marketing/medicare-marketing-guidelines/agent-broker-compensation>.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2024b. Contract year 2025 Medicare Advantage and Part D final rule (CMS-4205-F). <https://www.cms.gov/newsroom/fact-sheets/contract-year-2025-medicare-advantage-part-d-final-rule-cms-4205-f>.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2024c. 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). Final rule. *Federal Register* 89, no. 79 (April 23): 30448–30848.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2024d. NAIC Q&A and follow-ups. <https://www.cms.gov/files/document/naic-faq-12-17-2024.pdf>.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2024e. *Report to Congress: Medicare beneficiary enrollment simplification required by Section 120 of Division CC, Title I, Subtitle B of the Consolidated Appropriations Act, 2021*. Washington, DC: CMS. <https://www.govinfo.gov/content/pkg/CMR-HE22-00191372/pdf/CMR-HE22-00191372.pdf>.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2024f. When does Medicare coverage start? <https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start>.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2023a. Medicare program; contract year 2024 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. Final rule. *Federal Register* 88, no. 70 (April 12): 22120–22345.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2023b. Medicare program; 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; health information technology standards and implementation specifications. Proposed rule. *Federal Register* 88, no. 219 (November 15): 78476–78630.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2023c. Prior authorization and pre-claim review initiatives: Prior authorization of repetitive, scheduled non-emergent ambulance transport (RSNAT). <https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/prior-authorization-and-pre-claim-review-initiatives/prior-authorization-repetitive-scheduled-non-emergent-ambulance-transport-rsnat>.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2022a. Contract year 2023 Medicare Advantage marketing policies: Frequently asked questions. <https://www.documentcloud.org/documents/23169211-agent-broker-marketing-faqs/>.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2022b. Medicare program; contract year 2023 policy and technical changes to the Medicare Advantage and Medicare prescription drug benefit programs; policy and regulatory revisions in response to the COVID-19 public health emergency; additional policy and regulatory revisions in response to the COVID-19 public health emergency. Final rule. *Federal Register* 87, no. 89 (May 9): 27704–27902.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2021. Medicare and Medicaid programs; contract year 2022 policy and technical changes to the Medicare Advantage program, Medicare prescription drug benefit program, Medicaid program, Medicare cost plan program, and Programs of All-Inclusive Care for the Elderly. Final rule. *Federal Register* 86, no. 11 (January 19): 5864–6135.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2019. Medicare Plan Finder gets an upgrade for the first time in a decade. <https://www.cms.gov/newsroom/press-releases/medicare-plan-finder-gets-upgrade-first-time-decade>.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2017. Medicare program; recognition of revised NAIC model standards for regulation of Medicare supplemental insurance. Final rule. *Federal Register* 82, no. 169 (September 1): 41684–41821.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2016a. Chapter 4: Benefits and beneficiary protections. In *Medicare Managed Care Manual*. Baltimore, MD: CMS.

Centers for Medicare & Medicaid Services. 2016b. Medicare prior authorization of non-emergent hyperbaric oxygen (HBO) therapy model status update. https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Prior-Authorization-Initiatives/Downloads/HBOPriorAuth_StatusUpdate_111616.pdf.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2012. Medicare program; changes to the Medicare Advantage and the Medicare prescription drug benefit programs for contract year 2013 and other changes. Final rule with comment period. *Federal Register* 77, no. 71 (April 12): 22072–22175.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2008a. 42 CFR 422.2260 definition of third-party marketing organization (TPMO). <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V>.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2008b. Medicare program; revisions to the Medicare Advantage and prescription drug benefit programs: Clarification of compensation plans. Interim final rule with comment period. *Federal Register* 73, no. 221 (November 14): 67406–67414.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2005. 42 CFR 422.2274 agent, broker, and other third-party requirements. <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-V/section-422.2274>.

Clark, C. 2022. Brokers earn more to steer new beneficiaries to Medicare Advantage. *MedPage Today*, October 14.

Commonwealth Fund. 2023. *The challenges of choosing Medicare coverage: Views from insurance brokers and agents*. New York, NY: The Commonwealth Fund. <https://www.commonwealthfund.org/publications/2023/feb/challenges-choosing-medicare-coverage-views-insurance-brokers-agents>.

Commonwealth Fund. 2021a. Agent commissions in Medicare and the impact on beneficiary choice. <https://www.commonwealthfund.org/blog/2021/agent-commissions-medicare-and-impact-beneficiary-choice>.

Commonwealth Fund. 2021b. *How agents influence Medicare beneficiaries' plan choices*. New York, NY: The Commonwealth Fund. April 21.

Congressional Research Service. 2023. *State Health Insurance Assistance Program (SHIP)*. IF10623. Washington, DC: CRS. <https://crsreports.congress.gov/product/pdf/IF/IF10623>.

Congressional Research Service. 2022. *Medicare Part B: Enrollment and premiums*. R40082. Washington, DC: CRS.

Congressional Research Service. 2020. *Health savings accounts (HSAs) and Medicare*. IF11425. Washington, DC: CRS. https://www.congress.gov/crs_external_products/IF/PDF/IF11425/IF11425.1.pdf.

CSG Actuarial. 2025. Medicare supplement business rules by state as of April 2025.

Department of Justice. 2025. United States files complaint against several national health insurance companies and brokers alleging unlawful kickbacks and discrimination against disabled Americans. <https://www.justice.gov/usao-ma/pr/united-states-files-complaint-against-several-national-health-insurance-companies-and>.

Direct Research. 2014. *Exploring the effects of secondary coverage on Medicare spending for the elderly*. Report prepared by Direct Research for the Medicare Payment Advisory Commission. Washington, DC: MedPAC.

Dugan, K., I. Peterson, A. Dorneo, et al. 2025. Accuracy of Medicare information provided by state health insurance assistance programs. *JAMA Network Open* 8, no. 4 (April 1): e252834.

Freed, M., J. Fuglesten Biniek, A. Damico, et al. 2024a. *Medicare Advantage in 2024: Premiums, out-of-pocket limits, supplemental benefits, and prior authorization*. Washington, DC: KFF. <https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2024-premiums-out-of-pocket-limits-supplemental-benefits-and-prior-authorization/>.

Freed, M., N. Ochieng, J. Cubanski, et al. 2024b. *Key facts about Medigap enrollment and premiums for Medicare beneficiaries*. Washington, DC: KFF. <https://www.kff.org/medicare/issue-brief/key-facts-about-medigap-enrollment-and-premiums-for-medicare-beneficiaries/>.

Freed, M., A. Cottrill, J. Fuglesten Biniek, et al. 2023. *What do people with Medicare think about the role of marketing, shopping for Medicare options, and their coverage?* Washington, DC: KFF. https://www.kff.org/report-section/what-do-people-with-medicare-think-about-the-role-of-marketing-shopping-for-medicare-options-and-their-coverage-report/#many_factors.

Fuglesten Biniek, J., A. Cottrill, N. Sroczynski, et al. 2023. *How health insurers and brokers are marketing Medicare*. Washington, DC: KFF. <https://www.kff.org/medicare/how-health-insurers-and-brokers-are-marketing-medicare/>.

Garrido, M. M., D. Biko, A. Dorneo, et al. 2024. Access to insurance navigation support through the State Health Insurance Assistance Program (SHIP). *Health Affairs Scholar* 2, no. 6 (June): qxae072.

Gen Re. 2025. Medicare supplement—Highlights of 2024 U.S. market survey. <https://www.genre.com/us/knowledge/publications/2025/september/surveylhmedsup25-en>.

Gen Re. 2024. Medicare supplement market keeps evolving: Overview of latest survey. <https://www.genre.com/us/knowledge/publications/2024/december/medicare-supplement-market-keeps-evolving-en>.

Government Accountability Office. 2023. *Medicare Advantage: Plans generally offered some supplemental benefits, but CMS has limited data on utilization*. GAO-23-105527. Washington, DC: GAO.

Government Accountability Office. 2019. *Medicare Plan Finder: Usability problems and incomplete information create challenges for beneficiaries comparing coverage options*. GAO-19-627. Washington, DC: GAO.

Gruber, J., B. R. Handel, S. H. Kina, et al. 2020. *Managing intelligence: Skilled experts and AI in markets for complex products*. NBER working paper no. 27038. Cambridge, MA: National Bureau of Economic Research.

Gurley, D. 2025. Agent's guide to selling Medicare [2025 edition]. <https://redbirdagents.com/ultimate-guide-selling-medicare-supplement-insurance/>.

Herman, B. 2025. Major health insurers like Humana, UnitedHealth are cutting broker commissions to avoid costly Medicare enrollees. *Stat News*, November 25. <https://www.statnews.com/2025/11/25/health-insurers-avoid-costly-new-medicare-enrollees-regulators-say/>.

Herman, B. 2024. Centene eliminates brokers' commissions for Medicare drug plans. *Stat News*, August 27. <https://www.statnews.com/2024/08/27/centene-medicare-part-d-brokers-commissions/>.

Humana. 2026. 2026 individual products producer partnership plan. <https://assets.humana.com/is/content/humana/Humana%20Individual%20Products%20PPP.pdf>.

Internal Revenue Service, Department of the Treasury. 2025. Publication 969 (2025), health savings accounts and other tax-favored health plans. <https://www.irs.gov/publications/p969>.

Kaplan Financial Education. 2025. Insurance licensing. <https://www.kaplanfinancial.com/insurance>.

Komisar, H., and K. Lind. 2024. *Millions of people pay Medicare late enrollment penalties for life after missing key deadlines*. Washington, DC: AARP. <https://www.aarp.org/content/dam/aarp/ppi/topics/health/coverage-access/millions-of-people-pay-medicare-late-enrollment-penalties-for-life-after-missing-key-deadlines.doi.10.26419-2fppi.00225.001.pdf>.

Kwon, Y., S. A. Jazowski, X. Hu, et al. 2025. Medigap protection and plan switching among Medicare Advantage enrollees with cancer. *JAMA Health Forum* 6, no. 6 (June 7): e252018.

Leonard, F., G. Jacobson, L. A. Haynes, et al. 2022. *Traditional Medicare or Medicare Advantage: How older Americans choose and why*. <https://www.commonwealthfund.org/publications/issue-briefs/2022/oct/traditional-medicare-or-advantage-how-older-americans-choose>.

McSpadden, J. 2024. *A new era for state pharmaceutical assistance programs that serve older adults*. Washington, DC: AARP. <https://www.aarp.org/content/dam/aarp/ppi/topics/health/prescription-drugs/new-era-for-state-pharmaceutical-assistance-programs-that-serve-older-adults.doi.10.26419-2fppi.00214.001.pdf>.

McWilliams, J. M., C. C. Afendulis, T. G. McGuire, et al. 2011. Complex Medicare Advantage choices may overwhelm seniors—especially those with impaired decision making. *Health Affairs* 30, no. 9 (September): 1786-1794.

Medicare Payment Advisory Commission. 2026. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2025a. *A data book: Health care spending and the Medicare program*. Washington, DC: MedPAC. https://www.medpac.gov/wp-content/uploads/2025/07/July2025_MedPAC_DataBook_SEC.pdf.

Medicare Payment Advisory Commission. 2025b. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2025c. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2024. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2019. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2018. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2012. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2008. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission. 2025. *Data book: Beneficiaries dually eligible for Medicare and Medicaid*. Washington, DC: MedPAC/MACPAC.

National Association of Insurance Commissioners. 2025. Model regulation to implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act. <https://content.naic.org/sites/default/files/model-law-651.pdf>.

NORC at the University of Chicago. 2025. *Beneficiary and clinician perspectives on Medicare and other issues: Findings from 2025 focus groups in St. Louis, Missouri, and 2021–2025 rural focus groups*. Report prepared by staff from NORC at the University of Chicago for the Medicare Payment Advisory Commission. Bethesda, MD: NORC.

NORC at the University of Chicago. 2024. *Beneficiary and clinician perspectives on Medicare and other issues: Findings from 2024 focus groups in select states*. Report prepared by staff from NORC at the University of Chicago for the Medicare Payment Advisory Commission. Chicago, IL: NORC.

Ochieng, N., M. Freed, J. Fuglesten Biniak, et al. 2025. *Medicare Advantage in 2025: Premiums, out-of-pocket limits, supplemental benefits, and prior authorization*. Washington, DC: KFF. <https://www.kff.org/medicare/medicare-advantage-premiums-out-of-pocket-limits-supplemental-benefits-and-prior-authorization/>.

Railroad Retirement Board. 2024. *Railroad retirement handbook*. Chicago, IL: RRB.

Seven Figure Medicare Agent Summit. 2025. 2024 summit recording. <https://sevenfiguremedicareagentsummit.com/recordings/>.

Social Security Administration. 2025. *Benefits for children with disabilities*. Washington, DC: SSA.

Social Security Administration. 2024a. HI 01101.010 *Modified adjusted gross income (MAGI)*. Baltimore, MD: SSA. <https://secure.ssa.gov/poms.nsf/lnx/0601101010>.

Social Security Administration. 2024b. *Program Operations Manual System (POMS): Description of CMS Medicare initial enrollment period package information sent to beneficiaries*. Baltimore, MD: SSA. <https://secure.ssa.gov/poms.nsf/lnx/0600805125>.

State Health Insurance Assistance Program. 2017. STARS manual Chapter 1: About STARS. https://www.shiphelp.org/application/files/2017/0958/5088/STARS_Manual_Chapter_1_-_About_STARS_March_2024_changes_highlighted.pdf.

Stults, C. D., A. S. Baskin, M. K. Bundorf, et al. 2018. Patient experiences in selecting a Medicare Part D prescription drug plan. *Journal of Patient Experience* 5, no. 2 (June): 147–152.

Taylor, E. A., K. G. Carman, A. Lopez, et al. 2016. *Consumer decisionmaking in the health care marketplace*. Santa Monica, CA: RAND Corporation.

Tepper, N. 2024. In a twist, Medicare Advantage insurers try to avoid selling plans. *Modern Healthcare*, November 13. <https://www.modernhealthcare.com/insurance/aetna-cigna-elevance-medicare-advantage-commissions-brokers/>.

Tolbert, J., S. Cervantes, C. Bell, et al. 2026. *Key facts about the uninsured population*. Washington, DC: KFF. <https://www.kff.org/uninsured/key-facts-about-the-uninsured-population/?entry=executive-summary-introduction>.

Tong, N. 2025. CMS weighs in on Medicare Advantage marketing commission disputes. *Modern Healthcare*, December 8. <https://www.modernhealthcare.com/insurance/mh-cms-medicare-advantage-marketing-commission-states/>.

U.S. House of Representatives. 2026. Consolidated Appropriations Act, 2026. 119th Cong., H.R. 7148.

U.S. House of Representatives. 2025. Continuing Appropriations, Agriculture, Legislative Branch, Military Construction and Veterans Affairs, and Extensions Act, 2026. 119th Cong., H.R. 5371.

U.S. Senate Committee on Finance. 2025. *Pushing Medicare Advantage on seniors: Unraveling the complex network of marketing middlemen*. Washington, DC: Government Printing Office. https://www.finance.senate.gov/imo/media/doc/pushing_medicare_advantage_on_seniors_unraveling_the_complex_network_of_marketing_middlemen_-_32425docx.pdf.

U.S. Senate Committee on Finance. 2022. *Deceptive marketing practices flourish in Medicare Advantage*. Washington, DC: Government Printing Office. <https://www.finance.senate.gov/imo/media/doc/Deceptive%20Marketing%20Practices%20Flourish%20in%20Medicare%20Advantage.pdf>.

Young, J., and N. Tepper. 2025. UnitedHealthcare nixes many Medicare Advantage commissions. *Modern Healthcare*, June 16. <https://www.modernhealthcare.com/insurance/mh-unitedhealthcare-medicare-advantage-broker-commissions/>.

