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January 5, 2024

Submitted via Regulations.gov

Office of the Secretary
U.S. Department of Health and Human Services
330 Independence Avenue, S.W.
Washington, D.C. 20201

Centers for Medicare & Medicaid Services
Attention: CMS-4205-P
7500 Security Boulevard
Baltimore, MD 21244

Re: *Medicare Program; Contract Year 2025 Policy and Technical Changes*, File Code CMS-4205-P; Docket No. CMS-2023-0187; RIN 0938-AV24

To the Office of the Secretary:

The Council for Medicare Choice (the "Council" or "CMC") respectfully submits these comments in response to the Proposal entitled *Medicare Program; Contract Year 2025 Policy and Technical Changes*, 88 Fed. Reg. 78,476 (Nov. 15, 2023). The Council appreciates the opportunity to comment on the Proposed Rule's agent- and broker-compensation provisions, which would be implemented by the Centers for Medicare & Medicaid Services ("CMS"), *see id.* at 78,624/1-2, 78,628/3 (proposing amendments to 42 C.F.R. §§ 422.2274, 423.2274).[1]

The Council is a nonprofit corporation representing many of the largest unaffiliated insurance agency, brokerage, and field-marketing organizations ("FMOs") with an established record in the industry. The Council's members help millions of individuals purchase health plans of all types, including Medicare Advantage ("MA") and Medicare Part D prescription drug plans, by connecting carriers and beneficiaries through a variety of business models. That unique role in the Medicare system makes Council members essential to sustaining enrollment in the MA program and matching individuals with the right health plans for their needs.

The Proposed Rule, however, threatens these vital services by: (1) expanding CMS's existing limits on compensation to encompass a range of administrative service payments that CMS previously did not consider to be "compensation"; (2) dramatically reducing the payments that agents and brokers can receive for these services to far below their fair-market value and even far below actual cost; and (3) imposing vague additional limitations on carriers' contracts with agents, brokers, and third-party marketing organizations. *See* 88 Fed. Reg. at 78,554/3-56/3. The full scope of these proposed changes is not clear from the Proposal. But

[1] This letter refers to the proposed rule's text as the "Proposed Rule," and CMS's preamble and proposed rule text collectively as the "Proposal."

if applied broadly, these changes would pose an existential threat to large segments of the agent and broker industry and would require many of the Council's members to either exit the industry or significantly curtail the essential services they provide to carriers and beneficiaries, including to the low-income and disabled beneficiaries who are most in need of the services Council members provide. The result would be to severely undercut CMS's stated—and statutorily mandated—goal of expanding MA and Medicare Part D enrollment and enabling beneficiaries to identify and select the plans that will "best meet their health care needs." 42 U.S.C. § 1395w-21(j)(2)(D).

For these reasons and others, the Council urges CMS to reconsider the Proposed Rule. At a minimum, before embarking on a course that could devastate the industry and undermine Congress's directives, CMS owes it to the public and the industry to carefully and deliberately study whether a problem even exists, disclose to the public and solicit comment on the data and evidence on which CMS intends to rely, and explore a range of reasonable solutions rather than the flawed approach set forth in the Proposal. CMS should therefore suspend this rulemaking, collect the information it needs, make that information available for public review, and—if justified—re-propose an appropriate rule with a fresh comment period. At the very least, CMS should extend the comment period to no sooner than 90 days after the date on which all necessary information is disclosed, including information submitted to the agency in response to this proposal.

Section I of this letter provides background on the industry. **Section II** of this letter addresses the Proposed Rule's provisions governing compensation rates and administrative payments. 88 Fed. Reg. at 78,554/3-56/3, 78,624/1-2 (proposing amended 42 C.F.R. § 422.2274(a), (d), (e)). **Section III** addresses the Proposed Rule's provisions governing limitations on contracts. *Id.* at 78,554/3, 78,624/2 (proposing amended 42 C.F.R. § 422.2274(c)(5)).[2]

We hope that you find this letter helpful. Please let us know, of course, if we can provide additional information.

[2] For ease of reference, this comment letter generally cites the regulations governing MA plans. *E.g.*, 42 C.F.R. § 422.2274. But the Council's comments apply equally to the regulations governing Part D plans. *E.g.*, *id.* § 423.2274.

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I. Background

Medicare Advantage is a thriving market for eligible Americans that want to obtain health care coverage. Indeed, "Medicare Advantage enrollment has been on a steady climb for the past two decades" and now includes over 30 million beneficiaries, with an eight-percent increase in enrollments between 2022 and 2023 alone. Nancy Ochieng et al., *Medicare Advantage in 2023: Enrollment Update and Key Trends*, KFF (Aug. 9, 2023), https://tinyurl.com/ykajezk5. In 2023, enrollments in Medicare Advantage exceeded enrollments in traditional Medicare for the first time ever. *Id.*

Medicare Advantage functions as a private alternative to traditional Medicare. Under traditional Medicare, nearly all physicians participate, but coverage is more limited and there is no annual cap on beneficiaries' out-of-pocket expenses. Dena Bunis, *The Big Choice: Original Medicare vs. Medicare Advantage*, AARP (June 29, 2023), http://tinyurl.com/37hjka97. Under Medicare Advantage, by contrast, beneficiaries can join specific health care plans with options better tailored to their individual needs. Beneficiaries typically must see in-network physicians, but plans include extra benefits absent from traditional Medicare (like vision, hearing, and dental benefits), and plans typically cap yearly out-of-pocket expenses. *See id.*; *Compare Original Medicare & Medicare Advantage*, Medicare.gov (last visited Dec. 19, 2023), http://tinyurl.com/3cf8z5uw. As a result, Medicare Advantage expands beneficiary choice—helping to explain its booming popularity in recent years. Beneficiaries can obtain greater and more tailored benefits for less cost by selecting from a "menu" of private alternatives. AARP, *The Big Choice*, *supra*. As of today, the average beneficiary now "has access to 43 Medicare Advantage plans, the largest number of options ever." KFF, *Medicare Advantage in 2023*, *supra*.

Those MA plans reach beneficiaries in a number of ways. Some health plan carriers use their own employees to sell plans directly to beneficiaries. These carrier-employed agents typically draw "a regular salary" plus incentives or bonuses for each policy sold, but they sell *only* that carrier's plans irrespective of what may be in the beneficiary's best interest. The Hartford, *Captive Agent vs. Independent Agent* (last visited Dec. 19, 2023), https://www.thehartford.com/independent-agent/captive-agent-vs-independent-agent. Conversely, other health plan carriers contract with third parties to sell plans, including individual agents and brokers engaged as independent contractors, and third-party firms that either employ individual agents directly or provide administrative services to a network of independent-contractor agents. *Id.* Some of those third-party individuals and firms may contract exclusively with a single carrier to sell that carrier's plan, while others may be

unaffiliated with any one carrier and sell multiple carriers' plans. These third-party firms perform a critical role to connect carriers, agents and brokers, and beneficiaries.[3]

The Council's members are many of the largest of these unaffiliated, third-party firms that contract with multiple carriers. They include: (1) digital marketing firms, which launch marketing campaigns for plans; (2) telesales companies, which contract with carriers to sell and service MA plans over the phone; and (3) FMOs, which build a broad network by contracting with multiple carriers offering health plans so they can offer those plans to independently contracted or employed agents and brokers who advise beneficiaries on the best available health plan for their needs. By contracting with multiple health plans and remaining carrier-agnostic, many of these third-party firms create cost-effective networks that give individual agents a broader array of health plans to offer to beneficiaries. Council members and other similar third parties thus help carriers distribute their plans to new audiences, help beneficiaries access more plans, and help agents and brokers "demystify the stressful process of choosing a health plan" for individuals. CMS, *Agents and Brokers in the Marketplace* at 1 (2020), tinyurl.com/2afffcyf.

Agents and brokers—the boots on the ground and licensed individuals answering the phones—rely on the vital services that Council members and similar firms provide. Employed agents and brokers rely on their employers, whereas agents and brokers operating as independent contractors often rely on FMOs, to connect with the various carriers who wish to reach beneficiaries. Council members likewise furnish agents and brokers with needed telephone and computer support services, assist in fielding customer calls and assessing their needs, and develop or license technology such as plan-comparison tools that agents and brokers deploy in the field. Agents and brokers also rely on Council members' assistance to help them comply with the complex regulatory web governing Medicare Advantage—including the legion rules and regulations that CMS has established.

None of these services is free, so appropriate payments are vital to the smooth functioning of this system. When carriers contract with third parties such as Council members, carriers generally agree to certain payments for the valuable administrative services provided by FMOs, telesales centers, and other similar firms. Council members and other organizations must obtain adequate payment to offset their considerable investments in labor, technology, training, oversight, overhead, and other costs. Likewise, agents and brokers may incur costs that are not covered by an employer or FMO, such as when they travel around the country, set up venues to interact with potential enrollees, and explain plan options in person and in detail.

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[3] This comment letter uses the terms "agent" and "broker" to refer to *individuals* who sell health plans—the licensed individuals who conduct enrollments and are the feet on the street or person on the phone. By contrast, this comment uses terms such as "firms" or "entities" to refer to third-party companies that employ or contract with individuals who sell plans, even if those firms or entities are licensed as agents or brokers.

Properly incentivizing all of these activities is crucial to support the steadily growing Medicare Advantage market and all the advantages it provides to beneficiaries.

Ultimately, carriers, agents and brokers, Council members, and similar firms throughout the industry are all working toward a common goal: providing beneficiaries the best experience and access to the best health care plans possible. Given the explosion in beneficiary choice and beneficiaries' ability to rapidly disenroll from plans they do not like, industry participants have powerful disincentives not to market subpar or ill-fitting plans to beneficiaries. The self-correction facilitated by a highly competitive, saturated market is swift and certain. That is why, at the end of the day, most beneficiaries attest that this process helped them select "the right choice" for their individual needs. Meredith Freed et al., *What Do People with Medicare Think About the Role of Marketing, Shopping for Medicare Options, and Their Coverage?*, KFF (Sept. 20, 2023), https://tinyurl.com/4ryrxra2.

II. The Proposed Rule's compensation-rate and administrative-payment provisions are fundamentally flawed.

The Proposed Rule's principal change to CMS's agent- and broker-compensation regulations would be to upend how plans pay for critical administrative services. Under current regulations, MA organizations must follow compensation requirements that "only apply to independent agents and brokers" who meet CMS's licensing and training requirements, which include meeting all state licensing requirements. 42 C.F.R. § 422.2274(d); *see also id.* § 422.2274(b), (d)(1). CMS imposes a cap on "compensation" related to enrollment, *id.* § 422.2274(d)(2)-(3), but narrowly defines that term to include commissions, bonuses, gifts, prizes, and awards, *id.* § 422.2274(a)(i). Certain reimbursements and fees are excluded from this definition. *Id.* § 422.2274(a)(ii).

Plans can also provide "administrative payments" outside of the compensation caps for "services other than enrollment of beneficiaries," up to the "value of those services in the marketplace." 42 C.F.R. § 422.2274(e)(1). As examples of these administrative services, the current regulations list "training, customer service, agent recruitment, operational overhead, or assistance with completion of health risk assessments." *Id.* Administrative payments "can be based on enrollment" so long as payments are "at or below the value of those services in the marketplace." *Id.* § 422.2274(e)(2). Often, third-party entities (such as Council members), not individual agents, receive these payments.

The Proposal, by contrast, would redefine "compensation" to include administrative fees and reimbursements—subjecting them for the first time to CMS's ceiling levels on enrollment-based compensation. 88 Fed. Reg. at 78,554/3-56/3. The Proposal would also transform the cap on compensation into a fixed payment by changing the regulation from permitting compensation "at or below" the amount determined by CMS to permitting compensation only "at" that amount. *Compare* 42 C.F.R. § 423.2274(e)(2), *with* 88 Fed. Reg.

at 78,624/1-2.[4] Although CMS would raise this compensation amount for MA initial enrollments by $31 (from $601 to $632) per enrollee to account for a small, cherry-picked subset of the administrative services provided to carriers—certain training and testing services, as well as recording—CMS did not otherwise attempt to reflect in the Proposed Rule's new compensation rates the value of the many other administrative services provided by agents, brokers, and the firms they work with. *See id.* at 78,556/2-3.

As an initial matter, it is unclear whether the Proposal would subject administrative payments to FMOs, telesales companies, and other similar third-party entities—as opposed to individual agents and brokers on the ground—to the compensation caps. CMS should clarify that such payments are *not* subject to the caps.

To the extent the Proposed Rule's changes apply to FMOs, telesales companies, and other third parties, however, the Proposal would essentially eliminate *any* payment for many of the essential administrative services that Council members currently provide at market rates, including: providing access to numerous carriers' plans and specific product training regarding those plans, providing telephone and computer support services, taking customer calls and routing them to agents and brokers as leads, developing technology that facilitates plan comparisons, purchasing hardware, conducting direct-mail or social media marketing campaigns, and more. These provisions would force many Council members to exit the business. Those that remain will have to operate at a loss if they continue to provide carrier access, marketing, support-service, and other administrative services. And without these services, beneficiaries will be presented with fewer plan options and will receive less help determining which of those options they should choose. That result is at odds with Congress's mandate to create incentives to sign up individuals for the plan that best meets their health care needs. 42 U.S.C. § 1395w-21(j)(2)(D).

The Council is specifically concerned about the following aspects of the Proposed Rule's provisions governing administrative payments and compensation rates.

- **Section II.A:** At the threshold, the Proposal is unclear in several respects. As the Council reads the Proposal, carriers' administrative payments to third-party firms, including licensed or unlicensed FMOs and telesales companies—as opposed to direct payments to individual agents and brokers—would *not* be subject to CMS's compensation caps. But the Proposal is opaque about whether such administrative payments are subject to CMS's compensation requirements, and that lack of clarity generates untenable uncertainty for Council members. If CMS moves forward with its Proposal, CMS should clarify that the proposed change to Section 422.2274(e)(2) applies only to administrative payments made by carriers to

[4] This comment letter nonetheless refers to CMS's proposed fixed-payment regime as a "cap" to emphasize its effect of prohibiting any greater compensation.

individual agents or brokers. If CMS intended otherwise—or will finalize a rule stating otherwise—applying the rule to firms would only exacerbate the host of legal and policy problems caused by the rule. CMS should also clarify the Proposed Rule's effect on renewal-based payments for enrollments that precede Section 422.2274(e)(2)'s effective date, and should make clear that the Proposed Rule is not intended to regulate the payments that third-party firms, as opposed to carriers, make to individual agents and brokers they may employ or with whom they may contract.

- **Section II.B:** The Proposed Rule's regulation of administrative payments would be an unprecedented and unlawful expansion of CMS's statutory authority. Congress gave the Secretary power to regulate "the use of compensation" to create incentives for agents and brokers to enroll individuals in the plans that best meet their health care needs. 42 U.S.C. § 1395w-21(j)(2)(D). CMS thus has authority to regulate the purposes for which agents and brokers are compensated and the form compensation takes, but it has no statutory authority to set the dollar amount of compensation permitted—a power that Congress grants sparingly and that agencies like CMS are particularly ill-equipped to wield. As CMS has recognized all along, moreover, administrative payments are *not* compensation, and CMS thus lacks statutory authority to regulate them. And at a minimum, CMS lacks authority to regulate administrative payments to firms, as opposed to individuals, under the ordinary meaning of "compensation."

  Council members have so far not objected to CMS's existing compensation caps because they were limited to payments for enrollment and were tied to the "[f]air market value" of each enrollment. 42 C.F.R. § 422.2274(a). But a decision by CMS to expand those caps to include payments for administrative services without permitting firms to recover the fair-market value of those services would prompt legal challenges to the Proposed Rule that would implicate the authority already asserted by CMS in its current regulations.

- **Section II.C:** Even if CMS is inclined to defend the expansive new authority it asserts in the Proposed Rule, it should not—and cannot—do so without further study and an opportunity for commenters to meaningfully address the rule's evidentiary basis. CMS rushed out its proposal without any meaningful effort to study the payment practices it seeks to regulate, understand the purported problem it claims to be addressing, or identify potential solutions based on objective data. It has made only the most cursory effort, if that, to study how administrative payments are structured, whether those services are necessary, or whether any firm could afford to provide them without compensation at market rates. Moreover, the Proposal is built on an impermissibly concealed and deficient factual record. CMS repeatedly refers to evidence that it has not made available to the public. At other

times, CMS asserts factual propositions without citing anything in support. And CMS solicits data from commenters that CMS presumably intends to use to finalize the rule, without giving stakeholders the opportunity to review and comment on such data. For each of these reasons, the Council and other commenters have yet to receive a genuine, adequate opportunity to subject the Proposed Rule's assumption to public scrutiny. CMS should therefore withdraw the Proposed Rule's compensation provisions because of these grave procedural deficiencies. Alternatively, CMS should suspend this rulemaking, collect the information it needs, make available the evidence it relies on, and—if justified—re-propose a revised rule with a fresh comment period. At a minimum, CMS should extend the comment period to no sooner than 90 days after the date on which all necessary information is disclosed, including information sent to the agency in response to this proposal.

- **Section II.D:** CMS's asserted justifications for eliminating administrative payments do not withstand scrutiny for at least three reasons. *First*, CMS's proposal is a solution in search of a problem. Accounting for inflation, administrative payments are *not* steeply increasing, and any increase would be justified because CMS has mandated additional services and its regulations have made other services more labor-intensive or technology-dependent over time. Moreover, administrative payments are not a means of circumventing limits on compensation for enrollments. Instead, administrative payments reflect fair-market value for vital and legitimate services provided by FMOs, telesales companies, and other firms supporting individual agents and brokers. Nor do administrative payments to firms influence agents and brokers (who do not receive those payments) or Council members (who sell plans in droves from carriers that offer lower administrative payments), as demonstrated by studies showing that beneficiaries are not bothered when agents or brokers have purported financial incentives to enroll them in an MA plan. In fact, Council members and similar firms benefit financially when beneficiaries stay with a plan for years, so they have every reason to ensure that individuals are enrolled in the right plan from the start. Some carriers also spread out administrative payments over several years or make additional administrative payments for persistent enrollment to ensure that third-party firms help beneficiaries find the right plans from the start. CMS's concerns about questionable financial incentives thus rest on unsupported and incorrect premises. *Second*, CMS's assertion that its Proposed Rule is necessary to promote industry competition is not a statutorily authorized consideration, nor will the Proposed Rule promote competition. In fact, if applied broadly, it will eliminate broad swaths of the industry. In any event, artificial price caps are the antithesis of healthy marketplace competition. *Third*, CMS's proposed $31 per-initial-enrollment increase to its payment limits does not come close to fully reimbursing Council members for the full suite of administrative services they provide to both

new and renewing enrollees. CMS should abandon its Proposal, which has no basis in reality and will, contrary to Congress's and CMS's stated goals, result in worse outcomes for beneficiaries and less competition.

- **Section II.E:** Especially if applied broadly, the Proposed Rule will have disastrous consequences, including for beneficiaries. If Council members and other similar firms are prohibited from recovering the fair-market value for the administrative services that they provide, many will lose so much revenue that long-term profitability will be out of reach, forcing them to exit the market entirely. Those that survive will severely curtail the services they provide, contract with fewer carriers, and carry fewer plans. And carriers, in turn, will fill these gaps by selling their plans—and only their plans—through their own employees and captive independent agents in the market. All of this is bad for beneficiaries—including low-income and disabled beneficiaries who most need help from Council members, agents, and brokers to select a suitable plan. They will have fewer plan options, not more. They will have fewer resources to help them choose the right plan, not more. And they will have fewer opportunities to enroll at all, not more. The Proposed Rule, in short, would upend an industry and undercut Congress's goal of encouraging incentives to get individuals enrolled in the plans that best meet their health care needs.

- **Section II.F:** CMS's approach is made more puzzling because CMS could have addressed its concerns—if such concerns were validated after collecting more information about administrative payments—by investigating administrative payments and, if proven to be necessary, enforcing existing regulations or by regulating the *use* of compensation, as Congress authorized. For example, CMS could enforce existing requirements aimed at preventing consumer confusion and keeping administrative payments at fair-market value. CMS also could have targeted specific practices that CMS believes are genuine end-runs around CMS's existing regulations, such as organizations improperly classifying certain bonuses as administrative payments—if CMS determined that such practices actually were occurring after collecting more information. If CMS nevertheless insists on regulating administrative payments and has the regulatory authority to do so, then it must ensure that *all* administrative services are reflected in the value of the rule's compensation cap. But CMS either failed to explain its rationale for rejecting these alternatives or did not consider them at all.

CMS should not, and cannot, proceed with the Proposed Rule.

A. The Proposed Rule is unduly ambiguous in multiple respects.

The Proposal contains several ambiguities regarding: (1) its application to carriers' administrative payments to firms, as opposed to individual agents and brokers; (2) its effect on renewal-based payments for enrollments that precede 2025; and (3) its application to third-party firms' payments to individual agents and brokers. The Proposal's lack of clarity makes it difficult for the Council to fully and accurately assess and comment on the Proposal. It also counsels against adopting the Proposal at all. At a minimum, CMS must clarify the following issues before proceeding.

1. As an initial matter, it is unclear whether the Proposed Rule's limitations on administrative payments would apply to the Council's members and other FMOs, telesales companies, and similar third-party firms—or whether it is instead limited to regulating administrative payments to individual agents and brokers. Council members believe that the Proposed Rule is best read as *not* applying to administrative payments to firms (even if those firms are licensed as agents or brokers), and *only* applying to payments to individuals. But the Proposal's opacity generates untenable uncertainty for Council members moving forward. To the extent CMS proceeds with its Proposal, CMS should clarify its intent and confirm that the Proposal does not apply to FMOs, telesales companies, and similar firms, regardless of whether those entities are licensed as agents or brokers. If CMS meant otherwise, then CMS would need to engage with the many legal and policy problems that would result from applying the Proposal to firms and that the Council identifies throughout this comment letter.

Under the Proposed Rule, administrative payments will be "included in the calculation of enrollment-based compensation" starting in 2025. 88 Fed. Reg. at 78,624/2 (proposed 42 C.F.R. § 422.2274(e)(2)). But under another provision of the regulation that CMS does not propose to change, the "compensation requirements only apply to independent agents and brokers"—not firms. 42 C.F.R. § 422.2274(d). That regulation further provides that MA organizations may "only pay agents or brokers who meet the requirements in paragraph (b) of this section," and paragraph (b) enumerates licensing and testing requirements that only individuals can meet. *Id.* § 422.2274(b)(1)-(3), (d)(1)(i). Likewise, the Proposal treats "agents and brokers" as distinct from third-party entities. The Proposal's limitations on contract terms, for example, expressly applies to contracts "with an agent, broker, *or other* [*third-party marketing organization*]." 88 Fed. Reg. at 78,624 (proposing 42 C.F.R. § 422.2274(c)(5)) (emphasis added). As Council members read the Proposed Rule, therefore, CMS would subject administrative payments to the compensation caps *only* when carriers make those payments directly to the individuals on the ground selling plans. Conversely, carriers could continue to make administrative payments to FMOs, telesales companies, and other third-party entities for their services without those payments counting toward compensation limits.

That distinct treatment of individuals and firms makes sense. FMOs, telesales companies, and other firms do not interact directly with beneficiaries or make plan

recommendations. They instead typically provide carrier-agnostic support for the agents and brokers who interact with the beneficiaries and make those recommendations. When plans pay these firms, therefore, those payments do not create the kinds of adverse incentives that CMS has identified as concerning because such administrative payments do *not* go to individual agents and brokers.

The Council's reading is also in accord with CMS's preamble. CMS states that its "proposals . . . are focused on payments and compensation made to agents and brokers." 88 Fed. Reg. at 78,553/1. CMS separately states that it "is *also* concerned about" payments from MA plans to third-party marketing organizations, including FMOs, and requests comments about how it can "*further* ensure that payments made by MA plans to FMOs do not undercut" the Proposal. *Id.* at 78,553/1-2 (emphases added). These statements indicate that CMS excluded administrative payments to FMOs and other third parties from the Proposal's compensation caps, even if CMS might decide to study such payments for purposes of a separate rulemaking.

But CMS has left room for lingering uncertainty. CMS would subject "administrative payments" to the enrollment-based compensation cap, without specifying whether CMS meant administrative payments *to anyone* or only administrative payments *to individual agents and brokers*. 88 Fed. Reg. at 78,624/2 (proposed 42 C.F.R. § 422.2274(e)(2)). CMS also does not define "agent" or "broker," even though a definition would make clear it is not (improperly) using those terms in a way that might be construed broadly enough to encompass FMOs, telesales companies, and other third-party entities.[5]

That lack of clarity is untenable. Some carriers might continue to make administrative payments to Council members, but other carriers might stop making administrative payments either because they (incorrectly) interpret the Proposed Rule or out of an abundance of caution. Council members, in turn, would exit the business or, for those that survive, have to choose between continuing to offer administrative services to carriers that do not pay for them or discontinuing those services. So some Council members would have to close up shop, while others would operate some services at a loss. Either way, the result would be harmful to beneficiaries, who would lose out on various valuable administrative services.

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[5] By contrast, when CMS promulgated its initial compensation rule, it defined "independent brokers or agents" to encompass only individuals: "By 'independent brokers or agents' we mean contracted brokers or agents, whether they sell for one plan, multiple plans, or work through a Field Marketing Organization (FMO), general agent (GA), or other similar subcontracted marketing organizations." *Medicare Program Revisions*, 73 Fed. Reg. 54,226, 54,238/1 (Sept. 18, 2008). But CMS did not define this specific term in the Proposal. Nor has CMS otherwise defined "agent" or "broker" in current regulations or the Proposal. *See* 42 C.F.R. § 422.2.

Council members' experience with other recent rulemakings highlights the dangers of an ambiguous rule. For example, when CMS issued a rule requiring a 48-hour cooling off period in between appointment scoping calls and agent meetings with beneficiaries, *see Medicare Program; Contract Year 2024 Policy and Technical Changes*, 88 Fed. Reg. 22,120, 22,122/3 (Apr. 12, 2023), carriers interpreted CMS's (misguided) requirements in different ways, subjecting Council members to uneven and varying carrier-imposed preferences for a rule that CMS never justified in the first place. The Proposal's opacity invites similar problems by opening the door to carriers interpreting the compensation provisions in different ways.

To be clear, the Council believes that CMS has proposed—and intended to propose—a rule in which carriers' ability to make administrative payments to FMOs, telesales companies, and other third-party entities (whether licensed or unlicensed) is unaffected. But CMS cannot adopt a rule that leaves its requirements uncertain. If CMS proceeds with its rulemaking, the Council requests that CMS make its intent clearer. To the extent CMS intended or now decides to subject all administrative payments to compensation requirements, however, the Proposal would exacerbate the host of additional legal and policy problems that will be discussed in Sections II.B through II.F.

2. Another point of uncertainty is how the Proposal would apply in 2025 or later to renewal-based administrative payments tied to enrollments that precede Section 422.2274(e)(2)'s effective date. The Proposed Rule states that "[b]eginning in 2025," administrative payments are included in the calculation of enrollment-based compensation. 88 Fed. Reg. at 78,624/2 (proposed 42 C.F.R. § 422.2274(e)(2)). But it is unclear whether that provision would subject to the cap administrative payments that carriers agreed *before* 2025 to pay but are *in fact paid* in 2025 or later, such as renewal-based payments for plans in which beneficiaries initially enrolled before Section 422.2274(e)(2)'s effective date and renewed after Section 422.2274(e)(2)'s effective date. It is also unclear whether that provision would apply to plans executed in *calendar year* 2024 for *plan year* 2025, or only to plans executed in calendar year 2025 for plan year 2025 or later.

Council members believe that CMS has proposed to apply its new rule only prospectively—i.e., to administrative payments that carriers agree after plan year 2025 to pay. Otherwise, CMS would create constitutional concerns. Carriers already have agreed, and will continue to agree, to make renewal-based payments in 2025 or later for enrollments that precede Section 422.2274(e)(2)'s effective date. And those payments would be for services that either have already been rendered or were already contractually required to be rendered. Carriers and firms therefore have and will have accounted for those payments in their business plans. CMS would violate due process guarantees if it were to deprive firms after-the-fact of administrative payments that carriers agreed to pay at a "time when [CMS] said it was lawful" to do so. *Mexichem Fluor, Inc. v. EPA*, 866 F.3d 451, 462 (D.C. Cir. 2017) (citing *Christopher v. SmithKline Beecham Corp.*, 567 U.S. 142, 156 (2012)).

Should CMS proceed with the Proposed Rule, therefore, it should clarify the Proposal to make clear that it does not impact administrative payments tied to renewals of plans in which beneficiaries enrolled prior to plan year 2025. If CMS were instead to clarify that it meant to impact such administrative payments, then it would have to grapple with the due process concerns described above and other legal and policy problems described in the remainder of this comment.

3. Finally, CMS should make clear that the Proposal would not require third-party firms, as opposed to carriers, to make standardized compensation payments to individual agents and brokers.

Under current regulations, MA organizations may pay individual agents and brokers compensation "at or below" the fair-market value amount calculated by CMS. 42 C.F.R. § 422.2274(d)(2). Third-party firms can also pay individual agents or brokers that they employ or contract with, and some firms pay amounts *below* the compensation cap. But the Proposed Rule would remove the "at or below" language, and instead provide that MA organizations "may pay compensation *at*" fair-market value. 88 Fed. Reg. at 78,624/2 (emphasis added) (proposed 42 C.F.R. § 422.2274(d)(2)).

As Council members read the Proposed Rule, the mandatory and uniform payment amount would apply only to *carriers*' payments to individual agents and brokers—not to *third-party firms*' payments to individual agents and brokers. Section 422.2274(d)(2) applies only to "MA organizations," which are defined elsewhere to mean public or private risk-bearing entities that are certified by CMS as meeting MA contract requirements. 42 C.F.R. § 422.2. CMS also described its Proposal as setting a "single" compensation rate "for all *plans*." 88 Fed. Reg. at 78,554/2-3 (emphasis added). But other statements create confusion. For example, CMS suggests that its Proposal would result in agents and brokers being paid the "same amount either from the MA plan directly or by an FMO." *Id.* at 78,555/1.

The Council requests that CMS make clear that the uniform payment requirement does not apply to third-party firms such as FMOs, telesales companies, and other similar entities. But if CMS intended otherwise, the Council urges CMS to reconsider. Forcing Council members to pay the exact same amount to every agent or broker that they employ or contract with—in some cases, at an hourly rate—regardless of the individual's performance or contributions, removes their flexibility to adjust compensation depending on what their business models and market forces support. And compelling firms to pay to their own employees or independent contractors a government-prescribed amount that cannot fluctuate by a single dollar would be the antithesis of competition. *See infra*, at 39. Given these disastrous consequences, CMS should confirm that the Council is correct in reading the Proposal as requiring only carriers, not third-party firms, to make standardized payments to individual agents and brokers. If CMS disagrees with the Council's reading, then CMS must

explain its reasons for taking a contrary approach despite the problems articulated above and elsewhere in this comment.

B. The Proposed Rule's compensation provisions exceed and are inconsistent with CMS's statutory authority.

CMS's proposal to subject administrative payments to price caps would represent an indefensible expansion of its authority under Section 1851(j)(2)(D) of the Social Security Act. Section 1851(j)(2)(D) provides:

> The Secretary shall establish limitations with respect to at least the following: … The use of compensation other than as provided under guidelines established by the Secretary. Such guidelines shall ensure that the use of compensation creates incentives for agents and brokers to enroll individuals in the Medicare Advantage plan that is intended to best meet their health care needs.

42 U.S.C. § 1395w-21(j)(2)(D). As its plain text reflects, that provision grants the Secretary a limited authority to regulate the "use" of "compensation." A grant of authority to regulate the "use" of compensation, however, is not a grant of authority to regulate the *amount* of compensation provided. As CMS has long recognized, moreover, reimbursement for administrative services rendered is not "compensation," 42 C.F.R. § 422.2274(e), so CMS has no authority to regulate it. And the term "compensation" ordinarily refers only to payments to individuals, so CMS cannot use its authority over "compensation" to regulate carriers' arm's-length payments to firms.

1. CMS has no authority to impose caps on the amounts of compensation paid to firms, agents, or brokers.

CMS has statutory authority to regulate how compensation is "use[d]"—not to regulate the *amount* of compensation provided. 42 U.S.C. § 1395w-21(j)(2)(D). CMS's first regulation on this issue got it right. *See Medicare Program Revisions*, 73 Fed. Reg. 54,226 (Sept. 18, 2008). There, CMS established "guidelines specifying how compensation is disbursed, whether an agent receives a new or renewal compensation, and what qualifies as compensation." *Id.* at 54,239/1; *see also id.* at 54,238/2 (describing CMS's approach to "compensation structure"). Yet CMS initially *declined* to set "specific dollar values" on the *rate* of compensation. *Id.* at 54,239/1. In other words, CMS regulated the "use of" compensation by dictating *how* it was deployed, without dictating how *much* plans could compensate for services.

Just months later, CMS went astray by setting price caps (at "fair market value") for compensation tied to enrollments. *Medicare Program; Compensation Plans*, 73 Fed. Reg. 67,406 (Nov. 14, 2008). CMS recognized that capping compensation at a specific rate was a "significant change in approach." *Id.* at 67,408/2, 67,409/1-2. Yet CMS never explained at

the time—nor has it ever explained since—how regulating the *rate* of compensation is consistent with Congress's statutory directive to regulate the "use" of compensation. *See*, *e.g.*, *Medicare Program*, 76 Fed. Reg. 54,600, 54,622/2 (Sept. 1, 2012); *Medicare Program; Contract Year 2015 Changes*, 79 Fed. Reg. 29,844, 29,862/3 (May 23, 2014).

Council members have not objected to these regulations because of their comparatively limited nature. CMS's price caps were limited to enrollment services, rather than reimbursement for administrative services or marketing expenses, so CMS's rules at least permitted agents, brokers, and the firms they worked with to recover market rates for their services. But CMS's new proposal would cast off those constraints by subjecting nearly everything—including legitimate "compensation" *and* administrative payments—to hard caps, making it effectively impossible to recoup those expenses. None of that is authorized by the statute, because none of that regulates the "use" of compensation.

Congress's deliberately qualified wording about the *use* of compensation stands in contrast to Congress's general practice of conferring regulatory authority to set rates of compensation only in clear and explicit text. "Rate regulation," after all, is a controversial and "complex process." *S. Union Co. v. Mo. Pub. Serv. Comm'n*, 289 F.3d 503, 507 (8th Cir. 2002); *cf. DoorDash, Inc. v. City of New York*, 2023 WL 6118229, at *12-23 (S.D.N.Y. Sept. 19, 2023) (holding that a "price-setting regulation" that "capped" commission rates one company charged another was plausibly unconstitutional). Congress accordingly does not lightly—or cryptically—confer that power.

Instead, when Congress intends to confer ratemaking authority, it does so expressly. For instance, Congress expressly directed that the Consumer Financial Protection Bureau may regulate "[t]he *amount* of any penalty fee or charge that a [credit] card issuer may impose," and then expressly designated four factors that the agency must consider in determining that amount. 15 U.S.C. § 1665d(a), (c) (emphasis added). Similarly, Congress empowered the Federal Energy Regulatory Commission to regulate prices for natural-gas storage "at market-based rates," and then directed the agency to consider multiple factors such as whether the rates are "just," "reasonable," "not unduly discriminatory," and not "preferential." *Id.* §§ 717c(a), 717c(f)(3).

So, too, in other portions of the Social Security Act itself. In the section of the Act immediately following the compensation provision at issue here, Congress empowered the Secretary to "establish separate *rates* of payment to … Medicare+Choice organization[s]" regarding individuals with end-stage renal disease. 42 U.S.C. § 1395w-23(a)(1)(H) (emphasis added). Elsewhere in the Act, Congress directed the Secretary to "determine … a per capita *rate* of payment" to certain plans that enroll individuals in risk-sharing contracts. *Id.* § 1395mm(a)(1)(A) (emphasis added). Even more striking is the Act's treatment of payments to physicians. *See id.* § 1395w-4. Congress expressly mandated caps on physician compensation at the lesser of "the actual charge for the service" or the price determined under

a "fee schedule" that CMS is authorized to promulgate. *Id.* § 1395w-4(a)(1)(A)-(B). The statute then sets forth sprawling instructions for how to establish fee schedules "for all physicians' services" in covered areas. *Id.* § 1395w-4(b).

By contrast, Section 1395w-21(j)(2)(D) makes no mention of ratemaking and omits anything resembling the detailed list of factors that Congress typically includes when authorizing agencies to set prices—including in other provisions of the Social Security Act. All of those express conferrals of rate-regulation power demonstrate that Congress's distinct choice here stopped short of empowering the Secretary to regulate the rate of compensation through caps. Where Congress includes such express authority in one portion of a statute but omits it in another, Congress presumptively "intended a difference in meaning." *Digit. Realty Tr., Inc. v. Somers*, 583 U.S. 149, 161 (2018); *see also Idaho Conservation League v. Bonneville Power Admin.*, 83 F.4th 1182, 1192 (9th Cir. 2023) (express provision of ratemaking authority in one portion of a statute counseled against reading another portion of the statute to silently encompass it). CMS cannot claim authority to set rates for MA firms based on briefly worded power to regulate the "use of compensation" when, for example, Congress elsewhere gave CMS an express and intricate roadmap to set rates for physicians.

CMS's approach is not only an unnatural reading of the statute, but it leaves the critical statutory term "use" superfluous with no independent work to perform, contrary to the "presumption" against "superfluous" statutory terms. *McDonnell v. United States*, 579 U.S. 550, 569 (2016). If Congress had meant to empower CMS to regulate *any* aspect of compensation, it easily could have said that the "Secretary shall establish limitations *on* compensation" or "shall limit compensation" or even "set rates of compensation," rather than framing a limitation on the *use* of compensation.

Moreover, the power to price-fix payments here is a "major" decision for which CMS lacks "clear congressional authorization." *West Virginia v. EPA*, 142 S. Ct. 2587, 2614 (2022) (quotation marks omitted). CMS has claimed "expansive" power to set rates for all kinds of services in an "industry constituting a significant portion of the American economy." *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 159–62 (2000); *see supra*, at 5 (noting that Medicare Advantage has 30 million enrollees). To pull off that move, CMS would need more than "merely plausible" or "colorable" textual arguments. *West Virginia*, 142 S. Ct. at 2609. The authority to regulate the use of compensation is too thin a reed to support CMS's broad Proposed Rule. *See id.*; *Biden v. Nebraska*, 143 S. Ct. 2355, 2373 (2023); *NFIB v. Dep't of Labor*, 595 U.S. 109, 117, 119 (2022) (per curiam). To conclude otherwise would risk opening many other industries to government price-fixing based on thin authority—a step that courts would rightly hesitate to endorse.

Finally, the Proposed Rule opens the door to constitutional non-delegation problems that are better avoided. Interpreting Section 1395w-21(j)(2)(D) as authorizing CMS to regulate the purposes for which agents and brokers are compensated is an appropriately "narrow

constructio[n]" of a statute that "might otherwise be thought to be unconstitutional," and should be favored. *Mistretta v. United States*, 488 U.S. 361, 373 n.7 (1989). But if Section 1395w-21(j)(2)(D) were to grant CMS broad freedom to regulate payments in this industry as it sees fit, it would violate the non-delegation doctrine. *See* U.S. Const. art. I, § 1. On that reading, Congress neither set forth "an intelligible principle to which the [agency] is directed to conform," *Whitman v. Am. Trucking Ass'ns*, 531 U.S. 457, 472 (2001) (quotation marks omitted), nor "ma[de] the policy decisions" while leaving CMS "with only details to fill up," *Gundy v. United States*, 139 S. Ct. 2116, 2136, 2143 (2019) (Gorsuch, J., dissenting).

CMS's proposal to extend its cap to administrative payments and reimbursements thus takes a bad idea and makes it worse. If CMS forges ahead with the Proposed Rule, the Council will have no choice but to challenge CMS's authority to set *any* price caps.[6]

2. Administrative payments and reimbursements are not "compensation."

CMS's Proposed Rule also exceeds CMS's authority under Section 1395w-21(j)(2)(D) because it purports for the first time to treat reimbursements for "mileage," "actual costs," state-certification costs, and administrative payments (like overhead and training costs) as "compensation." 88 Fed. Reg. at 78,624/1. That approach is an about-face from CMS's own longstanding understanding of that term and is at odds with the ordinary meaning of "compensation."

When CMS first promulgated Section 422.2274 and determined "what qualifies as compensation," it agreed that reimbursements and fees simply "are … not considered compensation." *Medicare Program Revisions*, 73 Fed. Reg. at 54,239/1. And when CMS added the operative provision about administrative payments, it agreed that an administrative payment (for a health-risk assessment, as an example) is a payment "*other than compensation* because the payment is not for the sale or renewal of a policy." 86 Fed. Reg. at 5,993/3-94/1 (emphasis added). Tellingly, administrative payments were not even excluded from CMS's preexisting definition of compensation. *See* 42 C.F.R. § 422.2274(a)(i). Rather, administrative payments were treated as an entirely separate kind of payment placed into an entirely separate subsection. *Id.* § 422.2274(e). Both rules rested on the understanding that "compensation" is not a limitless concept that encompasses every payment from a plan to an

[6] CMS also has never justified its decision to limit administrative payments—which are not compensation, *see infra*, at 19-20—to "the value of those services in the marketplace." 42 C.F.R. § 422.2274(e)(1), (2). When CMS promulgated that subsection, it did not point to a source of statutory authority. *See Medicare Programs; Contract Year 2022 Changes*, 86 Fed. Reg. 5,864, 5,993/3-94/1 (Jan. 19, 2021). Accordingly, CMS's ability to impose upper limits on administrative payments would also be called into question if it insists on imposing price-specific caps on compensation.

agent, broker, or firm. Now, in a blink, CMS would "includ[e] in the definition of compensation" administrative payments, reimbursements, and fees. 88 Fed. Reg. at 78,555/2.

CMS had it right the first time. Its long-held view accords with the statute's ordinary meaning. Everyday speakers would not understand the term "compensation" in an employment-related context to encompass reimbursements or administrative payments. "Compensation" instead typically refers to a payment for services, not a reimbursement for costs incurred in rendering that service (such as "actual costs" the broker incurs, state certification fees, or overhead). For instance, an attorney's "compensation" (*i.e.*, salary for performing legal services) is distinct from a reimbursement the attorney may receive from her firm for the cost of purchasing a legal treatise.

Consistent with everyday usage, Congress has historically distinguished between "compensation" and "reimbursement," rather than considering them interchangeable terms. *See, e.g.*, *In re Reynolds Investing Co.*, 130 F.2d 60, 61 n.1 (3d Cir. 1942) (statute expressly encompassed "compensation for services rendered *or* reimbursement for costs and expenses incurred" (quoting 11 U.S.C. § 649) (emphasis added)). Similarly, the Fair Labor Standards Act provides that "reimburs[ements]" are "not" compensation, and therefore are not included in the calculation of an employee's "regular rate" for purposes of overtime payments. 29 U.S.C. § 207(e)(2); *see also* 29 C.F.R. § 778.217(a) (reimbursement for reasonable expenses "is not compensation for services rendered"). Given this traditional distinction between compensation and reimbursements, it would be incongruous for Congress's Medicare statute to sweep in administrative payments and reimbursements as "compensation."

CMS's new reading of "compensation" would also pull the rug out from under an industry that has relied on CMS's correct, longstanding interpretation. The reliance interests threatened by CMS's proposal cannot be understated: An entire industry has developed around the understanding of "compensation" that CMS has adhered to for fifteen years. Companies with thousands of employees—Council members included—have designed their business models on the assumption that expenses and administrative payments are not "compensation" subject to restrictive caps, but instead are other payments that can be recouped at market rates. Those businesses structured their contracts with carriers on that assumption, secured loans on it, and even based their initial public offerings on it. Their business model is predicated on the understanding that CMS cannot simply regulate them out of existence by lopping off a significant portion of their revenue based on a newfound statutory interpretation. Those "serious reliance interests … must be taken into account" by an agency in evaluating whether to change positions. *Encino Motorcars, LLC v. Navarro*, 579 U.S. 211, 222 (2016) (quotation marks omitted). And they strongly counsel against modifying CMS's approach in the expansive manner set forth in the Proposal.

3. "Compensation" does not encompass payments to firms.

Even if administrative payments to individual agents and brokers may qualify as "compensation" in certain circumstances, administrative payments to Council members and other third-party firms do not. Any attempt to extend the compensation caps to FMOs, telesales companies, and other firms would be unauthorized and unnecessary.

First, the ordinary meaning of "compensation" does not extend to payments from MA organizations to third-party firms such as FMOs at all. No one would naturally think that a business earns "compensation," rather than yearly "revenue" or "profits." That is because "compensation" in an employment-related context is typically understood to include payments *to individuals* akin to a salary and bonuses (and, perhaps, other payments). "Compensation" means "payment for services," especially "wages or remuneration." Webster's New World College Dictionary 289 (2d ed. 1970). Individuals, not firms, are paid wages. And remuneration, in turn, means payments to "a person," not payments from one company to another company for discrete services. *Id.* at 1202; *cf. Lazarus v. Chevron U.S.A., Inc.*, 958 F.2d 1297, 1302 (5th Cir. 1992) (attorneys' fees "not payable to the employee . . . cannot constitute compensation within the plain meaning" of that term).

The statute tracks that basic distinction. Congress provided that guidelines about "the use of compensation" should "creat[e] incentives *for agents and brokers*" to enroll beneficiaries in appropriate plans. 42 U.S.C. § 1395w-21(j)(2)(D) (emphasis added). If "compensation" were intended to sweep in not only payments to individuals but also payments to firms, Congress would not have used the limited language that it chose. CMS would overstep its legislative mandate if it were to regulate administrative payments made to firms, as opposed to individuals.

Second, administrative payments to Council members and other firms do not raise the same policy concerns as payments to individuals. Council members and other firms are not advising individual beneficiaries which plans to enroll in. Nor are Council members telling individual agents and brokers which plans to sell. Instead, Council members typically provide carrier-agnostic support services to agents and brokers, such as making and receiving calls, developing technology, and providing training. *See supra*, at 8. Accordingly, when carriers make administrative payments to Council members for their services, those payments do not affect which plans beneficiaries select: the payments do not flow down to the individual agents and brokers selling plans to beneficiaries, and Council members who have already received payment for services rendered have no financial motivation to influence the decisions of those individual agents and brokers. *See infra*, at 35-36.

CMS suggests only once, and without support, that payments to firms might create incentives to enroll individuals in particular plans. CMS vaguely asserts its "belie[f]" that when plans pay FMOs for generating leads and then give leads to the FMO's agents, those contractual terms between carriers and FMOs "can trickle down to influence agents and

brokers" that receive the leads. 88 Fed. Reg. at 78,554/2. But CMS fails to support that belief with anything more than conjecture. *See id.*; *infra*, at 36-37. In any event, CMS's concern with one particular business model does not suggest that CMS should be concerned about administrative payments to *all* third-party firms—particularly firms that *solely* provide administrative services wholly divorced from the merits of underlying plans, such as tech-support or call-center services. CMS should not press an aggressive and dubious reading of the statute in the absence of a clear policy justification.

C. CMS should not move forward without careful study and a sufficient opportunity for public review of the Proposal's evidentiary basis.

Even if CMS is inclined to defend the expansive new authority it asserts in the Proposal, it should not, and lawfully cannot, exercise that authority without further study and without giving the public a meaningful chance to review and comment on the evidence and data that CMS relies upon. To ensure public participation and reasoned agency responses to public comment, the Administrative Procedure Act ("APA") requires that agencies follow a "logical and rational" rulemaking process, *Michigan v. EPA*, 576 U.S. 743, 750 (2015) (quotation marks omitted), that gives "interested persons an opportunity to participate," 5 U.S.C. § 553(b), (c).

Instead of the rational process envisioned by the APA, CMS's rulemaking bears the unfortunate hallmarks of a rush to implement a predetermined result. CMS published this highly significant proposal on November 15, during the annual open enrollment period, which is one of the busiest times of the year for industry members. The comment period spanned three federal holidays and closed less than a week after New Year's Day, which further restricted the Council's ability to assess the rulemaking. Yet CMS declined to extend the comment period by a reasonable period that would give stakeholders the necessary time to provide meaningful input.

CMS's rushed rulemaking timeline falls short of the APA's requirements in multiple, independent ways. To start, it provides no opportunity for CMS to study and understand the purported problem it claims to be addressing and to identify potential solutions based on objective data. Instead, CMS has put forward a half-baked proposal supported by evidence ranging from nothing to rumor to unreliable data—nearly all of which CMS hid from public view. The Proposal bases key assumptions about the industry on vaguely referenced complaints and studies, yet fails to disclose or identify those sources in any meaningful way that would allow commenters to understand what evidence CMS relies upon. For other key assumptions, the Proposal simply fails to cite *any* evidence or data—disclosed or undisclosed—for support. And the smattering of identifiable evidence that CMS does cite is unreliable and overstated. Finally, CMS improperly attempts to backfill these evidentiary gaps by sourcing information from commenters in the first instance that other commenters will have no chance to review or discuss.

Any one of these problems is reason enough for CMS to rethink its haphazard approach to this rulemaking. Collectively, they compel a change of course. CMS thus should suspend the current rulemaking, complete the data collection necessary for a reasoned rulemaking, make that information available for public comment and only then determine whether to proceed with a new notice of proposed rulemaking and a fresh comment period that would permit commenters to weigh in meaningfully on the Proposal's factual underpinnings. At a minimum, CMS should extend the comment period to no sooner than 90 days after the date on which all necessary information is disclosed, including information sent to the agency in response to this proposal.

1. CMS's current notice period does not provide adequate opportunity for CMS to study the perceived problem.

The first predicable consequence of CMS's rushed rulemaking process is that CMS does not seem to understand the industry its Proposed Rule targets. CMS's premise is that a problem needs fixing because (1) there has been a "steep increase" in administrative payments; (2) "some" plans "may" have used those payments "to circumvent the regulatory limits on enrollment compensation"; (3) that supposed practice creates "questionable financial incentives" for agents and brokers; and (4) those incentives "could" or "may" result in agents and brokers steering individuals toward plans that do not best meet those individuals' needs. 88 Fed. Reg. at 78,552/2-3, 78,553/2, 78,555/3. But practices plans "may" have used, and "questionable" incentives that "could" create adverse outcomes, *id.* are not an adequate basis to regulate. Before CMS restructures this industry, it must take the time to examine the practices and incentives it seeks to curtail and determine whether they actually exist and actually result in the harmful outcomes about which CMS speculates.[7]

Instead, CMS has made no apparent effort to study how administrative payments are structured for most industry participants, why payments are structured that way, whether the corresponding services are necessary, how much they cost to provide, or whether anyone could afford to provide them (or could do without them) if they were not reimbursed at market rates or at all. Of the myriad administrative services that agents and brokers provide to plans, for example, CMS identifies only three—certain training and testing services, as well as recording—whose cost it considers sufficiently "predictable" to quantify and thus to warrant an increase in CMS's cap on compensation. 88 Fed. Reg. at 78,596/2. But when an agency elects to place a cap on payments for an entire broad category of services, it does not have the luxury of considering only those costs it finds "predictable" (much less to do so without providing the affected industry participants adequate notice and opportunity to participate in

[7] CMS also should study the effects of its many recently issued changes on industry stakeholders before deciding whether yet another regulatory requirement is necessary. *E.g.*, CMS, *Value-Based Insurance Design Model Calendar Year 2024* (2023) (issuing guidelines for various communications and marketing materials), http://tinyurl.com/bdp5ddu8.

the rulemaking). To the extent that, after proper rulemaking, costs for various services remain "[un]predictable," that is a powerful reason to impose no cap at all, and certainly does not justify *making no account* for costs the government knows exists but feels unqualified to "predict." This assertion is therefore a tacit admission that CMS lacks sufficient data to quantify the cost of other administrative services, and thus lacks any basis to determine whether agents and brokers are receiving fair payment for those services.

CMS openly concedes, moreover, that it "lack[s] the data" to quantify the Proposed Rule's "economic effects" on plans, firms, agents, brokers, and beneficiaries. *Id.* at 78,610/3-11/1. Given the Proposed Rule's potentially catastrophic consequences for MA and Medicare Part D plan enrollment levels and the ability for beneficiaries to make informed choices about enrollment, *see infra* at 45-48, CMS should obtain that data before it decides whether and how to regulate in this area. Indeed, it is folly—and plainly arbitrary and capricious—for an agency to engage in price regulation while admitting ignorance about the costs its chosen price covers, and about the economic impact the price will have. What is price-setting about, if not determining the underlying costs and the impacts the price will have?

These problems were all avoidable. CMS had the option of requesting relevant information from stakeholders *before* proposing a rule that would effect an industry-wide sea change—an approach that CMS has previously followed. *See, e.g.*, *Request for Information; Episode-Based Payment Model*, 88 Fed. Reg. 45,872 (July 18, 2023); CMS, *Request for Information: Transforming Clinical Practices* (2014), tinyurl.com/fysheab3. CMS further asserts that it has "authority to collect detailed information from MA" carriers. 88 Fed. Reg. at 78,478/1. CMS should not forge ahead in the admitted absence of critical data without employing available information-gathering processes and then sharing such data publicly for stakeholder review and comment.

2. CMS improperly relies on undisclosed evidence and information.

As part of the APA's notice-and-comment requirements, all agencies have the "duty to identify and make available technical studies and data that [they] ha[ve] employed in reaching the decisions to propose particular rules." *Owner-Operator Indep. Drivers Ass'n v. FMCSA*, 494 F.3d 188, 199 (D.C. Cir. 2007) (quotation marks and citation omitted) (applying 5 U.S.C. § 553(b)(3), (c)). And where an agency omits some of the "critical factual material" and analyses from a proposed rule, it must disclose that material and provide further "opportunity to comment." *Chamber of Commerce v. SEC*, 443 F.3d 890, 900-01 (D.C. Cir. 2006). "An agency commits serious procedural error when it fails to reveal portions of the technical basis for a proposed rule in time to allow for meaningful commentary." *Owner-Operator Indep. Drivers Ass'n*, 494 F.3d at 199 (quotation marks and citation omitted).

Despite those principles, the Proposal repeatedly refers to complaints, reports, or studies that purportedly support CMS's key premises—yet fails to disclose the relevant source or make that information available for review. For example, the Proposal states that CMS has

"received complaints [about administrative payments] from a host of different organizations, including State partners, beneficiary advocacy organizations, and MA plans" about the levels of agent and broker compensation. 88 Fed. Reg. at 78,552/2. But CMS does not cite or otherwise disclose those complaints. Similarly, the Proposal states that CMS has "received reports that some larger FMOs are more likely to contract with national plans, negatively impacting competition." *Id.* at 78,553/2. CMS does not disclose those reports or even specify which reports it is invoking. Likewise, CMS claims that "according to recent market surveys and information gleaned from oversight activities, payments purportedly for training and testing and other administrative tasks for agents and brokers selling some MA plans seem to significantly outpace payments for similar activities made by other MA plans, ..." *Id.* at 78,555/3. Here again, CMS does not disclose those surveys or the "information" from oversight activities on which the Proposal relies.

CMS's reliance on non-public information violates the APA's requirement that agencies must publicly disclose the data and analysis on which their rulemaking is based. Without identifying what complaints, reports, surveys, and oversight information it is talking about, CMS leaves commenters unable to assess whether the purported evidence says what CMS claims it does, whether it is reliable, and whether it can justify CMS's proposal.

3. CMS fails to support numerous key assumptions with any evidence.

In addition to vaguely invoking undisclosed "studies," "complaints," and "information," the Proposal repeatedly posits numerous key assumptions without citing or even mentioning any relevant, supporting evidence. That is improper.

Agencies "must explain the assumptions and methodology" underlying a proposed rule. *Small Refiner Lead Phase-Down Task Force v. EPA*, 705 F.2d 506, 535 (D.C. Cir. 1983) (quotation marks omitted). An agency's failure to "provide [any] evidence supporting" a proposition is therefore a "dereliction of [its] fundamental procedural obligation" to consider "the potential negative consequences" of a rule. *Whitman-Walker Clinic, Inc. v. HHS*, 485 F. Supp. 3d 1, 45 (D.D.C. 2020).

Here, the Proposal's frequent omission of citations or supporting evidence frustrates the notice-and-comment process and violates those procedural safeguards. The Council (and other commenters) have no way of knowing whether CMS's assertions are backed by supporting evidence and, if they are, whether that evidence was soundly or arbitrarily chosen to support CMS's proposal. As a result, the public is stripped of the opportunity to discuss the data or information that CMS believes supports its decisionmaking.

Several parts of the Proposal exemplify these critical omissions. To provide a non-exhaustive list of examples:

- CMS asserts that it has "learned" that "additional payments [to agents and brokers] appear to be increasing." 88 Fed. Reg. at 78,477/3; *see also id.* at 78,552/2 ("CMS has observed that such payments have created an environment, not dissimilar to … 2008, where the amounts being paid for activities that do not fall under the umbrella of 'compensation,' are rapidly increasing."). CMS cites no sources backing what it purports to have "learned" or "observed" about those increases, nor does it attempt to quantify those purported increases or indicate whether they persist after adjusting for inflation. CMS also does not specify whether the increases are in the *degree* of remuneration, or the *kinds* of activities for which payments are made. Nor does it address the key question whether the purported problem involves increased payments to individual agents and brokers, or to firms too. And CMS nowhere attempts to compare any increases in the MA context with increases in the ordinary Medicare context.

- CMS asserts that "complaints" about beneficiary confusion have "escalated at a pace that mirrors the growth of administrative or add-on payments." 88 Fed. Reg. at 78,552/3. CMS cites nothing supporting that assertion nor to demonstrate that the current "pace" of complaints is problematic, rather than merely higher than before. And it does not attempt to explain whether that relationship is causal, correlative, or coincidental, or whether it is a reflection of the growth in MA plans as a whole.

- As for FMOs that are paid both for marketing (*i.e.*, leads generated) and brokering (*i.e.*, enrollments), CMS asserts that it "believe[s] it is likely that these arrangements are having" the effect of influencing agents or brokers in determining which plan meets a beneficiary's needs. 88 Fed. Reg. at 78,554/2. It likewise "believe[s]" that current contracts between FMOs and MA plans "can trickle down to influence agents and brokers." *Id.* CMS provides no concrete evidence or data to support either assertion.

- CMS posits that "some MA organizations are paying for things such as travel or operational overhead on a 'per enrollment' basis." 88 Fed. Reg. at 78,554/1. CMS provides some hypothetical "example[s]"—like reimbursement of travel costs multiplied by the number of enrollments at a single event—but does not cite any evidence to show that this practice exists, much less that it is prevalent. *Id.*

- CMS acknowledges that under the Proposed Rule, agents and brokers will be "unable to directly recoup administrative costs such as overhead or lead purchasing," but simply asserts based on assumed enrollment levels that it does not "believe" there to be a "large risk" of agents and brokers failing "to recoup their administrative costs." 88 Fed. Reg. at 78,556/1. Yet CMS does not attempt to quantify the amount of administrative costs the Proposed Rule will make

impossible to recoup or determine whether and to what extent the inability to recoup those costs will disincentivize agents' and brokers' enrollment activities.

If CMS has evidence that supports the propositions it advances, CMS must disclose it and give stakeholders the opportunity to comment on it. Failing to make available the underlying data that motivated the Proposal "in time to allow for meaningful commentary" transforms "what should be a genuine interchange" into "mere bureaucratic sport." *Connecticut Light & Power Co. v. NRC*, 673 F.2d 525, 530-31 (D.C. Cir. 1982). If, on the other hand, CMS lacks evidence to support those propositions, then its views about both the existence and scope of the problems it purports to identify and the likely effects of the proposed countermeasures are mere speculation, and fall short of the APA's requirement that an agency base its decisions on "substantial evidence." 5 U.S.C. § 706(2)(E). "Professing that [a rule] ameliorates a real industry problem but then citing no evidence demonstrating that there is in fact an industry problem is not reasoned decisionmaking." *Nat'l Fuel Gas Supply Corp. v. FERC*, 468 F.3d 831, 843 (D.C. Cir. 2006). Either way, the Proposal is incompatible with the "reasoned decisionmaking" agencies are required to employ. *Michigan*, 576 U.S. at 750 (quotation marks omitted).

4. CMS relies on unreliable studies and "complaints."

In the handful of instances where CMS *does* cite and disclose evidence, a review of that evidence indicates that it is impressionistic and unreliable. Two prominent examples illustrate the problem.

First, the Proposal repeatedly cites a so-called "research articl[e]" from the Commonwealth Fund. 88 Fed. Reg. 78,554/1 & nn.136-37, 78,555 n.140. But even taking the Commonwealth Fund's article at face value, it provides scant support for the Proposal. The article reports that "most brokers and agents in the focus groups recalled receiving higher commissions"—"sometimes much higher"—for enrolling people in MA plans compared to Medigap. *See* Faith Leonard et al., *The Challenges of Choosing Medicare Coverage: Views from Insurance Brokers and Agents*, The Commonwealth Fund (Feb. 28, 2023), http://tinyurl.com/h749x9at. But that compares apples and oranges: MA plans have more enrollment periods than Medigap plans. That, in turn, creates more opportunities for individuals to enroll or disenroll in MA plans, more enrollment and disenrollment work for third parties servicing MA plans, and ultimately higher costs to sell and service MA plans than Medigap plans. MA plans pay third parties commensurately higher rates to cover for those increased costs. In any event, the fact that some agents and brokers *sometimes* (how often, the article does not say) received higher commissions (how much higher, the article does not say) falls far short of proving that MA plan payments "have significantly outpaced the market rates for similar services" in non-MA markets. 88 Fed. Reg. at 78,554/1.

The Commonwealth Fund's research methods also provide little reason to expect that its conclusions represent systemic trends in the industry. The Commonwealth Fund asked just

twenty-nine agents and brokers to share personal anecdotes about enrolling beneficiaries in Medicare plans. Leonard, *Challenges of Choosing Medicare Coverage*, *supra*. The survey gives no indication of how the participants were selected nor any basis to conclude that they constitute a representative and statistically significant sample of the *100,000* or more agents and brokers that CMS estimates operate in the United States. 88 Fed. Reg. 78,597/2 & Table J5. Anecdotes from the field are not the kind of empirical or scientific evidence that CMS should use to make important health care decisions that affect "more than 100 million people." CMS, *Data & Research* (last accessed Dec. 15, 2023), https://www.cms.gov/data-research. Neither CMS nor the Commonwealth Fund adequately explains why personal recollections from a handful of agents or brokers can be extrapolated to support industry-wide changes affecting at least 100,000 other participants. For that matter, neither CMS nor the Commonwealth Fund even explains whether certain anecdotes were representative of agents and brokers *in the focus group*. *See, e.g.*, Leonard, *Challenges of Choosing Medicare Coverage*, *supra* ("One broker recalled" a high fee, one "focus group participant" described what he or she "*think*[*s*]" was needed to obtain a bonus, and "[s]ome brokers described" purported concerns about beneficiaries' plan coverage).

Second, CMS's assertions rest heavily on vague concerns that its hotlines have received an increasing number of "complaints" about the enrollment process in recent years—but CMS's reliance on these complaints is pockmarked with open questions and unreliability. 88 Fed. Reg. at 78,552/3. As an initial matter, Medicare's enrollment rules create an incentive for some beneficiaries to lodge complaints because doing so can grant them additional flexibility to switch plans outside of Medicare's open enrollment period, artificially inflating the number of complaints that CMS receives. Beneficiaries ordinarily may disenroll or switch plans only during the annual open period. See CMS, Medicare Open Enrollment (last visited Dec. 15, 2023), https://tinyurl.com/53ydrz2x. But beneficiaries can also switch plans during special enrollment periods that open at other points in the year under a variety of circumstances, including when an individual demonstrates that the plan failed to provide services or when the beneficiary meets any other conditions that CMS specifies. *See* 42 C.F.R. § 422.62(b)(1)-(27); Medicare, *Special Enrollment Periods* (last visited Dec. 15, 2023), tinyurl.com/544mxh34. CMS at least should have studied whether special enrollment periods caused or contributed to any rise in the number of complaints that CMS received—and disclosed the complaints so that the public could look for themselves.

CMS also relies on an increase in complaints in a single year—from 2020 to 2021—yet fails to account for broader context. CMS does not quantify the increase in complaints over the span of multiple years (for example, 2008 to 2021). Similarly, while 2021 data was the "most recent data available" *last* year, 88 Fed. Reg. at 78,552/2 (citing data from *Medicare Program; Contract Year 2023 Policy and Technical Changes*, 87 Fed. Reg. 27,704 (May 9, 2022)), it presumably is not the most recent data available *now*. And more recent data may show a different picture, because CMS promulgated rules in 2022 and 2023 targeting the kinds of misleading communications that might result in complaints. *See Medicare Program;*

Contract Year 2024 Changes, 88 Fed. Reg. at 22,234 (adding provision about misleading communications); *Medicare Program; Contract Year 2023 Policy and Technical Changes*, 87 Fed. Reg. 27,704 (May 9, 2022) (adding standard disclaimer requirements). Further still, CMS's 2022 rule acknowledged that it was "unable to say that every one of the complaints" received in 2021 was the "result of [third-party marketing organization] marketing activities," 87 Fed. Reg. at 27,707/1, so it is unclear how many additional complaints that CMS received in 2021 were even relevant to the issues CMS is raising now.[8] Nor is it clear how many complaints CMS concluded were valid and whether CMS correctly made those determinations. For Council members who reported complaints, the percentage of founded complaints is generally between 10 and 20 percent, further suggesting that it makes little sense for CMS to simply recite the raw number of total complaints in a single year as evidence of a purported problem. Without further study by CMS—or at least disclosure of the complaints for public analysis—it is impossible to know whether any increase in complaints from 2020 to 2021 was a pure anomaly, a consequence of growth in MA plans as a whole, or representative of larger trends with respect to the payment issues addressed in the Proposal.

Data from 2020 and 2021 also may have been skewed by the COVID-19 pandemic. In the spring of 2020, CMS adopted guidance that gave MA organizations a "number of flexibilities" during the COVID-19 pandemic. CMS, *Information Related to Coronavirus Disease 2019* at 1 (Apr. 21, 2020), https://tinyurl.com/ypz3jvmv. For example, MA plans could limit cost-sharing, waive certain notification requirements, adopt mid-year benefits changes, and delay certain disenrollments. *Id.* at 1-5. These abrupt changes may have influenced the number of complaints that CMS received in 2020. Yet CMS does not even acknowledge this possibility, much less study it. 88 Fed. Reg. at 78,552/2.[9]

Although CMS has failed to share complaint data from each of 2022 and 2023 (even though it obviously has this data), it is the experience of some Council members that complaints to Medicare, as a percentage of enrollments, have gone down each year since 2021.

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[8] CMS's counting of complaints in 2022 was unclear, to say the least. In its proposed rule, CMS asserted that it received "39,617" marketing-related complaints in 2021 and "15,497" in 2020. *Medicare Program; Contract Year 2023 Policy and Technical Changes*, 87 Fed. Reg. 1,842, 1,845/1 (Jan. 12, 2022). But later, CMS claims that misleading activities "related to" third-party marketing organizations resulted in "hundreds" of complaints. *Id.* at 1,901/2.

[9] There is also reason to believe that CMS's system double-counts complaints. A beneficiary may lodge complaints with his or her plan, and the plan in turn must report those complaints to CMS. *See* 42 C.F.R. § 422.516(a). A beneficiary may also lodge complaints with CMS directly. *See generally* CMS, *Parts C & D Enrollee Grievances Guidance* (Aug. 3, 2022), tinyurl.com/5athu7a3. But CMS has no system for reconciling these duplicative complaints, so CMS may be counting the same beneficiary's same problem twice, artificially inflating the number of complaints that CMS claims it received.

Therefore, CMS cannot justify its proposal on an alleged increase in complaints because complaints are decreasing, not increasing. And part of the reason for the decrease is that firms like Council members are investing more resources in robust compliance programs, funded by administrative payments. Taking those payments away, or reducing them, is likely to cause an increase in complaints.

These methodological concerns with the Commonwealth Fund research article and the (undisclosed) complaints show why the Council and other stakeholders cannot simply take CMS for its word that the problems CMS invokes are real. It is critical for CMS to disclose "the technical studies and data" on which it relied in deciding "to propose particular rules." *Conn. Light & Power Co.*, 673 F.2d at 530; *see supra*, at 24-27. Without disclosing such data and studies, the public is deprived of the chance for meaningful input, and the agency is deprived of the "chance to avoid errors and make a more informed decision." *Azar v. Allina Health Servs.*, 139 S. Ct. 1804, 1816 (2019). CMS's citations to unreliable sources suggest that the Proposal is an attempt to paper over a pre-determined and arbitrary outcome, as opposed to the sort of science- and evidence-based decisionmaking that is the proper domain of a federal agency.

5. CMS improperly intends to collect and rely on additional data that stakeholders cannot review or comment on.

Because the Proposal rests largely on speculation, unsupported assertions, and low-quality information, the agency invites commenters to backfill missing information needed to legitimate critical aspects of the Proposal. For instance, CMS requests that commenters inform it how many agents are even involved in selling health plans (admitting that the Proposal rests on assumptions about that figure) and admits it does "not have any data" on the percentage of new enrollments who use agents and brokers. 88 Fed. Reg. at 78,597/Table J5. These missing data will be the basis upon which CMS calculates the amount by which the compensation cap should be increased to account for certain administrative services that CMS deems appropriate. *Id.* CMS also concedes that it "lack[s] the data to quantify" the Proposed Rule's potential economic effects on all the key players in a giant industry serving millions of beneficiaries: carriers, firms, agents, and brokers. *Id.* at 87,610/3.

Such an admittedly incomplete and crude assessment of the Proposed Rule's impact falls far short of what the APA requires—particularly for a rulemaking as consequential as this one. The purpose of notice-and-comment rulemaking is to give the public "an opportunity to be heard," which "affords the agency a chance to avoid errors and make a more informed decision." *Allina Health Servs.*, 139 S. Ct. at 1816. Commenters have the legal right to know—*before* they prepare and file comments on the proposal—the evidence on which CMS will rely to take final agency action. Agencies cannot simply posit a problem based on admitted speculation, solicit key information during the comment period that commenters have no chance to see, and fill in the blanks in the final rule.

Because assembling the relevant information *after* the comment period is legally improper, the appropriate solution is for CMS to withdraw the Proposed Rule. If it does not withdraw the rule, CMS should suspend this rulemaking, complete the data collection and analysis necessary to support crafting a properly calibrated rule, and make that information available to the public. CMS then could consider whether to re-propose the rule in light of that additional data and analysis. *See Conn. Light & Power Co.*, 673 F.2d at 531. At a minimum, CMS should extend the comment period to no sooner than 90 days after the date on which all information is collected and disclosed.

D. CMS's reasons for redefining and capping compensation do not withstand scrutiny.

Had CMS studied the industry, it would have learned that no problem exists to justify CMS's sweeping changes to the way agents, brokers, and the firms that employ or provide services to them are paid. After years of allowing plans to pay for administrative services at market rates, CMS now proposes to set rates for a very limited list of certain administrative services and to effectively eliminate any payment for myriad other valuable administrative services. *See* 88 Fed. Reg. at 78,554/3-56/2. But agents and brokers already have financial incentives to enroll individuals in the plan that best meets their needs, and CMS has not come close to proving otherwise. Nor has CMS shown that the Proposed Rule promotes competition, even if that were a permissible consideration. Further still, CMS's proposed $31 increase to the compensation cap arbitrarily fails to account for many administrative services and drastically undervalues those few services for which CMS does attempt to account. CMS should abandon its proposal, which is a classic "solution in search of a problem" that should go no further than it already has. *District of Columbia v. Dep't of Agriculture*, 444 F. Supp. 3d 1, 31 (D.D.C. 2020).

1. The Proposed Rule responds to a purported problem about skewed financial incentives that does not exist.

CMS's Proposal asserts that "action" is needed based on three premises: (1) there has been a "steep increase" in administrative payments; (2) "some" plans "may" have used those payments "to circumvent the regulatory limits on enrollment compensation"; and (3) the increase in payments creates "questionable financial incentives" for agents and brokers that "could" or "may" result in agents and brokers steering individuals toward plans that do not best meet their needs. 88 Fed. Reg. at 78,552/2-3, 78,553/2, 78,555/3. CMS has not supported adequately or explained reasonably any of these premises, much less all of them. To the contrary, evidence and logic refute the Proposal's assertions.

a. Administrative payments are not steeply increasing.

CMS has not supported its threshold premise that there have been troubling "shifts in the MA industry" with respect to how agents, brokers, and the firms that employ or provide

services to them are paid. 88 Fed. Reg. at 78,552/1. CMS claims that there has been a "steep increase" in plans' administrative payments. *Id.* at 78,552/2, 78,553/2. And CMS claims that "overall payments to agents and brokers can vary significantly" from plan to plan. *Id.* at 78,555/1. As discussed above, however, CMS cites no evidence (or any source at all) to support these purported facts. *See supra*, at 24-27.

Moreover, in many Council members' experiences, administrative payments are *not* steeply increasing. In practice, plans often fix administrative payments for multiple years before raising them to reflect natural changes in the costs of providing administrative services or types of administrative services that firms are capable of providing. But many of the Council's members have reported that these administrative payments are *not* keeping pace with inflation, and may have been close to stagnant for nearly 10 years in certain instances.

At the same time, there would be ample justification for administrative payments to increase because the demands on agents and brokers have greatly increased—in large part due to CMS. Council members have long provided some administrative services that have now become more labor-intensive or costly because of CMS regulations, such as meetings with potential enrollees that are now longer than ever because of CMS-required disclosures and disclaimers. *Medicare Program; Contract Year 2024 Changes*, 88 Fed. Reg. at 22,122-203. Similarly, CMS has promulgated rules that require FMOs to coordinate approval from multiple carriers for multi-plan marketing materials and then file those marketing materials with CMS. *See* 42 C.F.R. § 422.2261(a). As many commenters previewed to CMS when those rules were promulgated, shepherding that process from start to finish with multiple carriers involved is labor-intensive and costly. To comply with CMS's regulations, Council members have had to assemble from scratch new teams staffed by multiple employees working full-time on these tasks alone. Likewise, CMS has required third parties to comply with additional oversight and reporting requirements and record video conferences with beneficiaries. *Medicare Program; Contract Year 2023 Policy and Technical Changes*, 87 Fed. Reg. at 27,707/1-3. And CMS has required a 48-hour waiting period between a scoping appointment and a meeting with a beneficiary, creating more travel and documentation costs for the industry and placing obstacles before beneficiaries to obtain the plan that best meets their needs. *Medicare Program; Contract Year 2024 Changes*, 88 Fed. Reg. at 22,247/1-48/3. To cover these additional costs, Council members need additional payment. Yet CMS did not stop to look in the mirror before asserting that "shifts in the … industry" warrant further action. 88 Fed. Reg. at 78,552/1.

Even if CMS's statements are taken at face value, CMS must further analyze its own propositions to understand if they are meaningful or not. For example, how do the increases compare to ordinary inflation-based increases? Over how much time have payments increased, and at what rate? Are all MA organizations' payments increasing, or only some? Are payments increasing or varying for all types of administrative services and activities, or only some? By how much do payments purportedly vary from plan to plan, and how have those

variations changed over time? How do any of these answers in the MA context compare to the ordinary Medicare context? And most important, of course, what evidence exists that those payments are incentivizing agents and brokers to offer plans that do not "best meet" customers' needs, 42 U.S.C. § 1395w-21(j)(2)(D), when agents themselves typically do not share in the administrative payments made by MA organizations? The Council cannot undertake this analysis for CMS, because CMS has not disclosed the evidence on which it relies. *See supra*, at 24-27. But analyzing these and other questions are important to understand properly whether the established industry structure needs to be revamped or, rather, left alone. CMS missed these "important aspect[s] of the problem," and must take them into account in any final rule. *Motor Vehicle Mfrs. Ass'n of U.S. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983).

b. Administrative payments are genuine payments for vital services, not end-runs around compensation caps.

CMS also has not supported its second premise: that "some" plans "may" have used administrative payments "to circumvent the regulatory limits on enrollment compensation." 88 Fed. Reg. at 78,555/3. Plans offer administrative payments to reimburse firms for the valuable services they provide at their fair-market value, not to artificially inflate compensation for enrollments.

Council members and others in their industry perform a variety of administrative services, including: provide telephone and computer support services to agents and brokers on the ground; field customer calls, assess their needs, and connect them to agents and brokers; develop technology that helps agents, brokers, and beneficiaries compare plans; conduct direct-mail or social media marketing of plans; perform health risk assessments to gauge the beneficiary's specific needs; and on the list goes.

These services empower agents and brokers to perform their work delivering plans to beneficiaries. For example, many small agencies lack the technology to fully comply with CMS's call-recording requirements without assistance from firms. As another example, individual agents may use an FMO's sophisticated plan-comparison software to help potential enrollees easily shop for plans.

Carriers could in theory do some of this work themselves. But FMOs and telesales companies, including Council members, have expertise and economies of scale that allow them to provide these services more efficiently and at lower cost than if plans performed this work in-house. Outsourcing administrative services thus helps lower the cost of operating a plan, reducing premiums. It also allows FMOs and telesales companies to provide tailored services to beneficiaries that carriers simply cannot provide given the sheer quantity of members. Because the "independent agent/FMO model affords the agent the ability to spend the time needed with their clients," seniors are "more satisfied" with their understanding of plan

coverage when they receive assistance from agents than from carriers directly. Deft Research, *The Value of the Health Insurance Agent/FMO Model* at 4-5 (Dec. 22, 2023).

Carriers pay these intermediary firms for this valuable work. Importantly, these are genuine payments in exchange for value—not payments to "circumvent" rules on agent and broker compensation, as CMS claims. 88 Fed. Reg. at 78,555/2. In fact, administrative payments *must* be genuine. By rule, administrative payments "must not exceed the value of those services in the marketplace." 42 C.F.R. § 422.2274(e)(1). As CMS explained just two years ago, plans must "limit these payments to the amounts that would be fairly negotiated on the open market." *Medicare Programs; Contract Year 2022 Changes*, 86 Fed. Reg. at 5,994/1. Administrative payments are further limited by CMS's medical loss ratio restrictions, which provide that 85 percent of plan resources must be used for patient care. *See* 42 C.F.R. § 422.2410(b). Plans' administrative and marketing payments to agents and brokers (and profit and all other administrative costs) must therefore fit within the remaining 15% of plans' resources, setting a natural upper boundary on the amount of administrative payments. Accordingly, plans do not enjoy unchecked power to dole out administrative payments, but rather are limited to prices dictated by supply, demand, and regulations.

That is why CMS misses the mark when, for example, it criticizes plans for paying agents and brokers to conduct health risk assessments. *See* 88 Fed. Reg. at 78,555/2. Health risk assessments are valuable services because they help plans deliver better coverage and preventative care that lowers long-term costs. CMS complains that agents and brokers are not health care providers, *id.* at 78,555/3, but agents and brokers are specially trained to perform these assessments. (In fact, FMOs and firms that employ agents provide that training—yet another valuable administrative service for which they need payment—whereas carriers' captive employees who perform HRAs are not required to be licensed and may not receive the same level of training.) Moreover, these assessments often take place during initial enrollment meetings because it is a guaranteed opportunity to have conversations about the beneficiary's health needs early in the process at a convenient time—*i.e.*, when that beneficiary is already on the phone discussing potential enrollment, rather than in a subsequent visit on some unknown date. Additionally, for an HRA to "really make a difference," the assessment must be completed properly and followed up appropriately—steps that Council members are particularly well suited to take. *See* Brian Schilling, *Health Risk Assessments: What You Don't Know Can Cost You*, The Commonwealth Fund (last visited Dec. 27, 2023), http://tinyurl.com/5hf8fxrz. And a "successful HRA is far more complex than meets the eye"; building the capability to provide HRAs directly can "blo[w]" a "budget sky high," while contracting out that service to experts with resources in place (such as Council members) can result in better HRAs at more predictable costs. Wellsource, *Build vs. Buy: Which Health Risk Assessment Approach is Right for You?* (last visited Dec. 27, 2023), http://tinyurl.com/yjsv8n28. So this service is worth far more than CMS gives it credit by pegging its fair-market value at "$12.50 per hour." 88 Fed. Reg. at 78,555/2. That estimate also overlooks the opportunity cost of diverting the time and attention of a highly trained agent

or broker—who could otherwise make $601 per enrollee—to perform HRAs. *See id.* at 78,554/3. And in any event, if CMS truly believes that a single carrier's $125 health risk assessment payment "is not consistent with market value," *id.* at 78,555/3, then CMS could enforce the rule on its books—rather than speculating that "some" plans "may" have used administrative payments to circumvent compensation limits. *Id.*

c. Administrative payments do not incentivize agents and brokers to advise beneficiaries against their interests.

Finally, CMS has not supported its conclusion that an increase in administrative payments creates "questionable financial incentives" for agents and brokers that "could" result in agents and brokers steering individuals toward plans that benefit agents' and brokers' pockets, rather than meeting individuals' health needs. 88 Fed. Reg. at 78,552/2. Industry stakeholders currently have every reason to ensure that agents and brokers enroll individuals in the health plan that best meets their health care needs. 42 U.S.C. § 1395w-21(j)(2)(D). CMS's contrary assertions are belied by evidence and do not withstand scrutiny.

1. Agents, brokers, and the firms they work with presently have strong incentives to give beneficiaries a "robust set of health insurance options." 88 Fed. Reg. at 78,477/3. To recruit potential customers agents and brokers need to offer a diverse array of plans to a beneficiary. That's Shopping 101: An individual looking to enroll in an MA plan is more likely to find one he or she is happy with if presented with multiple options. Accordingly, it would seldom make financial sense for firms or individuals to contract with only one carrier or to sell only one plan. Market-wide evidence demonstrates that current industry practices have created a healthy MA market: The "typical beneficiary has a choice of 43 Medicare Advantage plans as an alternative to traditional Medicare for 2024," which is "more than double the number of plans offered in 2018." KFF, *With Medicare Open Enrollment Underway, Beneficiaries Typically Will Have a Choice* (Nov. 8, 2023) ("KFF *Beneficiary Choice* Study"), tinyurl.com/2p82mcxv. Under CMS's regulations, therefore, the "market is attractive to both enrollees and insurers." *Id.*

Council members also have strong incentives to enroll beneficiaries in the plan that *best* meets their needs out of the available options. Council members make significant upfront expenditures to enroll a beneficiary. They may incur marketing costs to find a potential beneficiary interested in enrolling in an MA plan. They then spend significant resources matching beneficiaries with plans. For some Council members, that means labor-intensive meetings with beneficiaries for hours at a time to discuss the individuals' needs. For others, that means developing costly technology that helps beneficiaries compare plans and efficiently enroll in the one they choose. Then Council members may incur paperwork and administrative costs to complete the enrollment process. All told, the initial payment for a new enrollment alone is not sufficient to recoup these costs. Instead, Council members reap financial rewards only if the beneficiary remains a long-term customer. In fact, some carriers spread out

administrative payments over multiple years, or make additional payments for persistent enrollments, specifically to ensure that firms match beneficiaries with the right plan from the start. People do not remain long-term customers, of course, unless they are satisfied with the plan they selected. Agents, brokers, and their employers and FMOs thus have every reason to get it right the first time and enroll individuals in a health plan that will make—and keep—the individual happy.

These incentives are sharpened by the fact that beneficiaries have many opportunities to change course if agents or brokers initially recommend the *wrong* plan. As discussed above, beneficiaries may disenroll or switch plans for any reason during the annual open enrollment period, and may also disenroll during special enrollment periods that open at other times in the year under certain conditions. *See supra*, at 27-28. When beneficiaries disenroll, Council members lose money—either through contractual penalties triggered by disenrollment, 42 C.F.R. § 422.2274(d)(5), or the loss of future revenue they would have earned if a beneficiary remained with the plan. Because the price of disenrollment wipes out their previous efforts to enroll a beneficiary, agents, brokers, and their employers and FMOs are motivated to ensure the beneficiary selects the right plan for his or her needs from the start.

An unhappy beneficiary might also cost agents and brokers the chance for other business. Individuals can refer their co-workers, friends, or other acquaintances to agents or brokers for potential enrollment, and CMS approves this practice. *See* 42 C.F.R. § 422.2274(f). But agents, brokers, and the firms they work with must maintain their reputation to increase the chances of receiving a referral. And to maintain their reputation, they must ensure that beneficiaries they have worked with—*i.e.*, the people who make the referrals—are satisfied with their MA plan. This is another reason why the Council's members already have strong incentives to ensure that individuals are enrolled in the health plan that best meets their needs.

2. CMS provides no actual evidence that any administrative-payment increases or variations have resulted in agents or brokers recommending plans that they otherwise would not recommend. *See supra*, at 24-30. All CMS has is conjecture: Increases in administrative payments "are likely to influence which MA plan" an agent or broker recommends; increases in payments "may" have an "undue influence" on agents and brokers; paying FMOs for leads and for enrollments "is likely" to influence agents or brokers in which plans is recommended. 88 Fed. Reg. at 78,552/2-3, 78,553/2, 78,554/2. CMS's because-I-said-so reasoning does not justify its course of action. Agency "'judgment[s] must be based on some logic and evidence, not sheer speculation.'" *Sorenson Commc'ns Inc. v. FCC*, 755 F.3d 702, 708 (D.C. Cir. 2014) (citation omitted).

Because it has no direct evidence, CMS attempts to support its conclusion collaterally. CMS cites a 2021 increase in "the number of beneficiary complaints related to marketing" and the agency's review of an unknown number of recorded marketing calls in which beneficiaries

were "clearly confused." 88 Fed. Reg. at 78,552/2-3. But as discussed above, CMS's reliance on this purported increase in complaints is shaky at best because the 2021 data do not account for any broader context. *See supra*, at 28-29. Additionally, evidence about consumer *confusion* does not support CMS's notion that consumers are enrolled in a health plan that does not serve their health care needs. They are two separate issues. And CMS has already addressed the former by promulgating marketing rules to "reduce the incidence of confusing and misleading marketing activities." *Medicare Program; Contract Year 2023 Changes*, 87 Fed. Reg. at 27,823/1; *see also Medicare Program; Contract Year 2024 Changes*, 88 Fed. Reg. at 22,234 (adding provision about misleading marketing). Further still, individuals have natural incentives to lodge complaints so that they can switch their plans during "special election" periods throughout the year. 42 C.F.R. § 422.62(b)(3); *see supra*, at 28. These incentives could drive up the number of complaints that CMS receives. CMS at least has to study the issue before relying on marketing-related complaints to make grand conclusions about agent and broker incentives.

While the Proposal cites to no relevant data, on-point evidence undermines CMS's invented problem. A "majority" of surveyed individuals confirmed that they "made the right choice" of MA plan. Meredith Freed et al., *What Do People with Medicare Think About the Role of Marketing, Shopping for Medicare Options, and Their Coverage?*, KFF (Sept. 20, 2023), https://tinyurl.com/4ryrxra2. Moreover, "when asked if they had concerns" about agents' or brokers' "potential biases or financial incentives to enroll them in a Medicare Advantage plan," "[m]ost of the participants who used brokers did not seem bothered" at all. *Id.* Consumers "prefer for people to make their money" and "don't care what" agents and brokers get paid as long as the consumers get what they need. *Id.*

Even on its own terms, moreover, the Proposal does not make sense. CMS speculates that payments to "FMOs" can "trickle down to influence agents and brokers," 88 Fed. Reg. at 78,554/2, but current payment structures insulate agents and brokers from participating in or receiving administrative payments. When agents contract with FMOs or telesales companies, the carrier typically pays the *entity* (the FMO or telesales company) administrative payments for administrative services; *individual agents* operating as independent contractors receive enrollment-based compensation for the sale, and those operating as employees are paid wages, but either way, the individual does not receive administrative payments. In Council members' experiences, agents and brokers are simply unaware of carriers' administrative payments. For example, one Council member operates a website allowing agents and brokers to compare plans, and that website is carrier-agnostic. The agent can use the website to evaluate plans' features, but the agent has no insight into or vested interest in what payments each carrier is making to the firm. More generally, Council members construct sales processes that are predicated on a robust analysis of a beneficiary's needs and a plan's ability to meet those needs—not on which carrier's plan will eventually be sold. Because agents and brokers do

not receive the administrative payments, they have no reason to care whether administrative payments to FMOs or other firms have "increased" generally or vary by plan. *Id.* at 78,552/3.[10]

CMS also does not explain why agents, brokers, or the firms they work with might act differently simply because they are receiving "increased" payments. 88 Fed. Reg. at 78,552/3. Reducing the amount of payments will not reduce the incentives to close a sale. All it would mean is that firms providing administrative services make less (or no) money, *regardless* of what plan they sell. The Proposal therefore does not establish a "rational connection between the facts found and the choice made." *Motor Vehicle Mfrs. Ass'n*, 463 U.S. at 43 (quotation marks omitted).

To the extent the Proposal asserts that *variations* in administrative payments to intermediary firms influence the ultimate choice of plan, 88 Fed. Reg. at 78,555/3, that also cannot be right. For example, many of the largest carriers in the industry make fewer and smaller administrative payments than their competitors. Those variations are the result of free-market choices. Yet these large carriers continue to have significant market share in the country, and Council members sell these plans in droves. *See generally* American Medical Ass'n, *AMA identifies market leaders in health insurance* (Dec. 12, 2023), https://tinyurl.com/jc35x88p; Nancy Ochieng et al., *Medicare Advantage in 2023: Enrollment Update and Key Trends*, KFF (Aug. 9, 2023), https://tinyurl.com/ykajezk5.

Finally, CMS's approach is itself discriminatory in ways that undermine the efficacy of its own proposal. CMS is proposing to regulate the rate of payments for services, but only when those payments are made to particular players in the industry (*i.e.*, agents and brokers). Presumably, anyone who is not an agent or broker could perform these same services and be paid for them at market rates. This suggests that CMS is not targeting problematic conduct, but rather is targeting unfairly a particular segment of an industry that it wants to harm.

For all of these reasons, CMS provides no evidence that the problem CMS wants to solve even exists, much less that it is "worthy of regulation." *N.Y. Stock Exch. LLC v. SEC*, 962 F.3d 541, 545 (D.C. Cir. 2020). CMS should not move forward with the Proposal on such a shaky foundation.

2. CMS's competition-based reasoning is impermissible and misguided.

CMS also claims that the Proposal promotes "competition and consumer choice" consistent with the current Administration's "commitment to promoting fair, open, and

[10] This reality even sets aside the fact that beneficiaries have multiple ways to learn about plan options and coverage—including from CMS, which provides seniors with many sources of information—separate and apart from agents and brokers.

competitive markets." 88 Fed. Reg. at 78,477/3, 78,553/2. By gutting the current fair-market system of administrative payments, CMS claims that it will "level the playing field for all plans," large and small. *Id.* at 78,555/1; *see also id.* at 78,553/2 (similar).

However laudable that objective might be in other contexts, it is not a proper consideration here. Because agencies are creatures of statute, agencies must point to a "textual commitment of authority . . . to consider" the factor at issue. *Whitman v. Am. Trucking Ass'ns*, 531 U.S. 457, 468 (2001) (holding that agency could not consider costs without express authorization). But at least where agent and broker compensation is concerned, Congress gave CMS one overriding goal: to "creat[e] incentives for agents and brokers to enroll individuals in the Medicare Advantage plan that is intended to best meet their health care needs." 42 U.S.C. § 1395w-21(j)(2)(D). That provision says nothing about government-mandated parity between large carriers and small carriers.

Imposing caps on administrative payments and setting uniform compensation rates is also the antithesis of competition. As things stand, plan carriers may compete by offering additional plan benefits and different administrative payments for services, and firms, agents, and brokers can compete by providing the best services at the most reasonable prices. Because administrative payments "must not exceed the value of those services in the marketplace," 42 C.F.R. § 422.2274(e), they are limited to what can be "fairly negotiated on the open market," *Medicare Programs; Contract Year 2022 Changes*, 86 Fed. Reg. at 5,864/1, and they can charge *less* than full fair-market value if doing so earns them an advantage, *see* 42 C.F.R. § 422.2274(e)(2) (administrative payments may be "at or below" fair-market value). Free-market negotiation *is* competition.

By contrast, the Proposed Rule's caps—especially if applied to firms rather than just individual agents and brokers—will artificially *prevent* fair-market payments (or even payments *below* the maximum fair-market value) and, in turn, competition. "[P]rice fixing . . . undermine[s] the free market," *N.C. State Bd. of Dental Examiners v. FTC*, 574 U.S. 494, 502 (2015), and is "plainly anticompetitive," *Catalano, Inc. v. Target Sales, Inc.*, 446 U.S. 643, 650 (1980). But the Proposal would place an artificial ceiling and floor on plans. Plans cannot pay fair-market value for administrative payments if that would take the overall compensation over the cap. And plans cannot pay *less* than CMS's prescribed compensation rate of $601 per initial enrollee, undercutting firms' ability to compete by offering their services at lower rates. 88 Fed. Reg. at 78,624/2 (proposing 42 C.F.R. § 422.2274(d)(1)(ii), which removes the current regulation's approval of compensation "at or below" fair-market value); *see also id.* at 78,554/2-3 (noting that CMS is setting a "single" compensation rate "for all plans"), 78,611/1 (noting the "requirement of uniform payment to agents and brokers"). The Proposal is therefore *anti*competitive. As other federal agencies attuned to market forces could attest, "prices are best governed by market competition, not by price caps or price regulation." Leigh M. Murray, *Sirius Mistake*, 59 Am. U. L. Rev. 83, 108 n.169 (2009) (noting that the "FTC and DOJ have expressly stated that they are not in the business of regulating

prices"). The industry will not be "fair [and] open," Executive Order 14036 § 1 (July 9, 2021), but throttled by government fiat. The result will be a race to the bottom: If subjected to the Proposed Rule, Council members will exit the industry or, for those that remain in business, be forced to curtail significantly their services or find the least costly way to provide those services, at the expense of making every effort to provide an industry-best experience for agents and beneficiaries. CMS should reconsider the Proposed Rule because it undermines, rather than effectuates, the Administration's own stated policy aims.

3. CMS's proposed increase to the compensation caps rests on an arbitrarily incomplete and undervalued list of services.

Even assuming that subjecting administrative payments to a capped rate were permissible, CMS's proposal to raise the cap by $31 per initial enrollment arbitrarily excludes numerous vital administrative services and undercompensates even those few services that CMS includes.

CMS's decision to cherry-pick some administrative services but not others is arbitrary and unreasoned. The Proposal would permit compensation for only three administrative services—testing, training, and call recording. 88 Fed. Reg. at 78,556/1-2. According to CMS, these services are "appropriate" to reflect in the compensation cap "given the significant and predictable cost of these mandatory activities." *Id.* (citing 42 C.F.R. § 422.2274(b) (training and testing requirements), (g)(2)(ii) (recording requirements)). But the Proposal would leave uncompensated the remainder of the full suite of administrative services that Council members and others provide. *See supra*, at 40-43. And those other administrative services are just as necessary as training, testing, and call recording. FMOs, telesales companies, and other firms must provide "customer service" and incur "operational overhead" costs, for example, simply to exist. 42 C.F.R. § 422.2274(e)(1). Similarly, firms that perform marketing services must ensure that marketing materials comply with CMS requirements. It is irrational to exclude administrative payments for those services and costs when CMS's own rationale favors their inclusion. Rather, once an agency decides to engage in price regulation when supported by statutory authority, it cannot ignore costs relevant to the price merely because it finds calculating them to be inconvenient.

Moreover, the additional services that CMS excludes from the proposed caps are valuable. Making firms provide these services without reimbursement would leave them on the hook for millions of dollars. Although more data is needed to fully and accurately estimate the costs of administrative services that would be unrecoverable under the Proposal—meaning the dollar figures stated below should not necessarily be used as final data to calculate the cost of services—a preliminary partial analysis shows that CMS's $31 per enrollee proposal is unreliable and would underpay firms by orders of magnitude, and further shows that CMS has utterly failed in its obligation to perform a thorough analysis as required by the APA:

- Overhead: Council members must lease space for their business to operate. The average cost of Class B office space—that is, office space that is neither state-of-the-art nor in need of substantial renovation—is about $30,370 nationwide per thousand square feet. Commercial Edge, *National Office Report* (Dec. 2023), http://tinyurl.com/mrypy5ye. Many Council members lease tens of thousands of square feet of office space, putting their annual rent in the hundreds of thousands or millions of dollars.

- Customer service: Even in industries where licensed agents are not necessary, the average cost to provide customer service generally may be $2,600 to $3,400 or more per non-licensed customer-service agent per month—and that does not include factors such as call volume, support channels such as chats, or languages. April Wiita, *How to Reduce Call Center Overhead Costs with On-Demand Customer Care*, Working Solutions (Apr. 23, 2023), http://tinyurl.com/npdsvtzd. For Council members, these costs are even higher because licensing and training agents to service complex MA plans is technical, time-sensitive, and costly. To determine the relevant costs of providing customer service in this industry, CMS would need to gather data about the number of customer-service personnel required per insurance agent selling MA plans.

- Technology: Firms invest in technology that make telephone systems, call routing, call recording, and other processes work. Technology also powers quote engines, enrollment features such as plan comparison tools, and personal shopping sites. *E.g.*, Brokerage Inc., *Why do insurance agents need an FMO?* (Oct. 27, 2022), http://tinyurl.com/3r8hsksm. Purchasing, developing, maintaining, and innovating in the future this technology is a costly endeavor.

- Sales centers: Some Council members operate sales centers to communicate with beneficiaries about their plan options and questions. Those sales centers need software to help with basic business processes such as call routing, dialing, and reporting. That software needs to be purchased, licensed, installed, maintained, and paired with equipment. All of that can range between $1,000 to $1,500 per agent, depending on the size of the sales center. Andy Nguyen, *How much does call center software cost?*, Time Doctor (last visited Dec. 27, 2023), http://tinyurl.com/4scuz65a. Using CMS's assumption that each agent recruits 10 enrollees per year, 88 Fed. Reg. at 78,597/2, that translates to between $100 to $150 per enrollment.

- Customer relationship management system: CMS states in passing that the "cost of a customer relationship management (CRM) system (the software used to connect and log calls to potential enrollees) is about $50 per month." 88 Fed. Reg. at 78,556/1. But a customer relationship management system is only one

component of running an overall call system center, which requires hardware, telephony carrier costs, setup and implementation costs, customization, and more. *See* Mark Fairlie, *Calculating the Costs of Call Center Systems*, Business.com (Apr. 17, 2023), http://tinyurl.com/28jxperc. Moreover, even as to CRM software specifically, CMS cites no data to support its $50 estimate. A cursory search shows that CMS's underestimates the realistic cost. Basic plans by Genesys and Five9 range from $75 to $149 per month, while more advanced plans run from $135 to $229 per month. Genesys, *Pick the perfect plan for your business* (last visited Dec. 27, 2023), www.genesys.com/pricing; Five9, *Five9 Solution Bundles* (last visited Dec. 27, 2023), www.five9.com/opt/products/pricing.

- Agent recruitment: Some Council members hire agents to work for them as employees. The median cost to hire a licensed agent is $1,633, without counting salary or training costs. Zippia, *How To Hire A Licensed Agent* (last visited Dec. 27, 2023), http://tinyurl.com/2p98mwds. The mean annual wage for an insurance agent is about $76,950 per year. U.S. Bureau of Labor, *Occupational Employment and Wage Statistics* (May 2022), http://tinyurl.com/3dxaczws. And fully onboarding agents is an expensive proposition: Firms often spend millions of dollars teaching, training, and supervising new agents to bring them up to speed and make them productive agents. During an agent's learning curve, firms are often losing money through their investments in training the agent and through purchasing leads that new agents still ramping up do not convert into sales.

- Agent management: Once agents are onboarded, firms continue to spend money managing those agents. Many Council members have management employees dedicated to supervising, monitoring, and providing ongoing coaching and feedback to agents. In other words, firms do not simply hire agents and then take a hands-off, cost-free approach. Constructing, developing, and maintaining this layer of middle management is a costly investment.

- Customer acquisition and marketing: Many Council members market MA plans so that carriers reach new audiences and beneficiaries learn about more options. Marketing strategies take many forms—social media ads, e-mail campaigns, online educational materials, and physical letters mailed to potentially interested parties. Marketing budgets accordingly can vary widely. Research, analytics, and strategy alone can cost "at least $5,000" per campaign, with some content strategy requiring a "$50,000" commitment or more. Ingage, *How Much Are You Really Spending on Marketing & Sales Materials* (last visited Dec. 27, 2023), http://tinyurl.com/mrx28s5u. Producing marketing materials can cost an additional $500 to $3,000 per campaign in other industries, *id.*, and often costs much more than that in this industry given firms' need to coordinate with multiple carriers to obtain approval of marketing materials, *see supra*, at 32; 42 C.F.R. § 422.2261(a).

For Council members that use direct-mail marketing to reach beneficiaries, moreover, the cost to directly mail materials can range from $0.30 to $10 per recipient, depending on design, copywriting, printing, and distribution choices. Hygrade Business, *How Much Does a Direct Mail Campaign Cost & How Can I Optimize Results?* (Sept. 12, 2018), http://tinyurl.com/2arhdbpk. Of course, these numbers reflect 2018 postage rates and production costs, which have increased substantially since then: first-class stamps cost 50 cents in 2018 and 63 cents today. All these numbers add up quickly when Council members mail many potential enrollees and beneficiaries because only a fraction of those contacts will lead to actual enrollments. All told, customer acquisition can cost hundreds if not thousands of dollars per successful new enrollment. *See, e.g.*, eHealth, Inc. Form 10-K at 55, SEC (2022) (reporting an estimated $888 variable marketing cost per approved member), http://tinyurl.com/3mpdmkpj; SelectQuote, Inc. Form 10-K at 51, SEC (2023) (reporting an estimated $1,224 operating expense per MA or Medicare policy), http://tinyurl.com/223dvstd.

- Compliance and quality assurance: Firms incur significant legal and compliance costs to staff legal departments, respond to CMS inquiries, handle EEOC matters in conjunction with employee termination or discipline, assess customer complaints, and, of course, interpret and ensure compliance with all of the many rules that CMS has promulgated and continues to propose. Firms also spend money to ensure that the quality of their services, such as call support, remains top notch. Though difficult, if not impossible, to quantify, these costs are significant.

- Data and information security: Firms also invest heavily to ensure that information in their possession is kept secure. For example, firms develop or purchase cybersecurity measures to keep electronic records private and confidential. And firms implement record-retention systems to keep electronic and private records in storage for years, as CMS requires. *See, e.g.*, 42 C.F.R. § 422.504(d) (10-year record retention requirement). Many document storage providers charge between $75 to $175 per month for off-site record storage, and that does not even count the costs for *electronic* record storage. Record Storage Systems, *Learn About Offsite Records Storage Costs* (last visited Jan. 3, 2024), http://tinyurl.com/mr3fjbva.

The Proposed Rule also undervalues the services that CMS purports to compensate. To calculate the cost of training and testing, CMS first determined that it costs $125 on average to complete training and certification through the America's Health Insurance Plans ("AHIP"). 88 Fed. Reg. at 78,597/1-2 & Table J5. CMS then determined that each agent recruits 10 enrollees: CMS estimates that MA non-employer enrollment is increasing by about 2 million per year, it guesses that 1 million of those enrollees use agents or brokers, and it estimates that about 100,000 agents or brokers sell Medicare. *Id.* CMS then divides a single agent's average cost of training ($125) by the number of enrollees one agent recruits (10) to produce a $12.50

per-enrollee cost of training. *Id.* at 78,597/2. To calculate the cost of recording, CMS assumes that each agent earns $37 per hour and estimates that it takes 30 minutes to record and store calls, which works out to $18.50 per enrollment. *Id.* Combined, the cost of training, testing, and recording is $31 per enrollment. *Id.* Even setting aside CMS's lack of support for many of these assumptions, *see supra*, at 25-30, CMS's estimates undersell the costs of providing these services, both qualitatively and quantitatively:

- Training and testing: CMS proposes to account for the $125 cost that it takes to complete training through the AHIP certification program. 88 Fed. Reg. at 78,597/1-2. But Council members take a more comprehensive and holistic approach to training. Many of them use a learning management system for training programs. A learning management system costs $10,000 per year for the typical user, and can cost up to $70,000 for tailored plans. May Ohiri, *LMS Pricing in 2024*, EducateMe (Feb. 3, 2023), https://www.educate-me.co/blog/lms-pricing. Apart from learning systems, businesses "invest an average of $1,286 per employee every year for training and development purposes." Alex Ryzhkov, *Top Operating Costs*, *supra*.

  Moreover, CMS's training and testing costs do not include the costs of obtaining state licenses, which CMS acknowledges agents and brokers must have to sell plans. 88 Fed. Reg. at 78,556/2; *see* 42 C.F.R. § 422.2274(b)(1) (agents and brokers must be "licensed and appointed under State law"). CMS's proposed $12.50 per-enrollee increase reflects only AHIP's certification program, which is distinct from state licensing processes. 88 Fed. Reg. at 78,597/1-2. Licensing costs vary. For example, it costs $170 to obtain certain insurance licenses in California, and $50 in Texas. Alex Ryzhkov, *Top Operating Costs for Insurance Agencies*, *supra*. And these costs cover only application-processing and examination fees—not any training required to pass these tests. *Id.* Nor does it include wages for agents undergoing training without producing any revenue, which requires capital to sustain and at a cost.

- Recording: CMS's proposed $18.50 per-enrollment increase for recording costs captures only the labor cost of recording calls—*i.e.*, an agent's hourly wage multiplied by the time it takes to record and store calls. 88 Fed. Reg. at 78,597/2. Even if that assumption is accurate, it ignores entirely other costs associated with recording calls, such as purchasing recording equipment or software, setting up telephony services to take the calls, and maintaining the hardware necessary to record and store calls. *See* Andy Nguyen, *How much does call center software cost?*, *supra*. It also ignores costs to retain the recordings and produce them when requested.

- Renewed enrollments: CMS's $31 increase to the compensation cap reflects payments only for *initial* enrollments; CMS declined to make a "proportionate increase to compensation for renewals." 88 Fed. Reg. at 78,556/2. But Council members incur costs for some services, such as recording video or telephone calls, for *initial* plan enrollments and *renewal* enrollments alike. Council members accordingly receive payments for services provided in conjunction with renewals—often because carriers spread out administrative payments over the life of a policy to ensure that the right plan policies are sold from the start. Providing services for renewals, such as recording calls, is no less a "significant and predictable cost" than when beneficiaries are initially enrolling, *id.*, so firms deserve payments for those recording costs even under CMS's own guiding lights.

For all of these reasons, a $31 per-initial-enrollee increase to CMS's payment limits does not come close to fully reimbursing Council members for the full suite of administrative services they provide to both new and renewing enrollees. CMS should abandon its Proposal, which rests on an incomplete list of administrative services and undervalues even those services CMS purports to approve.

E. The Proposed Rule would restrict beneficiaries' choices by driving many firms, agents, and brokers out of business or forcing them to curtail significantly their services, narrow their offerings, or serve fewer clients.

The cost of CMS's attempt to solve this nonexistent problem, especially if the Proposed Rule is applied broadly, would be enormous, not only for firms, agents, and brokers whose bottom lines would be squeezed, but also for beneficiaries who will have less plan choice than before. The Proposed Rule would thus undercut CMS's statutory mandate. And CMS has not even bothered to try to quantify these effects of its proposal.

If applied to firms rather than just individual agents and brokers, the Proposed Rule could be a death knell for a vital segment of the MA industry. CMS would wipe out Council members' ability to get paid for many of their administrative services. Although some carriers currently make fewer administrative payments than others based on what free-market forces support, *see supra*, at 38, eliminating *all* of those payments would be catastrophic. By preventing Council members from receiving market-rate administrative payments, the Proposed Rule would eliminate a significant percentage of Council members' business—in some cases, more than one-third of their total revenue (not profit). But some Council members, and other publicly traded companies in this industry, are *already* losing money on a year-to-year basis and cannot afford the drastic revenue cuts that would result from losing administrative payments. The Proposal puts long-term profitability for current business models even further out of reach, and delays the path to profit in an industry that is still finding its footing. With their revenue streams drying up, many Council members would go out of business. Others that manage to survive would perform fewer—or none of—the valuable administrative services they perform currently.

Ultimately, that result undercuts beneficiaries' access to robust plan options. As discussed above, Council members and other intermediaries are financially motivated to secure a variety of health plans for agents and brokers to offer to beneficiaries, and the typical beneficiary today has a robust "choice of 43 Medicare Advantage plans"—"more than double the number of plans offered in 2018." KFF *Beneficiary Choice Study*, *supra*. Under the Proposed Rule's system of compensation caps and unreimbursed administrative services, however, Council members and other intermediaries that survive the rule's impact will have less money to invest in contracting with carriers. Similarly, intermediaries operating on marginal profits will have less money to contract with agents and brokers. In turn, those intermediaries will have fewer plans to provide to fewer agents and brokers—and fewer people offering fewer plans means less beneficiary choice. Meanwhile, the market will depend more heavily on carriers to sell their own plans directly to individuals, in lieu of agents and brokers offering a wide variety of plans for beneficiaries to consider. CMS acknowledges this outcome: Under its Proposal, "plans may increase money allocated to outreach and advertising," *i.e.*, carriers may more often sell their own plans. 88 Fed. Reg. at 78,611/1. But CMS does not square that outcome with its stated aims. Although CMS notes that "people join plans because of outreach from a wide variety of sources," *id.*, CMS is undercutting the source that offers the greatest variety of options to beneficiaries (third parties such as Council members that sell a full slate of plans) in favor of the source that offers the fewer options to beneficiaries (carriers marketing only their own plans). All told, beneficiaries would have *less* choice, not more, under the Proposed Rule—contrary to Congress's commands. *See* 42 U.S.C. § 1395w-21(j)(2)(D). CMS should not move forward with a Proposal that would "thwar[t] the intent of Congress" by "accomplish[ing] the opposite of what Congress intended" in the statute. *Hernstadt v. FCC*, 677 F.2d 893, 906 (D.C. Cir. 1980) (reversing agency order and rejecting deference).

The Proposal would also reduce agents' and brokers' ability to enroll individuals in the plans that best meets their health care needs among the (now limited) options. Take one example. Agents and brokers "spend hours" with individuals helping them decide on the best plan for their specific needs. Susan Rupe, *Proposed change to Medicare Advantage agents' compensation draws fire*, Insurances Newsnet (Nov. 22, 2023), https://tinyurl.com/42pt69n2. Those meetings are productive: seniors "are more than twice as likely" to report that an agent "made sure they knew the basics of using coverage" when compared to receiving a call from their carrier at the start of a plan year, in large part because seniors need "one-on-one communication" and carriers have too many members to reach in a personalized way. Deft Research, *The Value of the Health Insurance Agent/FMO Model*, *supra*, at 3. Hours-long, personalized meetings between agents and potential enrollees take time and money. But if CMS artificially constrains Council members' ability to earn revenue from selling health plans, Council members will have to look for ways to cut costs to survive financially. That could include reducing the amount of time that agents and brokers spend discussing plan options with beneficiaries. This creates worse incentives, not better incentives, for enrolling

individuals in the plans that best meet their health care needs. That result also undermines Congress's objectives. *See* 42 U.S.C. § 1395w-21(j)(2)(D).

Further still, the Proposal would deprive beneficiaries of important services. Some administrative services, such as training and complying with marketing requirements, are non-negotiable. Council members should not be expected to provide these services at a loss. But other services, such as health risk assessments, are conditional. Council members do not, and would not, perform these services absent receiving administrative fees. Those services would disappear under the Proposed Rule if it were to apply broadly to firms. Beneficiaries would thus lose the valuable and convenient opportunity to have an agent or broker perform a health risk assessment when already meeting with the beneficiary. *See supra*, at 34. Given that many Council members predominantly serve lower-income, rural, and disabled individuals, the Proposal would ultimately harm the beneficiaries that *most* need help to select the plan that best meets their needs—contrary to the current Administration's commitment to health equity. *See* CMS, *Health Equity* (last visited Dec. 27, 2023), http://tinyurl.com/ycxh8msr.

CMS's proposal to raise the compensation cap by $31 per enrollee does nothing to avert the economic collapse threatened by the Proposed Rule. As discussed *supra* at 39-45, that increase is based on an incomplete list of the administrative services provided by Council members, and it undercompensates even the three services that CMS attempts to compensate. The $31 increase to the compensation caps is therefore a drop in the bucket that will not meaningfully reduce the risk of firms going out of business or reducing their services, all to the detriment of beneficiaries.[11]

CMS admits that one "drawback[]" of the Proposed Rule is that agents, brokers, and the firms they work for would be "unable to directly recoup administrative costs." 88 Fed. Reg. at 78,556/1. CMS brushes aside this drawback by pointing to a single administrative cost—$50 per month per agent for a customer relationship management software—and proclaiming its "belie[f]" that there is not a "large risk of agents or brokers failing to cross" the break-even point. *Id.* at 78,556/1. Even setting aside the fact that $50 underestimates the cost of customer relationship management software, *see supra*, at 41, CMS's prediction about break-even points is impossible to make without any attempt to quantify the value of *all* of the administrative payments that agents, brokers, and the firms they work for will now forgo. Nor does CMS attempt to explain how firms could make up for lost revenue when there is a ceiling on permissible payments under which all administrative services cannot possibly squeeze. As Council members know too well, their administrative payments constitute a significant portion

[11] The Proposal's financial harms would be further exacerbated if it were to eliminate administrative payments that carriers agreed *before* 2025 to pay *after* plan year 2025, such as renewal-based payments for enrollments that precede the proposed effective date—further reason for, at a minimum, clarifying CMS's intent to avoid due process concerns. *See supra*, at 14.

of their revenue. Many firms would have to *operate at a deficit* to continue to serve the market. Plainly, they will not do so.

If CMS had studied the industry in full, all these severe consequences would come as no surprise. Instead, CMS buried its head in the sand and failed to "apprise itself … of the economic consequences of [its] proposed regulation." *Chamber of Commerce v. SEC*, 412 F.3d 133, 144 (D.C. Cir. 2005). CMS concedes that its Proposed Rule would "have potential economic effects" on carriers, firms, agents, brokers, and beneficiaries. 88 Fed. Reg. at 78,610/3. CMS also concedes that it "lack[s] the data to quantify these effects." *Id.*; *see also id.* at 78,597 (admitting that CMS does "not have any data" on the number of enrollments affected by agents or brokers and using a "50%" assumption). CMS's candor is appreciated. But it only confirms that CMS's efforts to justify its proposal are plainly insufficient. CMS cannot just throw up its hands and fail to "make [the] tough choices" needed to properly estimate the economic impacts of its proposals. *Bus. Roundtable v. SEC*, 647 F.3d 1144, 1150 (D.C. Cir. 2011).

F. Alternative, reasonable solutions would address the agency's stated concerns.

There is no need for CMS to go as far as it has proposed. It is "well established that an agency has a duty to consider responsible alternatives to its chosen policy and to give a reasoned explanation for its rejection of such alternatives." *Farmers Union Cent. Exch., Inc. v. FERC*, 734 F.2d 1486, 1511 (D.C. Cir. 1984); *see also Yakima Valley Cablevision, Inc. v. FCC*, 794 F.2d 737, 746 n.36 (D.C. Cir. 1986). The Proposal flunks this elementary requirement. There are obvious, viable alternatives that CMS could have—but did not—consider to address the problematic practices it claims to have identified. The Council believes that CMS's best course is to abandon the compensation proposal entirely, but if the agency insists on pressing ahead, it should consider these alternatives to CMS's proposed industry-upheaving re-write of the existing compensation rules.

1. CMS could enforce existing rules that prevent consumer confusion and payments that exceed fair-market value.

CMS could enforce existing rules that prohibit misleading communications to beneficiaries. CMS asserts that purportedly improper financial incentives for firms, agents, and brokers are "contributing to behaviors that are driving an increase in MA marketing complaints" from beneficiaries, which complaints (in CMS's view) reflect an increase in beneficiaries receiving health plans that do not meet their needs. 88 Fed. Reg. at 78,552/2. Increased telemarketing, CMS asserts, in "some instances" results in beneficiaries becoming "clearly confused" while talking to agents or brokers. *Id.* at 78,552/3.

As CMS acknowledges in the next breath, however, the agency's "existing regulations already prohibit" plans, agents, and brokers "from engaging in misleading *or confusing*

communications" with individuals. 88 Fed. Reg. at 78,553/1 (emphasis added). For example, MA plans cannot provide "inaccurate or misleading" information, cannot use unsupported "superlatives," and cannot engage in activities that could "confuse" beneficiaries. 42 C.F.R. § 422.2262(a). Third-party marketing organizations also must provide standard disclaimers to beneficiaries when selling plans. *Id.* § 422.2267(e)(41). To the extent CMS is concerned that firms, agents, and brokers' financial incentives have created a rise in consumer confusion and that consumer confusion is a reflection of beneficiaries receiving less-than-best health plans, the appropriate response is to prioritize enforcement of an existing, on-point regulation.

Moreover, CMS amended and strengthened its regulation of misleading or confusing communications twice in the last two years. *See Medicare Program; Contract Year 2024 Changes*, 88 Fed. Reg. at 22,234 (adding provision about misleading communications); *Medicare Program; Contract Year 2023 Policy and Technical Changes*, 87 Fed. Reg. at 27,704 (adding standard disclaimer requirements). The Administration touted these amendments as "critical steps" toward protecting people from "confusing" marketing "while also ensuring they have accurate and necessary information to make coverage choices that best meet their needs." CMS, *Fact Sheet: 2024 Medicare Advantage and Part D Final Rule* (Apr. 5, 2023), http://tinyurl.com/yrmr28ts. These changes were adopted less than nine months ago; CMS must allow them to take effect, and study their efficacy, before determining that the Proposed Rule is "necessary to adequately address the rise in MA marketing complaints" about beneficiary confusion. 88 Fed. Reg. at 78,553/1.

Additionally, if CMS thinks, after gaining more information about the value of the legitimate administrative services provided by FMOs and other third parties, that plans are making administrative payments in excess of fair-market value for services, it could investigate and enforce the existing regulation providing that administrative payments must not exceed "the value of those services in the marketplace." 42 C.F.R. § 422.2274(e)(1), (2). This alternative would seemingly address CMS's concerns about agents or brokers receiving "excess payments." 88 Fed. Reg. at 78,610/3. And this alternative would be feasible: In other contexts, such as limits on physician referrals, CMS has experience implementing and enforcing requirements that certain charges be "consistent with fair market value." 42 U.S.C. § 1395nn(e)(1)(B)(iv). As a result, if CMS were correct that administrative payments are excessive, it already has the tools to remedy that perceived problem without amending the current regulations.

2. CMS could target specific practices that purportedly run afoul of current compensation requirements.

At various points in the Proposal, CMS points to specific conduct that it believes skirts the compensation rules currently on the books. To determine whether that belief is grounded in reality, CMS would first have to collect information about the nature and amount of administrative payments to understand the industry and the issues. To the extent those

concerns are legitimate and supported by evidence after further study, CMS should address those practices in a tailored way, rather than broadly changing compensation rules.

For example, CMS expresses concerns that "bonuses and perks" such as "golf parties, trips, and extra cash" are being paid to agents in exchange for enrollments, and that plans can "credibly account" for these payments as "administrative." 88 Fed. Reg. at 78,552/2. But CMS's current regulation counts as compensation "*bonuses*," "gifts," and "prizes or awards." 42 C.F.R. § 422.2274(a)(i)(B)-(D) (emphasis added). CMS does not explain how plans are credibly accounting for bonus payments as something other than bonuses. In any event, if the problem is that certain bonuses can nevertheless be construed as administrative payments, CMS could address that problem by clarifying that bonuses and perks are not permissible administrative payments, rather than subjecting all administrative payments (including payments that clearly are *not* bonuses and perks) to the compensation cap or removing the ability to recoup those costs at all.

CMS, however, fails to consider this targeted approach or explain why it would not provide a less burdensome solution to the problem it is purportedly trying to solve. This runs counter to CMS's obligation "to consider responsible alternatives to its chosen policy and to give a reasoned explanation for its rejection of such alternatives." *Am. Radio Relay League, Inc. v. FCC*, 524 F.3d 227, 242 (D.C. Cir. 2008).

3. CMS could modify the compensation cap to account for all administrative services.

If CMS nevertheless presses ahead, it must at least increase the compensation cap by an amount that fairly reflects market rates for *all* administrative services—not an arbitrary subset of them.

As discussed above, CMS's decision to increase the compensation cap by only $31 per initial enrollee is inadequate and unreasoned. *See supra*, at 40-45. CMS cherry-picks three kinds of administrative services—testing, training, and recording—to add to the compensation cap. 88 Fed. Reg. at 78,556/2. But there are many other valuable administrative services that would be excluded from the compensation cap. *See supra*, at 40-45. And CMS does not even capture the full costs of providing testing, training, and recording services. *See supra*, at 43-45.

Instead of selecting the three administrative services that it found easiest to quantify, CMS could have attempted to calculate the fair-market rates for *all* administrative payments that are currently permitted under Section 422.2274(e), and then adjusted the new compensation cap by a corresponding amount. More data would be needed to determine an appropriate estimate, but suffice it to say that $31 per initial enrollee does not cut it. *See supra*, at 40-45. That alternative would at least reduce some of the most severe economic consequences flowing from CMS's recategorization of administrative payments, *see supra*, at

45-48, while serving CMS's goal of ensuring that administrative payments are made to the right parties for the right reasons.

III. CMS's proposed limitation on contract provisions should be withdrawn or clarified.

CMS also proposes to limit plans' ability to contract with agents, brokers, or third-party marketing organizations (including FMOs). 88 Fed. Reg. at 78,624/2. Specifically, the Proposed Rule would require MA organizations to "[e]nsure that no provision of a contract with an agent, broker, or other [third-party marketing organization] has a direct or indirect effect of creating an incentive that would reasonably be expected to inhibit an agent or broker's ability to objectively assess and recommend which plan best fits the health care needs of a beneficiary." 88 Fed. Reg. at 78,624/2 (proposing amended 42 C.F.R. § 422.2274(c)(5)).[12]

This proposal is flawed for many of the same reasons the compensation provisions are flawed: CMS relies on data that is either hidden from public view or is unreliable, articulates a problem about financial incentives that does not withstand scrutiny, and does not consider alternatives. *See supra*, at 22-50. But CMS's proposed limitation on plans' contractual terms also suffers from two additional and related problems.

First, CMS has no statutory authority to limit contractual provisions that are unrelated to compensation. As discussed above, CMS has authority to regulate the "use of compensation" to create "incentives for agents and brokers to enroll individuals in the Medicare Advantage plan that is intended to best meet their health care needs." 42 U.S.C. § 1395w-21(j)(2)(D); *see supra*, at 15-16.

But the Proposed Rule on its face sweeps much broader than contractual provisions related to compensation. It prohibits *any* provision that has the effect of "creating an incentive that would reasonably be expected to inhibit" an agent's or broker's objective assessments of health plans. 88 Fed. Reg. at 78,624/2. If, for example, a contract's length or notice-of-termination provisions were deemed to have an impermissible effect for *any* reason, those provisions would apparently be unlawful—even though they have nothing to do with the compensation of agents or brokers for enrolling an individual in Medicare Advantage. CMS cannot stray outside of its statutory authority, which is limited to regulating the use of compensation, by dictating the terms of contracts generally.

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[12] In the preamble, CMS states that it proposes to add this provision at "§ 422.2274(c)(13)." 88 Fed. Reg. at 78,554/3. In the proposed codified text, CMS would add this provision as § 422.2274(c)(5). 88 Fed. Reg. at 78,624/2. The Council will use the numbering from the proposed amended text—(c)(5), not (c)(13).

Second, the Proposed Rule's limitations on contracts are impermissibly vague, sweeping in legitimate business practices and raising constitutional concerns.

The Proposed Rule would require MA organizations to "[e]nsure that no provision of a contract with an agent, broker, or other [third-party marketing organization] has a direct or indirect effect of creating an incentive that would reasonably be expected to inhibit an agent or broker's ability to objectively assess and recommend which plan best fits the health care needs of a beneficiary." 88 Fed. Reg. at 78,624/2 (proposing amended 42 C.F.R. § 422.2274(c)(5)). Although CMS claims this proposal "gives plans further direction as to the types of incentives and outcomes that must be avoided without being overly prescriptive," *id.* at 78,554/3, the Proposed Rule produces only confusion. For example, are *non-financial* incentives covered by this provision, notwithstanding CMS's exclusive focus on "financial" incentives throughout the Proposal's compensation provisions? *E.g.*, *id.* at 78,553/1-2. If so, which non-financial incentives? Is *any* inhibition sufficient to trigger this prohibition, or only inhibitions that would be material enough to change an agent's or broker's assessment or recommendation of a health plan? And just how indirect can effects be?

If CMS adopts the Proposed Rule, then plans, FMOs, agents, and brokers will be left to guess whether their contracts are unlawful. The result will be counterproductive: Plans, FMOs, agents, and brokers may be chilled into refraining from perfectly legitimate conduct. For example, some plans' contracts with FMOs have termination clauses providing that if an agent or broker sells fewer than a specified number of policies in a year, the plan has the right to unilaterally terminate that agent or broker. That provision is perfectly sensible. The administrative burdens and costs of having a low-selling agent on the roster outweighs the benefits. And predictable performance standards in contracts are important so that it is clear what conduct could result in terminating an agreement. But the Proposed Rule might outlaw—or might not, it's hard to say—these important contractual provisions. It's bad enough to rewrite private parties' contracts. It's worse still to do so while leaving the industry with this much uncertainty.

The Proposed Rule's opacity is not only bad policy, but also raises constitutional concerns. The Due Process Clause prohibits laws that fail to give adequate notice of what they prohibit. That is because a "vague law is no law at all." *United States v. Davis*, 139 S. Ct. 2319, 2323 (2019). The Proposed Rule fails this standard. Given the looseness of CMS's language—indirect, incentive, inhibit—it will be impossible for plans, FMOs, agents, and brokers to "settle upon a single definition" of what makes a contract impermissible. *Georgia Pac. v. OSHRC*, 25 F.3d 999, 1005 (11th Cir. 1994); *see also Davis*, 139 S. Ct. at 2325 (laws "must give people of common intelligence fair notice of what the law demands of them"). That uncertainty opens the door to "arbitrary and discriminatory enforcement." *City of Chicago v. Morales*, 527 U.S. 41, 56 (1999).

Although CMS provides "[e]xamples" of prohibited contract terms, the constitutional questions do not evaporate. 88 Fed. Reg. at 78,554/3. CMS does not propose to codify these examples, *id.* at 78,624/2, so the operative language remains the broad, vague standard with outer limits that cannot be discerned. Even if there is "some conduct that clearly falls within the provision's grasp," that does *not* make "a vague provision . . . constitutional." *Johnson v. United States*, 576 U.S. 591, 602 (2015).

CMS should not adopt a rule that leaves so much to chance. At a minimum, CMS should clarify that certain conduct is not covered by its new regulation, including contractual terms that—as discussed above—supply termination provisions tied to enrollments.

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CMS should withdraw the Proposed Rule's agent- and broker-compensation provisions or, at a minimum, adopt the changes identified above.

Thank you for your consideration of this comment on behalf of the Council for Medicare Choice.

Respectfully submitted,

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