Spotlight On Medicare Marketing Practices Enforcement Trend

By **Ellen London, Li Yu and Erica Hitchings** (July 10, 2025)

Ellen London

Li Yu

Erica Hitchings

Medicare Advantage organizations provide health insurance coverage to nearly 33 million Medicare beneficiaries.[1] But, as courts have recognized, there have been examples of MAOs using Medicare Advantage's basic structure to improperly exploit the program to maximize profits.[2]

From 2016 to 2023, Medicare Advantage civil fraud cases mainly focused on the submission of inaccurate diagnoses to inflate risk adjustments from the Centers for Medicare and Medicaid Services to MAOs[3] and, downstream, gainsharing payments from MAOs to providers.[4]

In the past year, however, U.S. Department of Justice enforcement, regulatory guidance and civil litigation have thrust into the spotlight improper payments to insurance brokers, physicians and medical staff to steer beneficiaries to enroll in specific Medicare Advantage plans.

On May 1, the DOJ **filed** a 213-page complaint-in-intervention in a qui tam case, U.S. ex rel. Shea v. eHealth Inc., alleging that three MAOs — Aetna, Elevance (formerly Anthem) and Humana — "knowingly and willfully paid hundreds of millions of dollars in kickbacks" to four large insurance brokers in return for steering beneficiaries.[5]

The Shea complaint not only details the specific conduct that the DOJ alleges to be improper kickback arrangements, but it also illustrates how the DOJ interprets the regulatory requirements pertaining to MAOs' compensation of insurance brokers and, more generally, the marketing of Medicare Advantage plans.

This article begins with a brief overview of the regulatory provisions and guidance on improper compensation and marketing activities. It then examines the DOJ's allegations in the Shea case and discusses how it fits with other recent settlements and litigation. Finally, we offer some practice suggestions to whistleblower and defense attorneys.

Medicare Advantage's Marketing and Broker Compensation Rules

Medicare Advantage, also known as Part C, allows Medicare beneficiaries to get coverage for hospital, physician and other healthcare services, other than prescription drug coverage from private insurers.[6]

A Medicare beneficiary typically can pick from multiple Medicare Advantage plans. The plan selection process, however, can be "confusing, difficult [and even] overwhelming" for beneficiaries, according to a KFF article.[7] As a result, Medicare beneficiaries often rely on insurance agents and brokers, and also may turn to their primary care providers, or PCPs, for advice.

However, because MAOs compete to enroll beneficiaries, they have an incentive to try to utilize the influence that insurance brokers and PCPs have over plan selection by Medicare beneficiaries. This may result in a situation, as the U.S. Department of Health and Human Services' Office of Inspector General has cautioned, in which the MAOs may offer improper inducements in return for inappropriate steering of patients to their plans.[8]

To address this risk, CMS has promulgated regulations and guidelines regarding MAOs' payments to insurance brokers and how MAOs must interact with PCPs in terms of marketing.

For insurance brokers, CMS regulations cap the amounts that an MAO can pay insurance brokers for each new enrollment[9] and reenrollment.[10] CMS regulations further define these total enrollment compensation limits to "include[] monetary or non-monetary remuneration of any kind," such as commissions, bonuses, gifts, prizes or awards.[11]

In addition to the enrollment-based compensation, CMS regulations also have permitted MAOs to pay insurance brokers for bona fide administrative services, which are often called override payments to brokers.

Recognizing the potential for abuse, CMS warned MAOs and brokers against using "these administrative payments as a means to circumvent the limits on compensation to agents and brokers."[12] CMS also has repeatedly highlighted the risk that excessive administrative payments from MAOs to brokers could violate the Anti-Kickback Statute.[13]

Prior to January 2021, CMS regulations specified that MAOs' administrative payments to insurance brokers must be for "services other than selling insurance products."[14]

While this regulatory restriction was relaxed in January 2021 to allow administrative payments to be based on enrollment, CMS nonetheless continues to require such payments to be set at or below fair market value.[15]

When it comes to PCPs and their staff, CMS regulations are designed to delineate between the medical services provided by PCPs and their staff and the marketing efforts of MAOs and brokers. For example, CMS regulations expressly prohibit marketing activities by MAOs and the distribution of enrollment forms in provider offices or places where healthcare is delivered.[16]

CMS guidelines also forbid MAOs from involving PCPs and their staff in marketing activities, including efforts by medical staff to "urge or attempt to persuade ... patients to enroll in a specific [MA] plan based on financial or any other interests of the provider [or staff]" or to perform "any marketing or enrollment activities" compensated by an MAO.[17]

Key Allegations in the DOJ's Shea Complaint-in-Intervention

While the DOJ's 213-page complaint in Shea contains a multitude of details, there are four key elements to the alleged kickback arrangements between the three MAOs and the four insurance brokers.

First, the DOJ alleges that the brokers exploited beneficiaries' confusion with the Medicare Advantage plan selection process. Specifically, the brokers typically advertised themselves as neutrally helping beneficiaries pick "plans from the nation's top insurers" and claimed to be unbiased in seeking to match the beneficiaries' needs to an appropriate plan.[18]

Second, the complaint highlights how the brokers utilized predictive scoring and lead handling systems that enabled them to assess how likely it was that a given beneficiary would enroll in a plan and tailor their call handling to steer beneficiaries to particular plans.

For example, according to the DOJ, a 2018 internal document touted eHealth's ability to pull levers — such as "more aggressively answer[ing]/rout[ing] the calls" likely to enroll with a specific MAO's plans — to "disproportionately drive … enrollments" to that MAO.[19]

Third, the DOJ alleges that executives at the three MAOs entered into marketing or administrative service arrangements with brokers under which a broker would steer beneficiaries to a particular MAO.

For example, according to the DOJ, Humana used its marketing agreements to get brokers to create pods of agents who either only sold Humana's Medicare Advantage plans or were rewarded with extra pay for selling Humana's plans.[20] In other words, those agents were steering beneficiaries to Humana's plans while representing that they were acting in the best interests of the beneficiaries in an unbiased way.[21]

Similarly, the DOJ alleges that Aetna decided to pay marketing fees to insurance brokers to buy sales of its Medicare Advantage plans as part of a pay-for-performance system.[22] For example, the DOJ quotes the testimony of an Aetna executive that because "other [MA] carriers were paying them earlier," "the only way [for Aetna] to participate and to have a seat at the table was to support [the brokers] with marketing funds."[23]

Fourth, the complaint asserts that MAOs disguised their payments to the brokers as for marketing or administrative services when, in fact, the payments were calculated based on enrollment targets that the brokers would generate for the MAOs' plans.

For example, the DOJ alleges that Aetna "attempted to hide the true purpose of payments" to the insurance brokers by characterizing the payments in the contracts as for "reimbursing the [brokers] for the cost of purchasing or generating 'leads' or calls."[24] But it was understood, according to the DOJ, this was a fiction — in one internal email, an eHealth employee opined that Aetna's payments were "not even a little compliant" and that "if Aetna got audited by cms, they'd be fu[**]ed."[25]

Similarity, the DOJ alleges that executives at Humana "back[ed] into" the specific amounts of the marketing reimbursements to the brokers based not on the brokers' costs or fair market value, but instead on Humana's desired cost per enrollment.[26]

An Enforcement Trend Focusing on Marketing in the Medicare Advantage Context

Recent DOJ enforcement actions, civil litigation and HHS OIG guidance show that Shea represents an increasing focus by both the government and whistleblower attorneys on Medicare Advantage marketing practices.

In September 2024, the DOJ announced a $60 million settlement with Oak Street Health, a subsidiary of CVS, based on allegations that Oak Street gave kickbacks to insurance agents to recruit patients to its clinics.[27] Specifically, the DOJ alleged that Oak Street paid insurance agents approximately $200 per referral in return for delivering marketing messages to seniors enrolled in Medicare Advantage plans and then connecting Oak Street employees to the seniors via "warm transfer[s]."[28]

Three months later, the DOJ announced a $15.2 million settlement with MMM Holdings LLC, an MAO in Puerto Rico, based on allegations of AKS violations involving a gift card incentive program.[29] According to the DOJ, MMM systematically distributed gift cards to administrative assistants working in healthcare providers' offices to induce them to recommend MMM's Medicare Advantage plans to thousands of Medicare beneficiaries.[30]

Marketing practices involving Medicare Advantage plans have also been litigated in declined qui tam cases. In September 2024, the U.S. District Court for the Southern District of Florida denied the MAO defendants' motions to dismiss, inter alia, alleged patient-steering AKS violations in U.S. ex rel. Butler v. Shikara.[31]

Specifically, relators allege that Mazin Shikara, a physician who operated a large medical practice, an insurance broker, and a medical management services organization, used his insurance brokerage to steer patients to the MAO that paid Shikara the most remuneration.[32] In return for patient steering, the MAOs allegedly paid commissions to Shikara's insurance broker and elevated reimbursements to Shikara's medical practice.[33]

By contrast, the U.S. Court of Appeals for the Eighth Circuit upheld the U.S. District Court for the Western District of Missouri's dismissal of a declined qui tam case, U.S. ex rel. Holt v. Medicare Medicaid Advisors Inc. which alleged, inter alia, a broker engaging in unlawful marketing practices such as cold-calling and door-to-door sales of Medicare Advantage plans.[34]

Specifically, the Eighth Circuit affirmed the court's dismissal on the grounds that the relator failed to adequately plead materiality.[35]

Finally, in December 2024, HHS OIG issued a special fraud alert to warn the healthcare industry about abusive payments relating to Medicare Advantage plan enrollment and provider selection.[36]

This fraud alert focused on (1) payments from MAOs to providers or their staff to steer beneficiary enrollment and (2) payments from providers to agents and brokers for patient referrals. Both practices, the OIG noted, implicate the AKS and can lead to "unfair competition and improper [patient] steering."[37]

The alert lists nine suspect characteristics of arrangements with heightened risk of fraud or abuse.[38] Six characteristics relate to gifts, payments or other remuneration from MAOs to providers or their staff. Such remuneration is suspect, according to the OIG, if it is tied to referrals, recommendations, marketing, sharing patient information or patients' demographic or health status.[39]

The OIG also highlighted three suspect characteristics where the remuneration from providers to agents and brokers is tied to referrals or recommendations or is contingent on patients' demographic or health status.[40]

Practice Suggestions

For whistleblower attorneys, the DOJ's intervention in Shea and other recent government actions are a reminder that Medicare Advantage fraud remains an enforcement priority for DOJ.

The range of improper arrangements alleged in these cases and highlighted in the OIG's fraud alert also makes clear that Medicare Advantage fraud takes many forms.

Whistleblower attorneys, therefore, must analyze the facts of each qui tam case to assess whether an arrangement has an improper purpose or violates a regulation.

Further, as Shea shows, parties to improper arrangements often use anodyne language to disguise their true goals. It is thus critical for whistleblower attorneys to identify discrepancies between the stated and the actual purposes of arrangements relating to Medicare beneficiary enrollment.

Finally, the different outcomes in Shikara and Holt underscore the importance to offer detailed materiality allegations and articulate why a claim is actionable under the False Claims Act. As Shikara noted, identifying past enforcement actions based on the same type of regulations or behavior can nudge a claim past the materiality threshold.[41]

For defense attorneys, it will be key to point out that not every payment to a Medicare Advantage insurance broker is fraudulent and not every form of advising beneficiaries is an example of improper steering. The level of detail in Shea described above shows that the government will take an extremely close look at the facts of a case to ensure that the alleged conduct has potentially crossed a line.

In addition, the Eighth Circuit's analysis in Holt will be critical in making materiality arguments. The district court holding in Holt raises fundamental questions about the premise of these types of fraud allegations, given that the payments at issue are not made directly by CMS. FCA practitioners should closely monitor this space as additional courts confront these issues.

Ellen London is a shareholder at London & Naor PC.

Li Yu is a partner at Bernstein Litowitz Berger & Grossmann LLP.

Erica Blachman Hitchings is a partner at the Whistleblower Law Collaborative LLC.

Disclosure: Erica Hitchings represents the qui tam relator in U.S. ex rel. Butler v. Shikara.

[1] See https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2024-enrollment-update-and-key-trends/.

[2] U.S. ex rel. Swoben v. United Healthcare , 848 F.3d 1161,1164 (9th Cir. 2016).

[3] See, e.g., United States v. Anthem, Inc. , 2022 WL 4815978 (S.D.N.Y. Sept. 30, 2022).

[4] See, e.g., https://www.justice.gov/archives/opa/pr/sutter-health-and-affiliates-pay-90-million-settle-false-claims-act-allegations-mischarging#.

[5] U.S. ex rel. Shea v. eHealth, Inc., 21-cv-11777 (D. Mass.), Dkt. 40 at 1 ("Shea DOJ Complaint").

[6] Medicare Part D provides prescription drug coverage.

[7] https://www.kff.org/medicare/report/what-do-people-with-medicare-think-about-the-role-of-marketing-shopping-for-medicare-options-and-their-coverage/.

[8] See HHS-OIG Special Fraud Alert: Suspect Payments in Marketing Arrangements Related to Medical Advantage and Providers (the "HHS-OIG MA Marketing Alert") (Dec. 11, 2024) (available at: https://oig.hhs.gov/compliance/alerts/).

[9] See 42 C.F.R. § 422.2274(a).

[10] See id. § 2274(d).

[11] Id. § 2274(a)(i).

[12] See 86 Fed. Reg. 5864, 5994 (Jan. 19, 2021).

[13] See, e.g., 73 Fed. Reg. 54,226, 54,239 (Sept. 18, 2008); 73 Fed. Reg. 67, 406, 67,410 (Nov. 14, 2008).

[14] 42 C.F.R. § 422.2274(b)(1)(iv) (2020).

[15] See 42 C.F.R. § 422.2274(e) (2021).

[16] 42 C.F.R. § 422.2268(c).

[17] Medicare Communications & Marketing Guidelines § 602.

[18] See Shea DOJ Complaint ¶¶ 54-55, 68.

[19] Id. ¶¶ 61-62. Similarly, GoHealth alleged utilized an "advance call routing methodology" that allowed it to prioritize calls likely to generate more enrollments for a favored MAO, such as by putting an "Anthem override" into its system to give Anthem-oriented calls "a higher overall value." Id. ¶¶ 63-64.

[20] Id. ¶¶ 109-110.

[21] Id. ¶¶ 107-108.

[22] Id. ¶¶ 380-382.

[23] Id. ¶ 386.

[24] Id. ¶ 385.

[25] Id.

[26] Id. ¶ 107. In 2020, for example, Human allegedly agreed to pay GoHealth approximately $40 million to supposed marketing services after GoHealth presented a plan to generate 288,740 enrollments for Human's plans. See id. ¶¶ 167-177.

[27] https://www.justice.gov/archives/opa/pr/oak-street-health-agrees-pay-60m-resolve-

alleged-false-claims-act-liability-paying-kickbacks.

[28] See id.

[29] https://www.justice.gov/usao-pr/pr/mmm-holdings-llc-agrees-pay-152-million-dollars-resolve-allegations-it-violated-false.

[30] See id.

[31] U.S. ex rel. Butler v. Shikara , 748 F.Supp.3d 1277 (S.D. Fla. 2024).

[32] Id. at 1289.

[33] Id. at 1289-90.

[34] U.S. ex rel. Holt v. Medicare Medicaid Advisors, Inc. , 115 F. 4th 908 (8th Cir. 2024).

[35] Id. at 917-923 (notably, the Eighth Circuit did not address the district court's holding that claims submitted to MAOs do not constitute "claims" under the FCA, which DOJ, as amicus, argued was "incorrect.").

[36] See HHS-OIG MA Marketing Alert at 1.

[37] Id. at 1-2.

[38] Id. at 5.

[39] Id.

[40] Id.

[41] See Shikara, 748 F.Supp.3d at 1302 n. 1.