United States Congress
Joint Economic Committee
Est. 1946

ISSUE BRIEF

# Right Plans or Wrong Incentives? How Broker Payments May Raise Federal Spending

June 23, 2026

## Executive summary


- **Broker spending is large and rising.** Across Medicare Advantage (MA), Part D, and *Affordable Care Act*-regulated markets, annual broker spending now exceeds $25 billion, with MA accounting for the largest share.

- **Agents and brokers therefore play a rapidly growing role in federally subsidized health insurance markets.** Despite this, relatively little is known about the effects of this spending. On one hand, agents and brokers may help consumers compare plans and make more informed choices. On the other, insurers pay brokers' commissions, creating incentives that may not align with consumers' interests.

- **ACA Marketplace broker spending rose sharply after 2020.** This increase coincided with rapid enrollment growth and expanded premium subsidies, raising questions about whether higher commissions reflect improved consumer assistance or subsidized enrollment growth in a market with documented program integrity concerns.

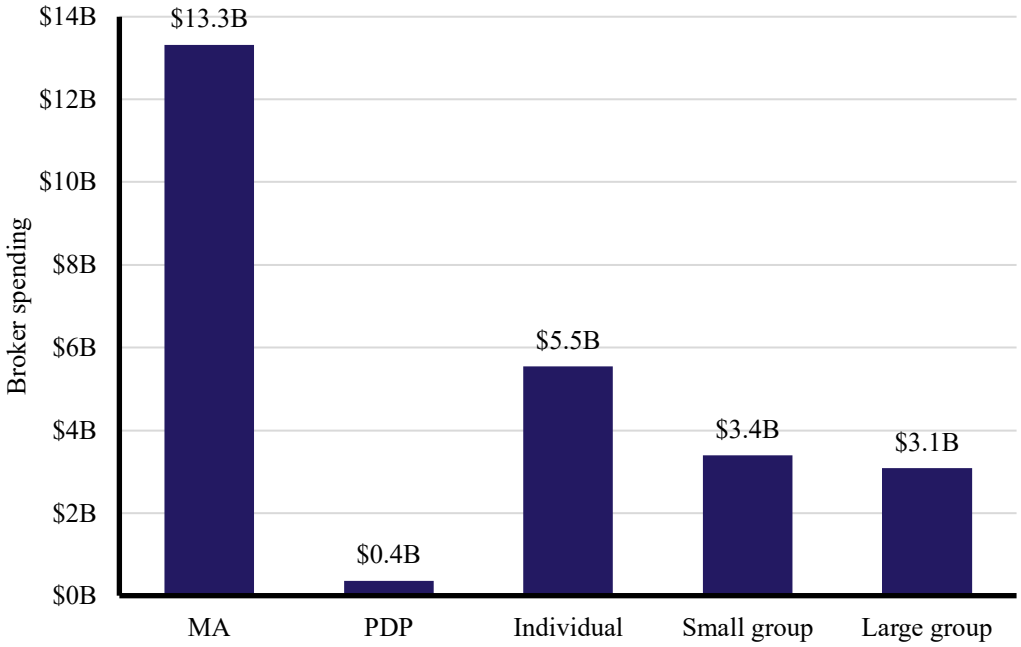
- **The Joint Economic Committee finds that MA insurers spent an average of $234 per member per year on brokers in 2023.** That exceeds the amount spent on vision, hearing, dental, and several other categories combined, and it amounts to about one-third of total reported spending on supplemental benefits.

- **Higher broker spending is associated with higher overpayments from coding intensity, especially among the largest insurers.** The positive relationship is driven by the ten largest MA insurers, suggesting that scale may matter in the broker-overpayment association.

## Introduction

Health insurance markets, including Medicare Advantage (MA) or the Affordable Care Act (ACA) Marketplace, are notoriously difficult for beneficiaries to navigate and enroll in their most suitable plans. Beneficiaries frequently struggle to accurately determine their health care needs and understand general pricing, including premium and out-of-pocket expenses. Agents and brokers have materialized to ameliorate beneficiaries' difficulties in navigating many health insurance markets. Brokers interact with tens of millions of beneficiaries across U.S. health insurance markets every year, resulting in broker spending that exceeds an estimated $25 billion annually, as shown in Figure 1.

**Figure 1:** Projected Broker Spending in U.S. Health Insurance Markets, 2025




Sources: Meyers et al.;[1] Centers for Medicare & Medicaid Services;[2] JEC calculations[3]

Agents' roles vary from market to market, but broadly, they collaborate with beneficiaries throughout the insurance process, from plan identification to enrollment. These plans provide

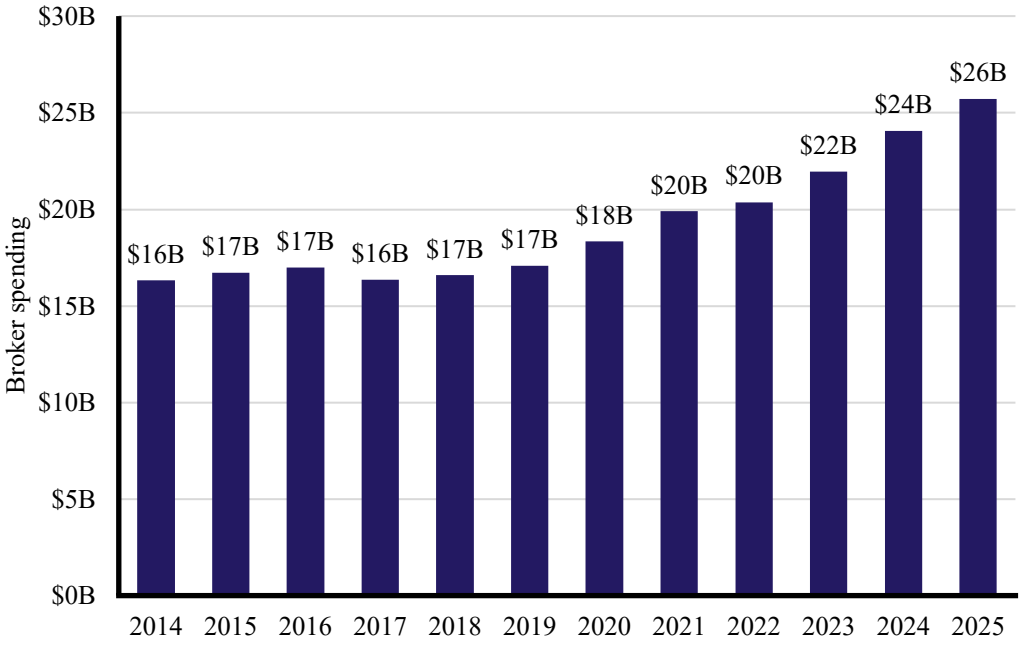
[1] David J. Meyers, J. Shroff, J. Marr, E. Balkan, Andrew M. Ryan, and Amal N. Trivedi. "Trends in Broker Enrollment and Spending in Medicare Advantage," *JAMA Internal Medicine*, published online May 18, 2026, https://doi.org/10.1001/jamainternmed.2026.0864.

[2] Centers for Medicare & Medicaid Services. 2026. "Medical Loss Ratio." Last modified March 25, 2026. Accessed June 18, 2026. https://www.cms.gov/medicare/health-drug-plans/medical-loss-ratio; Centers for Medicare & Medicaid Services. 2026. "Medical Loss Ratio Data and System Resources." Last modified March 13, 2026. Accessed June 18, 2026. https://www.cms.gov/marketplace/resources/data/medical-loss-ratio-data-systems-resources; Centers for Medicare & Medicaid Services. 2026. "Monthly MA Enrollment by State/County/Contract." Last modified May 15, 2026. Accessed June 18, 2026. https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-advantagepart-d-contract-and-enrollment-data/monthly-ma-enrollment-state/county/contract.

[3] All values are linear projections of broker spending for the Contract Year 2025 Medicare markets and the reporting-year 2025 ACA Marketplace based on inflation-adjusted spending data. All spending data are inflation-adjusted to 2025 dollars.

care to tens of millions of beneficiaries every year, and any inefficiencies in plan selection can amount to substantial economic losses to consumers. The use of agents in plan selection has grown significantly in recent years, with assistance in the ACA marketplace alone growing from 3.4 million in the 2021 Open Enrollment Period (OEP) to 8.2 million in the 2026 OEP, far outpacing overall growth, along with substantial increases in overall spending across markets.[4] This could reflect better choice assistance, with more beneficiaries turning to market experts for plan decisions, consistent with the classic theoretical case for intermediation: experts help consumers navigate complex markets and choose appropriate insurance plans.

**Figure 2:** Total Annual Health Insurance Broker Spending, 2014–2025




Source: Meyers et al.; Centers for Medicare & Medicaid Services; JEC calculations[5]

However, if broker incentives are not fully aligned with beneficiaries' interests, their role in plan selection may produce limited, or even negative, value for consumers. In practice, broker commissions throughout Medicare and ACA markets are paid by insurance companies themselves. The recently observed increase in broker compensation across markets, as seen in Figure 2, may reflect better plan allocation. Alternatively, this increase in spending may reflect incentives that are not fully aligned with enrollees' interests, potentially encouraging improper enrollment, plan steering, and increased coding intensity, practices that raise spending without commensurate value to beneficiaries or taxpayers.

[4] Centers for Medicare & Medicaid Services, "Health Insurance Exchanges 2026 Open Enrollment Report," 9, https://www.cms.gov/files/document/health-insurance-exchanges-2026-open-enrollment-report.pdf.
[5] Part D spending for years 2018 through 2022 is interpolated and 2024 through 2025 is linearly projected, while MA spending for 2023 through 2025 is linearly projected. All 2025 ACA Marketplace broker spending are linear projections based on the preceding three years of observed CMS data. All spending data are inflation-adjusted to 2025 dollars.

This issue brief evaluates the efficacy of brokers in the health insurance sector by analyzing broker spending totals across markets, assessing claims of improper enrollments, and testing correlation between broker spending and overpayments due to coding intensity in MA. The Joint Economic Committee finds that the increase in federal spending to brokers in the market is associated with higher estimated overpayments from coding intensity. Because insurers pay broker commissions directly, brokers may have incentives to steer beneficiaries toward plans that generate the largest compensation.

The brief begins with an overview of intermediation and information retrieval literature, which provides a detailed explanation of the existence and theoretical purpose of brokers and agents in complex marketplaces. We then review more contemporary analysis of broker activity in health insurance marketplaces, noting the potential mechanisms by which value to beneficiaries may be added, as well as improper activity and shortcomings of the current structure. Following this literature review, we briefly explain our methodology for analyzing broker commissions across health care markets, then present results showing significant growth across observed markets. Expanding on our findings in the MA market, we then test the relationship between broker spending per member and overpayments from coding intensity.

**Literature review**

Individuals entering any market face the problem of being undereducated on the intricacies of a product and the firms selling the product that would best suit their needs. To become knowledgeable in any market, the cost to the consumer is entirely dependent on how much that consumer's time is worth to research the product. Moreover, as discussed extensively by Stigler (1961), consumers attempting to find the best price for a particular good must spend time canvassing vendors of the product to encounter the most optimal price in the market. Stigler demonstrates that, particularly in complex marketplaces, consumers typically fail to search the market optimally. As such, it is concluded that when intermediaries operate to canvass vendors of the product, price dispersion decreases as the information becomes more accessible to consumers, in turn lowering overall cost burdens to consumers.[6]

Biglaiser (1993) advances this concept of intermediaries as a price-gathering mechanism, regarding them as experts of quality. This paper contends that intermediaries become knowledgeable of the quality of the service provided by a vendor within a particular market. Additionally, it is noted that by these intermediaries becoming experts of a particular market, they also reduce the imbalance of information on a given product between vendor and consumer. Biglaiser identifies that intermediaries are more prevalent in markets where quality is difficult to

[6] George J. Stigler, "The Economics of Information," *Journal of Political Economy* 69 no. 3 (1961): 213–225, https://www.jstor.org/stable/1829263.

assess, expertise is costly, and where switching costs are low. He also predicts that prices are likely to be higher in intermediated markets, but the quality of product that a particular consumer is matched with is far higher than if that same market were not intermediated.[7] In a more sector-specific and contemporary analysis in Gürel (2024), enhanced direct enrollment (EDE) pathways, which are designed to improve broker workflows during the enrollment process in the individual ACA Marketplace, were found to have effectively facilitated enrollment and reduced complexity for beneficiaries.[8]

While intermediaries are largely determined to have positive outcomes on the markets in which they operate, the issue of incentive structures bears much weight on this issue, as in any case when consumers and producers are typically motivated toward diverging ends. Preliminary analysis of this phenomenon as expanded upon in Crawford & Sobel (1982) determine that as main objectives among senders and receivers of information diverge, communication becomes less informative, and in some cases, more biased.[9] Relating this to the literature from Stigler (1961) and Biglaiser (1993), it is shown that a divergence of incentives may greatly impact the quality of information relayed by intermediaries to consumers, for example price, quality of the good, and fit to consumer.

Misalignment of incentives has been an observable phenomenon in the ACA Marketplace and a priority for CMS for years. Federally-facilitated Marketplaces (FFMs) have been plagued by agents making changes to recipients plans without consent, attempting to draw commission-based compensation without enrollee knowledge.[10] CMS estimates that roughly 200,000 consumers in the ACA Marketplace were victims of unauthorized plan manipulation in 2025 alone.[11] However, not all of the onus falls on the brokers, as a recent Government Accountability Office (GAO) investigation into the fraud risks in the ACA Marketplace revealed other shortcomings of the system. In plan year 2025, GAO found that 18 out of 20 fictitious consumers remained actively enrolled in subsidized coverage through the federal marketplace.[12] While this does not directly implicate brokers in every case, it does point to vulnerabilities in the enrollment system.

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[7] Gary Biglaiser, "Middlemen as Experts," *RAND Journal of Economics* 24, no. 2 (1993): 212–223, https://doi.org/10.2307/2555758.
[8] Aleka Gürel, "The Impact of Brokers on ACA Marketplace Growth," *Risk Management and Insurance Review* 27, no. 2 (2024): 227–236, https://doi.org/10.1111/rmir.12280.
[9] Vincent P. Crawford and Joel Sobel, "Strategic Information Transmission," *Econometrica* 50, no. 6 (1982): 1431–1451, https://doi.org/10.2307/1913390.
[10] Centers for Medicare & Medicaid Services, "CMS Update on Actions to Prevent Unauthorized Agent and Broker Marketplace Activity," Press Release, October 17, 2024, https://www.cms.gov/newsroom/press-releases/cms-update-actions-prevent-unauthorized-agent-broker-marketplace-activity.
[11] Centers for Medicare & Medicaid Services, "CMS Actions to Protect Consumers and Strengthen Exchange Program Integrity," Fact Sheet, January 28, 2026, https://www.cms.gov/newsroom/fact-sheets/cms-actions-protect-consumers-strengthen-exchange-program-integrity.
[12] U.S. Government Accountability Office, *Patient Protection and Affordable Care Act: Preliminary Results from Ongoing Review Suggest Fraud Risks in the Advance Premium Tax Credit Persist*, GAO-26-108742 (Washington, DC: GAO, December 3, 2025), https://www.gao.gov/assets/gao-26-108742.pdf.

While some literature illustrates the value of intermediaries in complex marketplaces such as insurance markets, other literature and broad evidence suggests that their effectiveness may be more limited. Behavioral studies summarized in Chandra et al. (2019) emphasize the difficulties consumers face due to the complexity of the healthcare insurance market.[13] A working paper by economists Jonathan Gruber, Benjamin Handel, Samuel Kina, and Jonathan Kolstad examines the role of agents and supplemental artificial intelligence in MA plan selection. Researchers used administrative data from a large private Medicare exchange and compared outcomes from before the agent in the exchange had access to decision support systems in 2015 to after their widespread adoption in 2017. They find that, in 2015, skilled agents failed to eliminate choice errors in plan selection, resulting in a cost to consumers of $1,260 on average. This finding, which is consistent with similar literature evaluating the efficacy of intermediaries in plan selection, indicates that agents frequently fail to make near-optimal choices for insurance plans.

The study highlights misaligned weighting of expenses as one of the systematic decision errors, finding that plan premiums are weighted 6.5 times more in plan evaluation than general out-of-pocket costs are. With the introduction of AI decision support tools in plan evaluation in 2017, the burden to the average financial loss fell by $278, indicating substantially more efficient plan selection while improving alignment between premiums and overall expected medical spending. In addition to these financial gains, AI was found to have improved the performance of low-skill agents, increased general productivity, and reduced enrollment time. This study highlights the shortcomings of brokers within the healthcare sector and their inefficiency in minimizing financial burden in plan selection. However, the evidence also indicates the potential for AI and other decision support technologies to reduce mistakes in plan selection, check brokers' incentives, and reduce overall costs to consumers.[14]

## Findings

*Methodology and empirical results:* Affordable Care Act *Marketplace*

This analysis uses publicly available data from the CMS Medical Loss Ratio (MLR) data. Public Use Files (PUFs) for reporting years 2011 through 2024 are obtained for the ACA Marketplace, and contract year data for years 2014 through 2017 and 2023 for the MA and Part D markets are initially used. Lack of reporting in the Medicare markets for years 2018 through 2022 is due to changes in reporting rules, which relaxed the data requirements for reporting organizations.[15]

[13] Amitabh Chandra, Benjamin Handel, and Joshua Schwartzstein, "Behavioral Economics and Health-Care Markets," in *Handbook of Behavioral Economics: Foundations and Applications 1*, vol. 2, ed. B. Douglas Bernheim, Stefano DellaVigna, and David Laibson (Amsterdam: Elsevier/North-Holland, 2019), 459–502, https://doi.org/10.1016/bs.hesbe.2018.11.004.
[14] Jonathan Gruber, Benjamin Handel, Samuel H. Kina, and Jonathan Kolstad, "Managing Intelligence: Skilled Experts and AI in Markets for Complex Products," NBER Working Paper No. 27038 (Cambridge, MA: National Bureau of Economic Research, 2020), https://doi.org/10.3386/w27038.
[15] MLR reporting requirements were initially relaxed by CMS-4182-F in April of 2018, altering the regulations at 42 CFR §§ 422.2460 and 423.2460. Reporting requirements for issuers that had been suspended were reinstated with CMS-4192-F in April of 2022, requiring broker fees reporting moving forward.

Due to this lack of broker data, we use data from Meyers et al. for years 2014 through 2022 for MA and interpolation for Medicare Part D.

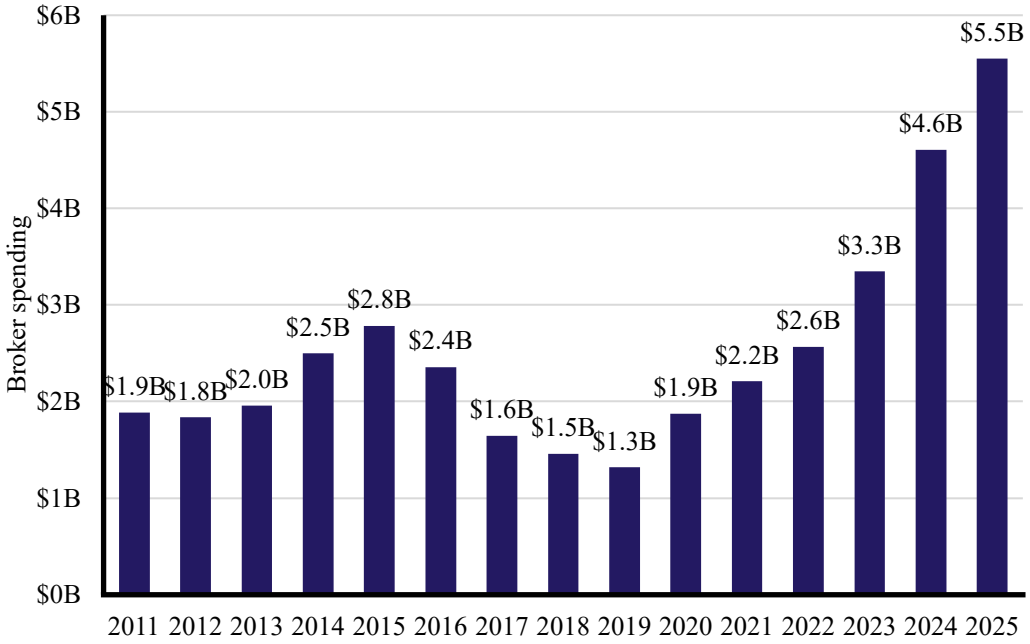
Among ACA Marketplace data, we use the issuer-reported MLR data, which contains claims and financial information ordered by market segment. Each issuer reports expenses of agent/broker commissions for the individual, small, and large groups. The Medicare MLR data include agent/broker fees and commissions data for all MA organizations and Part D contracts for a given contract year. Because this dataset includes MA and Part D plans, it is filtered by the result of aggregation and deduplication of the monthly MA Enrollment datasets for every observed year, yielding separate MA and Part D MLR datasets. ACA broker fees are calculated as the sum of the broker compensation across issuers from 2011 through 2024 and the Medicare health insurance markets for reporting years 2014 through 2017 and 2023.

We find that there is substantial evidence to conclude that broker compensation in the ACA individual market is large and growing as an expenditure category.[16] As shown in Figure 3, broker compensation was relatively level and constant throughout roughly the first half of the data selection (2011–2019), and accelerated growth after 2020 is evident in the data, with a nearly 200 percent increase from 2020 onward. Much of this growth in the ACA Marketplace may be attributed to the enhanced premium tax credits implementation during the *American Rescue Plan Act* of 2021 (ARPA) and extension in the *Inflation Reduction Act* of 2022 (IRA).[17]

[16] Centers for Medicare & Medicaid Services. 2026. "Medical Loss Ratio Data and System Resources." Last modified March 13, 2026. Accessed June 18, 2026. https://www.cms.gov/marketplace/resources/data/medical-loss-ratio-data-systems-resources; JEC Calculations.

[17] Section 9661 of the ARPA established a "temporary rule for 2021 and 2022" that removed the income eligibility cap, previously set at 400 percent of the federal poverty level—$128,600 per year for a family of four in 2025. Section 12001 of the IRA extended this temporary rule to the end of 2025.

**Figure 3:** ACA Individual Marketplace Broker Spending, 2011–2025

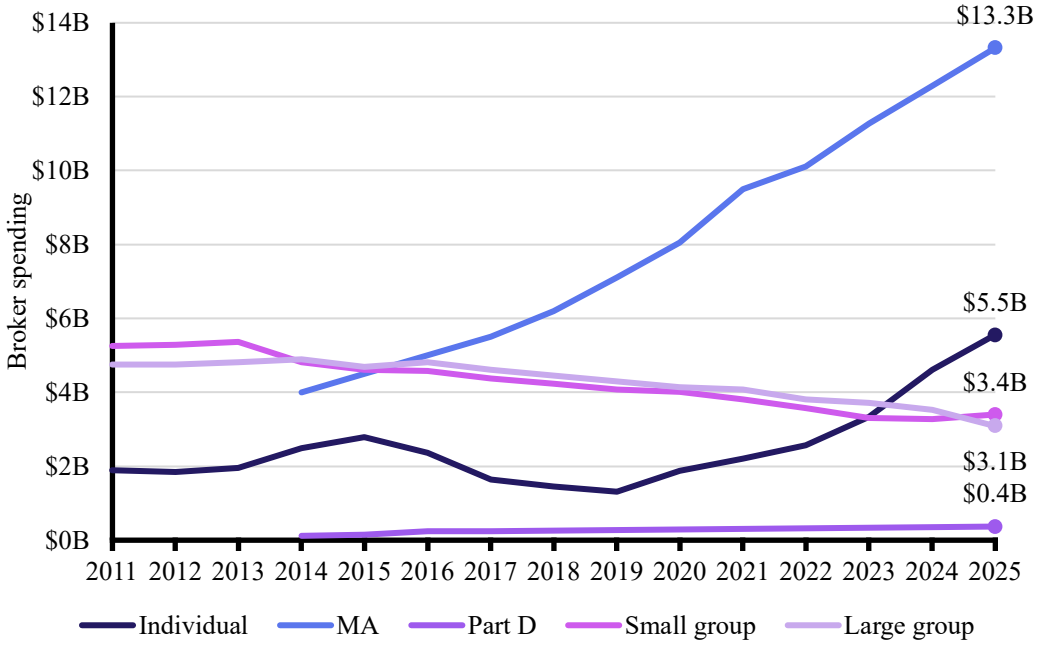



Source: Centers for Medicare & Medicaid Services; JEC calculations[18]

While the changes to premium tax credits have since expired, the long-term effects on price signals and market integrity have yet to be fully evaluated as it was previously determined that other ACA Marketplace expenditures will remain at heightened levels into 2026 and beyond.[19] Some of the growth in broker spending might be due to these downstream effects, but evidence suggests there may be other factors at play. Massive instances of unauthorized enrollment cancellations identified by CMS, as well as GAO investigations into fictitious enrollment in the marketplace may point to both brokers and insurers operating outside the bounds of consumers' interests. With increases in the individual ACA market mirroring those observed in MA, as seen in Figure 4, these trends raise questions about whether broker incentives are aligned to improve plan selection and create value for consumers, or instead drive higher costs for taxpayers across insurance marketplaces.[20]

[18] 2025 value projected via linear trend on the last three years of observed data. All spending data are inflation-adjusted to 2025 dollars.
[19] U.S. Senate Joint Economic Committee. *Long Overdue: Enhanced Premium Tax Credits Should Expire.* Issue Brief. Washington, DC: Joint Economic Committee, November 6, 2025.
[20] Meyers et al., "Trends in Broker Enrollment and Spending in Medicare Advantage."

**Figure 4:** Agent/Broker Spending in U.S. Health Insurance Marketplaces, 2011–2025




Sources: Meyers et al.; Centers for Medicare & Medicaid Services; JEC calculations[21]

*Methodology and empirical results: Medicare Advantage*

For our analysis of the relationship between broker spending and overpayments due to coding intensity, we linked contract-level agent and broker spending from the 2023 Medical Loss Ratio data to contract-level MA coding-intensity estimates from the MediCode dataset provided by researchers at Brown University.[22] Broker spending is measured as agents' and brokers' fees and commissions per member per year. The primary outcome is estimated overpayments from coding intensity per member per year, based on the Demographic Estimate of Coding Intensity, or DECI. The DECI measure accounts for baseline demographic differences including age, sex, Medicaid eligibility, and institutional status, and attributes any remaining differences in risk scores between the traditional Medicare and MA populations to coding intensity.

MediCode uses 2021 MA encounter data and projects the estimates forward to 2025 enrollment and payment levels. We construct measures of overpayments due to coding intensity that are net of the 5.9 percent coding adjustment that CMS applies. Positive values indicate estimated overpayments remaining after the CMS adjustment; negative values indicate that CMS's adjustment exceeds the contract's estimated differential coding. However, note that the DECI

[21] Part D spending for years 2018 through 2022 is interpolated and 2024 through 2025 is linearly projected, while MA spending for 2023 through 2025 is linearly projected. All 2025 ACA Marketplace broker spending are linear projections based on the preceding three years of observed CMS data. All spending data are inflation-adjusted to 2025 dollars.
[22] Brown University Center for Advancing Health Policy Through Research, "MediCode Report Card Public Use Data," https://doi.org/10.26300/60aa-zt74.

measure does not account for favorable selection, so negative values does not necessarily mean that the contract is being paid less per member than it would cost for the government if that member was covered under traditional Medicare.

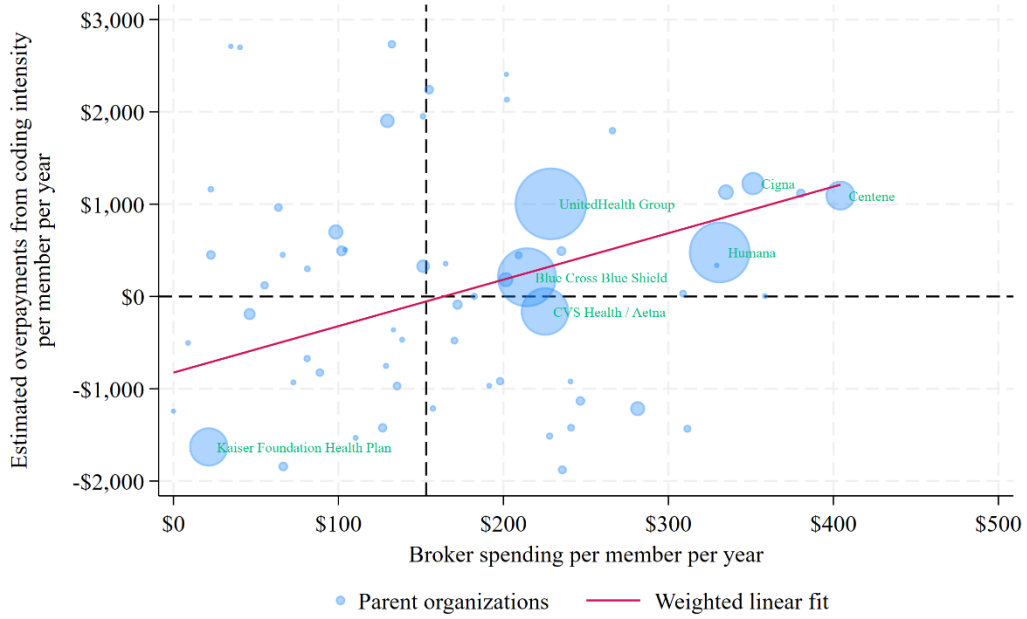
The main results are shown at the parent-organization level because broker compensation, distribution strategy, enrollment growth, and coding infrastructure are often business-model decisions made at the organizational, rather than the individual contract level. Contracts are therefore aggregated to their respective parent organizations.[23]

*Broker spending is associated with higher overpayments from coding intensity*

Figure 5 shows the parent-organization relationship between agent and broker spending and estimated overpayments from coding intensity. Each circle represents an MA parent organization, and the circle size reflects the organization's enrollment. The horizontal axis shows the annual broker spending per member for each organization. The vertical axis shows estimated coding-related overpayments per member per year after accounting for CMS's 5.9 percent coding-pattern adjustment. The dashed vertical line shows the unweighted median level of broker spending of about $153 per member per year.

[23] This aggregation primarily groups contracts listed under the same parent organization but also combines Blue-plan entities such as Blue Cross, Blue Shield, Blue Cross Blue Shield, Anthem/Elevance, and related entities, under a single umbrella, in cases where those entities are legally organized separately.

**Figure 5:** Broker Spending is Associated with Higher Coding-Related Overpayments




Source: JEC analysis of 2023 CMS Medical Loss Ratio data and MediCode data[24]

The figures show a clear positive overall relationship between broker spending and estimated coding-intensity overpayments. Parent organizations with higher broker spending tend to have higher estimated overpayments per member. The linear fit, weighted by enrollment, shows this pattern is visible as a clear upward-sloping relationship: higher broker spending is associated with higher estimated overpayments from coding intensity.

Interestingly, this relationship is not uniform across the market. Insurers in the upper-right quadrant, those with both high broker spending and high overpayments from coding intensity, tend to be large. Figure 6 investigates this further by plotting the same data, but estimating the relationship separately for the ten largest insurers and all other insurers. It shows that the positive overall association is entirely driven by the ten largest insurers; among insurers outside the top ten, the relationship between broker spending and estimated coding-intensity overpayments is negative. In other words, the aggregate positive relationship reflects the behavior of the ten largest parent organizations rather than a general pattern across all MA insurers.

[24] Each circle represents a MA parent organization; circle size reflects projected 2025 enrollment. Contract-level values are aggregated to the parent level. The vertical dashed line shows the unweighted median parent-level broker spending. The horizontal dashed line marks zero. Positive values indicate estimated overpayments remaining after the CMS coding adjustment; negative values indicate that the CMS adjustment exceeds measured differential coding.

**Figure 6:** The Ten Largest Insurers Drive Relationship Between Broker Spending and Overpayments


Source: JEC analysis of 2023 CMS Medical Loss Ratio data and MediCode data[25]

While this analysis is exploratory and may not reflect a causal relationship, the evidence is consistent with broker spending being a channel through which large insurers may be able to raise federal payments. Understanding whether this relationship is causal, and if so, through which mechanism it operates, is of great importance to policymakers, as it can inform which policy levers would be most effective in addressing overpayments from coding intensity.

While a full causal analysis is beyond the scope of this brief, we do investigate whether broker spending is related to two specific mechanisms through which coding intensity can raise federal payments: Health Risk Assessments (HRAs) and chart reviews. These mechanisms have been estimated to account for approximately half of measured coding intensity in recent years. HRAs are a plausible channel because prior investigations have raised concerns about the role of brokers in initiating them. Notably, a Senate Finance Committee report found that two insurers spent more than $35 million on broker-initiated health risk assessments.[26]

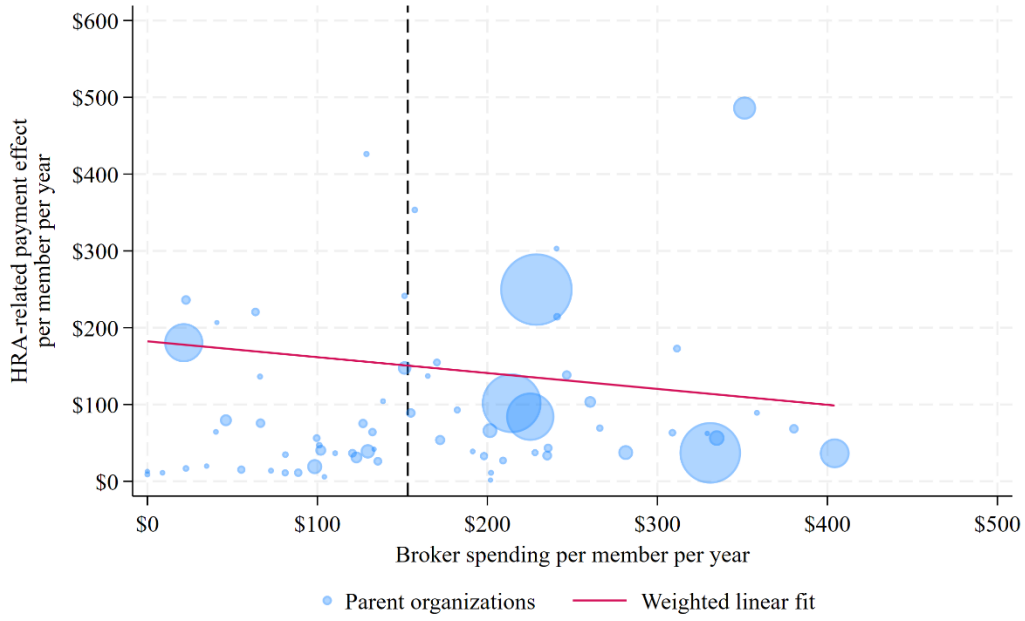
[25] Each circle represents a MA parent organization; circle size reflects projected 2025 enrollment. Contract-level values are aggregated to the parent level. The vertical dashed line shows the unweighted median parent-level broker spending. The horizontal dashed line marks zero. Positive values indicate estimated overpayments remaining after the CMS coding adjustment; negative values indicate that the CMS adjustment exceeds measured differential coding. The solid red line shows the enrollment-weighted linear fit for the ten largest parent organizations by projected 2025 enrollment. The dashed green line shows the enrollment-weighted linear fit for all other parent organizations.

[26] U.S. Senate Committee on Finance, Ranking Member Ron Wyden, "Pushing Medicare Advantage on Seniors: Unraveling the Complex Network of Marketing Middlemen," March 25, 2025, 18, https://www.finance.senate.gov/imo/media/doc/pushing_medicare_advantage_on_seniors_unraveling_the_complex_network_of_marketing_middlemen_-_32425docx.pdf.

*Broker spending is not associated with higher overpayments related to Health Risk Assessments*

Figure 7 does not support HRAs as a significant channel linking broker spending to higher coding-intensity overpayments. If broker spending raised federal payments partly by increasing HRA-related coding, parent organizations with higher broker spending would be expected to have higher HRA-related payment effects. Instead, the enrollment-weighted linear fit slopes modestly downward, indicating a negative relationship between broker spending and HRA-related payment effects. While this relationship is not statistically significant, the absence of a positive association suggests that brokers' direct involvement in HRAs, or broker spending's correlation with HRA-related coding, does not appear to be a major contributor to the broader positive relationship between broker spending and coding-intensity overpayments.

**Figure 7:** Broker Spending is not Positively Associated with HRA-Related Payment Effects




Source: JEC analysis of 2023 CMS Medical Loss Ratio data and MediCode data[27]

## Conclusion

It is clear that national broker spending has risen sharply in recent years, particularly in MA and the ACA Marketplace. What is less clear is how policymakers should think about this trend. The growth could reflect a valuable service, with agents and brokers helping consumers navigate complex plan choices and enroll in coverage that better fits their needs. This could add significant value given the substantial resources spent on health insurance each year.

[27] Each circle represents a MA parent organization; circle size reflects projected 2025 enrollment. Contract-level values are aggregated to the parent level. The solid red line shows the linear fit weighted by projected 2025 enrollment.

However, it could also reflect a less efficient system in which insurer-paid commissions reward improper enrollment growth, plan steering, and practices that increase coding intensity, raising federal spending without improving consumer outcomes. Reports of unauthorized plan switching and improper enrollment in the ACA Marketplace underscore the risk that broker incentives can diverge from consumers' interests.

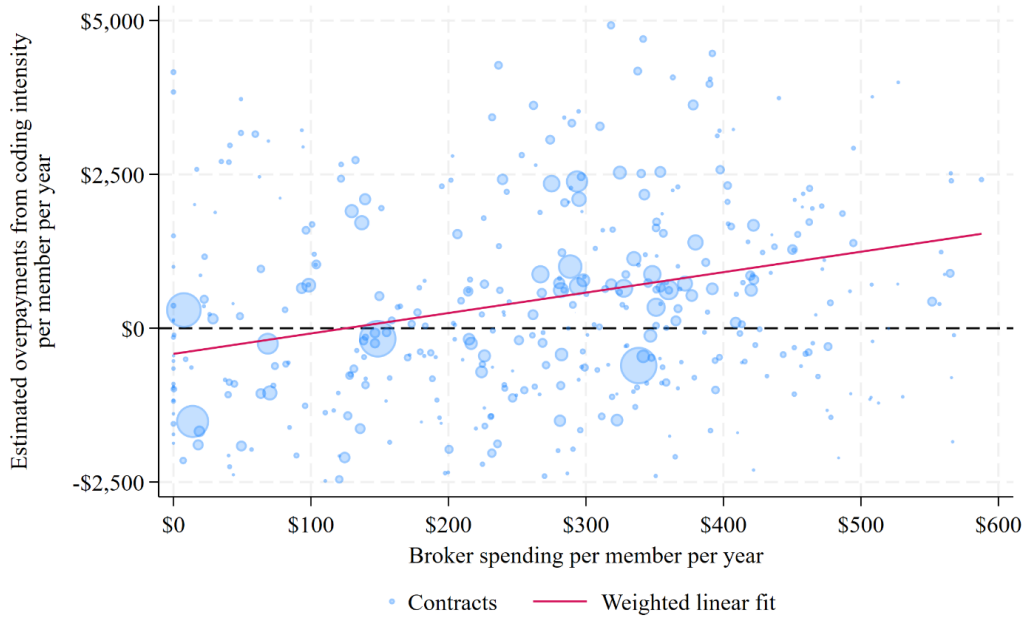
This issue brief therefore asks whether rising broker spending should concern policymakers as a contributor to higher federal costs. In MA, we find that higher broker spending is strongly associated with higher estimated overpayments from coding intensity. While this analysis is exploratory and should not be interpreted as causal, our findings are consistent with the hypothesis that broker spending may be one channel through which insurers code more aggressively, thereby increasing federal payments, or at minimum is a marker of broader business strategies that do so.

Interestingly, the relationship between broker spending and overpayments appears to be driven entirely by the ten largest insurers. This suggests that scale is central to the broker-overpayment association, and that large insurers may be especially well-positioned to pair aggressive enrollment strategies with sophisticated coding operations. Scale may allow these organizations to identify and exploit gaps in MA payment rules more effectively than smaller organizations.

While this brief does not identify the exact practices driving the broker-overpayment relationship, our findings suggest that broker-initiated HRAs are not a primary mechanism linking broker spending to higher coding-intensity overpayments. This is an important negative finding because it narrows the policy question. If the relationship is not driven by HRAs, then it becomes important for policymakers to understand which practices do connect broker spending to higher federal payments.

## Appendix

**Figure 8:** Contract-Level Association of Broker Spending and Coding-Related Overpayments




Source: JEC analysis of 2023 CMS Medical Loss Ratio data and MediCode data[28]

Markus Bjoerkheim, *Senior Economist*
Jack Dacey, *Research Assistant*

[28] Each circle represents a MA contract; circle size reflects projected 2025 enrollment. The horizontal dashed line marks zero. Positive values indicate estimated overpayments remaining after the CMS coding adjustment; negative values indicate that the CMS adjustment exceeds measured differential coding.