Issue Brief
March 27, 2025

Center for Medicare Advocacy
MedicareAdvocacy.org

Marketing Medicare Advantage and Part D Plans: Regulation and Recent Legal Challenges

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Introduction

In response to an increase in complaints about marketing misconduct surrounding the sale of Medicare Advantage (MA) and Part D prescription drug plans, the Centers for Medicare & Medicaid Services (CMS) has issued a series of rules intended to curb inappropriate conduct by insurance companies, agents and brokers, and other third-party marketing organizations. In April 2024 the agency issued a rule to help ensure that compensation for marketing activities aligns with the health care needs of Medicare beneficiaries. But firms that support agents and brokers challenged the rule in court, and the compensation regulations are now on hold.

This Issue Brief explores the role of, payment to, and incentives for Medicare agents, brokers, and other third-party marketing organizations. It also examines the regulatory oversight of Medicare marketing and sales, CMS's efforts to better protect beneficiaries, and legal challenges to the April 2024 rule.[1]

Background

Medicare relies heavily on private insurance plans to administer benefits — these include Medicare Advantage (MA) plans, Part D prescription drug plans, and Medigap supplemental plans. When deciding whether to enroll in an MA plan, or whether to select traditional Medicare with a Part D drug plan and a Medigap plan, beneficiaries are expected to conduct extensive research, weigh complex tradeoffs, and review an overwhelming set of options. In 2025, a typical Medicare beneficiary may face a choice

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of 10 Medigap plans, an average of 42 MA plans, and between 12 and 16 stand-alone prescription drug plans.[2] Additionally, beneficiaries receive a flood of unsolicited marketing materials, further muddling the decision-making process. Marketing peaks every fall, before and during the annual Medicare open enrollment period (October 15**th** - December 7th), when beneficiaries have the opportunity to make changes to their private plans.

As a result of aggressive marketing campaigns, as well as the overwhelming number of plan options available, in 2022 about one in three beneficiaries used insurance agents or brokers to help them choose a plan.[3] Agents contract with insurers to enroll beneficiaries into those companies' plans.[4] Agent compensation and bonuses (such as trips, parties and cash)[5] has historically been tied to enrolling large numbers of beneficiaries into specific plans.[6] This incentive model creates a situation where an agent's own financial interest might be at odds with the health care needs of the beneficiary he or she is advising. Insurers also make payments to companies known as field marketing organizations (FMOs) that provide administrative and operational support to agents and brokers, such as marketing and technology infrastructure. Collectively, individuals or organizations compensated to market, sell, or enroll beneficiaries into private Medicare plans are referred to as third-party marketing organizations (TPMOs).[7]

This payment and bonus structure, coupled with disjointed state and federal oversight over marketing practices, has made these consumer interactions ripe for misconduct. It should not be surprising that when the Senate Finance Committee studied and reported on MA marketing across 14 states in 2022, they found rampant misleading and predatory actions. Its report uncovered "that some TPMOs, brokers, and agents are cold calling seniors, enrolling seniors and people living with disabilities in plans without their consent, and enrolling seniors in plans that don't meet their needs. Most troubling, it appears that vulnerable individuals with cognitive impairments and dual eligibility are being targeted."[8] In fact, one of the report's proposals aimed at protecting beneficiaries included: "[r]eview the agent/broker compensation model to ensure that agent/broker

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incentives align with a beneficiary's interest and do not distort the incentives for choosing in an MA, standard [sic] alone Part D, or Medigap plan."[9]

While private health insurance is regulated at both the federal and state levels, states have traditionally been the primary regulators, addressing issues including coverage, access, and affordability.[10] Despite this tradition, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003[11] significantly limited state oversight of MA plans, removing most authority to review marketing practices and to penalize misconduct.[12] State health insurance regulation simply does not apply to MA plans – other than in the limited areas of licensure and solvency.[13] Therefore, CMS has jurisdiction over MA plans, but does not have authority to sanction agents and brokers for misconduct; however, states have limited oversight over licensure of agents and brokers, but do not have oversight over the MA plans. This division of jurisdiction has led to an uncoordinated patchwork of oversight.[14]

In the absence of robust state oversight of private Medicare plans, CMS released a series of regulations aimed at protecting consumers from marketing misconduct.

CMS Actions to Curb Marketing Misconduct

The Medicare statute gives the Secretary of Health and Human Services (HHS) authority to oversee MA and Part D plans, including activities surrounding the marketing and sale of such plans.[15] Accordingly, CMS has periodically issued regulations relating to such oversight, including:

- significant marketing restrictions in 2008, such as a compensation structure and testing requirements for agents and brokers, as well as limitations on products sold during marketing appointments;[16]
- increased oversight of TPMOs in 2022, aimed at detecting and preventing the use of confusing or potentially misleading marketing activities;[17] and
- provisions relating to plans, advertising, sales, and agent/broker conduct in 2023, aimed at limiting confusing, misleading or inappropriate advertisements or conduct and promoting more informed decision-making by beneficiaries.[18]

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The Medicare statute also directs HHS to set limits on the compensation for marketing and enrolling beneficiaries into private Medicare plans. The Secretary must establish guidelines that "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."[19] In previous rules implementing this statute, CMS had set upper limits on the amount of compensation that agents and brokers can receive for enrolling beneficiaries into MA and Part D plans. But CMS subsequently observed insurers and third-party entities (such as FMOs) structuring payments to agents and brokers "that have the effect of circumventing compensation caps," which could lead to inappropriate steering of beneficiaries.[20] In response, CMS issued a final rule in April 2024 (hereinafter "Final Rule"), with certain provisions relating to marketing changes, including compensation. [21] Compliance with the updated standards was to begin on October 1, 2024, applying to Medicare plans that started in calendar year 2025.

The Final Rule sought to curb tactics that incentivize agents and brokers to inappropriately steer beneficiaries into particular plans by implementing the following changes:[22]

- setting a uniform compensation rate to agents and brokers for each new enrollment, regardless of plan (one standardized rate for all MA plans and one for all Part D plans);
- prohibiting certain contract terms between private Medicare plans and agents, brokers or other TPMOs that may affect their ability to objectively assess and recommend plans best suited to each enrollee's needs; and
- eliminating the regulatory framework that allowed for separate payments to agents and brokers for administrative services, as well as capping payment for administrative services and consolidating such payments under the general umbrella of "compensation" for enrollment.

In explaining the need for the changes, CMS catalogued a number of practices that it was concerned were improperly influencing agent and broker behavior. These included bonuses and perks, such as "golf parties, trips, and extra cash . . . in exchange for

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enrollments," which had been framed as allowable administrative add-ons to sell particular plans.[23] CMS also noted inflated payments for agent and broker training and testing; inflated payments for separate health risk assessments of enrollees paid for by particular plans; and providing agent or broker leads or other incentives based on enrolling beneficiaries into particular plans regardless of their health care needs.[24]

Citing a backdrop of increased consolidation among both health insurance plan sponsors and FMOs that combine to create "an unlevel playing field among plans," CMS asserted that "these financial incentives are contributing to behaviors that are driving an increase in MA marketing complaints received by CMS in recent years."[25] This included beneficiaries alleging that they were "encouraged or pressured to join an MA plan" that turned out to not be what they expected or what had been explained to them by an agent or broker.[26] Note that there is reason to believe that marketing misconduct is underreported to CMS, and is more prevalent than even CMS suggests.[27] In CMS's view, the Final Rule was needed to realign agent and broker incentives with beneficiaries' health needs.

Litigation

Following publication of the Final Rule, trade associations representing firms that provide administrative services to agents and brokers, such as FMOs, filed three lawsuits. Two actions were brought in a Texas federal court where the plaintiffs were nearly certain to draw Judge Reed O'Connor., who has ruled against the federal government in several high-profile cases.[28] The third case was filed in federal court in Florida.[29]

The plaintiffs in the consolidated Texas cases asked the court to pause the effective date of certain portions of the Final Rule as the litigation proceeded. They sought to stay 1) the contract-term restrictions between insurers and agents, brokers, and other TPMOs, and 2) the inclusion and capping of administrative payments within the uniform compensation rate. They claimed that these provisions were "arbitrary and capricious" in violation of federal law, and that CMS did not follow certain required procedures when issuing the Final Rule. Judge O'Connor found that the plaintiff firms would likely

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succeed on the merits of most of their claims, and that their business interests would be "irreparably harmed" if the Final Rule was not stayed during the litigation. In a July 2024 decision he therefore paused implementation of the Rule's contested provisions during the pendency of the lawsuit and any appeal.[30] Meanwhile, the litigants in Florida requested that the court hold their case in abeyance pending the outcome of the litigation in Texas, which the Florida court agreed to do.[31]

The Texas plaintiffs and the government then filed motions for "summary judgment," asking the court for a decision on the merits. In their briefing, the plaintiffs alleged that the Final Rule threatened to "upend the thriving markets for [MA]…and Part D plans by pricing out the firms, agents, and brokers who make that market possible by helping beneficiaries enroll in MA or Part D plans."[32] They accused CMS of "price fixing" to "set rates for private goods and services."[33] The firms pointed to their own comments on the Rule while it was still in the proposal phase, in which they had claimed that the new regulations would "devastate" the industry, and that firms "would be forced to exit the market or severely curtail their services, reducing plan options available to beneficiaries and their ability to make informed choices among those options."[34] It is not clear, however, how a reduction of plan *marketers* would reduce plan "options."

The plaintiffs also touted their role as "the most important resource beneficiaries rely upon to make informed plan decisions," though they acknowledged that agents and brokers do not represent all available plans.[35] Thus, beneficiaries may not be advised of all options if they depend on agents and brokers for information. In contrast, the federally-funded State Health Insurance Assistance Programs (SHIPs), offer free, unbiased counseling and information to Medicare beneficiaries in each state.[36] Beneficiaries can also compare all plans online using Medicare's Plan Finder, or by seeking assistance from a representative at 1-800-Medicare.

The plaintiffs' legal arguments against the Final Rule were both substantive and procedural. They maintained that the Medicare statute does not grant HHS the authority to regulate and cap administrative fees. They also argued that CMS failed to engage in reasoned decision making and to adequately substantiate its findings regarding

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administrative payments. Plaintiffs claimed that there was a lack of evidence that administrative payments were being used to circumvent compensation limits or that they create problematic incentives. They called CMS's rationale for the Rule "feather weight," and based only on unsubstantiated suspicions and conjecture.[37] They also claimed that the agency did not properly take the firms' "reliance interests" into account, meaning that they had structured their business model around the previous rules and would be excessively harmed by the Final Rule's changes.[38] The plaintiffs additionally claimed that CMS failed to comply with procedural requirements because it did not disclose certain factual materials that it relied on in formulating the Final Rule.

In response, the government described the investigations that CMS undertook before it concluded that "administrative payments were often structured as per enrollee 'overrides' and other add-ons, and that an agent or broker may walk away with double the compensation limit for each enrollment."[39] "To make matters worse," the government explained, "the generosity of those administrative payments varied by plan, incentivizing agents and brokers to funnel beneficiaries into higher paying plans instead of the best plan for the enrollee."[40] The government stated that "these conclusions added to CMS's existing concerns about a recent spike in marketing misconduct, such as calls where CMS found that beneficiaries were pressured to enroll in plans they did not understand."[41]

As for legal arguments, the government noted that Congress has expressly delegated authority to HHS in the Medicare statute to regulate the marketing of Medicare Advantage and Part D plans. It argued that CMS acted well within that authority in defining administrative payments as "compensation" and capping the amount of those payments.[42] It pointed to the Supreme Court's recent decision in *Loper Bright Enterprises v. Raimondo* to support its position that Congress often "delegates discretionary authority to an agency" to regulate in specific areas, and that when it does so, the court's only role is to ensure that the agency acts within the boundaries of that delegation and exercises its discretion consistent with federal law.[43] The government also noted that "Congress did not instruct CMS to wait until it could prove that specific bad practices had harmed beneficiaries, but instead required CMS to act affirmatively

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so that agents and brokers never had an incentive to harm beneficiaries in the first place."[44] The government also asserted that CMS had in fact explained and supported its findings regarding administrative fees with evidence from its own oversight activities and with observations from many different parties, including researchers and even from marketing firms themselves. In its final brief the government summarized its arguments as follows:

> Put plainly, the Medicare statute does not leave the government—not to mention Medicare beneficiaries and taxpayers—helpless to only watch as agents, brokers, and other marketers siphon limited government health care dollars into administrative fees without regard to the impact on the information agents and brokers provide to Medicare beneficiaries. The statute instead authorizes—and, indeed, requires—the agency to take action to prevent this."[45]

The parties' motions have been pending with the court since January 2025 and could be ruled on at any time, possibly after the court conducts a hearing. However, the Trump Administration may have a different view of the Final Rule and the issues it sought to address than the Biden Administration, which issued the Rule.

Conclusion

The Trump Administration may take a different approach to the litigation regarding agent and broker compensation and to the regulation of marketing private Medicare plans in general. While this Administration's health officials are generally understood to have favorable views toward the Medicare Advantage program and to private market participation in publicly-funded health programs, the Trump campaign did not articulate a particular position on the marketing of private Medicare plans, or on compensation for agents and brokers. It remains unknown to what extent the Trump Administration will defend the Final Rule in court, and whether CMS will continue to prioritize the alignment of agent and broker financial incentives with Medicare beneficiaries' health needs.

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Glossary

- **U.S. Department of Health & Human Services (HHS)** – Cabinet-level federal agency that oversees a number of programs "to enhance the health and well-being of all Americans" – see https://www.hhs.gov/about/index.html
- **Centers for Medicare & Medicaid Services (CMS)** – Federal agency within HHS that oversees Medicare, the federal portion of Medicaid and State Children's Health Insurance Program (CHIP), the Health Insurance Marketplace, and related quality assurance activities
- **Third-Party Marketing Organizations (TPMOs)** - "Organizations and individuals, including independent agents and brokers, who are compensated to perform lead generation, marketing, sales, and enrollment related functions as a part of the chain of enrollment" relating to private Medicare plans; 42 C.F.R. § 422.2260
- **Field Marketing Organizations (FMOs)** – A type of TPMO that often provides administrative and operational support to agents and brokers, such as marketing and technology infrastructure
- **Medicare Advantage (MA) plan –** A private health insurance plan that offers an alternative to traditional Medicare. MA plans bundle coverage of services that traditional Medicare covers through Part A (hospital insurance), Part B (medical insurance), and usually Part D (prescription drugs)
- **Part D plan -** An optional, stand-alone prescription drug plan offered by private insurance companies to beneficiaries in traditional Medicare
- **State Health Insurance Assistance Programs (SHIPs)** - Federally-funded program that offers free, objective counseling and information to Medicare beneficiaries in each state (often go by different names in some states, e.g. HICAP in CA, CHOICES in CT)

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[1] *See also* David Lipschutz, et al., "A New Rule to Protect Medicare Beneficiaries Against Inappropriate Sales Tactics Is Stuck in the Courts," *To the Point* (blog), Commonwealth Fund, Jan. 16, 2025.
[2] Grace McCormack & Melissa Garrido, "Medicare vs. Medicare Advantage: Choices Can be Overwhelming & Impartial Help is Not Equally Available," *Tucson Sentinel*, Oct. 29, 2024.
[3] Steven Findlay, et al, "The Role of Marketing in Medicare Beneficiaries' Coverage Choices" (explainer), Commonwealth Fund, Jan. 5, 2023.
[4] Riaz Ali & Lesley Hellow, "Agent Commissions in Medicare and the Impact on Beneficiary Choice," *To the Point* (blog), Commonwealth Fund, Oct. 12, 2021.
[5] CMS, Proposed Rule, 88 Fed. Reg. 78476, 78552 (Nov. 15, 2023).
[6] Faith Leonard, et al., "The Challenges of Choosing Medicare Coverage: Views from Insurance Brokers and Agents," feature article, Commonwealth Fund, Feb. 28, 2023.
[7] TMPOs are "organizations and individuals, including independent agents and brokers, who are compensated to perform lead generation, marketing, sales, and enrollment related functions as a part of the chain of enrollment (the steps taken by a beneficiary from becoming aware of an MA plan or plans to making an enrollment decision)." 42 C.F.R. § 422.2260. Note that Senate Finance Committee Ranking Member Ron Wyden issued a report on TPMOs titled "Pushing Medicare Advantage on Seniors: Unraveling the Complex Network of Marketing Middlemen" in March 2025.
[8] U.S. Senate Committee on Finance, Majority Staff, "Deceptive Marketing Practices Flourish in Medicare Advantage," Nov. 2022, at 19. Note that "dual eligibility" refers to individuals who are eligible for both Medicare and Medicaid.
[9] *Id*. at 20.
[10] National Association of Insurance Commissioners (NAIC) Resource Center, Health Insurance: Background, updated July 25, 2024; *see also* Kaye Pestaina et al., "The Regulation of Private Health Insurance," KFF, updated July 29, 2024.
[11] Pub. L. No. 108-173, 117 Stat. 2066 (2003) (also called the Medicare Modernization Act).
[12] Letter from NAIC to Senators Charles E. Schumer and Mitch McConnell ("NAIC Letter"), May 5, 2022.
[13] *Id*.; CMS, Medicare Managed Care Manual, Pub. No. 100-16, Ch. 10 § 30.1 ("The scope of Federal preemption is broad. MA standards set forth in 42 CFR 422 supersede any State laws, regulations, contract requirements, or other standards that would otherwise apply to MA plans, with the exception of licensing laws and regulations and laws and regulations relating to plan solvency. In other words, unless they pertain to licensure and/or solvency, State laws and regulations that regulate health plans do not apply to MA plans offered by MA organizations.").
[14] In 2022, NAIC urged Congress to enact legislation that would return oversight of private Medicare plans to the states, with the aim of protecting beneficiaries against marketing misconduct. NAIC's letter argued that with proper oversight authority, states would be better equipped than the federal government to rein in the misconduct. "Without the restoration of oversight authority (or, at least, greater authority) over the plans, state insurance departments are too often unable to prevent the abusive marketing practices," NAIC said. (NAIC Letter.) NAIC is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia and five U.S. territories. Through the NAIC, state insurance regulators establish standards and best practices, conduct peer review, and coordinate their regulatory oversight. NAIC staff supports these efforts and represents the collective views of state

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regulators domestically and internationally. NAIC members, together with the central resources of the NAIC, form the national system of state-based insurance regulation in the U.S. *See* NAIC & Center for Insurance Policy & Research, State Insurance Regulation, 2011.

[15] *See* 42 U.S.C. §1395w-21(j) (MA); 42 U.S.C. §1395w-104(*l*) (Part D).

[16] Medicare Improvements for Patients and Providers Act (MIPPA), Pub. Law No. 110-275, 122 Stat. 2494 (2008); *see also* CMS, Interim Final Rule, 73 Fed. Reg. 54226 (Sept. 18, 2008); CMS, "CMS Issues Interim Final Rule: Changes to the Medicare Advantage and Prescription Drug Benefit Programs (CMS 4138-IFC)," (Fact Sheet), Sept. 15, 2008.

[17] CMS, Final Rule, 87 Fed. Reg. 27704 (May 9, 2022); *see also* CMS, "CY 2023 Medicare Advantage and Part D Final Rule (CMS-4192-F)" (Fact Sheet), Apr. 29, 2022.

[18] CMS, Final Rule, 88 Fed. Reg. 22120 (April 12, 2023); *see also* CMS, "2024 Medicare Advantage and Part D Final Rule (CMS-4201-F)" (Fact Sheet), April 5, 2023; Center for Medicare Advocacy "Summary of Final 2024 Medicare Advantage and Part D Rule: Important Consumer Protections regarding MA Prior Authorization, Marketing and Other Issues" (Special Report), May 2023.

[19] 42 U.S.C. §1395w-21(j)(2)(D); *see also* 42 U.S.C. §1395w-104(*l*)(2) (applicable to Part D).

[20] CMS, Proposed Rule, 88 Fed. Reg. 78476, 78477 (Nov. 15, 2023) ("Proposed CY 2025 Rule).

[21] CMS, Final Rule, 89 Federal Register 30448 (Apr. 23, 2024); *see also* CMS, "Contract Year 2025 Medicare Advantage and Part D Final Rule (CMS-4205-F)" (Fact Sheet), April 4, 2024.

[22] *See, e.g.*, Proposed CY 2025 Rule at 78610 (summarizing rule provisions).

[23] Proposed CY 2025 Rule at 78552.

[24] Proposed CY 2025 Rule 78552-55. For examples of plan sponsor incentives, such as rewards, contests, and other additional payments to agents and brokers, see Center for Medicare Advocacy, "Senate Report Highlights Widespread Medicare Advantage Marketing Misconduct – But the Driving Forces of Misconduct Are Broader," (Alert), Nov. 10, 2022. For examples of incentives for agents and brokers to cross-sell other health-related products, see Center for Medicare Advocacy, "Sale of 'Ancillary Products' to Fill Gaps in Medicare Advantage Highlight Both Coverage Shortfalls and Need for Stronger Regulation of the MA Marketplace" (Alert), Nov. 17, 2022.

[25] Proposed CY 2025 Rule at 78552-53.

[26] *Id*.

[27] In addition to the Nov. 2022 Senate report (n.8) and the May 2022 NAIC letter (n.12) (noting "an increase in complaints from seniors about confusing, misleading and potentially deceptive advertising and marketing of [MA] plans"), *see also, e.g.,* Laura, Skopec, et al., "The Medicare Complaints Process: Problems and Opportunities," Urban Institute, Sept. 2024. The report notes that: "The limited number of complaints received by CMS should not be taken as evidence that beneficiaries do not have problems using their Medicare coverage, however. Research has established that very few enrollees with any type of health insurance coverage file complaints or appeals despite widespread reports of unsatisfactory experience with the program […] Roundtable participants noted several common themes in the complaints they hear from beneficiaries, including access to post acute care, being subjected to confusing or deceptive MA marketing practices that may lead to unwanted enrollment, and problems with prior authorization in MA [… and] A 2022 study found that 10 percent of Medicare beneficiaries said they felt pressured by an agent or broker to switch plans [citations omitted]."

[28] *Americans for Beneficiary Choice v. U.S. Dep't of Health & Human Servs.*, No. 4:24-cv-00439-O (N.D. Tex.) (filed May 13, 2024); *Council for Medicare Choice v. U.S. Dep't of Health & Human Servs.*, No. 4:24-cv-00446-O (N.D. Tex) (filed May 15, 2024).

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[29] *AmeriLife Holdings, LLC v. Ctrs for Medicare & Medicaid Servs.,* No. 8:24-cv-01305-TPB-UAM (M.D. Fla.) (filed May 29, 2024).
[30] *Americans for Beneficiary Choice v. U.S. Dep't of Health & Human Servs*., Memorandum Opinion and Order, 2024 WL 3297527 (N.D. Tex. July 3, 2024). The plaintiffs also sought to pause Final Rule provisions that prohibit TPMOs from sharing the personal information of beneficiaries—such as names, addresses, and telephone numbers—with other TPMOs, unless they first obtain the beneficiaries' consent. The court, however, found that the plaintiffs were not likely to succeed in their argument that the consent requirement was in tension with the purpose of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to "promote" necessary data sharing, and allowed the requirement to go into effect.
[31] Endorsed Order, *AmeriLife Holdings, LLC*, No. 8:24-cv-01305-TPB-UAM (M.D. Fla. May 29, 2024) ECF No 44.
[32] Plaintiffs' Brief in support of Motion for Summary Judgment, *Council for Medicare Choice*, No. 4:24-cv-00446-O (N.D. Tex. Sept. 27 2024) at 1.
[33] *Id*. at 2.
[34] *Id*. at 9.
[35] *Id*. at 9, 39.
[36] *See* http://shiphelp.org.
[37] Plaintiffs' Brief in support of Motion for Summary Judgment, *Council for Medicare Choice*, No. 4:24-cv-00446-O (N.D. Tex. Sept. 27 2024) at 15.
[38] *E.g.,* Brief in Support of Plaintiffs' Motion for Summary Judgment*, Americans for Beneficiary Choice*, No. 4:24-cv-00439-O (N.D. Tex. Sept. 27, 2024) at 29.
[39] Brief in support of Defendants' Motion for Summary Judgment and Response to Plaintiffs' Motion for Summary Judgment ("Defendant's Summary Judgment Brief"), *Americans for Beneficiaries Choice*, No. 4:24-cv-439-O & *Council for Medicare Choice*, No. 4:24-cv-446-O (N.D. Tex. Nov. 8, 2024) at 2.
[40] *Id*.
[41] *Id*.
[42] *See* 42 U.S.C. § 1395w-21(j)(2)(D).
[43] 603 U.S. 369, 394 (2024).
[44] Defendants' Summary Judgment Brief, at 6.
[45] Reply in support of Defendants' Cross-Motion for Summary Judgment, *Americans for Beneficiary Choice*, No. 4:24-cv-00439-O, *Council for Medicare Choice*, No. 4:24-cv-446-O (N.D. Tex. Jan. 31, 2025) at 2.

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