DO NOTHING PREEMPTION

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Do nothing. That mandate from President Trump and the courts to the federal bureaucracy is the motivation behind budget and staffing cuts throughout the Executive Branch. Much has been said about the impact of these cuts on government services, with the White House encouraging states to pick up the tab and take responsibility for programs including education, Medicaid, and disaster relief. But what happens when broad preemption prevents states from picking up the slack in the face of federal retrenchment and inaction?

In this Article, I define do nothing preemption as the inability of federal agencies to regulate, either because of political pressure or judicial interference, in combination with statutory preemption of state law. I primarily examine the issue through the case study of predatory marketing and sales of Medicare Advantage plans. Congress directed the Centers for Medicare & Medicaid Services (CMS) to regulate to ensure that the compensation incentives of insurance agents and brokers who connect one-third of Medicare beneficiaries with supplemental health insurance coverage are designed to help them enroll beneficiaries in plans that best fit their needs. In 2024, CMS issued regulations capping those incentives, but a federal district judge quickly issued a universal injunction against implementation of key parts of the rule. Given preemption of state laws and regulations relating to Medicare Advantage plans, the situation seemed to be a stalemate.

Yet the growing backlash suggests that states can push back against do nothing preemption with a strong communications strategy and a broad interpretation of any exceptions to

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statutory preemption. Statutory changes or jurisprudence that allow for state action unless and until the federal government acts would also change the calculation and restore states' ability to solve problems. Simply because the federal government does nothing should not mean state governments must also do nothing. An Executive Order signed by President Trump on December 11, 2025, that seeks to preempt state regulation of artificial intelligence indicates the high stakes involved beyond health insurance when failing to acknowledge and respond to do nothing preemption.

INTRODUCTION[1]

Do nothing. That is the apparent mandate from those in the second Trump Administration to everyone else in the federal government. Those in good stead with the White House have cut budgets and employees, making sure the federal bureaucracy will be limited in its ability to act, and power will be concentrated in the President's hands.[2] But they have help from the federal courts, which have grown increasingly hostile to agency action and discretion.[3]

Preemption is the final piece of the puzzle. Previous rhetoric about reining in the federal bureaucracy focused on returning power to the states.[4] Broad preemption of state laws on a particular issue shows that federalism concerns are not driving efforts to shrink federal administrative agencies, however. The combination of preemption with an inability of federal agencies to regulate—whether because of budget and staffing cuts, presidential hostility to action and political polarization, or judicial interference to strike down regulation through universal injunctions or class actions—is resulting in a growing crisis of do nothing preemption.

The predatory marketing and sales of Medicare Advantage plans presents an ideal case study of do nothing preemption and once again shows that health insurance is the canary in the coal mine for how administrative law can harm health and wealth. While left-leaning politicians advocated for Medicare for All,[5] the government was busy privatizing the successful traditional Medicare program (also known as original Medicare) that provides care mainly to those over the age of 65 but also to some disabled Americans.[6]

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1. Supported by the Commonwealth Fund, a national, private foundation based in New York City that supports "independent research on health care issues and mak[es] grants to improve health care practice and policy." *About Us*, COMMONWEALTH FUND, https://www.commonwealthfund.org/about-us [https://perma.cc/5Q2B-EPAV] (last visited Apr. 20, 2026). The views presented here are those of the author and not necessarily those of the Commonwealth Fund, its directors, officers, or staff.

2. *See* Exec. Order No. 14,158, 90 Fed. Reg. 8,441, 8,441 (Jan. 20, 2025).

3. *See* Loper Bright Enters. v. Raimondo, 144 S. Ct. 2244, 2270–73 (2024); *see* West Virginia v. EPA, 142 S. Ct. 2587, 2608, 2615–16 (2022).

4. *See, e.g.*, Richard Reinsch, *The American People Must Relocate Power to the States*, HERITAGE FOUND. (May 9, 2022), https://www.heritage.org/the-constitution/commentary/the-american-people-must-relocate-power-the-states [https://perma.cc/UD62-PWG9].

5. *See Medicare for All 2023 Executive Summary*, OFF. OF U.S. SEN. BERNIE SANDERS, https://www.sanders.senate.gov/wp-content/uploads/Exec-Summary_Medicare-for-All-2023.pdf [https://perma.cc/4BR3-CMW9] (last visited Apr. 20, 2026).

6. *See* Meredith Freed, Jeannie Fuglesten Biniek, Anthony Damico & Tricia Neuman, *Medicare Advantage in 2024: Enrollment Update and Key Trends*, KFF (Aug. 8, 2024), https://www.

Previously, Medicare beneficiaries could purchase Medicare Supplement Insurance, or Medigap plans, from an insurance company to help pay for costs not covered by the government under traditional Medicare.[7] With Medicare Advantage plans, however, the federal government contracts with private insurance companies to provide all care for those eligible for Medicare (Medicare beneficiaries) with the goal of providing more care for less money.[8]

Project 2025 paints a rosy picture of Medicare Advantage plans, emphasizing that the program "provides beneficiaries with a wide range of competitive health plan choices—a richer set of benefits than traditional Medicare provides and at a reasonable cost."[9] In fact, the report lauds the "high-quality, specialty care" provided through these private plans.[10] As a result, it implores the federal government to "[m]ake Medicare Advantage the default enrollment option."[11]

In reality, however, the Medicare Advantage plans that now cover half of Medicare beneficiaries have caused widespread concern because of high costs, the need for prior authorization, and limited provider networks.[12] While beneficiaries enrolled in traditional Medicare pay twenty percent of Part B medical services after the deductible, those enrolled in a private Medicare Advantage plan have varying cost sharing obligations that can add up as beneficiaries get older and sicker.[13] Similarly, traditional Medicare

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kff.org/medicare/issue-brief/medicare-advantage-in-2024-enrollment-update-and-key-trends/ [https://perma.cc/9E4D-DFJG].

7. *See Get Medigap Basics*, MEDICARE.GOV, https://www.medicare.gov/health-drug-plans/medigap/basics [https://perma.cc/24EW-Z53Y] (last visited Apr. 20, 2026) (stating that Medigap "is extra insurance you can buy from a private insurance company to help pay your share of out-of-pocket costs in Original Medicare, like copayments, coinsurance, and deductibles").

8. Medicare Advantage plans typically include benefits not provided by traditional Medicare, such as vision and hearing care, and they also combine hospital, medical, and prescription coverage into a single plan similar to employer-sponsored insurance. CMS, UNDERSTANDING MEDICARE ADVANTAGE PLANS 1, 4–6, 12 (2025), https://www.medicare.gov/publications/12026-understanding-medicare-advantage-plans.pdf [https://perma.cc/84MG-TRAF].

9. Roger Severino, *Department of Health and Human Services*, *in* MANDATE FOR LEADERSHIP: THE CONSERVATIVE PROMISE [Project 2025] 449, 464 (Paul Dans & Steven Groves eds., The Heritage Found. 2023).

10. *Id.*

11. *Id.* at 464–65.

12. *See* Freed et al., *supra* note 6.

13. *Compare Original Medicare & Medicare Advantage*, CMS, https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/your-coverage-options/compare-original-medicare-medicare-advantage [https://perma.cc/Z2ZE-ZMAR] (last visited Apr. 20, 2026); Christina Ramsay, Gretchen Jacobson, Steven Findlay & Aimee Cicchiello, *Medicare*

participants can visit any physician or hospital that is covered by Medicare, while Medicare Advantage enrollees face increasingly limited networks as insurers restrict access to providers and then providers dissatisfied with limitations on care and low reimbursements also continuously leave their networks.[14] Although the original motivation for enacting private Medicare plans paid for by the federal government in 1997 was to decrease costs, Medicare Advantage plans cost more per beneficiary than traditional Medicare plans—six percent more in 2023.[15]

Consumers do have more options than ever, and they often find it difficult to know which options to select. Many Medicare beneficiaries struggle to make the best decisions for themselves—both (1) between traditional Medicare with a Medigap plan and a Medicare Advantage plan and (2) among different Medicare Advantage plans. This leaves them vulnerable to paying more and not having appropriate coverage in the long-term, particularly because it can be difficult to switch later to traditional Medicare with a Medigap plan. With only a few state exceptions (i.e., Connecticut, Maine, Massachusetts, and New York), Medicare beneficiaries have just six months after initial Medicare eligibility to enroll in a Medigap plan without underwriting that takes into account their medical history and health status, also known as a guaranteed issue right.[16] This raises the stakes for early choices about enrollment that Medicare beneficiaries make.

The federal government and states have been particularly focused on deceptive and misleading sales tactics by insurance agents and brokers that result in Medicare beneficiaries selecting supplemental insurance plans that are a poor fit for their health and financial needs. Compensation incentives for insurance brokers who connect one-third of Medicare participants with supplemental plans push them towards Medicare Advantage plans, even where enrolling in traditional Medicare with a Medigap plan would be a better

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Advantage: A Policy Primer 2024 Update, COMMONWEALTH FUND (Jan. 31, 2024), https://www.commonwealthfund.org/publications/explainer/2024/jan/medicare-advantage-policy-primer [https://perma.cc/A5GT-YR5P] (stating that "the people who switch to traditional Medicare are disproportionately dually eligible for Medicare and Medicaid; they are also more likely to live in rural areas, be in poor health, need more help with activities of daily living, and use more health care services than people who do not switch").

14. *See Original Medicare & Medicare Advantage*, *supra* note 13.

15. *See* Ramsay et al., *supra* note 13.

16. *See* Meredith Freed, Nancy Ochieng, Juliette Cubanski & Tricia Neuman, *Medigap May Be Elusive for Medicare Beneficiaries with Pre-Existing Conditions*, KFF (Oct. 18, 2024), https://www.kff.org/medicare/medigap-may-be-elusive-for-medicare-beneficiaries-with-pre-existing-conditions/ [https://perma.cc/DDD3-9SMS].

option.[17] Notably, in 2008, Congress directed the Secretary of the Department of Health and Human Services (HHS) to create guidelines that "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."[18] Congress and the President told the Centers for Medicare & Medicaid Services (CMS), situated under HHS, to regulate to fix a specific problem—even if they did not tell CMS exactly how to fix it.

In 2024, CMS took action and published a final rule changing and capping broker payments to eliminate incentives to steer beneficiaries to inappropriate and costly plans. Judge Reed O'Connor of the U.S. District Court for the Northern District of Texas quickly issued a universal injunction to stay key portions of that rule.[19] On August 18, 2025, Judge O'Connor permanently overturned important parts of the rule that capped administrative payments to brokers and prohibited contract terms that could motivate brokers to favor one insurance company's Medicare Advantage plans.[20]

While many Medicare advocates expected the Trump Administration to side with insurance companies and broker organizations on the issue of predatory marketing and sales of Medicare Advantage plans (and it has done so),[21] it has also taken limited action against insurance companies and broker organizations under the guise of preventing fraud and abuse. On May 1, 2025, the Department of Justice intervened in a *qui tam* suit against three insurance companies and three broker organizations alleging violations of the False

17. *See* Faith Leonard, Gretchen Jacobson, Michael Perry, Sean Dryden & Naomi Mulligan Kolb, *The Challenges of Choosing Medicare Coverage: Views from Insurance Brokers and Agents*, COMMONWEALTH FUND (Feb. 28, 2023), https://www.commonwealthfund.org/publications/2023/feb/challenges-choosing-medicare-coverage-views-insurance-brokers-agents [https://perma.cc/6BHN-M42T].

18. 42 U.S.C. § 1395w-21(j)(2)(D).

19. *See* Ams. for Beneficiary Choice v. U.S. Dep't of Health & Hum. Servs., No. 24-446, 2024 WL 3297527, at *3–5 (N.D. Tex. July 3, 2024); *see also infra* Part I.B. (discussing *Trump v. Casa, Inc.* and the legality of district court judges issuing nationwide injunctions).

20. *See* Ams. for Beneficiary Choice v. U.S. Dep't of Health & Hum. Servs., 795 F. Supp. 3d 895 (N.D. Tex. 2025); *see also* A. Bers, *Court Strikes Down Key Medicare Marketing Regulations*, CTR. FOR MEDICARE ADVOC. (Aug. 28, 2025), https://medicareadvocacy.org/court-strikes-down-key-medicare-marketing-regulations/ [https://perma.cc/A47Z-ZFTV] (calling the decision "a major setback for Medicare beneficiary protections").

21. *See* Memorandum from CMS to State Departments of Insurance: Important Communication from the Centers for Medicare & Medicaid Services (Dec. 4, 2025), https://www.seniormarketsales.com/hubfs/documents/advocacy/Important_Communication_from_the_Centers_for_Medicare_Medicaid_Services.pdf [https://perma.cc/9ZN3-WW23] ("CMS is issuing this memo to remind all parties of the statutory and regulatory framework applicable to MA, and to notify parties that federal law likely preempts state law in such areas.").

Claims Act and the Federal Anti-Kickback Statute.[22] The complaint in *United States ex rel. Shea v. eHealth, Inc.* alleged that Medicare Advantage insurers paid broker organizations for increased sales of their plans, as shown through conversations and emails that tied marketing money directly to sales—all while their contracts falsely discussed insurers paying for marketing leads and websites.[23] Brokers even acknowledged selling low quality plans that did not suit beneficiaries to get access to incentives and bonuses.[24] While splashy enforcement actions like this case may generate headlines, in a time of deregulation, the federal government is likely to over-expend resources on a small number of high profile fraud cases instead of regulating the industry and preventing harms before they occur.

While the federal government stays silent, states are restricted by a broad Medicare Advantage preemption clause. Federal law "shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to [Medicare Advantage] plans which are offered by [Medicare Advantage] organizations under this part."[25] Yet there are signs that states are growing more active in the face of do nothing preemption. My survey of the state insurance department websites for all fifty states shows that most are trying to draw public attention to the problem. They have issued special bulletins and alerts, longer publications directed at beneficiaries who need to choose supplemental Medicare plans and even calls for Congress to remove federal preemption impeding their ability to act.[26]

While I argue below that states should go even further and interpret the exception from preemption for their duties related to licensing Medicare Advantage brokers more broadly, the actions taken by states in constrained

22. Complaint in Partial Intervention at 1, United States *ex rel.* Shea v. eHealth, Inc., No. 21-cv-11777 (D. Mass. May 1, 2025) [hereinafter *Shea* Complaint].

23. *See id.*

24. *See id.*

25. 42 U.S.C. § 1395w-26(b)(3); *see* H.R. Rep. No. 108-391, at 557 (2003), *as reprinted in* 2003 U.S.C.C.A.N. 1808, 1926; Elizabeth C. Borer, Note, *Modernizing Medicare: Protecting America's Most Vulnerable Patients from Predatory Health Care Marketing Through Accessible Legal Remedies*, 92 MINN. L. REV. 1165, 1178–82 (2008); *see also* Michael J. Jackonis, Jr., *Considerations in Medicare Reform: The Impact of Medicare Preemption on State Laws*, 13 ANNALS OF HEALTH L. 179, 200–13 (2004). *See generally* Elizabeth Y. McCuskey, *Body of Preemption: Health Law Traditions and the Presumption Against Preemption*, 89 TEMP. L. REV. 95 (2016) (analyzing expansive federal preemption doctrine in health law, including Medicare Advantage).

26. *See* Jakob Emerson, *CMS: States Cannot Regulate Medicare Advantage Broker Compensation*, BECKER'S PAYER ISSUES (Dec. 8, 2025), https://www.beckerspayer.com/payer/medicare-advantage/cms-states-cannot-regulate-medicare-advantage-broker-compensation/ [https://perma.cc/N489-6P7F].

circumstances are instructive for what is likely to follow federal administrative retrenchment.[27] This case study is an early road map for future state action beyond health care. Given the Executive Order signed by President Trump on December 11, 2025, that seeks to preempt state regulation of artificial intelligence (AI) after a failed attempt by the House of Representatives to do the same,[28] the case study I analyze in this Article is instructive for responding to do nothing preemption and analyzing this recent development in administrative law.

In Part I, I define do nothing preemption as an issue of federalism and administrative law. I further flesh out the concept through parallels to preemption of employer-sponsored health insurance plans under the Employee Retirement Income Security Act of 1974 (ERISA), consumer protection statutes, and recent attempts to regulate new technologies that include President Trump's executive order attempting to preempt state regulation of AI.

In Part II, I begin my discussion of this Article's main case study on the longstanding problem of predatory marketing and sales of Medicare Advantage plans by brokers and broker organizations and unsuccessful federal administrative attempts to address it. After many complaints by states, advocates, and Medicare beneficiaries, CMS followed a congressional directive to regulate incentives provided to Medicare brokers—only to face judicial rebuke and an inability to solve the much-acknowledged problem.

Next, in Part III, I address the expansive preemption provision for Medicare Advantage plans and how it limits the ability of states to redress the harms being suffered by Medicare beneficiaries. In spite of a long tradition of state powers to regulate insurance, courts have interpreted the provision broadly.

In Part IV, I discuss my empirical work on how states are poised to push back against both federal preemption and inaction, even when faced with preemption. On an issue that crosses the partisan divide—and harms rural residents more than urban residents because of already limited access to health care providers, states have become activists on behalf of their residents. They have warned consumers and also sought to have Medicare Advantage preemption narrowed. This is and can be a roadmap in other domains such as AI regulation.

Finally, in Part V, I draw from the Medicare Advantage case study to provide suggestions for how to respond to do nothing preemption outside of health insurance. With a rapidly shrinking federal administrative state, health care offers lessons that can apply to all contexts. Do nothing preemption

27. *See infra* Part V.B.

28. *See* Exec. Order No. 14,365, 90 Fed. Reg. 58,499, 58,499–501 (Dec. 11, 2025).

presents a warning about the balance between the federal government and states but also about the balance between the federal Judiciary and regulators—both federal and state.

I. DO NOTHING PREEMPTION

Do nothing preemption is likely to see a dramatic uptick over the next few years. First, the polarization of Congress makes it less likely that either party will have the votes to legislate on issues where its members are deeply divided, including health, environmental, and technology law.[29] That leaves executive agencies to regulate on issues of concern, even where there is a consensus that a problem exists. Given the Trump Administration's efforts to slash the budgets and staffing of numerous federal agencies and general hostility to federal regulation, those agencies may be unable to act.[30] At the same time, where agencies do regulate, district courts repeatedly strike down such regulations, issuing universal injunctions (and now likely certifying many class actions),[31] and the Supreme Court has overturned traditional deference to agency actions.[32] When federal agencies are muzzled, preemption of state law in effect becomes a legally enforced void.

Medicare Advantage marketing represents a rare example—the epitome of do nothing preemption. If one believes that Congress has spoken because it directed CMS to regulate to ensure that broker incentives are aligned with the goal of placing Medicare beneficiaries in the supplemental plans that best fit their needs, then it is CMS who has done nothing in spite of congressional efforts to preempt all state action "with respect to" Medicare Advantage plans.[33] Though the Judiciary may have tied its hands, CMS first refused to act to meet the congressional direction and only later was stymied by the court.[34] On the other hand, if one believes that Congress did not speak or did not speak clearly by passing the buck to CMS instead of changing the rules for brokers itself, then it is Congress who has in fact done nothing.[35]

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29. *See* Clare Brock & Daniel Mallinson, *Measuring the Stasis: Punctuated Equilibrium Theory and Partisan Polarization*, 52 POL'Y STUD. J. 31, 32 (2024).

30. David A. Super, *Many Trump Administration Personnel Actions Are Unlawful*, CTR. ON BUDGET & POL'Y PRIORITIES (Feb. 14, 2025), https://www.cbpp.org/research/federal-budget/many-trump-administration-personnel-actions-are-unlawful.

31. See *infra* Part I.B for the impact of *Trump v. Casa, Inc.* on nationwide injunctions.

32. *See* Loper Bright Enters. v. Raimondo, 144 S. Ct. 2244, 2266 (2024).

33. 42 U.S.C. § 1395w-26(b)(3).

34. *See* 42 C.F.R. § 422.2260 (2025); Ams. for Beneficiary Choice v. U.S. Dep't of Health & Hum. Servs., 795 F. Supp. 3d 895, 910 (N.D. Tex. 2025).

35. Pamela J. Clouser McCann & Charles R. Shipan, *How Many Major US Laws Delegate to Federal Agencies? (Almost) All of Them*, 10 POL. SCI. RSCH. & METHODS 438 (2022).

Either way, any state laws and regulations that a court deems within the contours of the preemption provision will face do nothing preemption.

Looking to other examples of do nothing preemption helps define and give color to the concept. The most direct precedent is through the ERISA and consumer protection statutes.[36] However, the technology field offers interesting insights as well. An effort to include a ten-year moratorium for state regulation of AI sparked furious debate in Congress as it considered President Trump's spending bill.[37] States' rights and the potential burden of voluminous or conflicting state regulation are mixed in with the desire to build up an industry—and related lobbying.[38] With Congress unable to either create a legislative framework to regulate AI or preempt AI explicitly, President Trump issued an executive order declaring that the Executive Branch must use existing laws and regulations to do so.[39]

If past history holds true, then part of the calculation made by the AI industry and its supporters is also the idea of breaking things fast and building up a business model that becomes difficult to unwind.[40] Do nothing preemption enables new industries to develop free of state efforts to rein in the harms done by those industries. By the time the harms become prominent and there is growing consensus about the need for action, the industries are entrenched and harder to restrict—as shown by Judge O'Connor's focus on protecting Medicare broker organizations instead of Medicare beneficiaries.[41]

A. Definition

Do nothing preemption includes (1) an agreed-upon problem requiring a legislative or regulatory solution; (2) broad federal preemption of state laws and regulations that relate to the problem; (3) one or more federal agencies that either fail to act on the problem or have their action(s) struck down by the courts; and (4) a legislative and regulatory void that allows the problem to remain and, often, to grow worse.

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36. *See* 29 U.S.C. § 1144(a).

37. *Senate Strikes AI Moratorium: What It Means for State Regulation*, BAKER BOTTS (July 11, 2025), https://www.bakerbotts.com/thought-leadership/publications/2025/july/senate-strikes-ai-moratorium [https://perma.cc/N2WG-J96P].

38. *See* Miranda Nazzaro, *AI Moratorium Sparks GOP Battle over States' Rights*, HILL (June 18, 2025, 6:00 AM), https://thehill.com/policy/technology/5355684-ai-moratorium-sparks-gop-battle-over-states-rights/ [https://perma.cc/96XN-NRH8].

39. *See infra* Part V.B.

40. A particular thank you to participants in the Theories of Administrative Law workshop at the University of Cincinnati College of Law for this idea.

41. See *infra* Part II.C for a discussion on the district court's decision to overturn the 2024 CMS rule capping broker incentives when enrolling beneficiaries in Medicare Advantage plans.

The problem at issue is generally agreed upon by parties interested in a particular field of legislation or regulation. Interested parties include members of Congress and state political leaders. There may not be consensus on how to solve the problem—or even who should solve the problem—but there is consensus on the existence of a problem that requires legislation or regulation to help solve it or ameliorate its impact. Uniform agreement on the existence of a problem (or on any political issue today) is too much to ask for or require, but a consensus that a problem exists is revealed by bipartisan discussion of the issue and assertion of the need for action at both the federal and state levels.

Broad federal preemption of state laws and regulations currently exists in health insurance, but the federal government has also moved to preempt state regulation of new technologies such as AI.[42] Both examples demonstrate that preemption of state law often furthers the goal of private enterprise, supposedly in the service of public needs. In the case of health insurance, the United States requires the voluntary participation of private insurance companies in the employment-based market and with the Affordable Care Act (ACA) has created exchanges because it lacks a universal public option.[43] Medicare Advantage represents a different scenario given the success of traditional Medicare prior to the advent of Medicare Advantage plans.[44] Medicare Advantage preemption furthers the goal of privatizing Medicare, supposedly to cut costs even though these plans have instead increased costs.[45] The result has been the growth of private enterprise at the expense of public needs and funds.[46] Preemption would allow businesses to grow in technology fields like AI and cryptocurrencies, unchecked by the burdens and costs of differing state laws and regulations. Growth would be faster, and profits would be higher.

Preemption is often justified by the supposed need for uniform federal oversight. However, that oversight is nonexistent when federal agencies are unable to act or have their actions struck down by courts. Congress is now frequently too polarized to speak itself. The agencies may also be unable to act for reasons such as uncertainty about the best solution to the problem and external political polarization and dissension that increases scrutiny of their actions. Given the need for public notice and comment under the

42. *See* Exec. Order No. 14,365, 90 Fed. Reg. 58,499, 58,499–501 (Dec. 11, 2025).

43. *See* 42 U.S.C. §18031.

44. *See generally* Marilyn Moon, *Medicare Matters: Building on a Record of Accomplishments*, HEALTH CARE FIN. REV., Fall 2000 (detailing Medicare's accomplishments from 1965-2000).

45. *See* David A. Lipschutz, *Commentary: Don't Further Privatize Medicare*, INQUIRY: J. HEALTH CARE ORG., PROVISION, & FIN., Jan.–Dec. 2019, at 1, 1–2.

46. *Id.* at 1–3.

Administrative Procedure Act (APA), this process can be fraught and time-consuming.[47] Agency action often leads to lawsuits in which courts strike down federal regulations and the inability of federal agencies to solve the problem.[48]

Finally, in the absence of federal action and given broad preemption of state law, a void exists where the problem continues and—often—grows. As private industry takes advantage of the lack of legal checks, it only becomes more difficult later to ameliorate the problem. New industries take hold, and constituencies gain power to lobby against regulation. The discussion shifts to the "rights" of private industry instead of consumer protection.

Do nothing preemption builds on—but is distinguishable from—the concept of null preemption presented by Jonathan Remy Nash, which he defines to include preemption of state regulation while the federal government decides not to legislate itself in an area.[49] Noting an increase in null preemption at the time of publication, Nash focuses on the example of motor vehicle tailpipe emissions regulation.[50] For years, the Environmental Protection Agency (EPA) took the position that it lacked authority to regulate (which was rejected by the Supreme Court) and so did the states.[51] "Null preemption raises the question of when one government—the federal government—should not only decide that it ought not to regulate, but also that it should deprive state governments of the prerogative to make a similar call."[52] Nash's focus is on the "how confident the federal government is that a setting of no regulation is absolutely appropriate," or the rational choice about whether or not to regulate.[53]

In Nash's main case study of motor vehicle emissions, the preemption provision in Section 209(a) of the Clean Air Act states that "[n]o State or any political subdivision thereof shall adopt or attempt to enforce any standard relating to the control of emissions from new motor vehicles or new motor

47. ACUS Recommendation 2024-6, Public Engagement in Agency Rulemaking Under the Good Cause Exemption, 89 Fed. Reg. 106,408, 106,408 (Dec. 30, 2024).

48. *Survey of Recent Challenges to Federal Agencies' Enforcement Powers and Potential Impacts on Consumer Protection*, NAT'L ASSOC. OF ATTY'S GEN. (July 8, 2022), https://www.naag.org/attorney-general-journal/survey-of-recent-challenges-to-federal-agencies-enforcement-powers-and-potential-impacts-on-consumer-protection/#footnote_1_24974 [https://perma.cc/k4zk-3dy2].

49. Jonathan Remy Nash, *Null Preemption*, 85 NOTRE DAME L. REV. 1015, 1015 (2010) (opening his article with the question: "How free should the federal government be, not only to preempt state regulatory law, but also to choose itself to adopt no law on point?").

50. *See id.* at 1017.

51. *See id.*

52. *Id.* at 1018.

53. *Id.*

vehicle engines subject to this part."[54] Section 209(b) allows states to receive waivers to enact more stringent standards than the federal government in certain circumstances.[55] The Supreme Court rejected arguments that the EPA lacked statutory authority to regulate in this area and also that it could decline to regulate except if "it determines that greenhouse gases do not contribute to climate change or if it provides some reasonable explanation as to why it cannot or will not exercise its discretion to determine whether they do."[56] Yet the EPA refused to legislate motor vehicle emissions until years later when President Obama took power.[57] In the meantime, it denied California a waiver to establish stringent standards.[58]

Because the Supreme Court ruled that the EPA had authority to regulate, this example at first resembles that of my case study below on Medicare Advantage plan marketing. Congress thinks CMS has authority to regulate Medicare broker compensation and incentives. Why else would it direct CMS to do so? Yet, for years, CMS did not do so. If it affirmatively declined to do so, then this is similar to the EPA's refusal to regulate tailpipe emissions.[59] If it was studying the issue or trying to find other ways to address the problem, then this is no longer a case of null preemption according to Nash, however.[60] More definitively, however, once CMS issued the final rule in 2024 that sought to limit Medicare brokers' incentives to sell inappropriate Medicare Advantage plans to beneficiaries and the district court struck it down, the case study became an example of do nothing preemption by judicial mandate.[61]

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54. *Id.* at 1022 (quoting Clean Air Act § 209(a), 42 U.S.C. § 7543(a)).

55. *Id.* at 1022–23 (discussing Clean Air Act § 209(b), 42 U.S.C. § 7543(b)).

56. *Id.* at 1025 (quoting Massachusetts v. EPA, 549 U.S. 497, 533 (2007)).

57. *Id.* at 1026.

58. *Id.* at 1027.

59. *Id.* at 1026.

60. Although Nash conceptualizes "regulatory-delay null preemption" as a type of null preemption where "Congress leaves it to an executive branch actor to promulgate federal regulation as it sees fit" and that actor delays, because Nash's theory explicitly involves a decision not to regulate, mere delay would seem not to fulfill the definition of null preemption at all. *See id.* at 1048. Indeed, he notes that examples of delay beyond what Congress intended or because the agency "never intends to regulate" are "more intentional, and more problematic." *See id.* at 1049. This further supports the idea that Nash is focused on examples of congressional and agency recalcitrance rather than the role of the judiciary and the ultimate outcome of the regulatory process.

61. Arguably, until the district court struck down CMS's 2024 rule, the situation was an example of Type II null preemption under Nash's typology—but only if CMS had chosen not to regulate in the area and was not merely studying the issue or trying other regulatory options to align the incentives of Medicare brokers and beneficiaries. The Nash typology is as follows:

In contrast to null preemption, do nothing preemption does not involve an affirmative decision by the federal government both not to regulate itself and also to preempt state regulation.[62] In fact, in the case of Medicare Advantage marketing and broker incentives, it involves an affirmative decision by Congress that CMS should regulate and an acceptance by CMS of its role. Instead, the agency either is unable to regulate because of political pressure and polarization or has its attempt(s) struck down by the courts. Even here, in the increasingly rare instance where Congress has spoken and directed the agency to regulate, the court will not allow it. In Nash's story of null preemption, courts can be the heroes—defenders of a presumption against null preemption and protectors of states' sovereign right to safeguard their citizens.[63] In my story, courts are typically the villains—striking down federal regulation and forcing the federal government to do nothing even when state regulation cannot take its place.

B. Trump v. Casa, Inc.

Universal, or nationwide, injunctions that prevent the implementation of federal regulations are a significant contributor to do nothing preemption—with the other side of the coin being agency inaction. In the recent decision of *Trump v. Casa, Inc.*,[64] the Supreme Court finally tackled the long simmering controversy over universal injunctions, although it did so as a way to dodge a decision on the three emergency applications before it about the constitutional question of the validity of birthright citizenship.[65] As Justice Barrett summarized the Court's holding when staying the universal injunctions in question:

> Traditionally, courts issued injunctions prohibiting executive officials from enforcing a challenged law or policy only against the plaintiffs in the lawsuit. The injunctions before us today reflect a more recent development: district courts asserting the power to prohibit enforcement of a law or policy against *anyone*. These injunctions—known

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> Congress could effect both steps ('Type I null preemption'), Congress could preempt state law and an executive branch actor could choose a zero level of federal regulation ('Type II null preemption'), an executive branch actor could preempt state law and Congress could choose a zero level of federal regulation ('Type III null preemption'), or an executive branch actor could effect both steps ('Type IV null preemption').

Id. at 1036.

62. "Under null preemption, the unitary federal choice is not to regulate at all." *Id.* at 1044.

63. *Id.* at 1074 ("[T]he alleged existence of null preemption plainly jibes with states' sovereign status. First, the injury, causation, and redressability all directly tie in to the failure to regulate, not the question of whether scientific evidence adequately supports the need to regulate. The injury is not loss of land, but loss of sovereign prerogative.").

64. 145 S. Ct. 2540 (2025).

65. *See id.* at 2549.

as "universal injunctions"—likely exceed the equitable authority that Congress has granted to federal courts.[66]

The Court's decision related to injunctions granted by three separate courts against the implementation of President Trump's Executive Order No. 14,160 seeking to curtail birthright citizenship when a child is born in the United States to a mother who is either unlawfully in the country or has only temporary status and the child's father is not an American citizen or lawful permanent resident at the time the child is born.[67] In all three cases, the courts responded to the plaintiffs' challenges that the Executive Order violates the Fourteenth Amendment's Citizenship Clause and Section 201 of the Nationality Act of 1940 by finding the Executive Order likely unlawful and entering a universal preliminary injunction.[68] Acting strategically, the Government challenged the "federal courts' equitable authority to issue universal injunctions" rather than the validity of the Executive Order substantively.[69] The Court held that because universal injunctions were not within the equitable powers of the High Court of Chancery in England at the time of the country's founding or the courts of equity during the early years of the new nation, they are not within the power of federal courts today.[70]

Although the Court's holding appears sweeping, letting stand executive actions that may ultimately be found to violate the constitution or federal statutes, the Court limited the impact of its pronouncement. First, the lower courts must review the injunctions they granted to make sure they are not "broader than necessary to provide complete relief to each plaintiff with standing to sue."[71] The Court noted that the respondent States have argued that their financial and administrative harms require a broad injunction, and the Court mainly left it to the lower court to decide how—and how much—to narrow the universal injunctions.[72] Though Justice Thomas's concurrence, joined by Justice Gorsuch, sought to limit the authority of the lower courts to use the principle of providing "complete relief" to the parties to get around the Court's mandate against universal injunctions, the majority opinion provided the lower courts with substantial remaining leeway to determine

66. *Id.* at 2548.

67. *See id.* at 2549.

68. *See id.*

69. *Id.* at 2550.

70. *Id.* at 2554 ("Because the universal injunction lacks a historical pedigree, it falls outside the bounds of a federal court's equitable authority under the Judiciary Act.").

71. *Id.* at 2562–63.

72. *Id.* at 2558 (noting but refusing to adopt the Government's suggestions that the lower court could instead prohibit the application of the Executive Order within the respondent states or require the Government to treat impacted children as eligible for the federal benefits in question).

appropriate equitable relief.[73] Second, class actions remain as a tool to include all impacted parties in the lawsuit against executive actions.[74] Though both the majority opinion and Justice Alito's concurring opinion extolled the need for rigorous adherence to the requirements of Rule 23 of the Federal Rules of Civil Procedure, Justice Alito in particular seems concerned that otherwise "the universal injunction will return from the grave under the guise of 'nationwide class relief,' and today's decision will be of little more than minor academic interest."[75]

Justice Kavanaugh's concurring opinion, however, is the most consequential for the doctrine of do nothing preemption. He noted that "in cases under the Administrative Procedure Act, plaintiffs may ask a court to preliminarily 'set aside' a new agency rule."[76] In effect, Justice Kavanaugh drew attention to the ease with which federal agency actions can still be set aside.[77] Limitations on universal preliminary injunctions then are meant to protect the President and Congress from their application, but not federal administrative agencies. Lower court judges are free to intervene and, in the case of statutes that broadly preempt state law, to force agencies to do nothing.

The Supreme Court's decision will have little impact then on either the litigation over birthright citizenship or the use of universal injunctions.[78]

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73. *Id.* at 2563 (Thomas, J., concurring); *see also id.* at 2565 (Alito, J., concurring) (discussing concerns that lower courts will use the doctrine of third party standing to allow respondent states to represent their impacted residents that are not parties to the case).

74. *Id.* at 2556 (majority opinion) ("The principal dissent's suggestion that these suits *could* have satisfied Rule 23's requirements simply proves that universal injunctions are a class-action workaround.").

75. *Id.* at 2566 (Alito, J., concurring).

76. *Id.* at 2567 (Kavanaugh, J., concurring).

77. *Id.* at 2569 (calling the grant or denial of a preliminary injunction to a putative nationwide class or "preliminary setting aside or declining to set aside an agency rule under the APA" the "functional equivalent of a universal injunction").

78. *See* Michael Casey, *Judge Blocks Trump's Birthright Citizenship Order in 3rd Ruling Since Supreme Court Decision*, PBS NEWS (July 25, 2025, 5:35 PM), https://www.pbs.org/newshour/politics/judge-blocks-trumps-birthright-citizenship-order-in-3rd-ruling-since-supreme-court-decision [https://perma.cc/FA9U-KLUQ] (finding that the nationwide injunction granted to states against enforcing the birthright citizenship executive order was still in effect).

C. Do Nothing Domains

1. ERISA

One example that is easily analogized to Medicare Advantage plans—and likely set the stage for the broad preemption provision enacted—is employment-based health plans governed by ERISA.[79] Scholars have been discussing the inadequate regulation of ERISA-covered health insurance plans in the areas of "information disclosure, coverage of benefits, and remedies for coverage disputes" for many years.[80] With minimal analysis of how it would impact employment-based health insurance and harm employees and their families, Congress included these plans within a broad preemption provision in a statute designed to address pension plans.[81]

ERISA preempts state laws that "relate to any employee benefit plan."[82] Although the statute's provision goes on to exempt state laws that regulate insurance, banking, and securities from preemption,[83] an employee benefit plan cannot be "deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies."[84] Self-funded ERISA plans are therefore not saved from preemption by this deemer clause, and employers sponsoring plans can avoid state regulation.[85]

ERISA preemption was designed to encourage the voluntary participation of employers in the health insurance marketplace by preventing burdensome

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79. Jackonis, *supra* note 25, at 181 ("On the other hand, failure to provide regulation of the structure and operation of a Medicare managed care plan invites the difficulties inherent in the current ERISA-governed plans, compounded by the current lack of a comparable insurance savings clause in Medicare.").

80. *Id.* at 197; *see* Carmel Shachar, *The Preemption Clause That Swallowed Health Care: How ERISA Litigation Threatens State Health Policy Efforts*, HEALTHAFFAIRS (Oct. 15, 2020), https://www.healthaffairs.org/content/forefront/preemption-clause-swallowed-health-care-erisa-litigation-threatens-state-health-policy [https://perma.cc/84VY-T3QL]. *See generally* Lauren R. Roth, *A Failure to Supervise: How the Bureaucracy and the Courts Abandoned Their Intended Roles Under ERISA*, 34 PACE L. REV. 216 (2014) (surveying longstanding deficiencies in ERISA regulation, including gaps in disclosure, benefit coverage, and remedies for denied claims).

81. Roth, *supra* note 80, at 268.

82. 29 U.S.C. § 1144(a).

83. *Id.* § 1144(b)(2)(A).

84. *Id.* § 1144(b)(2)(B).

85. *See* Elizabeth Y. McCuskey, *ERISA Reform as Health Reform: The Case for an ERISA Preemption Waiver*, 48 J.L. MED. & ETHICS 450, 451–52 (2020).

and perhaps contradictory state laws and regulations, and therefore decreasing administrative costs for employers with employees in multiple states.[86] The goal of uniformity caused Congress to sacrifice state experimentation and consumer protection in health insurance, however.[87] Recently, the "federalism trap" of ERISA preemption has impeded state efforts to enact single-payer health insurance systems[88] and regulate pharmacy benefits managers (PBMs),[89] and scholars have recommended solutions such as changing the statutory text or instituting waivers issued by the Department of Labor.[90] In the end, "ERISA preempts far more regulation than it enacts," resulting in a "regulatory vacuum."[91]

Medicare Advantage plan marketing regulation is analogous. Just as ERISA allows for conflicts of interests because of the need to encourage employers to offer these voluntarily provided benefits to employees, federal regulators have not responded adequately to predatory marketing of Medicare Advantage plans because they want to maintain and increase the participation of private plans in Medicare.[92] However, just as "[t]he breadth of ERISA preemption thus elevates the interests of private businesses above the interests and police powers of sovereign states,"[93] the breadth of Medicare

86. Erin C. Fuse Brown & Elizabeth Y. McCuskey, *Federalism, ERISA, and State Single-Payer Health Care*, 168 U. PA. L. REV. 389, 395 (2020); Carmel Shachar & I. Glenn Cohen, *Restoring the Preemption Status Quo: Rutledge, ERISA, and State Health Policy Efforts*, HEALTHAFFAIRS (Dec. 17, 2020), https://www.healthaffairs.org/content/forefront/restoring-preemption-status-quo-i-rutledge-i-erisa-and-state-health-policy-efforts [https://perma.cc/N62G-ZCWW] ("ERISA is perhaps most notable because it includes one of the broadest preemption clauses of any federal statute. This clause blocks any state regulation of the administration of these employee benefit plans in favor of federal regulation. The purpose of this clause was to allow multistate employers to offer a single, consistent plan to all of their workers, reducing administrative and regulatory burdens while keeping administrative costs low.").

87. *But see* Jake Spiegel & Paul Fronstin, *ERISA at 50: No Midlife Crisis for ERISA Preemption*, EBRI (Nov. 14, 2024), https://www.ebri.org/content/erisa-at-50--no-midlife-crisis-for-erisa-preemption-abc [https://perma.cc/9A4F-F8A3] ("ERISA preemption fosters innovation that would otherwise be stifled by different states requiring different coverages or administrative rules (such as claims procedures or the like).").

88. Brown & McCuskey, *supra* note 86, at 395.

89. Pharm. Care Mgmt. Ass'n v. Mulready, 78 F.4th 1183 (10th Cir. 2023), *cert. denied*, 145 S. Ct. 2843 (2025).

90. Brown & McCuskey, *supra* note 86, at 395–96; McCuskey, *supra* note 85, at 450–51.

91. McCuskey, *supra* note 85, at 452.

92. Borer, *supra* note 25, at 1186 ("CMS has acted more as a cheerleader for the private programs than an enforcement agency, and was slow to respond to initial reports of marketing abuses. Substantial federal payments to private plans make federal agencies a suspicious enforcer.").

93. Brown & McCuskey, *supra* note 86, at 395.

Advantage preemption elevates the interests of businesses above states' police powers and the needs of Medicare beneficiaries.[94]

A textual analysis of the ERISA and Medicare Advantage preemption clauses reflects the reliance of the latter on the former for precedent. ERISA "supersede[s] any and all State laws" that "relate to any employee benefit plan."[95] Federal standards "supersede any State law or regulation" except for licensing and solvency laws "with respect to" Medicare Advantage plans.[96] Both statutes use the word "supersede" to describe the type of preemptive effect the statutes have on state law, which does not mean "replace"—implying that there must be a direct match or conflict between the laws.[97] Instead, the preemptive effect is "akin to field preemption" and prevents any (defined as all) state law that attempts to regulate the plans, regardless of whether there is a federal law or standard to fill its place.[98] ERISA provided the basis for the current Medicare Advantage preemption provision.

2. Consumer Protection

Consumer protection involves both federal and state legislation and regulation,[99] resulting in the same concerns about uniformity and federalism that underlie Medicare Advantage regulation. State Unfair and Deceptive Practices (UDAP) laws operate on a diverse area of consumer activities and transactions "such as mortgage lending and servicing, debt collection, rent-to-own transactions, automobile financing, student lending, insurance, health care services, apartment rentals, data breaches, wrongful foreclosures, and just about all retail transactions for goods and services."[100] An important feature

94. *See* Medicaid & Medicare Advantage Prods. Ass'n of P.R., Inc. v. Hernandez, 58 F.4th 5, 7 (1st Cir. 2023) (striking down as preempted Puerto Rican law requiring Medicare Advantage plans to pay health care providers as much as reimbursements under traditional Medicare to prevent the ongoing exodus of providers to domestic locations with higher levels of reimbursement).

95. 29 U.S.C. § 1144(a).

96. 42 U.S.C. § 1395w-26(b)(3); *see* H.R. Rep. No. 108-391, at 556–57 (2003), *as reprinted in* 2003 U.S.C.C.A.N. 1808, 1926 (showing congressional intent to broadly preempt state laws related to Medicare Advantage plans).

97. Pharm. Care Mgmt. Ass'n v. Mulready, 78 F.4th 1183, 1206 (10th Cir. 2023) (noting that while "'[s]upersede' can mean 'replace,'" it may also mean "[o]bliterate, set aside, annul, . . . make void, inefficacious or useless, repeal").

98. *See id.* at 1205–08.

99. Myriam Gilles, *The Private Attorney General in a Time of Hyper-Polarized Politics*, 65 ARIZ. L. REV. 337, 338 (2023).

100. *Id.* at 338–39 (discussing how state UDAPs have been narrowed and private

of state UDAPs is that most allow consumers to file lawsuits to enforce their protections, although corporations and trade groups have made progress in their recent campaigns to restrict this right.[101] Consumers have historically been "largely impervious to political pressure," making private litigation rights successful but also subject to pushback from industry.[102] The original reasons for the implementation of private rights of action within state UDAPs included the limited resources of state AGs and the lobbying of lawyers hoping to profit from bringing these actions.[103] In a time where the federal administrative state is shrinking, a private right of action can outsource the costs of the enforcement of consumer protections to private actors.[104]

Consumer protection laws regulating Uber and other rideshare platforms are instructive for the sale of Medicare Advantage plans. "Under conditions of platform dominance, seller [(driver)] autonomy is illusory."[105] In other words, rideshare platforms like Uber and Lyft have become the main way that drivers can connect to customers who want rides.[106] As a result, the platform controls the prices set for the services—not the sellers, and advertising enables the platform to take more of the seller's revenues.[107]

The way ridesharing platforms connect drivers and passengers is analogous to the way broker organizations connect Medicare Advantage plans with Medicare beneficiaries who enroll in the plans. Broker organizations dominate because they connect one-third of Medicare beneficiaries with the plans they enroll in, and they know much more about the plans than beneficiaries do.[108] As a result, they have the power to push customers to some plans (and insurance companies) and away from others. The result is that they can take more of the insurance companies' revenues in the form of uncapped compensation for administrative or marketing expenses. The main reason the analogy is imperfect is that Uber drivers are viewed as sympathetic

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enforcement rights restricted by legislatures and courts in recent years, harming consumer protection and the goal of uniform regulation).

101. *Id.* at 338–39, 369–70.

102. *Id.* at 349–50 (exploring historical issues with state attorney general enforcement of antitrust laws).

103. *Id.* at 363–64 (relating the history of private rights of action in state UDAPs).

104. *Id.* at 383 ("So, the argument goes, if society wants greater enforcement without expending greater resources, private litigation—flaws and all—presents our best option.").

105. Christopher L. Peterson & Marshall Steinbaum, *Coercive Rideshare Practices: At the Intersection of Antitrust and Consumer Protection Law in the Gig Economy*, 90 U. CHI. L. REV. 623, 624 (2023).

106. Michal Kaczmarski, *Uber vs. Lyft: Who's Tops in the Battle of U.S. Rideshare Companies*, BLOOMBERG SECOND MEASURE (Apr. 15, 2024), https://secondmeasure.com/datapoints/rideshare-industry-overview/ [https://perma.cc/6622-nqxj].

107. Peterson & Steinbaum, *supra* note 105.

108. Leonard et al., *supra* note 17.

victims of the gig economy—dubbed independent contractors instead of employees, with all of the attendant vulnerabilities this role brings.[109] Few are concerned about the vulnerabilities of health insurance companies or whether their large profits are a little less, however.[110]

Just as ridesharing platforms have been able to avoid laws that would protect drivers and passengers such as antitrust, employment, and consumer protection laws,[111] broker organizations have managed to avoid antitrust and consumer protection laws while making the process of connecting sellers and buyers in the Medicare Advantage plan market increasingly impenetrable. Rideshare pricing is opaque for drivers but not consumers to drive down wages (and increase platform operators' profits).[112] Rideshare platforms control ride price and even set the price without letting drivers know it until the end of the ride to prevent them from rejecting the ride and thereby impacting pricing strategies and also to make sure that competing platforms cannot undercut them.[113] They also implement platform most-favored nations clauses so that drivers cannot charge more on another platform.[114] Unlike with rideshare platforms, the prices of Medicare Advantage plans are transparent for all, but the services actually provided for the price are not because consumers may not understand those terms and be able to effectively comparison shop. Plans compete on plan terms rather than price. Because broker organizations are not competing on the price of Medicare Advantage plans sold to consumers but instead their own margins—the extent to which the broker organizations and insurance companies can sell lower cost and lower quality plans to consumers at a competitive price and keep more of the money from consumers—broker organizations are playing the rideshare game except with insurance companies keeping more of the money rather than the consumers that benefit from low Uber and Lyft fares.[115]

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109. *See* Peterson & Steinbaum, *supra* note 105, at 624–25 (discussing how ridesharing platforms have had early wins in the "battle over employment classification in the gig economy").

110. Joel Brown, Molly Glass & Doug Most, *A CEO Is Murdered and Consumers Rage Against the Healthcare Industry. Why?*, BU TODAY (Dec. 11, 2024), https://www.bu.edu/articles/2024/consumers-rage-against-the-healthcare-industry/ [https://perma.cc/562D-8FZ4].

111. Peterson & Steinbaum, *supra* note 105, at 625.

112. *Id.* at 628–30.

113. *Id.* at 629–32.

114. *Id.*

115. *See id.* at 645–46 (explaining how Uber drivers can be considered consumers under state UDAP laws, including discussion of how Uber terms the drivers "consumers" of its software in litigation over licensing fees).

The regulation (or lack thereof) of ridesharing platforms presents an example of do nothing preemption. As Christopher Peterson and Marshall Steinbaum argue,

> Under a fair-minded theory of the gig economy's place in the topography of American contract law, Uber, Lyft, and other similar platforms cannot have it both ways: either they must face responsibility to workers under labor and employment law, or they must run the gauntlet of the antitrust and consumer protection laws that prohibit price fixing, deception, and unfair acts or practices.[116]

While there is no federal law preempting state regulation of rideshare platforms, courts have thwarted state and local labor and employment regulation without protecting drivers as "consumers,"[117] and the federal government has not stepped in to regulate.

3. Technology

When new technologies develop, the calls for regulation to counteract the dangers resulting from unfettered growth directly meet calls to prevent regulation and allow technology companies to experiment and meet the great potential of the moment. Although the link between do nothing preemption and AI regulation is a subject for a future paper, it is worth saying a few words here on the recent attempts to preempt state regulation of AI.

On July 1, 2025, the United States Senate voted 99 to 1 to remove a ten-year moratorium on state regulation of AI that the House passed as part of President Trump's "One Big Beautiful Bill."[118] In spite of lobbying from technology companies and bipartisan attempts to craft a compromise, the Senate chose—for the moment—to allow several state and local AI regulations to take effect as federal regulatory efforts by the Federal Trade Commission continue.[119]

On December 11, 2025, President Trump signed an Executive Order titled *Ensuring a National Framework for Artificial Intelligence*.[120] The Order focuses on the need "[t]o win" in the technological "race with adversaries for

116. *Id.* at 646.

117. *See* Jonathan F. Harris, *Consumer Law as Work Law*, 112 CALIF. L. REV. 1, 1 (2024) (arguing in favor of the integration of employment and consumer protection law to protect gig employers who "treat the workers themselves as consumers by offering them services and credit products").

118. BAKER BOTTS, *supra* note 37.

119. *Id.*; *see* Artificial Intelligence Training Data Transparency Act, CAL. CIV. CODE § 3110 (West 2026); Responsible AI Safety and Education Act, N.Y. GEN. BUS. LAW § 1420 (McKinney 2026); Responsible Artificial Intelligence Governance Act, TEX. BUS. & COM. CODE ANN. § 553.001 (West 2026); S.B. 25-205, 75th Gen. Assemb., 2025 Reg. Sess. (Colo.).

120. *See* Exec. Order No. 14,365, 90 Fed. Reg. 58,499 (Dec. 11, 2025).

supremacy."[121] Ostensibly, the way to win is by preempting "excessive State regulation [that] thwarts this imperative."[122] The three reasons provided for this preemption are: (1) the need for uniformity to make compliance easier for businesses, especially start-ups; (2) to counter the increasing efforts of states to "embed ideological bias within models" to avoid harming "protected groups"; and (3) to prevent states from "impinging on interstate commerce."[123] Though the Order discusses working with Congress to create a "minimally burdensome national standard—not 50 discordant State ones," it touts the urgent need to preempt until Congress passes legislation.[124]

The Executive Order enumerates several strategies to preempt state AI laws without a national standard to take their place. First, the Order directs the Attorney General to create an AI Litigation Task Force to "challenge State AI laws . . . , including on grounds that such laws unconstitutionally regulate interstate commerce, are preempted by existing Federal regulations, or are otherwise unlawful in the Attorney General's judgment."[125] Second, the Order directs the Secretary of Commerce to evaluate state AI laws that conflict with the President's policies, particularly those that "require AI models to alter their truthful outpoints, or that may compel AI developers or deployers to disclose or report information in a manner that would violate the [Constitution]."[126] Third, the Secretary of Commerce and executive departments and agencies must assess where they can withhold funds from states that have "onerous AI laws" or condition grants on states not enacting and/or enforcing AI laws that conflict with the President's stated policies.[127] Fourth, the Chairman of the Federal Communications Commission shall consider adopting a "[f]ederal reporting and disclosure standard for AI models that preempts conflicting State laws."[128] Finally, the Order directs the Chairman of the Federal Trade Commission to issue a policy statement on how the Federal Trade Commission Act's prohibition on unfair and deceptive acts or practices applies to AI, including when "[s]tate laws that require alterations to the truthful outputs of AI models are preempted."[129]

Preemption issues are similarly up front in the developing congressional cryptocurrency legislation. Technology insiders have expressed a desire for

121. *Id.* § 1.
122. *Id.*
123. *Id.*
124. *Id.* §§ 1, 8.
125. *Id.* § 3.
126. *Id.* § 4.
127. *Id.* § 5(a), (b).
128. *Id.* § 6.
129. *Id.* § 7.

broad federal preemption, and Congress is poised to enact major legislation in 2026.[130] The extent to which Congress and the agencies assigned to watch over the industry will fill in the regulatory gaps left by preemption remains to be seen.

The oft-cited motto of Facebook's Mark Zuckerberg to "move fast and break things" is evident in the strategies of AI and crypto companies and previously drove the growth of Uber and other ridesharing platforms. Preempting or ignoring state and local laws is an integral part of this philosophy. A decade ago, Uber was growing quickly and refused to play by the same laws that the taxi industry had to comply with all over the world.[131] Even as it pushed the gig economy forward to reduce labor costs and reports surfaced of crimes committed by drivers, part of its early business model was to evade legal compliance and fight the regulators.[132] Absent such blatant legal evasion or perhaps in conjunction with it, technology companies must rely on federal regulators to preempt state and local laws and then lobby for minimal federal action as well.

II. A DO NOTHING CASE STUDY: MEDICARE ADVANTAGE PLAN MARKETING AND SALES

Unlike Uber passengers or AI platform users, Medicare-eligible consumers are a particularly vulnerable population, and health insurance meets an essential need—not a want for easier transportation or assistance with daily tasks. This often makes the need for regulation more urgent.

Medicare beneficiaries receive a large volume of phone calls, mail, and email regarding enrolling in different Medicare plans, including not only Medicare Advantage plans but also Medigap supplemental plans that pair with traditional Medicare and separate Part D prescription drug plans.[133] Reports of bad

130. Jasper Goodman, *Republicans Propose Changes to Crypto Bill in Compromise Offer to Democrats*, POLITICO (Dec. 9, 2025), https://www.politico.com/live-updates/2025/12/09/congress/gop-crypto-compromise-offer-00683813 [https://perma.cc/BW8X-F2KH].

131. *See* Johana Bhuiyan & Dan Milmo, *"Embrace the Chaos": A History of Uber's Rapid Expansion and Fall from Favour*, GUARDIAN (July 15, 2022), https://www.theguardian.com/news/2022/jul/15/embrace-the-chaos-a-history-of-ubers-rapid-expansion-and-fall-from-favour [https://perma.cc/NF33-KPCZ].

132. *Id.* (citing a 2014 email from Uber's head of global communications that said "sometimes we have problems because, well, we're just fucking illegal"); Rebecca Bellan, *Leaked Uber Files Reveal History of Lawbreaking, Lobbying and Exploiting Violence Against Drivers*, TECHCRUNCH (July 10, 2022), https://techcrunch.com/2022/07/10/leaked-uber-files-reveal-history-of-lawbreaking-lobbying-and-exploiting-violence-against-drivers/ [https://perma.cc/KZ5Y-P3RT].

133. *See* Gretchen Jacobson, Faith Leonard, Elizabeth Sciupac, Molly Fisch-Friedman &

behavior by Medicare brokers include activities that constitute fraud and false or misleading advertising and show that low-income seniors are more likely to be the victims of Medicare fraud.[134] Their vulnerability makes Medicare beneficiaries an easy target for insurance agents and brokers trying to sell them Medicare Advantage plans that may not fit their long-term needs.[135] It has become an annual tradition for insurance plans and brokers to increase their marketing campaigns as Medicare's open enrollment period approaches[136]—and for states to warn their residents about unacceptable sales tactics.[137]

Many of the unacceptable sales tactics are predictable based on the compensation incentives provided to Medicare brokers. Medicare brokers need not market all available plans in a geographic area.[138] They also typically receive higher commissions for enrolling Medicare beneficiaries in Medicare Advantage plans than for enrolling them in Medigap supplemental plans that pair with traditional Medicare, and also for enrolling beneficiaries in plans with higher premiums.[139] Insurers provide agents and brokers with bonus commissions for meeting enrollment targets that "create an incentive for a broker or agent to steer clients to a plan regardless of whether it's the best one for their clients."[140] The brokers also acknowledge the difficulty in switching clients from Medicare Advantage plans to Medigap plans after the "guaranteed issue" period has expired, increasing the harm to beneficiaries.[141]

Robyn Rapoport, *The Private Plan Pitch: Seniors' Experiences with Medicare Marketing and Advertising*, COMMONWEALTH FUND (Sept. 12, 2023), https://www.commonwealthfund.org/publications/issue-briefs/2023/sep/private-plan-pitch-seniors-experiences-medicare-marketing-advertising [https://perma.cc/69WS-2QW5] ("Nearly all people age 65 and older reported receiving at least one phone call, mailing, or email per week . . . . Two in five reported receiving at least seven marketing appeals weekly . . . .").

134. *See id.*

135. Ben Mattlin, *Brokers, Agents Incentivized to Push Medicare Advantage Plans That Hurt Clients, Urban Institute Claims*, FIN. ADVISOR (Oct. 28, 2025), https://www.fa-mag.com/news/beware-bad-medicare-guidance-says-the-urban-institute-84635.html [https://perma.cc/CST3-TZNN].

136. *See* Jacobson et al., *supra* note 133.

137. See *infra* Part IV.B discussing warnings posted to Medicare consumers on state department of insurance or State Health Insurance Assistance Program (SHIP) websites.

138. *See* Faith Leonard, Gretchen Jacobson, Michael Perry, Sean Dryden & Naomi Mulligan Kolb, *The Challenges of Choosing Medicare Coverage: Views from Insurance Brokers and Agents*, COMMONWEALTH FUND (Feb. 28, 2023), https://www.commonwealthfund.org/publications/2023/feb/challenges-choosing-medicare-coverage-views-insurance-brokers-agents [https://perma.cc/UJ4T-X5VV].

139. *Id.* (reporting commissions of up to "three times" higher for the sale of Medicare Advantage plans).

140. *Id.*

141. *Id.*

Educating Medicare beneficiaries about the risks of misleading advertising and sales tactics by Medicare brokers has been a leading part of the effort to protect them.[142] Seniors are told to report bad behavior by brokers to a hotline, 1-800-MEDICARE.[143] Expecting beneficiaries to monitor the compliance of Medicare brokers with federal advertising rules, however, seems unlikely to ameliorate the problem,[144] and the Biden Administration acknowledged as much when next targeting the incentives brokers have to sell them plans that are not a good fit.[145]

A high (and increasing) number of consumer complaints resulted in the Biden Administration taking regulatory action at the federal level.[146] In 2024, CMS adopted a final rule that capped payments to brokers for administrative expenses and prohibited contract terms between insurers and broker organizations that provided incentives for brokers to enroll Medicare beneficiaries in inappropriate Medicare Advantage plans, such as volume-based bonuses.[147] After a federal district court in Texas stayed the implementation of that rule and then permanently overturned it, though, Medicare beneficiaries were left vulnerable to the problem of predatory sales tactics amidst a regulatory vacuum, since CMS did not take further action and states are subject to broad preemption that hinders their efforts to legislate or regulate.[148] This is a case of do nothing preemption.

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142. Susan Jaffe, *Uncle Sam Wants You . . . to Help Stop Insurers' Bogus Medicare Advantage Sales Tactics*, KFF HEALTH NEWS (Nov. 30, 2023), https://kffhealthnews.org/news/article/medicare-advantage-deceptive-sales-tactics-federal-crackdown/ [https://perma.cc/QXR7-QJAM] ("After an unprecedented crackdown on misleading advertising claims by insurers selling private Medicare Advantage and drug plans, the Biden administration hopes to unleash a special weapon to make sure companies follow the new rules: you.").

143. *Id.*

144. *Id.* (quoting a social worker: "Medicare beneficiaries should [not] be the police").

145. *See infra* part IV.C (detailing state actions in targeting brokers' incentives).

146. *See* Jacobson et al., *supra* note 133; Jaffe, *supra* note 142 (addressing how "[b]eneficiary complaints prompted the government's action" on this problem of fraudulent and misleading Medicare marketing); Kimberly Blanton, *What's Up with Medicare Advantage Ads?*, CTR. FOR RET. RSCH. AT BOS. COLL. (Jan. 19, 2023), https://crr.bc.edu/whats-up-with-medicare-advantage-ads/ [https://perma.cc/X9FU-PEU7] (recording many comments below the posting about the "very tiresome" for Medicare Advantage plans and the disadvantages of limited networks).

147. Erica J. Kraus & Calla Simeone, *Increased Scrutiny into Agents & Brokers in the Medicare Advantage Space*, SHEPPARD MULLIN (Apr. 15, 2024), https://www.sheppard.com/insights/blogs/increased-scrutiny-into-agents-brokers-in-the-medicare-advantage-space.

148. Calla Simeone & Christine M. Clements, *Texas Court Stays CMS CY2025 Final Rule on Agent and Broker Compensation and Contract Term Restrictions*, SHEPPARD MULLIN (July 5, 2024), https://www.sheppard.com/insights/blogs/texas-court-stays-cms-cy2025-final-rule-on-agent-and-broker-compensation-and-contract-term-restrictions.

A. Bad Brokers

On November 3, 2022, then Chair of the Senate Finance Committee Ron Wyden (D-Oregon) released a report titled *Deceptive Marketing Practices Flourish in Medicare Advantage*.[149] The Committee's majority staff began researching the problem after complaints to CMS by Medicare beneficiaries about the marketing of Medicare Advantage plans "more than doubled from 2020 to 2021."[150] States also reported similar increases in complaints about marketing.[151] Committee staffers gathered information about "widespread" inappropriate and misleading behavior, including seniors being approached by insurance brokers while grocery shopping, brokers telling beneficiaries that their doctors would be covered in-network if they switched plans when they were not, brokers calling up to twenty times per day, and television advertisements with celebrities stating that seniors are "missing out on benefits, including higher Social Security payments."[152] Communications often included "Medicare" in the marketing companies' names or branding or were designed to look like they came from federal agencies, attempting to deceive beneficiaries about the source of the information provided.[153] Unscrupulous brokers even changed beneficiaries' plans without their consent.[154] Low-

149. *See generally Wyden Reports Deceptive Marketing Practices in Medicare Advantage that Harm Seniors*, U.S. S. COMM. ON FIN. NEWSROOM (Nov. 3, 2022), https://www.finance.senate.gov/chairmans-news/wyden-reports-deceptive-marketing-practices-in-medicare-advantage-that-harm-seniors [https://perma.cc/MV4G-KSBN]; MAJ. STAFF OF S. COMM. ON FIN., REP. ON DECEPTIVE MARKETING PRACTICES FLOURISH IN MEDICARE ADVANTAGE, [hereinafter REP. ON DECEPTIVE MARKETING PRACTICES], https://www.finance.senate.gov/imo/media/doc/Deceptive%20Marketing%20Practices%20Flourish%20in%20Medicare%20Advantage.pdf [https://perma.cc/Z8D4-9PJV].

150. REP. ON DECEPTIVE MARKETING PRACTICES, *supra* note 149, at 2, 5 ("In its survey of state insurance commissioners, the National Association of Insurance Commissioners (NAIC) reports there has been an increase in complaints from seniors about false and misleading advertising and marketing of MA plans. Similarly, CMS reported it received more than twice as many complaints in 2021 compared to 2020 (15,497 in 2020 to 39,617 in 2021).").

151. *Id.* at 6 (noting that nine out of ten states surveyed by the Committee's staff that tracked complaints experienced as increase from 2020 to 2021).

152. *Id.* at 2. One example of a misleading television advertisement features former football player Joe Namath and tells beneficiaries to "get what you deserve," including adding money to their Social Security checks. After litigation, the advertisement was updated based on CMS regulations but still failed to include information about networks and benefits varying based on location. The advertisement was sponsored by TogetherHealth, a subsidiary of Benefytt Technologies, previously known as Health Insurance Innovations (HII), which has connections with 14,000 agents and brokers in forty states. *Id.* at 12.

153. *Id.* at 3.

154. *Id.*

income individuals and those with cognitive impairments were more likely to be targeted.[155]

In addition, concerning incidents were undoubtedly underreported and often went uncorrected. Reasons for the underreporting can include the difficulty seniors and disabled individuals enrolled in Medicare have in finding the appropriate place to report or even the nonexistence of a reporting mechanism.[156] Embarrassment over feeling like the victim of a scam can also contribute to underreporting.[157] Beneficiaries do have a limited window in which to disenroll from Medicare Advantage plans that they were misled into enrolling in, but victims of marketing improprieties often end up having to stay until the next open enrollment period.[158] They may forgo or delay necessary care because of concerns about costs.[159]

Many of the complaints to CMS revolved around television ads produced by a type of broker organization called third-party marketing organizations (TPMOs), which are "organizations and individuals, including agents and brokers, who are compensated to perform lead generation, marketing, sales, and enrollment related functions as a part of the chain of enrollment."[160] TPMOs also generate many of the mailers, frequently designed to look like urgent notices coming directly from the Internal Revenue Service or Medicare program, that allow brokers to evade federal marketing rules that prohibit cold calling since they result in beneficiaries reaching out to the brokers.[161] While insurance companies and brokers are bound by state insurance laws, TPMOs are not licensed by the states and thus are also used to evade relevant state laws.[162]

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155. *Id.*

156. REP. ON DECEPTIVE MARKETING PRACTICES, *supra* note 149, at 5 ("Federal law does not require states to collect MA complaints and each state retains complaints data differently."). The report also notes the problem of marketing Medicare Advantage plans to individuals with dementia. *Id.* at 6, 9. The same vulnerabilities that make them easy targets for predatory marketers also make it more difficult for these individuals to report the improper behavior by Medicare brokers.

157. *Id.* at 10 (noting that the Alliance of Community Health Plans (ACHP) "believes that these [high-pressure sales] tactics affect many more consumers than identified because beneficiaries may be embarrassed to report marketing abuses," and they also lead to substantial disenrollment during the next open enrollment period).

158. *Id.* at 9 (discussing beneficiaries' "limited window to disenroll from a new plan and might not realize network problems [for example] until it is too late").

159. *Id.*

160. *Id.* at 9–10, 24–26.

161. *Id.* at 11 (discussing how the mailers circumvent Section 103 of the Medicare Improvement for Patient and Providers Act (MIPPA) of 2008).

162. REP. ON DECEPTIVE MARKETING Practices, *supra* note 149, at 11 ("A majority of

When proposing additional warnings for seniors and the disabled during the annual Medicare enrollment period, Wyden's report stated that TPMOs "are using sneaky tactics to get your information and then sell your information to agents or brokers who can call you."[163] The report also noted that the "agent or broker does not have to tell you about all of your options in the Medicare program, and does not have to ensure that your plan will meet your needs."[164] The report recommended the following:[165]

1. Reinstate Medicare Advantage Plan (MA plan) requirements loosened during the Trump Administration.[166]
2. Monitor MA disenrollment patterns and use enforcement authority to hold bad actors accountable.[167]
3. Require agents and brokers to adhere to best practices.[168]
4. Implement robust rules around MA marketing materials and close regulatory loopholes that allow cold-calling.[169]
5. Support unbiased sources of information for beneficiaries, including State Health Insurance Assistance Programs and the Senior Medicare Patrol.[170]

TPMOs do not hold insurance licenses due to the fact that lead generation falls outside the definition of solicitation under the . . . (NAIC) Producer Licensing Model Act.").

163. *Id.* at 14.

164. *Id.*

165. *Id.* at 3–4.

166. *Id.* at 19. Among the requirements that the report suggests reinstating are "regular proactive oversight over a broad range of marketing materials," the prohibition of holding educational and marketing events together, forcing marketing materials to include information on how to file a grievance or appeal, and having plans report unlicensed agents and notify any beneficiaries they enrolled. *Id.*

167. *Id.* at 19–20. One of the best indications of predatory marketing is later disenrollment when beneficiaries realize they are not enrolled in a plan that suits their needs. The report recommends that CMS track "rapid disenrollments" and Special Enrollment Periods (SEPs) for misleading marketing by plans and brokers. *Id.*

168. REP. ON DECEPTIVE MARKETING PRACTICES, *supra* note 149, at 20 (focusing on the need for brokers and agents to review whether a beneficiary's drugs and regular health care providers are covered, in-network under the new plan).

169. *Id.* The report has eight suggestions under this broader recommendation, including prohibiting Medicare Advantage plans from contracting with agents or brokers that purchase lists of "leads" or harass beneficiaries. One other noteworthy recommendation here is to "[r]eview the agent/broker compensation model to ensure that agent/broker incentives align with a beneficiary's interest and do not distort the incentives for choosing in an MA [sic], standard alone Part D, or Medigap plan." *Id.*

170. *Id.* at 20–21 (recommending greater funding for state departments of insurance, SHIPs, and SMPs).

B. Previous Federal Interventions

CMS issues and enforces restrictions on marketing Medicare Advantage plans.[171] Although CMS has repeatedly issued regulations and guidance in this area, during a nearly five-year period from September 2017 to April 2022 only one of its enforcement actions involved deceptive marketing.[172] Therefore, any discussion of federal regulation in this area should be viewed in the context of both enforceability and actual enforcement.

CMS monitors marketing complaints through the Complaint Tracking Module (CTM) database.[173] Beneficiaries convey their complaints through Medicare's helpline (1-800-MEDICARE), state-administered programs designed to inform and assist Medicare programs such as State Health Insurance Assistance Programs (SHIPs) and Senior Medicare Patrols (SMPs), agents and brokers, and the plans, and then they are compiled in the CTM.[174] Complaints are also incorporated into the Part C Star Rating that beneficiaries see when they research a Medicare Advantage plan.[175] As discussed above, complaints to CMS have more than doubled in recent years, and CMS responded by issuing (and then sometimes reversing) regulations.[176]

The regulatory story begins after Congress created Medicare Advantage plans—originally called Medicare + Choice plans—as part of the Balanced Budget Act of 1997.[177] The law required all marketing materials to be submitted to the Secretary of Health and Human Services for review "at least 45 days before the date of distribution."[178] Silence meant that the marketing materials were effectively approved and could be used as desired.[179] Substantively, those Medicare Advantage plan marketing materials are prohibited from "provid[ing] for cash or other monetary rebates as an inducement for enrollment or otherwise" and allowing their agents to complete the enrollment forms on behalf of beneficiaries.[180] Any "managed care entity" is also prohibited from directly or through an agent distributing marketing materials in any state without state approval and distributing materials "that

171. *Id.* at 17.

172. *Id.* at 17–18 (discussing practice by Solis Health Plans, Inc. of transporting "potential patients" to the clinic for a marketing presentation where 84% of beneficiaries enrolled on these outings subsequently disenrolled).

173. *Id.* at 18.

174. REP. ON DECEPTIVE MARKETING PRACTICES, *supra* note 149, at 18.

175. *Id.*

176. *See supra* Part I.A.

177. Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 251.

178. *Id.* § 1851(h)(1), 111 Stat. at 285.

179. *Id.* § 1851(h)(3), 111 Stat. at 285.

180. *Id.* § 1851(h)(4), 111 Stat. at 285–86.

contain false or materially misleading information."[181] The Secretary is empowered to set forth "procedures and conditions . . . in order to ensure that, before an individual is enrolled with the entity, the individual is provided accurate oral and written information sufficient to make an informed decision whether or not to enroll."[182] No "cold-call" marketing—whether by telephone or in-person—is permitted.[183] In the Consolidated Appropriations Act of 2001, the time for the Secretary to review and disapprove Medicare Advantage marketing materials decreased from 45 days to ten.[184]

The Medicare Prescription Drug and Modernization Act of 2003 (MMA) was a sea change for Medicare Advantage marketing. It first renamed Medicare + Choice plans to Medicare Advantage plans.[185] Beyond semantics, the Act created the Part D voluntary prescription drug benefit program, which could be accessed through a Medicare Advantage plan in addition to standalone Part D benefit plans.[186] Finally, the law put in place a sweeping preemption provision that declared, "[t]he standards established under this part shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to MA plans which are offered by MA organizations under this part."[187] At this point, complaints of predatory marketing by Medicare brokers "skyrocketed."[188] While the repercussions of this broad preemption clause will be discussed further below,[189] the addition of prescription drug benefit programs—which were immediately in demand—added both to the incentives for beneficiaries to enroll in Medicare Advantage plans and to the costs that private insurance companies could charge for those plans. At the same time, the hands of state regulators were seemingly tied by the Preemption Clause, which was a recipe for fraudulent and misleading marketing.[190]

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) continued the piecemeal legislative attempts to protect beneficiaries

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181. *Id.* § 1932(a)(2), 111 Stat. at 502.

182. *Id.* § 1932(a)(2)(D), 111 Stat. at 502 (using the subheading of "Prohibiting Marketing Fraud").

183. *Id.* § 1932(a)(2)(E), 111 Stat. at 502.

184. Consolidated Appropriations Act of 2001, Pub. L. No. 106-554, 114 Stat. 2763, 2763A–560 (amending § 1851(h), 42 U.S.C. § 1395w-21(h)(1)(A)).

185. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 201, 117 Stat. 2066, 2176 (changing the name of the program).

186. *Id.* § 1860D-1(a)(1), 117 Stat. at 2071.

187. *Id.* § 232, 117 Stat. at 2208 (amending § 1856(b)(3), 42 U.S.C. § 1395w-26(b)(3)).

188. REP. ON DECEPTIVE MARKETING PRACTICES, *supra* note 149, at 15.

189. *See infra* Part III.A.

190. *See* Medicare Prescription Drug, Improvement, and Modernization Act of 2003 § 232, 117 Stat. at 2208.

from improper marketing efforts. In addition to cash and monetary rebates, gifts (other than nominal gifts) and prizes were also prohibited as part of Medicare Advantage marketing.[191] The statute clarified that prohibited marketing activities included any type of "cold-calling," cross selling other types of insurance, providing free meals, and marketing activities at hospitals and physicians' office as well as "educational events."[192] MIPPA also required annual training sessions for agents, broker, and other third parties selling Medicare Advantage plans.[193] Under the statutory heading of "[s]trengthening the ability of states to act in collaboration with the secretary to address fraudulent or inappropriate marketing practices," agents and brokers had to be licensed by the states under state law to sell Medicare Advantage plans.[194]

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191. Medicare Improvements for Patients and Providers Act of 2008, Pub. L. No. 110-275, § 103, 122 Stat. 2494, 2498 (amending § 1851 of the Social Security Act, 42 U.S.C. § 1395w-21).

192. *Id.* § 103(j), 122 Stat. at 2499 (amending § 1851 of the Social Security Act, 42 U.S.C. § 1395w-21). The prohibited activities described are:

> (A) Unsolicited means of direct contact.—Any unsolicited means of direct contact of prospective enrollees, including soliciting door-to-door or any outbound telemarketing without the prospective enrollee initiating contact.
>
> (B) Cross-selling.—The sale of other non-health related products (such as annuities and life insurance) during any sales or marketing activity or presentation conducted with respect to a Medicare Advantage plan.
>
> (C) Meals.—The provision of meals of any sort, regardless of value, to prospective enrollees at promotional and sales activities.
>
> (D) Sales and marketing in health care settings and at educational events.—Sales and marketing activities for the enrollment of individuals in Medicare Advantage plans that are conducted—
>
> (i) in health care settings in areas where health care is delivered to individuals (such as physician offices and pharmacies), except in the case where such activities are conducted in common areas in health care settings; and
>
> (ii) at educational events.

Id.

193. *Id.* § 103(b)(2)(E), 122 Stat. at 2499–500 (amending § 1851 of the Social Security Act, 42 U.S.C. § 1395w-21).

194. *Id.* § 103(d), 122 Stat. at 2501 (amending § 1851 of the Social Security Act, 42 U.S.C. § 1395w-21) (citation modified). With respect to state licensing, the statute provided: Each Medicare Advantage organization shall—

> (i) only use agents and brokers who have been licensed under State law to sell Medicare Advantage plans offered by the Medicare Advantage organization;
>
> (ii) in the case where a State has a State appointment law, abide by such law; and
>
> (iii) report to the applicable State the termination of any such agent or broker, including the reasons for such termination (as required under applicable State law).

Id.

Notably, as discussed above, MIPPA also included a provision that requires the Secretary to create guidelines that "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."[195] When revising its manual, Medicare Managed Care, to reflect the changes made under MIPPA, CMS spoke in detail about allowable font sizes for marketing materials and what qualifies as a nominal gift for Medicare beneficiaries,[196] but it also attempted to meet MIPPA's mandate to focus on agent and broker compensation.[197] As stated in the manual, the relevant regulations limit agent and broker compensation:

> to ensure that compensation does not create incentives for agents and brokers to assist beneficiaries with plan selection using criteria, other than the beneficiaries' health care needs and preferences. . . . These compensation rules are designed to eliminate inappropriate moves of beneficiaries from plan-to-plan. . . . A beneficiary in a new plan should not be enrolled based on the agent's or broker's financial interests but rather the beneficiary's health care needs.[198]

An agent or broker receives initial compensation for the first year of the beneficiary's enrollment in a new plan and then lower (50%) renewal compensation for five years after that initial enrollment year, creating a "6 year compensation cycle."[199] Yet if an enrollee switches to a different plan type (i.e., a Medicare supplement plan to a Medicare Advantage plan), the cycle starts again, while switching to a different plan of the same type results only in the lower renewal compensation.[200] This increased compensation for switching beneficiaries from Medigap plans to Medicare Advantage plans precipitated the rapid increase in Medicare Advantage plan enrollments by beneficiaries. Although compensation must be clawed back when there is "rapid disenrollment" by a beneficiary (i.e., disenrollment within the first three months that is frequently indicative of dissatisfaction with the enrollment process),[201] it often takes beneficiaries far longer to realize that they are enrolled in an inappropriate plan. With regard to TPMO compensation, the

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195. *Id.* § 103(b)(2)(D), 122 Stat. at 2500 (amending § 1851 of the Social Security Act, 42 U.S.C. § 1395w-21).

196. CMS, *Medicare Marketing Guidelines*, *in* PUB. NO. 100-16, MEDICARE MANAGED CARE MANUAL §§ 40.2, 70.2 (2009) [hereinafter *Medicare Marketing Guidelines*], https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/downloads/r91mcm.pdf [https://perma.cc/PF7V-KN77] (revising Chapter 3, "Medicare Marketing Guidelines" of publication on Medicare managed care to reflect passage of MIPPA).

197. *Id.* § 120.5.

198. *Id.*; *see* 42 C.F.R. §§ 422.2274, 423.2274.

199. *Medicare Marketing Guidelines*, *supra* note 196, § 120.5.2–.3.

200. *Id.*

201. *Id.* § 120.5.6.

guidance is briefer and directs that compensation "must be fair-market value and must not exceed an amount that is commensurate with the amounts paid by the plan sponsor to a third party for similar services during each of the previous 2 years."[202]

In 2016, the 21st Century Cures Act prohibited sending "unsolicited marketing or marketing materials" to Medicare Advantage eligible individuals during the first three months of the year—the open enrollment period.[203]

After that point, the action shifted to a battle of CMS marketing regulations that changed with each presidential administration; the first Trump Administration loosened restrictions on insurers and their agents and brokers, and then the Biden Administration tightened them again. The 2018 Final Rule narrowed the definition of marketing, limiting the scope of actions and materials that qualified for restrictive treatment.[204] In 2020, CMS began permitting health plans and agents and brokers to hold educational and marketing events on the same day, which meant that beneficiaries might attend to learn more about plans and wind up with a sales pitch instead.[205] Other CMS efforts continued the process of loosening marketing restrictions for Medicare Advantage plans.[206]

Under the Biden administration, CMS once again moved to tighten restrictions on marketing. The 2022 Final Rule increased oversight of TPMOs because of the sharp increase in consumer complaints noted by the Wyden

202. *Id.* § 120.5.8.

203. 21st Century Cures Act of 2016, Pub. L. No. 114-255, 130 Stat. 1033, 1334 (codified as amended at 42 U.S.C. § 1395w–21(e)(2)) ("[N]o unsolicited marketing or marketing materials may be sent to an individual described in clause (i) during the continuous open enrollment and disenrollment period established for the individual under such clause, notwithstanding marketing guidelines established by the Centers for Medicare & Medicaid Services.").

204. Medicare and Medicaid Programs: Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Programs of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021, 84 Fed. Reg. 15,680, 15,680 (Apr. 16, 2019); Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program, 83 Fed. Reg. 16,440, 16,625–27 (Apr. 16, 2018).

205. Kathryn A. Coleman & Amy K. Larrick Chavez-Valdez, *Medicare Communications and Marketing Guidelines*, CMS 3 (Aug. 6, 2019), https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Medicare_Communications_and_Marketing_Guidelines_Update_Memo_-_8-6-19.pdf [https://perma.cc/HDC9-E6WA].

206. *E.g.*, Medicare and Medicaid Programs; Contract Year 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly, 86 Fed. Reg. 5,864, 6,108 (Jan. 19, 2021).

report.[207] In addition to clarifying the definition of TPMOs to "remove any ambiguity," the regulatory guidance added a new, required disclaimer when TPMOs market Medicare Advantage plans.[208] The definition of TPMOs was both designed to include more third parties within its scope and to broaden the temporal scope of the restrictions by encompassing "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)."[209] CMS also announced in October 2022 that, beginning January 1, 2023, it would enhance its screening of television advertisements because it was

> particularly concerned with recent national television advertisements promoting MA plan benefits and cost savings, which may only be available in limited service areas or for limited groups of enrollees, overstate the available benefits, as well as use words and imagery that may confuse beneficiaries or cause them to believe the advertisement is coming directly from the government.[210]

Also effective in September 2023, CMS prohibited insurers and TPMOs from marketing Medicare Advantage plan benefits and savings that are not available in the geographic area where the beneficiary resides.[211] The new rules, however, still focused on accurate disclosure and educating Medicare beneficiaries instead of brokers' financial incentives to mislead those consumers.[212]

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207. Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefits Programs; Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency; Additional Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency, 87 Fed. Reg. 27,704, 27,707 (May 9, 2022) ("We are unable to say that every one of the complaints is a result of TPMO marketing activities, but based on a targeted search, we do know that many are related to TPMO marketing.").

208. *Id.* at 27,822. The disclaimer, which must be provided regardless of the form of communication, states "We do not offer every plan available in your area. Any information we provide is limited to those plans we do offer in your area. Please contact *Medicare.gov* or 1-800-MEDICARE to get information on all of your options." *Id.*; 42 C.F.R. § 422.2267(e)(41).

209. Medicare Program, 87 Fed. Reg. at 27,822; 42 C.F.R. § 422.2260(2)(iii).

210. Kathryn A. Coleman, *CMS Monitoring Activities and Best Practices During the Annual Election Period*, CMS (Oct. 19, 2022), https://s3.documentcloud.org/documents/23168640/cms-memo-101922-medicare-advantage-marketing.pdf [https://perma.cc/EB7H-PAEU] (announcing that no television advertisements could be submitted under File and Use authority and that it would review all previously submitted advertisements to confirm compliance with CMS rules).

211. Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly, 88 Fed. Reg. 22,120, 22,122 (Apr. 12, 2023).

212. *Id.*

One corrective action that CMS took in 2021 to help Medicare beneficiaries who have been the victims of misleading or fraudulent marketing activities post-enrollment is the creation of a "special enrollment period" or SEP where such victims can disenroll after the open enrollment period.[213] SEPs are also available when a certain number of plan members are unable to access providers because they have left the network.[214] This action, while helpful to reduce harms caused by improper marketing of Medicare Advantage plans, was an ex-post fix instead of an ex-ante solution to prevent marketing abuses.

C. Failed Attempt to Regulate Broker Incentives

After years of handwringing over Medicare Advantage marketing, the Biden Administration finally targeted broker compensation and TPMOs.[215] On April 4, 2024, CMS issued a final rule that sent the industry built around marketing Medicare Advantage plans into a frenzied opposition campaign.[216]

TPMOs have been evading CMS prohibitions on cold calling by having beneficiaries who call or click on a website consent to the use and sale of their personal information for marketing.[217] This allows multiple organizations that have not previously had contact with the beneficiary to call to sell Medicare Advantage and Part D prescription drug plans because the beneficiary has previously "consented" to the contact—often unwittingly.[218] New CMS regulations required TPMOs to get consent for disclosure to each TPMO

213. Susan Jaffe, *Medicare's Open Enrollment Is Open Season for Scammers*, KFF HEALTH NEWS (Nov. 11, 2021), https://kffhealthnews.org/news/article/medicares-open-enrollment-is-open-season-for-scammers/ [https://perma.cc/AN97-PNY3] (quoting David Lipschutz, associate director of the Center for Medicare Advocacy as saying, "This is a really important safety valve for beneficiaries that clearly goes beyond just the limited opportunity to switch plans when someone feels buyer's remorse").

214. *Id.*

215. *Contract Year 2025 Medicare Advantage and Part D Final Rule (CMS-4205-F)*, CMS NEWSROOM (Apr. 4, 2024), https://www.cms.gov/newsroom/fact-sheets/contract-year-2025-medicare-advantage-and-part-d-final-rule-cms-4205-f [https://perma.cc/K2JV-386N].

216. *Id.*

217. Medicare Program; Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program for Contract Year 2024–Remaining Provisions and Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (PACE), 89 Fed. Reg. 30,448, 30,449 (Apr. 23, 2024).

218. *Id.* at 30,449.

that receives beneficiary information.[219] This would reduce the volume of solicitations and prevent contact that feels "harassing and unwanted."[220]

More provocatively, however, CMS turned to Medicare agent and broker compensation as a means of addressing the incentives that those service providers have *ex ante* to engage in aggressive marketing to beneficiaries. As discussed above, § 1851(j) of the Social Security Act requires the Secretary to 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."[221] CMS has long set compensation limits for agents and brokers when they enroll beneficiaries in Medicare Advantage plans.[222] However, Medicare Advantage plans and TPMOs have found ways to create additional compensation opportunities for agents and brokers beyond those caps.[223] CMS made changes designed to bring all forms of agent and broker compensation under an increased cap instead of allowing unlimited fees for "administrative services," reducing anti-competition payments from large insurers.[224] When discussing the final rule, CMS explicitly tied the financial incentives found in administrative or "add-on" payments paid to agents and brokers to the increasing number of marketing complaints by beneficiaries.[225]

Finally, CMS attempted to address concerns about a "bidding war" among Medicare Advantage plans created by increasing fees to obtain the exclusive services of large Field Marketing Organizations (FMOs), a type of TPMO that works with agents and brokers to complete plan enrollment.[226] Based on the contracts between the Medicare Advantage plans and these large, national FMOs, the agents and brokers affiliated with the FMOs have incentives to focus their enrollment activities on the plans who pay the most—instead of the ones that would best suit beneficiaries' needs.[227] The payments for these administrative services provided by FMOs are typically higher for enrolling beneficiaries in Medicare Advantage plans than in

219. *Id.*

220. *Id.* ("This final rule protects beneficiaries against unwanted calls, texts, email solicitations, and other contacts, while still ensuring that beneficiaries have control over their personal data and can connect with the TPMOs they would like to speak with, creating a more transparent and safer environment for beneficiaries to find the plan that best fits their health needs.").

221. Social Security Act § 1851(j)(2), 42 U.S.C. § 1395w-21(j)(2).

222. Medicare Program, 89 Fed. Reg. at 30,449.

223. *Id.* (noting that these additional compensation opportunities have been increasing).

224. *Id.* at 30,449–50, 30,617.

225. *Id.* at 30,618.

226. *Id.* at 30,618–19.

227. *Id.* at 30,618–19.

Medigap plans.[228] As a result, CMS attempted to (1) prohibit contract terms between Medicare Advantage plans, agents, brokers, and TPMOs that disincentivize an agent or broker's ability to objectively market the appropriate plans for each beneficiary based on their needs; (2) set a single compensation rate for selling all plans that redefines "compensation"; and (3) bring all administrative expenses under the compensation rate.[229] Volume based bonuses or incentives, as well as provisions that do not allow agents or brokers to sell competitor plans, are among the contract terms that CMS prohibited.[230]

The public comments on the proposed CMS rule indicate the difficulty involved in using a flat rate such as the $100 chosen to reimburse agents and brokers for administrative costs.[231] CMS states that its new definition of compensation "[i]ncludes monetary or non-monetary remuneration of any kind relating to the sale, renewal, or services related to a plan or product offered by an MA organization including, but not limited to" commissions, bonuses, gifts, prizes or awards, and fees related to state appointment and certification costs (among other examples).[232]

After CMS announced the foregoing rule changes, FMOs and trade associations filed three lawsuits in federal courts in Texas and Florida.[233] On May 16, 2024, the Texas cases were consolidated under the purview of Judge Reed O'Connor,[234] known for previous decisions limiting the powers of the

228. Medicare Program, 89 Fed. Reg. at 30,619–20 (explaining how the administrative fees have "outpaced the market rates for similar services provided in non-MA markets, such as Traditional Medicare with Medigap" and sometimes result in the same travel expenses being reimbursed multiple times and other illogical compensation examples).

229. *Id.* at 30,620.

230. *Id.* at 30,620–21.

231. *E.g.*, *id.* at 30,625 ("As discussed previously, the true cost of most administrative expenses can vary greatly from one agent or broker to another and is based in data and contracts that CMS does not have access to, so it would be extremely difficult for us to accurately capture, making a line-item calculation not practicable.").

232. *Id.* at 30,829; 42 C.F.R. § 422.2274.

233. Complaint, Ams. for Beneficiary Choice v. U.S. Dep't of Health & Hum. Servs., No. 4:24-cv-00439-0 (N.D. Tex. May 13, 2024); Complaint, Council for Medicare Choice v. U.S. Dep't of Health & Hum. Servs., No. 4:24-cv-446-0 (N.D. Tex. May 15, 2024); Complaint, AmeriLife Holdings, LLC v. CMS, No. 8:24-cv-01305 (M.D. Fla. May 29, 2024); *see Lawsuits Attack Protections Against Improper Medicare Marketing Tactics*, CTR. FOR MEDICARE ADVOC. (June 6, 2024), https://medicareadvocacy.org/lawsuits-attack-protections/ [https://perma.cc/3GNH-92FX].

234. Order, Council for Medicare Choice v. U.S. Dep't of Health & Hum. Servs., No. 4:24-cv-446-0 (N.D. Tex. May 16, 2024), ECF No. 11.

federal government.[235] On July 9, 2024, the Florida case was stayed pending the outcome of the Texas litigation.[236]

In an opinion dated July 3, 2024, Judge O'Connor stayed implementation of the CMS final rule.[237] He found that plaintiffs showed a likelihood of success on the merits with respect to the capped administrative fee and the contract terms restrictions, calling both likely arbitrary and capricious, though not on the new rules related to consent for the distribution of beneficiaries' personal information.[238] Judge O'Connor found the $100 cap on administrative fees to be arbitrary and capricious because it did not properly factor in the broker costs for overhead, marketing, and security, for example.[239] He cited comments to the regulatory proposals that had warned that these services would need to be provided at a loss under a $100 cap and stated that "CMS cannot flout APA standards by merely insisting that administrative costs are unquantifiable."[240]

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235. *E.g.*, Suzanne Monyak, *Texas Judge in Boeing, ESG Cases Known for High-Profile Docket*, BLOOMBERG L. (Jan. 16, 2025), https://news.bloomberglaw.com/us-law-week/texas-judge-in-boeing-esg-cases-known-for-high-profile-docket [https://perma.cc/7JWV-NRMH] (noting that Judge O'Connor has a case that is later ruled on in the Supreme Court most years, which is extremely rare and indicates the high profile nature of the cases filed in his small district); Nate Raymond, *Texas Judge Favored by Conservatives Blasts "Judge Shopping" Reform*, REUTERS (Sept. 23, 2024), https://www.reuters.com/legal/government/texas-judge-favored-by-conservatives-blasts-judge-shopping-reform-2024-09-23/ [https://perma.cc/N4GV-MCLG] ("O'Connor, perhaps best-known for once declaring Obamacare unconstitutional in a holding the U.S. Supreme Court later reversed, acknowledged his court today often plays host to high-profile cases."); Josh Blackman, *Judge Reed O'Connor's Remarks on Forum Selection and "Judge Shopping,"* VOLOKH CONSPIRACY (Sept. 22, 2024), https://reason.com/volokh/2024/09/22/judge-reed-oconnors-remarks-on-forum-selection-and-judge-shopping/ [https://perma.cc/BF42-JFUK] ("In our current climate of efforts to undermine the judiciary, and when law schools and law professors across the country increasingly teach students to presume malicious intention on the part of judges with whom they disagree, there is no place more resilient to host critical conversations about the judiciary than at this conference, in this circuit, and in this division.").

236. Order, AmeriLife Holdings, LLC v. CMS, No. 8:24-cv-01305 (M.D. Fla. July 9, 2024), ECF No. 44.

237. Ams. for Beneficiary Choice v. U.S. Dep't of Health & Hum. Servs., No. 4:24-cv-00439-0 (N.D. Tex. July 3, 2024), 2024 WL 3297257, at *3 ("This requires the movant to show (1) a substantial likelihood of success on the merits; (2) a substantial threat of irreparable harm; (3) that the balance of hardships weighs in the movant's favor; and (4) that issuance of a preliminary injunction will not disserve the public interest.").

238. *Id.*

239. *Id.* at *4.

240. *Id.* at *4–5 (ruling against CMS on the $100 administrative fee cap because they "failed to substantiate how they calculated the costs of administrative expenses").

Judge O'Connor seemed to give CMS an impossible task, however. No flat rate, capped fee for administrative expenses could take account of the exact expenses for enrolling each beneficiary in a Medicare Advantage plan; there is too much variation. Instead, CMS made a choice that the plans and their service providers would have $100 to work with and would either need to eliminate some services and expenses previously funded or perhaps not engage in the business of enrolling beneficiaries in Medicare Advantage plans if they cannot do so and make a profit with the new reimbursement rate.[241]

Judge O'Connor's opinion on the injunction gives those who provide services related to enrolling beneficiaries in Medicare Advantage plans a vested right to their continued financial success. His opinion focused extensively on the economic well-being of the Medicare broker industry and the right to continue doing business as usual under the guise of "reliance interests."[242] Because CMS's prior regulations did not include administrative payments within the definition of compensation, it needs to sufficiently address comments that the new rule "would harm long standing business models and possibly upend the industry."[243] Discussion of harm to beneficiaries from compensation that incentivizes industry players to sell them Medicare Advantage plans that do not meet their needs is conspicuously absent in this part of the opinion.[244]

With respect to the CMS effort to regulate contract terms between Medicare Advantage plans and agents, broker, and third parties, Judge O'Connor said the rule was unclear about what contract terms would be prohibited.[245] The rule prohibited a contract term that "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."[246] While CMS provided examples of contract terms that would violate the rule in the preamble to the final rule, the court was not satisfied.[247]

As required by the test to issue an injunction that stays the final rule, Judge O'Connor found that plaintiffs were likely to suffer irreparable harm if the rule was implemented. First, the rule "will alter their business operations,"

241. *Id.*

242. *Id.* at *4.

243. *Id.*

244. *Id.*

245. *Id.* ("In this same vein, the Contract-Terms Restriction failed to provide fair notice of what was prohibited.").

246. *Id.* (quoting Changes to MA for Contract Year 2024, 89 Fed. Reg. 30,448, 30,829 (Apr. 23, 2024)).

247. *Id.*

requiring them to revise contracts "at great expense."[248] Plaintiffs claimed that the rule could reduce their total revenue by one-third and force them to cease business operations.[249]

When balancing the equities and the public interest, Judge O'Connor discounted the harm to Medicare beneficiaries and found in favor of both business reliance interests and the status quo.[250] In fact, all he said about the interests of beneficiaries that motivated the final rule is: "The Court is not convinced that the current compensation framework—which has been in place for over fifteen years—is so flawed that it requires these sweeping new requirements now or that beneficiaries would be unfairly prejudiced by granting a stay pending final judgment."[251]

Finally, Judge O'Connor proceeded to implement the stay of the CMS final rule nationwide, ruling that "relief should not be party restricted" and should instead be "universal."[252] This is an interesting example of the use of universal injunctions to disrupt the policy agenda of a president from the party that did not appoint the lower court judge. Although *Trump v. Casa, Inc.* took aim at universal injunctions, the Trump Administration never challenged Judge O'Connor's stay.[253]

On August 18, 2025, Judge O'Connor granted in part the plaintiffs' motion for summary judgment and vacated the final rule provisions that capped administrative fees and restricted contract terms.[254] Judge O'Connor agreed with the plaintiffs both that CMS had "exceeded its statutory authority" and that the vacated provisions were arbitrary and capricious.[255]

On the first point, Judge O'Connor applied his "independent judgment" under *Loper Bright* to hold that the congressional mandate requiring CMS's "guidelines shall ensure that the use of compensation creates [appropriate]

248. *Id.* at *6 (explaining that the need to scale back business operations and make "necessary alterations in operating procedures" is irreparable harm).

249. *Id.* This focus on the economic impact of agency regulations instead of countervailing public interests is a hallmark of recent jurisprudence related to public health, and COVID-19 litigation is illustrative. *See* Lauren R. Roth, *Sanitation: Reducing the Administrative State's Control over Public Health*, 75 RUTGERS U. L. REV. 777, 787 (2023).

250. *See Ams. for Beneficiary Choice*, 2024 WL 3297257, at *7.

251. *Id.*

252. *Id.* at *7 (alteration in original) (quoting Mock v. Garland, 75 F.4th 563, 587 (5th Cir. 2023), when focusing on potential harm to the Medicare Advantage "ecosystem" and holding that "[a]t bottom, limiting relief to only the parties before the court would likely distort the market 'prove unwieldy and . . . only cause more confusion'").

253. See *supra* Part I.B for a discussion of *Trump v. Casa, Inc.*

254. Ams. for Beneficiary Choice v. U.S. Dep't of Health & Hum. Servs., 795 F. Supp. 3d 895, 910 (N.D. Tex. 2025).

255. *Id.* at 901–02, 909.

incentives for agents and brokers" only authorizes CMS to "regulate how compensation is *used*, not engage in ratemaking."[256] The $100 payment cap for administrative expenses fees is not authorized under this language, given the lack of "explicit delegation" like those used in other statutes that demonstrate an intent to limit fees.[257] Judge O'Connor next found that CMS also exceeded its authority by treating administrative expenses as compensation.[258] Viewing administrative payments as reimbursements for costs incurred in providing non-enrollment services and not "payment or remuneration" to enroll beneficiaries in Medicare Advantage plans, he relied in part on CMS's previously stated position that such payments are not compensation.[259] In addition, Judge O'Connor narrowly construes CMS's power to regulate fair marketing standards.[260] He also held that CMS exceeded its statutory authority when adopting the contract terms restriction because it too "regulates terms that are not 'compensation.'"[261] The final rule prohibited contract terms that have "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," which includes a prohibition on the payment of administrative fees that have such an effect.[262] Therefore, Judge O'Connor concludes that because CMS cannot regulate administrative expenses as compensation, it also cannot do so by restricting contract terms governing administrative expenses.[263] The bootstrapping in this analysis demonstrates quickly the expansive impact of *Loper Bright*. In addition, Judge O'Connor stated that the contract terms CMS attempted to prohibit went beyond compensation, including, for example, provisions that condition contract renewal between the insurance company and the broker organization on higher numbers of enrollments—which involves not the use of compensation but instead the continuation of the business relationship.[264] On the second point, Judge O'Connor incorporated the reasoning of his July 3, 2024 opinion on the

256. *Id.* at 902–03 ("The 'application or employment' of 'compensation'—read collectively with the term 'guidelines'—allows CMS to regulate '*how* agents and brokers put compensation into action,' not the specific *rate* of compensation.").

257. *Id.* at 903–04.

258. *Id.* at 904.

259. *Id.* at 904–05, 908–09.

260. *Id.* at 905–06 ("Rather, CMS's power to regulate 'fair marketing standards' in § 1395w-21(h)(4)(D) is cabined by § 1395w-21(j)(2)(D)'s narrow delegation of power to CMS to regulate the 'use of compensation.'").

261. *Id.* at 907.

262. *Id.*

263. *Id.*

264. *Id.* at 907–08.

preliminary injunction, finding that CMS's administrative expense cap and the contract term restriction were arbitrary and capricious.[265]

Federal efforts to address predatory Medicare Advantage marketing through *ex ante* compensation incentives are, for the moment, dead on arrival.

D. False Claims Act Litigation

In the middle of this regulatory drama, the Department of Justice (DOJ) stepped into the breach with investigations and litigation related to Medicare Advantage marketing and overcharging.

On May 1, 2025, the DOJ announced that it had filed a complaint against three large health insurance companies and three Medicare broker organizations alleging False Claims Act (FCA) violations because of kickbacks and also discrimination against disabled Medicare beneficiaries.[266] The False Claims Act holds liable any person who "(A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval [to the federal government]; (B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim; [or] (C) conspires to commit a violation of subparagraph (A) [or] (B)."[267] The statute defines "material" as "having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property."[268] The lawsuit against insurers Aetna Inc. and affiliates, Elevance Health Inc. (formerly Anthem), and Humana Inc. and broker organizations eHealth, Inc. and its affiliate GoHealth, Inc. and SelectQuote Inc. alleges that the insurers knowingly paid illegal kickbacks to brokers to drive sales of their Medicare Advantage plans—even where those plans did not suit beneficiaries' needs.[269]

Although the DOJ only intervened in the case and filed its complaint recently, the action was originally filed under seal by relator Andrew Shea—a former employee of broker organization eHealth—in November 2021 under the *qui tam* provision of the False Claims Act.[270] Under the statute, the

265. *Id.* at 908.

266. Press Release, U.S. DEP'T. OF JUST., The U.S. Files False Claims Act Complaint Against Three National Health Insurance Companies and Three Brokers Alleging Unlawful Kickbacks and Discrimination Against Disabled Americans (May 1, 2025) [hereinafter DOJ Press Release].

267. 31 U.S.C. § 3729(a)(1).

268. *Id.* § 3729(b)(4).

269. DOJ Press Release, *supra* note 266; *Shea* Complaint, *supra* note 22.

270. *Shea* Complaint, *supra* note 22, ¶ 5; 31 U.S.C. § 3730(b)(1) ("A person may bring a civil action for a violation of section 3729 for the person and for the United State Government. The action shall be brought in the name of the Government. The action may be dismissed only if the court and the Attorney General give written consent to the dismissal and their

government has sixty days to decide if it wants to intervene and conduct the lawsuit,[271] but in reality, the DOJ often needs years to investigate the allegations and decide whether to intervene, and the seal period is extended accordingly.[272] For successful claims under the False Claims Act, the government is entitled to a civil penalty plus treble damages.[273] The relator (also called the *qui tam* plaintiff) is generally entitled to between fifteen and twenty-five percent of any judgment or settlement from the action (depending on their role in advancing the case), plus "reasonable" expenses and attorneys' fees and costs.[274]

This lawsuit also alleged violations of the federal Anti-Kickback Statute (AKS).[275] Subsection (b)(1) of that law prohibits the solicitation or receipt of illegal remuneration, "including any kickback, bribe, or rebate" in exchange for "referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program" or in exchange for "purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program."[276] Subsection (b)(2) prohibits the offer or payment of illegal remuneration in such situations.[277] "Claims submitted to federal health care programs that result from violations of the AKS are per se false or fraudulent within the meaning of [the FCA]."[278]

The DOJ's 217-page complaint details repeated conversations and emails that tied tens of millions of dollars of marketing money directly to increased

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reasons for consenting."). "*Qui tam* is an enforcement mechanism whereby Congress enables a private individual, known as a 'relator,' to bring a civil action on behalf of the U.S. government in exchange for a share of the proceeds therefrom." Sarah Leitner, *The Private Rights Model of Qui Tam*, 76 FLA. L. REV. 865, 866 (2024) (advocating that *qui tam* suits only cover the federal government's private rights so as not to raise concerns about the usurpation of executive power).

271. 31 U.S.C. § 3730(b)(4), (c).

272. Joel Hesch, *It Takes Time: The Need to Extend the Seal Period for Qui Tam Complaints Filed Under the False Claims Act*, 38 SEATTLE U. L. REV. 901, 905–08 (2015).

273. 31 U.S.C. § 3729(a)(1) ("Subject to paragraph (2) [discussing reduced damage where violators cooperate with the government], any person . . . [who submits a false claim] is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 . . . , plus 3 times the amount of damages which the Government sustains because of the act of that person.").

274. 31 U.S.C. § 3730(d)(1).

275. 42 U.S.C. § 1320a-7b(b).

276. *Id.* § 1320a-7b(b)(1).

277. *Id.* § 1320a-7b(b)(2).

278. *Shea* Complaint, *supra* note 22, ¶ 30.

broker sales of the insurers' Medicare Advantage plans.[279] Insurers allegedly discussed and negotiated cost per sale and policies issued, often paying for dedicated pods of brokers who would focus on selling plans from one or two particular insurance companies.[280] The money was not tied to marketing or administrative costs, and if broker organizations did not meet their sales targets, they either lost money or had to make up the sales in the following fiscal quarter or year.[281] The result was a disproportionate market share, where sales of an insurer's Medicare Advantage plans by a particular broker organization far exceeded its share of the national market for such plans.[282]

While the insurers and brokers talked about paying for Medicare Advantage plans sales, they allegedly sanitized their contract language because they knew that what they were doing was illegal, even under the pre-2024 regulations, and both sides could be penalized if CMS discovered the deals.[283] Instead of talking about sales and cost per sale, they discussed paying for marketing leads and websites.[284] In conversations and emails, the parties made clear that the contract language did not affect the true terms of their relationships and that the false contract terms were designed to prevent CMS from discovering their actions.[285]

In order to drive sales to the insurers who paid them additional funds, broker organizations supposedly steered Medicare beneficiaries who responded to their

279. *Id.* at 1–2.

280. *Id.* ¶¶ 109–10 (discussing Humana's creation of "pods" or "teams" of brokers by paying agents extra to sell their Medicare Advantage plans, and the resulting sales increase).

281. *Id.* ¶¶ 126 (noting that, for Humana and GoHealth, "[i]f targets not hit, remaining 'Balance' of funds would be rolled in to AEP [Annual Enrollment Period]").

282. *E.g.*, *id.* ¶ 685 ("GoHealth 'ended with 24.7% Anthem policies across Captive and the Anthem Focused team' during the 2020 AEP. Anthem's national market share in 2020 and 2021 was approximately six percent.").

283. *E.g.*, *id.* ¶¶ 106–07 (relating internal Humana conversations that "[p]er compliance, we cannot pay any fee per sale so marketing agreements are tied to marketing reimbursements essentially").

284. *E.g.*, *id.* ¶¶ 127–30 (discussing how Humana's contract said it was purchasing 300,000 "leads" from GoHealth, but GoHealth understood and memorialized in slides that the money was for 3,000 enrollments in Humana plans).

285. *E.g.*, *id.* ¶¶ 585–86 (detailing how an Anthem executive told her staff that "[a]bsolutely nothing in writing or in verbal conversations internally or externally can refer to this as a bonus, incentive or anything other than marketing reimbursement" and labeling the payments as "marketing development funds (or MDF)" to generate "call and lead volume"—even though Anthem "had no way to track or confirm the calls for which it was purportedly paying millions of dollars").

advertisements towards these carriers.[286] They pushed beneficiaries towards these insurance benefactors even when their plans were of poor quality and another insurer's plans were of higher quality.[287] The broker organizations also frequently turned off beneficiaries' access to the plans of insurance companies who did not pay them extra funds.[288] All of this occurred while brokers were aware of their duty to find the plans that best fit the needs of beneficiaries.[289]

Insurers also conditioned the money they paid to broker organizations on decreasing the number of their plans sold to Medicare beneficiaries under the age of 65, who were enrolled because of a disability and typically more costly to cover.[290] Although allegedly aware of the legal requirement that they not discriminate against disabled beneficiaries, broker organizations found ways to drop calls made by these beneficiaries or funnel them into plans offered by insurers who did not pay marketing funds.[291] Insurers offered additional funds for these services, threatened to withhold funds if sales to under-sixty-five beneficiaries exceeded targets, or did both.[292]

Insurers who paid broker organizations saw increased sales of their Medicare Advantage plans.[293] The complaint shows that insurers who paid broker organizations for sales had inflated market share among plans sold by the organizations compared to plans sold by outside brokers or through other enrollment avenues.[294]

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286. *Id.* ¶ 58 (noting that the defendant brokers handled most of their sales by telephone and not online); *id.* ¶¶ 62–66 (explaining how defendant brokers used the automated calling system to score leads and route them to particular Medicare Advantage organizations).

287. *E.g.*, *id.* ¶ 381 ("As eHealth's William Kinkead told his colleague . . . 'more money will help drive more sales [be]cause your [i.e., Aetna's] product is dog sh[*]t.'"); *id.* ¶ 756 (relaying competitor's view that GoHealth pushed Humana's Medicare Advantage plans even when they do not have a presence in that beneficiary's market or are "an absolute wrong fit for that customer").

288. *E.g.*, *id.* ¶¶ 217, 262–63 (quoting eHealth's Director of Medicare Sales as saying, "[w]e have committed to drive more sales to Humana. We need to turn off some carriers in 5-7 states to do so."); *id.* ¶¶ 392, 548–49.

289. *Id.* ¶ 56 (explaining that "the majority of the Defendant Brokers' contacts with beneficiaries stemmed from carrier-neutral advertisements"); *id.* ¶¶ 68–74 (providing examples of brokers' claims to offer "unbiased" services that "match a beneficiary's needs to an insurance plan").

290. *E.g.*, *id.* ¶¶ 305–13.

291. *E.g.*, *id.* ¶¶ 323–26, 330, 340, 344.

292. *E.g.*, *id.* ¶ 322.

293. *E.g.*, *id.* ¶¶ 225, 436 (including charts showing dramatically increased SelectQuote sales of Aetna and Humana plans during 2017 and 2018 because of funds provided and an extreme decrease for UnitedHealthcare sales, which did not pay this broker organization similarly).

294. *E.g.*, *id.* ¶ 685.

The defendants allegedly took these actions even though they signed contracts with the federal government that included repeated acknowledgments that they could not violate the False Claims Act or federal Anti-Kickback Statute.[295] Medicare Advantage organizations must execute annual written agreements with CMS for each plan they administer.[296] Those contracts include the organizations' agreements to comply with such federal laws.[297] In addition, to receive monthly payments, the insurers must certify the "accuracy, completeness, and truthfulness" of the information provided to CMS and that "each enrollee for whom the organization is requesting payment is validly enrolled in an MA plan offered by the organization."[298]

Historically, *qui tam* litigation has been used to constrain executive power.[299] The litigation above, however, is an example of one federal agency taking action when another cannot or will not.[300] The DOJ stepped in because existing regulations were insufficient to address a pervasive problem with the Medicare Advantage program.[301] Political polarization made regulation difficult or resulted in an ebb and flow of regulation.[302] However, federal investigations and enforcement actions such as this one deal with the problem *post hoc*—after Medicare beneficiaries have been harmed. While a few lawsuits may have a deterrent effect on insurers and broker organizations, they are insufficient to fully address the problem.[303] In addition, this investigation largely took place during the Biden Administration.[304] Although the DOJ could now settle the lawsuit on terms that favor the

295. *Id.* ¶¶ 92–97.

296. *Id.* ¶ 92.

297. *Id.* ¶¶ 93–94 (citing 42 C.F.R. § 422.504 (2024)).

298. *Id.* ¶¶ 95–97. "If such data are generated by a related entity, contractor, or subcontractor of an MA organization, such entity, contractor, or subcontractor must similarly certify (based on best knowledge, information, and belief) the accuracy, completeness, and truthfulness of the data." *Id.* (quoting 42 C.F.R. § 422.504(*l*)(3) (2024)).

299. Randy Beck, *Promoting Executive Accountability Through Qui Tam Legislation*, 21 CHAP. L. REV. 41, 41–46 (2018) ("Regulation of government officials through *qui tam* legislation was widely practiced in the American colonies and early states.").

300. *See* DOJ Press Release, *supra* note 266 (stating that the DOJ has intervened and is handling the lawsuit with some assistance from HHS and the FBI).

301. *See id.*; *see also supra* Part II.C (discussing challenges with CMS's past attempts at regulating broker incentives and TPMOs).

302. *See supra* Part II.B (contrasting congressional oversight and government enforcement across different presidential administrations).

303. *See* REP. ON DECEPTIVE MARKETING PRACTICES, *supra* note 149, at 2–4 (recommending several regulatory actions to combat the findings of widespread fraudulent Medicare Advantage (MA) marketing tactics).

304. *See Shea* Complaint, *supra* note 22, ¶ 5. The complaint was first filed in 2021.

defendants if its priorities shift or if the insurers and brokers lobby officials, the False Claims Act has already become a favored tool of the current Administration for rooting out financial fraud and government waste in an era of less government regulation.[305]

United Healthcare is also currently under investigation by the DOJ for fraud related to its Medicare Advantage plans.[306] It is unclear whether the investigation is focused on marketing, and United Healthcare has also faced allegations of upcoding, or using diagnosis codes that correspond to more serious health conditions, because Medicare Advantage insurers "are paid extra for covering sicker patients."[307] In this government game of whack-a-mole, the government will over-expend its resources investigating and enforcing insufficient laws and regulations instead of revamping the framework and preventing beneficiary harm from the start.[308] Preventing CMS from regulating here enriches private industry at the expense of Medicare beneficiaries.[309]

III. MEDICARE ADVANTAGE PREEMPTION

Federal law regulating Medicare Advantage plans provides that "[t]he standards established under this part shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to MA plans which are offered by MA organizations under this part."[310] As the legislative history states, "[T]he [Medicare Advantage]

305. *See* Mark Feaster, *The False Claims Act Could Become the New "It" Statute in an Uncertain Enforcement Landscape*, ZUCKERMAN SPAEDER (Mar. 14, 2025), https://www.zuckerman.com/news/insightzs/false-claims-act-could-become-new-it-statute-uncertain-enforcement-landscape [https://perma.cc/H4NZ-EA9L]; *see also* Glenn Thrush & Alan Blinder, *Justice Dept. to Use False Claims Act to Pursue Institutions Over Diversity Efforts*, N.Y. TIMES (May 19, 2025), https://www.nytimes.com/2025/05/19/us/politics/false-claims-act-dei-harvard.html [https://perma.cc/8J4H-LQMS].

306. Christopher Weaver & Anna Wilde Mathews, *UnitedHealth Group Is Under Criminal Investigation for Possible Medicare Fraud*, WALL ST. J. (May 14, 2025), https://www.wsj.com/us-news/unitedhealth-medicare-fraud-investigation-df80667f [https://perma.cc/GV44-KWCU].

307. *Id.*; Steven Lieberman & Paul Ginsburg, *Improving Medicare Advantage by Accounting for Large Differences in Upcoding Across Plans*, HEALTH AFFS. (Feb. 3, 2025), https://www.healthaffairs.org/content/forefront/improving-medicare-advantage-accounting-large-differences-upcoding-across-plans [https://perma.cc/7KWR-ATBF].

308. *See* REP. ON DECEPTIVE MARKETING PRACTICES, *supra* note 149, at 2–4 (stating that regulatory action is needed to prevent insurers from continuing to take advantage of beneficiaries).

309. *See id.*

310. 42 U.S.C. § 1395w-26(b)(3); *see* H.R. Rep. No. 108-391, at 557 (2003), *as reprinted in* 2003 U.S.C.C.A.N. 1808, 1926 (showing congressional intent to broadly preempt state laws related to Medicare Advantage plans).

program is a federal program operated under Federal rules. State laws, do not, and should not apply, with the exception of state licensing laws or state laws related to plan solvency."[311] Preemption requires that state law give way to federal law, either in the event of a conflict or—in the case of complete instead of partial preemption—when a statute announces Congress's intent to fully occupy a particular field and prevent state action.[312]

Those focused on expanding market-based competition as part of the Medicare program—those pushing for the expansion of Medicare Advantage plans—were concerned that extensive regulation by both states and the federal government would reduce participation in that market.[313] The difficulty of complying with different (and perhaps conflicting) state laws would almost certainly reduce participation in any private Medicare plans.[314]

As concerns about Medicare Advantage plans have grown, however, including but not limited to complaints about predatory marketing, senators and representatives have called for reform. On January 26, 2024, Representative Pramila Jayapal (D-Washington) and Senator Elizabeth Warren (D-Massachusetts), a member of the Senate Finance Committee, urged CMS

311. H.R. Rep. No. 108-391, at 557. Although the Secretary (via CMS) initially "continue[d] to believe that generally applicable State tort, contract, or consumer protection law" and standards "based on case law precedents" would not be preempted under the 2003 Medicare Advantage provision, in the final rule, she wrote that "all State standards, including those established through case law, are preempted to the extent that they specifically would regulate [Medicare Advantage] plans, with exceptions of State licensing and solvency laws." Medicare Program; Establishment of the Medicare Advantage Program, 69 Fed. Reg. 46,866, 46,913–14 (Aug. 3, 2004); Medicare Program; Establishment of the Medicare Advantage Program, 70 Fed. Reg. 4,665 (Jan. 28, 2005).

312. *See* McCuskey, *supra* note 25, at 96–97 (noting congressional power under the Supremacy Clause of the Constitution and stating that "[p]reemption generally describes the displacement of state law by federal law").

> The most conclusive, and rarest, form of preemption, "complete preemption," applies when "a federal statute's preemptive force [is] so extraordinary and all-encompassing that it converts an ordinary state-common-law complaint into one stating a federal claim for purposes of the well-pleaded-complaint rule." Under complete preemption, "a federal statute wholly displaces [any] state-law cause of action" for the same alleged harm and confers federal question jurisdiction over the claim.

Id. at 102–04 (internal citations omitted).

313. Jackonis, *supra* note 25, at 181 ("Medicare reformers are faced with a Hobson's choice: rely on a highly regulated express and conflict preemption program that could diminish the market of available participating plans, or deregulate Medicare managed care to broaden the market of providers while facing the problems created by field preemption in a regulatory void.").

314. *Id.* Note that this also served as a justification for broad preemption of laws related to employee benefit plans, including health plans, under ERISA.

in a letter to reduce "overpayments" to Medicare Advantage insurers.[315] As the press release noted, "The Medicare Payment Advisory Commission estimates that CMS pays MA plans 6 percent more per enrollee than what it would cost to cover the same enrollee in Traditional Medicare (TM), even though MA plans spend up to 25 percent less on health care per enrollee."[316] Similarly, on October 17, 2024, Senator Richard Blumenthal (D-Connecticut), former Chair of the Senate Permanent Subcommittee on Investigations, released a majority staff report on the Subcommittee's investigation findings that the three largest Medicare Advantage insurance providers—UnitedHealthcare, Humana, and CVS—used preauthorization requirements to deny post-acute care to beneficiaries in skilled nursing facilities, inpatient rehabilitation facilities, and long-term acute care hospitals.[317] Yet congressional polarization has made solving Medicare Advantage problems difficult and resulted in the back and forth of tightening and loosening CMS regulations and guidance as the party in the White House changes.[318]

The preemption clause that has made it difficult for states to take action on predatory marketing of Medicare Advantage plans has implications for the long held (if not recently observed) legal notion that states have primacy in regulating the health and welfare of their citizens because of their police

315. Press Release, Representative Pramila Jayapal, *Jayapal, Warren Call for Action Against Private Medicare Advantage Insurers That Waste Taxpayer Dollars and Unlawfully Deny Care* (Jan. 26, 2024), https://jayapal.house.gov/2024/01/26/warren-jayapal-call-for-action-against-private-medicare-advantage-insurers-that-waste-taxpayer-dollars-and-unlawfully-deny-care/ [https://perma.cc/6TK5-Q7BT] (noting, among other overpayment concerns, substantial upcoding, problems with the Quality Bonus Program, and unlawful denials of care to increase profits).

316. *Id.* MedPAC, "an independent agency that advises Congress on Medicare issues," has been focusing its recent efforts on overpayments and pushing for congressional reform. Julie Carter, *Annual Assessment and New Investigation Highlight High Medicare Advantage Overpayment*, MEDICARE RTS. CTR. (Aug. 22, 2024), https://www.medicarerights.org/medicare-watch/2024/08/22/annual-assessment-and-new-investigation-highlight-high-medicare-advantage-overpayment [https://perma.cc/NCL6-PDER].

317. C. Huberty, *Senate Subcommittee Report Details Medicare Advantage Coverage Denials*, CTR. FOR MEDICARE ADVOC. (Oct. 24, 2024), https://medicareadvocacy.org/medicare-advantage-coverage-denials/ [https://perma.cc/LJ3D-D9FG]; Press Release, Sen. Richard Blumenthal, *Senate Permanent Subcommittee on Investigations Releases Majority Staff Report Exposing Medicare Advantage Insurers' Refusal of Care for Vulnerable Seniors* (Oct. 17, 2024), https://www.blumenthal.senate.gov/newsroom/press/release/senate-permanent-subcommittee-on-investigations-releases-majority-staff-report-exposing-medicare-advantage-insurers-refusal-of-care-for-vulnerable-seniors [https://perma.cc/T46Z-DY8Y]; MAJ. STAFF OF S. PERMANENT SUBCOMM. ON INVESTIGATIONS, 118TH CONG., *REFUSAL OF RECOVERY: HOW MEDICARE ADVANTAGE INSURERS HAVE DENIED PATIENTS ACCESS TO POST-ACUTE CARE* (2024), https://www.hsgac.senate.gov/wp-content/uploads/2024.10.17-PSI-Majority-Staff-Report-on-Medicare-Advantage.pdf.

318. *See supra* Part II.B.

power.[319] While parties to litigation seeking to overturn federal COVID-19 restrictions often referenced the state police power to prevent federal administrative agencies from using federal law to protect the health of individuals (and were aided by conservative judges in doing so),[320] federal inaction—aided again by conservatives judges—can stymie states and their ability to protect the health and welfare of their citizens. The result is an increasing concentration of the power over health in the Judiciary.[321] The role played by the courts is not one of passive statutory interpretation, but instead an active role that weighs policy arguments and errs in favor of administrative retrenchment at both the federal and state levels.

Elizabeth McCuskey writes about the idea that states do and should regulate matters of health and insurance because they have traditionally done so. She discusses the tradition presumption, which "assumes that states have traditionally regulated a particular field, then infers that Congress did not intend to disturb that tradition" and asserts that it has unclear applicability to the varied field of health law, which encompasses "a uniquely heterogeneous array of regulatory areas, including provider liability, facility regulation, insurance, product safety, public health, and privacy."[322] She advocates for a "scalpel approach" to determine whether states have long regulated the particular area at issue and, thus, whether the presumption against preemption should apply. The presumption against preemption is relevant in spite of the broad Medicare preemption clause because courts must still interpret its language and the language of the enumerated exceptions. Although states have traditionally regulated insurance, including health insurance, the federal government upended that tradition when implementing Medicare and the federal regulation of employee benefit plans under ERISA.[323] It is thus unclear whether courts should apply a presumption against preemption when deciding how broadly or narrowly to construe the Medicare Advantage preemption provision.

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319. *See, e.g.*, Roth, *supra* note 249, at 800, 810–11.

320. *Id.* at 795–96.

321. I predicted this result in a previous article, explaining how the COVID-19 cases actually gave the power over public health to the federal Judiciary—not to the states. *Id.* "The recent federal court COVID-19 decisions discussed above contain rhetoric about a shift of power back toward the states, but the way they are likely to actually narrow state power signals that federalism is not the true motivation for these decisions. Instead, individual liberties are ascendant now (with federal courts playing referee when public health authorities step over the blurry new lines of the major questions doctrine), and federalism concerns play a lesser role—with perhaps devastating consequences for regulating public health." *Id.*

322. *See* McCuskey, *supra* note 25, at 99–100.

323. *See* Shachar, *supra* note 80.

The additional preemption wrinkle here is the combination of preemption without federal regulation. The federal government is preempting state action on the compensation incentives of Medicare Advantage brokers by refusing to act—essentially by doing nothing. The current concern is not only whether courts have gotten it right and the federal government does have such broad preemption powers over Medicare Advantage plans but also whether the scope of the preemption is so complete that it can preempt state action by essentially refusing to act.

Courts play a role here in two ways. First, they can invalidate any efforts by CMS to regulate Medicare Advantage plans, as the district court in Texas has done.[324] This leaves a regulatory vacuum that the states may try to fill. That results in a second role for courts if and when they step in and strike down state efforts to legislate or regulate—even though the federal government is prevented from doing so by the courts here (or, in other cases, may simply decline to do so).

Parallels to the Dormant Commerce Clause cases abound. Courts have essentially found that state laws that might apply to Medicare Advantage plans are preempted because they disrupt the uniform system of Medicare health insurance regulation and also because one state's efforts to protect its consumers might harm those in other states by increasing costs or pushing insurance companies out of the Medicare Advantage market entirely.[325] Yet states have a right to protect their consumers as long as there is no undue burden on consumers in other states. Currently available technology like geolocation services used to advertise to Medicare beneficiaries demonstrates the ease of complying with each state's marketing and sales laws.

A. Case Law

Courts have repeatedly struck down efforts by states to protect Medicare beneficiaries in light of the broad preemption provision. Many cases are dismissed because plaintiffs enrolled in Medicare Advantage plans fail to exhaust the required administrative remedies provided by the Social Security Act.[326] As a first step, participants in a Medicare Advantage plan can only seek relief from a federal district court after they have completed a review process that includes both the plan's internal procedures for an initial

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324. *See* Ams. for Beneficiary Choice v. U.S. Dep't of Health & Hum. Servs., No. 4:24-cv-00439-0, 2024 WL 3297257, at *3–5, (N.D. Tex. July 3, 2024).

325. *See infra* part III.A.

326. 42 U.S.C. § 1395w-22(g); *see* Aylward v. SelectHealth, Inc., 35 F.4th 673, 678–79 (9th Cir. 2022) (reviewing the statutory administrative remedies provided for Medicare Advantage participants when appealing a plan's denial of their claims for benefits).

decision[327] and subsequent reconsideration,[328] as well as review by an independent contractor.[329] Only then may a plan participant (with more than $100 at stake in the matter) pursue a hearing before an administrative law judge.[330] The participant may then pursue review by the Medicare Appeals Council.[331] And then, if the participant has not obtained relief and the amount in controversy is at least $1,000, the Secretary's decision is final and the participant may seek judicial review.[332]

In *Uhm v. Humana, Inc.*,[333] the district court dismissed a case where plaintiffs brought state law claims against their Medicare Part D prescription drug plan.[334] Plaintiffs filed claims of breach of contract, violation of state consumer protection statutes, unjust enrichment, fraud, and fraud in the inducement after they enrolled in the plan based on defendants' advertisements and were unable to make any benefit claims for their prescription drugs when defendants would not send them the claim forms and instructions in spite of their repeated requests.[335] The Medicare Advantage preemption clause is also applicable to Part D plans, and the court decided the case under that same preemption standard.[336] The court held that the coverage determination regulations superseded the state law claims, and the plaintiffs would need to pursue their claims through the grievance procedures even for "any non-coverage-determination dispute between a PDP sponsor and its enrollees about any operations, activities, or behavior of the PDP sponsor."[337]

Affirming the district court's decision, the Ninth Circuit specifically

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327. 42 U.S.C. § 1395w-22(g)(1).

328. *Id.* § 1395w-22(g)(2).

329. *Id.* § 1395w-22(g)(4).

330. *Id.* § 1395w-22(g)(5) (citing *id.* § 405(g)); 42 C.F.R. § 422.600 (2025).

331. 42 C.F.R. § 422.608 (2025).

332. 42 U.S.C. § 1395w-22(g)(5); 42 C.F.R. § 422.612; *see* Heckler v. Ringer, 466 U.S. 602, 629–30 (1984) (Stevens, J., dissenting in part) (finding in dissent that a Medicare participant's inability to exhaust the administrative remedies because he could not afford to pay for the surgery the Secretary had broadly ruled inappropriate for his medical condition and then file a claim for reimbursement was unjust while stating that "[t]he cruel irony is that a statute designed to help the elderly in need of medical assistance is being construed to protect from administrative absolutism only those wealthy enough to be able to afford an operation and then seek reimbursement").

333. Uhm v. Humana, Inc., No. C06-0185-RSM, 2006 WL 1587443 (W.D. Wash. June 2, 2006), *aff'd*, 620 F.3d 1134 (9th Cir. 2010).

334. *Id.* at *1.

335. *Id.* at *1–2.

336. *Id.* at *2 (citing 42 U.S.C. § 1395w-112(g) (2006), which made the preemption clause applicable to Part D prescription drug plans).

337. *Id.* at *3 (rejecting plaintiffs' claims about the insufficiency of the federal grievance procedures due to the lack of independent review and noting that defendants could be subject to fines).

discussed the Uhms' fraud and consumer protection act claims.[338] The plaintiffs alleged that Humana used deceptive marketing when it told them that their coverage would begin on January 1, 2006, the coverage would provide "reliable customer service," and Humana "has been a trusted Medicare insurer for more than 20 years, helping the Medicare population with their health insurance needs."[339] The court found that plaintiffs did not need to exhaust these claims administratively because they did not arise under the Medicare Act.[340]

Turning to whether these claims were preempted, the Ninth Circuit considered when a state law or regulation is one "with respect to" a plan, but found that it did not need to decide the limits of this phrase's definition to decide the case because the state laws at issue were covered by the standards in the Medicare Act and also conflicted with those standards.[341] Extensive CMS marketing regulations made preemption clear, even under the narrower preemption standard that applied before the MMA.[342] With respect to plaintiffs' tort claims for fraud and fraud in the inducement, the court found that they required the court to determine whether the advertising materials were misleading, which "would directly undermine CMS's prior determination that those materials were not misleading and in turn undermine CMS's ability to create its own standards for what constitutes 'misleading' information about [the plan]" and were therefore preempted.[343] Similar attempts to turn claims for benefits into state common law claims that are not preempted have repeatedly failed.[344]

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338. Uhm v. Humana, Inc., 620 F.3d 1134, 1145 (9th Cir. 2010).

339. *Id.*

340. *Id.*

341. *Id.* at 1148–49.

342. *Id.* at 1150–52 ("The state consumer protection acts . . . are 'inconsistent' with these standards in that they are much less specific and also in that they do not provide for CMS review.").

343. *Id.* at 1156–57; *see* Quishenberry v. UnitedHealthcare, Inc., 532 P.3d 239, 244–45 (Cal. 2023) (confirming that Congress intended to preempt duplicative state law duties with respect to Medicare Advantage plans).

344. *Uhm*, 620 F.3d at 1143 (finding that a plaintiff who has been denied benefits under a Medicare Advantage plan cannot use a state tort or contract claim as "a backdoor attempt to enforce the Act's requirements and to secure a remedy for the [plan's] alleged failure to provide benefits"); Williams v. Aetna Better Health of Ohio, No. 2:23-cv-2985, 2024 WL 3925879, at *3 (S.D. Ohio Aug. 22, 2024) ("It is well-accepted that common law claims are encompassed in the preemption rule's scope of 'any State law or regulation.'" (internal citations omitted)); Masey v. Humana, Inc., No. 8:06-cv-1713-T-24-EAJ, 2007 WL 2788612, at *3 (M.D. Fla. Sept. 24, 2007) (finding fiduciary and consumer protection claims preempted because they are "'inextricably intertwined' with what is 'in essence' a claim for Medicare benefits" (citations omitted)).

The Ninth Circuit went a step further in *Aylward v. SelectHealth, Inc.*[345] and found that the Medicare Advantage preemption provision "preempts a state law cause of action that parallels, enforces, or supplements express standards established under Part C and its implementing regulation."[346] In that case, Naomi Aylward filed a lawsuit in state court against the administrator of her husband, Philip Aylward's, Medicare Advantage plan because of an alleged failure to investigate and timely respond to an appeal for testing related to a potential lung transplant.[347] Addressing preemption, the court found that "[t]here is no basis for concluding that a state law duty that parallels, enforces, or supplements an express federal MA standard on the subject is *not* one 'with respect to MA plans.'"[348] Because the Medicare Advantage standards establish the procedures and timeframes for expedited review of preauthorization determinations, those standards "'supersede' any state law duty that would impose obligations on MA plans on that same subject" regardless of "whether or not they would be inconsistent with federal regulations."[349] Thus, the court found that even state laws that came near federal standards imposed on Medicare Advantage plans are preempted—in effect creating penumbras where states are no longer free to act.[350]

However, courts have also found that federal courts do not have original or exclusive jurisdiction over Medicare Advantage claims—small solace. The Eleventh Circuit held that state law claims filed by beneficiaries enrolled in a Medicare Advantage plan against that plan could not be removed by the defendants to federal court.[351] In *Dial v. Healthspring of Alabama, Inc.*,[352] the court ordered the case remanded to state court where the plaintiffs made only state law claims.[353] Healthspring argued that the Medicare Act results in complete preemption of state law and thus original jurisdiction in the federal courts, but the Eleventh Circuit denied that federal courts have original jurisdiction over disputes related to Medicare Advantage plans.[354] Instead, the Medicare Act requires an administrative hearing by the Secretary of the

345. 35 F.4th 673 (9th Cir. 2022).

346. *Id.* at 681.

347. *Id.* at 675–77.

348. *Id.* at 681 (internal citations omitted).

349. *Id.*

350. *See* Pharm. Care Mgmt. Ass'n v. Wehbi, 18 F.4th 956, 971 (8th Cir. 2021) (holding that "the effect of the 2003 amendment was to expand the scope of express Medicare preemption from conflict preemption to field preemption").

351. *See* Dial v. Healthspring of Ala., Inc., 541 F.3d 1044, 1046 (11th Cir. 2008).

352. 541 F.3d 1044 (11th Cir. 2008).

353. *Id.* at 1046.

354. *Id.* at 1047 ("Complete preemption occurs when a federal statute both preempts state substantive law and 'provides the exclusive cause of action for the claim asserted.'").

Department of Health and Human Services.[355] Only after a decision from the administrative hearing can beneficiaries seek judicial review before a federal district court.[356] Such a case is therefore not removable.[357] In dicta, the court noted that even if one of plaintiffs' state law claims is truly a claim under the Medicare Act masquerading as a state law claim, "the district court would lack subject-matter jurisdiction over their complaint because it is not against the Secretary of the Department of Health and Human Services for review of an administrative decision."[358]

Similarly, the federal district court in *Harris v. Pacificare Life & Health Insurance Co.*[359] denied that removal to federal court was appropriate where beneficiaries in a Medicare Advantage plan alleged state law claims related to misrepresentations made by plan agents when enrolling them, including fraud, unjust enrichment, negligent infliction of emotional distress, wantonness, and outrage.[360] Distinguishing between ordinary preemption, where federal law may "displace state law" but the case may remain in state court, with complete preemption, which requires removal to federal court in addition to the displacement of state law, the court found that the Medicare Advantage preemption provision does not establish a scheme of complete preemption.[361] As the court stated:

> In short, Pacificare has not demonstrated that 42 U.S.C. § 1395w-26(b)(3) or the MMA's regulatory provisions provide an exclusive private federal remedy for the alleged wrongful conduct alleged by Plaintiffs or, in other words, that Congress intended to displace Plaintiffs' state common-law claims in favor of an exclusive private federal remedy.[362]

The doctrine of complete preemption has been used to provide federal courts with jurisdiction over "a set of preemptive federal statutes for special

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355. *Id.* at 1047–48.

356. *Id.*

357. *Id.* at 1048.

358. *Id.*

359. 514 F. Supp. 2d 1280 (M.D. Ala. 2007).

360. *Id.* at 1284–85 ("Defendants misrepresented that Plaintiffs 'were required to enroll in Secure Horizons Direct under the federal government's new prescription drug program,' and misrepresented that Defendants, in actuality, were 'dis-enrolling Plaintiffs from their Medicare coverage and enrolling them' in Secure Horizons Direct's private Medicare Advantage plan." (internal citations omitted)).

361. *Id.* at 1287–94 ("[C]omplete preemption is a jurisdictional concept quite different and separate from ordinary preemption. Ordinary preemption is a defense to a state-law claim, but it does not create federal question jurisdiction for lawsuits removed from state to federal court." (internal citations omitted)); *accord* Lassiter v. Pacificare Life & Health Ins. Co., No. 2:07-cv-583-MEF, 2007 WL 4404051 (M.D. Ala. Dec. 13, 2007).

362. *Harris*, 514 F. Supp. 2d at 1296.

jurisdictional treatment."[363] Although the well-pleaded complaint rule traditionally allows the parties to gain access to the federal courts through federal question jurisdiction when the claims are pleaded through federal law and not state law, this doctrine allows judges to distinguish a narrow set of statutes and deny review to state courts,[364] effectively "convert[ing] an ordinary state-common-law complaint into one stating a federal claim for purposes of the well-pleaded-complaint rule."[365] Although the "undertheorized" or "*un*theorized" jurisprudence of complete preemption has resulted in circuit splits regarding which statutes it applies to and even calls for it to be abolished,[366] it is noteworthy that courts have thus far chosen not to apply it to Medicare Advantage litigation.

B. State Powers

Historically, insurance has been regulated by the states, although the federal government has been chipping away at state regulation of health insurance.[367] Justifications for the traditionally limited role of the federal government typically include the "public interest" element of insurance because of the high financial stakes for consumers as well as the difficulty consumers have in properly evaluating risk and insurance policy terms.[368] Solvency concerns go hand-in-hand with consumer protection since an insurer's insolvency also harms beneficiaries.[369]

Each state has an executive department that regulates insurance, with the leader of the department typically appointed by the governor and titled the

363. Gil Seinfeld, *The Puzzle of Complete Preemption*, 155 U. PA. L. REV. 537, 538 (2007); *see* Beneficial Nat'l Bank v. Anderson, 539 U.S. 1 (2003).

364. Seinfeld, *supra* note 363, at 538–39 (explaining that the federal question doctrine typically seeks to promote uniform interpretation of the laws but that the complete preemption doctrine has not explicitly been justified on that ground).

365. McCuskey, *supra* note 25, at 103.

366. Seinfeld, *supra* note 363, at 548–49, 578 ("It is little wonder, then, that Justice Scalia recently called for the virtual abandonment of the complete preemption rule."); *see* Anthony Salzetta, *Unpuzzling Complete Preemption:* Beneficial National Bank v. Anderson *After Two Decades in the Circuit Courts*, 43 PACE L. REV. 319, 341–48 (2023).

367. McCarran-Ferguson Act, 15 U.S.C. § 1011 ("Congress hereby declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States."); Susan Randall, *Insurance Regulation in the United States: Regulatory Federalism and the National Association of Insurance Commissioners*, 26 FLA. STATE U. L. REV. 625, 626 (1999).

368. Randall, *supra note* 367, at 627.

369. *Id.* at 627.

commissioner or director of insurance.[370] In spite of their broad powers, most state insurance departments lack the funding and the political support for activism absent collective action.[371]

The National Association of Insurance Commissioners (NAIC) is an association of state insurance commissioners that attempts to promote state coordination and uniformity.[372] Any trends seen or discussed in this paper regarding state insurance departments are likely the result of actions taken by and with NAIC.[373]

Federal intervention into state regulation of insurance has often involved health care or a major financial crisis and has frequently resulted in less consumer protection.[374] The 2008 financial crisis resulted in concerns about systemic risk that were used to justify federal intervention through the creation of the Federal Insurance Office and the Dodd-Frank Wall Street Reform and Consumer Protection Act in 2010.[375] Health insurance and employee benefits have repeatedly resulted in federal intervention, however, not because of a one-time crisis but instead because of an asserted need to encourage voluntary participation in the market by employers and private insurance companies or administrators through federal tax incentives, limited judicial review and liability, and uniform regulation that exists outside the realm of activism by liberal states.[376]

The Medicare Advantage preemption clause contains an exception for "State licensing laws or State laws relating to plan solvency" when it says that federal law supersedes all state laws "with respect to MA plans which are offered by MA organizations under this part."[377] The power to license Medicare agents and

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370. *Id.* at 629 (describing how state insurance departments have "broad, legislatively delegated powers to enforce state insurance laws, promulgate rules and regulations, and conduct hearings to resolve disputed matters").

371. *Id.*

372. *Id.* at 629–30. *But see* Daniel Schwarcz, *Is U.S. Insurance Regulation Unconstitutional?*, 25 CONN. INS. L.J. 197, 256 (2018) ("It is now time for states to take back their power from rogue state insurance regulators by holding the NAIC accountable.").

373. *See* Randall, *supra* note 367, at 635–42 (describing the growth and power of NAIC and comparing it to a federal agency that simultaneously attempts to avoid intervention by the actual federal government). "When the threat of federal intervention recedes, the states tend to reclaim their authority." *Id.* at 641.

374. *See* Christopher French, *Dual Regulation of Insurance*, 64 VILL. L. REV. 25, 70 (2019).

375. Patricia McCoy, *Systemic Risk Oversight and the Shifting Balance of State and Federal Authority over Insurance*, 5 U.C. IRVINE L. REV. 1389, 1396–415 (2015).

376. *See* CHRISTOPHER HOWARD, THE HIDDEN WELFARE STATE: TAX EXPENDITURES AND SOCIAL POLICY IN THE UNITED STATES (Princeton Univ. Press 1997); Roth, *supra* note 80, at 216, 223–25, 271.

377. 42 U.S.C. § 1395w-26(b)(3).

brokers includes the power to discipline.[378] Agents and brokers can typically be disciplined or have their licenses revoked for engaging in misleading or fraudulent practices with respect to the sale of insurance policies.[379]

Yet, there has been little risk before now that Medicare agents or brokers would be disciplined for predatory marketing of Medicare Advantage plans. States lack the financial resources to carry out extensive investigations or disciplinary proceedings.[380] In addition, states have preemption concerns because CMS has, until recently, effectively sanctioned the practices by failing to regulate the financial incentives that the brokers are entitled to—making it difficult, though not impossible, for states to treat these practices as improper under state licensing laws.[381]

However, New York pushed back on the idea that the Medicare Advantage preemption provision preempts all New York insurance laws in a 2007 opinion.[382] While acknowledging that "state laws affecting insurers offering Medicare Parts C or D are to a large extent pre-empted by federal law," the opinion affirms the state's right to license entities performing adjusting services for insurers because the statutory requirements "pertain to entities performing adjusting services" and not to Medicare Part C or D plans.[383] Remarkably, New York takes this position while acknowledging and quoting a lengthy portion of CMS's position statement set forth as follows in the Federal Register:

> We believe State licensure requirements cannot be used as an indirect way to regulate MA plans by imposing requirements not generally associated with licensure. For

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378. Nat'l Ass'n of Ins. Comm'rs, *Producer Licensing Model Act* § 12 (Jan. 2005), https://content.naic.org/sites/default/files/model-law-218.pdf [https://perma.cc/W3DU-N2S5] ("The insurance commissioner may place on probation, suspend, revoke or refuse to issue or renew an insurance producer's license or may levy a civil penalty in accordance with [insert appropriate reference to state law] or any combination of actions, for any one or more of the following causes: . . . (5) Intentionally misrepresenting the terms of an actual or proposed insurance contract or application for insurance; . . . (7) Having admitted or been found to have committed any insurance unfair trade practice or fraud; (8) Using fraudulent, coercive, or dishonest practices, or demonstrating incompetence, untrustworthiness or financial irresponsibility in the conduct of business in this state or elsewhere; (9) Having an insurance producer license, or its equivalent, denied, suspended or revoked in any other state, province, district or territory . . . .").

379. *Id.*; Nat'l Ass'n of Ins. Comm'rs, *Producer Licensing Model Act* (2020), https://content.naic.org/sites/default/files/model-law-state-page-218.pdf [https://perma.cc/S9JW-HE88].

380. *See* Randall, *supra* note 367, at 629.

381. *See infra* Part IV.B

382. N.Y. State Dep't of Fin. Servs., OGC Opinion No. 07-07-20, *Medicare Prescription Drug Program; Use of Adjusters* (July 24, 2007), https://www.dfs.ny.gov/insurance/ogco2007/rg070720.htm [https://perma.cc/M3U2-XUP4].

383. *Id.*

> example, we stated that reasonable licensure requirements may include the filing of articles of incorporation with the appropriate State agency or satisfying State governance requirements. However, we chose not to establish the parameters of State licensure in our regulations as there may be other legitimate aspects of State licensure we have not noted. . . .
>
> [W]e believe that under the MMA, States are preempted from applying any regulatory requirements on MA plans with the sole exception of State licensure and solvency requirements. We also believe that licensure and solvency requirements cannot be used as an indirect method of imposing State regulatory requirements that a State might impose on non MA health plans. We recognize that there still may be questions about the extent of allowable State regulation. As in the case of the pre-MMA pre-emption provisions, we intend to address these specific type of preemption questions in cooperation with States.[384]

New York's opinion represents an example of a state interpreting the Medicare Advantage preemption provision and its licensing exception to allow it to regulate actors operating in the Medicare Advantage ecosystem but not administering the plan. Moreover, CMS's position on preemption still does not define the contours of the exception for state licensure requirements. There is room for states to maneuver under this exception to the Medicare Advantage preemption provision.

C. Courts' Role

Medicare Advantage preemption jurisprudence echoes Dormant Commerce Clause jurisprudence and invokes similar debates about the role of federal courts and judges in preempting state laws.

Article I, Section 8 of the Constitution states, "The Congress shall have [the] Power . . . To regulate Commerce with foreign Nations, and among the several States, and with the Indian Tribes."[385] Congress is permitted to regulate three types of activities: "(1) the channels of interstate commerce; (2) the instrumentalities of interstate commerce or the flow of goods across state lines; and (3) activities that substantially affect interstate commerce."[386] Courts have defined interstate commerce to include more than the buying and selling of products and services across state borders.[387] At times,

384. Medicare Program; Establishment of the Medicare Advantage Program, 70 Fed. Reg. 4,588, 4,664–65 (Jan. 28, 2005).

385. U.S. CONST. art. I, § 8, cl. 3.

386. Laura Hu, *State Telemedicine Abortion Restrictions and the Dormant Commerce Clause*, 91 U. CHI. L. REV. 1,411, 1,423 (2024) (citing Gonzales v. Raich, 545 U.S. 1, 16–17 (2005)).

387. *See Gonzales*, 545 U.S. at 22 (holding that Congress has the power to regulate local cultivation and use of marijuana through the Controlled Substances Act); Wickard v. Filburn,

however, the Supreme Court has backed away from this ever-expanding interpretation of what activities fall under the affirmative Commerce Clause and are subject to exclusive federal law.[388]

Even where there is no current conflict between federal law and state law—and the state does not explicitly seek to enact a protectionist state law that will benefit its economy at the expense of another state's interests (the anti-discrimination principle), the Dormant Commerce Clause Doctrine means that states cannot act in a way that will unlawfully burden interstate commerce.[389] That is, even if Congress has done nothing, courts may rule that the Commerce Clause preempts state or local action. Courts have previously struck down laws designed to protect the public's health under this theory.[390]

The balancing test a court uses to decide whether a state law is an undue burden on interstate commerce is drawn from the Supreme Court case of *Pike v. Bruce Church, Inc.*:[391]

> Where the statute regulates even-handedly to effectuate a legitimate local public interest, and its effects on interstate commerce are only incidental, it will be upheld unless the burden imposed on such commerce is clearly excessive in relation to the putative local benefits. If a legitimate local purpose is found, then the question becomes one of degree. And the extent of the burden that will be tolerated will of course depend on the nature of the local interest involved, and on whether it could be promoted as well with a lesser impact on interstate activities.392

In *National Pork Producers Council v. Ross*,[393] the Supreme Court attempted to clarify the Dormant Commerce Clause Doctrine.[394] The case involved a California law, adopted by ballot initiative, that banned the sale of pork products "derived from breeding pigs confined in stalls so small they cannot lie

317 U.S. 111, 127–29 (1942) (holding that a farmer could not use his own excess wheat crop on his farm because of its impact on the outside market for wheat).

388. *See* United States v. Morrison, 529 U.S. 598, 614, 618 (2000) (striking down the private civil remedy in the federal Violence Against Women Act because there are supposedly no national effects to violence against women); United States v. Lopez, 514 U.S. 549, 565–67 (1995) (holding that Congress exceeded its authority under the Commerce Clause by making gun possession in a school zone a federal offense because it did not "substantially affect" interstate commerce).

389. Hu, *supra* note 386, at 1423–24.

390. *But see Gonzales*, 545 U.S. at 22 (holding that Congress has the power to regulate local cultivation and use of marijuana through the Controlled Substances Act).

391. 397 U.S. 137, 140, 145 (1970) (striking down statute where the "practical effect" required a company to build a $200,000 packing plant for cantaloupes in the state).

392. *Id.* at 142 (citations omitted).

393. 143 S. Ct. 1142 (2023).

394. *See generally id.* at 1149–50 (analyzing the challenged statute under Dormant Commerce Clause Doctrine).

down, stand up, or turn around."[395] Congress had yet to adopt a conflicting statute that would preempt Proposition 12.[396] Two out-of-state pork producers sued, alleging violation of the Dormant Commerce Clause Doctrine.[397] The Supreme Court, however, upheld the state law, referencing the long history of state laws designed to protect state residents, including laws preventing animal cruelty.[398]

First, the Court struck down petitioners' argument under the supposed "extraterritoriality doctrine" that interpreted the Dormant Commerce Clause cases to add an "'almost *per se*' rule forbidding enforcement of state laws that have the 'practical effect of controlling commerce outside the State,' even when those laws do not purposely discriminate against out-of-state economic interests."[399] The Court, however, found no such extraterritoriality doctrine exists and instead stated that the cases cited typify the Court's concerns with "preventing purposeful discrimination against out-of-state economic interests."[400]

Second, given that petitioners were admittedly not arguing purposeful discrimination, the Court next dealt with their argument that the California law imposes an undue burden on interstate commerce. However, Justice Gorsuch's opinion did not command a majority for the rationale it had when striking down the *Pike* test.[401] Writing for a majority, Gorsuch first clarified that the *Pike* test is designed to examine the state law's "practical effects" to see if they reveal "a discriminatory purpose"—making it another way to examine the core goal of preventing state laws that discriminate against out-of-state economic interests.[402] Justice Gorsuch next rejected the petitioners' invitation to read *Pike* as permitting judges to strike down state laws "based on nothing more than their own assessment of the relevant law's 'costs' and 'benefits.'"[403] He specifically noted the difficulty of weighing "economic costs (to

395. *Id.* at 1149.

396. *Id.* at 1152.

397. *Id.* at 1151–52.

398. *Id.* at 1151 (noting also that advocates of the law asserted it would reduce the risk of food poisoning).

399. *Id.* at 1154 (arguing that Proposition 12 offends this extraterritoriality rule because of the substantial compliance costs on out-of-state pork producers).

400. *Id.*

401. Jack Goldsmith & Eugene Volokh, *The Relevance of* Ross *to Geolocation and the Dormant Commerce Clause*, 102 TEX. L. REV. ONLINE 30, 36–37 (2023) [hereinafter Goldsmith & Volokh, *The Relevance of* Ross].

402. *Nat'l Pork*, 143 S. Ct. at 1157.

403. *Id.* at 1159 (calling such a power freewheeling and reviewing precedent that rejects the premise that courts may use the Dormant Commerce Clause to decide what and when states and local governments may regulate).

some) against noneconomic benefits (to others)."[404] Instead, Justice Gorsuch gives the petitioners a choice—they may comply with the state law or withdraw from the market.[405] Given the other opinions filed in the case, the narrowest holding for lower courts to apply is the one that applies *Pike* to the facts.[406]

With the Dormant Commerce Clause, courts are trying to determine whether states have gone over the line and unduly burdened interstate commerce. The question is whether states are legislating or regulating in an area that is not within their domain but also, ultimately, whether they are trying to protect their own residents at the expense of the residents of other states by adding requirements or costs to out-of-state businesses.

Similarly, with Medicare Advantage preemption doctrine, courts are trying to determine whether states have gone over the line and are regulating Medicare Advantage plans—as opposed to activities related to the plans that do not reach the plans themselves. The question also becomes whether they are trying to protect their own residents in a way that will harm the residents of other states indirectly by burdening the private insurance companies that offer Medicare Advantage plans and adding requirements or costs that force them to raise costs on all states or even leave the market. Uniformity is often touted as a goal in health insurance regulation because of the country's system requiring the voluntary participation of private companies.

But why shouldn't states be able to protect their Medicare beneficiaries from predatory marketing, especially if it is easy for brokers to determine which state callers or website users reside in and comply with that state's laws? Jack Goldsmith and Eugene Volokh have argued that the Dormant Commerce Clause should only prevent states from regulating internet activity if the geolocation of users is infeasible—meaning that as long as websites or other online service providers can easily determine which state its users are in, they should be constitutionally required to apply applicable state laws to those users.[407] As they say, "The best-known reason for firms to geolocate

404. *Id.*

405. *Id.* at 1161–62 ("They may provide all their pigs the space the law requires; they may segregate their operations to ensure pork products entering California meet its standards; or they may withdraw from that State's market.").

406. *See* Goldsmith & Volokh, *The Relevance of* Ross, *supra* note 401, at 36–37 (noting also that the Chief Justice's partial dissent affirms that *Pike* is "not limited to 'laws either concerning discrimination or governing interstate transportation'" and *Pike*'s test "remains valid and within the Court's competence, even for incommensurable costs and benefits").

407. Jack Goldsmith & Eugene Volokh, *State Regulation of Online Behavior: The Dormant Commerce Clause and Geolocation*, 101 TEX. L. REV. 1083, 1083 (2023) [hereinafter Goldsmith & Volokh, *State Regulation of Online Behavior*]. *But see* David G. Post, *The Internet and the Dormant*

is that they want to advertise, and advertising success correlates with geography. A firm might want to deliver high-end advertisements to wealthy neighborhoods, or to deliver coupons when customers enter the mall, or offer a Burger King discount at a McDonald's, or promote farm-related software in rural areas."[408] Geolocation and filtering technology makes it easier for businesses to comply with the law, including copyright law for online content providers and gambling laws.[409] They highlight the way people have traditionally been protected by state laws such as consumer protection statutes.[410]

Although Goldsmith and Volokh focus only on the Dormant Commerce Clause and acknowledge that Congress can choose to value uniformity by preempting state law in an area,[411] their argument applies equally in cases of do nothing Medicare Advantage preemption. Broker organizations have built up businesses that compile detailed information about beneficiaries seeking to enroll in supplemental Medicare plans.[412] The analytics help them determine which beneficiaries are likely to enroll and even which will be profitable for the insurance companies.[413] That information could easily be put to use to comply with any marketing and sales restrictions enacted by particular states. That it might be easier to have one, uniform set of regulations is inapposite here—CMS has not been able to speak on the issue. Where CMS chooses not to speak or cannot speak, the states should be able to do so. "Just as '[p]igs are not trucks or trains'" and "social media posts are not trucks or trains," television or online advertisements and marketing calls are not trucks or trains.[414] They neither "impede the *flow* of interstate goods,"[415] nor interfere with the operation of Medicare Advantage plans nationally.

Commerce Clause: A Reply to Goldsmith and Volokh, 101 TEX. L. REV. ONLINE 157, 161–62 (2023) (responding that Goldsmith and Volokh's argument misses the increased burdens of determining what the law is in each state where users are located and applying that law, even given the ease of geolocation).

408. Goldsmith & Volokh, *State Regulation of Online Behavior*, *supra* note 407, at 1105 (discussing how advertisers want to partition the market to advertise different products to different groups at different prices).

409. *Id.* at 1107–08.

410. *Id.* at 1124 (listing state consumer protection laws among other statutes that regulate "everyday behavior of Americans—shopping, speaking, gathering").

411. *Id.* at 1125.

412. *See generally Shea* Complaint, *supra* note 22 (DOJ's False Claims Act complaint detailing targeted marketing efforts by broker organizations).

413. *Id.*

414. Goldsmith & Volokh, *The Relevance of* Ross, *supra* note 401, at 43 (quoting *Nat'l Pork*, 143 S. Ct. at 1158 n.2).

415. *Nat'l Pork*, 143 S. Ct. at 1158 n.2.

IV. EMPIRICAL STUDY OF STATES' RESPONSE TO MEDICARE ADVANTAGE MARKETING

A. Methodology

To determine states' responses to the federal government's failure to successfully regulate Medicare brokers' incentives to sell beneficiaries inappropriate Medicare Advantage plans while preempting almost all state regulation, my research assistants and I conducted a fifty-state survey of licensing requirements, disciplinary proceedings, and educational or advocacy materials on (or linked from) state insurance regulators' websites. We searched all of the department of insurance websites using the term "Medicare Advantage"[416] in addition to browsing through the site for any relevant information or connection to another site with relevant information.

Unsurprisingly, most states have statutes based on the NAIC model law discussed above, which allow for the denial, suspension, revocation, or refusal to renew of an insurance agent or broker's license due to "[i]ntentionally misrepresenting the terms of an actual or proposed insurance contract or application for insurance"; "[h]aving admitted or been found to have committed any insurance unfair trade practice or fraud"; "[u]sing fraudulent, coercive or dishonest practices, or demonstrating incompetence, untrustworthiness or financial irresponsibility in the conduct of business in this state or elsewhere"; or "[f]orging another's name to any document related to an insurance transaction."[417] The agent or broker may also face civil penalties.[418]

States, however, rarely discipline Medicare agents and brokers and only in the most egregious circumstances.[419] First, states may not know about the inappropriate conduct. If the Medicare beneficiary fails to report the conduct or reports a complaint to the federal government, states may not have the chance to investigate or respond. Second, states may not have the resources to respond to each of the many and growing numbers of complaints reported by beneficiaries with respect to Medicare agents and brokers.

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416. Note Nebraska did not provide the ability to search its department of insurance website.

417. ARIZ. REV. STAT. ANN. § 20-295 (2025); *see, e.g.*, COLO. REV. STAT. § 10-2-801 (2025).

418. COLO. REV. STAT. § 10-2-801 (2025).

419. *But see* Karen Fletcher, *Insurance Agent Prohibited from Selling Medicare Advantage Plans*, CAL. SENIOR MEDICARE PATROL (July 20, 2010), https://cahealthadvocates.org/agent-barred-from-selling-ma-plans/ [https://perma.cc/UE4M-XPZ8] (detailing California Department of Managed Health Care's order indefinitely barring an agent from selling Medicare Advantage plans after she "cancelled the Medicare coverage of elderly consumers without their consent or knowledge, and then enrolled them in private Medicare Advantage plans she represented, causing some to unknowingly incur unexpected medical bills").

Finally (and perhaps most importantly), much of the concerning conduct is currently permitted under federal law. Brokers are permitted to earn higher compensation by selling Medicare Advantage plans from particular insurance carriers in the form of uncapped "administrative fees."

When evaluating federal and state efforts on this issue involving health insurance regulation, consumer protection, and federalism, it is also difficult to quantify the extent of the problem.[420] It is exceedingly difficult to determine whether a broker has sold a particular beneficiary a plan that is a good fit for that individual and how far off the plan sold was from the acceptable range.[421] In addition, it is difficult to determine the extent to which the problem is the result of a lack of federal action, the preemption of existing state laws of general applicability to insurance, or the preemption of potential state laws and regulations directly targeting Medicare Advantage plans.

As a result, states have focused on educating the public about how to best select supplemental Medicare coverage and to be wary of the sales tactics used by Medicare agents and brokers.[422] At the same time, they have pushed for more power to regulate on this issue.[423]

B. Educational Role

Searching all the department of insurance websites and browsing the sites and any linked sites reveals the extent to which these departments have made it their mission to post reliable information and also used strong language to try to capture the attention of their residents about predatory Medicare Advantage marketing and sales.

For years, states have mainly conducted public education campaigns, often in conjunction with the State Health Insurance Assistance Program (SHIP)—a federally funded network of organizations that help Medicare beneficiaries with enrollment—and lobbied federal officials rather than disciplining or suspending brokers and agents.[424] With the help of SHIP, nearly

420. Abbe Gluck & Nicole Huberfeld, *What Is Federalism in Healthcare For?*, 70 STAN. L. REV. 1689, 1697 (2018) (discussing the difficulties they experienced trying to "quantitatively measure the ACA's federalism in implementation, evaluating where federalism delivered and where it failed").

421. *But see Shea* Complaint, *supra* note 22, ¶¶ 15, 21–22 (showing successful efforts, on a federal level, assisting in determining broker performance).

422. *See infra* Part IV.B (discussing how state resources in its Medicare Supplement educate the public).

423. *See infra* Part V.A (discussing Abbe Gluck's argument that state efforts may be both caused by and the result of political polarization).

424. *About the Center*, STATE HEALTH INS. ASSISTANCE PROGRAM, https://www.shiphelp.org/what-we-do/about-the-center/ [https://perma.cc/4RRC-FW2H] (last visited Feb. 24, 2026).

all states have education programs designed to teach beneficiaries the difference between Medigap and Medicare Advantage plans[425] and warn them about prohibited sales and marketing practices, particularly as open enrollment periods approach.[426]

States create videos[427] and publications (including annual guides,[428] news alerts,[429] and bulletins) to educate beneficiaries and warn them about improper sales and marketing tactics[430] through the insurance department's

425. *Choosing Between Medicare Supplement 101*, STATE OF VT. DEP'T OF FIN. REGUL., https://dfr.vermont.gov/medicare-supplement-101 [https://perma.cc/6WM3-U4LM] (last visited Jan. 10, 2026).

426. *FAQ on Medicare Advantage Open Enrollment Period 2024*, ARK. DEP'T OF INS., https://insurance.arkansas.gov/site/assets/files/2100/medicare_advantage_oep_2024.pdf [https://perma.cc/LVC8-TLPF] (last visited Jan. 16, 2026) (including response to question of "What happens if you enrolled in a plan by mistake or because of misleading information?"); *Medicare Advantage Plans: Know Before You Enroll*, KY. DEP'T OF INS., https://insurance.ky.gov/ppc/Documents/camedicareadv061318.pdf [https://perma.cc/2CV5-GYUY] (last visited Jan. 16, 2026).

427. *2024 Medicare Mondays Webinar Series: Medicare Marketing Guidelines*, OKLA. INS. DEP'T, https://www.youtube.com/watch?v=6ShaM1UZjtg [https://perma.cc/ZT5Y-6VTF] (last visited Jan. 16, 2026) (speaker Ray Walker, Medicare Assistance Program Director at Oklahoma Insurance Department explains that beneficiaries have to understand what they are getting with Medicare Advantage plans and flags that rural residents may have issues with the limited provider networks while noting enforcement issues for marketing problems and warning that agents are not supposed to "steer you into a particular plan" because of compensation incentives).

428. ARK. SHIIP, AR SHIIP QUICK GUIDE TO MEDICARE 2025 (2025), https://insurance.arkansas.gov/wp-content/uploads/2026/02/AR-SHIIP-Quick-Guide-to-Medicare-2025.pdf [https://perma.cc/FH3A-BKNG]; IOWA SHIIP, MEDICARE ADVANTAGE & OTHER HEALTH PLANS IN IOWA 2025, at 5–8 (2025), https://shiip.iowa.gov/media/91/download?inline [https://perma.cc/N6FA-QWUT]; S.C. DOI, MEDICARE SUPPLEMENT INSURANCE: 2025 SHOPPER'S GUIDE 19–20 (2025), https://www.doi.sc.gov/DocumentCenter/View/14582/2025-Medicare-Supplement-Shoppers-Guide?bidId= [https://perma.cc/MH3W-4STE]; WYO. DEP'T OF INS. & SHIIP, 2025 WYOMING BUYER'S GUIDE TO MEDICARE SUPPLEMENT "MEDIGAP" AND MEDICARE ADVANTAGE INSURANCE 12–15 (2025), https://drive.google.com/file/d/1jDzPjM54gg_E9tLxBkoHt7NDjqnnJfXI/view [https://perma.cc/C3QX-FJ95].

429. *Tips to Protect Yourself During Medicare/Medicare Advantage Open Enrollment*, ALA. DEP'T OF INS. (Oct. 28, 2024), https://aldoi.gov/currentnewsitem.aspx?ID=1274 [https://perma.cc/8ZG5-GS7U] ("Read the fine print of Medicare Advantage plans. When you hear something is 'free' or 'zero premium,' you need to exercise caution. While some plans may have 'zero co-pays,' those could be limited to your primary care provider. If you see a lot of specialists, you may pay more out of pocket.").

430. Press Release, Vt. Dep't of Fin. Regul., DFR Reminds Vermonters to Avoid Medicare Open Enrollment Scams, https://dfr.vermont.gov/press-release/dfr-reminds-verm

website or linking to the state SHIP program. Regardless of how many beneficiaries access these resources,[431] they use strong language and show states attempting to change policy. For example, Vermont's working group reported that beneficiaries in Medigap plans were generally happier than those in Medicare Advantage plans, but the penetration of Medicare Advantage plans in the market was the "main driver" of plan selection and increased costs.[432] Because of such concerns, states have pushed for the ability to regulate the sales and marketing of Medicare Advantage plans through letters to Congress—one of which was signed by the Executive Committee of NAIC[433]—and congressional testimony,[434] and they publicize their efforts on state insurance websites.

There are states that provide little information on Medicare Advantage plans on state websites. They rely on the federal Medicare.gov website, likely because of politics or a lack of resources.

C. Blue States, Red States

The Medicare Advantage marketing problem is more acute in rural states and regions because limited provider networks in areas that already have too few health care providers can make it difficult for beneficiaries to receive care.[435] In addition, the rationing of care through prior authorization

onters-avoid-medicare-open-enrollment-scams [https://perma.cc/6UXS-7G7K] (last visited Jan. 16, 2025).

431. Melissa M. Garrido, Allison Dorneo & David Biko, *State Health Insurance Assistance Program Provides Valuable Guidance to Medicare Beneficiaries, but Many Don't Know It Exists*, COMMONWEALTH FUND (Nov. 21, 2024), https://www.commonwealthfund.org/blog/2024/state-health-insurance-assistance-program-provides-valuable-guidance-medicare [https://perma.cc/D3M2-NZJP].

432. VT. DEP'T OF FIN. REGUL., ACT 99 REPORT: MEDICARE SUPPLEMENT OPEN ENROLLMENT STUDY (2023), https://dfr.vermont.gov/sites/finreg/files/doc_library/MedSup-%20Report-Act-99-20230125.pdf [https://perma.cc/ML2M-DJKB].

433. Press Release, N.D. Ins. Dep't, *Godfread Signs Letter Asking Congress for Medicare Advantage Plan Marketing Authority* (May 17, 2022), https://www.insurance.nd.gov/news/godfread-signs-letter-asking-congress-medicare-advantage-plan-marketing-authority [https://perma.cc/73WL-U5SG].

434. Press Release, Ohio Dep't of Ins., OSHIIP Director Chris Reeg Testifies Before U.S. Senate About Deceptive Practices Targeting Ohioans on Medicare and Solutions (2023), https://www.finance.senate.gov/imo/media/doc/10182023_reeg_testimony.pdf [https://perma.cc/ZC2R-K22K].

435. Press Release, N.D. Ins. & Securities Dep't, Insurance Department Issues Alert to Humana Medicare Advantage Customers, (Dec. 5, 2024), https://www.insurance.nd.gov/news/insurance-department-issues-alert-humana-medicare-advantage-customers

requirements has reduced reimbursements to struggling hospitals in rural areas and puts their continued existence at risk.[436] Rural states and rural areas in urban states have attempted to educate consumers to address these concerns.[437]

For example, an Idaho information sheet discusses a man with a spouse enrolled in a Medicare Advantage plan who should not simply pick the same plan because his providers may not be in-network.[438] Similarly, a presentation from New York's Health Insurance Information Counseling and Assistance Program has slides under the heading "Medicare Advantage Plan network issues" with a case study on Olive, a rural resident enrolled in a Medicare Advantage HMO plan that stops contracting with a large hospital system nearby and has no other local option for her knee replacement surgery.[439] Since the changes are not significant under the network adequacy requirements and she is not notified of a Special Enrollment Period, Olive is stuck until the next open enrollment period.[440] As Kansas notes in its Medicare Supplement Shopper's Guide, "[Y]ou should weigh your decisions very carefully before switching to a Medicare Advantage plan. You may have

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[https://perma.cc/UF24-4CRX] (alerting residents with Humana Medicare Advantage plans that they will no longer be able to receive care at Sanford Health in-network and discussing their eligibility for a Special Election Period); Press Release, Vt. Dep't of Fin. Regul., Significant Medicare Advantage Plan Changes Will Occur in Vermont Beginning January 1, 2025 (Oct. 10, 2024), https://dfr.vermont.gov/press-release/significant-medicare-advantage-plan-changes-will-occur-vermont-beginning-january-1 [https://perma.cc/M58D-XQMW] ("During the Medicare Advantage Annual Open Enrollment Period, check if your current providers are in-network. Not all Medicare Advantage plans have the same networks of providers.").

436. *See* Alana Semuels, *The Surprising Reason Rural Hospitals Are Closing*, TIME (July 1, 2025), https://time.com/7298891/rural-hospitals-closing-explained-health-care/ [https://perma.cc/UT24-62GB]; Jed Hansen, *Medicare Advantage: A Growing Risk to Nebraska's Rural Health Care*, NEB. EXAMINER (Oct. 25, 2024), https://nebraskaexaminer.com/2024/10/25/medicare-advantage-a-growing-risk-to-nebraskas-rural-health-care/ [https://perma.cc/UJP8-WW9W].

437. *What is Prior Authorization?*, ALA. DEP'T OF INS. (Nov. 6, 2024), https://aldoi.gov/currentnewsitem.aspx?ID=1307 [https://perma.cc/4DZU-GDEM]; *2024 Medicare Mondays Webinar Series: Medicare Marketing Guidelines*, *supra* note 427.

438. MEDICARE RTS. CTR., SHIP & SMP, MEDICARE MINUTE TEACHING MATERIALS—SEPTEMBER 2024: MEDICARE'S OPEN ENROLLMENT PERIOD (2024) https://doi.idaho.gov/wp-content/uploads/shiba/MedicareMinutes/September-2024-Medicare-Minute-Teaching-Materials-Open-Enrollment-English.pdf [https://perma.cc/Z646-HB8M].

439. *Medicare Case Studies*, MEDICARE RTS. CTR. (2024), https://www.medicarerights.org/media-center/medicare-rights-center-releases-new-case-study-series-to-inform-policy-improvements-in-medicare-medicaid-integration.

440. *Id.*

difficulty getting a Medicare Supplement plan again in the future if you decide to switch back."[441]

States seem unsure how to best advise beneficiaries about unscrupulous brokers and agents, however. Ohio's Department of Insurance has a webpage devoted to "Medicare Predatory Sales Practices" telling consumers not to sign anything until "a trusted advisor confirm[s] the product will meet your needs," implying that brokers and agents are not trusted advisors.[442] Oregon's video advises beneficiaries to turn to Senior Health Insurance Benefits Assistance or a "trusted licensed insurance agent" to review a plan before enrolling.[443] Texas hedges by directing consumers to "[t]ry to buy from an agent you know and trust" but "[h]ave someone you trust with you when you talk to an agent or company."[444]

The New Hampshire Insurance Department proposed but did not pass legislation to require insurance companies to notify the Insurance Commissioner at least 120 days before "significant changes to or discontinuation" of Medicare Advantage Plans.[445] The state thus focused on notice and communication.

With CMS's role in regulating incentives for Medicare brokers and agents uncertain given the recent district court decision, the question is whether state activism will lead to greater state action or powers. States may also use their existing power to license Medicare agents as a way to discipline brokers and agents who violate current rules, although these efforts will likely be challenged in court.

V. RESPONDING TO DO NOTHING PREEMPTION

At first blush, there seems to be no way out of the gridlock represented by do nothing preemption. Congress is stymied in its ability to take direct action

441. KAN. INS. DEP'T, MEDICARE SUPPLEMENT SHOPPER'S GUIDE, https://insurance.ks.gov/documents/department/publications/medicare-supplement-ins-shoppers-guide.pdf [https://perma.cc/VX75-A4DL] (last visited Jan. 16, 2026).

442. *Medicare Predatory Sales Practices*, OHIO DEP'T OF INS., https://insurance.ohio.gov/consumers/medicare/medicare-predatory-sales-practices [https://perma.cc/L4BT-SXME] (last visited Jan. 16, 2026).

443. *Medicare Open Enrollment*, OR. SHIBA, https://www.youtube.com/watch?v=rd33fm5TXdE [https://perma.cc/H6ND-MSJP] (last visited Jan. 16, 2026).

444. *Medicare Supplement Insurance Guide*, TEX. DEP'T OF INS., https://www.tdi.texas.gov/pubs/consumer/medsup.html [https://perma.cc/5H3C-AVNR] (last visited Jan. 16, 2026).

445. Press Release, N.H. Ins. Dep't New Hampshire Insurance Department Proposes Legislation to Strengthen Consumer Protections for Medicare Advantage Beneficiaries, (Dec. 4, 2024), https://www.insurance.nh.gov/news-and-media/new-hampshire-insurance-department-proposes-legislation-strengthen-consumer [https://perma.cc/G5FA-2U8B].

by political polarization. Federal agencies struggle to regulate given the same many and varied demands that have paralyzed Congress. Even if they do manage to regulate, courts throughout the country rush to issue universal injunctions (or now, likely, to certify class actions) that undo their rulemaking. Frustrated states face broad preemption. Hearings and reports go nowhere at either level of government, and private industry is often the beneficiary.

Empirical research on state responses to the issue of predatory Medicare Advantage marketing and sales, however, indicates that there is room for further state involvement and progress on do nothing preemption. The regulatory vacuum and growing problem has in fact pushed states towards agreement on the need for action, and unity can bring change in a moment of federal paralysis. With the country demonstrating dissension and weakness at the federal level, states can step into the breach. While the legal theory indicates a stalemate, states are engaged in education and advocacy. The proposals on health and administrative law in this paper can advance their efforts to respond to do nothing preemption and indicate a path forward outside of the health insurance context as well.

A. State of the Federal Administrative State

Political science research has demonstrated that Congress "has become increasingly dysfunctional over the last twenty-five years, as a two-party system fueled by partisan polarization fails to create a workable national legislature."[446] In addition to polarization, a lack of legislative "capacity" because of electoral demands and scarce financial resources have resulted in outsourcing legislative drafting to lobbyists and agencies, often allowing the private parties who will be regulated to write their own rules.[447]

In the case study discussed in this Article, states "bristle" over their lack of authority to regulate Medicare Advantage plan marketing and sales.[448] They

446. Andrew Hammond, *On Fires, Floods, and Federalism*, 111 CALIF. L. REV. 1067, 1100 (2023).

447. *See id.* at 1101–02.

448. Fred Schulte, *Some States Bristle at Lack of Authority over Medicare Advantage Plans*, KFF HEALTH NEWS (Aug. 19, 2014), https://kffhealthnews.org/news/states-angered-over-lack-of-authority-in-medicare-advantage-plans/ [https://perma.cc/TA9M-5X9U]; Press Release, N.H. Ins. Dep't, New Hampshire Insurance Department Outlines Key Federal Measures to Enhance Market Competitiveness and Consumer Protection in Meetings with Congressional Delegation (July 1, 2024), https://www.insurance.nh.gov/news-and-media/new-hampshire-insurance-department-outlines-key-federal-measures-enhance-market [https://perma.cc/PJ5T-SUJU] ("The NHID urges reconsideration of the provision within the Medicare Modernization Act of 2003 that limits state oversight on MA marketing to safeguard consumers from deceptive practices. Commissioner Bettencourt calls for collaboration between federal and state authorities to strengthen enforcement of consumer protection laws.").

have asked specifically for more authority over marketing practices.[449] State efforts may be both caused by and the result of political polarization. Polarization at the federal level results in a lack of federal action. But states also channel partisan conflict through the mechanism of federalism.[450] Individuals are more likely to identify with their states when they are politically controlled by the party that does not control the federal government—and when the residents of that state disagree with federal policy and the state is controlled by the other party.[451] The result, whether mediated through party politics or disagreement with the federal government's actions on specific policies, is state opposition to federal rules or lack of rules.

Abbe Gluck has written extensively about federalism in health law and the role of states in implementing federal statutes. She discusses how even as Congress expands federal power over health care through statutes like the Affordable Care Act, it often "invites states to participate."[452] Though judicial efforts to protect state power by relieving them of responsibilities to play the congressionally-designated role in this type of cooperative legislation may seem on target, Gluck instead argues that they may actually diminish state involvement and powers that are derivative of broad federal statutes in this partnership with the federal government.[453] Although Gluck's description of the cooperative role of the federal and state governments in federal health legislation may seem to contrast with the Medicare Advantage case study discussed *supra*, even here the states play a role in educating consumers and licensing brokers. Along a spectrum of federal legislation, the states are limited but not absent.

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449. *See, e.g.*, Press Release, *supra* note 448; Press Release, N.H. Ins. Dep't, NHID Urges Congress to Restore State Agencies Authority to Regulate Marketing of Medicare Advantage Products (Aug. 24, 2022), https://www.insurance.nh.gov/news-and-media/nhid-urges-congress-restore-state-agencies-authority-regulate-marketing-medicare [https://perma.cc/SRX8-N22Y].

450. Jessica Bulman-Pozen, *Partisan Federalism*, 127 HARV. L. REV. 1077, 1082 (2014) ("States controlled by one party challenge the federal government when it is controlled by the other party. . . . And they administer federal laws in ways not intended or welcomed by the federal administration.").

451. *See id.* at 1112–13.

452. Abbe Gluck, *Federalism from Federal Statutes: Health Reform, Medicaid, and the Old-Fashioned Federalists' Gamble*, 81 FORDHAM L. REV. 1749, 1749, 1750 (2013) (noting that her argument relates to key federal health care statutes that "entrust to the states much of their implementation and elaboration").

453. *Id.* at 1753–54; *see* Nicole Huberfeld, *High Stakes, Bad Odds: Health Laws and the Revived Federalism Revolution*, 57 U.C. DAVIS L. REV. 977, 982 (2023) (addressing the implications of the Supreme Court "recentering a formal, separate-spheres vision of federalism that favors states' rights, regardless of state capacity to wield that power or evidence that they do not").

Therefore, as Gluck poses the question, it is "federal legislation administered by *whom*?"[454] Her answer is that when states share in legislative implementation, they gain power. My argument is that when federal legislation is administered by no one, states lose their cooperative powers and more. Preemption without speaking abrogates this modern role for states that Gluck discusses where federal legislation can spur states to action in conjunction with the federal government rather than merely limiting their efforts.

My Article adds to the discussion that Abbe Gluck and Nicole Huberfeld fleshed out after studying the implementation of the Affordable Care Act and concluding that where the goals of federalism are unclear, the appropriate structure and interpretation of major federal legislation will also be unclear.[455] The term federalism today "stand[s] in for so many different values, as well as for many different types of structural arrangements—whether separation, checks and balances, variation, autonomy, or experimentation."[456]

In addition, there will be administrative law scholars who charge that health law is different, unique, and therefore conclusions reached from a case study about Medicare are not generalizable to other policy domains. In this Article, I have attempted to refute those arguments by discussing other examples of the phenomenon I explore and how the similarities are more significant than the differences across policy areas.

B. Recommendations

States have a variety of tools to defend against do nothing preemption. On a spectrum from doing nothing to defiance or even nullification, states can interpret federal statutory text narrowly to expand their powers. They can also lobby to change the statutory preemption clause, but resistance may not require that much.

One option is to have a conditional preemption doctrine, which allows states to regulate until the federal agency chooses or is able to do so.[457] Nash's proposed solutions to null preemption are instructive here when considering responses to do nothing preemption. He suggests that Congress could allow agency inaction to last for a specific amount of time before either a private right of action permits citizens to enforce the time limit or a "regulatory hammer" goes into effect, automatically implementing strict rules that industry would not

454. Gluck, *supra* note 452, at 1754.

455. *See generally* Gluck & Huberfeld, *supra* note 420.

456. *Id.* at 1696.

457. Many thanks to the participants in the Theories of Administrative Law conference held at the University of Cincinnati College of Law for this idea.

prefer.[458] Finally, Nash suggests what I call conditional preemption—that states will not face preemption in an area until federal regulators issue rules.[459]

Solutions can also be specific to the statutory field, as the case study on Medicare Advantage plans demonstrates. States can ramp up their efforts to connect Medicare beneficiaries with supplemental plans through their SHIPs to minimize the role of brokers. However, given that research shows that too few beneficiaries are aware of and connecting with SHIP resources, community advocacy could be added in. Previous research on the role of barbershops and churches in community health advocacy could be applied to enable information distribution and counseling with these partners.[460] In addition, employers or at least places of employment could play a role in educating employees about supplemental Medicare coverage as they near retirement age.[461]

Connecticut's Broker Academy is an example of creative problem solving that could be targeted to Medicare beneficiaries. The state's ACA insurance marketplace, Access Health CT, created a program to help diversify insurance brokers by training people to work directly with vulnerable communities to find appropriate coverage and also covering the costs of the broker licensing exam.[462] While "embedding a network of trusted healthcare coverage advisors in Connecticut's traditionally hardest-to-reach communities" is a lofty goal,[463] it is unclear how these brokers would respond to financial incentives to sell inappropriate Medicare Advantage plans to beneficiaries if a similar program were enacted in that market. Focusing on economic

458. Nash, *supra* note 49, at 1071–72.

459. *Id.* at 1072.

460. *See, e.g.*, Pavan Khosla, Kanhai Amin, & Rushabh Doshi, *Combating Chronic Disease with Barbershop Health Interventions: A Review of Current Knowledge and Potential for Big Data*, 97 YALE J. BIOLOGY MED. 239 (2024); Marci Kramish Campbell, Marlyn Allicock Hudson, Ken Resnicow, Natasha Blakeney, Amy Paxton & Monica Baskin, *Church-Based Health Promotion Interventions: Evidence and Lessons Learned*, 28 ANN. REV. PUB. HEALTH 213 (2007).

461. Many thanks to Jennifer Herbst, Professor of Law and Medical Sciences at Quinnipiac University, for a discussion we had on this subject at the 2025 ASLME Health Law Professors Conference at Boston University.

462. *Access Health CT Diversifying Brokers to Increase Access to Health Insurance for Underserved Communities*, NBC CONN. (May 3, 2023), https://www.nbcconnecticut.com/community/connecticut-in-color/access-health-ct-diversifying-brokers-to-increase-access-to-health-insurance-for-underserved-communities/3025435/ [https://perma.cc/B8BY-TAWB]; *Broker Academy Program*, ACCESS HEALTH CT, https://www.accesshealthct.com/broker-academy/ [https://perma.cc/Y3X2-95W7] (last visited Jan. 24, 2026).

463. *Broker Academy Program*, *supra* note 462.

development by touting the high salaries for brokers demonstrates the conflicts that may be present.[464]

Inevitably, the potential for AI to help connect Medicare beneficiaries with supplemental plans will be explored. Although some may have privacy concerns or worries about brokers and insurers steering people by influencing the data used by the AI model, there will hopefully be workarounds that prevent these outcomes in the future. Regardless, there will still be a question of who implements and supervises the AI programs—the federal government or the states. Technology does not erase the federalism issues in this case.

State-by-state innovation such as AI models to help with enrollment could be developed through a waiver system, if one were added under the federal statute. CMS could implement a waiver system with respect to Medicare Advantage plan marketing and sales similar to the ACA's waiver program under § 1332 of the ACA.[465] "The ability to suspend important swaths of preemptive law make the innovation waiver a particularly big waiver."[466] Preemption's "rigidity" can be countered by "preapproving state legislation" with Medicare Advantage marketing and sales, just as has been done under the ACA.[467] Although I support the "agency imprimatur" model that Elizabeth McCuskey explores for managing federalism in health law,[468] recent political developments make such congressional delegation to agencies and federal judicial deference to agencies on preemptive impact unlikely. In addition, a lack of state uniformity can perpetuate inequalities in health insurance, which is exactly what preemption is designed to prevent.[469]

Gluck advocates instead for new statutory interpretation tools designed to better fit states' roles in federal legislation.[470] Among other proposals, she focuses on "interagency statutory interpretation" that allows for flexibility

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464. Tammy Hendtricks, *Access Health CT Launches New Broker Academy*, ACCESS HEALTH CT, https://accesshealthctsmallbiz.com/for-brokers/access-health-ct-launches-new-broker-academy/ [https://perma.cc/3YX7-FE3E] (last visited Jan. 24, 2026) (discussing the goal of "economic development" while promoting the average salary for a new broker of $74,356 in the Hartford area).

465. *See* Elizabeth McCuskey, *Agency Imprimatur & Health Reform Preemption*, 78 OHIO ST. L.J. 1099, 1127–39 (2017) (explaining why the Section 1332 waiver has been called by Barron and Rakoff an example of their "big waiver" theory since it allows the agency to "'substantially revise and not modestly tweak' the statute's core requirements").

466. *Id.* at 1138–39.

467. *Id.* at 1139.

468. *See id.* at 1141–50.

469. *See* JAMILA MICHENER, FRAGMENTED DEMOCRACY: MEDICAID, FEDERALISM, AND UNEQUAL POLITICS 160–69 (2018) (studying how politics and federalism have resulted in disparate health treatment and outcomes with respect to Medicaid).

470. Abbe Gluck, *Intrastatutory Federalism and Statutory Interpretation: State Implementation of Federal Law in Health Reform and Beyond*, 121 YALE L.J. 534, 615–620 (2011).

when courts interpret state obligations and a "presumption of deference to state agency interpretations of federal regulations, unless Congress states otherwise."[471] But what if there is a need to take it one step further? I recommend a presumption of deference to state agency actions in areas of do nothing preemption. Rules to govern federal "supervision" of these "national agents" can allay concerns about unchecked state power resulting.[472]

CONCLUSION

In this Article, I have introduced and explored the concept of do nothing preemption. Federal inaction caused by political polarization and judicial intervention, in combination with broad statutory preemption of state law, is creating a crisis and inability to solve problems. As the President and Congress shrink the federal administrative state, states must be empowered to alleviate the resulting vacuum. Medicare Advantage marketing is the present crisis, but AI regulation is likely the next.

471. *Id.* at 616–17.

472. *See* Gillian Metzger, *The States as National Agents*, 59 ST. LOUIS U. L.J. 1071, 1076–78 (2015) (discussing the need for "rules of engagement" when states have power under federal statutes).