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April 10, 2025

The Honorable Robert F. Kennedy, Jr.
Secretary, U.S. Department of Health and Human Services
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Submitted electronically via www.regulations.gov

RE: CMS-9884-P – Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability Proposed Rule

Dear Secretary Kennedy,

On behalf of the National Association of Benefits and Insurance Professionals (NABIP), which represents over 100,000 licensed health insurance agents, brokers, general agents, consultants, and employee benefits specialists, I appreciate the opportunity to provide comments on the proposed rule "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability." Our members work daily to assist millions of individuals and employers in purchasing, administering, and utilizing health insurance coverage. We are committed to ensuring a stable and competitive market that fosters affordability and consumer protections.

We appreciate HHS/CMS's efforts to refine and enhance Marketplace regulations and would like to offer our feedback on key provisions within the proposed rule:

Past-Due Premium Payments (§147.104(i))

Summary: This provision reinstates the ability for insurers to apply premium payments to past-due amounts, including those owed under the same control group per IRS codes 52(a), 52(b), 414(m), and 414(o).

Background: Previously, CMS had restricted insurers from applying new premium payments toward past-due balances, making it easier for consumers to start fresh. However, this led to adverse selection, as some enrollees would strategically drop coverage and re-enroll when needed.

Our Stance: We **support** allowing the reinstatement of past-due premium payments but recommend limiting this practice to the same product line to maintain continuity without unfairly disrupting consumers. Our concern with broadly permitting premium payments to cover "past-due premiums at an issuer within the same control group" is that it lacks specificity. For instance, if an individual is behind on payments for a vision insurance plan, which typically

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costs around $15 per month, their payment could be applied to the vision plan instead of their health insurance premium. Even a small reduction in the amount allocated to their health coverage could push them below the net de minimis threshold, ultimately leading to the loss of their health insurance due to an unrelated policy.

Issuers often provide multiple lines of coverage, including health insurance, disability insurance, dental, vision, critical illness, and indemnity insurance. To ensure better continuity of coverage and reduce financial strain on consumers, we recommend that the final rule specify that premium payments must be applied solely to the same type of insurance (e.g., major medical → major medical, dental → dental).

Standard of Proof for Terminations (§155.220(g)(2))

Summary: This proposal requires CMS to adopt a "preponderance of the evidence" standard when considering the termination of agents, brokers, or web-brokers for misconduct.

Background: Currently, CMS applies a higher evidentiary threshold, offering greater protection to brokers before termination. A small subset of agents, brokers, and web-brokers have exploited poor policy implementations from the prior administration to access systems and process a high volume of inaccurate enrollments. During this time, CMS/CCIIO was slow to acknowledge and respond to reports of fraud, despite repeated alerts from ethical agents.

As noted in the proposed rule, enforcement and public engagement increased only after congressional and public pressure peaked in 2024, following several years of reports from brokers seeking assistance. However, since April 2024, CMS's own Agent/Broker Termination data indicates that over 70% of terminated brokers were later reinstated—highlighting major flaws in enforcement. Given this high rate of overturned terminations, we are concerned that characterizing CCIIO's enforcement as effective does not accurately reflect the data.

Our Stance: We **strongly oppose** this change, as it increases subjectivity in enforcement and weakens due process for brokers and agents. Lowering the burden of proof may lead to inconsistent and biased enforcement actions, as the "preponderance of the evidence" standard relies on what a "prudent person" would consider evidence. However, individual interpretations of a "prudent person" vary significantly based on personal biases and experiences.

Given that the previous agency was forced to overturn the majority of suspensions and terminations due to insufficient evidence, we are deeply concerned that these errors will continue at an even higher rate—needlessly punishing innocent individuals. To uphold fairness and due process, a higher evidentiary standard should be maintained.

Furthermore, many of the other proposals in this rule introduce stronger safeguards that will significantly reduce the need for enforcement actions by proactively closing back doors in the

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Marketplace. Focusing on eliminating these system vulnerabilities should be the priority—preventing bad actors from exploiting weaknesses before enforcement becomes necessary. By strengthening Marketplace integrity at the structural level, CMS can better protect consumers and ethical brokers alike.

Failure to File and Reconcile (FTR) Policy (§155.305(f)(4))

Summary: This provision reinstates the policy that a tax filer is ineligible for APTC if they fail to file and reconcile their tax returns within one year.

Background: A previous rule extended the grace period to two years, allowing continued APTC eligibility even when tax reconciliation was not completed, which increased the risk of fraudulent subsidy use.

Our Stance: We **support** reverting to the one-year policy, as it aligns with IRS processing timelines and prevents prolonged eligibility for unverified subsidies. The one-year Failure to Reconcile (FTR) policy is reasonable because IRS processing delays—whether due to system backups or taxpayers filing extensions—can create overlap between the IRS review process and Open Enrollment Period (OEP). This ensures that individuals who eventually comply with tax filing requirements are not unfairly penalized.

However, extending this policy to two years is excessive and opens the door to abuse, allowing individuals to continue receiving Advanced Premium Tax Credits (APTCs) without verification for an extended period. This increases the risk of fraudulent access and undermines the integrity of the program. Maintaining the one-year standard strikes the right balance between administrative feasibility and preventing misuse.

Income Verification Timeline (§155.315(f))

Summary: This provision eliminates the extra 60-day grace period beyond the standard 90-day period for verifying income inconsistencies.

Background: The extra 60-day extension was initially introduced during the pandemic to account for economic volatility, as frequent regulatory changes and industry disruptions made income projections more fluid. However, in the current environment, this extension has proven unnecessary.

Our Stance: We **support** your statements that under normal circumstances a 90-day period to verify one's income is sufficient. The extension was reasonable during the pandemic, when businesses faced sudden shutdowns and reopenings, leading to unpredictable income fluctuations. However, maintaining an additional 60 days beyond the standard period is no longer warranted as economic conditions have stabilized.

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Income Data Matching Inconsistencies (§155.320(c)(3)(iii))

Summary: This change allows a Data Matching Issue (DMI) to be triggered when an application reports income between 100% and 400% of the Federal Poverty Level (FPL), including cases where IRS records previously showed income below 100% FPL. Additionally, it lowers the threshold for triggering a DMI from 25% to 10% when reported income differs from IRS data.

Background: The higher 25% threshold was originally established to provide flexibility for self-employed individuals and those with fluctuating incomes, acknowledging that annual tax data may not always reflect real-time earnings.

Our Stance: We **oppose** lowering the DMI trigger threshold to 10%. Reducing the threshold to 10% would significantly increase the number of DMIs, adding unnecessary workload for applicants, brokers, and administrators. The previous 25% threshold better accommodated self-employed individuals and others with variable income, allowing them to manage cyclical revenues without triggering undue verification issues.

We **support** that DMIs should be generated when an individual reports income above 100% FPL, but IRS records indicate they previously earned below 100% FPL. This has been publicly reported on as a backdoor used to get access to coverage in non-Medicaid expansion states.

Removal of Household Income Verification Exception (§155.320(c)(5))

Summary: This change eliminates the ability of Exchanges to accept income attestation when IRS tax data is unavailable.

Background: Certain populations, including business owners, self-employed individuals, and recent immigrants, often rely on self-attestation due to difficulties accessing prior-year tax data. Business owners represent one of the largest cohorts enrolled in the individual market, as they often lack access to employer-sponsored insurance, Medicare, or Medicaid.

With fluctuating income, their established tax history may not accurately reflect current income projections, making it difficult to verify eligibility under this proposed change. Without a flexible verification process, these individuals may face significant barriers to maintaining coverage despite meeting eligibility requirements.

Our Stance: We are **concerned** that this change could disproportionately impact small businesses and lawfully present immigrants, making it harder for them to demonstrate income eligibility. Rather than eliminating income attestation entirely, alternative verification methods should be explored to ensure legitimate applicants are not unfairly excluded.

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For instance, income attestation could still be permitted but only if supported by evidence of business profit/loss via:

- The most recent tax return with business-related schedules (for established business owners)
- A state-filed business license (for startups)

These measures would provide a reasonable backstop for those who face challenges accessing prior-year IRS data, ensuring that eligibility verification remains fair while maintaining program integrity.

Automatic Re-enrollment (§155.335(a)(3) and (n))

Summary: This proposal introduces a $5 minimum premium for auto-renewed plans instead of allowing a $0 net premium option.

Background: A $0 premium plan can lead to automatic renewals without enrollees' knowledge, resulting in unexpected repayment obligations when reconciling tax credits with the IRS. Additionally, individuals who become eligible for other coverage mid-year may assume their Marketplace plan was canceled, only to later discover they owe repayments because there was no premium payment signaling ongoing coverage.

Our Stance: We **support** implementing a minimum premium tied to auto-renewals to reduce confusion and long-term financial risk for enrollees. However, we advocate for a market-wide $1 minimum monthly premium model, similar to New Mexico's approach, with the $5 minimum acting as a safeguard specifically for auto-renewals.

Given the complexities of projected income, APTCs, and PTC reconciliation, no one should be in a $0 premium plan, as it increases the risk of unintentional enrollment and surprise tax liabilities. A small, mandatory premium helps ensure enrollees remain aware of their coverage and provides a clear indicator of plan activity without being cost-prohibitive. A $1 minimum premium strikes this balance, maintaining affordability for low-income individuals while improving program integrity.

Re-enrollment of CSR-Eligible Enrollees from Bronze to Silver Plans (§155.335(j)(4))

Summary: This provision removes the automatic migration of Cost-Sharing Reduction (CSR)-eligible enrollees from Bronze to Silver plans.

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Background: Brokers have raised concerns that Bronze plans may sometimes be a better fit for certain consumers, depending on their specific health and financial circumstances. Automatic migration could override personalized recommendations and consumer preferences.

Our Stance: We **support** this change, as it prioritizes consumer choice. For several years, brokers have presented evidence to CCIIO demonstrating that, in certain cases, a Bronze plan may be more suitable than a Silver plan. By allowing enrollees to actively choose, rather than defaulting them into a Silver plan, this policy ensures that consumers can select the coverage that best aligns with their needs and financial situation.

Modification of Payment Consideration Rules for Partial Payments (§155.400(g))

Summary: This proposal removes provisions that allowed issuers to consider enrollees "paid current" based on percentage thresholds of gross premiums.

Background: Under the previous rule, some enrollees remained in coverage despite underpaying premiums, as issuers could determine payment status based on a percentage of gross premium rather than the actual amount owed after APTCs. This allowed individuals with low net premiums to meet payment thresholds without contributing their full share.

Our Stance: We **support** ensuring that payment standards are based on net premium amounts, as this enhances accountability and program integrity. To ensure fairness and accountability, payment thresholds should be tied to net premiums rather than gross premiums. This approach preserves consumer protections while ensuring that enrollees meet their actual financial responsibilities.

Examples

Gross Premium vs. Net Premium Impact

- If an individual's gross premium is $500 but their net premium after APTCs is only $3, a 95% payment threshold based on gross premium would require $475 in payments.
- Since APTCs cover $497, the enrollee would still meet the 95% requirement without actually paying their $3 share—effectively remaining in coverage despite failing to fulfill their financial obligation.

Fixed-Amount Threshold Impact

- If the same enrollee's net premium is $3, a fixed-amount threshold (e.g., a $10 minimum) could also allow an enrollee with a $3 balance to remain current without actually paying their portion.

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Open Enrollment Period (OEP) (§155.410(e))

Summary: This proposal reinstates the Open Enrollment Period (OEP) to its original dates of November 1 – December 15.

Background: The OEP was previously extended to January 15 to provide consumers with additional time to enroll. While reverting to the original November 1 – December 15 timeframe streamlines administrative processes and aligns with prior norms, it also reduces enrollment opportunities—particularly for consumers who struggle to navigate coverage options within a shorter window.

Additionally, the extended OEP served as a safety net for enrollees who received inaccurate renewal estimates from issuers, which often projected gross premiums using the prior year's Advanced Premium Tax Credit (APTC)—a calculation that inevitably changes. Many provider contracts and formularies operate on a calendar-year basis, making the additional time valuable for consumers who may need to adjust coverage after the new plan year begins.

Our Stance: We acknowledge the operational efficiencies of reinstating the November 1 – December 15 OEP but express concerns about the impact on consumers that rely on the wayfinding expertise of certified and licensed agents/brokers. The shorter period could strain agents, who facilitate the majority of enrollments, especially given:

- The new $5 auto-renewal requirement, which is expected to increase active renewals
- Higher Data Matching Issues (DMIs), requiring additional documentation and follow-ups
- New three-way call requirements and broker consent mandates

With nearly 80% of enrollments facilitated by an agent or broker (A/B) and an estimated 20 million individuals enrolling in the next OEP, approximately 16 million consumers will rely on broker assistance. A shorter enrollment period risks overloading the distribution channel, reducing overall enrollments, and limiting consumer access to expert guidance—ultimately straining brokers' capacity and hindering consumers' ability to make informed coverage decisions.

Rather than eliminating the extended OEP entirely, we **recommend** either omitting this change from the final rule or adjusting the start date in addition to moving the end date back to December 15th. Moving the start date to a Medicare-like model, where consumer discussions begin on October 1 and enrollments open on October 15, would give brokers more time to educate consumers, navigate increased administrative requirements, and manage enrollments efficiently—while still maintaining the December 15 deadline for January 1 coverage.

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Special Enrollment Period (SEP) for Low-Income Individuals (§155.420(d)(16))

Summary: This provision eliminates the special enrollment period (SEP) for individuals with household incomes below 150% of the Federal Poverty Level (FPL).

Background: The 150% FPL SEP was originally introduced to ensure continuous access to coverage for lower-income individuals. However, evidence has emerged of widespread misuse, particularly in non-expansion states, where it is exploited to bypass Medicaid eligibility restrictions and manipulate Marketplace enrollment.

In non-expansion states, this SEP circumvents the 100% FPL lower limit, allowing individuals to gain access to APTCs despite being ineligible under normal rules. In Medicaid expansion states, APTC eligibility requires applicants to exceed 138% FPL (133% + 5% disregard), which is determined based on the date of application. Meanwhile, the 150% FPL SEP threshold is based on the FPL table as of November 1 for the Open Enrollment Period (OEP) of the corresponding plan year. This misalignment creates a razor-thin window for legitimate SEP use in expansion states, reinforcing that the primary exploitation of this provision occurs in non-expansion states.

Our Stance: We **support** eliminating this SEP due to clear evidence of misuse, particularly in non-expansion states, where it serves as the primary backdoor for bad actors to manipulate coverage. While this policy may have been well-intended, it is now being used to game the system, and closing this loophole is necessary to preserve Marketplace integrity.

Pre-enrollment Verification for SEPs (§155.420(g))

Summary: This proposal reinstates pre-enrollment verification for Special Enrollment Periods (SEPs) and requires Exchanges to verify eligibility for at least 75% of new SEP enrollments.

Background: SEP verification was previously removed to improve access to coverage, but this also led to increased fraud and improper enrollments. Restoring pre-enrollment verification enhances program integrity and ensures that enrollees meet eligibility requirements before coverage begins.

Our Stance: While verification can be burdensome, our experience suggests that it effectively reduces fraud. We **support** reinstating pre-enrollment verification as a necessary safeguard to protect program integrity while maintaining access to legitimate SEP enrollees.

As an aside: We encourage CMS to ensure that verification processes are designed in a way that supports timely enrollment to help minimize administrative lag and consumer disruption.

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This becomes especially important when consumers are enrolling in plans toward the end of the SEP window.

Premium Growth Measure

Summary: This proposal updates the premium growth measure methodology to better reflect premium growth across all affected markets.

Background: The premium growth measure has traditionally been based on employer-sponsored plan growth rates to determine year-over-year plan changes. It is used to adjust various program parameters, including cost-sharing limits and employer penalties. This proposal aims to improve accuracy by incorporating individual market data alongside employer-sponsored plan data, providing a more representative measure of premium trends and better reflecting overall market conditions.

Our Stance: We are relatively **neutral** to this change but recognize that if it helps actuaries justify lower overall premiums, it would be beneficial for consumers. Any adjustment that contributes to greater affordability while maintaining market stability is a welcome improvement.

Out-of-Pocket Maximums (OOPM) for CSR Plans (§155.605(d)(2))

Summary: This proposal establishes new out-of-pocket maximums (OOPM) for cost-sharing reduction (CSR) plans based on income levels:

- $3,500 for 100–150% FPL
- $3,500 for 150–200% FPL
- $8,450 for 200–250% FPL

Background: These adjustments aim to align cost-sharing protections with enrollees' ability to pay. However, concerns remain about their impact on access to care, particularly for lower-income individuals who may struggle to cover out-of-pocket expenses.

Our Stance: We are **neutral** on the proposed OOPMs but recognize that many consumers rely on hospital charity care and prescription savings programs to offset high out-of-pocket costs.

For many enrollees, meeting their deductible is often triggered by an acute hospital event or high-cost medications. Many consumers live within the footprint of nonprofit hospitals, which offer financial assistance or charity care programs that can cover unpaid balances. In these cases, the higher OOPM may have little direct impact on their actual financial burden.

Additionally, because ACA plans are classified as "commercial insurance," many prescription savings programs help reduce the cost of high-cost drugs. Greater consumer education on these financial assistance resources could bridge gaps in cost-sharing responsibilities. However, we acknowledge that relying on charity care as a justification for raising OOPMs may be controversial, particularly among groups like the AMA and AHA.

This proposal also does not address the challenges faced by rural providers, who often lack the capacity to absorb unpaid care costs when low-income consumers delay payments or let expenses go to collections due to high deductibles.

As an aside: If finalized, states should reassess silver loading percentages to reflect the increased risk premium imposed on issuers due to these cost-sharing changes.

De Minimis Thresholds for Actuarial Value (AV) (§156.140(c))

Summary: This proposal adjusts de minimis thresholds for actuarial value (AV) to +2/-4 percentage points for most metal-level plans, +5/-4 for expanded Bronze plans, and +1/-0 for CSR Variations.

Background: These changes provide issuers with greater flexibility to design plans that comply with metal-level requirements while also improving risk management. By allowing slightly wider AV ranges, issuers can better balance cost-sharing structures and premium affordability, ultimately leading to more stable plan offerings.

Our Stance: We **support** increasing AV flexibility, as it allows issuers to better align with metal-level requirements while maintaining a balanced risk pool. This adjustment gives issuers the necessary flexibility to design plans that remain actuarially sound, helping to mitigate risk, stabilize premiums, and ensure a diverse range of plan options for consumers.

Acknowledgment of Contributors

The National Association of Benefits and Insurance Professionals (NABIP) would like to recognize members of our Individual Market Working Group whose expertise and insights were instrumental in preparing these comments. Their deep knowledge of Marketplace operations, consumer challenges, and regulatory impacts ensures that our recommendations reflect the realities faced by brokers, consumers, and insurers alike.

The following members played a key role in shaping this response and are valuable resources for further discussions on Marketplace integrity, affordability, and consumer protections:

- Joshua Brooker, CVO at SnapHealth, jbrooker@pahealthadvocates.com

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Conclusion

We appreciate HHS and CMS's ongoing efforts to engage with stakeholders and refine Marketplace regulations to better serve consumers and industry participants. Ensuring that policies strike the right balance between affordability, access, and program integrity is critical to maintaining a stable and competitive health insurance market.

As representatives of over 100,000 licensed health insurance professionals, NABIP members work daily with individuals, families, and small businesses navigating the complexities of health coverage. Our collective expertise provides a real-world perspective on how policy changes impact enrollees, plan issuers, and the overall functioning of the Marketplace. We urge HHS, CMS, and CCIIO to continue working closely with NABIP and other key stakeholders to ensure that final regulations reflect the needs of consumers while maintaining the viability of the Marketplace.

We welcome the opportunity to continue to serve as a resource for CMS in developing implementation strategies, refining guidance, and addressing any emerging concerns as these policies take shape. Our Individual Market Working Group members, highlighted in this letter, are available to provide further insights and collaborate on solutions that enhance consumer protections while preserving access to the expertise of ethical brokers and agents in the market .

Thank you for your consideration of our comments. We look forward to working with you to ensure that Marketplace regulations continue to support consumer choice, affordability, and program integrity.

Sincerely,

Michael Andel
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