National Association of Benefits and Insurance Professionals
NABIP
Shaping the *future* of healthcare

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Office of Management and Budget
Executive Office of the President
725 17th Street, NW
Washington, DC 20503

RE: Request for Information on Areas of Deregulation

To Whom It May Concern:

On behalf of the National Association of Benefits and Insurance Professionals (NABIP), formerly NAHU, we appreciate the opportunity to provide comments in response to the Office of Management and Budget's request for information regarding federal regulations that may be outdated, overly burdensome, or in need of reform. NABIP represents thousands of licensed health insurance professionals who assist individuals, families, and employers in accessing health coverage and navigating the healthcare system.

We are committed to a regulatory framework that protects consumers while supporting efficient market operations, accessibility, and the elimination of fraud, waste, and abuse. Below, we outline several specific regulations that merit reconsideration or reform. These suggestions are a compilation of ideas from NABIP members who actively serve beneficiaries in the Medicare and ACA marketplaces, as well as small and large group markets.

Medicare

Regulation & CFR Citation: Call Recordings - Requirement to Store for 10 years (42 CFR Part 422)

Impact of Regulation and Justification for Reform: This requirement imposes a significant financial and operational burden on independent agents and brokers. Digital

call recordings are often large and expensive to store in the cloud, especially for small businesses. The rule also creates potential privacy risks for beneficiaries whose personal data is retained for extended periods.

Proposed Solution: Reduce the required retention period to 1 year or for the duration of the plan year. This aligns with practical needs and modern data security practices without compromising compliance integrity.

Outcome of Deregulation: This change would alleviate unnecessary burdens on small businesses and agents, reduce compliance costs, and still protect consumer data appropriately.

Regulation & CFR Citation: Disclaimer Requirement Within First 60 Seconds of Call (42 CFR Part 422)

Impact of Regulation and Justification for Reform: NABIP members find this requirement disruptive, especially during the early part of a call when agents are typically orienting the conversation or responding to beneficiary inquiries. The disclaimer interrupts the flow and confuses beneficiaries.

Proposed Solution: The disclaimer should only be required for unsolicited calls, and not for those placed by existing clients or initiated by the beneficiary. It should be treated similarly to a privacy notice—delivered once annually—and presented at a contextually appropriate time in the conversation. NABIP also recommends a revision of the disclaimer language to eliminate the need for agents to list every plan option available. Instead, a simplified statement indicating which plans the agent represents in the area should suffice.

Outcome of Deregulation: Streamlines conversations, reduces confusion, and respects beneficiaries' need to understand the purpose of the interaction before regulatory language is introduced.

Regulation & CFR Citation: Scope of Appointment 48-Hour Rule (42 CFR § 422.2264(c)(1)

and § 423.2264(c)(1))

Impact of Regulation and Justification for Reform: The 48-hour requirement can hinder timely assistance for beneficiaries facing urgent needs. While beneficiaries often do not expect to require immediate enrollment help, appointments frequently reveal pressing issues -- especially near the end of the month -- that necessitate swift action. This rule may therefore lead to delays in securing coverage.

Proposed Solution: NABIP recommends incorporating a safe harbor within the scope-of-appointment form, where a beneficiary can opt out of the 48-hour requirement. This would preserve consumer protection while enabling more timely service.

Outcome of Deregulation: Balances timely care access with meaningful consent, giving flexibility to both consumers and agents in urgent scenarios.

Regulation & CFR Citation: Late Enrollment Penalties for Federal Retirees and Veterans (42 CFR § 406.27)

Impact of Regulation as It Currently Stands: Many federal retirees and veterans have credible coverage but are penalized due to a lack of clarity in eligibility exceptions. This results in financial harm and confusion.

Proposed Solution: Create a permanent SEP and exempt these populations from LEPs when they can demonstrate continuous, credible coverage through federal or military sources.

Outcome: Protects vulnerable populations and ensures fair treatment of those who have served or worked in public service.

ACA Marketplace

Regulation & CFR Citation: Special Enrollment Period (SEP) for Low-Income Individuals (§155.420(d)(16)

Impact of Regulation and Justification for Reform: The SEP for individuals with incomes below 150% of the Federal Poverty Level (FPL) was intended to improve access for lower-income individuals. However, NABIP members report widespread misuse—particularly in non-expansion states—where the SEP is exploited to bypass Medicaid eligibility limits and gain improper access to Advance Premium Tax Credits (APTCs). In these states, it effectively circumvents the 100% FPL threshold. In expansion states, inconsistent eligibility criteria and timing of FPL updates further enable manipulation, highlighting systemic flaws in the SEP's current structure.

Proposed Solution: 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.

Outcome of Deregulation: Eliminating or restricting this SEP will strengthen Exchange integrity, reduce instances of fraud and manipulation and restore proper eligibility alignment across states.

Three-Way Call Requirement for Coverage Changes in the Federally-facilitated Marketplace (FFM)

Impact of Mandate: The lack of robust identity verification in the Federally-facilitated Marketplace (FFM) has led to a surge in unauthorized coverage changes and fraudulent plan switching. Consumers often discover these changes only when seeking care, resulting in denied claims, unexpected costs, and disrupted treatment. Ethical agents and brokers are also affected, losing commissions and client trust when their enrollments are overridden. Bad actors—often overseas call centers or private firms—have exploited these gaps at scale, in some cases altering millions of enrollments. Without a secure authentication system, the integrity of the Marketplace is compromised, and CMS's enforcement resources are overwhelmed.

Proposed Solution: We support the widespread recommendation that CMS implement multiple-factor authentication (MFA) within the FFM to prevent the majority of unauthorized coverage changes that are occurring within the Federal Exchange.

Outcome of Proposed Solution: Replacing the three-way call requirement with multi-factor authentication within the Direct Enrollment (DE) and Enhanced Direct Enrollment (EDE) platforms would most efficiently and effectively address this issue, protect consumers, maintain the integrity of the FFM, and decrease the resources required from CMS to institute security.

Group/Employer Market

Regulation: ICHRA–APTC Coordination Rule

Impact of Regulation and Justification for Reform: Current IRS regulations prohibit pretax treatment of Individual Coverage Health Reimbursement Arrangement (ICHRA) funds when an employee purchases a qualified health plan on the ACA Exchange and declines the Advance Premium Tax Credit (APTC). This creates a tax disadvantage for employees who opt out of subsidies, particularly lower- and middle-income workers who would otherwise benefit from tax-free employer contributions. It also imposes administrative burdens on employers and third-party administrators (TPAs), who must track subsidy eligibility to determine tax status—raising compliance costs and complexity. This misalignment discourages employer adoption of ICHRAs and limits a valuable pathway for expanding affordable coverage through small businesses and non-traditional workforces.

Proposed Solution: Amend IRS regulations or issue clarifying guidance to allow ICHRA reimbursements to be treated as pretax if the employee voluntarily declines the APTC. This would align the tax treatment of ICHRAs with that of traditional group health plans, where employer contributions are not taxed regardless of income or subsidy eligibility. Ensure this change applies regardless of whether the individual plan is purchased on-exchange or off-exchange, so long as it meets the ACA's definition of individual health insurance coverage.

Outcome of Deregulation: Allowing pretax treatment of ICHRA funds when an employee declines the APTC would remove a regulatory barrier and align tax treatment with traditional group health plans. This change would encourage greater employer adoption - especially among small businesses—expanding access to affordable, portable coverage

without increasing reliance on federal subsidies. It would also reduce administrative burdens for employers, TPAs, and agencies by eliminating the need to track subsidy eligibility for tax purposes. Crucially, this policy would generate federal savings as more consumers shift from public subsidies to employer-funded coverage, while also promoting consumer choice, strengthening the individual market, and simplifying oversight through a more incentive-aligned framework.

Regulation & CFR Citation: ERISA Plan Disclosures (29 CFR § 2520)

Impact of Regulation and Justification for Reform: The current disclosure requirements for group health plans rely on outdated, paper-based delivery standards that impose unnecessary administrative burdens on employers, particularly small and mid-sized businesses with limited compliance infrastructure. Although the Department of Labor established a modernized electronic disclosure safe harbor, it applies exclusively to retirement plans, leaving health and welfare benefits subject to legacy rules. This forces employers to operate two parallel systems: one digital and efficient for retirement communications, and another antiquated and paper-heavy for health plans.

This regulatory inconsistency results in avoidable inefficiencies, elevated costs, and operational complexity. In a modern workforce, where the majority of employees communicate online and many work remotely or in hybrid environments, defaulting to paper delivery is no longer reasonable or aligned with participant expectations. For instance, employers with fully remote staff are still required to print and mail Summary Plan Descriptions (SPDs) to employees' home addresses, even when all employees have confirmed access to email and online HR platforms.

Proposed Solution: Extending the electronic disclosure safe harbor to include health and welfare plans—and allowing digital delivery as the default, with a paper opt-out—would reflect the realities of today's workplace.

Outcome of Deregulation: Reduces compliance costs and streamlines administration, all while preserving participant rights and access to information.

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Statutory Requirement: Gag Clause Prohibition Compliance Attestation

Impact: While NABIP supports the intent of the gag clause prohibition, the current enforcement framework lacks the clarity and reach needed to ensure plan sponsors have full access to their own claims data. Many service provider contracts still include non-disclosure clauses that restrict employer-sponsored plans from using their data to negotiate rates, evaluate networks, or improve plan design. Plan sponsors also face systemic barriers to obtaining provider taxpayer identification numbers (TINs), which are critical for transparency and fraud prevention. Access to prescription drug data remains inconsistent, particularly when managed by separate vendors or carved-out PBAs.

In addition, some third-party administrators (TPAs) and pharmacy benefit managers (PBMs) employ non-contractual tactics that effectively impose gag clauses—such as long delays in fulfilling data requests, excessive fees, or supplying unusable formats like scanned PDFs. These practices undermine the law's intent while maintaining surface-level compliance.

Proposed Solution: NABIP urges the Departments (Treasury, HHS, and DOL) to:

- Explicitly define provider TINs and prescription drug claims data as components of de-identified claims data required to be accessible to plan sponsors.
- Prohibit non-contractual practices that restrict data access through indirect means.
- Shift primary compliance responsibility from plan sponsors to service providers.
- Require that all claims data be shared in real-time, machine-readable formats.
- Establish enforceable financial penalties for service providers that impose undue restrictions or delays.

Outcome: These improvements would ensure meaningful access to critical data, enabling plan sponsors to meet fiduciary obligations, detect fraud, improve plan efficiency, and better serve enrollees. True transparency depends on both regulatory intent and practical enforceability.

We thank you for your consideration of these recommendations. NABIP welcomes the opportunity to collaborate further and can facilitate direct conversations with impacted

members who are willing to share additional insight. We are confident that these suggested changes would modernize compliance, reduce administrative burdens, and improve consumer outcomes.

Sincerely,

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