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

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U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: Request for Information: Ensuring Lawful Regulation and Unleashing Innovation To Make American Healthy Again

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to the Department of Health and Human Services' request for information regarding federal regulations that may be outdated, overly burdensome, or in need of reform.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 better promotes the health and well-being of the American people. 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.

ACA Marketplace

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. Bad actors—often overseas call centers or private firms—have exploited these gaps at scale, in some cases altering millions of enrollments. 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. The temporary solution of the three-way call requirement for coverage changes is a clunky and time-consuming process for consumers and agents and brokers alike. 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, decrease the resources required from CMS, decrease the time expected of consumers and agents to institute security.

Consumer Consent Documentation 10-year Requirement (45 CFR 155.220)

Impact of Regulation and Justification for Reform: The current 10-year documentation retention requirement places an undue financial and administrative burden on independent agents and brokers, particularly small businesses. Many agents manage large client bases, and maintaining consent records for a decade requires costly long-term cloud storage solutions and added administrative oversight.

Proposed Solution: Reduce the required retention period to 3-5 years. Most agency audits occur on documentation going back this length of time. This aligns with practical needs without compromising compliance integrity.

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

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Group/Employer Market

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.

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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 3 years. The vast majority of CTMs are submitted within 2 years and carriers typically request data of up to 3 years, if they request. 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.

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To better promote the health and well-being of the American people, we ask the Department to review opportunities to minimize disruption to beneficiaries during the upcoming Annual Enrollment Period (AEP). Ahead of last year's AEP and now this year's, carriers have been determining ways to steer beneficiaries towards preferred plans by removing products from electronic enrollment platforms and restrict to just telephonic or Medicare.gov channels, limiting beneficiary choices. Additionally, carriers eliminated agent commissions after AEP had already begun last year and they have already made these decisions for both initial enrollments and renewal enrollments ahead of this year's AEP. Both developments will prevent millions of Medicare beneficiaries from receiving the help of agents to navigate a complex, overly confusing system and set of decisions. We ask CMS to **require carriers to prohibit changes to 1) which plans are displayed on electronic enrollment platforms and 2) posted commissions after October 1, coinciding when plans are finalized and released ahead of AEP.**

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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