NABIP
Shaping the *future* of healthcare

999 E Street NW, Suite 604
Washington, DC 20004
www.NABIP.org

March 13, 2026

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted electronically via www.regulations.gov

Re: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2027 and Basic Health Program

Dear Administrator Oz:

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, we 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, and 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. Within each section, we summarize the proposed rule to confirm our understanding, provide relevant policy background, and share our perspectives.

Timing of the Final Rule
NABIP greatly appreciates the willingness of HHS and CMS to consider the comments from all stakeholders on this critical regulation, which covers such a wide array of health-policy issues. While we certainly hope you give adequate weight and attention to all viewpoints, we also want to make sure that you act with expediency when finalizing this regulation. Across all commercial health insurance market segments, plan design and other administrative decisions for the 2027 benefit year will be affected by the content of the final rule. We are concerned that if a final version is not promulgated quickly, coverage options for all consumers in 2027 will be limited and there will not be enough time to implement any new requirements.

Plan Design

999 E Street NW, Suite 604
Washington, DC 20004
www.NABIP.org

Risk Adjustment Factors & Fees

NABIP Position: Support the proposed risk adjustment methodology and user fee while encouraging CMS to evaluate improvements to the program's settlement mechanics.

Risk adjustment remains a foundational component of the ACA's guaranteed-issue market structure. By transferring funds from plans with healthier enrollees to those covering higher-risk populations, the program reduces incentives for risk selection and supports market stability.

High-Cost Risk Pool / Truncation Methodology
NABIP generally supports CMS's proposal to maintain the high-cost risk pool truncation policy. Currently the policy removes 60 percent of costs above the $1 million threshold from transfer calculations.

This adjustment mitigates distortions created by rare catastrophic claims that are not broadly predictive of overall population morbidity. Maintaining the current truncation structure helps ensure that the risk adjustment model reflects meaningful morbidity differences rather than extreme outlier events.

From a market stability perspective, truncating a portion of very high-cost claims can reduce the magnitude of risk adjustment transfer volatility. By limiting the influence of catastrophic outliers in the transfer formula, the policy may also reduce the need for issuers to incorporate additional risk premia into premium rates to hedge against unpredictable high-cost events.

At the same time, NABIP recognizes that the share of catastrophic costs remaining outside of risk adjustment transfers must ultimately be absorbed by the covering issuer. In smaller or emerging markets, where enrollment pools are limited, this residual exposure may represent a meaningful financial risk for smaller or regional carriers and could influence participation or expansion decisions.

NABIP therefore encourages CMS to evaluate whether the current $1 million high-cost risk pool threshold continues to appropriately reflect the evolving distribution of catastrophic claims. Adjusted for inflation since the threshold was originally established, the equivalent value today would likely fall in the range of $1.3–$1.5 million.

Industry reporting from stop-loss carriers indicates growth not only in the number of claims exceeding the current threshold, but also in the magnitude by which those claims exceed it. Both trends reflect the increasing prevalence of high-cost specialty pharmaceuticals, gene therapies, and complex medical interventions.

As these cost dynamics continue to evolve, periodic review of the truncation threshold may help ensure that the high-cost risk pool remains appropriately calibrated and continues to distribute catastrophic risk across issuers as originally intended.

999 E Street NW, Suite 604
Washington, DC 20004
www.NABIP.org

As discussed further below, improvements to the timing and mechanics of risk adjustment settlements could help mitigate potential liquidity pressures associated with catastrophic claims while preserving the current methodology and maintaining the program's stabilizing role within the ACA marketplaces.

Risk Adjustment User Fee
NABIP also supports maintaining the $0.20 PMPM federal risk adjustment user fee for PY2027.

The proposed fee level appears reasonable given the operational costs associated with EDGE data collection, model calibration, payment processing, and program oversight.

Structural Considerations for Risk Adjustment Settlements
While NABIP supports the current methodology, we encourage CMS to evaluate whether the current annual lump-sum settlement structure remains aligned with the program's stabilizing intent.

Large single-cycle transfer payments can introduce financial volatility for issuers, particularly in smaller or emerging markets where enrollment scale is limited. These liquidity pressures may discourage participation or encourage defensive premium pricing that ultimately increases consumer costs.

CMS should consider exploring operational enhancements that maintain budget neutrality while reducing solvency stress, including:

- installment payment flexibility
- quarterly provisional settlements
- federal clearing or netting mechanisms
- improved transparency in transfer calculations

Such changes could preserve the core risk adjustment framework while improving financial predictability for participating issuers.

Rate Factors & Fees

NABIP Position: Support **continuation of the current Exchange user fee levels, support restoration of clear EHB defrayal standards, and encourage flexible implementation of CSR transparency requirements.**

Exchange User Fees
NABIP supports CMS's proposal to maintain current Exchange user fee levels for PY2027:

- 2.5% of premium for Federally Facilitated Exchanges (FFEs)
- 2.0% for State-Based Exchanges on the Federal Platform (SBE-FPs)

999 E Street NW, Suite 604
Washington, DC 20004
www.NABIP.org

Maintaining stable user fee levels promotes predictability for issuers when developing premium rates and avoids unnecessary administrative cost volatility that could otherwise translate into premium changes for consumers.

Adult Dental as an Essential Health Benefit (§156.115(d))
NABIP supports CMS's proposal to remove routine adult dental services from Essential Health Benefits (EHB).

Traditional medical carriers generally do not possess the provider network infrastructure necessary to administer comprehensive dental benefits. Requiring adult dental coverage within EHB may increase premiums without materially improving access to dental care.

Allowing adult dental coverage to remain outside the EHB framework ensures that dental benefits can continue to be offered through specialized dental carriers that maintain appropriate provider networks and benefit design expertise.

State-Mandated Benefits and EHB Defrayal (§155.170)
NABIP supports restoring clear statutory alignment regarding State defrayal obligations for benefits mandated after December 31, 2011. This position is consistent with NABIP's comments on the 2025 Payment Notice, in which we opposed allowing State-mandated benefits incorporated into EHB-benchmark plans to be treated as EHB without requiring State defrayal.

Allowing post-2011 State mandates to be incorporated into EHB-benchmark plans without defrayal shifts costs to Federal taxpayers and undermines the benchmark framework established under section 1311(d)(3)(B) of the Affordable Care Act. Requiring States to defray the cost of newly mandated benefits restores the statute's original policy structure and appropriately aligns fiscal responsibility with State policy decisions while preventing State-level benefit mandates from indirectly increasing Federal APTC expenditures.

However, the proposal would alter the treatment of State-mandated benefits that some States incorporated into their EHB-benchmark plans in reliance on the policy finalized in the 2025 Payment Notice. Because States may have taken legislative or regulatory action based on the understanding that these benefits would be treated as EHB without requiring State defrayal, this regulatory change could create operational and fiscal disruption across State regulators, issuers, and marketplaces. A longer transition period would allow States time to evaluate existing mandates, determine potential defrayal obligations, pursue legislative adjustments where necessary, and provide regulatory clarity to issuers prior to rate filing deadlines.

NABIP also notes the potential interaction between this proposal and CMS's statement that it is pausing review of State applications to select EHB-benchmark plans while the Department conducts a broader review of section 1302 of the Affordable Care Act. If benefits enacted after December 31, 2011 are once again treated as non-EHB while benchmark updates are not being reviewed, some States could temporarily retain benchmark structures that include benefits not eligible for APTC. In these circumstances, States may face defrayal obligations for benefits embedded in benchmark plans that cannot readily be modified during the review pause.

999 E Street NW, Suite 604
Washington, DC 20004
www.NABIP.org

If finalized, NABIP recommends a PY2030 implementation to allow States to align any necessary statutory or regulatory changes with the EHB-benchmark update cycle, under which benchmark selections must be submitted two years prior to the applicable plan year. This sequencing would allow legislative changes enacted during upcoming sessions to be incorporated into subsequent benchmark submissions, reducing the risk that States or issuers must operationalize defrayal for benefits embedded in benchmark plans that cannot otherwise be modified.

For example, Nevada's legislature meets biennially and will not convene again until 2027. Even if legislative action occurred during that session, State agencies would still require time to complete regulatory implementation, actuarial review, and issuer filing guidance that would likely place the required timeline for implementation between the PY2029 and PY2030 rate filing cycle.

These timing considerations illustrate the practical constraints many States may face when aligning statutory mandates, regulatory implementation, and issuer filing timelines. Providing a PY2030 implementation timeline would allow States to evaluate existing mandates, determine potential defrayal obligations, and make any necessary legislative or regulatory adjustments in an orderly manner while maintaining stability for issuers, marketplaces, and consumers.

Silver Loading Actuarial Documentation
NABIP supports transparency in cost-sharing reduction pricing practices but encourages CMS to implement any documentation requirements with flexibility.

Silver loading strategies vary significantly across states and issuer structures. Overly prescriptive reporting requirements could introduce unnecessary administrative complexity and discourage market participation.

CMS should ensure that any documentation framework allows issuers sufficient flexibility to maintain pricing strategies that reflect local market dynamics.

Elimination of Standardized Plan Requirement (§156 Plan Design Standards)

NABIP Position: Support proposal to eliminate the federal standardized plan design requirement.

Standardized plan designs were originally intended to simplify consumer comparison across plans. However, our members' experience assisting consumers suggests that standardized plans often create additional complexity rather than clarity.

Plans with identical cost-sharing structures frequently differ in other critical areas such as:

- provider network composition
- formulary coverage
- utilization management policies
- prior authorization requirements

999 E Street NW, Suite 604
Washington, DC 20004
www.NABIP.org

These elements often play a more significant role in consumer decision-making than cost-sharing design alone. As a result, standardized plan requirements may increase the number of available options without materially improving consumers' ability to evaluate coverage. Licensed agents and brokers are necessary to help interpret these differences and navigate plan selection.

Furthermore, allowing issuers greater flexibility in plan design may encourage innovation and allow products to better reflect regional market dynamics.

CMS should instead continue prioritizing improvements in areas that more directly support consumer decision-making, including provider directory accuracy, network transparency, and broker engagement tools.

Plan Mapping Considerations
As CMS evaluates the elimination of standardized plan design requirements, NABIP encourages the agency to ensure that clear plan mapping and plan transition standards remain in place to support consumer clarity during the annual coverage renewal process.

Each year, Marketplace issuers may modify, consolidate, or discontinue plan offerings as part of their product strategy. When this occurs, consumers must evaluate replacement coverage options based on information provided during the annual renewal and open enrollment period. Clear guidance regarding how issuers should map discontinued or modified plans to comparable coverage options can help reduce consumer confusion and support more informed enrollment decisions.

NABIP members frequently assist consumers who receive renewal notices indicating that their current plan will be discontinued or modified. In some cases, early renewal communications issued prior to final premium tax credit determinations or updated plan filings may create confusion regarding expected premiums or benefit structures. Establishing clearer mapping standards and communication expectations could help ensure consumers receive more accurate and consistent information as they evaluate coverage options during open enrollment.

NABIP therefore encourages CMS and the Center for Consumer Information and Insurance Oversight (CCIIO) to provide additional guidance on plan mapping practices that prioritize continuity of coverage and minimize unexpected changes in cost-sharing or provider access, while still preserving issuer flexibility in plan design.

High Impact Proposals

Catastrophic Plan Hardship Eligibility Expansion (§156.155)

NABIP Position: Support **expansion for individuals below 100 percent of the Federal Poverty Level but** Oppose **expansion to individuals between 250 percent and 400 percent of the Federal Poverty Level (FPL).**

999 E Street NW, Suite 604
Washington, DC 20004
www.NABIP.org

NABIP supports targeted hardship eligibility expansion for individuals below 100 percent FPL who are ineligible for Marketplace subsidies, particularly those residing in non-Medicaid expansion states, but does not support extending catastrophic plan eligibility to individuals between 250 percent and 400 percent FPL who already have access to Advanced Premium Tax Credits.

Expanding catastrophic eligibility for individuals below 100 percent FPL may provide a limited coverage pathway for consumers who fall into the coverage gap and currently lack realistic access to Marketplace subsidies. For this population, catastrophic plans may offer at least baseline financial protection against severe medical events when paired with existing safety-net resources such as hospital charity care.

However, NABIP does not support expanding catastrophic plan eligibility to individuals between 250 percent and 400 percent FPL who already qualify for Advanced Premium Tax Credits. Subsidized metal-level plans generally provide substantially greater actuarial value and financial protection than catastrophic coverage. Expanding catastrophic eligibility into this income band risks steering cost-sensitive consumers toward lower-premium options that expose them to significantly higher out-of-pocket liability.

NABIP therefore encourages CMS to limit hardship eligibility expansion to populations that lack meaningful access to subsidized Marketplace coverage while maintaining appropriate consumer protections and disclosure standards.

Multi-Year Catastrophic Plans

NABIP Position: Support **consumer choice through multi-year catastrophic plan options while emphasizing safeguards to protect consumers and maintain risk pool stability.**

Multi-Year Catastrophic Coverage Duration
NABIP supports exploring the option for multi-year catastrophic plan offerings, including coverage terms extending beyond the traditional annual contract structure.

For consumers who are ineligible for Advance Premium Tax Credits (APTCs), longer-duration catastrophic coverage may offer greater premium predictability and continuity of coverage for individuals primarily seeking protection against high-cost medical events.

Deductible and Maximum Out-of-Pocket (MOOP) Flexibility
NABIP recognizes CMS's proposal to allow flexibility in how deductibles and maximum out-of-pocket limits (MOOP) may be structured across multi-year catastrophic plans. We support allowing cost-sharing structures that extend beyond a single plan year if tied to the duration of the multi-year coverage term.

However, cost-sharing resets should not occur more frequently than annually. Allowing deductibles or MOOP thresholds to reset on a monthly or similarly frequent basis would undermine the core purpose of catastrophic coverage by repeatedly restarting a consumer's financial exposure during ongoing treatment.

999 E Street NW, Suite 604
Washington, DC 20004
www.NABIP.org

To preserve meaningful financial protection, NABIP encourages CMS to establish guardrails ensuring that catastrophic plans maintain predictable cost-sharing protections, while allowing flexibility for cost-sharing periods that extend beyond one year when aligned with the plan's multi-year coverage term.

Risk Pool and Market Stability Considerations
Catastrophic plans have historically attracted healthier enrollees. Multi-year enrollment structures could amplify this dynamic if individuals remain locked into high-deductible plans over extended periods.

CMS should closely evaluate potential impacts on Marketplace risk pools and ensure that implementation includes safeguards to prevent unintended segmentation between catastrophic and metal-tier coverage.

Consumer Education and Disclosure
If multi-year catastrophic plans are implemented, NABIP strongly encourages CMS to pair the policy with robust consumer education and disclosure requirements.

Consumers must clearly understand the financial exposure associated with high-deductible coverage and the tradeoffs between catastrophic plans and subsidized metal-tier options. Clear decision-support tools and enrollment guidance will be essential to ensuring that consumers select these plans intentionally rather than based solely on premium affordability.

Essential Community Provider Threshold Reduction (§156.235)

NABIP Position: Oppose **reducing the Essential Community Provider (ECP) participation threshold from 35 percent to 20 percent.**

Essential Community Providers serve a critical role in ensuring access to care for low-income, medically underserved, and vulnerable populations that rely heavily on Marketplace coverage. Lowering the threshold may weaken network robustness and reduce meaningful access in communities where provider availability is already constrained.

While numeric participation thresholds alone do not guarantee real access to care, reducing the standard risks signaling a broader relaxation of network adequacy expectations at a time when provider consolidation, workforce shortages, and capacity constraints already strain access across many markets. NABIP supports continued refinement of network adequacy standards, including improved alignment of time and distance metrics with real-world access indicators such as appointment availability and acceptance of new patients, but does not believe that lowering ECP participation requirements advances those goals.

Additionally, NABIP is concerned that reducing the ECP threshold may interact with other proposed flexibilities in plan design in ways that collectively weaken network protections. Any changes to ECP participation standards should be evaluated within the broader context of

999 E Street NW, Suite 604
Washington, DC 20004
www.NABIP.org

Qualified Health Plan (QHP) certification requirements to ensure that Marketplace coverage continues to support meaningful access to providers serving vulnerable populations.

Also, NABIP asks CMS to clarify that telehealth and virtual-only providers, while an important component of modern care delivery, should not be considered a substitute for in-person providers when evaluating network adequacy standards. Clarifying this distinction would help ensure that Marketplace networks continue to provide real-world access to providers while still allowing issuers to incorporate telehealth innovations that improve convenience and care coordination for consumers.

Non-Network QHP Certification Pathway (QHP Certification Standards)

NABIP Position: Oppose **establishing a non-network Qualified Health Plan (QHP) certification pathway within the Marketplace.**

While the proposal attempts to incorporate transparency and balance-billing safeguards, real-world experience with reference-based pricing and other non-network reimbursement models demonstrates significant operational and consumer protection challenges.

In practice, non-network payment models depend on providers voluntarily accepting reimbursement amounts without negotiated contracts. Many health systems and physician groups have declined to participate in such arrangements, resulting in billing disputes, scheduling barriers, and continuity-of-care disruptions that ultimately fall on the patient. These challenges are particularly concerning in the individual market, where consumers typically lack the administrative support structures available in employer-sponsored coverage.

Marketplace consumers, especially those enrolling without the assistance of a licensed agent or broker, may not fully understand the mechanics of non-network reimbursement structures. Even with advance publication of payment amounts and balance-billing prohibitions, disputes related to provider acceptance, reimbursement processing, and access to care can create confusion and delays.

NABIP is also concerned that introducing a non-network QHP certification pathway while simultaneously lowering ECP participation requirements could weaken the overall integrity of Marketplace network standards. Taken together, these proposals could create pathways for plans with materially narrower or functionally undefined provider access, increasing consumer confusion and potential access barriers.

NABIP encourages CMS to instead prioritize improvements that strengthen consumer protections within existing network-based coverage models, including enhanced provider directory accuracy, network transparency, and enforceable access standards.

Benchmark Pricing Dynamics
NABIP is also concerned how non-network QHP designs, if finalized as proposed, would interact with Marketplace benchmark premium calculations used to determine advance premium tax

999 E Street NW, Suite 604
Washington, DC 20004
www.NABIP.org

credits (APTC). Because APTC amounts are tied to the premium of the second-lowest-cost silver plan (SLCSP) in a rating area, the introduction of extremely low-premium products can materially alter benchmark pricing for the entire market.

Recent Marketplace experience demonstrates how benchmark pricing can shift over time as lower-cost plan designs enter the market. Analysis from the Urban Institute shows that national average benchmark premiums declined for several consecutive years between 2019 and 2022, reflecting increased competitive pressure and the introduction of lower-premium products in many rating areas. Research examining Marketplace plan design has also found that narrower provider networks are frequently associated with meaningfully lower premiums, with studies published in *Health Affairs* documenting that plans with narrower networks can materially reduce premiums and depress the SLCSP benchmark used to calculate subsidies.

Past Marketplace experience has therefore demonstrated that when lower-cost plan designs capture the benchmark position, the resulting shift in the SLCSP can increase net premiums for consumers enrolled in other plans that maintain broader provider access or more established networks. This dynamic creates a cascade effect in which consumers are forced to choose between changing providers, accepting materially different coverage structures, or absorbing higher out-of-pocket premium costs.

Non-network reimbursement models could amplify this dynamic if their lower premium structure allows them to capture benchmark positions within rating areas. While such products may appear to expand plan choice, their interaction with the subsidy benchmark may unintentionally destabilize existing enrollment patterns and disrupt established provider relationships for many Marketplace enrollees.

Federal MLR Standard Adjustment RFI (45 CFR Part 158)

NABIP Position: Support **carefully structured federal authority to adjust Medical Loss Ratio (MLR) standards where necessary to promote individual market stability, provided such authority is accompanied by clear guardrails, transparent criteria, and regulatory predictability.**

The federal 80 percent MLR standard remains an important consumer protection, ensuring that a substantial share of premium dollars is directed toward clinical care and quality improvement. However, the impact of a uniform national threshold may vary across states depending on market maturity, issuer competition, and enrollment scale. In certain thin or emerging markets, limited flexibility may constrain issuer participation or contribute to premium volatility.

Accordingly, NABIP supports maintaining federal authority to adjust the MLR standard where doing so demonstrably promotes market stability. At the same time, such authority should be governed by objective, data-driven triggers, such as sustained issuer exits, measurable declines in competition, persistent underwriting losses, or other indicators of structural market stress. Clear

999 E Street NW, Suite 604
Washington, DC 20004
www.NABIP.org

criteria would help ensure that adjustments address genuine instability while preserving regulatory predictability for issuers and consumers.

In addition to adjustment authority, NABIP encourages CMS to examine whether the current MLR framework continues to reflect the realities of an increasingly vertically integrated healthcare system. Payments flowing between insurers and affiliated entities, including pharmacy benefit managers, provider groups, specialty pharmacies, and administrative service organizations, can complicate how medical and administrative expenditures are reflected in MLR reporting. Ensuring that MLR accountability follows healthcare dollars through commonly controlled entities would strengthen transparency and reinforce the consumer protection intent of the statute.

NABIP also encourages CMS to evaluate whether enhanced transparency across major spending categories—such as pharmacy benefits, behavioral health services, and care management—could improve oversight within the MLR framework. Additional examination of Quality Improvement Activity classifications, administrative expenditure growth, closely held provider, surgery, and pharmacy entities, and pharmacy benefit manager practices may further ensure that MLR calculations reflect meaningful healthcare value delivered to consumers.

Overall, NABIP supports CMS's exploration of both targeted MLR adjustment authority and modernization of the reporting framework, provided these efforts maintain the core consumer protections established under current law while strengthening transparency and stability within the individual market.

Expanded Catastrophic and Bronze MOOP Flexibility (§156.130 / §156.140)

NABIP Position: Oppose **expanding consumer cost exposure through higher MOOP thresholds as a solution to the growing divergence between actuarial value (AV) requirements and the statutory maximum limitation on cost sharing (MOOP).**

NABIP recognizes the structural tension CMS identifies between actuarial value requirements and the statutory maximum limitation on cost sharing (MOOP). Rising healthcare costs and evolving claims patterns have made it increasingly difficult for issuers to design bronze plans that meet actuarial value standards while remaining within existing MOOP limits.

However, increasing allowable cost-sharing exposure is not the appropriate solution. For many households, the current statutory MOOP already represents a significant financial risk. Allowing bronze plans to exceed this threshold, or increasing catastrophic exposure to 130 percent of MOOP, risks worsening underinsurance and undermining the financial protection Marketplace coverage is intended to provide.

To address the underlying challenges while preserving consumer protections and Marketplace stability, NABIP recommends that CMS consider the following actions:

999 E Street NW, Suite 604
Washington, DC 20004
www.NABIP.org

NABIP Recommendations

- **Revisit prior actuarial alignment proposals** from the Marketplace Integrity and Affordability Rule that addressed AV–MOOP divergence through actuarial calibration rather than increasing consumer cost exposure.
- **Prioritize system-wide healthcare cost containment efforts** through interagency coordination within HHS, including collaboration with the Center for Medicare & Medicaid Innovation (CMMI), the National Institutes of Health (NIH), and other relevant agencies.
- **Evaluate pharmaceutical pricing reforms**, including policies such as Medicare drug price negotiation, international reference pricing frameworks, and patent reform efforts that address pharmaceutical "evergreening" practices extending brand exclusivity beyond intended patent lifecycles.
- **Continue exploration of site-neutral payment policies**, which may reduce unnecessary cost variation across care settings and help lower overall healthcare spending.
- **Preserve the integrity of the Medical Loss Ratio framework** while ensuring that evolving cost containment initiatives and market dynamics are considered when evaluating future MLR policy adjustments.
- **Explore risk adjustment payment smoothing mechanisms**, such as installment payment schedules or interim settlement structures, to reduce financial volatility for issuers while maintaining the program's budget-neutral structure.

Addressing the structural drivers of healthcare costs, rather than increasing consumer cost exposure, will better preserve both Marketplace stability and the financial protection Marketplace coverage is intended to provide.

Compliance Oversight

AGENTS/BROKERS/WEB-BROKERS (ABs)

Mandatory HHS Consumer Consent Form Requirement and Valid Consent Action (§155.220(j)(2))

NABIP Position: Opposed. **Encourages CMS to prioritize system-based authorization controls within the Marketplace application process rather than relying primarily on documentation-based consent requirements. Static consent documentation requirements are unlikely to prevent large-scale unauthorized enrollments. If CMS proceeds with the proposed standardized HHS consent form, clearer operational standards are necessary for documenting consent through electronic signature systems and telephonic call recordings.**

NABIP appreciates CMS's continued focus on protecting consumers from unauthorized Marketplace enrollments and ensuring that agents, brokers, and web-brokers obtain meaningful

999 E Street NW, Suite 604
Washington, DC 20004
www.NABIP.org

authorization before accessing consumer applications. Consumers should have clear visibility into who is assisting with their Marketplace enrollment, and regulators must be able to review documentation when investigating potential misconduct.

CMS proposes to standardize consent documentation through the use of an HHS-approved consumer consent form. NABIP encourages the agency to ensure that any such requirement, if finalized, is implemented in a manner that remains operationally workable for agents, brokers, and web-brokers assisting consumers through common enrollment channels, including digital and telephonic interactions.

Marketplace rules already require consumers to take an affirmative action authorizing an agent, broker, or web-broker to assist with an application or enrollment. The proposed rule would further clarify how a consumer may "take an action," how that authorization must be documented, and what constitutes sufficient evidence that a consumer has reviewed and confirmed the accuracy of eligibility information.

NABIP has previously expressed concern that documentation-based consent requirements alone are unlikely to serve as an effective safeguard against large-scale fraud. Static documentation, such as signed forms or retained consent records, may be difficult to rely upon in cases involving coordinated fraud schemes and therefore provides limited protection against the types of systemic enrollment manipulation in the Marketplace.

For this reason, NABIP previously encouraged CMS to incorporate consumer authorization directly into the Marketplace application process, allowing the Federally Facilitated Marketplace (FFM) to record consent events within the platform itself. Embedding authorization within the Marketplace system would ensure consistent documentation, reduce opportunities for fraudulent record creation, and allow CMS to maintain a centralized and verifiable record of consumer consent tied directly to the individual's application.

More broadly, NABIP believes the most effective safeguards against unauthorized enrollments are platform-based security controls, including stronger account authentication measures such as multi-factor authentication (MFA), enhanced identity verification tools, and improved monitoring of abnormal enrollment activity. These system-level protections are significantly more effective at preventing unauthorized access than reliance on documentation that may only be reviewed after an enrollment has already occurred.

If CMS proceeds with the proposed standardized consent form, additional clarification will be necessary to ensure the requirement can be implemented effectively in two common enrollment environments:

- electronic signature systems
- telephonic interactions and call recordings

To ensure the consent framework remains operationally feasible while providing regulators with clear documentation, NABIP recommends the following approaches.

999 E Street NW, Suite 604
Washington, DC 20004
www.NABIP.org

Electronic Signature Systems

CMS should recognize electronic consent workflows that comply with the Electronic Signatures in Global and National Commerce Act (ESIGN) and the Uniform Electronic Transactions Act (UETA). These frameworks establish that electronic signatures are legally valid when the process demonstrates three core elements:

- consumer intent to authorize the transaction
- attribution of the action to the consumer
- record integrity demonstrating that the executed document has not been altered

Many commercially available electronic form systems already operate within these frameworks and generate auditable records documenting the consumer's interaction with the consent form.

Consistent with these principles, digitally typed names should be permitted where the consent workflow includes a verification step tied to the consumer's email address. For example, a system may generate a unique one-time PIN sent to the consumer's email address that must be entered into the consent form to complete the authorization.

Upon completion, the system should generate a confirmation record sent to the consumer and carbon copied to the assisting agent or broker of record. The system should also retain a record of the PIN request and confirmation event. This process creates a timestamped and auditable record demonstrating that the consumer accessed the consent form through their email account and knowingly authorized the assistance.

Recognizing electronic consent workflows that produce these types of verifiable records would strengthen consumer authorization documentation while ensuring the consent framework remains operationally feasible in digital enrollment environments.

Telephonic Interactions

CMS notes that agents, brokers, and web-brokers who previously relied exclusively on phone recordings or text messaging to document consumer authorization may be particularly impacted by the proposed requirement to use the standardized HHS consumer consent form. NABIP agrees that a standardized consent document can help ensure consumers receive consistent disclosure language and provide regulators with documentation that can be reviewed for compliance.

However, many Marketplace consumers interact with licensed agents and brokers through telephonic conversations when seeking enrollment assistance. Requiring the full consent form to be read verbatim during a call would create unnecessary operational burden for both consumers and agents and could discourage consumers from seeking assistance.

NABIP therefore recommends that CMS clarify that telephonic authorization may remain a valid method of obtaining consumer consent when supported by delivery of the standardized HHS consumer consent form.

Under this approach, the consent form would be transmitted electronically to the consumer on or before the time the consumer provides verbal authorization during the recorded interaction.

999 E Street NW, Suite 604
Washington, DC 20004
www.NABIP.org

During the recorded call, the consumer would confirm receipt of the disclosure and verbally attest that they authorize the assisting agent or broker to access the Marketplace and assist with submitting or updating application information. This verbal attestation would constitute the consumer's affirmative consent action, while the transmitted consent form would provide the standardized written disclosure of the required consent elements.

The call recording would serve as a timestamped record of the authorization event, while the electronically delivered consent form would ensure the consumer receives the standardized disclosure language required by CMS.

Together, the recording and transmitted consent form would create a clear and auditable documentation record demonstrating that the consumer received the required disclosures and knowingly authorized the assistance without requiring a physical or electronic signature during the call.

Prohibited Marketing Standards (§155.220(j)(2)–(3))

NABIP Position: Oppose the proposed marketing framework as drafted and encourage CMS to prioritize enforcement against systemic sources of fraud rather than expanding compliance obligations for licensed agents and brokers.

NABIP strongly supports protecting consumers from deceptive marketing practices and ensuring that Marketplace enrollment occurs with the informed consent of the consumer. However, NABIP has significant concerns that the proposed marketing standards may unintentionally expand regulatory oversight over licensed agents and brokers who are already operating within extensive federal and state compliance frameworks, while failing to address the systemic actors responsible for many of the large-scale abuses observed in recent years.

Licensed agents and brokers already operate under multiple layers of oversight, including state licensure requirements, continuing education obligations, carrier compliance programs, and annual Marketplace certification standards. In addition, several federal and state enforcement bodies, including the Federal Trade Commission (FTC), Federal Communications Commission (FCC), Office of Inspector General (OIG), Department of Justice (DOJ), and state Departments of Insurance, already possess authority to address deceptive marketing conduct.

Recent Marketplace enforcement activity suggests that many large-scale fraud cases originate not from traditional community-based agents and brokers, but from centralized enrollment operations, including offshore call centers, lead-generation networks, and technology platforms capable of processing enrollment activity at a scale far beyond typical brokerage practices.

For example, CMS suspended Speridian Health, whose enrollment arm had processed more than one million Marketplace applications after identifying credible evidence of unauthorized enrollment activity and manipulation of consumer applications. The operational scale observed in that case highlights the fundamental difference between traditional broker activity and centralized

999 E Street NW, Suite 604
Washington, DC 20004
www.NABIP.org

enrollment infrastructure capable of conducting enrollment activity across multiple states simultaneously.

These types of systemic actors often rely on sophisticated marketing networks, offshore call centers, and technology platforms that allow them to generate and process consumer applications at volumes that individual brokers and small agencies could not realistically replicate. The current enforcement framework that oversees agent conduct relies heavily on carriers and other organizations, even as evolving distribution models and intermediary relationships may complicate comprehensive oversight. This dynamic may allow problematic marketing practices in which unethical agents are rightfully removed while the broader marketing structures that facilitated systemic misconduct remain unaddressed. As a result, regulatory frameworks designed primarily around individual broker marketing conduct may not be appropriately calibrated to address the sources of large-scale Marketplace abuse.

NABIP is also concerned that expanding marketing compliance requirements for licensed agents could create unintended consequences for ethical brokers acting in good faith. In recent enforcement cycles, a number of agents and brokers have faced suspension or termination actions that were later reversed after additional review. In many cases, these individuals had originally identified and reported suspicious activity affecting their clients. When enforcement mechanisms inadvertently penalize those attempting to protect consumers, it risks discouraging the very professionals who serve as the Marketplace's front-line safeguard against fraud.

Furthermore, cases involving large enrollment infrastructure actors often involve extended investigation periods during which activity may continue while regulators evaluate evidence and enforcement options. This raises important questions about how many entities operating at similar scale may currently be under review or investigation and whether the existing enforcement framework adequately addresses the structural risks posed by centralized enrollment operations.

NABIP therefore encourages CMS to prioritize enforcement efforts directed at the systemic infrastructure that enables large-scale fraudulent activity, such as offshore call centers, lead-generation firms, and technology platforms, rather than expanding regulatory obligations that primarily affect licensed agents and brokers already operating within well-established compliance structures.

CMS has made important progress in recent years by strengthening account security, improving monitoring of unauthorized enrollments, and addressing certain technological vulnerabilities. NABIP strongly encourages the agency to continue focusing on these types of structural safeguards, including enhanced identity verification tools, improved oversight of enrollment platforms, and greater transparency regarding enforcement actions involving large-scale actors.

NABIP remains committed to working collaboratively with CMS to strengthen Marketplace integrity while ensuring that enforcement policies support, rather than inadvertently discourage, the licensed professionals who assist the majority of Marketplace consumers in navigating their coverage options.

999 E Street NW, Suite 604
Washington, DC 20004
www.NABIP.org

Removal of FFM Agent/Broker Training Vendor Pathway (§155.222)

NABIP Position: Oppose **Removal of the Vendor Certification Pathway**

NABIP opposes CMS's proposal to eliminate the vendor certification pathway under §155.222.

Marketplace certification is a mandatory annual requirement for agents and brokers who assist consumers with Exchange enrollment. Over the past decade, a portion of the agent and broker community has integrated vendor-facilitated certification platforms into their existing compliance workflows. These platforms often provide additional features such as integrated compliance tracking, training management tools, and technical support that supplement the federal Marketplace Learning Management System (MLMS).

Removing the vendor option may introduce unnecessary operational disruption for agents and brokers who may rely on third-party platforms to most effectively serve consumers and could create certification bottlenecks during peak training periods.

ISSUERS

Civil Monetary Penalties (CMP) Enforcement Authority (Exchange Enforcement Authority – QHP Issuers)

NABIP Position: Oppose **Federal Enforcement Override of State Exchange Authority**

NABIP opposes the proposed expansion of HHS authority to impose Civil Monetary Penalties based on a federal determination that a state has "failed to substantially enforce" Exchange or Qualified Health Plan (QHP) requirements.

Under the Affordable Care Act, states operating State-Based Exchanges retain primary responsibility for enforcement of Marketplace standards. Allowing CMS or CCIIO to independently override state regulatory decisions introduces regulatory uncertainty for issuers and undermines the established state-federal oversight structure.

Federal intervention should be limited to circumstances where a state explicitly notifies HHS that it is not enforcing applicable requirements. Expanding federal authority beyond this threshold risks unnecessary federal overreach and could disrupt established state regulatory frameworks governing Marketplace plans.

Quality Improvement Strategy Initiative Flexibility (QIS Standards)

NABIP Position: Support **Increased Flexibility with Enhanced Transparency**

NABIP supports CMS's proposal to provide issuers with greater flexibility in the design and implementation of Quality Improvement Strategy (QIS) initiatives.

999 E Street NW, Suite 604
Washington, DC 20004
www.NABIP.org

Allowing issuers to allocate quality improvement efforts across initiative categories recognizes that enrollee populations, provider networks, and care delivery models vary across markets. Greater flexibility may enable issuers to implement programs that are better aligned with local population health needs.

As flexibility increases, NABIP asks CMS to improve transparency around how QIS resources are deployed and the outcomes these initiatives produce. After more than 10 years of QIS programs, we need centralized transparency in federal spending and outcomes across carriers. Clear reporting of program goals, investments, and measurable results would help stakeholders evaluate the effectiveness of QIS efforts while maintaining accountability for quality improvement investments.

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

NABIP Position: Support **Alignment with Net Premium Obligations**

NABIP supports CMS's proposal to permanently align payment sufficiency standards with the enrollee's net premium obligation.

Determining payment status based on the net premium owed after application of Advance Premium Tax Credits improves consistency and program integrity by ensuring that payment requirements reflect the consumer's actual financial responsibility. Allowing issuers to treat enrollees as current based on a percentage of gross premium created inconsistencies in how payment obligations were applied across income levels.

Maintaining a de minimis threshold for minor payment discrepancies provides appropriate operational flexibility while reinforcing clear and equitable premium contribution standards.

CONSUMERS

Failure to File & Reconcile (FTR) 1-Year Lockout (§155.305(f)(4))

NABIP Position: Support **Reinstatement of the One-Year FTR Standard**

NABIP supports CMS's proposal to reinstate the one-year Failure to File & Reconcile lockout period for Advance Premium Tax Credit eligibility.

Reconciling APTC payments through the federal tax filing process is a core safeguard for ensuring that subsidy amounts accurately reflect household income. The one-year standard provides sufficient time for taxpayers to resolve filing obligations while maintaining accountability for federal subsidy dollars.

Extending the reconciliation window to two years increases exposure to improper payments by allowing individuals to continue receiving subsidies without verified eligibility. Restoring the

999 E Street NW, Suite 604
Washington, DC 20004
www.NABIP.org

one-year timeframe strikes an appropriate balance between administrative feasibility, consumer fairness, and program integrity.

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

NABIP Position: Support **Reinstatement of SEP Pre-Enrollment Verification**

NABIP supports CMS's proposal to reinstate pre-enrollment verification requirements for Special Enrollment Period eligibility and to require verification for a substantial portion of new SEP enrollments.

Our members' experience indicates that pre-enrollment verification is an important safeguard against improper enrollments, fraud, and adverse selection that can destabilize Marketplace risk pools. Confirming eligibility documentation prior to coverage activation helps ensure that Special Enrollment Periods remain available for consumers experiencing legitimate qualifying life events.

As CMS implements these requirements, NABIP encourages the agency to ensure verification processes remain efficient and timely so that eligible consumers do not experience unnecessary delays in obtaining coverage.

Removal of Income Attestation Without IRS Data (§155.320(c)(5))

NABIP Position: Oppose **Elimination Without Alternative Verification Pathways**

NABIP opposes CMS's proposal to eliminate income attestation in cases where IRS data is unavailable without establishing reasonable alternative verification pathways.

Certain consumer populations—including small business owners, self-employed workers, retirees, and lawfully present immigrants—often rely on income attestation when federal data sources do not accurately reflect current-year income. For these groups, prior-year tax filings may not provide a reliable indicator of projected income under the Marketplace's prospective eligibility framework.

Eliminating attestation without practical verification alternatives could create unnecessary barriers to coverage for otherwise eligible consumers.

NABIP encourages CMS to work in coordination with the U.S. Department of the Treasury and the Internal Revenue Service to evaluate whether additional limited indicators could be incorporated into the Federal Data Services Hub to identify whether a prior-year tax return included certain income schedules. Such indicators should be implemented consistent with the disclosure authority provided under IRC §6103(l)(21). Treasury and CMS should explore regulatory, guidance, or interagency agreement mechanisms that would allow the Exchange to receive a simple binary indicator reflecting whether a schedule was filed on the return, without transmitting any data contained within that schedule. These indicators could help identify returns associated with self-employment, pass-through business income, or other non-wage income sources.

999 E Street NW, Suite 604
Washington, DC 20004
www.NABIP.org

Examples of schedules that could be identified through such indicators include:

- Schedule C – Profit or Loss From Business (self-employment income)
- Schedule F – Farm Income
- Schedule E – Supplemental Income and Loss, including rental income and partnership or S-corporation pass-through income
- Schedule SE – Self-Employment Tax
- Schedule K-1 income from partnerships or S corporations

Similar indicators could also identify taxpayers receiving certain non-wage income sources reported through information returns, including:

- Form 1099-R – Retirement plan distributions
- Form SSA-1099 – Social Security benefits

Where such indicators are present, NABIP recommends that applicants be permitted to rely primarily on income attestation when projecting current-year income. These categories of income frequently fluctuate or reflect prior-year activity that may not accurately represent expected income for the coverage year.

Allowing attestation in these circumstances would help Exchanges avoid unnecessary data matching issues while maintaining program integrity and acknowledging the unique income variability faced by self-employed individuals, small business owners, individuals with pass-through business income, and retirees. These limited indicators would not disclose detailed tax return information but would provide Exchanges with sufficient context to evaluate the reliability of prior-year income data while preserving taxpayer confidentiality protections under applicable federal law.

Forward-Looking Policy Consideration:
Retrospective Income & Program Alignment

Beyond the operational concerns associated with eliminating income attestation, NABIP encourages CMS and federal policymakers to consider longer-term structural modernization of Marketplace income verification and subsidy administration.

The current framework relies on projected household income to determine Advance Premium Tax Credit (APTC) eligibility, with reconciliation conducted up to 18 months later through the federal tax filing process. This structure creates persistent data matching challenges, repayment risk for consumers, and administrative complexity for agents, brokers, navigators, and call center representatives who must assist consumers in forecasting income that is often inherently volatile, particularly among self-employed and small business populations.

A longer-term policy alternative, requiring Congressional action, would be to transition from prospective income projections toward a retrospective income verification framework, using verified historical income as the baseline eligibility determinant. Under such a model, structured appeals similar to Medicare's IRMAA process would allow consumers experiencing material income

999 E Street NW, Suite 604
Washington, DC 20004
www.NABIP.org

changes to seek real-time adjustments. This approach would eliminate the need for income forecasting while preserving flexibility for life events.

Additionally, moving toward capitated subsidy payments administered through HHS, rather than tax-based APTC flows through Treasury, could better align Marketplace financing with existing CMS program structures. This shift would improve transparency into the true federal cost of coverage programs, reduce consumer repayment exposure, and alleviate the income quantification burden currently placed on enrollment assisters, allowing them to focus on healthcare coverage guidance rather than tax forecasting.

While such reforms extend beyond the scope of this specific rule, the verification challenges highlighted in this proposal underscore the need for broader alignment between subsidy design, income verification realities, and program administration.

Rising beyond 100% FPL - Income Data Matching Inconsistencies (§155.320(c)(3)(iii))

NABIP Position: Support **Expanded Verification with Strong Consumer Protections**

NABIP supports CMS's proposal to expand Data Matching Issue (DMI) triggers when an applicant reports projected income above 100 percent of the Federal Poverty Level while IRS data reflects prior income below that threshold.

Ensuring that subsidy eligibility determinations align with reliable data sources promotes program integrity and helps prevent situations where consumers unintentionally receive subsidies for which they may ultimately be ineligible.

At the same time, NABIP encourages CMS to ensure that DMI processes include clear consumer notices, reasonable documentation standards, and accessible assistance pathways. Many consumers experience legitimate income fluctuations, and verification processes should be implemented in a manner that protects program integrity without creating unnecessary enrollment barriers.

STATES

State Network Adequacy Oversight Authority Shift (§155.1050)

NABIP Position: Support **Restoration of State Network Adequacy Authority**

NABIP supports CMS's proposal to restore primary network adequacy oversight authority to State-Based Exchanges (SBEs) and their respective Departments of Insurance.

Many states already maintain comprehensive network adequacy standards that reflect local provider supply, rural access challenges, and regional care delivery structures. Allowing states to

999 E Street NW, Suite 604
Washington, DC 20004
www.NABIP.org

administer these standards reduces duplicative regulatory review and administrative burden while restoring alignment with traditional state insurance regulation.

NABIP continues to support a targeted federal backstop where a state demonstrably lacks sufficient adequacy standards or enforcement capacity. However, where states maintain robust oversight systems, primary regulatory authority should remain at the state level.

Removal of SBE-FP 1 yr Requirement (§155.105(b)(4))

NABIP Position: Support **Removal of the Mandatory SBE-FP Transition Year**

NABIP supports CMS's proposal to eliminate the requirement that states must operate as a State-Based Exchange on the Federal Platform (SBE-FP) for one plan year before transitioning to a fully state-operated Exchange.

States have historically transitioned successfully from the Federally-Facilitated Exchange to fully state-operated Exchanges through a variety of operational pathways. Requiring a universal intermediary year introduces unnecessary delay, administrative burden, and cost without clear evidence of improved consumer protections.

While NABIP supports strong readiness reviews and federal approval oversight, states should retain flexibility to determine the most effective transition pathway based on their technological infrastructure, vendor partnerships, and market needs.

Remove SBE Blueprint progress regs

NABIP Position: Oppose **Removal of Blueprint Readiness Verification Authority**

NABIP opposes CMS's proposal to remove its authority to request supporting documentation and implementation evidence from states establishing a State-Based Exchange.

Launching a State-Based Exchange is a complex operational undertaking involving eligibility determinations, subsidy calculations, carrier integrations, and consumer assistance systems. The ability for CMS to request documentation or demonstrations verifying operational readiness helps prevent enrollment errors, subsidy miscalculations, and coverage disruptions.

While NABIP supports efforts to reduce unnecessary regulatory burden, eliminating this oversight tool could weaken important safeguards that protect consumers and Marketplace stability. CMS should maintain the ability to verify Exchange readiness prior to approving new State-Based Exchanges.

SBE-EDE Enrollment Infrastructure Flexibility (§155.205(b)(4)–(5))

NABIP Position: Support **EDE Expansion but Oppose elimination of a Centralized Consumer Enrollment Pathway**

999 E Street NW, Suite 604
Washington, DC 20004
www.NABIP.org

NABIP supports the continued expansion of Enhanced Direct Enrollment (EDE) and recognizes that EDE platforms have become an important infrastructure for broker-assisted Marketplace enrollment. EDE has improved operational efficiency and consumer engagement, particularly for individuals working with licensed agents and brokers.

However, NABIP is concerned with the proposal to allow a State-Based Exchange to rely exclusively on web-brokers for the consumer-facing eligibility and enrollment pathway without maintaining a centralized Exchange-operated enrollment option.

While EDE works well for broker-assisted consumers, an EDE-only model could disadvantage individuals who enroll without an agent or broker, including those relying on Exchange call centers, Navigators, or community assistance programs. A centralized Exchange pathway helps ensure a consistent enrollment experience and provides a reliable support channel when consumers encounter application or eligibility issues.

NABIP encourages CMS to preserve a centralized, Exchange-operated consumer enrollment pathway even where states expand EDE use, ensuring that all consumers have access to a consistent and supported enrollment experience.

Statute and Regulatory Alignment

Statutory Implementation Provisions

Several proposals within this section are intended to bring Marketplace regulations into alignment with statutory provisions enacted through the Working Families Tax Cuts Act, also known as the One Big Beautiful Bill or OB3. Federal agencies within the Executive Branch are responsible for implementing statutes passed by Congress and ensuring that regulatory language accurately reflects the governing law. Where statutory changes dictate program parameters, the role of rulemaking is primarily to clarify operational implementation and ensure that regulatory text appropriately reflects congressional intent. Accordingly, NABIP's comments in this section focus on implementation considerations, consumer communication, and operational impacts rather than the underlying statutory policy itself.

CMS should ensure clear consumer notices, agent/broker/assister training, and transition guidance to minimize confusion during implementation.

No APTC During DMI Verification (WFTC §71303 Implementation)

NABIP Position: Neutral on Statutory Alignment – Request Careful Implementation to Protect Consumer Access and Operational Stability

NABIP recognizes that the proposed eligibility verification requirements are established by statute and appreciates CMS's request for stakeholder feedback on implementation.

999 E Street NW, Suite 604
Washington, DC 20004
www.NABIP.org

Because eligibility verification will now determine when premium tax credits can be applied to coverage, the operational design of these processes will be critical to preventing enrollment delays and consumer confusion.

NABIP encourages CMS to prioritize automated verification through trusted federal data sources before requesting documentation from consumers and to develop pre-enrollment eligibility verification tools that allow applicants, agents, and brokers to confirm eligibility status prior to enrollment.

CMS should also ensure that verification status indicators, documentation submission processes, and security protocols are consistent across both Exchange-operated platforms and Enhanced Direct Enrollment systems. These safeguards will help ensure that the new statutory requirements strengthen program integrity while preserving a smooth and understandable enrollment experience for consumers.

NABIP recommends that CMS prioritize the following operational elements when implementing these statutory requirements:

1. Real-Time Data Verification Before Manual Documentation Requests
Exchanges should prioritize automated verification through trusted federal data sources (IRS, SSA, DHS, and other existing verification systems) before generating documentation requests to consumers. Maximizing real-time verification will significantly reduce the number of Data Matching Issues and prevent unnecessary delays in subsidy eligibility determinations.

2. Pre-Enrollment Eligibility Verification Tools for Agents, Brokers, and Consumers
To meet the statutory August 1 pre-enrollment verification requirement, CMS should implement tools that allow applicants and agents/brokers to confirm income eligibility status prior to Open Enrollment. This functionality should be available through both Exchange platforms and EDE systems so that consumers receive consistent eligibility feedback regardless of enrollment pathway.

3. Clear Verification Status Indicators in Enrollment Systems
Exchange and EDE platforms should display a clear verification status indicator showing whether an applicant's eligibility has been verified, is pending documentation, or requires additional action. This will allow agents, brokers, call center representatives, and Navigators to guide consumers effectively during the enrollment process.

4. Standardized Documentation Request and Submission Processes
CMS should standardize documentation request formats, submission methods, and timelines across Exchanges where possible. Consistent processes will help reduce confusion for consumers and assisters and ensure documentation is submitted correctly the first time.

5. Consumer Notification and Outreach Standards
Verification notices should clearly explain required documentation, submission deadlines, and the

999 E Street NW, Suite 604
Washington, DC 20004
www.NABIP.org

impact on subsidy eligibility if verification is not completed. CMS should also ensure that notices are accessible to individuals with limited English proficiency and individuals with disabilities.

6. Standardized EDE Verification and Security Controls
Because a majority of Marketplace enrollments are facilitated through Enhanced Direct Enrollment (EDE) platforms used by agents and brokers, CMS should establish standardized verification protocols across both Exchange-operated systems and EDE partner platforms. Without consistent requirements, differences in platform workflows could create unintended pathways that allow applicants to bypass or delay required eligibility verification steps. CMS should require EDE partners to implement the same verification checkpoints, eligibility validation processes, and documentation requirements that apply to Exchange-operated enrollment systems, including consistent verification status indicators and standardized documentation submission processes.

CMS should also require multi-factor authentication (MFA) or two-factor authentication (2FA) when accessing or updating consumer eligibility information through EDE platforms, particularly for identity lookups or application retrieval functions, to help protect vulnerable populations that are disproportionately subject to Data Matching Issues (DMIs) and to reduce the risk of unauthorized account access or identity misuse.

Implementing these operational safeguards will help ensure that the statutory verification requirements strengthen program integrity while preserving a smooth and understandable enrollment experience for consumers and the professionals assisting them.

APTC Eligibility Redefinition for Noncitizens (§155.20)

NABIP Position: Neutral on Statutory Alignment – Emphasis on Market Impact Awareness

NABIP recognizes that CMS is implementing statutory changes enacted through Section 71301 of the WFTC legislation and supports aligning Marketplace regulations with governing law.

At the same time, the removal of APTC eligibility for an estimated 1.2 million lawfully present noncitizens may have broader implications for Marketplace participation, regional risk pools, and premium stability in certain markets. These individuals are currently participating in Marketplace coverage and their removal from the subsidized population may affect enrollment dynamics in areas with higher concentrations of impacted consumers.

NABIP encourages CMS to clearly communicate the scope of these changes and provide early transition guidance to agents, brokers, and consumers to ensure affected individuals understand how their eligibility may change beginning in plan year 2027.

Migrants Ineligible for Medicaid Due to Waiting Period Ineligible for APTC (§155.305(f)(2))

NABIP Position: Neutral on Statutory Alignment – Concern for Potential Coverage Gaps

999 E Street NW, Suite 604
Washington, DC 20004
www.NABIP.org

NABIP recognizes CMS's intent to align regulatory language with statutory eligibility requirements and therefore remains neutral on the proposed change.

However, NABIP is concerned that eliminating this exception may create coverage gaps for certain lawfully present individuals who are ineligible for Medicaid due to immigration-related waiting periods and unable to qualify for Marketplace subsidies due to income thresholds.

In particular, elderly migrants without sufficient work history for Medicare eligibility may face limited coverage options if they fall below the Marketplace subsidy threshold. NABIP encourages CMS to clearly communicate available coverage pathways and work with stakeholders to minimize unintended gaps in access to affordable coverage.

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

NABIP Position: Support **Removal of the 150% FPL SEP**

NABIP supports CMS's proposal to remove the 150% Federal Poverty Level Special Enrollment Period from regulation.

While originally intended to expand access to coverage for lower-income individuals, this SEP has been widely associated with improper enrollment practices and has been used by bad actors to manipulate Marketplace eligibility rules. Evidence suggests the provision has been particularly vulnerable to misuse in non-expansion states, where it can function as a workaround to standard subsidy eligibility thresholds.

Because the Marketplace Integrity Rule and subsequent legislation have already paused the SEP beginning in plan year 2027, removing §155.420(d)(16) from regulation is a reasonable step to simplify program rules and reinforce Marketplace integrity.

State Exchange Improper Payment Measurement (SEIPM) Program (State Exchange Audit Requirements)

NABIP Position: Support **efforts to strengthen program integrity but urges CMS to avoid policies that could create federal overreach or disrupt Marketplace stability.**

The proposed SEIPM framework aims to standardize improper payment measurement across state-based exchanges. While program integrity oversight is essential, the proposed structure raises concerns regarding both federal-state regulatory balance and consumer data access standards.

State-based exchanges currently operate under varying governance structures, and requiring application-level data reporting at the federal level may introduce unnecessary risk related to consumer data handling.

NABIP encourages CMS to consider the following implementation safeguards:

999 E Street NW, Suite 604
Washington, DC 20004
www.NABIP.org

- prioritize aggregated reporting structures rather than application-level data transfers where feasible
- ensure compliance with federal data access and privacy standards
- clearly define the scope of federal oversight authority relative to state exchange governance

Additionally, NABIP is concerned about the broader implications of federal authority to withhold Marketplace funding in connection with program integrity investigations.

Recent discussions surrounding potential federal actions related to state program oversight illustrate how such authority could create uncertainty within the Marketplace ecosystem. Withholding APTC payments could have severe consequences for market stability if applied to state exchanges with large enrollment populations.

CMS should ensure that SEIPM implementation prioritizes program improvement rather than enforcement mechanisms that could destabilize coverage markets.

Conclusion

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

As representatives of more than 100,000 licensed health insurance professionals nationwide, NABIP members work daily with individuals, families, and small businesses navigating the complexities of health coverage. This front-line experience provides valuable insight into how policy changes affect enrollees, plan issuers, and the overall functioning of the Marketplace. We encourage HHS, CMS, and CCIIO to continue working closely with NABIP and other stakeholders to ensure that final regulations reflect the needs of consumers while maintaining a strong and viable Marketplace.

NABIP welcomes the opportunity to continue serving as a resource to CMS as the agency refines these policies and develops implementation guidance. We appreciate your consideration of these comments and look forward to continued collaboration to ensure that Marketplace regulations support consumer choice, affordability, and program integrity.

Sincerely,

Michael Andel
Senior Vice President of Governmental Affairs

National Association of Benefits and Insurance Professionals (NABIP)
999 E Street NW, Suite 604
Washington, DC 20004
www.NABIP.org

999 E Street NW, Suite 604
Washington, DC 20004
www.NABIP.org

Acknowledgment of Contributors

The National Association of Benefits and Insurance Professionals (NABIP) would like to recognize the 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 NABIP 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
- John Czajkowski
- David Cook
- Samantha George
- Dee McFarland
- Jesse McDonald
- Robert Mulcare
- Courtney Peterson
- Justin Reinig
- Emily Trevino
- Dustin VanDuine
- Robert Williams
- Rebecca Yates

Citations:

Blumberg, Linda J., Jessica Banthin, and John Holahan. Marketplace Premiums and Competition: 2019–2022. Urban Institute, April 2022.
https://www.urban.org/sites/default/files/2022-04/Marketplace%20Premiums%20and%20Competition%202019-22.pdf
Polsky, Daniel, Michael Richards, Simon Basseyn, et al. "Narrow Networks on the Health Insurance Marketplaces: Prevalence, Pricing, and the Cost of Network Breadth." Health Affairs 36, no. 9 (2017): 1606–1614.
https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.1669