



February 19, 2019

The Honorable Seema Verma
Administrator, Centers for Medicare and Medicaid Services
200 Independence Ave, SW
Washington, DC 20201

RE: 2020 Notice of Benefits and Payment Parameters

Submitted Electronically via www.regulations.gov

Dear Ms. Verma:

I am writing on behalf of the National Association of Health Underwriters (NAHU), a professional association representing more than 100,000 licensed health insurance agents, brokers, general agents, consultants, and employee benefits specialists. We are pleased to have the opportunity to provide comments in response to the proposed rule titled “Patient Protection and Affordable Care Act: Notice of Benefit and Payment Parameters for 2020.”

The members of NAHU work daily to help millions of individuals and employers purchase, administer and utilize health insurance coverage. Over the past eight years since the passage of the Patient Protection and Affordable Care Act (ACA), our members have worked directly and tirelessly with millions of individuals and employers of all sizes to help them obtain new coverage, including coverage through both the individual and Small Business Health Options Program (SHOP) marketplaces. NAHU members also work directly with individuals and employers to help them implement health-plan changes related to the ACA. Ensuring market stability and competition, as well as improving health coverage affordability, are among our top goals. Our comments are organized by regulatory section, and they reflect the views of experts who fully understand the needs and interests of today’s individual and group health insurance consumers.

Timing of the Final Rule

NAHU 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 2020 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 2020 will be limited and there will not be enough time to implement any new requirements.



Changes to Premium Adjustment Factor § 156.130

The proposed rule would change the methodology for the annual premium adjustment factor and allow for the use of data taken from the National Health Expenditure Account data, as opposed to the previous method, which relied on claims data from employer-sponsored health plans. The stated goals of these changes would be to better reflect the historic growth in premiums for all private health insurance options and to lower overall federal costs for premium tax credit payments. In addition to these defined goals, the change will reduce the value of premium tax credits for individual-market consumers, and increase consumer cost-sharing across all private-market plan options. The new method will also impact the amount employers and employed individuals will pay for coverage, and could have an impact on benefit plan options and design.

NAHU members do not have expertise in developing premium-adjustment methodologies, so we cannot comment directly on whether or not this change will produce a more accurate result for consumers over time. However, we do believe that the data used to calculate adjustments should be reflective of actual marketplace costs borne by consumers. We want to express our general concerns about the goal changing the method to specifically reduce premium tax credit payments to consumers. While we support keeping federal costs reasonable, we are concerned that a reduction in the value of the tax credits will have an adverse effect on the number of uninsured individuals. Instead, we would prefer that efforts be directed at lowering the overall cost of medical care rather than forcing consumers to pay more for coverage.

Additionally, we note that if any methodology change is authorized, it will impact the coverage "affordability" rate that is typically released by the IRS each spring. The federal affordability percentage is used by applicable large employers to determine liability under the employer shared responsibility requirements and it helps all employer group plan sponsors, regardless of the size of their group, determine employee premium contribution rates for the year ahead. As such, we urge CMS to work closely with the IRS on the timing of any change and recognize that employer plans rely on the timely release of this data each spring for their annual plan-development processes.

Mid-Year Changes to Drug Formularies §§ 147.106(e)(5), 146.152, 148.122

The proposed rule would allow all insurers and health plan issuers to change their prescription drug formularies mid-plan-year and replace a brand-name drug with a generic equivalent should one be introduced into the marketplace for the first time during the plan-year. This regulatory change would apply to all private-market plans, including fully insured and self-funded employer plans of all sizes and grandfathered plans. The proposal includes a notice requirement for plan beneficiaries, and CMS does plan to require issuers to develop an exceptions process for consumers so that if an individual needs to continue with the brand-name version of a drug for medical reasons, the person could appeal its exclusion from the formulary.



In the proposed rule, CMS solicits comments about the length of time necessary to notify consumers in advance of a formulary change. NAHU notes that employer plan sponsors subject to ERISA will need to follow those existing rules about informing plan participants about a material modification to benefits, such as this one, and suggests that CMS requirements that may apply to other types of plans mirror the existing ERISA rules for expediency purposes. Furthermore, in a final rule, we request a template notification form for issuers and plan sponsors to use and clarification on whether plans will need to distribute new summaries of benefits and coverage to individuals in the case of any such formulary change.

NAHU believes that all plan beneficiaries need to be notified about general formulary changes and the requirements for the related coverage appeals process. However, to make the notification more meaningful and consumer-friendly, NAHU suggests that CMS consider specific notifications for any plan beneficiaries who are currently taking any affected medications with personalized information about the change. Additionally, NAHU feels that the development of a clear, expedient and equitable exceptions process for beneficiaries to utilize will be essential for such a policy requirement, given that individual patients may be prescribed brand-name drugs over generics for a wide range of medical reasons. Cost savings are important, but they should not be at the expense of quality medical care.

Finally, given the scope of applicability of this regulatory change, NAHU asks that CMS consider as to how it will inform all affected plans of their new options and related requirements concerning disclosure and coverage appeals, including what resources it will devote to compliance education and assistance.

Allowing Plans to Eliminate a Brand-Name Drug as an Essential Health Benefit When a Generic Is Available §§ 156.122 and 146.130

To the extent permitted by state law, the proposed rule would allow insurers that cover both a brand-name drug and its generic equivalent to specify that only the generic drug qualifies as a covered benefit under the essential health benefit (EHB) standards. Therefore, advanced premium tax credit payments would not apply to the portion of the premium attributable to the coverage of the brand-name drug. Additionally, any money an individual spends on a brand-name drug would not apply to any annual or lifetime limits that the policy might have for non-essential health benefits. This proposed change would appear to apply to all insurers, including those offering coverage to individuals and large and small employer groups, not just QHP issuers. While large-group insurers do not have to cover essential health benefits, they may not impose lifetime or annual limits on any EHBs they do include.

The proposed rule contemplates two different strategies for handling the application of a consumer's cost for a brand-name drug concerning annual and lifetime cost-sharing limitations. One would be to apply the price the consumer would have paid for a generic version of the drug toward cost-sharing limitations, and the other would be not to count any brand-name drug costs toward a consumer's out-of-pocket



limits. CMS does plan to require issuers to develop an exceptions process for consumers so that if an individual needs a brand-name version of a drug for medical reasons, the person could appeal its application.

NAHU has concerns about this proposed policy because all of the different components of this policy would be very difficult and costly for issuers and group health plan sponsors to administer. Furthermore, we see little evidence that the substantial execution costs and complications would be made up in prescription drug savings. For example, qualified health plan (QHP) issuers would be required to determine a premium amount attributable to the coverage of each brand-name drug and report that to the exchange marketplaces so that it could be excluded from advance premium tax credit payments. However, given the required individual exceptions process, this calculation and reporting would need to be done for each individual every month basis so that people who have a medically necessary need for a specific brand-name drug over a generic equivalent will not receive a tax credit penalty. Timely monthly reconciliation also would be necessary to prevent people who switch prescriptions or no longer need to take a particular brand-name drug from being penalized through a reduced tax credit. This process will be extraordinarily complicated and costly to implement and require administrative effort both at the issuer and exchange level.

Additionally, issuers and administrators of self-funded health plans will be required to develop technology systems to track individual prescription spending and reassign cost-sharing and out-of-pocket expenses on a case-by-case, prescription-by-prescription basis. These systems and the workforce needed to operate them come at a price that will ultimately be borne by policyholders and the taxpayers in higher premiums and related premium tax credit expenditures.

Furthermore, NAHU believes that the development of a clear, expedient and equitable exceptions process for beneficiaries to utilize will be essential for such a policy requirement, given that individual patients may be prescribed brand-name drugs over generics for a wide range of medical reasons and cost savings should not be at the expense of quality medical care. However, we caution that the creation and execution of a new exceptions process like this will come with both monetary and human capital costs for health insurance issuers and employer group health plan sponsors.

The proposed rule asks if this proposal should be a requirement rather than an option for issuers. NAHU feels very strongly that CMS should contemplate if this proposal would indeed yield any significant cost savings and produce any evidence to that effect before finalizing this portion of the rule. If this policy is finalized, the proposed change should be at the option of the issuer or self-funded plan sponsor.

Additionally, CMS solicits comments as to whether states should have authority over the treatment of generic versus brand-name drugs and their relationship to the essential health benefits requirements. Given the current state-level base benchmark standards for the determination of essential health benefits



and the general primacy of state law over the business of insurance granted by the McCarran-Ferguson Act, we believe that state authority, requirements, and existing and future laws would need to be taken into consideration.

Given the scope of applicability of this regulatory change, if it is adopted, NAHU asks that CMS consider how it will inform all affected plans of their new options and related requirements concerning disclosure and coverage appeals, including what resources it will devote to compliance education and assistance. NAHU also asks that CMS consider how this proposed change might impact employer plans and the "credibility" of their prescription drug offerings as compared to the average Medicare Part D plan and related employer disclosures to both CMS and plan beneficiaries.

Prescription Drug Coupons/Accumulator Adjustment Program §156.130

The proposed rule would allow insurers to refuse to count toward out-of-pocket limits any amounts paid by consumers for brand-name drugs if the plan also covers a generic equivalent and the consumer receives any assistance or coupon from the drug manufacturer to reduce or eliminate their out-of-pocket expenses for the brand-name drug. NAHU opposes this change for several reasons.

While we understand that the practice of drug manufacturers subsidizing consumer costs for brand-name drugs does, in many cases, keep prescription drug costs artificially and often unreasonably high, the policy change in the proposed rule does nothing to target the real source of the problem—the drug manufacturer. Instead, it targets consumers merely for having a medical condition that requires treatment through a high-cost prescription drug. As we have already noted, there are a wide range of reasons why a person might be prescribed a brand-name drug over a generic, including differences in the ways the two drugs are metabolized or different binders in the various medications that might make a difference in efficacy for a particular individual. If individuals need a brand-name drug for better treatment of their condition, then they should be able to take advantage of all possible coupons or discounts if those things are available to them without suffering other financial harm. If CMS objects to the existence of manufacturer cost-sharing assistance programs, it should address them at their source.

Additionally, NAHU believes that this policy change would be costly and administratively cumbersome to implement. Just the existence of a cost-sharing assistance program or the availability of a coupon does not mean that an individual actually will use it. Insurers and self-funded plan administrators would have to develop a means of tracking each beneficiary's use of cost-sharing assistance, which would be costly. It is also not clear that the required information would be readily available in many cases, and unless the data can be compiled consistently, accurately and promptly for all beneficiaries, the program could be deemed discriminatory.

The proposed rule solicits comments as to whether states should have authority over the treatment of prescription drug discounts and coupons. NAHU opposes this policy idea generally, but we also believe



that state requirements and existing law would need to be taken into consideration. The proposal also asks if this policy should apply to all plans or just QHPs. NAHU opposes this idea for all plan options and sees no reason why our practical objections would not apply just as strongly to QHPs as they do to all commercial plan options.

Requirement That QHP Issuers Offering Non-Hyde Abortion Coverage Offer Coverage Omitting Abortion Services as Well § 156.280

The proposed rule would require issuers that offer QHPs that include coverage of abortion and related services that are not financed with federal monies, as required by the Hyde Act, to also provide consumers the choice of a comparable QHP option that does not include coverage of abortion and related services. In the preamble, CMS specifically solicits comments as to whether health insurance agents and brokers and direct-enrollment agencies should have to adhere to standards for displaying both types of plan options to consumers. The proposed rule also asks what requirements should be put into place to limit the confusion of consumers who may not carefully review the differences between QHP options.

Licensed and exchange-certified health insurance agents and brokers are already required by existing state laws, market-conduct standards, exchange requirements, and issuer contracts to present individual insurance consumers with the full range of products available to them and to explain the details of all of these policy options. As such, NAHU feels that additional requirements regarding the display of specific types of products are superfluous. Furthermore, if CMS wants to help consumers overcome any potential confusion about policy options, we believe the agency should do everything in its power to encourage consumers to use a licensed and exchange-certified health insurance agent when purchasing a QHP.

SHOP Toll-Free Hotline § 155.205

NAHU supports the proposed change that would eliminate the requirement that SHOP exchanges maintain a fully staffed call center but instead merely require the maintenance of a toll-free hotline to serve consumers.

New Special Enrollment Period § 155.420

NAHU supports the proposed addition of a special enrollment period for individuals who experience a reduction of income and had minimum essential coverage in place for at least one of the past 60 days before the change in financial circumstance. Since so many people are self-employed in today's economy and may not have access to employer-sponsored coverage, we think this new SEP will provide meaningful access to coverage and premium tax credit subsidies. However, NAHU cautions that verification of eligibility for this SEP may be challenging and requests more information from CMS as to what documentation will be required.



Cost-Sharing Transparency §155.220(d)

NAHU strongly supports the principle of helping consumers make more informed purchasing decisions through the greater transparency of healthcare price and quality information. However, we question the usefulness of requiring insurers to ex-post-facto disclose estimated costs for services beyond what is already disclosed to plan participants through the explanation of benefits statements. NAHU members believe that there would be high associated administrative costs with producing such cost estimates, which will ultimately be passed on to consumers in the form of higher premiums. Furthermore, since this information will not come to individuals at the point of care, NAHU members doubt that the data will be of much use to beneficiaries and will have little impact on purchasing and care decisions, particularly for one-time care events. If CMS were to pursue requiring issuers to disclose costs to consumers for standard services, we suggest that it focus on requiring cost estimates that are specific to the consumer, particularly if the consumer has a chronic medical condition.

An alternate idea that CMS may wish to explore for the commercial health insurance marketplace is the one it is already considering for Medicare beneficiaries regarding their prescription drug coverage expenses. CMS is considering proposed changes to e-prescribing standards that will ultimately allow Part D plan participants to get real-time, personally specific prescription drug cost information at the time of care. Perhaps this kind of point-of-care transparency could ultimately reach other health plan beneficiaries as well. If covered individuals and their providers have more opportunities to transparently discuss the prices of various care options while examining each option's efficacy, then patients and providers will be able to make fully informed treatment decisions.

Beyond the transparency questions posed in the rule, NAHU encourages CMS to continue to look for other opportunities to promote the disclosure of data to consumers, particularly regarding the quality of service provided. Bending the cost curve is critical to ensure access to care long-term, but the cost of services should only be one factor in an informed decision about health plan and provider selection. Individual consumers need additional education and resources to help them determine the weight to give price, quality and other factors when making specific medical-care decisions. The public release of more data about the efficacy of healthcare providers and institutions will also spur market advances to help consumers access high-quality care that meets all of their personal needs at the best possible price.

The proposed rule also asks what CMS could do to encourage the sale of more high-deductible health plans paired with Health Savings Accounts. As you know, under federal law, a prerequisite for a taxpayer to contribute to an HSA is their coverage through a high-deductible health plan (HDHP) as defined in IRC § 223(c)(2). That statutory requirement states that an individual's deductible and maximum out-of-pocket costs must be two times the amount of self-only coverage. However, during the Obama Administration, HHS, along with the Departments of Labor and Treasury, released guidance known as PPACA FAQ 27 questions 1-3, which prohibited application of that statutory requirement. The result has been market confusion as to what constitutes an HDHP on the part of regulators, employers, and insurers.



The inconsistent and confusing implementation of this FAQ by issuers has created the very cumbersome market phenomenon known as an "embedded deductible" and made HDHPs combined with HSAs a much less consumer-friendly market choice. It has also negatively impacted the cost paid by consumers for these plans. To improve the market viability of HDHPs and HSAs, NAHU recommends that HHS, Labor, and Treasury rescind the guidance contained in FAQ 27 questions 1-3 and that the Trump Administration encourage Congress to address the gap between the HDHP requirements and the PPACA's mandates for out-of-pocket limits.

Navigator Requirements §§ 155.210 and 155.215

The proposed rule would make it optional, rather than mandatory, for health insurance exchange navigator grant recipients to provide post-enrollment support to health insurance exchange enrollees. NAHU supports this specific change, as we have never believed it appropriate for navigator program participants to provide post-enrollment support to health insurance consumers given that they are not licensed or subject to privacy requirements. However, NAHU has historically been very concerned about the quality of information provided to consumers by navigators, given that navigators generally are not subject to market-conduct, and continuing education requirements. As such, we are not sure that reducing the content of navigator training, which is also proposed in the rule, would be in the best interest of consumers. Even if navigators do not provide individuals with post-enrollment support, that does not mean that they would not benefit from a greater understanding of health insurance processes and advance premium tax credit procedures.

Provisions Related to Web-Brokers and Direct-Enrollment Entities §155.221

The proposed rule would formally differentiate between licensed health insurance producers, classified as agents, brokers, and web-brokers, and direct-enrollment technology providers. Under current regulations, web-brokers and the technology providers that facilitate direct-enrollment services are conflated. NAHU appreciates the distinction that unlicensed technology entities, which can either be owned by licensed producers or simply provide contracted services to licensed web-brokers, are different from state-licensed health insurance producers.

Concerning the requirements for health insurance issuers and web-brokers that elect to serve as direct-enrollment entities, NAHU supports the requirements that prevent these entities from displaying QHP options to consumers in a way that is based on the amount of compensation an entity may receive from a QHP issuer. However, NAHU notes that the proposed rule does not address preferential displays or other steering based on compensation or consideration a direct-enrollment entity may receive from healthcare providers or provider networks. Steering individuals to QHPs that only cover, or preferentially cover certain healthcare providers or healthcare systems, is a market-based problem and consumer-protection concern that NAHU believes warrants regulatory attention.



Additionally, NAHU has significant concerns with the proposal to allow direct enrollment entities to allow unlicensed application assisters to help individuals purchase QHP coverage and apply for premium tax credit subsidies. While the proposed rule stipulates that these assisters would be required to complete a certification program similar to the one required of exchange-certified health insurance agents and brokers, these individuals would not be subject to a host of other state and federal requirements that are essential for consumer protection. For example, it is unclear if these individuals would be subject to federal and state requirements to protect the privacy of consumers' identifying information. Additionally, these individuals would not be subject to conflict-of-interest requirements and could potentially steer individuals to inappropriate products. Finally, unlike licensed health insurance agents and brokers, assisters may not hold professional liability insurance to protect consumers against enrollment errors.

NAHU believes that an exchange certification program should always be viewed as a supplement to state-level producer licensure and accountability standards. Certification can in no way be a replacement or an acceptable alternative for licensure should an individual working or volunteering for a navigator entity cross the threshold of what triggers the need for producer licensure in all states today—soliciting, selling or negotiating insurance.

Laws on producer licensure are incredibly consistent from state to state, as the federal Gramm-Leach-Bliley Act (GLBA) enacted in 1999 essentially mandated uniformity. In every state today, a producer's license is an individually held license. What triggers the need for an insurance producer's license is not how an individual is compensated, whether they are paid a commission or a salary, where they work or their job title. Instead, the consistent trigger is the individual's actions: Anyone working or volunteering for a professional entity that sells, solicits or negotiates an insurance product must have a producer's license.

The terms "sell," "solicit" and "negotiate" are used virtually uniformly in all state licensing statutes as they are all based in whole or in part on the NAIC Producer Licensing Model adopted in 2000 in response to the GLBA requirements. These terms are defined in the NAIC Producer Licensing Model as:

"Sell" means to exchange a contract of insurance by any means for money or its equivalent on behalf of an insurance company.

"Solicit" means attempting to sell insurance or asking or urging a person to apply for a particular kind of insurance from a particular company.

"Negotiate" means the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms or conditions of the contract, provided that the person engaged in that act either sells insurance or obtains insurance from insurers for purchasers.



It is NAHU's view that anyone who facilitates enrollment in qualified health plans would likely trigger the existing standard for state producer licensure. Further, we believe that there is absolutely no reason to exempt individuals who work for or with a direct-enrollment entity from existing state consumer-protection laws if they trigger the standard for producer licensure. Ensuring licensure will ensure adherence to market-conduct standards so that all individuals who help consumers will be required to present all QHP options to consumers fairly and to operate without conflicts of interest. Requiring that direct-enrollment entity application assisters be licensed as producers in the state if they advise consumers on health plan options is also the most expedient way to ensure that all health insurance exchange clients receive equal protection of their private financial and health information. Individuals assisting in qualified health plan enrollment would have access to a great deal of sensitive identifying information, such as Social Security Numbers, tax and income information and other health and financial information protected under federal law by both GLBA and HIPAA. Licensure provides each state with a means of tracking all individuals who have access to this protected information and hold them legally accountable for ensuring its security.

Beyond our view that all individuals who help consumers purchase QHP products and apply for premium tax credits should be licensed, NAHU feels that the requirements outlined in the proposed rule for web-brokers and direct-enrollment entities for any agents and brokers who represent their organizations should be extended to direct-enrollment assisters as well. This would include parity in the requirement that any web-broker provide CMS with a list of agents who will be enrolling individuals using the entity's website and allowing CMS to terminate or suspend an agent's ability to transact information for the exchange for cause so that it applies to assisters too.

Greater Flexibility for Web-Brokers to Work with Assistors, Application Counselors and Navigators §155.225

The regulation proposes numerous ways to make it simpler for assistors, application counselors and navigators to work with web-brokers and direct-enrollment entities and asks for comments about a range of ideas to improve the interactions between these entities. As we have previously expressed, our organization has significant concerns about the appropriateness and legality of unlicensed individuals making plan recommendations to consumers. As such, we oppose the proposition that unlicensed assistors, application counselors and navigators could use web-brokers and direct-enrollment technology to advise consumers about what plan options to select, and believe that web-brokers should be prohibited from making plan recommendations or prioritizing plan options on their websites if they are to be used by assistors. NAHU also would support a mandatory certification process for web-brokers to ensure that they are compliant with all requirements, and we support HHS maintaining a public listing of all certified web-brokers so that the public can readily identify certified entities. If a web-broker does not offer all QHP options available in a geographic area, then NAHU believes that a brief statement to that effect should be prominently displayed on all pages or screens of its web interface. Finally, just as web-brokers are prohibited from preferentially displaying plan options on the basis of compensation from



issuers, NAHU believes that web-brokers should be banned from displaying plan options in any way that shows preference to a particular provider or network of healthcare provider entities.

Cost-Sharing Reductions and Silver-Loading

The proposed rule does not make any changes to the current CMS policy of allowing health insurance issuers to increase prices for silver level policies to account for lack of federal reimbursement for required cost-sharing reductions. However, the preamble to the regulation solicits comments on this lack of policy change and suggests that CMS might change its policy on silver-loading in the future. NAHU strongly supports CMS's current policy stance, as it has enabled health insurers to continue to serve individual-market consumers. Without this policy, NAHU believes that individual-market stability will become far more precarious. While we certainly would prefer that the cost-sharing reduction costs not being passed down to consumers, in many geographic areas, without silver-loading, it would be difficult to ensure that all counties in the United States have at least one individual market carrier to serve exchange-based consumers. In the absence of Congressional action to fully fund cost-sharing reduction payments to issuers, NAHU urges CMS to continue to allow for private health insurance market adjustments to compensate for this expense and help ensure individual market choices and stability.

Reference-Based Pricing

In the proposed rule, CMS notes that reference-based pricing could be employed to reduce prescription drug costs and seeks comments on potential risks and opportunities associated with either implementing or incenting its use. Reference-based pricing is defined in the rule as a commercial issuer covering a similar group of drugs up to a set price, with the enrollee paying the price difference if the enrollee elects a prescription that exceeds the reference price. According to this CMS definition, the issuer would have the discretion to set the reference price for each class of drugs.

Reference-based pricing is certainly one strategy that can be used to help control prescription drug spending. NAHU believes that CMS would be wise to study the various ways group benefit plans are already employing reference-based pricing before acting on regulatory requirements or incentives. Furthermore, NAHU cautions CMS against defining reference-based pricing explicitly before actually engaging in any formal regulatory activity concerning this practice, as premature definitions can be limiting.

Redeterminations and Reenrollment

The proposed rule does not make any changes to current policy concerning coverage redeterminations and reenrollment, but it does solicit comments about this process. NAHU urges CMS to reconsider its policies on marketplace redeterminations and reenrollments and strongly suggests that auto-reenrollments be prohibited. While NAHU recognizes the need to keep people continuously enrolled in coverage to prevent adverse selection, we do not think that reenrollment in coverage should be at the expense of an individual's choice in coverage options. We question the appropriateness of CMS's current



practice of reassigning people into new binding insurance contracts, particularly when this can involve significant cost and tax consequences for the enrollee. If an individual's current coverage option is no longer available through the marketplace, then we believe that CMS should make direct contact with the consumer and obtain consent before passively placing the individual in a new health insurance coverage option.

The decision about what is most important to a customer regarding coverage choices—metal level, carrier, provider network, premium prices, cost-sharing expenses, tax credit implications—is highly personal. What a customer desires or what is most appropriate for the consumer could change from year to year. It is not suitable for the federal government to make health-plan decisions on a customer's behalf, even if the marketplace ascertained "preferences" for such a decision ahead of time, such as during the initial exchange enrollment process. A wide range of studies show that individual exchange consumers would likely be better off if they shopped annually for a new policy or at least actively reviewed their coverage options with a professional, but they often do not do so. CMS has been perpetuating this problem by placing consumers into new policies based on a government-designed hierarchy with no guarantee that it yields the best or even an appropriate coverage choice for the consumer. In fact, NAHU members report that consumers that have been auto-reenrolled represent the single greatest source of coverage errors that independent agents see. Reenrolled consumers often turn to independent agents in desperation for help and resolving the confusion auto-enrollments, and redeterminations cause wastes tremendous amounts of time. It also usually ends with an uninsured person for the rest of the year.

NAHU urges CMS to discontinue its policies of reenrollments and redeterminations. If CMS decides to retain the system of reenrolling individuals in exchange policies and making coverage redeterminations, then NAHU requests that the broker of record associated with that marketplace account be notified of the reenrollment or redetermination at the same time as the consumer so that the agent can proactively address any issues.

We sincerely appreciate the opportunity to voice our viewpoint on the proposed rule, as well as your commitment to gathering the views of all stakeholders about these critical topics. If you have any questions about our comments, or if NAHU can be of assistance as you move forward, please do not hesitate to contact me at either (202) 595-0639 or jtrautwein@nahu.org.

Sincerely,

Janet Stokes Trautwein
CEO
National Association of Health Underwriters