November 12, 2024

The Honorable Chiquita Brooks-LaSure
Administrator, Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Submitted electronically via www.regulations.gov

RE: CMS-9888-P

Dear Ms. Brooks-LaSure:

I am writing on behalf of the National Association of Benefits and Insurance Professionals (NABIP), formerly known as NAHU, which is an association representing over 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 2026," which was published in Volume 89, No. 197 of the *Federal Register* on October 10, 2024.

The members of NABIP work on a daily basis to help millions of individuals, Medicare recipients, and employers purchase, administer and utilize health insurance coverage. Ensuring market stability and competition, as well as improving health coverage affordability, are among our top goals. NABIP greatly appreciates the willingness of HHS and CMS to hear from stakeholders on this important regulation, which covers such a wide array of these health-policy issues. This letter was developed by a group of agents and brokers who routinely work with consumers seeking individual health insurance coverage, including through federal and state exchanges. Their coverage will be significantly affected by the proposed rule changes.

Separate from these proposed provisions, we support the widespread recommendation that CMS implement multiple-factor authentication (MFA) within the Federally-facilitated Marketplace (FFM) to prevent the majority of unauthorized coverage changes that are occurring within the Federal Exchange. We appreciate the steps that CMS has taken already to introduce further security into the marketplace enrollment process, including the association requirement, three-way call requirement, and the ongoing monitoring already highlighted here. Implementing the multi-factor authentication within the Direct Enrollment (DE) and Enhanced Direct Enrollment (EDE) platforms would most efficiently and effectively address this issue, minimizing the negative impact on consumers and the resources required from CMS to institute security.

Suspension Authority against Noncompliant Agents and Agency-Level Enforcement — 45 CFR § 155.220(k)(3)

The proposed rule addresses the very serious criminal acts of utilizing broker credentials on the Federally-facilitated Marketplace (FFM) to switch consumer's plan choices without their knowledge, with the intent to collect a commission from the individual's new insurance issuer. NABIP greatly appreciates CMS's actions to eliminate these bad actors from the FFM and to protect vulnerable consumers from switching their health insurance plans. The proposed rule would expand CMS's authority to address illegal actions perpetrated by both individual agents and brokers and responsible agencies.

Our detailed comments on these proposals are delineated below, but in addition to taking action in this area, NABIP suggests that the Healthcare.gov enrollment platform implement multiple-factor authentication (MFA) within the FFM as soon as possible. We understand CMS plans to introduce this user identity validation methodology early in 2025, and our association believes this strategy, which is utilized by health insurance issuers and state-based exchanges, will prevent the majority of unauthorized plan changes that are occurring within the Federal Exchange. Beyond increased identification security measures, NABIP suggests that CMS review and improve upon its existing special enrollment period (SEP) verification strategies. It is our observation that many of these actors are exploiting unverified SEPs as the justification for unauthorized plan switches, and by providing more strenuous checks on the veracity of SEP status, it will reduce the current system's vulnerability and prevent plans switching without consumers' consent and agents and brokers knowledge.

To further clarify, our association believes that the practice of "plan switching" is being carried out by a small group of unethical companies taking advantage of gaps in the enrollment application process. Each licensed health insurance agent or broker is given a National Producer Number (NPN)—a unique identifier used to track their licensing, compliance, and activities within the industry. To be correctly linked to an insurance application, this NPN should belong to an individual who has completed the marketplace's annual FFM certification and registration, contracted with carriers in order to represent the marketplace plans. However, some brokers are using an "NPN override" feature to enter the NPN of the agency principal instead of their own. As a result, the Form 834 enrollment file sent to the insurance carrier reflects the agency head's NPN, crediting them instead of the individual broker who actually helped the consumer. In private Medicare's (i.e., Medicare Advantage, Medicare Advantage Prescription Drug plans, Part D Prescription Drug Plans) presentation and sale process, only individual NPN is permitted, to ensure the correct broker receives credit. NABIP recommends that CMS adopt this same standard within the Federal Exchange by verifying that only individuals with proper certification are using their own NPNs during the broker certification process and enrollment process, with transparency and accountability.

Regarding the specific proposed changes to FFM, the proposed rule clarifies HHS's authority to suspend an agent's or broker's ability to participate in the Exchange in instances where HHS discovers actors' lack of compliance with established standards of conduct. NABIP supports HHS' position that consumer protection is of utmost importance in the plan enrollment process.

NABIP requests that additional transparency and urgency be incorporated into CMS' investigation processes. In communications to investigated parties, we request a clearer explanation of the "unacceptable risk" posed to consumers and ask CMS to improve their investigation process to more quickly clear or confirm agents and brokers of wrongdoing, so that brokers who are cleared of any wrongdoing can promptly resume serving FFM consumers. Actors suspected and found guilty during the investigation process should be barred from the Marketplace.

Currently, our membership reports that the process of removing a suspended agent's NPN from a case is challenging, with no timely notifications of such bad acts having been committed. NABIP also encourages the FFM to coordinate with state insurance regulators regarding conduct issues, and take actions to uphold the health insurance program's integrity.

In addition, should an agent who works for an insurance agency be found committing FFM conduct infractions, we request that CMS provides clear guidance and a transition process for the insurance agencies to remove offending agents and brokers from consumers' applications, so that these clients can be served by another upstanding agent or broker.

The proposed rule would extend CMS authority in these cases, so that "lead agents"—the directors or officers of broker agencies—could be held accountable for the actions of the individual agents or brokers working under the agency per contractual agreements. NABIP supports CMS' focus on addressing bad actors at both the individual and agency levels. Given the complexity of upline/downline structures within agencies, that include agents, brokers, support staff, contractors, and third-party affiliates, it is essential to clarify whether a compliance issue within a single downline could trigger penalties for the entire upline network that may impact all consumers working with one particular agency. Clear compliance guidelines would provide essential protection for consumers, as well as the professionals that support them.

Additionally, we request that CMS be transparent and establish clear guidance and processes about reporting complaints. Multiple press releases from CMS have cited statistics surrounding the number of reported complaints[1] and how many cases were resolved to thwart bad actors. These reports failed to report the significant role that ethical brokers have been playing in reporting fraudulent activities and safeguarding consumers by fulfilling our ethical duties according to our insurance requirements per state regulations. As a result, the reputation of all agents and brokers is negatively impacted by CMS' public messaging.

Expanding the Model Consumer Consent Form—42 CFR 600.320(c)

NABIP appreciates that CMS listened to stakeholders, including our members, regarding the need to improve the model consumer consent form that CMS-certified agents and brokers can use with their clients who are seeking coverage and coverage updates through the FFM. The update will increase transparency, accuracy, and accountability in the application and

[1] CMS Update on Actions to Prevent Unauthorized Agent and Broker Marketplace Activity. October 2024.

enrollment process, and NABIP supports the changes to the model form as a voluntary resource for agents and brokers to adopt.

Initial Warning to Tax Filers—45 CFR § 155.305(f)(4)
NABIP members support that all exchanges should be required to send annual notices to advance premium tax credit (APTC) recipients who fail to reconcile their APTC. This annual requirement would address long standing concerns about tax errors that may translate into incorrect APTC calculations and the related financial repercussions. We welcome CMS to advise consumers to file taxes returns timely by consulting with tax professionals for further advice.

More Flexibility on Premium Payment Thresholds—42 CFR 600.320(c)
CMS proposes to give insurers two additional options (fixed and premium-percent thresholds) to help individuals triggering a coverage termination grace period when an enrollee fails to pay the complete premium by a *de minimis* amount. The proposed rule also clarifies the termination thresholds permissible under the existing option. NABIP members appreciate CMS' efforts to further expand on the established thresholds.

Addressing Codification of Allowable Silver Loading—45 CFR § 155.420(b)
The proposed rule requests public comment on whether to codify previous guidance indicating that certain silver-loading practices are allowed when the adjustments are reasonable, adequately justified, and follow state law. When making plan selections, a consumer is encouraged to make a decision based on their health care needs, copay vs. deductible, coinsurance, medication costs and maximum out-of-pocket expenses. 5.5 million Federal Exchange consumers pay full premiums with $0 subsidy, with maximum out-of-pocket costs for individuals $9,450 and families $18,900 in 2024. Solely basing subsidized monthly premiums after tax credits, and/or the cost sharing reduction (CSR) as financial assistance, as stated in many marketplace advertisements and reports, incorrectly reports the number of consumers enrolled into a $10 or less premium plan after tax credit. A revised, more realistic calculation amounts to 9.4 million consumers (44% of consumers), not 4 out of 5 consumers as previously reported.[2] Consumers have the choice to apply for premium tax credits (PTCs) to cover all or part of their premium costs and lower other costs for a plan of choice considering risk of health care needs when using the plan at the point of care.

Given CMS' initiative in expanding FFM plan to consumers who do not qualify for State Medicaid programs into the marketplace, we request public access to sub-population plan enrollment data and its impacts to the overall marketplace consumers plan of choice.

Standardized Plan Options and Non-Standardized Plan Option Limits
CMS proposes to update standardized plan options for plan year 2026 to ensure these plans continue to have actuarial values (AVs) aligned with the plan's metal ("bronze," "silver," "gold," or "platinum") level. CMS also proposes requiring issuers to offer multiple standardized plan

[2] Affordability and Choice Anchor Biden-Harris Administration's Launch of Window-shopping for 12th HealthCare.gov Marketplace Open Enrollment. October 2024.

options within the same product network type, metal level, and service area. NABIP supports this proposal, as it will allow for increased customer choice.

The proposed measure would also codify the flexibility issuers have to vary whether they include coverage for adult dental, pediatric dental, and adult vision benefits under their non-standardized plan options. We argue that non-standardized plans will create additional confusion for consumers. NABIP has received the feedback from both consumers and providers that the dental benefits currently offered in some plans are not sufficient in quality, including little coverage provided.

Another challenge we face is that the standard plans are tiered based on premium subsidy and cost sharing reduction (CSR), therefore, any changes in income reported during the plan year can significantly impact consumers premium and benefits even if remaining in the same health plan. We call for clarity in within the FFM, DE and EDE platform to display all plan options available for consumers to make the choice to remain on the current plan and pay the premium, instead of having to change plans in the middle of the plan year, incurring additional out-of-pocket expenses if the standards plans become no longer available to them.

Essential Community Providers (ECPs)
ECPs typically serve people with low-income or traditionally unmet medical needs. Beginning in plan year 2026, CMS proposes to conduct reviews of Qualified Health Plans (QHPs) in FFMs in states performing plan management functions to ensure issuers include in their provider networks a sufficient number and geographic distribution of ECPs. NABIP supports this proposal. However, we do recommend that CMS revisits and refines the time and distance standards they currently use to assess network adequacy. Additionally, network adequacy standards should consider not only a provider's presence in the network but also their accessibility, including how quickly the provider can actually see new patients.

State-Based Exchange Transparency
NABIP members support the proposal to increase transparency and promote program improvements by publicly releasing the annual State-based Marketplace Annual Reporting Tools and accompanying financial and programmatic audits (for State Marketplaces and State-based Marketplaces on the Federal Platform), as well as additional data points for all Marketplaces.

Information Sharing
This measure would have CMS start sharing aggregated, summary-level information publicly on an annual basis starting January 1, 2026 (with data submitted during the 2025 QHP Application Period). NABIP members strongly support this proposal, as it would increase public transparency and accountability for QHP issuers and encourage best practices for improving health care coverage quality.

Federal Exchange User Fee Rates
The proposed rule would increase the FFM user fee rate to 2.5% of monthly premiums and the State-based Marketplace on the Federal platform (SBM-FP) user fee rate to 2.0% of monthly

premiums, subject to the contingency below. However, the proposal indicates if enhanced PTC subsidies are extended through the 2026 benefit year by March 31, 2025, the 2026 FFM user fee rate and the 2026 SBM-FP user fee rate would be within a range between 1.8% and 2.2% of total monthly premiums for the FFM, and would be set within a range between 1.4% and 1.8% of total monthly premiums for SBM-FP.

NABIP members note that health insurance coverage is already extraordinarily expensive for many consumers, per 2025's affordability measure of 9.02% of one's household income, creating the most significant barrier to healthcare access. We believe CMS should take all necessary steps to avoid increasing exchange user fees. Further, given that CMS cannot accurately predict 2026 plan rates, given the uncertainty over extended subsidies, we suggest that CMS postpone finalizing any fees until early in 2025, when the new Congress' decision regarding enhanced premium tax credit subsidies becomes known.

Risk Adjustment Fee

The proposed rule contains a risk adjustment user fee for the 2026 benefit year of $0.18 per member per month, which is the same fee rate used for the 2025 benefit year. NABIP members believe risk adjustment is critical to the health of the marketplace, but we note that all such fees are ultimately borne by the consumer.

Actuarial Calculator[3]

Noting that few stakeholders ever provide substantive comments when CMS has historically released draft changes to its annual actuarial value calculator, CMS proposes to only publish a single, final version of the calculator each plan year. To ensure that public feedback is still considered, the proposal would allow public comment on the calculator after its annual release and constructive feedback would be incorporated into the following year's version. Given the lack of public feed-back on the calculator to-date, NABIP members support this proposal.

Clarifying the Timeliness Standard for State Marketplaces to Review and Resolve Enrollment Data Inaccuracies

CMS proposes to formalize guidance for state-based exchanges on requirements to review and resolve enrollment data inaccuracies received from issuers. NABIP members agree that enrollment inaccuracies can easily lead to access issues for consumers. Accordingly, we support CMS's proposed efforts to mitigate enrollment issues using state-based exchange models.

Reconsidering Denied QHP Certifications

Beginning with the 2026 plan year, CMS proposes that the Marketplace be able to deny certification to any plan that does not meet applicable criteria, while at the same time refining standards for issuers to submit written requests for reconsideration of a certification denial. NABIP supports this proposal.

[3] Affordable Care Act Estimator Tools. October 2024.

Basic Health Program (BHP) Updates—42 CFR 600.320(c)
NABIP members support the two changes proposed to the Basic Health Program (BHP). The first would recalculate the payment adjustment factor if a state is using the premiums from a year in which BHP was only partially implemented as the basis for their federal BHP payments, which should result in more accurate federal BHP payments to states newly implementing a BHP. The proposed rule would also clarify how to calculate BHP payment rates when there are multiple "second lowest cost silver plan premiums" in a county.

Reducing the Rate Insurer Insolvency
When health insurance issuers become financially insolvent, consumers lose out on critical health coverage options. Accordingly, the proposed rule seeks comment on ways to reduce the risk of issuer insolvencies. NABIP members believe that keys to mitigating insurer insolvencies are appropriate rate approval processes and adequate spreading of risk throughout the entire marketplace, so that no one issuer bears too large of a burden. To help reduce the number of insurers with solvency issues, NABIP believes that CMS can help by ensuring adequate risk spreading in FFM states and working to build a competitive marketplace. In addition, we would suggest increasing coordination with State Departments of Insurance and the National Association of Insurance Commissioners to identify issuers that are at risk before issues arise.

We truly appreciate the opportunity to comment on this draft regulation, as well as your willingness to consider the viewpoints of all stakeholders. If you have any questions or need additional information, please do not hesitate to contact Michael Andel, Vice President of Government Affairs, at mandel@nabip.org.

Sincerely,

Michael Andel
Vice President of Government Affairs
National Association of Benefits and Insurance Professionals