January 27, 2022

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

RE: CMS-9911-P

Dear Ms. Brooks-LaSure:

I am writing on behalf of the National Association of Health Underwriters (NAHU), a professional association representing over 100,000 licensed health insurance agents, brokers, general agents, consultants, and employee benefits specialists. We are grateful to have the opportunity to comment on the proposed rule titled "Patient Protection and Affordable Care Act: Benefits and Payment Parameters for 2023" and published in the *Federal Register* on January 5, 2022.

The members of NAHU work daily to help millions of individuals and employers of all sizes purchase, administer, and utilize employee benefit plans. Since the passage of the Affordable Care Act in 2010, our members have been helping clients with everything from enrolling individuals in exchange-based coverage to assisting group plan sponsors with complex ACA compliance issues. As such, our association has a strong interest in many of the issues addressed in the proposed rule, and we appreciate your consideration of feedback from stakeholders. Our comments were informed by consultations with members who specialize in ACA markets and compliance issues. For your convenience, they are broken out by topics.

Guaranteed Availability of Coverage and Past-Due Premiums

The proposed rule would prevent issuers in the individual and group marketplace from applying premium payments made for new coverage to any outstanding debt owed from any previous coverage. It would also prohibit issuers from refusing to effectuate new coverage due to failure to pay outstanding premium debt from the previous year. NAHU understands your position that outstanding debt does not supersede the intent of the guaranteed availability of coverage provisions. However, as noted in the preamble, this change to the rules will at least create the possibility of individuals gaming the system to obtain months of "free" coverage. While we cannot predict how many individuals will partake of this loophole, we do know that its very existence, combined with the requirement that insurers forgive prior debts, will affect premium costs. Additionally, we note that all the evidence and concerns listed in the preamble to support this decision are centered on low-income people who may be prohibited from obtaining coverage in the individual market. Businesses that fail to pay their group premiums are an entirely different matter. However, as written, this proposed change would apply to both the individual and employer markets, causing the possibility of higher premiums for all in both to subsidize the transgressions of a few. NAHU members ask you to consider the cost impact for all this proposal could create and, at minimum, limit the change to the individual market.

Changes to Provisions and Standards of Conduct to Prevent Discrimination Based on Sexual Orientation and Gender Identity

NAHU supports the numerous proposed changes to revert to pre-2020 nondiscrimination protections. NAHU opposed the prior regulatory changes that removed the definition of "on the basis of sex" and we endorse the return to the original definitions and protections, which explicitly prohibit discrimination based on sexual orientation and gender identity. Our association is committed to inclusion and does not stand for discrimination of any kind. Additionally, we feel that clarity in the federal nondiscrimination rules will be very helpful for health insurance issuers, group and individual health insurance plan sponsors, health insurance exchange marketplaces, health insurance agents, brokers and web-brokers, and all others who assist individuals and employers with obtaining and maintaining health insurance coverage. The proposed changes to the federal rules should also help address any potential group plan compliance issues that have lingered even after the Supreme Court of the United States' decision in *Bostock v. Clayton County.*

New Standards of Conduct for Agents, Brokers and Web-Brokers

NAHU members support all the new standards of conduct for agents, brokers, or web-brokers who help people purchase and enroll in health insurance coverage and apply for premium tax credits and cost-sharing reductions through the federally facilitated exchange marketplace and state-based exchanges that rely on the federal platform. The first of these changes would expand on and codify the existing requirement that agents, brokers and web-brokers provide correct information to the exchanges. The new requirements provide specific examples of what it means to provide correct client information to the exchanges, especially concerning the consumer's email address, mailing address, telephone number and household income projections. Our association does not condone any agent or broker providing incorrect information about a client to the exchange or submitting consumer information to an exchange without an applicant's consent and knowledge. However, we believe that providing more clarity about what constitutes acceptable practices can only help compliance and consumer protection and reduce the number of bad actors preying on consumers in the marketplace.

Similarly, NAHU supports the new proposed standards that say that agents, brokers, and web-brokers may not engage in scripting and other automation of interactions with CMS systems or DE pathways unless approved in advance in writing by CMS. Again, our association does not condone any situation where an agent or broker is involved in unauthorized enrollments, unauthorized application changes or unauthorized access to a consumer's protected information. We understand that these automated interactions have increased the likelihood of this type of fraudulent behavior, which harms consumers, the health insurance exchange marketplace, and honest agents and brokers alike. However, our association does note that certain web-broker interactions with the federally facilitated exchanges and state-based exchanges that rely on the federal platform do involve automation. As such, we appreciate the design of the proposed rule to allow the limited instances when legitimate automation is necessary in connection with CMS systems or DE pathways when approved in advance in writing by CMS. That way, when automation is necessary for genuine business purposes, a channel is available to achieve it.

We also believe the new clarification that brokers and agents must ensure all exchange-based identify-proofing uses the identity of the actual consumer is warranted. Clearly this identity-proofing process is intended to protect consumers.

Ensuring that the process cannot be circumvented is critical to preventing unauthorized enrollments, identity theft, and fraud.

Finally, we support the new rules that will ensure that when helping individuals with eligibility for a special enrollment period, agents, brokers, and web-brokers will obtain authorization from the consumer to submit the request for a determination of eligibility for a SEP. These rules also establish an explicit requirement that agents, brokers and web-brokers make the consumer aware of the specific triggering event for the SEP eligibility-determination request being submitted on the consumer's behalf. Again, while our association in no way condones fraudulent behavior by any individual enrolling others in health coverage, we believe that creating clear, enforceable standards will both help mitigate consumer harm and protect the thousands of honest agents and brokers who help consumers with their coverage options every day.

Verification Process Related to Eligibility for Insurance Affordability Programs—Employer-Sponsored Plan Verification
The proposed rule would revise the verification process health insurance exchanges must undertake to determine if individuals are truly qualified to be premium tax credit recipients due to their eligibility status for qualified employer-sponsored coverage. Moving forward, each exchange would have the flexibility to tailor its employer-sponsored plan-verification process based on its assessment of the risk of inappropriate eligibly determinations and the composition of their enrolled population. NAHU members have concern with this approach.

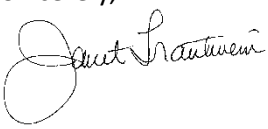
Based on the role many of our members have in assisting employer group plan sponsors with their health plan-enrollment processes and compliance with the ACA's employer shared responsibility requirements, we believe that there are many instances where individuals receive exchange-based premium tax credits inappropriately. Inappropriate tax credit awards do not just create tax consequences for the individual enrollees, but also liability concerns for any involved applicable large employers (ALEs). Each year, thousands of ALEs are issued IRS 226-J letters because one or more of their employees received an advance premium tax credit through an exchange. Given the number of employer shared responsibility penalties that have been eliminated or abated over the years, many individuals do receive premium tax credits inappropriately. The process of IRC 4980(h) penalty enforcement is an arduous and costly one for both the IRS and the affected employers. NAHU members have long held that more effective eligibility verification at the exchange level would greatly reduce the volume of enforcement actions that are ultimately resolved by ceding that the ALE did offer qualified coverage. While we understand that the existing verification process is not effective, we urge CMS to reconsider working with the IRS to improve the process on a national level rather than simply not enforcing the existing process (as has been done over the past several years) or abandoning a cohesive process for a patchwork exchange-based one.

Requiring Essential Health Benefit Design Standards to Be Based on Clinical Evidence
NAHU members support the proposed change to the essential health benefit (EHB) design criteria to require the use of clinical evidence during plan design, including when determining plan exclusions and making coverage decisions. This change would apply to health insurance issuers offering coverage in the individual and small-group health insurance marketplaces. While EHB benchmark standard enforcement will still be primarily the role of state insurance regulators, the preamble to the proposed rule indicates that CMS will be able to assist the states with technical assistance, data,

and research. NAHU members believe this approach will reduce discriminatory benefit designs in the individual and small-group markets and will help reduce the liability of small-group plan sponsors that are entirely reliant on their issuers to offer non-discriminatory products that meet the standards of other laws, such as the Mental Health Parity and Addiction Equity Act. Further, since small-group health insurance product design often influences large-group fully insured coverage offerings and self-funded plan designs, the proposed change will likely have a beneficial effect in other health insurance market spaces. The examples of what types of practices would be considered discriminatory, and the specification that the source of the discriminatory benefit design is immaterial even if it is state-level mandated benefit statute, are very helpful. To further their reach, should these provisions be finalized, NAHU members suggest that CMS publish sub-regulatory guidance further clarifying what are (and are not) discriminatory practices.

NAHU appreciates CMS's consideration of our feedback on this proposed rule, as well as the feedback of other stakeholders. If you have any questions about our comments or need more information, please do not hesitate to contact me at (202) 595-0639 or jtrautwein@nahu.org.

Sincerely,



Janet Stokes Trautwein
Executive Vice President and CEO
National Association of Health Underwriters