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

January 8, 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

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 2025."

The members of NABIP work on a daily basis to help millions of individuals 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. We've broken our comments down by relevant section of the proposed rule. This letter was developed by a group of agents and brokers who routinely work with individual market health insurance exchange consumers and other consumers who would be affected by the proposed rule, so it reflects the views of experts who fully understand the needs and interests of today's individual and group health insurance consumers.

Section 1332 State Innovation Waivers—31 CFR 33 and 45 CFR 155
This proposed rule would amend to allow states the flexibility to hold a state public hearing or post-award forum in a virtual or hybrid format and consider that the equivalent of holding an in-person meeting. NABIP supports this change and believes it will increase public participation in the waiver-approval process.

Medicaid Eligibility Calculation—42 CFR 435.601(d)
This measure would give states with greater flexibility to adopt income and/or resource disregards in determining Medicaid financial eligibility for individuals excepted from application of financial methodologies based on modified adjusted gross income (MAGI) so that they can target disregards at discrete members of individuals within an eligibility group. NABIP members support this change.

Basic Health Plan Effective Eligibility—42 CFR 600.320(c)
NABIP supports this provision of the proposed rule, which would give states that create a Basic Health Plan option the ability to make the effective date of this coverage on the first day of the month following the date of application.

Changes for States That Wish to Begin a State-Based Exchange—45 CFR § 155.105(b)
The proposed rule would require that all states that want to transition from the federally facilitated marketplace to a state-based exchange operate as a state exchange on the federal platform for at least one plan year, including its open enrollment period. Further, the proposed rule would significantly expand HHS's authority over states that are seeking to create a state-based exchange by giving HHS more authority to require information from states as part of their exchange blueprint and approval process. NABIP opposes all of these changes.

The ACA clearly gave states the ability to create their own exchanges and outlined a specific process for doing so. We believe that the proposed rule goes above and beyond the intention and scope of the statute. Further, almost uniformly, states that have elected to transition to their own exchanges have done so without any issue and are quite successfully meeting the needs of their populations, often at much lower cost than when they participated in the federally facilitated marketplace. Unless a state proposes an exchange that would differ on extreme level from the traditional model, we see no such need for additional federal controls.

Essential Health Benefits (EHB) Benchmark Changes—45 CFR § 155.170(a)(2)
This measure proposes to codify that benefits covered in a state's EHB benchmark plan would not be considered in addition to EHB, even if they had been required by state action taking place after December 31, 2011, other than for purposes of compliance with federal requirements. This change would eliminate the obligation for the state to defray the cost of a state mandate enacted after December 31, 2011. NABIP opposes this change, as we believe it is directly in conflict with both the intent of the ACA and the statute.

Exchange Call Centers—45 CFR § 155.205(a)
NABIP endorses the proposed new requirement that would require most FFM call centers to provide consumer access to a live representative during the exchange's published hours of operation to provide application assistance. NABIP agrees with CMS that this proposed standard will help reduce consumer frustration, reduce unnecessary follow-up and lead to fewer application errors. In our view, this should be the minimum standard, and should apply to all exchange call centers.

Centralized Eligibility and Enrollment Platforms—45 CFR § 155.205(b)(4) and § 155.205(b)(5)
This measure would require all exchanges to operate a centralized eligibility and enrollment platform on the exchange's website and perform eligibility determinations for all consumers based on submission of a single, streamlined application. Further, the proposed rule would clarify that the exchanges, or their direct contractors, are the only entities that could make eligibility determinations on behalf on the exchanges. Finally, all exchanges would be required to maintain record of all effectuated enrollments in qualified health plans (QHPs), including changes in effectuated QHP enrollments. NABIP supports these changes.

Establish the CMS Administrator as the FFM Reconsideration Entity—45 CFR § 155.220(h)
The proposed rule would specify that if HHS decided to terminate an agent's, broker's or web-broker's authority to work with consumers in the federally facilitated exchange marketplaces, then the individual or entity can submit a request to the CMS administrator to reconsider HHS's decision to terminate their

exchange agreement(s) for cause. NABIP appreciates the clarity this proposed regulatory specification provides.

Standards for Web-Brokers and Direct-Enrollment Entities—45 CFR §§ 155.220 and 155.221
This measure would extend minimum web-broker and direct-enrollment (DE) entity standards to apply across all exchanges, including in states with state exchanges, as opposed to simply providing those standards for the federally facilitated exchange marketplaces. These requirements would apply to website displays of standardized comparative information, disclaimer language, information on eligibility for tax credits and cost-sharing reductions, operational readiness, and access by downstream agents and brokers.

The proposed rule would also require all DE entities to update their websites to reflect any changes on HealthCare.gov within a notice period set by HHS. The new rule would permit entities to request deviations from the required display changes, but establish some changes that would still need to be clearly and prominently displayed. Similarly, state exchanges would have to require their DE entities to implement and prominently display changes on their non-exchange websites.

NABIP supports these changes, as our members who are active in the web-broker and DE space report that they appreciate the framework the federally facilitated marketplaces provide for them, and would appreciate uniformity in consideration and standards across state-based exchanges.

Initial Warning to Tax Filers—45 CFR § 155.305(f)(4)
NABIP members strongly agree that all exchanges should be required to send notices to advance premium tax credit (APTC) recipients who fail to reconcile their APTC so that they know they need to do this, or they will be deemed ineligible for a tax credit if they fail to file and reconcile for a second consecutive year. Our members have had longstanding concerns about individuals who may have made tax errors regarding APTCs and the related financial repercussions. We believe any warning to these vulnerable consumers is appropriate.

Incarceration Status Verification—45 CFR § 155.315(e)
This measure will allow state-based exchanges to accept individual incarceration status attestations without further verification, and instead verify their status with an HHS-approved verification data source. NABIP supports this proposed change.

Deceased Enrollees—45 CFR § 155.330(d)
The proposed rule would require all exchanges to conduct checks for deceased enrollees twice yearly and subsequently end their coverage. It would also allow the secretary the authority to temporarily suspend the periodic data matching during certain situations (for example, a declared national public health emergency). NABIP supports this proposed change, as not only will it help align the state exchange with FFM practices, but it will also be very helpful for the families of the deceased individuals.

Catastrophic Coverage Reenrollment—45 CFR § 155.335(j)(1) and (2)
This measure would require all exchanges, including state-based, to re-enroll individuals enrolled in catastrophic coverage into a new QHP for the coming plan year, if the issuer does not continue to offer a catastrophic plan for the new plan year, or these individuals are no longer eligible for enrollment in a

catastrophic plan for the new year, and these individuals do not actively select a different QHP. NABIP understands that this is already the practice for federally facilitated exchanges; however, we have concerns with this practice. In general, our membership would prefer that all exchange beneficiaries to be actively encouraged to review their plan choices themselves annually and make an informed decision about their coverage choices rather than be subject to automatic reenrollment. The practice of reenrolling someone automatically from a catastrophic plan to a QHP, which are two very different products, is particularly disturbing. Our association believes each individual should have the opportunity to select the health-coverage product that best meets their individual needs and budget.

Issuer Flexibility—45 CFR § 155.400(e)(2)
NABIP supports how the proposed rule would codify existing flexibility for issuers experiencing billing or enrollment problems due to high volume or technical errors and not limiting it to extensions of the binder payment.

State Exchange Open Enrollment Period Dates—45 CFR § 155.410(e)(4)(ii)
NABIP strongly objects to the component of the proposed rule that would require state-based exchanges to mirror their open enrollment periods exactly to the federal exchange, meaning that they must begin open enrollment on November 1 of the calendar year preceding the benefit year and end it no earlier than January 15 of the applicable benefit year. The proposed rule would give the state-based exchanges the option to extend the open enrollment period beyond January 15 of the applicable benefit year, but it would not allow them to begin open enrollment earlier or change the overall dates.

Our association notes that the ACA specifically did not define the open enrollment period dates for the exchanges, and the November 1-January 15 open enrollment dates that are currently employed by the federally facilitated exchanges are a relatively recent HHS construct. Further, the ACA allows for state-based exchanges so that the states may make their own choices that are in the best interest of their populations. NABIP believes that it is imperative that these choices extend to the dates and lengths of their open enrollment periods.

Effective Dates of SEP Coverage—45 CFR § 155.420(b)
NABIP supports the proposed change to align effective dates of coverage after selecting a plan during certain special enrollment periods across all exchanges, including state-based exchanges. This measure would require all exchange marketplaces to provide coverage that is effective on the first day of the month following plan selection, if a consumer enrolls in a QHP during certain special enrollment periods. NABIP agrees that this change would prevent coverage gaps and would be beneficial to consumers in all states.

SEPs for Individuals with Projected Family Incomes Below 150% FPL—45 CFR § 155.420(d)(16)
This measure would change the special enrollment period (SEP) for tax-credit eligible individuals for people with projected family incomes below 150 percent of the Federal Poverty Level (FPL), so that all exchanges have the option to permanently provide this special enrollment period. While NABIP does not have concerns about this particular change to the SEP, we feel obliged to caution about the increased frequency and availability of SEPs generally, and overall eligibility enforcement.

Retroactive Terminations for Medicare-Eligible Individuals—45 CFR § 155.430(b)(1)(iv)(D)

NABIP members wholeheartedly endorse the provision of the proposed rule that would allow enrollees to retroactively terminate their QHP enrollment effectuated through a federally facilitated exchange when the individual enrolls in Medicare Parts A or B. This termination date would be retroactively effective to the day before Medicare coverage begins. Our members who work with Medicare beneficiaries on their coverage needs believe that this is a critical change, as most seniors do not manage to perfectly align the end of their individual QHP enrollment with the commencement of their Medicare coverage. Retroactive termination will not only save these individuals in unnecessary expenditures of premium dollars, but also alleviate administrative issues for this population.

Our members who work within the individual market also note that it is a complex process to cancel beneficiaries on applications where one household member ages into Medicare and their younger spouse must stay covered under the QHP. In recent years, members have received conflicting answers and witnessed conflicting processes within the Healthcare.gov call center regarding these enrollments. In some cases, beneficiaries were advised to contact the marketplace on the last day they needed coverage (end of the month). In other circumstances, they had to call on the first day they needed to be removed (first of the month). If they call on the wrong day, under current regulations, the beneficiary is forced to keep coverage for an additional month, which causes undue harm. By allowing for retroactive terminations, under the proposed rule, more consumers will have a method to terminate QHP plans on the proper date.

Finally, the proposed rule would make the retroactive terminations optional for state-based exchanges and requests comment on whether a final rule should make the requirement mandatory for them. NABIP strongly believes that all Medicare beneficiaries should have the option to retroactively terminate their coverage, regardless of the state in which they purchased exchange-based coverage.

Network-Adequacy Standards—45 CFR § 155.1050

The proposed rule would require all state-based exchanges, including those on the federal management platform, to establish and impose network-adequacy controls, including quantitative time and distance network-adequacy standards for QHPs and conducting quantitative network-adequacy reviews prior to certifying any plan as a QHP, that are at least as strict as the controls currently being imposed by the fully federally facilitated exchange. In addition, the proposal would require enhanced data reporting by the state-based exchanges regarding telehealth benefits and a participation in a CMS-based process for states that cannot meet certain network-adequacy standards.

NABIP has concerns with this proposal since almost all state-based exchanges have their own, very robust network-adequacy standards and this would force them to adopt different and likely at least partially duplicative processes, as well as require additional administrative reporting. Since CMS has the authority to take remedial action with states that do not have sufficient network-adequacy standards and systems in place already (which is a very small minority of state-based exchanges), we would suggest that CMS focus on those deficient states. All states with sufficient standards can easily be identified and allowed to continue with their current endeavors, which in many cases are even more stringent and progressive than the federally facilitated marketplace. CMS could embark on an initial identification process now, then establish network-adequacy competency during the approval process for any new state-based exchange.

State Selection of EHB-Benchmark Plans—45 CFR § 156.111
This measure would make changes to the process states must engage in to select or revise their EHB benchmark plans after January 1, 2027. The current standards were adopted in 2019; since then, states have indicated that they are both overly burdensome and actually impedes a state's ability to select a plan design that is as or more generous than a typical employer plan, as these plans have begun to typically cover more services voluntarily over time, such as telehealth benefits, gender-affirming care, bariatric surgery, hearing aids and others. Also, the current process requires the state to document formulary information even if the state is not seeking to change its formulary. The proposed rule would change these processes to make it easier for states to select their plans and only require formulary information in the case of change to prescription drug benefits. NABIP supports these EHB process adjustments.

Option to Expand EHB Coverage to Include Routine Adult Dental Care—45 CFR § 156.115(d)
The proposed rule would give states the option to add routine adult dental services as an essential health benefit. Currently, issuers are required to include pediatric dental services as part of the ACA's EHB standards. However, traditional health insurance issuers do not typically specialize in dental care. Therefore, their dental provider networks for pediatric coverage are small and their benefits are very limited. Our members already have to explain to clients about the limited pediatric services available to them, and there is no reason to believe that traditional medical carriers will expand their services should dental coverage become an EHB requirement for adults. Dental health is extraordinarily important, and dental carriers specialize in this coverage and benefits. Forcing medical carriers to assume a role they are unsuited to, with the result of adults having access to substandard benefits, is a poor idea. Not to mention that if a state were to include adult dental coverage as an EHB, then premiums would rise to account for those increased benefits, no matter how limited, thereby increasing costs for both individual consumers and the federal government through an increase in APTC expenditures.

Additionally, the proposed rule seeks comment as to whether or not CMS should allow states to include vision care for adults and/or long-term care as EHBs. NABIP strongly opposes both of these ideas for the same reasons we have concerns about the extension of dental coverage to adults.

Prescription Drugs—45 CFR § 156.122
The proposed rule would amend § 156.122 to codify that prescription drugs in excess of those covered by a state's EHB-benchmark plan are considered EHB. As a result, they would be subject to requirements, including the annual limitation on cost sharing and the restriction on annual and lifetime dollar limits, unless the coverage of the drug is mandated by state action, in which case the drug would not be considered EHB. NABIP supports this change since, as noted in the proposed rule, currently some plans are asserting when they cover additional medications in excess of the EHB rule's drug-count standards, and consider those drugs as "non-EHB," which we believe to be contrary to the 2013 rules, as well as a confusing practice that is detrimental to consumers. Making this clarification should result in all carriers and PBMs in the marketplace treating these medications in the same way.

The proposed rule would also require health plans and issuers to include a consumer representative on their Pharmacy & Therapeutics (P&T) committee for plan years beginning on or after January 1, 2026. NABIP members have concerns about the feasibility and practicality of this proposal. As the proposed rule notes, issuer and PBM P&T committees are composed of actively practicing physicians, pharmacists

and other healthcare professionals. If finalized, insurers would be required to select a consumer representative with experience in public health and the analysis and interpretation of complex pharmaceutical and medical data. Further, these people could not have a fiduciary obligation to a health facility or other health agency and must have no material financial interest in the rendering of health services. Finding individuals who would be willing to engage in such services for no compensation would be next to impossible, and it would expose these individuals to confidential information and potential trade secrets.

Exceptions Process to Offer More Non-Standardized Plan Options—45 CFR § 156.202
The proposed rule would allow an exception process so that issuers could offer more than two non-standardized QHP options per product network type, metal level, inclusion of dental and vision benefit coverage, and service area for PY 2025 and subsequent plan years. The exception would be granted if the issuer could demonstrate that these additional non-standardized plans have specific design features that would substantially benefit consumers with chronic and high-cost conditions. NABIP members support this proposed change.

CO-OP Loan Terminations
This measure would create a new regulatory provision to allow ACA CO-OP loan recipients to voluntarily terminate their loans and cease to be a CO-OP so that they can pursue new business plans that do not meet the ACA's governance and business standards for CO-OPs. All outstanding CO-OP loans would need to be repaid in full prior to termination. The proposed rule contends that allowing the CO-OPs to terminate their loan agreements would enable them to expand their operations and offer additional health insurance products while maintaining their non-profit status. Given that there are only three CO-OPs still in operation, NABIP is not sure how much additional market power this proposed change will bring, but we do not object if the federal government is made whole and all loan funds are repaid.

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 John Greene, senior vice president of government affairs, at jgreene@nabip.org or (202) 595-3677.

Sincerely,

John Greene
Senior Vice President of Government Affairs
National Association of Benefits and Insurance Professionals