January 30, 2023

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-9899-P

Dear Administrator Brooks-LaSure:

I am writing on behalf of the National Association of Benefits and Insurance Professionals (NABIP), a professional association representing over 100,000 licensed health insurance agents, brokers, general agents, consultants, and employee benefit specialists. We are pleased to respond to your proposed rule titled "2024 Notice of Benefits and Payment Parameters," published in the *Federal Register* on December 21, 2022.

The members of NABIP work daily to help millions of people purchase, administer, and utilize health insurance coverage, including individuals purchasing private individual-market coverage and employers of all sizes who are designing and purchasing group coverage for their employees and their dependents. As such, we are pleased to be able to provide comments on the proposed rule. To develop our comments, we sought input from members who specialize in individual-market sales, as well as those who work directly in group employee benefit plan compliance. We grouped our comments by topic, as addressed in the proposed rule.

Prescription Drug Cost-Sharing Tier Placement

The federal exchange marketplace uses four standard tiers of prescription drugs for its formularies: generic, preferred brand, non-preferred brand and specialty drugs. The proposed rule would not only retain this tier structure, but also require all issuers to place covered drugs in the appropriate cost-sharing tier unless there is an "appropriate and non-discriminatory basis" for placing the drug in the specialty tier instead. This change is proposed to address complaints of discriminatory placement of medications on high-cost tiers by certain issuers, and NABIP supports the proposal.

Limits to Standardized Plan Options or Meaningful-Difference Changes

To reduce consumer confusion, the proposed rule would limit the number of non-standardized plans that issuers can offer through the federally facilitated exchange or state-based exchanges that utilize the federal marketplace platform to two per product, network type and metal level, by service area. Based on the proposed rule's own estimates, this change would cause

approximately 2.72 million current enrollees to have their plans discontinued in 2024, requiring issuers to place all these individuals in new coverage options.

As an alternative, the rule also contemplates reinstating the “meaningful-difference standard” that issuers were required to abide by several years ago. According to that standard, plans designs offered by issuers had to be different enough that an exchange shopper could easily differentiate between them. However, the proposed rule considers an even stricter standard, proposing to group plans by issuer ID, county, metal level, product network type and deductible integration type, and then evaluate whether plans within each group are meaningfully different, based on differences in deductible amounts of at least $1,000. The proposed rule seeks comments on both potential approaches.

NABIP members assist consumer in evaluating coverage options every day, so our members understand the overwhelm exchange consumers without adequate guidance may feel when confronted with dozens of seemingly similar plan choices. However, our membership also values the innovation and price controls increased plan competition brings, and believes that consumers should have a wide range of plan choices available to ensure their coverage needs are truly met. CMS’s own ZIP Code-based enrollment data shows that the highest rates of exchange coverage take-up come in ZIP Codes with the greatest number of plans participating in the marketplace, offering the greatest number of plan choices. Therefore, we can conclude that too many plan options is not an actual barrier to enrollment in coverage.

Instead, we believe that it is the consumer’s lack of ability to sort through and compare plan options easily, based on their most important coverage values. Accordingly, we recommend a third approach, one that is utilized in many state-based exchange, including Pennie and Covered California. That approach involves using technology and the customers’ preferences to narrow down plan choices and lead them to the most appropriate products. Multiple state-based exchanges ask enrollees to complete a coverage survey before beginning the enrollment process, and the answers to those survey questions filter and sort the plan results made immediately available to the prospective enrollee. NABIP members recommend the federal exchange utilize a similar approach. We suggest the use of approximately five short questions to gauge coverage preferences, focusing on the following topics: (1) any preference toward lower premiums versus lower up-front cost-sharing; (2) average coverage utilization and need for broad-based benefit design; (3) any preference toward specific providers and/or a broad or narrow network; (4) prescription drug needs; and (5) preferences toward subsidy amounts and cost-sharing assistance. Should your agency elect to utilize all or part of our proposed design, our members who work with individual consumers on their coverage needs would be happy to assist you in developing and testing potential coverage-assessment questions.

Plan Names

The proposed rule would prevent the use of misleading plan names for marketplace-qualified health plans by requiring a review of names plans are marketed under during the annual QHP certification process, in collaboration with state regulators. NABIP members support this proposed change.

Marketplace Plan Network Requirement

Currently all marketplace plans, apart from those that do not utilize a provider network, must abide by network-adequacy and essential-community-provider standards. The proposed rule would require all plans to use a network and abide by those standards. NABIP members note that this proposed change would eliminate the potential of reference-based pricing plan options from being sold in the exchange marketplace. However, given the rarity of those plans generally, and the data provided in the preamble to the proposed rule noting that since 2016 only one FFM issuer has offered a plan that does not use a provider network, NABIP members do not oppose this proposed change.

Dependents to Age 26

The federally facilitated exchange marketplace has a longtime practice of requiring issuers that cover dependent children to maintain that coverage until the end of the plan year in which they turn 26. This proposed rule would codify that operational practice for clarity's sake. State-based exchanges could implement a similar rule at their option. Any advance premium tax credits will continue to be paid during this time. NABIP members support this codification.

Establishing a Timeliness Standard for Notices of Payment Delinquency

When a plan enrollee becomes delinquent in making premium payments, current rules require issuers to send a delinquency notice, giving the enrollee appropriate time deal with unpaid premiums and avoid coverage termination. Since market examinations and audits have revealed that certain issuers are not sending delinquency notices in a timely fashion, the proposed rule contemplates enforcing a delivery timeframe and seeks comment on such a timeframe. NABIP members believe exchange consumers should have at least 30 days to correct any unpaid premium balances prior to termination.

Allowing Door-to-Door Assistance

The proposed rule would repeal current federal rules that prohibit navigators, certified application counselors and other enrollment assisters from going door to door or using unsolicited means to provide enrollment assistance to consumers. NABIP members vehemently oppose this proposed repeal of the prohibition on door-to-door solicitation.

Our association understands the concerns about enrolling transportation-challenged and immunocompromised people addressed in the preamble to the proposed rule. However, we

note that these concerns could be addressed through the use of technology, and allowing door-to-door assistance could actually put vulnerable potential exchange consumers at further risk. Not only does the proposed repeal create safety concerns for both potential enrollees and those who may approach strange homes to attempt to enroll people, it also increases the likelihood that exchange enrollees become the subject of fraud or feel pressured to make quick and inadequate enrollment decisions. Most important, allowing for door-to-door exchange coverage enrollment denigrates the product and financial decisions at stake. When selecting an exchange plan option and applying for premium tax credits, consumers need to make critical financial and health decisions that will affect their personal and monetary wellbeing for at least a year. This process should not be put on the same level as ordering cookies for delivery.

NABIP members note that when the Medicare Advantage marketplace first came into fruition, unsuspecting consumers were besieged by door-to-door solicitations by unscrupulous actors. The consumer backlash was enormous and immediate. CMS quickly banned the practice and has not looked back. It would seem unfathomable that your agency is considering allowing such a practice now for exchange-based consumers.

Rules for Brokers and Agents

The proposed rule would establish new requirements for agents, brokers and web-brokers by mandating they document that their clients (or authorized representatives) have reviewed and confirmed their eligibility information before they apply for exchange-based coverage. CMS has offered a draft model form for brokers and agents to use, and the proposed rule would require them to maintain this documentation for at least 10 years and be able to provide it to HHS upon request. The proposed rule would also require FFM and SBM-FP agents, brokers and web-brokers to document that they have received consumers' consent to assist them with a marketplace-eligibility application.

NABIP members, who would be directly affected by this new requirement, appreciate the need to verify eligibility information and consent for brokers to help individuals with their coverage needs. Additionally, we appreciate that, following the release of the proposed rule, CMS proposed a sample template document for brokers to use when documenting client consent and eligibility.

However, NABIP members feel strongly that requiring brokers to obtain and maintain such consents is not truly in the best interest of the consumer. In fact, an unscrupulous actor could easily create fraudulent consent documents and/or complete them for clients after the fact, especially since consent could take the form of either a signature or a voice recording, which could easily be faked. Instead, NABIP members would like to see a consumer's eligibility review and consent to use a broker for assistance to be built into the exchange application process, with the record-keeping becoming part of the person's official application maintained by the federally facilitated marketplace. That way, the data will be consistently available, the consent approaches

will be uniform, and all entities that assist consumers with coverage enrollment can verify consumer eligibility and assent.

Should the exchange marketplace receive notification of a change to the broker of record on an individual's account, then NABIP members propose that the exchange assume that such a transaction is valid, given that they will have the new broker's unique identifier in their national producer number (NPN) for verification and tracking purposes. In this case, NABIP proposes that the exchange consumer receive an automatic communication from the federally facilitated marketplace, ideally in writing, although electronic mail or text-messaging could be used. This notification could alert consumers to a potential change to their broker of record and inform them how to contact the exchange to rectify the matter if they did not authorize the change. NABIP members believe these simple changes to the application process would provide consumers with greater protection and peace of mind and allow CMS to better monitor broker behavior.

Income Attestations

When individuals apply for exchange-based premium tax credit subsidies, their stated income is typically verified by the exchange using tax data from the Internal Revenue Service. However, under certain circumstances, tax data is not readily available. Currently, the exchanges must treat missing tax data as if the tax data is inconsistent with the individual's stated income and create a data-matching issue to resolve. Should they fail to resolve it within 90 days, the plan premiums adjust to full cost, starting the month following the 90-day deadline.

The proposed rule would allow an individual's income attestation to stand if the tax data is truly not available, thereby not affecting the subsidy process. While our association notes that this proposal does generate minor fraud concerns, overall, this policy change is likely to help more consumers than it will result in the issuance of fraudulent tax credits. Given there are often legitimate reasons for missing tax data, using the attestation will be quicker and more accurate in most cases. Further, if an individual receives an excessive tax credit because of a faulty attestation, that will ultimately be adjudicated anyway.

Data-Matching Issue Timeline Extension

The proposed rule would give all exchange consumers a 60-day extension for resolving income-based data-matching issues. NABIP members support this proposed change.

Special Enrollment Period Changes

The proposed rule would allow for changes to exchange-based special enrollment periods (SEPs). The first would allow exchanges to require issuers to start coverage one month earlier in cases where the old coverage ends before the end of the month, to avoid gaps in coverage. If a consumer reported loss of coverage and chose a plan during the month before the old coverage ended, the proposed rule would also allow exchange coverage to begin on the first day of the

month during which the old coverage expired. The second change would extend from 60 to 90 days the window Medicaid recipients have to enroll in exchange coverage when they lose Medicaid eligibility. NABIP members support both proposed changes and note they will likely serve consumers well once the National Health Emergency ends and millions of individuals will lose their Medicaid eligibility and potentially suffer gaps in coverage.

Auto-Enrollment Changes

The proposed regulation would change the rules the federally facilitated exchange marketplace uses to auto-enroll individuals who do not proactively reenroll in their exchange-based health insurance coverage. If finalized, this regulation would change the reenrollment decision-making hierarchy in two ways. The first would allow the exchanges to switch consumers who do not proactively reenroll from a bronze-level plan to a silver-level plan so that the consumer would benefit from cost-sharing reductions, even though that means their monthly premiums could be higher. This proposed change would be allowed even if the consumer's bronze plan was still on the table, as long as the silver premium net of APTC was no greater than the bronze premium. The second change would allow for a change to the reenrollment hierarchies to factor in a preference for keeping individuals in provider networks that are like their current plan. The proposal also asks for comments on changing the auto-enrollment system and hierarchies in a wide range of other ways.

NABIP members have long expressed concern about the federal exchange's policy of re-enrolling individuals into exchange-based coverage if they do not enroll themselves proactively. Our members especially find the practice of mapping consumers into new coverage options that they did not expressly pick, without discussing other options with them first problematic. We have a particular concern with the first described proposed change, which would discount an individual's choice of coverage with a potentially lower premium even though that plan could potentially still exist. Consistent with our prior-year comments, NABIP members would prefer that all exchange consumers re-visit their benefit choices yearly with a licensed professional so that we can be assured that consumers' enrollment choices truly meet their needs, preferences and budgets.

Making the Timeframe for Creating a State-Based Exchange More Flexible

The proposed rule would reduce the amount of time a state seeking to create its own state-based exchange from at least 14 months before the state's first proposed open-enrollment period for a full state-based exchange and two months beforehand for those states seeking to move to a state-based model using the federal technology platform. States would retain the same blueprint-submission timeframe, but approval or conditional approval would now be required before the first OEP rather than months in advance of it.

NABIP supports this proposed change to the state-based exchange blueprint-approval timeframe. Our membership has been extremely supportive of the creation of state-based

exchanges, and thousands of our members nationwide serve these markets, both as agents and brokers, and as members of exchange advisory boards and in other capacities. We believe allowing states to gain quicker federal approval for state-based exchange marketplace endeavors will benefit local individual market consumers.

Exchange User Fees

The proposed rule would reduce the user fees for issuers that participate in the federally facilitated exchange marketplace and state-based exchanges utilizing the federal marketplace technology platform. The .25% reduction for each type of exchange reflects a general trend of reducing the exchange user fees, and NABIP members support it, as it will have a positive impact on both the competitive marketplace and consumer prices.

NABIP members appreciate the opportunity provided by CMS to respond to this RFI. If you have any questions about our comments, or if you need additional information or assistance, please do not hesitate to contact me at either jtrautwein@nabip.org or (202) 595-0639.

Sincerely,

Janet Stokes Trautwein
Executive Vice President and CEO
National Association of Benefits and Insurance Professionals